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People-Centered Accountability amid the Gaza Genocide: Doctors Against Genocide, Healthcare Workers Watch, and the Freedom Flotilla Coalition

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Abstract

This paper examines how people-centered accountability initiatives are operating to enforce the right to health amid Israel's genocide in Gaza. Drawing on a critical case study of Doctors Against Genocide, Healthcare Workers Watch, and the Freedom Flotilla Coalition, we situate these actors' work within

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international human rights law, social accountability scholarship, and decolonial and abolitionist critiques. We show how these actors are able to combine clinical documentation, survivor testimony, and direct action to monitor human rights violations, generate medically literate records of the harm inflicted, and press for remedies that state-centered mechanisms have failed to deliver despite findings of war crimes and genocide by United Nations bodies and human rights groups. Across these cases, we identify some common practices and tensions surrounding coalition-building, risks to documentation, navigating a media environment of mis/disinformation, and engaging strategically with institutions that often reproduce health harms or are directly complicit. We argue that these movements treat people-centered accountability as part of their professional duty and act on a mandate to prevent mass atrocity crimes rather than being silent. We conclude by outlining some practical implications for clinicians, professional associations, and health systems seeking to align their global health practice with a people-centered approach to accountability.

Introduction

Human rights policies are effective when power—state or popular—makes them operative in practice. Often, it requires both formal state mechanisms (e.g., courts, sanctions, embargoes, administrative remedies) and people-centered accountability from below (e.g., public tribunals, boycotts, demonstrations) for enforcement. The persistence of impunity for Israel's egregious human rights violations against Palestinian patients, clinicians, health systems, and people in Gaza exposes the structural frailties of state-centered human rights enforcement. It has catalyzed a proliferation of community-led actions led by health workers themselves.[1] This paper interrogates those practices by analyzing three prominent initiatives—Doctors Against Genocide, Healthcare Workers Watch, and the Freedom Flotilla Coalition—against the normative architecture of the right to health and emergent theories, such as "accountability from below."[2] We argue that these actors operationalize monitoring, review, and remedial action in ways that complement and unsettle the United Nations human rights treaty-based paradigm, pointing to a reconfigured, people-centered accountability ecology in global public health.[3]

Article 12 of the International Covenant on Economic, Social and Cultural Rights, as interpreted in General Comment 14, encompasses the state obligations to respect, protect, and fulfill health care and health protection, including by ensuring the availability, accessibility, acceptability, and quality of health-related facilities and services.[4] Yet enforcement of this and other human rights has been weakened by geopolitical asymmetries, jurisdictional limits, and the reluctance of powerful states to sanction allies.

Accountability is foundational in law, human rights, bioethics, and public health.[6] It includes criminal prosecutions, civil lawsuits, and non-judicial arrangements (e.g., truth and reconciliation commissions and national human rights commissions).[5] Human rights accountability encompasses state-level accountability (SLA) and

people-centered accountability (PCA). Accountability to affected populations is a subset of PCA.[6] In health, SLA requires states and armed actors to uphold legal obligations and ensure minimum essential services, such as those outlined in the Geneva Conventions, the Universal Declaration of Human Rights, the International Covenant on Civil and Political Rights, and other instruments.[7] PCA centers affected persons through access to information—safely providing feedback and exposing human rights violations—and active participation in designing, monitoring, and adapting aid and other programs to meet people's evolving needs and remedies.[8] It aims to make aid relevant, appropriate, and effective and to shift power dynamics from one-way aid provision to bidirectional community partnerships.

SLA is concerned with state duties to citizens and the international community. PCA includes a commitment by humanitarian actors directly to affected persons, supporting or substituting when states fail. Together, SLA and PCA are theoretically complementary, where SLA reinforces a state's obligation to provide aid and the PCA ensures that such aid is delivered adequately and responsively. In practice, however, SLA often fails the victims of war and genocide.

These shortcomings are evident in the case of the genocide in Gaza, where Israeli attacks on hospitals, ambulances, and health workers, combined with siege-induced deprivation of fuel, essential medicines, drinkable water, and food, have produced an unprecedented health catastrophe and affront international law.[9] In January 2024, the International Court of Justice ordered Israel to comply with provisional measures to prevent genocide in Gaza, which was followed by another order in March and another in May to halt the Rafah ground invasion—all of which Israel disregarded.[10] In November 2024, the International Criminal Court issued warrants for the arrest of Israeli Prime Minister Benjamin Netanyahu and Israeli Minister of Defense Yoav Gallant, citing war crimes and crimes against humanity.[11] At the time of writing, despite these actions, the genocide persists with minimal state-supported military or humanitarian intervention. Instead, many governments continue arms transfers and resist enforcing international humanitarian law or International Criminal Court warrants, and in some cases have even levied sanctions against entities raising alarm, such as appointees of the United Nations (UN) and the International Criminal Court.[12]

PCA is less dependent on state action and thus less easily immobilized by such sanctions; for example, UN Special Rapporteur Francesa Albanese continues her work while the International Criminal Court's work has been delayed. PCA resists the premise that large institutions are the only path to justice. It is guided by communities in need of redress: they determine the terms of accountability and what it entails for the harms they have endured.[13] Abolitionist traditions critique institutions built on oppression as structurally incapable of centering justice.[14] From this perspective, SLA's ineffectiveness arises from inadequate design. Poet and activist Audre Lorde famously wrote, "the master's tools will never dismantle the master's house."[15] The UN has been criticized for enabling the 1948 Nakba (Zionist paramilitary-led ethnic cleansing of Palestine and violent displacement of Palestinians).[16] PCA holds that accountability for genocide cannot be dictated by those enabling it or distant from affected communities.

