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Neglected Harms: Health Workers Organizing for Accountability in Tigray

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Abstract

Among the many crimes committed during the Tigray war from 2020 to 2022, the systematic destruction of health care has been extensively documented and contributed to the suffering and death of hundreds of thousands of civilians. Despite the direct harm that Tigray's health care workers experienced and their role in sustaining care under siege, these professionals have been excluded from a transitional justice process that remains performative rather than substantive. We argue that this exclusion represents a violation of international legal obligations and a failure of both the Ethiopian government and the multilateral organizations involved through financing and diplomacy. Despite their marginalization, Tigrayan health workers have continued to exercise agency through sustained grassroots advocacy, documentation, and collective action. In this case study, we amplify the voices of these professionals as they assert their rights, record unacknowledged harms, and demand meaningful participation in the very mechanisms intended to deliver justice. Their experience demonstrates that truly centering victims requires centering health workers as well—addressing their material, legal, and psychological needs as part of any effort to uphold health as a human right.

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Introduction

Beginning in late 2020, the war in Tigray quickly devolved into a campaign of mass violence against civilians. United Nations (UN) investigators and human rights groups have concluded that Ethiopian, Eritrean, and Amhara forces committed war crimes, crimes against humanity, and acts of genocide—through starvation, sexual violence, and the destruction of civilian infrastructure.[1] Hundreds of thousands of civilians died, many from preventable causes such as hunger and untreated illness. By mid-2021, more than 90% of the population required humanitarian aid.[2]

The region's health system was systematically dismantled. The Ethiopian National Defense Forces, Eritrean troops, and Amhara regional forces bombed and looted hospitals and clinics.[3] Health professionals labored unpaid, often without electricity, anesthesia, or sterile equipment. Some were displaced; others struggled to deliver care as the health system around them collapsed.

Yet as Ethiopia's transitional justice process unfolds, the voices of the health workers who continued working amid such devastating conditions remain sidelined and ignored. They have received no back pay and no mental health support. Some continue to work in damaged or unreconstructed facilities, while others now face eviction or legal action for unpaid debts. Still others have been arrested for protesting or have been forced to flee. The consequences ripple outward across communities: a fractured health system, worsening care, and deepening public harm.

This paper advances two arguments. First, the destruction of Tigray's health system and the exclusion of its workers from transitional justice constitute a violation of international legal obligations, including the right to health under the International Covenant on Economic, Social and Cultural Rights (ICESCR).[4] Second, despite their exclusion, Tigrayan health workers have maintained agency and efficacy through sustained, grassroots advocacy and action. We highlight Tigrayan health professionals who, in response to this institutional failure, seek to assert their rights, document unacknowledged harms, and demand inclusion in the very processes that claim to deliver justice. This case study emphasizes that centering victims means also centering health workers and addressing their material, legal, and psychological needs as part of a broader mandate to uphold health as a human right.

Destruction of Tigray's health system

The war in Tigray dismantled one of Ethiopia's strongest regional health systems, leaving it in ruins. Before the conflict, Tigray maintained an extensive network of hospitals, clinics, and village-level health posts, all connected by a functioning ambulance referral system.[5] Ethiopian government forces, Eritrean troops, and Amhara militias targeted and destroyed infrastructure during the war.

Humanitarian assessments documented widespread attacks, looting, and the obstruction of care. At Semema, a rural health post was looted twice before being burned by soldiers; at Sebeya, a rocket destroyed the maternity ward.[6] Ayder Hospital in Mekelle, the region's flagship facility, operated under siege conditions, while many smaller clinics were overrun or deserted.[7] Only 3%–3.6% of health facilities in Tigray remained fully operational during the war.[8] More than 77% of health centers and 60% of hospitals were partially damaged or destroyed.[9] In Eastern Tigray, 83% of infrastructure was affected, and just 11.5% of ambulances remained functional.[10] Rural health posts were virtually non-operational.

