The Palestinian Initiative for the Promotion of Global Dialogue and Democracy

The Right to Health and Human Dignity of Women and Girls in the Gaza Strip:

The Health and Psychological Impacts of the Genocidal War

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The Right to Health and Human Dignity of Women and Girls in the Gaza Strip: The Health and Psychological Impacts of the Genocidal War

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Foreword

The Palestinian Initiative for the Promotion of Global Dialogue and Democracy (MIFTAH) continues its efforts to monitor, document, and analyze the multifaceted impacts of the genocidal war on the Gaza Strip, guided by its commitment to defending human rights, advancing justice and accountability, and integrating a gender perspective into the analysis of Palestinian realities. Within this framework, the present report sheds light on the war's health, psychological, social, and livelihood-related consequences by documenting the experiences of older women; women and girls who have undergone limb amputations or remain at risk of losing additional limbs; and mothers and children who have faced congenital conditions and complications associated with pregnancy and childbirth.

The significance of this report lies in its effort to move beyond an immediate assessment of human and material losses to develop a deeper understanding of the war's lasting impacts on affected populations, amid the collapse of the healthcare system, the destruction of essential services, the erosion of social protection networks, repeated displacement, and the loss of income and livelihoods. Health-related harms cannot be separated from the surrounding socioeconomic conditions, just as injury and illness cannot be addressed independently of access to treatment, rehabilitation, and the essential conditions for a dignified life.

The report reveals overlapping patterns of harm whose severity varies according to age, gender, disability, economic circumstances, and family situation. Older women face challenges arising from disruptions to treatment for chronic illnesses, reduced mobility, and the loss of independence. For women and girls who have undergone amputations, suffering extends beyond the initial injury to the lack of rehabilitation services and assistive devices, with far-reaching social and economic consequences. Mothers and children also face serious risks resulting from disruptions to maternal healthcare during pregnancy and childbirth, alongside inadequate nutrition and shortages of medical examinations and specialized interventions. The testimonies further highlight the disproportionate burden borne by women and girls in caring for family members and meeting everyday needs, exacerbating existing forms of marginalization and deprivation.

From a human rights perspective, MIFTAH emphasizes that safeguarding the right to health extends beyond restoring hospital services and ensuring the availability of medicines. It also requires guaranteeing access to food, water, adequate housing, continuity of treatment and rehabilitation, and social protection. MIFTAH further underscores the responsibility of the international community to ensure respect for international humanitarian law and international human rights law; protect civilians, healthcare personnel, and medical facilities; facilitate humanitarian assistance and medical evacuations; and support independent investigations, accountability mechanisms, and reparations. In this context, recovery and reconstruction efforts must be grounded in a rights-based and gender-responsive approach that recognizes differing needs and ensures the meaningful participation of affected groups in setting priorities and shaping responses.

MIFTAH hopes that this report will serve as a valuable source of knowledge and a human rights reference to support advocacy and policy influence, help direct interventions toward the actual needs of affected populations, and strengthen pathways to protection, accountability, and recovery, thereby upholding human dignity and advancing the rights of Palestinian women and girls.

Dr. Tahreer Al-Araj

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Executive Summary

This report addresses the health, psychological, social, and living impacts of the genocidal war on the Gaza Strip by analyzing the experiences of older women, women and girls who have undergone amputation or face the risk of losing an additional limb; and mothers and children who have experienced congenital conditions or pregnancy- and childbirth-related disorders. It combines health, human rights, and legal literature with 63 field testimonies under oath, or affidavits, to read individual experiences within the context of the collapse of the health system and the damage to basic determinants of health, most notably food, water, shelter, sanitation, transport, and social protection. It aims to document patterns of harm, analyze their gender and intersectional dimensions and human rights implications, and identify priorities for protection, continuity of care, accountability, and recovery.

The report adopted a descriptive-analytical method from a human rights perspective that takes into account gender, age, disability, family and economic status, and displacement. Its primary sources included 54 testimonies distributed equally across the three groups, at 18 testimonies per group, and 9 testimonies from health and professional personnel used to explain the institutional and clinical constraints facing the provision of care. The testimonies were collected between 1 January and 11 March 2026 in several areas of the Gaza Strip. They reflect experiences accumulated from 7 October 2023 until the time of collection. They were supplemented by a review of sources available during the preparation of the report in 2026.

Each testimony underwent an independent analysis of the facts and their sequence, needs, services, obstacles, and effects. Common patterns were then coded and compared with testimonies from health personnel and published reports. The analysis took into consideration the conditions of bombardment and displacement, difficulties of movement and communication, limited privacy, and the restrictions these imposed on information collection and verification. The findings are read within the limits of the sample, without statistical generalization to the population of the Strip or assuming causal relationships not supported by evidence, while distinguishing between documented harm, possible indicators of violation, and legal characterization that requires verification of the conditions of applicability and responsibility.

The findings reveal that the damages did not occur separately, but were formed through cumulative pathways linking injury or illness to the disruption of diagnosis and treatment, then to deprivation from rehabilitation, food, adequate housing, and social support. The existence of a partially functioning facility, a

drug prescription, or a referral form was not sufficient to ensure care; access to the service remained contingent on the availability of personnel, equipment, and supplies, the ability to reach it and bear costs, and obtaining the intervention within the time necessary for the medical condition. Testimonies from health personnel support this conclusion by explaining the gap between clinical need and the actual capacity of the health system to respond.

Regarding older women, the analysis of testimonies showed the simultaneous interruption of medicines, examinations, follow-up, and specialized treatment, alongside displacement, malnutrition, weak social protection, and a lack of assistive devices. These conditions interacted with chronic diseases and mobility and sensory limitations, increasing the risks of complications and falls, loss of movement and independence, and deepening dependence on the family for daily and personal needs. The distance of facilities, high transport costs, and the lack of adaptation of shelters and bathrooms also impeded access to care in a safe and dignified manner. The testimonies revealed that the presence of children or relatives does not guarantee the availability of support when family members themselves suffer injury, unemployment, or displacement.

In the cases of women and girl amputees, amputation was not the end of the injury but the beginning of an extended pathway of needs and risks. Injuries and bleeding were associated with delayed ambulances, overcrowded facilities, and a lack of equipment. Then difficulties continued in pain management, infection control, wound care, and nutrition. After discharge from the hospital, women faced environments that did not allow the use of wheelchairs, access to bathrooms, or protection of wounds, alongside the disruption of physical therapy, prosthetics, and medical evacuation. As a result, the damage extended to independence, education, work, income, privacy, and caregiving roles. The findings confirm that recovery requires a continuum beginning with first aid and safe surgery and extending to rehabilitation, appropriate devices, mental health, the adaptation of the environment and social protection.

In congenital and neurological conditions and pregnancy and childbirth disorders, the testimonies revealed a successive breakdown of the conditions for prevention, detection, and treatment. Women faced shortages of food, iron, folic acid, and supplements, and difficulties with examinations, imaging, and pregnancy follow-up, followed by childbirth in overcrowded facilities or during transport, and shortages of incubators, oxygen, medicines, and specialized nutrition. After diagnosis, the absence of certain surgical and rehabilitative interventions and delayed evacuation led to continued risk, waiting, and anxiety. The cases included cardiac, neurological, and skin disorders and congenital

masses, along with prematurity, low birth weight, pregnancy loss, malnutrition, and respiratory diseases. The testimonies do not prove that all these cases are congenital anomalies or that they had a single cause, but rather clearly document the undermining of women and children's opportunities to obtain prevention, diagnosis, and treatment in a timely manner.

The gender and intersectional analysis showed that damage varied according to the overlap of age, disability, chronic illness, pregnancy, widowhood, poverty, and displacement. The loss of the breadwinner deepened economic dependency and difficulties of movement and managing treatment, while sick or injured women continued to perform household care work. Service gaps were transferred to daughters, sisters, daughters-in-law, and granddaughters in the form of unpaid work, expanding the impact of damage to include their health, time, and educational and professional opportunities. Mothers bore the burdens of searching for medicine, following up on referrals, and caring for sick children, alongside the needs of the rest of the family. The absence of privacy and accessible facilities also increased difficulties of hygiene, personal care, and examination, and the risk emerged of blaming the mother for her child's condition without medical evidence, which requires health communication that distinguishes between confirmed diagnosis, suspicion, and assumptions.

Regarding the rights, the repetitive patterns indicate widespread infringement of the rights to life, health, food, housing, water, rehabilitation, social protection, education, work, privacy, and the guarantees of protection for women, children, older persons, persons with disabilities, the wounded, the sick, and health care. The report examines these facts in light of International Human Rights Law (IHRL), International Humanitarian Law (IHL), the Geneva Conventions, specialized conventions, and the Women, Peace and Security Agenda. The facts may amount to multiple violations once responsibility and the conditions of applicability are established. However, assessing attacks or attributing specific complications to delayed treatment requires additional evidence proportionate to the nature of the finding.

Based on the findings, the report identifies the following priorities:

- **Protection and removing barriers to care**: Stop attacks and acts that target or obstruct health care, protect patients, medical teams, facilities, and transport, ensure the entry of supplies, fuel, food, and water, and safe passage for ambulances and relief. Accelerate evacuation according to medical necessity and the time available for intervention, while ensuring accompaniment, family unity, and continuity of treatment.

- **Accountability and international response**: Take effective political, diplomatic, and legal measures to protect civilians and health care, refrain from providing support that may contribute to grave violations, and support independent investigations, preservation of evidence, and reparation. This includes strengthening United Nations monitoring and coordination among its agencies, stable arrangements for receiving patients, and sustainable financing for recovery measured by actual access and non-discrimination.
- **Restoring the health care system and social protection**: Adopt a national plan that links the rehabilitation of facilities with restoring personnel, supplies, specialized services, and mental health, and establish a clear system for case management and referrals. Expand mobile teams, home visits, accessible transport, and assistance covering individual needs, with secure information systems and accessible registration and complaint mechanisms.
- **Responses that take into consideration different needs**: Provide medicines, home follow-up, and appropriate nutrition for Older women, with an integrated post-amputation care process covering pain, wounds, rehabilitation, prosthetics, education, and work; restore pregnancy and childbirth care, incubators, emergency referrals, and early intervention for children, with psycho-social support for mothers and families, and avoid unproven causal interpretations.
- **Participation and community oversight**: Support the role of local institutions and civil society in reaching out to those excluded from services, documentation, monitoring fair distribution and providing legal, psycho-social support. Ensure the participation of women, girls, and affected groups in planning and evaluation, protect privacy and informed consent, and reduce the burdens of unpaid care.

These priorities are based on the distinction between responsibility for violations and the roles of local and humanitarian actors in addressing their impacts, and on considering health restoration a process that includes living conditions, recovery, and independence, alongside reopening facilities and providing treatment.

Introduction

The right to health constitutes a fundamental right in International Human Rights Law (IHRL), and it continues to apply during armed conflicts in parallel with the rules of International Humanitarian Law (IHL) that provide special protection for the wounded, sick, pregnant women, children, older persons, and persons with disabilities, as well as for medical facilities, teams and transport. This right is not limited to treatment, but also includes the availability of services and accessibility without discrimination, their acceptability and quality, alongside the basic determinants of health, such as food, water, shelter, sanitation, a safe environment, information, and social protection. This is especially important for women and girls because of sexual and reproductive health needs, caregiving roles, and the disproportionate effects of conflict.

In the Gaza Strip, the war on Gaza since 7 October 2023 has led to a widespread weakening of the components of the health system and the disruption of basic, specialized, and rehabilitative services, in parallel with repeated displacement, hunger, deterioration of water and sanitation, and loss of shelter and income. The damage to facilities and equipment, the depletion of personnel, the shortage of medicines, fuel, and consumables, and the disruption of referrals and medical evacuation overlapped, so that illness or injury was no longer an isolated health event, but part of an environment that undermines prevention, diagnosis, treatment, recovery, and independence.

The effects of the war were not distributed equally. Women, girls, and the most vulnerable groups faced compounded harm because of the intersection of gender with age, disability, chronic illness, poverty, displacement, loss of a breadwinner, and caregiving burdens. This is revealed in the experiences of older women, women and girl amputees, and mothers, children, and premature infants born with congenital anomalies or disorders amid the disruption of care, examinations, incubators, surgery, and treatment referrals.

Significance and objectives

The significance of the report stems from its combination of legal, human rights, and health literature and 63 field testimonies, enabling the reading of individual experiences within the context of the widespread collapse of the health system and the basic determinants of health in the Gaza Strip. The report is not restricted to descriptive documentation, but analyzes the pathways of health, psycho-social, and living conditions damages, focusing on women and girls and the most vulnerable groups, especially older women, women and girl amputees or who are at risk of amputation, and mothers, children, and premature infants born with

congenital anomalies or disorders, without treating women as a homogeneous category.

The report aims to:

- Analyze the impact of the genocidal war on the ability of the health system in Gaza to provide preventive, diagnostic, therapeutic, specialized, and rehabilitative services, and on access to referrals and medical evacuation.
- Document the health, psychological, and social harms and violations against the target groups, and read them in light of IHRL, IHL, the Geneva Conventions, the Rome Statute, and the Women, Peace and Security agenda.
- Highlight the gender and intersectional dimensions of harm, including displacement, poverty, loss of a breadwinner, privacy, dependence on others, stigma, and unpaid care burdens.
- Analyze recurring patterns in individual testimonies, support them with testimonies from health personnel, and compare them with relevant literature and reports, thereby enhancing the trustworthiness of the findings.
- Draw practical conclusions and recommendations that support immediate protection, continuity of care, advocacy and accountability, recovery, and rebuilding the health system based on rights.

Methodology

The report adopted a descriptive-analytical methodology from a gender-sensitive and intersectional human rights perspective. It combines desk review, systematic analysis of testimonies, professional corroboration, legal analysis, and triangulation among sources. The report viewed the persons whose experiences appear in the testimonies as rights-holders, not merely aid beneficiaries, and assessed the facts in light of the elements of availability, accessibility, acceptability, quality, and continuity of health services, taking into account differences in harm according to age, disability, health condition family and economic status, displacement experience, and caregiving roles.

The desk review included legal, human rights, health, and humanitarian documents and reports issued by the United Nations, the World Health Organization, humanitarian and human rights bodies, and Palestinian institutions, as well as relevant scientific literature. The review addressed the protection of the right to health and health care during conflict and under occupation, the rights of women, children, older persons and persons with disabilities, the reality of the health system in the Gaza Strip, attacks on health care, shortages of supplies, referrals, sexual and reproductive health, nutrition, water, sanitation, and displacement.

The primary sources consisted of 63 testimonies under oath, including 54 testimonies from women, mothers, or persons with affected health conditions, and 9 testimonies from health and professional personnel. The testimonies of the groups under study were distributed as follows:

- 18 testimonies from older women.
- 18 testimonies from women and girls who underwent amputation or face the risk of losing an additional limb.
- 18 testimonies from women and mothers regarding children and premature infants born with congenital anomalies or disorders.

Testimonies from health personnel were used in a corroborative and intersectional manner to explain the institutional and professional constraints faced by the health system, especially those related to shortages of medicines, equipment, and personnel, and the disruption of services, referrals, medical evacuation, and rehabilitation.

It should be noted that the testimonies under oath were collected by qualified male and female field researchers who received specialized training from experts at MIFTAH in the fields of monitoring and documentation, in accordance with procedures that respect the privacy, integrity and dignity of the testimony providers. The testimonies were collected in multiple areas of the Gaza Strip, including displacement sites and camps in the northern Strip and Gaza City, the central area, the central governorates, and the southern governorates. This distribution made it possible to observe differences in access to health and humanitarian services according to location, displacement conditions, proximity to health facilities, and the availability of transportation and support networks.

The documentation and testimony collection took place under extremely difficult field conditions characterized by ongoing bombardment and military operations, repeated displacement, instability of places of residence, difficulty moving between areas, high risks on roads, damage to transportation and communication networks, fuel shortages, high transport costs, in addition to overcrowding and limited privacy inside shelters. Researchers and testimony providers also faced additional challenges, including difficulty reaching some areas, changing locations of families, communication cuts, physical and psychological exhaustion, fear of security risks, and difficulty completing some interviews or verifying some details in a timely manner.

These restrictions were taken into consideration upon analyzing the testimonies and assessing their evidentiary weight, without underestimating their human rights value or their significance for recurring patterns of deprivation and harm.

Each testimony was treated as an independent source, and then compared with other testimonies, testimonies from health personnel, and available reports and data, with the aim of enhancing triangulation and verifying the general consistency of findings, while avoiding generalizing individual cases beyond the sample or drawing causal relationships not supported by available evidence.

The boundaries of the study are spatially defined by the Gaza Strip, where the experiences and facts that the testimonies addressed occurred, including internal displacement, access to hospitals, medical points, shelters, and rehabilitation services, in addition to referral and medical evacuation outside the Strip related to obtaining treatment services unavailable inside it. In terms of time, the report covers the health and human rights effects of the war since 7 October 2023, based on field testimonies collected during the period from 1 January to 11 March 2026. These testimonies reflect the experiences of those who provided them, including the cumulative effects of the war on their health, rights, and conditions of access to health care, up to the time the testimonies were collected. They were supplemented by a review of reports, studies, and available sources during the preparation of the report in 2026. These boundaries clarify the scope of interpreting and methodologically relying on the findings, without underestimating the importance of the testimonies or their human rights significance.