Against this backdrop, Doctors Against Genocide, Healthcare Workers Watch, and the Freedom Flotilla Coalition represent coalitions of health care workers, civil society, and parliamentarians who refuse the role of passive witnesses. Their praxes exemplify human rights globalization: translocal networks translating global norms into localized, insurgent institutional practices, thereby expanding who enforces human rights and how. In this analysis, we proceed as follows: we apply a PCA lens to these three cases, distill cross-cutting lessons (e.g., coalition dynamics, engagement with legal and multilateral forums, the ethics and security of documentation, and mis/disinformation), and conclude by charting direct, practical steps for clinicians, professional bodies, and civil society.

Case studies of grassroots movements

Case study 1: Doctors Against Genocide

Founded in 2023, Doctors Against Genocide is a coalition of thousands of health care workers responding to Israel's genocide in Gaza, often claiming they are "Sick from Genocide."[17] The organization frames accountability as an explicitly preventive, clinician-led duty grounded in both legal and medical reasoning, treating genocide as a measurable public health and human rights emergency demanding early warning, triage, and intervention. It defines accountability as the obligation to avert mass death rather than merely document it, anchoring this obligation to the settled protections of humanitarian and international human rights law, which require uninterrupted access to care and categorical respect for medical personnel and facilities. A combination of clinical "signs"—including forced starvation, blockade, the systematic destruction of health care, mass deaths, child suffering, and incitement—can constitute a diagnosis of genocide.

Doctors Against Genocide blends clinical documentation, open-source investigation, and survivor testimony to meet evidentiary standards while minimizing risk. It co-designs campaigns with survivors and uses community consultation to determine advocacy priorities. Its collaborative submission to the UN Special Rapporteur on the right to health brought clinician testimonies, hospital-based observations, humanitarian field notes, satellite imagery, and time-stamped media to show recurring hospital raids, impeded evacuations, and deliberate deprivation of determinants of health.[18] The submission further illustrated how clinically anchored indicators can be organized into an accountability record that is intelligible to investigators and adjudicators, reframing physicians' retrospective witness as a sentinel for atrocity prevention.

Doctors Against Genocide couples these documentation practices with a repertoire of remedial actions that targets both professional gatekeepers and state actors, thereby attempting to shift the locus of accountability from distant courts to present harm reduction. Its advocacy includes petitions and open letters to national medical associations, public-facing campaigns that reframe complicity as a breach of professional ethics and human rights, and legislative briefings that argue for embargoes and humanitarian access as health interventions. Their organizers have frequently protested inside the United States Congress and been subject to arbitrary detention and arrests.[19] Doctors Against Genocide situates this work within the growing body of normative and policy commitments that require states and armed actors to protect health services in war, and it leverages the authority of clinicians to press for compliance and sanctions. This strategy mirrors what public health and humanitarian scholars have urged for a decade—namely, that attacks on health care demand an immediate protective response by governments, donors, and professional bodies.

Although legal outcomes remain slow and contested, the organization's campaigns have normalized a clinical vocabulary for genocide risk and delineated a predictable epidemiology of health system collapse—marked by excess deaths from trauma, sepsis, obstetric complications, and chronic disease when hospitals are targeted, ambulances obstructed, and supply chains disrupted. Doctors Against Genocide reframes "medical neutrality" as a mandate for care and prevention, rather than professional quietism. By fusing legal prohibitions, clinical evidence, and professional ethics into a single practice of accountability, the organization demonstrates how PCA can complement and pressure SLA.

Doctors Against Genocide also challenges the notion that medical neutrality requires political neutrality by recognizing that every physician advocates for a system, even if that system is a status quo. PCA can begin by identifying one's own place in the power structure and how politics is ever present in medicine.

Case study 2: Healthcare Workers Watch

Launched in 2023 by Palestinian physician Muath Alser, Healthcare Workers Watch documents attacks on Palestinian health personnel and facilities,

operating in an environment of mis/disinformation propagated by state actors and international media.[20] Healthcare Workers Watch emphasizes its independence and its mandate to document human rights violations experienced by health care workers, drawing on a network of advisors skilled in Gaza's health system and in quantitative and qualitative methods. This blends rapid incident verification with clinical interpretation, positioning outputs as medically literate, people-driven evidence in relation to international humanitarian law and human rights standards protecting medical personnel and facilities. Healthcare Workers Watch triangulates direct contacts with peers and families, verified clinician social media, and formal channels. Reports are often corroborated through multiple contacts and first-person testimonies collected with informed consent in Arabic or English and translated by native speakers.