Independent investigations have concluded that this destruction was intentional. Médecins Sans Frontières (MSF) reported that many health facilities appeared "deliberately vandalised to make them non-functional."[11] In town after town, medical equipment was smashed, pharmacies ransacked, and clinics set on fire after being stripped of supplies.

Under international humanitarian law, medical units are specially protected objects. Attacks

on them violate the Geneva Conventions and their Additional Protocols.[12] Yet Ethiopian federal forces and allied troops repeatedly breached these protections. Ambulances were commandeered—about 20 were seized in one area alone and later observed transporting military goods.[13] MSF reported that one in five facilities they visited had been occupied by armed forces, some for extended periods, in clear violation of medical neutrality.[14]

These acts cannot be justified by military necessity. They reflect a calculated effort to dismantle health infrastructure, disrupt emergency care systems, and erode the region's social foundation. The systematic looting, vandalism, and militarization of medical spaces suggest an intent not only to disable care but to destroy the region's social foundation and ability to sustain life—an intentional constellation of actions that, when directed at a specific ethnic group like the Tigrayans, can constitute an act of genocide under article II(c) of the Convention on the Prevention and Punishment of the Crime of Genocide ("inflicting on the group conditions of life calculated to bring about its physical destruction"). As seen in other contexts of genocide and mass atrocity—such as Gaza, Yemen, and Darfur—attacks on hospitals, the denial of medical supplies, and the obstruction of humanitarian relief have transformed health systems into instruments of collective destruction.[15]

Health effects

The war in Tigray triggered a region-wide collapse of health service delivery, cascading into overlapping humanitarian crises. By mid-2021, maternal and child health services were nearly nonexistent, with only a fraction of facilities offering limited care. Maternal mortality surged from 186 to 840 deaths per 100,000 live births—a more than fourfold increase—reflecting a near-total breakdown in obstetric care and a severe reversal of Sustainable Development Goal 3.[16]

Routine immunization programs halted, and 91% of the population became food insecure, with more than a quarter of children screened found malnourished.[17] Tens of thousands of patients with chronic illnesses—including HIV and diabetes—lost access to life-sustaining treatment.[18] HIV prevalence more than doubled, from 1.4% to 3.0%, rising to 5.5% among internally displaced persons and 8.5% among sex workers, largely due to conflict-related sexual violence and loss of preventive services.[19]

Mental health burdens rose sharply: more than 50% of internally displaced persons met the criteria for posttraumatic stress disorder or depression.[20] Sexual and gender-based violence was widespread yet critically under-addressed. Nearly half of surveyed women experienced violence, but most received no medical or psychological care.[21]

The conflict displaced more than 2 million people and killed an estimated 600,000 civilians, many due to starvation and treatable illness.[22] The health workforce was devastated—only 1,300 of 20,000 pre-war professionals remained by 2022. Facilities resorted to expired supplies and ad hoc materials to maintain minimal services.[23]

Together, these indicators suggest the deliberate dismantling of Tigray's health infrastructure, with lasting consequences for population health and any future recovery.

Health effects on health care providers

Tigrayan health professionals endured profound physical and psychological hardship throughout the conflict.[24] Many lost colleagues and family members, suffered displacement, or were directly targeted. On June 24, 2021, three MSF staff members were executed by Ethiopian National Defense Forces near Abi Adi while clearly marked in MSF gear.[25] This targeted attack highlights the extreme dangers medical workers face and reflects a disturbing collapse of medical neutrality in the region.