It must be emphasized that the study only focused on the themes of health, psycho-social, and living conditions effects related to the right to health, the collapse or disruption of the health system, and the basic determinants of health. The study paid particular attention to the three target groups by analyzing their experiences, needs, and the challenges they faced in obtaining care and health services. This includes issues of availability, accessibility, quality, and continuity of care, medicine, diagnosis, treatment, and rehabilitation, mental health, referral and medical evacuation, food, water, shelter, and sanitation, social protection, and gender and intersectional impacts.

Procedural concepts

For the purposes of this report, procedural definitions were adopted for the three groups under analysis, clearly defining the scope of each group and helping to interpret the findings and link them to the health, human rights, and gender context of the genocidal war on the Gaza Strip. These definitions are not intended to establish general and binding legal or medical definitions, but rather to specify what is meant by each group used in collecting and analyzing the testimonies within the framework of this report:

- **Older women**: Procedurally defined as Palestinian women in the Gaza Strip who were included in the group of testimonies of older women for the purposes of the study, based on advanced age and the associated special health, functional, and care needs. The report did not adopt a strict legal age limit for exclusion or inclusion, but rather relied on the field classification of cases; the documented ages of the eighteen women in this group ranged between 59 and 89 years, with a median age of 65 years. The report views aging as one of the determinants of vulnerability that interacts with gender, chronic illness, disability or limited mobility, poverty, displacement, and the loss of support networks and caregivers. Therefore, the analysis is not restricted to the woman's age, but addresses how the intersection of age with these factors affected her ability to access treatment, medicine, food, water, shelter, assistance, and protection in a safe, independent, and dignified manner.
- **Women and girl amputees**: Procedurally defined as females of various age groups, including young girls, adolescents, young women, mothers, and older women, who lost one or more upper or lower limbs, completely or partially, in the context of injuries related to the war on the Gaza Strip, as well as cases that underwent amputation and later faced the risk of losing an additional limb due to complications or the inability to complete treatment. The operational definition of amputation in this report includes the extended effects of the injury, not just the loss of the limb as a single surgical event. Hence, the analysis extends to post-surgical care, pain and infection management, physical therapy and rehabilitation, prosthetics and assistive devices, movement and access, and medical evacuation, in addition to the psycho-social, familial, educational, economic, and gender effects of acquired disability.
- **Mothers who gave birth to infants with congenital anomalies or disorders**: Procedurally defined as mothers whose testimonies addressed the experience of pregnancy and childbirth and the care of one or more children who, from birth or during the early neonatal period, exhibited congenital anomalies, or health, neurological, motor, or functional disorders, or conditions related to prematurity and high-risk birth that required specialized care, incubators, or continuous follow-up, diagnosis, and treatment.

Context and introduction: From vulnerability to genocide

Before the war, the health system in the Gaza Strip suffered from structural fragility accumulated because of the blockade, restrictions on movement, dependence on medical referrals, and shortages of medicines, consumables, and spare parts. With the war on the Gaza Strip since 7 October 2023, this fragility turned into a widespread collapse affecting the institutional and functional capacity of the system. The problem was no longer limited to damage to

individual facilities, but included the shrinking of functioning service points, the disruption of primary and specialized care, the accumulation of surgical, rehabilitative, and psychological needs, and the widening gap between demand and the available capacity to respond[1].

The literature reveals an interconnected pattern of damage that included hospitals, health centers, medical teams and ambulances. Taking hospitals out of service or operating them partially led to overcrowding of the wounded, disruption of operating theaters and intensive care, maternity, kidney, oncology, and neonatal services, and performing interventions in conditions lacking electricity, water, sterilization, and supplies. The killing, injuring, arresting, and abuse of health personnel is not only an individual loss but also drains the specialized expertise and human capital on which the health system relies. Obstruction of ambulances and access to the injured turns treatable injuries into death or permanent disability and hits the emergency first response[2].

Direct damage coincided with the blockade and restrictions on the entry of medicines, consumables, and fuel, which disrupted surgery, intensive care, dialysis, incubators, cold chains, and chronic disease services. Medical referrals and treatment evacuation also became a limited and complex process subject to crossing closures, security approvals and the availability of host countries, despite thousands of patients and wounded who need treatment unavailable inside Gaza. Displacement, overcrowding, water contamination, disruption of sanitation, and lack of hygiene materials contributed to raising the risks of communicable diseases. Thus, the collapse of health care intertwined with the destruction of the basic determinants of health, especially food, water, shelter, electricity, and a safe environment[3].

Data show that the collapse was not a fixed event but a changing path in which operational capacity remained far below the scale of need. As of 25 April 2026, only 296 of 683 service points (43 %) were operational, mostly partially, with just 23 fully functional. This included 20 hospitals, 13 field hospitals, 117 primary health care (PHC) centers, 124 medical points, and 22 ambulance centers[4].
As for hospitals and primary care, by 31 December 2025, all thirty-six hospitals in Gaza had been damaged; only 18 hospitals (50%) were operating partially, no hospital remained functioning in northern Gaza, while only 99 out of 203 primary

[1] WHO. Attacks on health care in the Gaza Strip. 31/Dec/2025. Accessed on 15/7/2026.
[2] Report of the Independent International Commission of Inquiry on the Occupied Palestinian Territory, including East Jerusalem, and Israel: note by the Secretary-General. A/79/23211/ September/ 2024. UN General Assembly – Seventy-ninth session.
[3] World Health Organization, ***Medical evacuation of patients from Gaza: Oct 2023–26 Jan 2026,***
[4] United Nations Office for the Coordination of Humanitarian Affairs (OCHA), Humanitarian Situation Report | 1 May 2026, published 2 May 2026.

health care centers (48%) were operating partially. These figures show that the survival of a functioning facility does not mean the restoration of its normal capacity, but may mean the continuation of a minimum level of service under severe pressure and shortages of personnel and supplies[5].

Health facilities were subjected to military attacks. The World Health Organization (WHO) documented 931 attacks on health care in the Gaza Strip during the period from October 2023 to 31 December 2025, associated with 990 deaths and 1,651 injuries, affecting 176 health facilities and 216 means of health transport. In terms of the pattern of attacks, 60% of them involved the use of heavy weapons, while 45% involved obstruction of health care provision. This shows that the damage was not restricted to direct bombardment but also included disruption of access and continuity of service provision[6].

In a related context, the United Nations Office for the Coordination of Humanitarian Affairs (OCHA) indicates that the Ministry of Health in Gaza reported that as of 7 October 2025, more than 1,700 health workers had been killed, equivalent to around 7% of the health workforce estimated before the war at about 25,000 health workers. This loss is not a mere figure of loss of lives, but a cumulative loss of experience, specialization, and the ability to operate emergency, surgery, intensive care, nursing, maternity, rehabilitation, and other departments[7].

Regarding the availability of medicines, consumables, and treatment capacity, the Ministry of Health stated at the end of 2025, according to the report of the WHO Director-General, that 51% of essential medicines in Gaza were at zero stock level, and that 65% of medical consumables were unavailable. In the same context, WHO estimated that more than 5,000 amputations had occurred since October 2023, and that about a quarter of injuries are life-changing injuries requiring long-term care and rehabilitation. This explains the gap between increasing specialized needs and shrinking treatment and rehabilitative resources[8].

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[5] World Health Organization, Health Conditions in the Occupied Palestinian Territory, Including East Jerusalem: Report by the Director-General, Seventy-ninth World Health Assembly, Document A79/12, 8 May 2026, paras. 4 and 15.

[6] World Health Organization, Attacks on Health Care in the Gaza Strip: October 2023–31 December 2025, WHO occupied Palestinian territory, 2025.

[7] United Nations Office for the Coordination of Humanitarian Affairs (OCHA), Humanitarian Situation Update #336 | Gaza Strip, 30 October 2025.

[8] World Health Organization, WHO's Response in the Occupied Palestinian Territory: January–December 2025, 2026; see also WHO, A79/12, 8 May 2026.

With regard to referrals and medical evacuation, they reveal the widening gap between need and the ability to access treatment outside Gaza. Since October 2023 until 26 January 2026, 10,762 patients were evacuated, including 5,715 children, while more than 18,500 patients and wounded, including about 4,000 children, remained in need of medical evacuation for specialized treatments unavailable inside Gaza. This confirms that the evacuation crisis is not a separate logistical matter but part of the actual capacity of the health system to complete the treatment chain, save lives, and prevent disability and avoidable complications[9].

The significance of the indicators shows that the deterioration of the health system in Gaza is multidimensional: physical damage to facilities, shrinking operational capacity, depletion of human resources, acute shortage of medicines and consumables, obstruction of ambulance and access, and widening need for treatment, rehabilitation and evacuation outside Gaza. Therefore, the operation of a health facility or the existence of a service should be perceived as an insufficient indicator in itself unless coupled with the actual ability to provide safe, stable, accessible, and good quality care. All statistics should also be read according to the date of the source, given the rapid change in the field situation and the differing monitoring methodologies among agencies.

Legal background

The right to health is a fundamental right linked to human dignity. It includes the enjoyment of the highest attainable standard of physical and mental health and access, without distinction , to health care and its underlying determinants, including food, water, housing, and sanitation[10]. The WHO Constitution affirmed this right, and Article 25 of the Universal Declaration of Human Rights linked it to an adequate standard of living, with special protection for maternity and childhood. Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) established obligations including reducing infant mortality, preventing and treating diseases, and creating conditions that ensure medical care for all[11]. General Comment No. 14 interpreted this right through four interrelated elements: availability, accessibility, acceptability, and quality, affirming states' obligations to respect, protect, and fulfil it, ensure non-

[9] World Health Organization, Medical Evacuation of Patients from Gaza: October 2023–26 January 2026, WHO occupied Palestinian territory, 26 January 2026; WHO, A79/12, 8 May 2026.

[10] World Health Organization. "Health is a fundamental human right". Check the following link: https://shorturl.at/KmQUS.

[11] OHCHR. "International standards on the right to physical and mental health: Universal Declaration of Human Rights". Check the following link: https://shorturl.at/JpWSh.

discrimination, and guarantee the minimum essential level of care, medicines, and the basic necessities of life[12].

In armed conflicts, the protection of the right to health is integrated with the IHL rules. Articles 18 and 20 of the Fourth Geneva Convention guarantee the protection of civilian hospitals and their personnel[13]. Article 19 limits the loss of special protection for hospitals to their use, outside their humanitarian duties, in acts harmful to the enemy, and after giving appropriate warning and a reasonable time limit where appropriate, without response to it[14]. Based on this protection, the report addresses attacks on health facilities and obstructing their work in terms of their impact on the safety of patients and personnel and the continuity of treatment, in addition to the damage to the facilities themselves.

The occupying Power has additional obligations; Articles 55 and 56 of the Fourth Geneva Convention obligate it, to the fullest extent of the means available to it, to ensure food and medical supplies and to maintain medical and public health facilities and services, in cooperation with national and local authorities[15]. Article 59 obligates consent to and facilitation of relief operations when the population lacks adequate supplies[16]. Customary Rule 55 also obligates parties to the conflict to allow and facilitate rapid and unimpeded passage of impartial humanitarian relief, while retaining the right of control[17]. These obligations provide a basis for assessing restrictions on the entry of food, medicine, and supplies necessary to operate health services in Gaza.

UN Security Council Resolution 2286 of 2016 reinforces this protection by condemning attacks, violence, and threats against the sick, the wounded, personnel, facilities, and medical transport, and calling for facilitating safe passage for individuals and medical supplies[18]. It also calls for preventive measures and independent, prompt, impartial, and effective investigations, and for appropriate action against those responsible for violations[19]. Based on these obligations, and on the inclusion of the right to health's underlying determinants, the report adopts a framework that examines disruption of prevention, diagnosis,

[12] E/C.12/2000/4: General Comment No. 14 on the highest attainable standard of health (2000), The Committee on Economic, Social and Cultural Rights. Check the following link: https://shorturl.at/glwJb.
[13] Geneva Convention Relative to the Protection of Civilian Persons in Time of War (Fourth Geneva Convention). Check the following link: https://shorturl.at/Gktes.
[14] Ibid.
[15] Ibid.
[16] Ibid.
[17] Ibid.
[18] United Nations Security Council. "Resolution 2286 (2016) - Adopted by the Security Council at its 7685th meeting, on 3 May 2016". Check the following link: https://shorturl.at/yVJBo.
[19] Ibid

treatment, and rehabilitation, and the impact of damage to water, electricity, and sanitation on the availability, accessibility, and quality of care[20].

This perspective is supported by statements of the Special Rapporteur on the right to health, Tlaleng Mofokeng, who described the situation in Gaza in April 2024 as a "war on the right to health," pointing to the destruction of the health structure, shortage of services and supplies, and long-term psychological risks[21]. Her 2025 report on health and care workers also affirmed their role as defenders of the right to health and the need to protect and empower them[22]. These reports are used to interpret the impact of targeting and disrupting health care on rights, and the obligations contained in treaties and international rules.

Protection acquires specific dimensions for women and girls; Article 12 of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) obligates the elimination of discrimination in health care and ensuring appropriate services for pregnancy, childbirth, and the postpartum period[23]. General Recommendation No. 30 clarifies States' obligations toward women in contexts of conflict, occupation, and post-conflict[24]. Security Council Resolution 1325 affirms the protection of women and girls, their participation in decision-making and peace building, and consideration of their needs in relief and recovery[25]. Based on these references, the report addresses disruption of reproductive health, loss of privacy and breadwinner, increasing care burdens and risks of violence, while highlighting women's participation in identifying response priorities.

Regarding women and girls who have undergone amputation or sustained long-term disabilities, the Convention on the Rights of Persons with Disabilities provides for protection in conflicts and humanitarian emergencies, accessibility and mobility, and the right to health, rehabilitation, and social protection, while addressing multiple discrimination against women and girls with disabilities[26].

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[20] OHCHR. "E/C.12/2000/4: General Comment No. 14 on the highest attainable standard of health (2000), The Committee on Economic, Social and Cultural Rights". 11 August 2000. Check the following link: https://tinyurl.com/y88k6m57.

[21] United Nations. "A war on the right to health– UN expert raised concern about Gazans mental health due to conflict". 22 April 2024. Check the following link: https://tinyurl.com/2na4xypk.

[22] United Nations. "A/HRC/59/48: Health and care workers as defenders of the right to health - Report of Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health". 22 April 2025. Check the following link: https://tinyurl.com/5x7chty5.

[23] United Nations. "Convention on the Elimination of All Forms of Discrimination against Women New York, 18 December 1979". Check the following link: https://tinyurl.com/4tdbknyv.

[24] United Nations. "General recommendation No. 30 on women in conflict prevention, conflict and post-conflict situations". 18 October 2013. Check the following link: https://tinyurl.com/4k9p4u6t

[25] United Nations. "United Nations Security Council Resolution 1325 (2000), S/RES/1325 (2000)". Check the following link: https://tinyurl.com/27srph32.

[26] United Nations. "Convention on the Rights of Persons with Disabilities". 12 December 2006. Check the following link: https://tinyurl.com/z2ukdzxd.

The Convention affirms the provision of care based on free and informed consent, and the availability of rehabilitation programs that support independence, inclusion, and participation[27]. Hence, the report examines the continuity of wound care and pain treatment, the availability of psychological support and physical therapy services, the availability of prosthetics and assistive devices, and access to shelter, transportation, and basic services, in a manner that guarantees for women and girls with disabilities effective opportunities for recovery and the restoration of independence and participation.

The protection of children, premature infants, newborns, and children born with congenital anomalies or disorders is based on the principles of non-discrimination, the best interests of the child, and survival and development affirmed by the Convention on the Rights of the Child[28]. Article 24 guarantees health care, reduction of infant mortality, combating malnutrition, and appropriate care for mothers before and after childbirth, while Articles 23, 27, and 38 address the rights of children with disabilities, an adequate standard of living, and protection during conflict[29]. General Comment No. 15 reinforces the interpretation of the child's right to health as a comprehensive right to prevention, treatment, rehabilitation, and the determinants of development, supporting early diagnosis, treatment, and support provided to the family[30].

As for the protection of older women, it is supported by the United Nations Principles for Older Persons, adopted by UN General Assembly Resolution 46/91 of 1991, with the themes of independence, participation, care, self-fulfilment, and dignity, and their inclusion of access to health care, social services and living in safe environments[31]. It is reinforced by the Madrid International Plan of Action on Ageing of 2002, as an international framework for responding to ageing issues and building a society for all ages[32]. The report relies on these two references in assessing the continuity of treatment for chronic diseases, care and social support, and the adequacy of shelter and services, upon the overlap of age, gender, illness, poverty, and loss of caregivers.

This system is complemented by the rules of responsibility and accountability; the Rome Statute criminalizes intentional attacks against civilians, civilian objects, protected hospitals and medical personnel, units, and transport, in

[27] Ibid.

[28] OHCHR. "Convention on the Rights of the Child". 20 November 1989. Check the following link: https://tinyurl.com/bdd4pcfk.

[29] Ibid.

[30] OHCHR. "CRC/C/GC/15: General Comment No. 15 on the right of the child to the highest attainable standard of health (2013), The Committee on the Rights of the Child". 17 April 2013. Check the following link: https://tinyurl.com/y8p6brt6.