Healthcare Workers Watch has synthesized extensive primary data by documenting both direct harms to individual clinicians and the functional collapse of specialist care.[21] It corroborates hundreds of killings and widespread detention of health care workers, often with severe ill treatment and death in custody. It details the disproportionate loss of senior clinicians in key specialties that were already limited pre-genocide and analyzes the cascading impacts on pathology, nephrology, radiology, and plastic surgery, as well as the knock-on effects on triage, theater capacity, and post-operative care. Healthcare Workers Watch is able to support accountability mechanisms by substantiating reports on attacks on health care, which in turn feed international media reports, prompt further advocacy efforts, and provide a citable source for legal actions.

Case study 3: Freedom Flotillas

The Freedom Flotillas are nonviolent maritime interventions challenging Israel's naval blockade while attempting to deliver aid and spotlight siege-related harms. Originating through the Free Gaza Movement and later coordinated by the Freedom Flotilla Coalition, the flotillas combine symbolic action with cargo (food, medical supplies, and mobility devices) and rely on public documentation of at-sea encounters to shift diplomatic and legal discourse. From 2008 to 2016, 31 boats sailed.[22] The Freedom Flotilla Coalition describes itself as civil society-led, aiming to break the blockade rather than substitute state relief channels it views as structurally constrained. Cargo prioritizes medical and pediatric needs.[23] The boats function as instruments to expose SLA failures.

On May 31, 2010, Israeli forces boarded vessels in international waters, killing 10 activists on the *Mavi Marmara*, including several at point-blank range.[24] The episode prompted widespread diplomatic fallout and a temporary easing of certain blockade restrictions. The UN Human Rights Council's fact-finding mission prioritized civilian protection and documented blockade-related harms to health and welfare, concluding that the blockade and the interception were unlawful due to disproportionate harm and collective punishment.[25]

In the years that followed, flotilla strategies adjusted to the new political climate while preserving a medical-humanitarian register. In 2011, Freedom Flotilla II, involving more than 300 participants, did not sail as planned after Greek authorities imposed a ban on departures to Gaza, citing safety reasons. The move was welcomed by Israel and some international actors but criticized by organizers, who argued that state-administered alternatives diluted scrutiny of the blockade's human impact. Only the French yacht *Dignité Al Karama* reached international waters near Gaza before being intercepted and towed to Ashdod.[26] In 2015, Freedom Flotilla III launched with the Swedish-flagged *Marianne*, which was stopped by the Israeli Navy about 100 nautical miles from Gaza and brought to Ashdod. Organizers said the boat carried limited aid and a symbolic gift for Palestinian fishers, using the voyage to refocus attention on the combined effects of the blockade on livelihoods, food security, and access to care. Activists were subsequently detained and deported.

In the summer of 2018, amid the Great March of Return, two vessels, *Al Awda* and *Freedom*, and their support yachts, *Mairead* and *Falestine*, were intercepted in international waters.[27] Cargo mani-

fests included nebulizers, surgical disposables, and mobility aids to illustrate how a chronic blockade turns routine conditions into emergencies. Documentation protocols anticipated interdiction and detention, reinforcing advocacy on the discordance between the blockade and the right to health and humanitarian access.

The 2024–2025 missions continued under harsher conditions. An April 2024 mission was delayed and rerouted after flag withdrawals and political pressure.[28] In May 2025, the Freedom Flotilla Coalition reported that its passenger vessel *Conscience* was struck by Israeli drones off Malta while at anchor awaiting additional passengers.[29] In June 2025, the small aid boat *Madleen* departed from Catania with baby formula, flour, rice, prosthetics, and medical kits. It was intercepted by Israeli naval forces in international waters and towed to Ashdod.[32] In July 2025, the trawler *Handala* was seized in international waters; the coalition's press statements framed both operations as violations of international law and of the International Court of Justice's orders on humanitarian access during the ongoing genocide.[30] The Global Sumud Flotilla, consisting of 42 vessels and 462 participants from more than 44 countries and territories, was intercepted in October 2025 in international waters, and its members were kidnapped. It marked the largest attempt to date to break Israel's naval blockade of Gaza, having reached the closest to its territorial waters. It was followed up shortly by nine vessels in the *Thousand Madleens* to Gaza.

These flotillas served as a test of civil society attempts to breach the blockade, document Israel's treatment of civilian crews and medical cargo, and inform growing scholarship and jurisprudence on the legality and health consequences of the blockade.

Tensions, ideals, and prospects for people-centered accountability

Coalition-building and accountability from below

Gaza exemplifies several tensions, ideals, and prospects of PCA and human rights from below. PCA can circumvent SLA's limits, especially when perpetrators are states. Doctors Against Genocide embodies this through its dedication "to succeeding where global governments have failed in confronting genocide."[31] Reflecting growing impatience with legacy professional bodies, Doctors Against Genocide affirms parallel, anti-genocide structures rooted in indivisible human rights and the sanctity of health, challenging the complicity of associations such as the American and Canadian Medical Associations. PCA actors address urgent needs from below: Healthcare Workers Watch documents attacks; Doctors Against Genocide raises public awareness and presses for interventions; and the International Committee of the Red Cross, Doctors Without Borders, and the Palestine Red Crescent provide medical aid.