Providers treated overwhelming numbers of critically injured civilians under siege conditions—without pay, without supplies, and often under threat. Some fled the region entirely, while others continued to work in extraordinary deprivation.[26]

Exposure to mass casualties, sexual violence, and other forms of violence without adequate psy-

chosocial support generated widespread vicarious trauma, moral injury, emotional exhaustion, and symptoms consistent with posttraumatic stress disorder. Many reported persistent anxiety, intrusive memories, and moral distress from impossible triage decisions.[27] Many health workers were unpaid for extended periods, exacerbating financial strain and eroding their ability to cope.[28]

The following testimonies—collected in March 2024 through in-person conversations and written accounts compiled by the Tigray Medical Association for advocacy and documentation purposes—illustrate the lived realities of health professionals working under siege. These accounts were later incorporated into advocacy letters submitted to the World Bank, the United States Agency for International Development (USAID), and other international organizations, and participants provided their experiences with the understanding that their words would be used publicly to raise awareness of the conditions faced by health workers under siege. We include them here to illustrate the physical, emotional, and psychological toll on providers working under blockades, with all identifying details removed to protect confidentiality and safety.

At Ayder Hospital, which remained partially functional despite the blockade, health workers faced immense obstacles. A nurse explained:

> *I walked 10 kilometers to and from the hospital each day, on an empty stomach, while drones circled overhead. I kept going because I felt obligated to care for patients who had traveled from rural areas hoping to be saved.*

A nephrologist reflected on the devastating consequences of medical supply blockades:

> *I lost two-thirds of my dialysis patients due to infection. We were using the same dialyzer more than 20 times, even though it was supposed to be a one-time use. There was no alternative.*

Another surgeon spoke of desperate improvisations to continue providing surgical care:

> *We had to use expired anesthesia. We even went to churches to ask people to donate their cotton clothes—traditional garments worn during religious services. We cut them, sterilized them, and used them as gauze for wound care and surgery.*

A nurse coordinator of the emergency department at Ayder recalled a moment of personal crisis:

> *When I heard my brother's house was destroyed by a drone attack, I still went to work, knowing the victims of the drone attack will be coming to the emergency room and the patients and staff depended on me. The need was overwhelming.*

These testimonies reveal the immense burdens carried by health workers at Ayder Hospital—members of the Tigray Medical Association who continued their lifesaving efforts despite near-impossible conditions.

Yet the experiences of Tigrayan health professionals also demonstrate how these burdens were refracted through dimensions of gender, profession, and geography. Female clinicians frequently faced gendered violence and emotional strain linked to caregiving roles; one medical intern described hearing that two students had been raped by soldiers in the same classroom where she trained.[29] Male ambulance drivers, by contrast, faced lethal security risks—as seen, for instance, in the June 2021 killing of MSF driver Tedros Gebremariam Gebremichael during a marked humanitarian mission.[30] Displaced providers such as Dr. Tewodros Tefera, who continued treating civilians in Sudanese refugee camps after mass expulsions in western Tigray, spoke of "the slow death of Ethiopia."[31] In Irob, near the Eritrean border, a health professional reported that colleagues were killed or detained by occupying forces, forcing most remaining staff to flee. Together, these accounts trace a spectrum of vulnerability shaped by profession, gender, and geography within the broader devastation of Tigray's health system.

Violations of the right to health under international law

The deliberate dismantling of Tigray's health

system constitutes a grave breach of the right to health as articulated in international human rights law. The violations documented are classifiable as war crimes under international and humanitarian law and the Ethiopian Penal Code.[32] Additionally, article 12 of the ICESCR, as elaborated in General Comment 14, establishes four interdependent criteria for the right to health: availability, accessibility, acceptability, and quality.[33] Each was systematically violated in Tigray by Ethiopian National Defense Forces, Eritrean troops, and Amhara regional forces:

- *Availability* was decimated: <10 % of facilities remained functional after looting and strikes.[34]
- *Accessibility* was blocked by road closures, bank shutdowns, and a blanket aid embargo.
- *Acceptability* eroded as clinicians were forced to reuse gloves, operate without anesthesia, and attempt equipment sterilization using makeshift materials.
- *Quality* collapsed as medications—antibiotics, insulin, and vaccines—ran out, maternal mortality quadrupled, and some hospitals discharged inpatients due to a lack of food, while others turned away new patients unless they brought their own supplies.