[31] OHCHR. "United Nations Principles for Older Persons". 16 December 1991. Check the following link: https://tinyurl.com/jcxdkdse.

[32] United Nations. "2025 Theme: Older Persons Driving Local and Global Action: Our Aspirations, Our Well-Being and Our Rights". Check the following link: https://tinyurl.com/pzxymrr5.

accordance with the elements of crimes and the conditions for their application[33]. The Statute entered into force for the State of Palestine on 1 April 2015[34]. Palestine also accepted the Court's jurisdiction over crimes committed since 13 June 2014[35]. Based on these legal references, the report links testimonies to patterns of harm and relevant obligations, leading to recommendations for protection, continuity of care, accountability, reparation, and rights-based recovery.

Findings

Each testimony has undergone an independent analysis that included extracting key data, identifying facts and their chronological sequence, describing the health condition, service needs, available services, obstacles that prevented access to them, and subsequent impacts. The data were organized using a unified analysis matrix that included facts, the affected group types of harm, and relevant rights and legal standards. A narrative analysis was conducted for each case to trace possible causal relationships between facts and their resulting effects, and to examine the accumulation of harm and its gender dimensions, with a preliminary legal reading and a qualitative assessment of the evidentiary value of the testimony and the severity of the harm described in it. The facts were then coded and classified within common thematic patterns across cases and others specific to each group, taking into consideration context and differences between individual experiences.

The analysis addressed the gender dimensions of harm by examining its connection to a set of dimensions and factors that we will elaborate on in presenting the findings. The facts were also linked to relevant rights and legal standards, with distinction between documented harm, restriction of the enjoyment of rights, possible indicators of a violation, and the final legal characterization that requires verification of the conditions for the applicability of legal rules and elements of responsibility under international law.

To enhance the reliability of the results, a comparison was made between the patterns extracted from the testimonies, and another comparison with testimonies of health personnel and published reports and data, to examine points of

[33] International Criminal Court. "Rome Statute of the International Criminal Court". Check the following link: https://tinyurl.com/y8xyf5vy.

[34] International Criminal Court. "State of Palestine: Situation in the State of Palestine - ICC-01/18". Check the following link: https://tinyurl.com/yh822kup.

[35] International Criminal Court. "Palestine declares acceptance of ICC jurisdiction since 13 June 2014". Check the following link: https://rb.gy/tqan6j.

convergence and divergence, taking into account the different scope of sources, their contexts, and their data collection methods, without assuming their conformity. The report was organized into four interrelated chapters addressing methodology, literature review, analysis of testimonies, and conclusions and recommendations, followed by references and annexes.

This chapter reads and analyses field facts as stated in the testimonies. It includes three interrelated analytical groups: testimonies of older women, testimonies of women and girl amputees, and testimonies of mothers regarding children and premature infants born with congenital anomalies or disorders. Testimonies of health personnel were also used to support recurring patterns and explain the impact of the collapse of services, medicines, referrals, and rehabilitation on the health of women and children.

Analysis of older women

Estimates indicate that the number of persons aged 60 and above in the Gaza Strip exceeds 106,000[36], while UNRWA estimates their number at about 111,500, constituting around 5% of the population[37]. UNRWA reports that repeated forced displacement has affected at least 90% of the population of Gaza, stressing that limited movement, disability, and dependence on family members make displacement extremely dangerous for older persons[38]. The particular risks facing older women are demonstrated by the documented attack on Al-Wafa Center for Elderly Care, which resulted in wounding a number of them, and the Center was forced to evacuate[39]. However, the absence of sex-disaggregated data prevents an accurate determination of the proportion of older women among the displaced or affected population in general.

The Palestinian NGO Network (PNGO) reports that more than 96% of older persons in Gaza suffer from chronic diseases, amid a severe shortage of essential medicines and medical supplies and the absence of adequate specialized care services[40]. Reference data in the UNRWA protection brief indicate that 97% of older persons had at least one health condition, and that 80% of them used or

[36] Palestinian Non-Governmental Organizations Network. (2025, May 11). Elderly People: The Hidden Victims of the War on Gaza [Fact sheet]. https://en.pngoportal.org/uploads/documents/2025/05/Ovv5E.pdf

[37] United Nations Relief and Works Agency for Palestine Refugees in the Near East. (2025, June). *Protection brief: The situation of older persons in Gaza*. https://www.unrwa.org/sites/default/files/content/resources/older_persons_in_gaza_updated.pdf

[38] Ibid.

[39] Palestinian Non-Governmental Organizations Network. (2025, May 11). Elderly People: The Hidden Victims of the War on Gaza [Fact sheet]. https://en.pngoportal.org/uploads/documents/2025/05/Ovv5E.pdf.

[40] Ibid.

needed medicines or medical supplies. This need was higher among older women, reaching 84%, compared with 76% among older men[41]. Joints pain, high blood pressure, and eye diseases were also more prevalent among older women compared with older men[42]. The war has exacerbated these vulnerabilities because of the destruction of health facilities, the shortage of medicines and assistive devices, and difficulty in accessing medical facilities and humanitarian aid distribution points. Regarding food security, neither source provides a recent ratio disaggregated according to age and sex[43]. Nevertheless, the UNRWA brief documents chronic shortages of food and clean water, and a decline in the ability to deliver humanitarian assistance amid repeated displacement and restrictions imposed on humanitarian operations. PNGO also documents the continuing need of older persons for food parcels and emergency cash assistance, in addition to medicines, assistive devices, and psycho-social care.[44]

General attributes of the case studies

Theme	Indicator	Number or value	Ratio of total testimonies
Sample size	Number of testimonies	18	100%
Age attributes	Age range	59-89 years	—
Age attributes	Age median	65 years	—
Marital status	Widows	10	55.60%
Marital status	Married	6	33.30%
Marital status	Divorced	1	5.60%
Marital status	Unspecified in the analysis file	1	5.60%
Health and functional status	Chronic diseases or continuous treatment needs	18	100%
Health and functional status	Obvious documented disability of (K.H) and (K.R).	2	11.10%
Health and functional status	Motor, visual or hearing impairments	Most cases; no specific number	—
Access to treatment and care	Disruption of medicine, or care and barriers to access	18	100%

[41] United Nations Relief and Works Agency for Palestine Refugees in the Near East. (2025, June). *Protection brief: The situation of older persons in Gaza*. https://www.unrwa.org/sites/default/files/content/resources/older_persons_in_gaza_updated.pdf.
[42] Ibid.
[43] Ibid.
[44] Palestinian Non-Governmental Organizations Network. (2025, May 11). Elderly People: The Hidden Victims of the War on Gaza [Fact sheet]. https://en.pngoportal.org/uploads/documents/2025/05/Ovv5E.pdf.

Economic condition and social protection	Low income or poor social protection	18	100%
Displacement and housing	Displacement experience, inadequate shelter or damaged house	17	94.40%
Food	Insufficient or inadequate food	16	88.90%
Devices and rehabilitation	Shortage in devices or supplies or rehabilitation services	15	83.30%
Care burden	Explicit indication of a women caregiving burden	12	66.70%
Living conditions	Problems of water, wastewater and privacy	Most cases; no specific number	—

The percentages were calculated based on 18 testimonies and rounded to one decimal place. Health and living indicators overlap, and a single testimony may include more than one indicator; therefore, their percentages are not summed.

An analysis of older women's testimonies shows the intersection of deprivation of treatment and care with displacement, deteriorating housing and food conditions, and weak social protection, which deepened health and living damage. The findings highlight the additional burdens associated with age, illness, functional limitations, and caregiving responsibilities, and the accompanying infringement on their ability to enjoy their basic rights.

Health care and continuity of medications, examinations, and rehabilitation

Continuity of care constitutes the most consistent pattern in the testimonies, as the eighteen testimonies described shortages or interruptions in medications, insufficient quantities, high prices, reduced doses and absence of examinations, monitoring means and follow-up. The harm was not caused by the pre-existing illness alone, but by the interruption of a chain of treatment that included, before the war, regular dispensing of medications, regular examinations, and specialized consultations.

Diabetes cases particularly show that medication alone is not enough; glucose test strips, insulin pens, or adequate food were unavailable, and some women were forced to reduce doses or estimate their blood sugar by physical sensation. This was linked, according to their accounts, to bouts of coma, loss of movement, or wounds and complications. In cardiac and respiratory cases, the shortage of medications and oxygen and delayed follow-up turned into a direct potential threat to life, especially in the testimonies of (K.Y.), (K.Z.), (K.M.), (K.F.), (K.S.), and (K.Sh.).

The testimonies show that actual care requires regular medication at the prescribed dose, regular examinations, monitoring means, follow-up upon deterioration, and post-operative and post-amputation care, not merely the intermittent availability of a medical point or an alternative item.

The accounts of older women about the interruption of diabetes, blood pressure, and heart medications and their high cost are consistent with the testimonies of health personnel. Dr. (S.W.) said, **"We observe a sharp gap between what is missing in government hospitals in terms of medications and what may be available on a limited basis in private pharmacies, where some medications are offered at prices beyond the capacity of the vast majority of the population, amid poverty, unemployment, and the absence of income sources**"[45]. Dr. Sharaf al-Din Ziyad Al-Sarafandi confirms the existence of a "severe shortage of essential medications for chronic diseases such as diabetes, blood pressure, and heart disease", and that "the high prices of commercial medications make them unavailable to many patients"[46].

Dr. (S.J.) provides dedicated and direct support for the conditions of older persons and kidney patients; he stated that dialysis service "**has been reduced to two sessions per week and only two hours for each patient, instead of three sessions of four hours each**"[47]. This testimony supports reports that the interruption or reduction of treatment is not merely an administrative delay, but raises the risks of accumulation of toxins and fluids, anaemia, infection, and death among older patients.

Access to services

Barriers to access appeared in all the testimonies, varying between the distance of facilities, high transportation costs, scarcity of transportation, difficult roads, overcrowding in hospitals, and long waiting. (K. R.) stated that the doctor told her, "There is no room in the wards for overnight stay... go home and put two pillows under your leg"[48].

Reference was made to delayed or absent ambulance response, inability to travel or obtain a companion, alongside motor, visual, and hearing limitations. It appears that the barrier is not only geographical; a nearby service may remain unavailable to a woman who is crippled, or visually impaired unless transportation, a companion, and assistive devices are available. The testimonies of (K.H), (K.A), (K.F), (K.R), (K.N), and (K.Sh) describe access to emergency

[45] Statement of Dr. (S.W) on 30 January 2026.
[46] Statement of Dr. (S.D) on 8 March 2026.
[47] Statement of Dr. (S.J) on 1 February 2026.

[48] Statement of (K.R.) on 30 January 2026.

care or examination as exhausting or practically impossible, including being carried by hand or on an unsuitable chair, returning without examination after waiting, falling while trying to fetch medication, or the absence of means of communication to request help. These barriers/obstacles turned chronic illness into complete dependence on others and loss of independence.

Three high-risk cases stood out: (K.Y)'s travel for open-heart surgery was disrupted because she was not allowed to travel with a companion. She said, "At first, I was able to obtain a medical referral to travel to Egypt, but I could not travel alone because they did not allow me a companion... I was afraid to travel for treatment alone, so I declined it"[49]. (K.S)'s travel for cancer treatment outside Gaza was delayed[50]; and the treatment and referral of the foot injury in (K.R.)'s testimony was delayed until it ended in amputation according to the account[51], as (K.R) had diabetes and sustained an injury from a nail in her foot.

The testimonies of health personnel reinforce this pattern; Dr. (S.H.) described the health system as "critical and dilapidated," and stated that patients died while waiting for evacuation or their conditions deteriorated to the point where they could no longer withstand the journey[52]. Dr. (S.J.) also indicated that there are more than 300 medical referrals for treatments unavailable within the Strip, and that older persons constitute about 20% of them, with most referrals halted[53]. This shows that the experiences of (K.Y.), (K.S.), and (K.R.) fall within a broader institutional gap between the issuance of a referral and actual access to treatment.

Displacement, housing, shelter, water, wastewater and privacy

Seventeen women who gave testimony experienced displacement or living in a tent, a classroom, a primitive shelter, or a damaged dwelling. The problem was not merely the loss of home; the shelter environment was linked to cold, heat, humidity, rain leakage, smoke, waste, wastewater, and distant or unsafe toilets, and that had a compounded effect on women with mobility limitations, or heart, respiratory, and skin diseases.

In the testimonies of (K. H.), (K. A.), (K. S.), and (K. N.), hygiene and toilet facilities were directly linked to dignity, safety, and protection from infection54. When an older woman needs diapers, help changing clothes, or to use the toilet inside a crowded shelter, the absence of private space, water, and supplies is not

[49] Statement of (K.Y.) on 24 February 2026.
[50] Statement of (K.S.) on 27 January 2026.
[51] Statement of (K.R.) on 30 January 2026.
[52] Statement of Dr. (S.H.) on 4 February 2026.
[53] Statement of Dr. (S.J) on 1 February 2026.

[54] See the annex with the list of testimonies of older women by codes and dates of giving testimonies

merely a living shortage, but an infringement on health, privacy, and independence. Ms. (K. S.) describes in her testimony the psychological harm and feeling of shame caused by the unavailability of the toilet or its distance by saying, **"I feel embarrassed to use a bucket to urinate inside my room, and there is no source of lighting in the house"[55].**

The testimony of Dr. (S. J.) supports these accounts; he described the impact of overcrowding, poor hygiene, and shared toilets in places of displacement, and the accompanying spread of infectious, fungal, and viral diseases, with older people more affected because of weaker immunity and multiple chronic diseases[56]. This confirms that inadequate shelter, water, and wastewater are not living conditions separate from health, but direct factors in the worsening of illness and the difficulty of continuing treatment.

The testimonies of (K.B.), (K.H.), (K.L.), (K.N.), and (K.Sh.) reveal that evacuation and displacement did not take into account mobility and visual limitations; walking long distances, carrying the person by primitive means, or their separation from their family shows that a general warning or an open road does not provide real protection without facilitated transport and individual tracking and accompaniment.

Food, nutrition, and freedom from hunger

Food insecurity or inadequate food was reported in 16 testimonies. The harm went beyond insufficient quantity to the absence of regularity, diversity, and health adequacy. Women with diabetes, heart disease, or high blood pressure needed a regular diet, while they relied on charity kitchen meals or bread and salt or limited starchy items. Some were forced to reduce their share in favor of children, or sell part of the aid to buy medicine. (K.A.) says, "Sometimes I wish I were provided with just a dry loaf of bread and a little salt to satisfy my hunger"[57].

The testimonies included risk indicators, such as severe weight loss or wasting in the cases of (K.H.), (K.S.), (K.R.), (K.N.), and (K.Sh.). (K.N.)'s testimony is among the most urgent cases, as the analysis file mentions a loss of nearly 45 kg over five months, a claim that requires urgent medical and nutritional documentation. The right to food must be understood in terms of sufficiency, regularity, quality, and therapeutic suitability, not merely in terms of the presence of any food.

The lack of food interacted with chronic illness and absence of medication. Hunger or an unsuitable diet may weaken control of diabetes and blood pressure,

[55] Statement of (K.S.) on 27 January 2026.
[56] Statement of Dr. (S.J) on 1 February 2026.

[57] Statement of (K.A.) on 11 March 2026.

and delay wound healing, while limited income forced some families to sell part of the food to pay for medicine or transport.

Dr. (S.J.) confirms the direct medical impact of malnutrition on older people. He stated that famine, malnutrition, and mineral and vitamin deficiencies among older people were associated with dehydration, anemia, and deterioration of kidney function[58]. This testimony supports the accounts of (K.H.), (K.S.), (K.R.), (K.N.), and (K.Sh.) regarding wasting, weight loss, and the trade-off between food and medicine.

Disability, assistive devices, rehabilitation and independence

The sample included two clear cases of disability: long-term hemiplegia in Ms. (K.H.), and acquired amputation in Ms. (K.R.). Most testimonies also described long-term or recurrent mobility, visual, or hearing limitations. Those limitations may interact with the environment to fall within the protection established for persons with disabilities after individual assessment.

A shortage of devices, supplies, or rehabilitation services appeared in 15 testimonies, and included wheelchairs, crutches, walkers, medical mattresses and beds, oxygen, diapers, blood sugar test strips, hearing and vision aids, and wound care supplies. These tools are not complementary needs, but constitute conditions for preventing falls, pressure ulcers, and infection, and for managing illness, reaching the toilet, and living independently and with dignity. (K.H.) indicated the following, "For around three years I have not been able to go to the toilet, and I wear diapers night and day ... and when they run out, my sons are forced to use torn clothes or fabrics from hospitals".[59]

(K.Y.)'s testimony calls for attention to her situation and to her adult son with mental disability. She is a heart patient and his primary caregiver[60]. This requires considering the son's rights independently, and that the mother's treatment plan include alternative arrangements for the continuation of his support, instead of making her choose between her treatment and his care.