That said, the mobilization and implementation of PCA under such an extreme and geopolitically precarious environment can be fraught with practical tensions and logistical barriers. For instance, the operational viability of PCA groups is directly undermined by deliberate state actions such as the weaponization of starvation and the systematic destruction of infrastructure and health care services. Furthermore, PCA organizations can face internal tensions relating to ideological values, the mode and degree of their interventions, and their target populations. For instance, on matters such as Israel's military assault on Iran, Syria, and Lebanon, PCA organization members may disagree on strategy, word choice, public statements, and calls to action. Cultural gaps can exist across internationally joined coalitions and social movements, especially broad-based coalitions, whose members may find discomfort, disagreement, or even radically opposed stances on a myriad of other sociopolitical issues. Consequently, a critical necessity emerges to delineate and distinguish coalition-building (inherently strategic- and issue-based) and deeper, reciprocal alliances involving mutual expectations and conditions.

Shared concerns and goals do not always imply shared belief systems and ideologies. Effective PCA coalition-building involves conscientiously avoiding conditional solidarity. Involved parties

can collaborate on shared concerns for Palestinian liberation without presupposing ideological or political alignment on other, even related, matters. This approach can help prevent the instrumentalization of solidarity and can aid in preserving the autonomy and integrity of each group's core principles and priorities, ensuring that activist participation comes from genuine concern for human dignity. While other deeply interrelated matters—such as colonialism, carceralism, women's health, racial prejudice, climate harms, and threats to migrants—exist in Palestine, effective global advocacy for the genocide in Gaza cannot, and should not, be conditional on the expectation of reciprocity (even though it often emerges naturally regardless). Practical coalition-building relies on strategic commonalities, not comprehensive ideological coherence, and supports claims that participation from advantaged group allies can positively influence public perceptions of disadvantaged groups.[32] Allies need not share identical ideological frameworks or worldviews with the groups they support, as their presence alone can amplify movement legitimacy, reduce negative stereotypes, and foster greater public support.[33]

Coalition politics also introduce practical and normative tensions. The constituencies mobilized for Gaza include hospital unions, faith-based organizations, disability justice advocates, professional societies, student encampments, abolitionist groups, medical societies, human rights organizations, and others. They bring different genealogies of struggle and lines they refuse to cross. PCA must therefore clearly articulate the norms that govern its coalitions. This does not suggest a single political platform as the price of collaboration, nor does it endorse sanitizing language to appease the sensibilities of elites. Rather, PCA requires adopting movement-level codes of conduct that safeguard the dignity of those most at risk and align with ethical norms. PCA also requires clarifying inside-outside roles.

One way that social movements have historically maintained accountability when some participants engage institutions is by organizing structured relationships of answerability between those "inside" and those "outside" the room. This practice is visible in how clinicians sit with survivors before and after meetings with UN rapporteurs, in how flotilla organizers brief and debrief their crews and passengers, and in how student encampments require delegates to report decisions to their assemblies. The immediate effect is to ensure that institutional recognition does not displace movement priorities; the longer-term effect is to form cadres of practitioners who understand that legitimacy comes from the people they serve, not from the podiums they reach. Practice-based analyses of social accountability in health indicate that embedding answerability through feedback loops and downward accountability contributes to government responsiveness and, in some settings, to sustained service improvements, especially where provider-patient power asymmetries are stark.[34]

Logistical tensions, ideals, and prospects

The potential of PCA lies in its refusal to outsource judgment, evidence, and remedial action to institutions that have repeatedly failed Palestinians, while still taking those institutions seriously enough to make their evasions visible. The cases examined in this paper illustrate the strengths and strains of that posture. They often organize the accountability triptych of monitoring, review, and remedy around the clinical consequences of siege and bombardment and around the legal status of health workers and patients. They do so while navigating co-optation risks, security threats to witnesses, divergent coalition norms, and a hostile information and security risk environment. The immediate ideal is not the purity of a social movement's identity but the protection of life and the reconstruction of a community's capacity to care for itself. There is a tension between the difficulties of maintaining community leadership and epistemic authority while engaging, strategically and instrumentally, with the state-centered parties whose authority has been put in doubt. This tension is amplified by the speed and scale of destruction, the abduction and killing of senior clinicians, and the collapse of health services that make even cautious documentation a matter of clinical risk management rather

than archival work. Efforts by the World Health Organization and the UN Office for the Coordination of Humanitarian Affairs to standardize incident reporting showcases both the necessity and the limits of institutional monitoring. They can agree on terms and phrasing, but they cannot, on their own, alter the pattern of impunity that renders those terms a ledger of anticipated harm rather than a trigger for prevention.