These outcomes cannot be justified as resource limitations, either hypothetically or given the specific details of direct targeting noted in this case. Under General Comment 14, states may not invoke scarcity to excuse the non-fulfillment of core obligations, including access to essential primary and emergency care.[35] The destruction of Tigray's health infrastructure and workforce reflects not mere neglect but active dismantling—violations that fall within the scope of non-derogable obligations under international law.

If left unaddressed, these violations not only re-traumatize survivors but legitimize retrogressive measures.[36] Any credible transitional justice process must recognize the right to health as both a site of harm and a domain of reparation.

The transitional justice process

The 2022 Pretoria Agreement marked an end to formal hostilities in Tigray and included the Ethiopian government's commitment to establish a transitional justice process.[37] In early 2023, a draft transitional justice policy was released for public consultation, with support from the African Union and the Office of the United Nations High Commissioner for Human Rights.[38] The policy invokes international frameworks, including the African Union Transitional Justice Policy and the UN Secretary-General's 2010 guidance note on transitional justice, which emphasize victim-centeredness, comprehensive redress, and participatory design.[39]

On paper, the policy reflects these standards. It acknowledges "gross violations," promises institutional reform, and adopts the four pillars of transitional justice: truth, accountability, reparations, and guarantees of non-repetition. In reality, however, these commitments are largely performative. No truth-seeking commissions have taken place, no perpetrators have been held accountable, and victims have received neither reparations nor recognition. The process suffers from three interlocking deficits:

- First, *it lacks impartial oversight*. No national or international bodies were invited to participate in the policy's design or implementation, despite credible allegations that state actors themselves committed crimes against humanity. This structural conflict of interest renders the process legally and morally suspect.
- Second, *it excludes key victim groups*, including frontline health professionals and civil society actors in Tigray. Despite their central role in sustaining care under siege, these individuals and health care unions were not consulted, not invited to testify, and not included in reparative planning. Their exclusion contradicts both the letter and spirit of the UN guidance note, which holds that victims must be agents in defining justice.[40]
- Third, *it fails to confront the role of Eritrean forces*, whose documented atrocities—massacres,

sexual slavery, and destruction of health infrastructure—are omitted entirely from the draft policy's mandate.

In sum, Ethiopia's transitional justice process, while procedurally constructed, substantively fails. By omitting social and economic rights, silencing health workers, and shielding perpetrators, it transforms what should be a reckoning into a narrative of forgetting. A justice framework that fails to account for the destruction of health care—both as a system and a site of human dignity—risks entrenching the very impunity it was designed to overcome.

Health professionals' mobilization: Accountability from below[41]

Against this backdrop, health professionals in Tigray are constructing an alternative, victim-led architecture of accountability. At the forefront of this effort is the Tigray Medical Association (TMA), a professional body that, during the siege of Mekelle, transformed into a rights-based coalition.[42] Its evolution reflects the demands of a health system in collapse and a transitional justice process that has largely ignored the economic, psychosocial, and professional harms endured by providers.

Throughout 2023 and 2024, TMA documented the conditions faced by health workers: more than 17 months of unpaid wages, forced labor under siege, and psychological trauma resulting from extreme shortages. Many clinicians were evicted from their homes, summoned to court for unpaid rent, or forced to pull their children from school. Despite these harms, the federal government's transitional justice blueprint—released in early 2023—excluded any reference to the health system's collapse or to the rights of public sector workers. In response, TMA began organizing formal petitions demanding salary restitution, psychosocial support, and participation in transitional justice policymaking. Letters were submitted to the Ministries of Health and Higher Education and to the Prime Minister's Office.[43]

When domestic appeals failed, TMA pursued a multi-track strategy. It appealed to donors such as the World Bank and the USAID, requesting that future health sector funding be conditioned on remedial action. These actions gave rise to a broader campaign framing the denial of pay and protection as violations of international and domestic law.