These facts align with the testimonies of (S.Z.) and Dr. (S.H.). (S.Z.) reported the insufficiency of crutches, walkers, wheelchairs, and prosthetics, and that their absence deprives the affected person of movement and independence and deepens the psychological and social impact.[61] Dr. (S.H.) also reported that, **"the raw materials designated for manufacturing children's limbs have been**

[58] Statement of Dr. (S.J.) on 1 February 2026.
[59] Statement of (K.H.) on 30 January 2026.
[60] Statement of (K.Y.) on 4 February 2026.
[61] Statement of (S.Z.) on 8 February 2025.

completely depleted, with a shortage of prosthetic materials for adults, and the lack of chairs, walkers, crutches, and physical therapy materials disrupts the return of wounded persons to their daily functions".[62] This provides direct support for the need of (K.H.), (K.L.), and (K.R.) for assistive devices and continuous rehabilitation, not only temporary family assistance

Social protection, income and livelihood

All testimonies expressed weak income, loss of the breadwinner and work, suspension of allowances, or insufficient aid. Some families, in trying to cope with these conditions, were forced into compulsory trade-offs between medicine and food, transport, rent, and hygiene. (K.N.) said, "**We were often forced to choose between buying food and buying the painkillers necessary to relieve pain"[63].** Some families resorted to borrowing, and some women reported that they reduced medicine doses, sold part of the food aid, or relied on intermittent support from relatives and charities.

The testimonies of (K.J.), (K.Y.), (K.T.), (K.L.), (K.M.), (K.S.) and (K.Sh.) show how the loss of the breadwinner or work deepened health damages. Medicine may be available in pharmacies, but it remains economically inaccessible due to weak income, and the clinic may exist but the transport fare impedes access. Moreover, counting the woman within her son's household does not guarantee access to assistance that takes into account her individual medical needs, especially if she cannot stand in queues or access registration because of her health condition or disability.
Social protection here is directly linked to the continuity of treatment, nutrition, and shelter; it is not an economic theme separate from health, but a condition for being able to buy medicine or move or provide diapers, devices, water, and adequate food.

The reports of Dr. (S.W.) and Dr. (S.D.) reinforce this analysis regarding the limited availability of some medicines in private pharmacies at prices beyond the capacity of the majority of the population[64]. The commercial presence of medicine does not achieve actual accessibility when the family is forced to choose between treatment, food, and transport, which explains the repeated reduction of doses or delay in purchase in the testimonies of older women.

Mental health, loss, dignity and family life

[62] Statement of Dr. (S.H.) on 7 February 2026.
[63] Statement of (K.N.) on 3 February 2026.

[64] Statement of Dr. (S.W.) on 30 January 2026 and statement of Dr. (S.D.) on 4 February 2026.

The eighteen analysis files included psychological or social harm or loss of independence and dignity. Factors ranged from loss of family members, repeated displacement, fear of running out of medicine, chronic pain, isolation, dependence on others for the toilet, food, and movement, and living in spaces lacking privacy.

The testimonies reveal that psychological impact is inseparable from material determinants; psychological support alone will have limited effect if the shortage of medicine, food, transport, shelter, and alternative care continues. Women with hearing, speech, and cognitive difficulties also need accessible means of communication, not just traditional verbal interventions. Mental health is part of the right to health, and repeated loss and declining independence and dignity constitute real damage factors requiring an integrated response.

Dr. (S.J.)'s testimony supports this conclusion from within clinical practice; he pointed to **"increased anxiety, depression, psychological stress, and high blood pressure, especially among older women as a result of fear, terror, and living burdens"**[65]. (S.Z.) also explained that, **"loss of movement or a limb and change of role and dependence on others leaves extended psychological and social effects"[66].** This confirms that the psychological distress described in the testimonies is closely linked to interruption of medicine, inadequate housing, and loss of independence**.**

Protection of civilians and civilian objects during displacement and bombardment

Nine testimonies included destruction or direct damage to housing, land, or property, and six testimonies mentioned the death or injury of family members or a shelling incident with direct impact. These facts call for the application of the rules protecting civilians and civilian objects, in addition to the rules specific to protecting shelters and medical units where applicable.

Shelling, threat, or damage to housing led to repeated displacement and loss of possessions, income, and care networks, then to new risks during flight, such as walking long distances, separation from family, injury, and falls. Thus, the direct damage of the attack is linked to a subsequent chain of health and living damages.

Testimonies of older women and linkages to the rights and the law

The testimonies show overlapping damages affecting older women in a way that infringes on their rights to health, life, housing, food, and social protection. The disruption of medicines, examinations, specialized treatment, and referral

[65] Statement of Dr. (S.J.) on 1 February 2026.
[66] Statement of (S.Z.) on 8 February 2026.

obstacles indicate restriction of the enjoyment of the right to health, guaranteed by Article 12 of the ICESCR, General Comment 14, Article 12 of CEDAW and General Recommendations 24, 27, and 30. The interruption of life-saving treatment is linked to Article 6 of the International Covenant on Civil and Political Rights (ICCPR). Also applicable, according to the facts, are the guarantees for protecting patients and securing care, supplies, and relief set out in Articles 16, 17, 23, 55, 56, and 59 of the Fourth Geneva Convention, Articles 10 and 70 of the First Additional Protocol, and Principle 19 of the Guiding Principles on Internal Displacement, with reference to UN Security Council Resolution 2286 on the protection of health care.

Displacement, damage to housing, and shelters lacking safety, privacy, water, and accessible sanitation reveal harm to the right to an adequate standard of living and housing, under Article 11 of the ICESCR, and to privacy, family, and home, under Article 17 of the ICCPR. These facts are linked to Articles 27, 49, 55, 56, and 59 of the Fourth Geneva Convention, Principles 18 and 19 of the Guiding Principles on Internal Displacement, and Articles 11, 19, and 28 of the Convention on the Rights of Persons with Disabilities, which requires taking into account age and disability-related needs when providing shelter and services.

The shortage of food and its irregularity or lack of health suitability affects the right to adequate food and freedom from hunger, established in Article 11 of the ICESCR. The facts are linked to the obligations to provide supplies, facilitate relief, and protect essential needs of survival, under Articles 55 and 59 of the Fourth Geneva Convention, Articles 54, 69, and 70 of the First Additional Protocol, and customary rules 53–55. The testimonies of hunger, wasting, and the trade-off between food and medicine constitute indicators requiring examination of responsibility, and the use of medical and nutritional evidence to assess causal relationship and complications.

The shortage of assistive devices, supplies, rehabilitation, and accessible transport limits independence and equal access to services. Its primary reference is Articles 5, 9, 11, 19, 20, 25, 26, and 28 of the Convention on the Rights of Persons with Disabilities, alongside Article 12 of ICESCR, and Principles 18 and 19 of the Guiding Principles on Internal Displacement. Achieving equality requires taking into account individual needs and providing reasonable accommodations. Denying such considerations may constitute discrimination once the conditions of obligation and responsibility are met.

Weak income and inadequate aid also restricted the ability to secure treatment, food, and transport, which is linked to the rights to work, social security, an adequate standard of living, and health, under Articles 6, 9, 11, and 12 of the

ICESCR, Articles 11 and 13 of CEDAW, and Article 28 of the Convention on the Rights of Persons with Disabilities. The affordability of services is an element of their accessibility under General Comment 14, and the exclusion of older women from assistance or the neglect of their needs within the family requires examining discrimination in access to social protection.

The combination of loss, displacement, and chronic pain with forced dependence on others and the absence of privacy affects mental health and family life, within the scope of Article 12 of ICESCR, Articles 17 and 23 of the ICCPR, and Principle 19 of the Guiding Principles on Internal Displacement. Article 7 of ICCPR may apply if the treatment reaches the threshold of cruel, inhumane, or degrading treatment, according to its severity, duration, and circumstances, while the United Nations Principles for Older Persons provide a normative framework for independence, care, participation, and dignity.

The facts relating to attacks, destruction of housing, and dispersal of families are read in light of Articles 6 and 17 of the ICCPR, Articles 27, 49, and 53 of the Fourth Geneva Convention, Articles 48, 51, 52, and 57 of the First Additional Protocol, and customary rules 1, 7, 11, 14, and 15. The testimonies provide indicators of harm to life, safety, and housing, but they are not sufficient alone to determine the legality of each attack or the attribution of responsibility. The final legal characterization remains contingent on the establishment of facts and the conditions of applicability and responsibility, just as characterization as war crimes requires the fulfilment of the elements, context, intent, and jurisdiction under Article 8 of the Rome Statute.

Analysis of the testimonies of women and girls who underwent an amputation

Between October 2023 and December 2025, more than 38,000 women and girls were killed in the Gaza Strip, including more than 22,000 women and 16,000 girls, equivalent to the killing of at least 47 women and girls per day on average. UN Women affirms that the actual number may be higher, given that victims remain under the rubble and monitoring and reporting systems are severely disrupted[67]. In addition to deaths, health estimates in the report indicate that about 42,000 persons in Gaza are living with injuries that have changed the course of their lives and need long-term rehabilitation. However, available injury data are not systematically disaggregated by sex and age[68]. Based on a conservative

[67] UN Women. (2026a, April 17). Advocacy brief: The cost of war in Gaza on women and girls. https://arabstates.unwomen.org/sites/default/files/2026-04/advocacy-brief-cost-of-war-gaza-on-women-and-girls-en.pdf.
[68] Ibid.

estimation scenario, the report estimates that about 11,000 women and girls sustained injuries whose impacts last a lifetime, including injuries that led to permanent disabilities requiring extended care and rehabilitation. This figure is not limited to amputations, but also includes a set of severs injuries that lead to long-term disability.[69]

With regard to amputation specifically, the UN Women report, based on Palestinian data it cited, indicates that about 2,000 women and girls became permanently disabled because of amputations during the war.[70] However, UN Women warns that the absence of data disaggregated by sex and age constitutes a structural data gap that prevents accurate estimation of the total number of women and girl amputees, the nature of their injuries, and their rehabilitation needs.[71] The conditions facing women and girls with disabilities are exacerbated by the repeated displacement of about one million women and girls, the suffering of about 790,000 of them from levels of food insecurity reaching crisis or catastrophe levels, in addition to the destruction of health facilities and severe restrictions on access to basic services.[72] Accordingly, the needs of women and girl amputees exceed the provision of prosthetics to include subsequent surgeries, physiotherapy, rehabilitation, psycho-social support, ongoing health care, accessible shelter, and accessible transportation. Their needs should also be integrated into humanitarian response, recovery, and reconstruction plans.[73]

[69] UN Women. (2026b, April 17). More than 38,000 women and girls were killed in Gaza between October 2023 and December 2025 [Press release]. https://palestine.unwomen.org/en/stories/press-release/2026/04/more-than-38000-women-and-girls-were-killed-in-gaza-between-october-2023-and-december-2025-un-women.

[70] UN Women. (2026a, April 17). Advocacy brief: The cost of war in Gaza on women and girls. https://arabstates.unwomen.org/sites/default/files/2026-04/advocacy-brief-cost-of-war-gaza-on-women-and-girls-en.pdf.

[71] Ibid.

[72] Ibid

[73] UN Women. (2026b, April 17). More than 38,000 women and girls were killed in Gaza between October 2023 and December 2025 [Press release]. https://palestine.unwomen.org/en/stories/press-release/2026/04/more-than-38000-women-and-girls-were-killed-in-gaza-between-october-2023-and-december-2025-un-women.

General attributes of the case studies

Theme	Indicator	Number or description	Percentage for total number of testimonies
General attributes	Sex	All cases are females	100%
General attributes	Age and family groups	A child, adolescents, young women, mothers and one older woman	—
Location of amputation	Amputation of a lower limb	12 cases	—
Location of amputation	Amputation of an upper limb	5 cases	55.60%
Location of amputation	Amputation of an upper and a lower limbs	One case; overlapping with classification according to location of amputation	33.30%
Cases with compound needs	Amputation of feet	Case (B.H.)	5.60%
Cases with compound needs	Amputation of the hand and the leg	Case (B.T.)	5.60%
Cases with compound needs	Risk of losing another limb	Two cases: Child "A" and case (B.J.)	100%
Displacement and housing	Displacement or living in an inadequate housing environment	All cases; includes tents, shelters, damaged or inaccessible houses	11.10%
Environmental obstacles	Difficulties in movement and access to utilities	Sandy floor, stairs, distant or inaccessible bathrooms, overcrowding and distant utilities	—
Living conditions	Lack of basic services and privacy	Recurrent water shortage and lack of privacy with varying degrees	100%
Transport and assistive devices	Obstacles to movement, shortage in or inadequate devices	High cost of transport, lack of wheelchairs, crutches and walkers, and unsuitable devices for the body or the nature of the floor	100%
Injury and amputation path	Circumstances of injury and emergency surgical intervention	Heavy bleeding, delayed ambulance, overcrowded facilities shortage in surgical resources and equipment, surgery decision taken under life-saving pressure	94.40%

Post-surgery path	Complications and treatment needs	Neuralgia (nerve pain or phantom pain), infections, lack of antibiotics, dressings and food, and wounds requiring frequent monitoring.	88.90%
Extended pathway of the disability	Disruption of rehabilitation services and specialized treatment	Disruption of rehabilitation services, access to prosthetics, and medical evacuations	83.30%
Extended pathway of the disability	Social, economic and family impacts	Loss of education, work and income opportunities, change in maternal and caregiving roles, and limitations on independence and privacy	66.70%
Interaction of physical condition and the environment	Factors affecting severity of functional restrictions	Interaction of loss of the limb with environmental factors and the absence of adequate services and equipment	—

Note: Amputation location classifications overlap due to the presence of combined upper and lower limb amputations; therefore, the numbers are not totaled to determine the sample size. Percentages were not calculated because the total number of reports was not explicitly stated.

Testimonies show that the impact of violations on girls and women amputees exceed physical injury, extending to their mental health, independence, opportunities for education and work, and their family and social roles. This damage is aggravated by displacement, disruption of treatment and rehabilitation, and the absence of an accessible environment, accumulating needs and restricting the ability to recover and practice daily life:

From injury to the decision to amputate: caring for the wounded under pressure of time and resources

Testimonies reveal that amputation was not a surgical moment separate from its context. In a number of cases, the series began with the bombing of a house or a nearby place or an injury during displacement, followed by bleeding and severe laceration and delay in the arrival of ambulances or transfer between unequipped or overcrowded facilities. (B.W.) describes waiting for the ambulance for more than two hours, and then her condition underwent emergency amputation in a clinic with limited capabilities before transfer to another hospital.[74] (B.H.) describes that first aid continued for three days before reaching specialized surgery.[75] (B.N.) recounts waiting two days before the operation according to her testimony.[76] In the case of the child Asmaa, the amputation occurred amid mass

[74] Statement of (B.W.) on 3/10/ 2026.
[75] Statement of (B.H.) on 3/2/ 2026.
[76] Statement of (B.N.) on 8/3/ 2026.

family injuries, burns, fractures, and shrapnels, while family members were either dead or wounded.[77]

"When I looked down, I saw that my legs had been torn apart and turned into small pieces covered in blood, and I could no longer move". (Testimony of B.D., 26/1/2026)

"The hospital was overcrowded with the numbers of martyrs and wounded... The left foot was amputated, while the bones of the other foot were severely broken" (Testimony of B.B. regarding the child "A", 6/1/2026)

The testimony of (S.Z.), from her position in mental health and rehabilitation, confirms that, "**When the cases arrived, some limb injuries were lacerated, and doctors' decision to amputate is made to save life when it is impossible to preserve the limb"[78].** This professional explanation is important, because it prevents reducing every amputation to a medical error, but it does not negate the need for examining whether delay or lack of fixation, antibiotics, and surgical debridement limited options or raised the probability of amputation in specific cases.

Treatment delay, infection, and widening of amputation

In a number of testimonies, there is a recurring medical condition, including: a severe wound or initial amputation, then a shortage in wound cleaning, or dressing changes, or antibiotics, or access to surgery, then inflammation, sepsis, or additional operations. The testimony of (B.W.) stands out as the clearest example of this path; she describes that, "**my treatment was supposed to continue for one month after the amputation operation, but I remained for about six months in a state of infections, fungi, and sepsis due to the absence of appropriate medical care, malnutrition, and a shortage of medicines and antibiotics, which led to amputation of the additional part"[79].** (B.N.) says that the delay before the operation was accompanied by gangrene and raising the level of amputation from an expected level below the knee to above it[80]. (B.H.) links the laceration and the three-day delay before reaching surgery with amputation above the elbow[81].

Testimonies of health personnel support this pattern in terms of capabilities and difficulties. (S.Z.) indicated that delayed treatment of fractures, wounds, and

[77] Statement of (B.B.) on 6 /1/ 2026.
[78] Statement of (S.Z.) on 8/2/2026.
[79] Statement of (B.W.) on 10/3/2026.
[80] Statement of (B.N.) on 8/3/2026.
[81] Statement of (B.H.) on 3/2/2026.

inflammations might lead to puss, infection, and widening of the amputation area. The testimonies of (S.A.), (S.W.), and (S.H.) clarify that the shortage of diagnosis, antibiotics, dressing materials, sterilization, and the exhaustion of operational capacity made the continuity of surgery and follow-up uncertain[82].