Another tension concerns engagement with formal legal and multilateral processes. Doctors Against Genocide, Healthcare Workers Watch, and the Freedom Flotillas all deploy documentation practices designed to meet evidentiary thresholds familiar to international court standards and UN mechanisms, yet none of them treat juridical success as the end point of accountability. The literature on social accountability is instructive.[35] Citizen-led oversight can produce gains when it combines pressure from below with tactical openings from above, but such gains depend on the responsiveness of the target institutions and on the ability of civic actors to sustain independent power.[36] Doctors Against Genocide's decision to pair UN submissions with clinician-facing actions and direct pressure on professional bodies, and Healthcare Workers Watch's insistence on clinically literate narratives that make the health systems consequences legible beyond the courtroom, reflect an understanding that prevention requires forms of authority that do not rely on state sanction. Accountability initiatives can be effective when they build on independent community power and elicit timely responses from authorities, rather than relying on retrospective review alone.[37]

Practical and ethical tensions of reporting

Another tension within PCA is the relation between professionalized nongovernmental organizations and dynamic social movements. Professionalization can stabilize methods, secure funding, and negotiate access. It also risks reproducing deference to the authorities that generate harm, narrowing vocabularies to what funders will tolerate, and deferring to legal advice that treats the accurate naming of atrocities as a reputational hazard.[38] Actors in grassroots movements, by contrast, find it easier at times to keep the horizon clear and the language honest. Yet they must contend with fragmentation, the duplication of efforts, and uneven standards for data protection.

In Gaza, this split is not abstract. In many instances, nongovernmental organizations fear that being more outspoken, doing interviews, or using terms like "genocide" will lead to a restriction of their ability to enter Gaza.[39] Furthermore, there is the tension of the epistemic and ethical nature. People often now say "center Palestinian voices," but in practice, the costs are borne disproportionately by Palestinian clinicians and families who consent to give testimony while living under occupation, surveillance, and displacement.[40] Ethical guidance from protection and humanitarian practice has long emphasized informed consent, do no harm, the minimization of re-traumatization, and robust data security; yet these injunctions meet a uniquely difficult setting when hospital raids and mass detentions target the very identities that make these testimonies credible.

Healthcare Workers Watch's methods, which prioritize direct contact with families and peers, multisource corroboration, and careful translation into medically meaningful narratives, sit within established protection standards but raise practical questions about risk, including digital interception, intimidation, and reprisals against those who speak.[41] It is sometimes not enough to redact names. An ethical documentation program in Gaza could include security protocols for storage and transmission, an explicit risk-benefit assessment for each disclosure, and the possibility of withholding publication even where verification is achieved, if the protective environment is absent (much of which Healthcare Workers Watch considers already). Movements may need to invest in encrypted infrastructures and community-led ethics boards that can set red lines independent of funder timelines. The ideal is credible, clinically grounded, and community-controlled knowledge that travels as far as necessary and no further than is safe.

Information warfare constitutes another source of tension for PCA. Gaza has exposed the limits of faith in Western-dominated mainstream

media as a mechanism of accountability.[42] The pattern is familiar from health emergencies: euphemisms for structural violence, the episodic amplification of official narratives, and the marginalization of Palestinian clinical authorities until their counts and warnings are retrofitted to match institutional sensibilities.[43] This is why Doctors Against Genocide emphasizes the importance of clinical language: it is harder to distort. The remedy is not disengagement but capacity. Movements must build their own media literacy, cultivate relationships with reporters who are committed to forensic standards, and develop internal protocols for the release of clinical data that anticipate misframing and preempt it with clear, medically anchored language. Where a headline can determine whether an intensive care unit receives diesel or not, messaging is not just a public relations task but a component of patient safety. Passive voice is too often used to deflect, diminish, and absolve Israel and its officials of their war crimes and acts of genocide in Gaza.

Charting a path forward

For effective PCA, coalitions must invest in trauma-informed, security-aware practices for clinicians and witnesses. The evidence on mental health burdens among health workers in conflict shows sustained elevations in anxiety, depression, and posttraumatic stress.[44] Programs that blend peer support, protected time away from exposure, confidential counseling, and fair remuneration are not luxuries; they are preconditions for ethical documentation and for continuity of care. Clinical networks can establish protected witness clinics, staffed by trained health care workers who can assess, document, and support colleagues who have faced harassment, been detained, or been assaulted. These clinics should function with strict confidentiality, encrypted records, and predefined referral relationships with trusted legal and protection partners. In parallel, medical schools and training programs can incorporate modules on documentation under duress, data security, and survivor-centered interviewing, with particular attention to the gendered and sexualized forms of violence that often occur in custody.

The cases here point to the need for curricular and research reforms that recognize PCA as a clinical competence and a domain of scholarly work. This means teaching students how to read and build medically literate records of harm, how to evaluate the probative value of imaging, telemetry, and clinical logs in areas of armed conflict, and how to integrate survivor testimony ethically into clinical advocacy. It also means supporting research programs that analyze health system collapse through combined epidemiologic and sociolegal lenses, recognizing that the excess mortality induced by the destruction of hospitals, blockade of supplies, and disruption of referral chains is not collateral but predictable. Assembling these frames while building methodological guidance on attacks on health care, including verification standards and analytic approaches, is essential in further expanding PCA practices. Embedding those methods in clinical training can help ensure that future documentation is not an improvisation but a practiced skill.