This advocacy work culminated in the creation of a transitional justice working group in 2024—a coalition of TMA, civil society organizations, women's associations, and legal advocates. Through workshops and structured dialogue, the working group began developing a victim-centered position statement grounded in international norms: the Committee on Economic, Social and Cultural Rights' General Comment 14 (on the right to health), article 16 of the African Charter on Human and Peoples' Rights, and International Labour Organization Convention 95 (on wage protection), alongside Ethiopia's own Labour Proclamation.[44]

The initiative has received coordination support from Irob Anina Civil Society, a Canada-based civil society organization, as well as financial and technical assistance from Irish Rule of Law International and pro bono guidance from independent international human rights lawyers. Additional engagement has come from the European Union, the African Union, and the US State Department's Bureau of Democracy, Human Rights, and Labor—though this remains limited relative to the scale of need. These modest partnerships highlight both the emergence of a fragile transnational solidarity and the enduring absence of sustained, rights-based support for survivor-led accountability within Ethiopia's transitional justice process.

One promising avenue for redress has emerged in domestic litigation. In 2025, TMA began exploring the possibility of suing the federal government in Tigrayan courts for unpaid wages, following a precedent set by the Tigray Teachers' Association, whose successful legal challenge resulted in the freezing of the Interim Administration's Commercial Bank of Ethiopia account.[45] TMA has consulted with the teachers' legal team to assess the viability of a similar strategy for health workers.

Collectively, these actions instantiate the tripartite conceptualization of accountability—monitoring, review, and remedy—as recognized

in human rights scholarship.[46] They assert that the exclusion of health workers from redress mechanisms constitutes a retrogressive measure under the ICESCR. Their campaign demands that transitional justice expand beyond the narrow focus on civil-political violations to encompass socioeconomic rights, positioning clinicians as primary claimants to restitution and setting a precedent for embedding health system reconstruction within post-conflict legal remedies.

Transitional justice literature emphasizes that victims often occupy complex roles and are simultaneously harmed and mobilized to alleviate harm. As Erin Baines argues, such "complex victimhood" challenges the passive portrayals and assumptions of survivors.[47] Health professionals in Tigray show this dual role: enduring trauma while coordinating efforts for redress. This demonstrates how survivor-led initiatives, such as TMA and the transitional justice working group, constitute emergent forms of accountability from below, transforming lived harm into a collective fight for justice.

Accountability lies at the heart of transitional justice, serving as the mechanism through which truth, reconciliation, and justice can be meaningfully achieved. Without it, transitional justice risks becoming symbolic or ineffective, as ongoing impunity erodes public trust, reconciliation, and respect for the rule of law. Conversely, robust accountability processes strengthen transitional justice by establishing clear legal norms and consequences for violations, thereby advancing human rights protection and the foundations for lasting peace.

Roadblocks: Structural barriers to health-worker-led accountability

The efforts of Tigrayan health professionals to construct a bottom-up framework for justice have encountered a set of formidable barriers—legal, institutional, and geopolitical. While the coalition's actions embody the participatory and remedial spirit of international human rights law, the architecture of transitional justice in Ethiopia has largely foreclosed their inclusion. The result is a justice process procedurally closed to those it purports to serve, structurally resistant to social rights claims, and increasingly complicit in the ongoing marginalization of those who sustained life during the war.

Despite multiple formal communications, the coalition has received no official response from the Ministry of Health, the Ministry of Higher Education, or the Office of the Prime Minister. This non-engagement constitutes a denial of procedural justice. Under ICESCR, the right to health includes not only access to care but meaningful participation in governance—especially by those most affected.[48] Excluding health workers from Ethiopia's transitional justice process violates this principle. The refusal to recognize them as a distinct victim group further undermines the process's legitimacy.