Pain, medication, dressing changes, and nutrition: harm continues after closing wound

Testimonies show that the end of the operation does not mean the end of treatment. Chronic, neuropathic, and phantom pain, inflammation, and the need for painkillers, antibiotics, ointments, bandages, vitamins, and food that helps healing were repeated. (B.D.) describes her brother moving between medical points carrying prescriptions and often returning without medication, then the family being forced to transport her on a cart to reach a clinic that dispensed for her one strip of medication that does not suffice her monthly needs. She states, "After all this suffering, I only got one strip containing only fifteen pills, although my monthly need is no less than thirty pills"[83]. (B.A.) recounts that most painkillers, antibiotics, and ointments were not available, and that commercial alternatives were beyond the family's capacity[84]. (B.Z.) links the lack of food to her general weakness, slow wound healing, and lack of energy needed for physical therapy[85].

Dr. (S.W.) reinforces this description from within health practice. She points to a gap between what is missing in government hospitals and what may be found in private pharmacies at prices beyond the capacity of the majority of the population[86]. Dr. (S.D.) also describes an acute shortage of essential medicines and rising prices of what enters commercially[87]. Thus, the availability of medicine in the market is not enough to judge that it is accessible; economic, geographic, and temporal availability are part of actual access.

Rehabilitation, assistive devices, and prosthetics

The disruption of rehabilitation represents the most consistent pattern after amputation. Some women obtained a wheelchair, crutch, or temporary limb, but the device was too light to withstand sand, or heavy and painful, or unsuitable for the level of amputation, or maintenance and training in its use were unavailable. In her testimony, (B.Z.) indicates that she used an unsuitable limb for about five months before replacing it with a lighter one; while (B.W.) assembled parts of a

[82] Statement of (S.Z) on 8/2/2026, statement of (S.W.) on 30/1/2026 and statement of Dr. (S.A.) on 29/1/2026.

[83] Statement of (B.D.) on 26/1/2026.
[84] Statement of (B.A.) on 26/1/2026.
[85] Statement of (B.Z.) on 2/2/2026.
[86] Statement of Dr. (S.W.) on 30/1/2026.
[87] Statement of Dr. (S.D.) on 8/3/2026.

temporary limb from more than one facility, and its weight was about five kilograms according to her testimony[88]. (B.L.) obtained an unsuitable limb, while (B.H.) and (B.A.) remained waiting for upper limbs that help them restore daily functions[89]. (B.W.) says in her testimony, "**I want to return to my normal life and regain my freedom, and obtain the prosthetic limb that enables me to move independently and return to my favorite sport, work, complete my studies, and participate fully in life"[90].**

Dr. (S.H.) confirms that the crisis was not merely long waiting lists, but reached the depletion of raw materials needed to manufacture children's limbs and a scarcity of adult limb materials[91]. The testimonies of Dr. (S.H.), Dr. (S.W.), and (S.A.) show that the absence of rehabilitation does not leave the condition static, but rather increases the risk of stiffness, atrophy, deformities, chronic pain, and loss of work and independence[92]. This is especially important for the child Asmaa because she is still in the growth stage, and for those who have an injury in the remaining limb, or in the hand used with the crutch.

These testimonies reveal that prosthetics are not a commodity delivered once, but part of a track that includes assessment of the amputation, skin, muscles, and balance, physical and occupational therapy, training, follow-up, maintenance, and replacement. Furthermore, the suitable limb in the training room may not be suitable for sand, stairs, narrow bathrooms, and displacement routes, and therefore suitability must be assessed in the person's actual environment.

From injury to the decision to amputate Displacement and shelter, accessibility, water and sanitation utilities

The tent, shelter center, or damaged house almost becomes part of the medical condition itself. The wheelchair does not move on sand, the bathroom may be far or primitive, stairs prevent going out, water may contaminate the wound, crowding reduces privacy, and sleeping on the floor increases pain and the risk of pressure sores. (B.B.) says in her testimony that, "the area is crowded with tents, the roads are narrow, and the sand also makes movement difficult; I stand in the middle of the road and ask any man in the street to help me pull the wheelchair for my sister Asmaa"[93].

[88] Statement of (B.Z.) on 2/2/2026 and statement of (B.W.) on 10/3/2026.
[89] Statement of (B.L.) on 1/1/2026, statement of (B.H.) on 3/2/2026 and statement of (B.A.) on 26/1/2026.
[90] Statement of (B.W.) on 10/3/2026.
[91] Statement of Dr. (S.H.) on 7/2/2026.
[92] Statements of Dr. (S.H.) on 4/2/2026, Dr. (S.W.) on 30/1/2026 and Dr. (S.A.) on 29/1/2026.
[93] Statement of (B.B.) on 6/1/2026.

In the same context, (B.D.) states that she spends most of her time inside the tent because movement is almost impossible[94]. As for (B.H.), (B.M.), and (B.S.), their testimonies show how amputation interacts with wounds, infections, old age, and chronic diseases in an unfavorable or unsuitable environment[95].

The obstacles mentioned in the testimonies directly affect self-care. The need for assistance in moving to the bathroom, bathing, undressing, protecting the limb from water, and changing dressings was repeated. In the case of (B.T.), the shortage of ostomy bags and diapers led to restricting food and delaying bodily functions[96]. These facts should not be perceived as mere sources of extra comfort, as they are linked to infection, skin health, privacy, dignity, and the ability of women and girls to choose who helps them.

Referrals, medical evacuation, and loss of recovery time

In the testimonies, requests for referral, evacuation, or specialized treatment outside the Strip were repeated, but the issuance of the referral did not enable travel. (B.D.) waited since her registration in late 2023 according to her testimony and did not leave, while (B.W.) obtained a referral, and a health entity contacted her to prepare for travel, then the plans were canceled with the resumption of war. (B.J.) faced the risk of losing the other limb while waiting for specialized treatment, and (B.Y.) is waiting for hand and leg operations and a prosthetic limb, while other cases continue to struggle with lost papers, rejected requests, the absence of a receiving party, or difficulty with escorts and transportation[97].

"I obtained approval, and my name has been registered in the electronic system since 20/12/2023, but I am still, as of the date of this statement, waiting in vain". (Testimony of B.D., 26/1/2026)

Dr. (S.H.) perceives this waiting within a wider gap between the numbers of those who obtained referral forms and those who were able to leave, and describes the system as "critical and dilapidated"[98]. Dr. (S.D.) points out that the damage constitutes a chain including damage to hospitals and loss of equipment, personnel, and medicines, weak coordination, and disruption of referral and evacuation. For amputees, time is not related to surgery alone; delay may lead to stiffness, atrophy, poor healing, deterioration of the remaining limb, and loss of education and work opportunities[99].

[94] Statement of (B.D.) on 26/1/2026.
[95] Statement on (B.H.) on 14/2/2026, statement of (B.M.) on 28/1/2026, and statement of (B.S.) on 9/2/2026.
[96] Statement of (B.T.) on 27/1/2026.
[97] Statement of (B.D.) on 26/1/2026, statement of (B.W.) on 10/3/2026 and statement of (B.J.) on 4/2/2026.
[98] Statement of Dr. (S.H.) on 4/2/2026.
[99] Statement of Dr. (S.D.) on 8/3/2026.

Psychological, family, economic, and educational impacts

The testimonies do not separate loss of limb from loss of previous life. The education of (B.J.), (B.D.), and (B.N.) was interrupted, the work of (B.W.) and (B.L.) was disrupted, and women lost the ability to manage the home, care for children, or earn income. (B.J.) and "H" were exposed to losing their parents, "S.J." lost her husband and breadwinner, child "A" lost multiple family members, and (B.H.) and (B.A.) lost relatives. Grief and trauma accompany pain, dependency, waiting, and anxiety about the future[100].

The testimonies also show the transfer of care burdens to children and other women. The daughter of (B.Z.), who is thirteen years old, took on cooking and lighting fires with her brother. (B.A.) depends on her daughters for washing clothes, preparing food, bathing, and caring for children. (B.Y.) depends on her sister daily, while "J," despite her need for care, became responsible for four younger siblings. Family support is a protective factor, but it should not turn into a permanent substitute for rehabilitation, personal assistance, and social protection.

"My daily dependence on my daughters heavily increased... I feel they should rather focus on their studies and future instead of being occupied with helping me in basic life matters". (Testimony of B.A. Adel Al-Danaf, 26/1/2026)."

"My daughter Rawan has come to bear responsibilities greater than her age... and I had to force myself to hold together and be strong to support my family, so I hide my pain and pretend to be okay". (Testimony of B.Z., 2/2/2026)

Psychological suffering takes gendered forms, including fear of the husband or society's perception, change in body image, feeling unable to perform motherhood or household work, and embarrassment in bathing, using the bathroom, and personal assistance. (B.Y.) says that she was deprived of performing the motherhood role she had anticipated after giving birth to her child because of hand amputation and leg fractures101. (B.A.) describes a painful feeling that she is a woman missing part of her body102. These ideas should not be used as a criterion for a woman's value, but should rather be understood as a consequence of stigma, social roles, and material barriers.

[100] See Annex of the list of statements of women amputees with codes and dates of testimonies
[101] Statement of (B.Y.) on 1/2/2026.
[102] Statement of (B.A) on 26/1/2026.

Testimonies of amputees and the linkage to the rights and the law

The testimonies show damages affecting the rights to life and health, guaranteed by Article 6 of the ICCPR and Article 12 of the ICESCR, and linked to the protection of the wounded and sick under Article 16 of the Fourth Geneva Convention and Article 10 of the First Additional Protocol. The facts of the shelling require examination of respect for the rules of distinction, the protection of civilians, and the precautions set out in Articles 48, 51, and 57 of the Protocol, with the testimonies alone not being sufficient to determine the legality of each attack and the attribution of responsibility for it.

The disruption of surgery, follow-up, pain management, and the shortage of medicine and bandages affect the availability, accessibility, quality, and continuity of care, in accordance with Article 12 of the ICESCR and General Comment 14. These facts are linked to guarantees of protection for medical facilities and personnel, and to securing supplies, care, and relief set out in Articles 18, 20, 55, and 56 of the Fourth Geneva Convention, Articles 12, 15, 16, and 70 of the First Additional Protocol , and UN Security Council Resolution 2286. Food shortage also affects the right stipulated in Article 11 of the Covenant, and its health effect remains subject to assessment even if it is impossible to prove its specific contribution to amputation complications. The disruption of medical evacuation is linked to Articles 16, 17, and 56 of the Fourth Geneva Convention and Article 10 of the Protocol, with the need to verify the medical need, the decision-making body, and the possibility of facilitation and available treatment alternatives.

The Convention on the Rights of Persons with Disabilities constitutes the central reference for analyzing the disruption of rehabilitation and prosthetics and difficulties of mobility, housing, and work, particularly Articles 6, 9, 11, 19, 20, 25, 26, 27, and 28. These rights require services, devices, and an environment responsive to individual needs, and denial of reasonable facilitating arrangements may constitute discrimination. Inaccessible housing and the shortage of water and food are linked to Article 11 of the ICESCR, Principles 18 and 19 of the Guiding Principles on Internal Displacement, and Articles 55 and 56 of the Fourth Geneva Convention.

The damages include mental health, independence, participation, and family roles, within the scope of Article 12 of the ICESCR, Articles 6, 19, and 25–28 of the Convention on the Rights of Persons with Disabilities, Article 12 of CEDAW, and General Recommendations 24 and 30. With regard to girls, the best interests, survival, development, health, rehabilitation, and recovery are taken into consideration under Articles 3, 6, 23, 24, and 39 of the Convention on the Rights of the Child, alongside education rights when injury or care burdens impede its continuation. The characterization of the facts as violations remains conditional

on verification of the applicable obligations, responsibility for acts, or documented omissions.

Analysis of statements related to congenital anomalies and disorders during the genocidal war

Data from the first half of 2025 provide the latest indicators at the Gaza Strip level regarding birth outcomes. Around 17,000 births were recorded between January and June 2025, compared with about 29,000 births during the same period in 2022, representing a decrease exceeding 41% in the number of registered births. Among births during this period, more than 1,460 children were born prematurely, equivalent to about 8.6%, while more than 2,500 newborns required admission to neonatal intensive care units. The United Nations Population Fund (UNFPA) places these figures within a broader composite indicator, as it reported that 5,560 newborns, or 33% of total births, were born prematurely, or with low weight, or required neonatal intensive care[103].

Moreover, 220 cases of stillbirth were recorded, while at least 20 newborns died during the first twenty-four hours of life. These deaths do not represent the full neonatal mortality rate, which covers the first twenty-eight days of life. The reviewed United Nations sources do not provide comprehensive and reliable data at the Gaza Strip level on the prevalence of congenital conditions. Hence, cases recorded in a particular hospital or medical department should not be generalized to all births in the Strip[104].

The deterioration in birth outcomes coincided with a sharp decline in the capacity to provide specialized care. In July 2025, the UNFPA reported that damage to half of the medical equipment and the depletion of 70% of essential medicines led to a 70% decrease in access to critical newborn care services[105]. WHO data also showed that, as of 14 March 2025, only eight out of 21 hospitals providing maternity care remained operational, alongside four field hospitals, and all of them were operating only partially[106].

Neonatal intensive care units were destroyed or deprived of essential equipment, incubators, medicines, and medical supplies, leading to severe overcrowding in the remaining units and forcing some newborns to share medical devices and oxygen sources. However, no recent, unified, and independently verified figure

[103] United Nations Population Fund (UNFPA), *UNFPA Warns of Catastrophic Birth Outcomes in Gaza amid Starvation, Psychological Trauma and Collapsing Healthcare*, 23 July 2025.
[104] Physicians for Human Rights and the Global Human Rights Clinic, University of Chicago Law School, Destroying Hope for the Future: Reproductive Violence in Gaza, 23 July 2025.
[105] United Nations Population Fund (UNFPA), UNFPA Warns of Catastrophic Birth Outcomes in Gaza amid Starvation, Psychological Trauma and Collapsing Healthcare, 23 July 2025.
[106] World Health Organization, Occupied Palestinian Territory Emergency Situation Update, Issue 57, 14 March 2025.

is available for the number of neonatal intensive care beds or incubators actually operating in the Gaza Strip. Therefore, the decline in access to newborn care constitutes a more accurate indicator of actual capacity than merely counting beds or nominally open facilities[107].

General attributes of the case studies

Theme	Indicator	Number or description	Percentage from total testimonies
Sample size	Number of testimonies used in the analysis	18 testimonies	100%
General characteristics	Women and girls who gave their testimonies	Women and mothers experiencing pregnancy, childbirth, and caring for children with congenital or neurological conditions or birth-related complications during the war on Gaza	—
Subject scope	congenital anomalies and disorders	A comprehensive framework for diverse medical conditions, including congenital defects, neurological disorders, pregnancy and childbirth complications, and infant health.	—
Health conditions	Congenital heart anomalies	3 statements: children (T.A.,T.D., T.K.)	55.60%
Health conditions	Neurological or cerebral conditions	6 statements: children (T.B., T.M., T.N., T. S., T.F., T.Y.)	33.30%
Health conditions	congenital mass in the neck	One statement: Child (T.H.)	5.60%
Health conditions	severe congenital skin disorder	One statement: Child (T.H.)	5.60%
Health conditions	Effects of prematurity, low weight, malnutrition, respiratory illness, neonatal death, or pregnancy loss	6 statements: (T.W.,T.Z., T.L., T.J., T.T., T.A.)	100%
Prenatal harm track	Nutritional and supplement deficiencies during pregnancy	Limiting food intake to one meal or having limited variety, and the lack of iron, folic acid, and supplements for a number of women	11.10%
Prenatal harm track	Disruption of pregnancy monitoring and diagnosis	Difficulty accessing imaging, tests and prenatal care	—
Track of harm at birth and	Birth conditions and access to care	Birth during displacement or moving, and overcrowding of health facilities	100%

[107] Physicians for Human Rights and the Global Human Rights Clinic, University of Chicago Law School, Destroying Hope for the Future: Reproductive Violence in Gaza, 23 July 2025.

immediately afterward			
Track of harm at birth and immediately afterward	Lack of specialized care services	Shortages of incubator beds, oxygen, medications, intravenous nutrition, and surgical specialists	100%
Track of harm after diagnosis	Disruption of treatment, rehabilitation, and medical evacuation	Drug shortages, lack of surgery or rehabilitation, and delays in transfers and evacuations.	94.40%
Psychological and livelihood impacts	Burdens shouldered by mothers and families	Prolonged waiting, anxiety, financial strain, and increasing caregiving burdens	88.90%
Common context	The circumstances surrounding the cases	Food deprivation, displacement, and disruption of health services, with varying natures of cases and their potential causes.	83.30%
Supporting sources of interpretation	Statements of the health personnel	It helps to explain delays in diagnosis and treatment, and the loss of opportunities for timely intervention.	66.70%
Interaction between physical and environmental conditions	Factors affecting the severity of functional restrictions	Interaction of Limb loss with environmental barriers and the lack of appropriate services and equipment.	—

Note: *The detailed health classification contains 17 statements, compared to 18 statements approved in the analysis; therefore, the classification of the remaining statements needs to be completed. The categories listed do not represent a unified medical diagnosis, nor do they prove a shared pattern of deprivation, disruption of care, or the severity of their cases.*

The testimonies reveal cumulative health, psychological, and living impacts affecting women and their children during pregnancy, childbirth, and afterwards, amid food deprivation, displacement, and disruption of care. These conditions restricted opportunities for timely diagnosis and therapeutic intervention, and deepened care burdens, anxiety, and financial depletion among families. However, this does not establish a direct causal relationship between them and the emergence of congenital conditions.