When the formal system withholds remedy, social movements have turned to public hearings (such as those often seen in the student encampments), juries convened by civil society, and people's tribunals to gather testimony, apply international standards, and issue findings that create a durable public record. These do not replace courts, and they should be designed to avoid replicating judicial exclusions. Their value lies in legitimating survivor knowledge, truth-telling, setting out standards of conduct for professions and institutions, and generating moral and political pressure that accumulates over time. For health sector harms, people's tribunals can be organized around human rights, including duties to respect medical neutrality, to allow humanitarian access, and to protect infrastructure essential to life. They can hear testimony from clinicians, patients, logisticians, and engineers; they can commission independent technical assessments; and they can specify remedial actions, including the restitution of equipment, reparations for destroyed services, and sanctions for officials and companies implicated in the de-

struction of care.[45] They can determine whether acts and omissions are grave breaches of human rights and humanitarian law. The jurisprudence on such tribunals shows that while they lack coercive power, they have shaped public understandings of atrocity and informed subsequent legal processes.[46]

Licensure boards, medical colleges, and hospital accrediting bodies have authorities that can be activated when clinicians or institutions abrogate the duties of medical ethics in contexts of atrocity. This delicate terrain demands robust consideration of a range of human rights, including due process and the prohibition against torture and cruel, inhuman, or degrading treatment, as well as the denial of health care. There is precedent for professional sanctions against clinicians complicit in abuse.[47] In Gaza, where testimonies describe medical neglect and complicity in ill treatment within detention settings, professional bodies can initiate inquiries into collaborations with complicit Israeli institutions and health care workers, suspend institutional partnerships where due diligence fails, and articulate conditions for an anti-apartheid, anti-genocide framework. These measures are neither collective punishment nor the politicization of scholarship. They are applications of long-standing commitments to do no harm and to refuse participation in cruelty. They reconfirm health professions as accountable actors.

PCA must confront directly the political economy that sustains impunity. Appeals to conscience have limited traction when the same states that arm perpetrators control the venues where verdicts are rendered. Arms-transfer suspensions, targeted sanctions on entities that dismantle health systems, and guaranteed safe humanitarian corridors are not extraneous to health; they are preconditions for the availability, accessibility, acceptability, and quality that define the right to health. The flotillas' experience shows both the possibility and the hazard of civil society routes. The task ahead is to combine that courage with policy design. Maritime and land corridors can be protected by third parties and monitored by independent medical observers. Also, emergency energy systems for hospitals can be leased and deployed by consortia of cities and health systems, not by states and states alone. None of this will substitute for political settlement, but all of it can reduce preventable mortality in the meantime. If the global health community takes seriously its commitments to equity and to the right to health, it must learn from PCA in Gaza and invest in structures that convert documentation into material protection, review into enforceable norms, and remedy into living capacity.

Conclusion

Despite profound challenges, PCA and human rights accountability from below show significant promise. Doctors Against Genocide, Healthcare Workers Watch, and the Freedom Flotilla Coalition demonstrate resilient, adaptable practices that fill gaps left by faltering SLA. The optimal model is synergy: SLA and PCA working together.

PCA, as articulated by Palestinian clinicians and allies, aligns with decolonizing critiques in global health. The aim is not to replace one authority with another but to reorder who can speak about, verify, and decide what counts as harm and repair. Social movements are part of the care ecology, with their own epistemologies, ethics, and practices of remembrance. For clinicians, allyship demands refusing to normalize the dismantling of care, the routinization of death in custody and disappearance, and the separation of duty from advocacy when separation costs lives. Debates on decolonization often call for shifts in authorship, agenda setting, and resource control. Gaza calls for restoring material conditions for health and centering Palestinian clinical authority as prerequisites for the right to health.

These ideals are not rhetorical. They are clinical, juridical, human rights, and ethical propositions tested in one of today's hardest cases. Gaza is both a site of suffering and one of methodological advance. Clinicians and communities have shown that credible, clinically grounded evidence can be produced under siege; coalitions can bridge professions and identities; and remedies can matter at the bedside. Still unfinished is building effective institutional protective arrangements, sustaining

inside-outside accountabilities that resist co-optation, and reorienting professional authority toward prevention rather than post hoc lament. If state-centered systems remain unable or unwilling to deliver, accountability from below will proceed—counting the dead with accuracy, confirming human rights violations and violators, preserving the names and methods of those who cared, and insisting that the right to health is a claim on power exercisable by the people themselves.