Federal-regional dysfunction compounds the problem. The Tigray Regional Health Bureau acknowledges the legitimacy of providers' demands but claims that jurisdiction lies with the federal government, which has disavowed responsibility and created no path for redress.

International donors—particularly the World Bank and USAID, two of Ethiopia's largest health sector financiers—have likewise failed to respond substantively to the coalition's appeals. While the considerable power over state affairs that their financing role affords them represents an unjust form of neocolonialism, their failure to exercise it in this case also stands in tension with their stated institutional commitments.[49] For example, USAID's Automated Directives System 201 series and human rights due diligence protocols mandate that US assistance not reinforce discriminatory or rights-violating practices.[50] Yet both donors have remained "neutral," effectively endorsing a state-centered approach that prizes institutional continuity over remedial justice. This abdication of responsibility contravenes General Comment 14, which affirms the obligation of international cooperation in realizing the right to health, especially in post-conflict settings.[51]

Attempts by health workers to publicly demand redress have also met with repression. In 2025, multiple physician associations in Ethiopia—including those in Oromia and Tigray—were threatened with

deregistration following coordinated labor actions over unfair and unpaid salaries.[52] Several health workers who participated in peaceful demonstrations were arrested.[53] This criminalization of protest violates rights to free expression and assembly and chills future mobilization. Without legal protections or institutional recognition, Tigrayan health professionals are simultaneously excluded from formal processes yet vulnerable to sanction when they assert their rights.

These obstacles expose the limits of a transitional justice process that favors procedural form over substantive inclusion. The government's rhetorical commitment to "best practices" contrasts with its refusal to engage frontline actors. Neglecting the harms suffered by health workers threatens not only justice but the survival of Tigray's public health system. Without redress, both individual clinicians and institutions are deteriorating—consequences already visible across Tigray.

Consequences of inaction: Individual and structural harm

The most immediate effects of exclusion have fallen on health workers themselves. Deprived of income, mental health support, and a voice in the justice process, many now face profound instability. With no pay, no restitution, and no pathway for reintegration, providers are being driven out of public service and out of the area altogether. The result is a slow, corrosive exodus that threatens the viability of Tigray's entire health system.

Systemically, the consequences are profound. After the war, the Health Resources and Services Availability Monitoring System baseline survey found that only 6.3% of 853 health facilities were fully functional, while 60% of health centers and 39% of hospitals sustained physical damage. Access to essential services remained critically impaired: only 2% of facilities provided full emergency care, and 5% surgical services.[54] The continued exclusion and attrition of trained personnel only deepens this crisis. Young doctors and nurses—many of whom remained during the war at enormous personal cost—are now being forced to leave in search of economic survival or safer working conditions. The result is a growing vacuum of clinical expertise at precisely the moment when rebuilding is most urgent.

This vacuum reflects a direct violation of international law. General Comment 14 makes clear that states must not adopt—or allow—policies that lead to a *retrogressive deterioration* in the availability and quality of health services. Paragraph 43 of the general comment affirms that the collapse of trained personnel and health infrastructure undermines the right to health for all.[55] The ongoing erosion of Tigray's medical workforce, combined with infrastructural paralysis, places the region's population at immediate risk of preventable death, disease, and protracted suffering.

Moreover, these conditions threaten the broader prospects for recovery and development. Without functioning health services, communities cannot return to work, children cannot safely attend school, and displaced populations cannot resettle. Public health emergencies—whether cholera, malaria, or malnutrition—are already emerging and will likely worsen in the absence of skilled providers.[56] Development, in any meaningful sense, is impossible when a population remains sick, untreated, and structurally neglected.

In this context, failing to support Tigrayan health professionals will have long-term, system-wide consequences. The right to health cannot be realized unless concrete action is taken to recognize, compensate, and reintegrate these professionals. These steps must include the reconstruction of health infrastructure in Tigray as a national priority, ensuring safe and functional facilities and a supportive working environment for those operating under extreme pressure. Psychosocial support programs should be integrated into health institutions, in partnership with professional associations, to address widespread trauma and burnout among health care workers.