Pregnancy under starvation and lack of supplements and preventive care

Food deprivation during pregnancy is the most frequent pattern in the testimonies. (T.D.) described her pregnancy under one meal per day or no food, with the loss of her husband and provider, anaemia, and the need for a blood transfusion at childbirth[108]. (T.S.) said that she, "**shared bread with ten people, then what was available to her became one loaf every two days"[109].** (T.K.) gave up her food share for her children, while (T.L.) relied on lentils, rice, canned food, and charity

[108] Statement of (T.D.) on 8/2/2026.
[109] Statement of (T.S.) on 4/2/2026.

kitchen meals while pregnant and breastfeeding at the same time[110]. Six mothers who gave testimonies also suffered from lack or irregularity of food, iron, and vitamins during highly sensitive periods of pregnancy.[111]

The testimonies show that food was not merely a superficial factor, but a condition for continuing pregnancy, recovery, and breastfeeding. Hunger, anaemia, and physical weakness were associated with fainting, dizziness, weight loss, reduced ability to move, and inability to breastfeed or low milk production. According to (T.J.)'s statement, her pregnancy coincided with severe anaemia and the need for iron treatment, then her health and her child's health deteriorated while she was living in a damp tent lacking conditions for nutrition and prevention[112]. In (T.L.)'s statement, the cycle recurred, between maternal malnutrition, low milk production, the family's inability to buy formula milk, and the child's diagnosis with acute malnutrition.[113]

The testimonies of health personnel support this pattern, but do not attribute every anomaly to malnutrition. Dr. (S.T.) indicated that famine and the lack of supplements and care affect the health of the mother and foetus, and may increase the risks of negative outcomes, but stressed that proving the cause of an individual anomaly requires specialized assessment[114]. Dr. (S.B.) also indicated that malnutrition and vitamin deficiency are two potential risk factors, but the matter requires more in-depth studies, stating, "**One cannot determine a single cause without an in-depth study of each case, genetic tests, and comparative data".[115]**

Disruption of Prenatal follow-up and delayed early detection

The testimonies show that the collapse of prenatal or antenatal care was not limited to a decrease in the number of visits, but included loss of equipment, unavailability of imaging and tests, the distance of medical points, the danger of roads, and the high cost of private doctors. (T.B.) was unable to obtain a clear diagnosis until an advanced stage of pregnancy, when an increase in the size of the foetus's head and fluid accumulation in the brain was diagnosed[116]. (T.S.) felt severe heaviness and pain from the fifth month, but the clinic did not have imaging devices or tests, and the family was unable to bear the cost of private care. The ultrasound machine at Nasser Hospital also stopped working, so the

[110] Statement of (T.K.) on 26/1/2026 and statement of (T.L.) on 2/2/2026.
[111] (T.A.), (T.B.), (T.Z.), (T.W.), (T.F.) and (T.AA.).
[112] Statement of (T.J.) on 9/3/2026.
[113] Statement of (T.L.) on 2/2/2026.
[114] Statement of Dr. (S.T.) on 30/1/2026.
[115] Statement of Dr. (S.B.) on 8/2/2026.
[116] Statement of (T.B.) on 3/2/2026.

diagnosis of the two children of (T.A.) and (T.K.), who had symptoms of heart deformation, was delayed[117].

In (T.F.)'s testimony, follow-up of the twin pregnancy stopped for two months due to disrupted access to Al-Sahaba Hospital. In (T.M.)'s testimony, follow-up of a high-risk twin pregnancy and thyroid treatment were interrupted, with clinics closing and medicine shortages. As for (T.N.), she did not obtain folic acid and pregnancy supplements, and did not have check-ups in the last two months except limited times. (T.L.)'s testimony shows that displacement affected not only the proximity of the service, but also knowing its location; she could not know the locations of the new medical points, so tests and vitamins stopped[118].

Dr. (S.T.) summarizes the impact of this interruption by saying, "**The disruption of follow-up, examination, and imaging before birth eliminated the possibility of detecting some anomalies and preparing for birth and surgery"[119].** Dr. (S.B.) indicates that a large proportion of cases reaching the incubator are detected after birth, which deprives the family and the health team of planning for the place of birth, preparing the incubator, providing a paediatric or cardiac surgery team, and arranging early referral[120].
The difficulty of early detection does not mean that every case could have been prevented or treated in the womb; the ability to detect varies according to the type of deformity, gestational age, quality of the device, and experience of the examiner. However, early examination remains crucial in planning, determining the place of birth, providing a specialized team, informing the family with accurate information, and avoiding the transfer of a critical newborn between unprepared facilities.

Unsafe childbirth, prematurity, and the collapse of newborn care

The risks of pregnancy moved to the moment of childbirth in a number of testimonies. (T.H.)'s labour began far from the hospital, it was impossible to get an ambulance, and none of the facilities admitted her, until the child was about to come out during transport, she says, "**Kuwait Hospital did not admit the birth, and the foetus almost came out on the way to Nasser Hospital**"[121]. (T.H.) underwent an emergency caesarean section after a large mass was discovered in the foetus's neck shortly before birth, and the girl immediately needed airway

[117] Statement of (T.A.) on 24/1/2026 and statement of (T.K.) on 26/1/2026.
[118] Statement of (T.M.) on 9/2/2026, statement of (T.F.) on 8/2/2026, statement of (T.L.) on 2/2/2026 and statement of (T.N.) on 10/3/2026.
[119] Statement of Dr. (S.T.) on 30/1/2026.
[120] Statement of Dr. (S.T.) on 30/1/2026.

[121] Statement of (T.H.) on 26/1/2026.

securement, an incubator, and oxygen[122]. In (T.K.)'s statement, the child needed urgent transfer after birth, but the family waited under the pressure of cases and the lack of incubator capacity[123].

The testimonies of (T.W.), (T.Z.), (T.F.), and (T.S.) reveal recurrent premature birth, low weight, and the need for an incubator. (T.W.) gave birth to her child in the seventh month after severe bleeding and a shortage of blood units, and he died after twenty-nine days. (T.Z.)'s newborn weighed one kilogram and needed an incubator, while his mother was suffering from inflammation of the caesarean wound, difficulty moving, and caring for three other children. (T.F.) gave birth to twins in the seventh month, who were later diagnosed with cerebral palsy. (T.S.)'s newborn was born in the eighth month with an enlarged head and small body, and remained for a long time in the incubator awaiting unavailable treatment[124].

Dr. (S.B.)'s testimony supports the picture the mothers depicted about incubator pressure, indicating the birth of twenty-five extremely premature children in one month, and a shortage of Surfactant[125], respiratory devices, antibiotics, intra-venous solutions and heart medications[126]. Dr. (S. T.) also said, "**Intravenous nutrition needed for children who cannot feed enterally is not available, neither in hospitals nor in pharmacies"[127],** a gap that is directly related with the cases of premature children, post-surgery children, and cases of breastfeeding difficulty.

These facts show that harm/complications in childbirth were not the result of the medical condition alone, but the result of its interaction with the shortage of beds, devices, medicines, specialized nutrition, and means of transport.

Patterns of health conditions: different diagnosis and similar obstacles and challenges

Pattern of health condition	Statements	Major health issues and needs	Obstacles to diagnosis and treatment
Congenital health anomalies	(T.A.), (T.D.), (T.K.)	Difficulty breast-feeding and breathing; diagnoses based on septal defects or cardiac enlargement and suspected congenital heart defects.	Echocardiography was disrupted, examinations were delayed, and cardiac medications were unavailable and

[122] Statement of (T.H.) on 3/2/2026.
[123] Statement of (T.K.) on 26/1/2026.
[124] See annex with the list of statements of women giving birth to newborns with congenital anomalies or disorders.
[125] A treatment that helps the lungs mature in premature babies
[126](S.B.) on 2/8/2026. Statement of
[127] Statement of Dr. (S.T.) on 30/1/2026.

		These cases require echocardiography, follow-up, medication, or surgery.	expensive. Referral procedures may take more than a month, while some cases require surgery within a week or two[128].
Neurological and cerebral cases and motor disabilities	(T.B.), (T.S.), (T.N.), (T.M.), (T.F.), (T.Y.)	Edema and fluid accumulation, atrophy or injuries associated with hypoxia, seizures and motor disorders. These cases require specialized diagnosis, imaging, medication, and surgical or rehabilitative interventions as needed.	In one case, a cerebrospinal fluid drainage device was unavailable, and in others, neurological medications were unavailable and evacuation procedures were delayed. It is necessary to differentiate between congenital conditions and birth-related injuries and subsequent disorders.
Severe congenital skin disorders	(T.H.)	A skin disorder present from birth, with tightness around the mouth and difficulty breast feeding; requiring a high-humidity incubator and specialized skin and nutritional care[129].	Specialized care and equipment are required, but no specific obstacle is detailed in the presented text.
Congenital masses	(T.H.)	A large mass in the neck that threatens breathing, requiring ventilator and feeding support, and confirmation of the diagnosis.	Diagnostic possibilities vary, and biopsy, surgery, and specialized team were unavailable (Report by T.H., 3/2/2026)
Pregnancy and infant health disorders without a confirmed	(T.J.), (T.T.), (T.L.), (T.Z.), (T.W.), (T.A.).	Maternal and infant malnutrition, small foetal size, respiratory symptoms and cyanosis, and recurrent pregnancy loss.	Displacement, food deprivation, disruptions to examinations and medications, and the unavailability of a

[128] Statement of Dr. (S.B) on 8/2/2026.

[129] Statement of (T.S.) on 4/2/2026.

congenital diagnosis			nebulizer and its solution in one case.
Health conditions	Congenital mass in the neck	One statement: Child (T.H.)	5.60%
Health conditions	Severe congenital skin disorder	One statement: Child (T.H.)	5.60%
Health conditions	Effects of prematurity, low birth weight, malnutrition, respiratory illness, neonatal death, or pregnancy loss	6 statements:(T.W, T.Z., T.L., T.J., T.T., T.A.).	100%
Pathway of prenatal damage	Nutrition and supplements deficiencies during pregnancy	Restricting food intake to one meal a day, or limited variety, and the lack of iron, folic acid, and supplements in a number of women	11.10%
Pathway of prenatal damage	Disruption of pregnancy follow-up and diagnosis	Difficulty accessing imaging, examinations, and antenatal care.	—
Pathway of damage at birth and immediately afterward	Birth conditions and access to care	Birth during displacement or transfer; overcrowding of health facilities;	100%
Pathway of damage at birth and immediately afterward	Lack of specialised care services	Shortage of incubators, oxygen, medications, intravenous nutrition, and surgical specialists.	100%
Pathway of damage after diagnosis	Disruption of treatment, rehabilitation	Lack of medications, lack of surgery or rehabilitation, and delays in referrals and evacuations;	94.40%

	and medical evacuation		
Psychological and living effects	Burdens on mothers and families	Prolonged waiting, anxiety, financial strain, and increased burdens of care.	88.90%
Common context	Circumstances surrounding cases	Food deprivation, displacement, and disruption of health services, with varying natures and potential causes of cases.	83.30%
Supporting interpretation sources	Statements of health personnel	Used to explain delays in diagnosis and treatment and the loss of opportunities for timely intervention.	66.70%
Interaction of physical and environmental conditions	Factors affecting the severity of functional limitations	Interaction of limb loss with environmental barriers and the absence of appropriate services and equipment.	—

Note: *The table presents the cases as reported in the statements and does not constitute a final medical diagnosis or proof of a common cause. The text does not include separate details for the cases of (T.Z.) and (T.W.).*

Shortage of medicines, devices, surgery, and rehabilitation

After the condition was discovered, families faced a wide gap between diagnosis and treatment. (T.A.) searched for heart medications, and the family had to deal with interruptions in some types and resort to alternatives, or splitting tablets not intended for children. (T. K.) faced difficulty in providing diuretics and anti-arrhythmic drugs. (T.Y.) faced a shortage of anticonvulsant medication and repeated intravenous sedatives without stability in the treatment plan. (T.S.)'s child remained in the incubator awaiting a shunt or valve to drain cerebral fluid, while (T.H.)'s child lacked skin care and a suitable specialized incubator[130].

The testimonies of health personnel reveal that the shortage is not limited to a medication type, but includes ultrasound, respiratory, and imaging devices, heart, anesthesia, antibiotic, fluid, and intravenous nutrition medications, incubator beds, in addition to cardiac surgery, pediatric surgery, and rehabilitation. Dr.

[130] See annex with a list of codes of testimonies and their dates for women mentioned in the text under the list of women who gave birth to infants with congenital anomalies or disorders.

(S.H.) described the health system as "critical and dilapidated," while Dr. (S.D.) confirmed that the damage formed an interconnected chain starting with damage to hospitals and loss of devices, personnel, and medicines, and ending with disruption of referrals and evacuations[131].

The shortage of resources changes the meaning of available service. A hospital may be open, but the device, anesthesia, medicine, specialist doctor, bed, or post-discharge follow-up may not be available. Therefore, it is not enough to consider that a child received service merely because he entered the hospital; actual care requires a continuous chain of examination, treatment, monitoring, nutrition, and rehabilitation, with a clear plan for the family.

Referrals, medical evacuation and loss of a window for treatment

The unrealized referral was repeated in ten testimonies (T.A., T.D., T.K., T.H., T.ḤH., T.Y., T.N., T.S., T.F., and T.M.). The statements show that issuing the referral was not the end, but rather the beginning of a wait depending on the crossing opening, coordination, security approval, acceptance by a hosting party, and the provision of suitable facilities and transport. According to (T.K.), she indicates that she, **"waited 8 months, the exit of sick children was intermittent, the child's complications continued, and I was forced to change companions after I was prevented from accompanying my child"[132].** In (T.D.)'s case, the mother continued to receive conflicting statements about the possibility of the hole closing spontaneously and the need for intervention, with continued cyanosis episodes and shortness of breath[133].

Dr. (S.H.)'s testimony shows the widening gap between the number of patients who obtained referral forms and those who were able to leave, and indicates that women and children represent a large proportion of the lists[134]. Dr. (S.B.) also shows that a number of children with heart defects need rapid intervention within a short period, while referral procedures exceed that period[135]. Dr. (S.T.)'s testimony shows that the absence of referral deprives children of surgeries and specializations unavailable inside the Strip, and may deprive them from the opportunity for treatment[136].

[131] Statement of Dr. (S.H.) on 4/2/2026 and Dr. (S.D.) on 8/3/2026.

[132] Statement of (T.K.) on 26/1/2026.
[133] Statement of (T.D.) on 8/2/2026.
[134] Statement of Dr. (S.H) on 4/2/2026.
[135] Statement of Dr. (S.B) on 8/2/2026.
[136] Statement of Dr. (S.T) on 30/1/2026.

It is worth emphasizing that not every delay automatically constitutes a legal violation. Clinical and logistical factors, the child's ability to be transported, and the availability of the receiving hospital may constitute overlapping factors. However, the absence of a transparent and rapid track for urgent cases, the failure to provide regular information to families, and leaving children waiting for a long time without a therapeutic alternative, raises serious issues related to the right to life and health, non-discrimination, and family unity.

Displacement, shelter, water, and environment

Most of the testimony givers lived through one or repeated displacement in tents, schools, and damaged buildings lacking water, bathrooms, ventilation, and safe energy. (T.K.) had to carry water to a damaged apartment on a high floor while pregnant. (T.S.) lived in a tent surrounded by insects and rats, where using the bathroom during pregnancy was difficult. (T.J.) suffered from humidity and smoke inside the tent, while (T.N.) moved between shelters and tents during two consecutive pregnancies. (T.A.) mentioned that she was displaced many times after her home was bombed and family members were lost. (T.A.) says, "**I was forced to displace and move repeatedly more than ten times, and I could not bear the cost of transportation to the south".** (Testimony of T.A. on 6/2/2026).

There were also repeated references to inhaling smoke from bombs and from burning wood, plastic, nylon, and cooking materials in shelters. (T.Ṭ.) suffered from shortness of breath during pregnancy, then cyanosis episodes and shortness of breath recurred in her child after exposure to smoke. (T.M.) had to walk a long distance while pregnant with twins, with bleeding and exhaustion, and lived in schools and tents lacking a safe cooking method. These testimonies do not prove that a specific environmental substance caused a particular anomaly, but they document exposures and unhealthy housing that affect health and require an independent environmental and toxicological investigation.

"**She had to walk about seven kilometers while in an unstable twin pregnancy, and was exposed to acute stress and bleeding**" (Testimony of T.M. on 9/2/2026).

Psychological, family, and economic impacts

The health conditions of children cannot be separated from the extended psychological impact on mothers. (T.B.) lived through the trauma of discovering a serious fetal condition at an advanced stage and feelings of guilt and fear. (T.D.) endured pregnancy and the loss of her husband, then caring for an infant with a heart condition as a widow and provider for three children. (T.W.) lost her first

child after twenty-nine days, while (T.A.) lived through the loss of family members, two consecutive miscarriages, and anxiety about repeated pregnancy. (T.Ḥ.), (T.HH.), (T.K.), and (T.A.) live in open-ended waiting for treatment of threatened children, with little sleep and constant anxiety[137].