References

1. M. Y. Khanji, L. Fast, A. Nimerawi, et al., "Safeguarding Healthcare Workers in Gaza and Throughout Occupied Palestine," *BMJ Global Health* 10 (2025).
2. B. Rajagopal, *International Law from Below: Development, Social Movements and Third World Resistance* (Cambridge University Press, 2003).
3. C. Williams and P. Hunt, "Neglecting Human Rights: Accountability, Data and Sustainable Development Goal 3," *International Journal of Human Rights* 21 (2017).
4. International Covenant on Economic, Social and Cultural Rights, G.A. Res. 2200A (XXI) (1966); Committee on Economic, Social and Cultural Rights, General Comment No. 14, UN Doc. E/C.12/2000/4 (2000).
5. The Advocates for Human Rights, "Chapter 8: Accountability," *Human Rights Tools for a Changing World* (2018).
6. United Nations High Commissioner for Refugees, "Accountability to Affected People (AAP)" (2024), https://emergency.unhcr.org/protection/protection-principles/accountability-affected-people-aap.
7. T. Eatwell, "State Responsibility for Human Rights Violations Committed in the State's Territory by Armed Non-State Actors," Geneva Academy Briefing No. 13 (2018), https://www.geneva-academy.ch/joomlatools-files/docman-files/Academy%20Briefing%2013.pdf.
8. A. A. An-Na'im, "The Spirit of Laws Is Not Universal: Alternatives to the Enforcement Paradigm for Human Rights," *Journal of Human Rights and Religion* 21/2 (2016).
9. Office of the United Nations High Commissioner for Human Rights, "UN Commission Finds War Crimes and Crimes Against Humanity in Israeli Attacks on Gaza Health Facilities and Treatment of Detainees, Hostages" (October 10, 2024), https://www.ohchr.org/en/press-releases/2024/10/un-commission-finds-war-crimes-and-crimes-against-humanity-israeli-attacks; Amnesty International, *"You Feel Like You Are Subhuman": Israel's Genocide Against Palestinians in Gaza* (2024); E. Ćerimović, *"They Destroyed What Was Inside Us": Children with Disabilities amid Israel's Attacks on Gaza* (Human Rights Watch, 2024); UN News, "Rights Expert Finds 'Reasonable Grounds' Genocide Is Being Committed in Gaza" (March 26, 2024), https://news.un.org/en/story/2024/03/1147976; Human Rights Council, Anatomy of a Genocide: Report of the Special Rapporteur on the Situation of Human Rights in the Palestinian Territory Occupied Since 1967, Francesca Albanese, UN Doc. A/HRC/55/73 (2024).
10. International Court of Justice, *Order of 26 January 2024*; International Court of Justice, *Application of the Convention on the Prevention and Punishment of the Crime of Genocide in the Gaza Strip (South Africa v. Israel): Request for the Modification of the Order Indicating Provisional Measures of 26 January 2024* (March 28, 2024).
11. International Criminal Court, "Situation in the State of Palestine: ICC Pre-Trial Chamber I Rejects the State of Israel's Challenges to Jurisdiction and Issues Warrants of Arrest for Benjamin Netanyahu and Yoav Gallant" (November 21, 2024), https://www.icc-cpi.int/news/situation-state-palestine-icc-pre-trial-chamber-i-rejects-state-israels-challenges.
12. R. Ingber, "Mapping State Reactions to the ICC Arrest Warrants for Netanyahu and Gallant," *Just Security* (March 6, 2025), https://www.justsecurity.org/105064/arrest-warrants-state-reactions-icc/; Associated Press, "Trump's Sanctions on ICC Prosecutor Have Halted Tribunal's Work," *AP News* (May 15, 2025), https://apnews.com/article/icc-trump-sanctions-karim-khan-court-a4b4c02751ab84c09718b1b95cbd5db3; US Department of State, "Sanctioning Lawfare That Targets U.S. and Israeli Persons" (July 2025), https://www.state.gov/releases/office-of-the-spokesperson/2025/07/sanctioning-lawfare-that-targets-u-s-and-israeli-persons/.
13. Interaction RBP, "People-Centered Approach: Recognizing Communities as the Experts" (November 25, 2025), https://protection.interaction.org/case-examples/people-centered-approach-recognizing-communities-as-the-experts/; A. A. An-Naim, *Decolonizing Human Rights* (Cambridge University Press, 2021), ch. 4.
14. P. Cullors, "Abolition and Reparations: Histories of Resistance, Transformative Justice, and Accountability," *Harvard Law Review* 132/6 (2019); R. D. Sirvent and B. Irfan, "Toward an Abolitionist Epidemiology of Displacement: Lessons from the United States on Border Detention of Migrants," *International Journal of Public Health* 70 (2025).
15. A. Lorde, "The Master's Tools Will Never Dismantle the Master's House," *The Anarchist Library*, https://theanarchistlibrary.org/library/audre-lorde-the-master-s-tools-will-never-dismantle-the-master-s-house.
16. Institute for Middle East Understanding, "Quick Facts: The Palestinian Nakba (Catastrophe)," https://imeu.org/article/quick-facts-the-palestinian-nakba.
17. Doctors Against Genocide, "About Doctors Against Genocide," https://doctorsagainstgenocide.org/.
18. T. Abughnaim, G. Abu Sittah, T. Ahmad, et al., *Healthcare Workers as Human Rights Defenders: A Medical*

Perspective on Israel's Genocide (2025), https://www.ohchr.org/sites/default/files/documents/issues/health/sr/cfis/health-and-care-workers/subm-health-care-workers-ind-43-rupa-marya.pdf.