Salary backlogs must be immediately resolved through transparent administrative action, backed by legal safeguards against retaliation. Where restitution is denied, domestic litigation—such as that being pursued by TMA—offers a legitimate

path toward reparation. TMA should be formally represented in transitional justice consultations, as the current policy framework lacks the participation and structural guarantees necessary to address health workers' rights claims.

The Ethiopian government bears the primary responsibility to uphold these obligations and to comply with fundamental labor rights under article 7 of the ICESCR. International donors to Ethiopia's health sector, including USAID and the World Bank, must also use their financial and diplomatic leverage to ensure compliance. Their conditional support should be explicitly tied to restitution, workplace safety, and psychosocial rehabilitation for health workers. Only through these coordinated actions—grounded in legal accountability and survivor participation—can the rebuilding of Tigray's health system be both just and sustainable.

Conclusion

A transitional justice process that overlooks the destruction of health systems—and the professionals who struggled to sustain them—is neither credible nor complete. Tigrayan health workers endured systematic violence, unpaid labor, and psychological trauma. Justice must begin by acknowledging these harms and offering redress grounded in international law. Under the UN Basic Principles on the Right to Remedy, reparations must extend beyond symbolic recognition to include the following:

- restitution: payment of salary arrears and reinstatement of employment;
- compensation: for financial losses and deprivation;
- rehabilitation: including mental health support and professional reintegration; and
- guarantees of non-repetition: through facility reconstruction and employment protections.[57]

Yet where formal mechanisms have failed to deliver these obligations, Tigrayan health professionals are working to advance accountability from below through grassroots, survivor-led efforts that seek justice through collective organization, legal innovation, and moral authority.

First, TMA is currently building collective awareness and delivering capacity-building trainings for its members on transitional justice principles, documentation techniques, and the rights of survivors. Additionally, it is sensitizing members to alternative accountability options. The goal of this effort is to reach a collective and informed decision, following which TMA aims to develop a consensus on whether, and to what extent, it should engage with the Ethiopian transitional justice process.

Second, TMA's strategy will prioritize domestic legal avenues to recover unpaid salaries and enforce labor rights. This approach will follow the precedent set by the Tigray Teachers Association's lawsuit, which achieved a landmark ruling that froze government bank accounts and protected funds for Tigrayan teachers. This shows how grassroots litigation can create legal and moral pressure from below.

Third, through the transitional justice working group, TMA and other members are in the process of organizing a synergistic movement for collective justice efforts. Together, they aim to document violations, organize truth-seeking through trusted local institutions, and engage international nongovernmental organizations and donors to press for payment of 17 months of unpaid salaries. Their advocacy reframes what might appear as administrative neglect into systematic violence and collective punishment—another expression of accountability from below that reclaims justice as a civic right rather than a political concession.

Fourth, acknowledging the institutional limitations of local justice, as in the case of the Tigray Teachers Association, TMA is preparing to pursue regional and international mechanisms. It is planning, for example, to submit the case to the African Commission on Human and Peoples' Rights and engage UN treaty bodies and Special Rapporteurs on the right to health and transitional justice. These steps position Tigray health professionals to demand justice before regional and international mechanisms, asserting that this matter is the re-

sponsibility of the state and international actors.

Further, a truly victim-centered process must be health-centered. This means including health workers in the design and oversight of justice mechanisms, recognizing them as victims, and repairing the systems that they held together under siege. What Tigrayan health workers have done—organizing in the aftermath of war, documenting harm, and articulating a vision for repair—must be met with action if transitional justice is to move beyond performance and toward genuine accountability. Their ongoing mobilization represents a living model of accountability from below, demonstrating that when institutions above fail, survivors themselves can drive justice upward.

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