The gaps in the health system turned into unpaid care work within the family. (T.A.) had to walk more than an hour and a half with her child and leave the other two children in unsafe conditions. (T.D.) moved near hospitals and left her two children with relatives to follow up treatment for the infant. (T.Y.) became almost a resident in the hospital with her child, while care for the older child was harmed. (T.Z.) was suffering from an inflamed cesarean wound, yet remained responsible for four children and a low-weight infant. These cases indicate that a sick child, not only adds a medical need, but also redistributes time, income, and care within the family in a manner that places the greatest burden on the mother.

Poverty appears as a direct link between diagnosis and treatment. The cost of transportation, medicine, formula milk, and special tests prevented regularity in care, even when some items were available in the market. Families were forced to rely on aid, limited manual work, or search among multiple institutions to obtain formula milk, diapers, and supplements. Consequently, economic accessibility constitutes an essential part of treatment, and not a social issue separate from health.

Testimonies of congenital anomalies and disorders and the linkage with the rights and the law

The testimonies reveal interrelated harms affecting the rights of women and children to life, health, food, and care during pregnancy, childbirth, and afterwards. Deprivation of adequate food, iron, folic acid, and necessary supplements is linked to the rights to food and health under Articles (11, 12) of the ICESCR, to care and nutrition during pregnancy and breastfeeding under Article (12/2) of the "CEDAW" Convention, and to the rights of the child to survival, development, health, and an adequate standard of living under Articles (6, 24, 27) of the Convention on the Rights of the Child. These facts are also connected to guarantees of supplies and protection of the elements of civilian survival in Articles (23, 55) of the Fourth Geneva Convention and Article (54) of the First Additional Protocol. This deprivation remains an infringement of health

[137] See annex with a list of testimonies and their dates for women mentioned in the text under the list of women who gave birth to infants with congenital anomalies or disorders.

needs, even when it is impossible to prove its causal relationship to the emergence of the individual congenital condition.

The disruption of pregnancy follow-up, delayed diagnosis, and shortage of childbirth, incubator, surgery services and medicines affect the availability, accessibility, quality, and continuity of care, under Article (12) of the ICESCR, General Comment (14), Article (12) of "CEDAW", and General Recommendation (24). This threatens the best interests of the child, his survival, development, and health, under Articles (3, 6, 24) of the Convention on the Rights of the Child, and the right to life under Article (6) of the ICCPR. The protection of patients, pregnant women, childbirth cases, facilities, health workers, and the securing of supplies and relief, fall within Articles (16, 18, 20, 23, 55, 56) of the Fourth Geneva Convention, Articles (12, 15, 16, 70) of the First Additional Protocol and UNSC resolution (2286).

Delay in referral and medical evacuation is connected to the rights to life and health, especially when it is impossible to provide necessary treatment locally. Its reference is found in Articles (16, 17, 56) of the Fourth Geneva Convention, Article (10) of the First Additional Protocol, Articles (3, 6, 9, 24) of the Convention on the Rights of the Child, including consideration of the child's interest and family ties, and Articles (11, 25) of the Convention on the Rights of Persons with Disabilities. Obstructing or delaying specialized treatment may constitute a violation when medical necessity is established, along with the responsibility of the party with decision-making and control, the possibility of facilitation, and the absence of a legitimate and proportionate justification for the delay.

Displacement, inadequate housing, and water shortage deepen difficulties of care and recovery, affecting the rights established in Articles (11, 12) of the ICESCR, Article (27) of the Convention on the Rights of the Child, and Principles (18, 19) of the Guiding Principles on Internal Displacement, and are linked to Articles (27, 49, 55, 56) of the Fourth Geneva Convention according to the facts and conditions of applicability. The facts of bombardment also call for examining respect for the rules of distinction and proportionality, protection of civilian objects, and precautions under Articles (48, 51, 52, 57) of the First Additional Protocol; in addition to the need to document the time of each attack, its place, the party responsible for it, and its circumstances in order to determine the legal characterization.

The damages extend to the mental health of mothers, the stability of families and their ability to bear treatment costs and care burdens, within the scope of Articles (9, 11, 12) of ICESCR, and Articles (18, 26, 27) of the Convention on the Rights

of the Child. Regarding children with disabilities, Article (23) of the Convention on the Rights of the Child and Articles (7, 11, 25, 26, 28) of the Convention on the Rights of Persons with Disabilities establish the guarantee of protection in emergencies, care, rehabilitation, and social protection, taking into account the needs of their families.

The right to health and health information requires providing the mother and family with accurate and understandable information that distinguishes between confirmed diagnosis, suspicion, and unproven hypotheses, in a way that supports informed consent under Article (12) of ICESCR and General Comment (14). It is not right to attribute the congenital or neurological condition to the mother's food or a specific exposure without medical evidence, because of the possible blame, stigma, and impact on care decisions that may result. The final characterization of violations remains conditional on verification of the facts, the applicable obligations, and responsibility for documented acts or omissions.

The following table links the facts with the law, providing a structured framework for interpreting the patterns documented in the testimonies by identifying the affected rights, the relevant legal obligations, and their references in IHRL and IHL:

Title	Central legal obligation	Main references
Medical personnel	Respect, protection, and non-obstruction; safeguarding of medical facilities, transport, and operations.	4th Geneva convention: 18,20,56; First protocol: 12,15,16; Customary rules: 25-29; UNSC Res. 2286.
Congenital cases	Maternal and child health, survival and development, prevention, detection, safe childbirth, and timely treatment.	ICESCR: 12 CEDAW: 12/2 Convention of the Rights of the Child: 3,6,24; 4th Geneva Convention: 16, 23,55,56; Disability Convention when applicable:

Title	Central legal obligation	Main references
Older women	Effective and non-discriminatory access to medicine, food, shelter, transport, and services, while upholding autonomy and dignity.	ICESCR and ICCPR :life, health, food, housing and privacy; CEDAW: 12 and Recommendations 27, 30; 4th Geneva Convention: 16, 55, 56, 59; UN principles for Older persons
Amputation	Care for the wounded, prevention of further avoidable damage, continuity of treatment, rehabilitation, mobility, and accessibility.	ICESCR and ICCPR 6&12 4th Geneva Convention: 16, 18, 20, 55, 56; Disability Convention: 9, 11, 20, 25, 26, 28; Convention of the Rights of the Child for cases of minors.

Gender and Intersectional Dimensions

A joint reading of the testimonies of older women, girls and women amputees, and mothers who have experienced congenital conditions or pregnancy- and childbirth-related disorders, reveals that harm is not determined by injury or medical diagnosis alone, but is shaped through the interaction of gender with age, family status, poverty, displacement, chronic illness, disability, and access to services. The gender dimension is not restricted to the fact that the persons who gave the testimonies are women, but rather, it appears in their unequal exposure to deprivation, the distribution of care responsibilities within the family, and their ability to recover, make decisions, and maintain autonomy. This perspective helps explain common patterns across groups, without overlooking differences in their needs or assuming identical experiences.

Accumulation of harm and the interaction of health condition with the collapse of services

The testimonies indicate successive pathways during which harm accumulates. In cases of amputation, the pathways begin with injury and bleeding and are affected by the speed of ambulance response and the health facility's capacity to provide surgery, blood transfusion, and anesthesia, then by the availability of antibiotics, painkillers, bandages, nutrition, and follow-up. In later stages, opportunities to regain autonomy are determined by the availability of

rehabilitation, appropriate devices, transport, adapted housing, and psychosocial support. Therefore, the impact of limb loss may extend to restricting education, work, participation, and family life when these services are disrupted.

A similar pathway appears in pregnancy and childbirth experiences; nutritional deprivation, interruption of supplements, and disruption of examinations overlap with difficulties of delivery, diagnosis, and treatment, then with long waits to obtain surgery, evacuation, or rehabilitation. This relationship alone does not establish the cause of the congenital or neurological condition, but it reveals the conditions that restricted opportunities to detect and address it in a timely manner. Among older women, chronic illness and functional limitations interact with interruption of medication, poor nutrition, and displacement, increasing dependence on others and limiting the ability to manage daily needs.

Accordingly, the impact of disability cannot be understood in isolation from the surrounding environment. The effects of physical or sensory impairment worsen in the absence of accessible facilities and appropriate devices and services. The testimonies of (T.F., T.M., T.N., and T.S.) illustrate this interaction between the child's health condition and delayed treatment, rehabilitation, and assistive devices[138].

Unpaid care and the transfer of burdens among women and across generations

The transfer of care burdens to women represents a common pattern across the three themes. The burden of female care appeared explicitly in 12 testimonies of older women, and the women who gave the testimonies authors relied on daughters, daughters-in-law, and granddaughters to fetch water, food, and medicine, change clothes, care for wounds, and accompany them to health facilities. In some cases, the sick women themselves continued to support or care for family members. Hence, gaps in health services, transport, and relief turn into unpaid domestic and care work, whose impact extends to caregivers' time, health, and opportunities for education, work, and social life.

In cases of amputation, the injury interacted with the existing distribution of labor within the family. The loss of an upper limb among (B. H., B. Y., B. K., and B. A.), and among (B. T.) who lost a hand and a leg, affected food preparation, washing, dressing, and childcare. The loss of a lower limb also restricted fetching water, access to the toilet and hospital, and performing household chores. Women's value is not reduced to these functions; rather, the testimonies reveal

[138] See the annex with a list of testimonies of women with infants with congenital conditions or disorders, particularly the statements of (T.F., T.M., T.N., T.S.) and the mentioned dates.

how the concentration of care responsibilities on them increases the familial and social impact of injury, and how some of these responsibilities transfer to daughters and sisters.

The same burdens are evident among mothers; some continued to fetch water, cook, move around, and care for family members despite anemia, cesarean delivery, or illness. After the child's health condition appeared, the mother became the primary link between hospitals, committees, and pharmacies, while continuing her responsibility for the other children. Thus, the need for care was coupled with the duty of providing it to others, narrowing opportunities for recovery and rest.

Widowhood, loss of breadwinner, poverty, and decline in family support

Gender overlaps with family and economic status in determining actual ability to access treatment. The older women sample included ten widows and one divorced woman, in addition to cases that had lost a husband or son who provided income or support. The absence of independent income led to reliance on irregular assistance, or on sons who themselves suffered unemployment, injury, or displacement. Therefore, the existence of relatives or children is not sufficient evidence of available support; a woman may remain without medicine or transport despite having a family network around her.

This overlap was repeated among women amputees and mothers; amputation, widowhood, and loss of breadwinner converged in the case of (B. T.), while the case of (B. J.) was coupled with orphanhood and bearing responsibility for younger siblings. (T.D.) and (T.M.) became widows responsible for children requiring long-term follow-up, so the loss of a husband combined psychological trauma with loss of income and support in mobility and managing care.

These cases show that assessing need at the household level alone may conceal individual deprivation within it. The availability of assistance to the family does not necessarily mean it is sufficient to cover medicine, special food, transport, devices, and accompaniment, nor does it guarantee the woman's access to them her ability to set priorities for their use.

Age, pregnancy, chronic illness, and different protection needs

The nature of harm and response requirements vary by age and health status. The child Asmaa needs devices suited to her growth, and educational and psychological support and age-appropriate participation in decisions related to her care. (B.D.) was a minor at the time of injury, making recovery, education, and reintegration essential elements in the response to her needs. On the other

hand, (B.S.)'s case intersected with old age, diabetes, and high blood pressure, requiring integration of rehabilitation with chronic disease follow-up and prevention of infection, pressure ulcers, and complications of prolonged bed rest. (B.Y.)'s case was coupled with pregnancy and recent childbirth, so the injury added needs related to recovery and caring for the newborn.

In the pregnancy and childbirth theme, (T.W.)'s testimony indicates the woman who gave the testimony was young at the time of pregnancy, which needs verification before adopting a specific age description, while taking into consideration the need for protection from stigma and pressure toward a rapid new pregnancy after the death of the newborn, and respecting recovery and free and informed choice. Dr. (S.B.) noted the young age of some mothers as a possible risk factor requiring services appropriate to adolescents, without blame or causal generalization[139].

These differences reveal that a uniform response does not necessarily achieve actual equality; the child needs growth-sensitive follow-up, the older woman needs integration of chronic disease treatment and rehabilitation, the woman who lost a hand needs occupational therapy and tools that support one-handed use, and the mother needs arrangements that allow her to receive treatment while meeting her child's needs.

Privacy, dignity, and autonomy in displacement environments

Privacy problems recur in using the toilet, bathing, changing clothes and diapers, wound care, and receiving examinations. They become more severe inside tents, schools, and overcrowded shelters. These problems acquire a gender dimension when they limit women and girls' ability to choose facilities or obtain help in a manner that respects their bodies and decisions.

Dignity and autonomy are inseparable from the availability of water, an accessible toilet, safe space, hygiene supplies, and appropriate bedding. Providing the same device or appointment to everyone does not ensure equal benefit; a woman living in a tent on sandy ground, without transport, facilities, or income, faces obstacles different from those faced by a woman in adapted housing. This also applies to the ability to stand in queues, hear instructions, or reach a distant toilet.

Health staff testimonies support the importance of these dimensions. Dr. (S.J.), when speaking about older women, referred to (severe psychological stress and

[139] Statement of Dr. (S.B.) on 8/2/2026.

high blood pressure)[140], while (S.Z.) explained that loss of movement or a limb is associated with changed body image, motherhood and care roles, and increased dependence on the family[141]. Here, the importance of providing support in a way that preserves the woman's choice and autonomy, and meets physical needs emerges.

Mother blaming, stigma, and the right to information and choice

A specific gender dimension appears in interpreting congenital and neurological conditions, when the mother is held responsible for her child's condition because of her nutrition or exposure to smoke, without reliance on medical evidence proving a direct causal relationship. This interpretation overlooks that food and supplement shortages, displacement, and exposure to unsuitable environments occurred under coercive conditions that greatly limited women's ability to make choices regarding their health and their children's health. It also obscures the multiplicity of possible medical, genetic, and environmental factors, and leads to stigmatizing women and holding them responsible without necessarily having a medical basis. From the right-to-health perspective, it is important to ensure that women obtain accurate and reliable health information, and respectful, non-stigmatizing care, that enable them to participate in decisions related to their health and their children's health, and to make informed choices within the limits their circumstances allow.

This discourse may deepen feelings of guilt and stigma and affect the family's understanding of the condition and its treatment decisions. Therefore, health communication should distinguish between a risk factor and a proven cause, and between a confirmed diagnosis and a suspicion requiring additional tests. Respecting the mother's autonomy includes providing her with clear information, psychological support, and space to make decisions, including decisions related to recovery and subsequent pregnancy, away from pressure and blame.

Rights implications of a gender and intersectional response

Article (12) of CEDAW, General Recommendations (24) on women and health, (27) on older women, and (30) on women in conflict prevention, conflict and post-conflict situations, support reading the varying impact of deprivation and the need to respond to women's needs as independent rights holders. Article (6) of the Convention on the Rights of Persons with Disabilities also provides a framework for understanding the overlapping discrimination that women and

[140] Statement of Dr. (S.J.) on 1/2/2026.
[141] Statement of (S.Z.) on 8/2/2026.

girls with disabilities face, and Articles (7, 11) support the protection of children with disabilities and responding to their needs in situations of risk and humanitarian emergencies. UNSC Resolution (1325) provides a framework for integrating a gender perspective into protection, participation, and conflict response, without replacing direct obligations under human rights treaties and IHL.

This reading requires designing services according to individual need and the actual conditions for benefiting from them, by linking treatment and rehabilitation with transport, adapted housing, social protection, psychosocial support, and support for caregivers. It also requires involving women and girls in decisions that affect their lives, and not assuming that the family is automatically able to fill service gaps. Removing barriers, reducing care burdens, and protecting privacy are essential conditions for actual access to health, recovery, and participation.

General conclusions

1. The literature review and aggregate analyses reveal that the damage inflicted on the health system in the Gaza Strip took the form of an interconnected collapse encompassing facilities, primary care, teams, ambulance services, medicines, fuel, tests, the referral system, medical evacuation, and rehabilitation. This was accompanied by a sharp deterioration in basic determinants of health, including food, water, sanitation, shelter, and a safe environment, deepening the impact of the health crisis on the entire population.
2. This collapse produced direct damages resulting from military actions, and indirect damages resulting from delayed ambulance response, interruption of treatment, inability to follow up, and shortages of food, medicine, and rehabilitation. The testimonies confirm that actual enjoyment of the right to health does not depend on the temporary or intermittent availability of a health service, but requires continuity of the care chain, from prevention and access to service, diagnosis, and treatment, through follow-up, rehabilitation, and long-term care.
3. The effects of the war were not distributed equally, but multiplied among those in whom gender, age, disability, chronic illness, poverty, displacement, and loss of breadwinner intersect. Gaps in the health and relief system also moved into the family and were translated into additional burdens of unpaid care and domestic work, the largest part of which women bear, exacerbating existing

inequalities and limiting their ability to access health services, resources, and recovery opportunities.