19. N. Davies, "Dearborn Heights Doctor Arrested While Marco Rubio Spoke to US Senate," *Detroit Free Press* (May 30, 2025), https://www.freep.com/story/news/local/michigan/2025/05/30/metro-detroit-doctor-nidal-jboor-arrested-u-s-capitol-israel-palestine-protest/83884949007/.

20. Healthcare Workers Watch, "About Us" (September 8, 2024), https://healthcareworkerswatch.org/about-us/.

21. Healthcare Workers Watch, *The Killing, Detention and Torture of Healthcare Workers in Gaza* (2024).

22. M. Ali, "Freedom Flotillas: A History of Attempts to Break Israel's Siege of Gaza," *Al Jazeera* (June 9, 2025), https://www.aljazeera.com/news/2025/6/9/freedom-flotillas-a-history-of-attempts-to-break-israels-siege-of-gaza.

23. Freedom Flotilla Coalition, "Who We Are," https://freedomflotilla.org/who-we-are/.

24. Ali (see note 22).

25. Human Rights Council, Report of the International Fact-Finding Mission to Investigate Violations of International Law Resulting from the Israeli Attacks on the Flotilla of Ships Carrying Humanitarian Assistance, UN Doc. A/HRC/15/21 (2010).

26. Ali (see note 22).

27. Ibid.

28. F. Marsi, "Israeli Pressure Delayed Freedom Flotilla's Departure for Gaza: Organisers," *Al Jazeera* (April 26, 2024), https://www.aljazeera.com/news/2024/4/26/israeli-pressure-delayed-freedom-flotills-departure-for-gaza-organisers.

29. Ali (see note 22).

30. Fédération des Médias Bénévoles, "Israeli Military Attacks Handala in International Waters," Freedom Flotilla Coalition (July 26, 2025), https://freedomflotilla.org/2025/07/26/israeli-military-attacks-handala-in-international-waters/.

31. Doctors Against Genocide (see note 17).

32. D. Manekin, T. Mitts, and Y. Zeira, "The Politics of Allyship: Multiethnic Coalitions and Mass Attitudes Toward Protest," *Proceedings of the National Academy of Sciences* 121 (2024).

33. Ibid.

34. A. Bailey and V. Mujune, "Multi-Level Change Strategies for Health: Learning from People-Centered Advocacy in Uganda," *International Journal for Equity in Health* 21 (2022).

35. S. Buchman, R. Woollard, R. Meili, and R. Goel, "Practising Social Accountability," *Canadian Family Physician* 62 (2016).

36. J. Fox, "Scaling Accountability Through Vertically Integrated Civil Society Policy Monitoring and Advocacy," Institute of Development Studies Working Paper (2016), https://jonathan-fox.org/wp-content/uploads/2011/11/fox_scalingaccountability_online5.pdf.

37. M. Schaaf, C. Warthin, L. Freedman, and S. M. Topp, "The Community Health Worker as Service Extender, Cultural Broker and Social Change Agent: A Critical Interpretive Synthesis of Roles, Intent and Accountability," *BMJ Global Health* 5 (2020).

38. B. Irfan, I. Omeish, A. A. Alamrain, et al., "The Political Determination of Gaza's Health System Destruction and Reconstruction and the Limitations of International Medical Deployments," *International Journal of Health Planning and Management* (September 22, 2025).

39. Ibid.

40. O. Shakir, *Born Without Civil Rights: Israel's Use of Draconian Military Orders to Repress Palestinians in the West Bank* (Human Rights Watch, 2019).

41. A. Ghali, E. Nasser, T. Nasser, et al., "Don't Shoot the Messenger: The Role of Journalists in Gaza's Health Sector," *Eastern Mediterranean Health Journal* 31 (2025).

42. Al Jazeera Staff, "'CNN Has Given Cover to the Israeli Operation,'" *Al Jazeera* (October 5, 2024), https://www.aljazeera.com/news/2024/10/5/failing-gaza-pro-israel-bias-uncovered-behind-the-lens-of-western-media.

43. J. S. Ryan Grim, "Leaked NYT Gaza Memo Tells Journalists to Avoid Words 'Genocide,' 'Ethnic Cleansing,' and 'Occupied Territory,'" *The Intercept* (April 15, 2024), https://theintercept.com/2024/04/15/nyt-israel-gaza-genocide-palestine-coverage/; "Over 150 New York Times Contributors to Boycott Paper over Gaza Coverage," *Middle East Eye* (October 27, 2025) https://www.middleeasteye.net/news/over-150-new-york-times-contributors-say-they-will-boycott-paper-over-gaza-coverage.

44. A. Y. Naser, M. Mustafa Ali, A.-K. H. Sammour, et al., "Prevalence of Stress, Anxiety and Depression Among Healthcare Workers in the Gaza Strip," *Medicine (Baltimore)* 104 (2025).

45. Tribunale Permanente dei Popoli, "Permanent Peoples' Tribunal," https://permanentpeoplestribunal.org.

46. A. Byrnes and G. Simm (eds), *Peoples' Tribunals and International Law* (Cambridge University Press, 2018).

47. S. Miles, "The New Accountability for Doctors Who Torture," *Health and Human Rights Journal* (January 22, 2014).