4. There were many barriers to access, including danger on roads, damaged facilities, overcrowding, high cost, absence of facilities, lack of accessibility in buildings, toilets, and shelters, and difficulty registering for assistance. Hence, it is not possible to separate economic, spatial, functional, and informational accessibility from one another.
5. Shelter, water, toilets, and privacy are not living issues separate from health; they affect infection, wound healing, chronic diseases, reproductive and mental health, autonomy, and dignity, especially among older women, women with disabilities, mothers, and children.
6. Health effects extend beyond the acute phase; amputation, neurological injuries, neonatal disorders, and uncontrolled chronic diseases require treatment, rehabilitation, and follow-up for years, while recovery requires restoring personnel, supply chains, referral, rehabilitation, social protection, and data, not only reconstructing buildings.
7. The documented patterns raise serious issues related to harm to the right to life, health, food, housing, dignity, and non-discrimination, and to special protection for the most vulnerable groups and health care during conflict, while the final legal characterization remains linked to independent verification of facts and responsibility, and the conditions for the applicability of legal rules.

Conclusions on older women's testimonies

1. The interruption of medicines, tests, monitoring means, adequate food, and medical follow-up turned manageable chronic diseases, such as diabetes, high blood pressure, and heart and kidney diseases, into acute risks threatening life, autonomy, and mobility.
2. Barriers to movement and transport and the need for accompaniment, along with inaccessible shelters and toilets, lack of privacy, and absence of basic supplies, doubled the difficulty of access to care and affected health, dignity, and physical and psychological well-being.
3. The overlap between food insecurity, weak social protection, and chronic diseases reveals an inseparable linkage among the rights to health, food, and social protection. Women forced to choose between buying medicine and securing food or transport is an indicator of the response's failure to guarantee the minimum of basic rights.
4. Older women relied on other women within the family to provide care and secure medicine and transport, while some older women continued to care

for grandchildren or persons with disabilities. This led to the transfer of the impact of the crisis across generations and increased physical and psychological burdens and unpaid care work.

5. Older women face the risk of exclusion from registration, aid distribution, and decision-making, especially when digital mechanisms are adopted, personal attendance is required, or the woman is included within a household file that does not reflect her individual needs. This requires facilitative and affirmative measures that ensure their actual and independent access to services.

Conclusions on testimonies of women and girl amputees

1. Amputation is not a single surgical event, but the beginning of a long pathway of care, including ambulance response, bleeding control, surgery, infection prevention, pain management, nutrition, physical and occupational therapy, assistive devices, prosthetics, and psycho-social and economic support.
2. Cases of wound inflammation, persistent pain, and shortages of painkillers, antibiotics, bandages, and nutrition reveal severe weakness in post-surgical care; closing the wound does not mean treatment is complete or that the risk of losing an additional limb or permanent complications has ended.
3. The disruption of rehabilitation and prosthetic services, and the absence of an accessible environment in shelters, transport, and toilets, expanded the scope of disability and limited autonomy and access to education, work, and community participation.
4. The amputation experience carried specific gender dimensions related to privacy, body image, sexual and reproductive health, motherhood, care, dependence on the family, stigma, and risks of violence and exploitation. Girls and adolescents in particular need continuous follow-up and periodic replacement of devices and prosthetics in line with growth, while ensuring continuity of education and psycho-social support.
5. The statements confirm that obtaining a referral or administrative approval does not necessarily equal actual access to treatment. Delay in evacuation or specialized surgery may lead to loss of a treatment opportunity, a higher level of amputation, or stiffness, atrophy, infection, and complications that are barely reversible.

Conclusions specific to congenital anomalies and disorders

1. The cases in the statements do not fall under a single diagnosis, but include structural congenital defects, cardiac, neurological, and skin disorders,

prematurity, low weight, oxygen deficiency, feeding disorders, pregnancy loss, and others. Therefore, there is a need to avoid automatically classifying all cases as congenital anomalies, and to make a distinction between confirmed diagnosis, suspicion, and medical hypothesis.

2. The clearest result supported by the testimonies is the collapse of conditions for prevention, detection, planning, and treatment during pregnancy, childbirth, and the postpartum period, including nutrition, supplements, follow-up, imaging, tests, incubators, oxygen, medicines, specialized nutrition, surgery, and medical referrals.
3. Delayed detection and referral led to loss of opportunities to plan for birth and prepare incubators and specialized teams. It also revealed a sharp contrast between clinical time and administrative time; some children need intervention within hours or days, while evacuation or obtaining approval may take longer than the acceptable treatment window.
4. Mothers bore a compound burden including daily care, searching for medicine and food, securing transport and referral, following up treatment, and dealing with anxiety, stigma, and uncertainty, amid the risk of neglect of their physical and psychological health after childbirth.
5. Cases that may lead to long-term impairment require an approach based on the rights of the child and the rights of persons with disabilities, including early intervention, rehabilitation, inclusive education, social protection, protection of the family and caregivers, and the establishment of independent records and epidemiological studies without drawing unproven causal relationships.

Legal and operational responsibility

Responsibility of the occupying power and parties to the conflict

The occupying power and the parties to the conflict, each within the scope of their obligations under IHL and IHRL, bear the responsibility to respect and protect civilians, the sick, and the wounded, and to ensure respect for and protection of medical facilities, personnel, and medical transport, and not to obstruct their work in violation of international law. These obligations also include facilitating access to medical and humanitarian supplies, ensuring the continuity of health care, not obstructing treatment or medical evacuation, and taking necessary measures to ensure that the population can access food, water, medical supplies, and other basic needs safely, in a timely manner, and without discrimination.

This responsibility is not limited to refraining from committing violations, but also includes taking the necessary affirmative measures to fulfil relevant legal

obligations, including protecting the health system and its workers, facilitating access to assistance and medical services, and ensuring continuity of care for groups most at risk, including women and girls, older persons, persons with disabilities, and persons with chronic diseases.

Responsibility of states and the international community

States are obligated to take all available political, diplomatic, and legal measures, to ensure respect for international law and to prevent violations of IHL and IHRL, or contribute to them. This includes using available means to press for respect for international law, facilitate access to humanitarian and medical assistance, support investigation and accountability mechanisms, and ensure victims' right to access remedies and reparation. The international community bears responsibility to support protection and accountability mechanisms, enhance access to assistance and health services, and follow up on the implementation of relevant international obligations.

Responsibility of Palestinian authorities and institutions

The Palestinian government, ministries, and public institutions bear responsibility for planning, organizing, and providing health, social, educational, and rehabilitation services, managing data and referrals, providing social protection, and establishing response mechanisms for groups most in need, within the limits of their jurisdiction and actual capacity. In assessing the responsibility of Palestinian authorities and institutions, the limits of jurisdiction, actual capacity, and available resources must be taken into account, in addition to restrictions imposed on service provision and access. This responsibility does not extend to effects arising directly from factors outside their control, including occupation, blockade, restrictions on movement and access, and the flow of supplies. Within the limits of their powers and capabilities, they remain obligated to take possible measures to reduce the effects of these restrictions and to enhance the continuity of basic services and the protection of groups most at risk.

Responsibility of UN agencies, humanitarian organizations, and donors

Their responsibility consists of providing sustainable technical, humanitarian, and financial support that responds to the actual needs of the population; securing supplies and specialized services regularly and safely; strengthening the capacities of local institutions and personnel, and supporting early recovery and the rehabilitation and rebuilding of the health system in a manner that ensures continuity of services, and based on the principles of justice, non-discrimination,

and equality of access, with particular attention to groups most at risk and their specialized health needs.

Responsibility for monitoring, investigation, and accountability

UN mechanisms, treaty bodies, fact-finding and investigation commissions, the Office of the High Commissioner for Human Rights, and judicial mechanisms and human rights institutions bear responsibility for monitoring, investigating, preserving evidence, and identifying patterns of violations and responsibilities, while ensuring the protection of victims and witnesses and not exposing them to retaliation or stigma. This role is fundamental to ensuring referral of violations to competent accountability mechanisms, holding those responsible accountable, preventing impunity, and supporting victims' right to access justice, remedies, and reparation.

Responsibility of civil society and local actors

Local, feminist, and human rights institutions, organizations of persons with disabilities, community committees, universities, and unions play a fundamental role in reaching out to marginalized groups, monitoring their needs and documenting violations they face, facilitating referral to available health, social, and legal services, and monitoring service quality and equity in aid distribution. Civil society also contributes to advocacy for the protection of rights, enhancing affected women's access to complaint and remedy mechanisms, and supporting their participation in recovery pathways and the rebuilding of services and reconstruction based on justice and non-discrimination.

Recommendations by responsible party

The following recommendations stem from the principle of multiple levels of responsibility, with distinction between responsibility for violations and the roles of humanitarian and local actors in responding to their effects. These actors' assumption of service provision does not transfer to them responsibility for the violation, nor does limited resources justify disrupting basic obligations, especially protecting life, non-discrimination, and ensuring access to life-saving health care. The recommendations are based on the principles of participation, accountability, transparency, do no harm, confidentiality, informed consent, and substantive equality, requiring the integration of gender, disability, and age considerations in all stages of planning, implementation, and evaluation.

Recommendations addressed to the occupying power and parties to the conflict

Immediate cessation of attacks and grave violations targeting health facilities, medical personnel, and medical transport, or obstructing their work, and full compliance with IHL obligations regarding respect for and protection of the wounded, sick, and health care.

- Lift all restrictions obstructing the entry of medicines, fuel, blood, medical consumables, surgical and sterilization supplies, oxygen, medical devices, rehabilitation materials, prosthetics, therapeutic food, water, and materials necessary for the continued operation of health facilities.
- Ensure safe, rapid, and non-discriminatory passage for ambulances, personnel, patients, the wounded, and supplies, preventing delays that cause medical intervention to lose its clinical value.
- Ensure evacuation and treatment outside the Gaza Strip for cases whose treatment is unavailable locally, according to medical priority and clinical time, while facilitating travel of companions, preserving family unity, and not separating children from their mothers or caregivers.
- Protect basic health infrastructure, including water, electricity, sanitation, food, and shelter, and ensure meeting the special needs of pregnant women, children, older persons, persons with disabilities, and chronic patients without discrimination.
- Allow independent and safe access for humanitarian and human rights bodies and monitoring and investigation mechanisms to facilities, sites, victims, and relevant records, and ensure preservation of evidence and not obstruct investigation into attacks or restrictions that led to disruption of health care.

Recommendations addressed to states and the international community

- Take effective and binding political, diplomatic, and legal measures to stop attacks and restrictions imposed on health care, and ensure respect for international law, not merely condemnation or subsequent response to damage.
- Refrain from transferring weapons or equipment or providing support that may contribute to the commission of grave violations, and subject military and security cooperation to strict standards related to the protection of civilians, health care, and accountability.
- Establish stable, multi-state arrangements to receive patients and the wounded, facilitate visas, transport, treatment, and follow-up, ensure travel of companions, and avoid family separation.
- Provide flexible, sustainable, multi-year funding to rebuild the health system, with clear allocation of resources for mental health, chronic diseases, maternal

and child health, rehabilitation, prosthetics, and services for older persons and persons with disabilities.
- Link funding to measurable indicators on equity, non-discrimination, and actual access, not merely to number of facilities or volume of supplies provided.
- Support independent investigations, evidence preservation, accountability mechanisms, and reparation, and ensure the participation of women and affected groups in designing response, recovery, and reconstruction programs.

Recommendations addressed to the United Nations and its international mechanisms

- Follow up the implementation of obligations and resolutions related to the protection of civilians, health care, and women, peace, and security, and issue periodic reports on attacks on health care, access, medical evacuation, and availability of supplies.
- Support independent investigation mechanisms, evidence collection, monitoring, documentation, and identification of patterns of responsibility; integrate gender and intersectional analysis, and document cases in which delay or denial of treatment led to death, complications, or disability.
- Strengthen the role of the Office of the High Commissioner for Human Rights, the international fact-finding and investigation commission, special procedures, and treaty bodies in following up on denial of health care and facilitate access of victims and Palestinian institutions to complaint and monitoring mechanisms.
- Strengthen the role of the World Health Organization (WHO) in monitoring attacks on health care, coordinating supplies and medical evacuation, restoring specialized services, building unified health information systems, and developing protocols for post-amputation care, chronic diseases, incubators, and rehabilitation.
- Strengthen the roles of UNICEF, United Nations Population Fund (UNFPA), and UN Women in the areas of child and premature infant care, maternal health, sexual and reproductive health, nutrition, rehabilitation, and inclusive education, with gender mainstreaming and ensuring the participation of women and feminist organizations.
- Improve coordination of access, shelter, and basic services, in cooperation with the UN Office for the Coordination of Humanitarian Affairs (OCHA), UNRWA, and relevant agencies, to adapt shelters, toilets, water, and privacy, and establish facilitated registration and grievance mechanisms for persons unable to attend in person or use digital platforms.

Recommendations addressed to the Palestinian government, ministries, and public institutions

- Adopt an integrated national health recovery plan that links rebuilding facilities with restoring personnel, supply chains, specialized services, referrals, rehabilitation, mental health, maternal and child health, and chronic diseases.
- Establish a unified high-risk case management system, that includes national lists for referral and evacuation according to medical priority and clinical time, a clear contact point, and updated information available to the patient or family.
- Rebuild a secure health information system, disaggregated by sex, age, disability, diagnosis, location, displacement status, and treatment outcome, while ensuring privacy protection and obtaining informed consent.
- Expand mobile services and home visits, facilitated health transport, and non-digital communication lines to ensure access for persons unable to reach facilities or use electronic platforms.
- Develop unified clinical protocols for chronic diseases, limb salvage, post-amputation care, incubators, high-risk pregnancy, early intervention, and pain and infection management, while providing training and quality review.
- Expand social protection and individual cash assistance programs to cover the costs of medicine, transport, therapeutic food, assistive devices, hygiene supplies, and shelter, and link them to education, work, rehabilitation, and protection from violence.
- Ensure the effective participation of older women, women with disabilities, mothers, and caregivers in planning, needs assessment, and monitoring service quality, and provide safe, confidential, and facilitated grievance mechanisms.

Recommendations addressed to international and humanitarian organizations, the International Committee of the Red Cross, and donors

- Provide regular and adequate health supplies based on updated needs lists, tracking gaps, and ensuring equitable distribution and access of groups most in need to materials and services.
- Fund and operate mobile health teams, home visit programs, and transport and accompaniment services, and link health care with shelter, food, water, and social protection.
- Support the restoration of rehabilitation, prosthetic, physical and occupational therapy, pain management, and mental health services, and secure raw materials, personnel, maintenance, and periodic replacement of devices.

- Adapt shelters and temporary housing according to accessibility, safety, and privacy standards, and provide accessible toilets, lighting, water, mattresses, diapers, and assistive devices.
- The International Committee of the Red Cross (ICRC) shall continue, as part of its mandate, its efforts to protect health care, facilitate family links, evacuation, treatment, and rehabilitation, and disseminate IHL rules, and monitor compliance.

Recommendations addressed to local institutions, civil society, universities, and unions

- Develop community access mechanisms to monitor women, older persons, persons with disabilities, mothers, and children unable to access registration and services, refer them, and follow up on responses by competent authorities.
- Continue systematic human rights and clinical documentation of denial of treatment, referrals and supplies, and their health impact, while protecting privacy and ensuring informed consent and the safety of victims and witnesses.
- Monitor equity in aid distribution, service quality, facility accessibility, and document cases of exclusion or discrimination, and report findings to governmental and international authorities and UN mechanisms.
- Provide legal, psychological, and social support and support groups for women amputees, older women, mothers, and families caring for children with complex health needs.
- Support the participation of affected women in advocacy, decision-making, and service evaluation, and not reduce their roles to mere beneficiaries or caregivers.
- Encourage universities, research centers, unions, and professional associations to conduct independent and long-term studies, develop professional protocols, review quality, support the protection of health personnel, and restore human capital.

Practical recommendations for the three groups

Practical recommendations for older women

- Establish an updated, voluntary, and confidential registry of older women with chronic diseases, disabilities, or multiple health needs, and provide regular home delivery of medicines and monitoring means.

- Form mobile health teams that take into account the needs of aging, chronic diseases, mental health, and rehabilitation, and provide examinations and wound care inside shelters and homes.
- Provide facilitated transport and accompaniment to clinics, hospitals, and referral centers, and not disrupt treatment when accompaniment is medically or functionally necessary.
- Provide accessible, safe, lighted, and close health facilities and toilets, along with diapers, mattresses, assistive devices, and personal assistance services, while respecting privacy and autonomy.
- Provide therapeutic nutritional support that suits chronic diseases, monitor weight, wasting, anaemia, and dehydration, and ensure individual entitlement to social protection, with home-based registration and grievance mechanisms, or through or a trusted representative.
- Conduct a dual assessment of the woman's needs and the needs of those she cares for, and provide alternatives or support for care work so that women are not forced to give up their treatment.
- Provide psycho-social interventions that take into consideration age and sensory and cognitive status, support autonomy, and alleviate isolation, violence, and neglect.
- Integrate older women into shelter management committees and service and recovery planning, and adopt indicators that measure their actual access to health, food, water, shelter, and protection.

Operational recommendations specific to women and girl amputees

- Upgrade protocols of limb salvage and complex injuries, document the causes for the amputation decision, its level, and prior interventions, and conduct an independent clinical review of cases where delay or inadequate care is suspected to have led to a higher level of amputation.
- Establish a unified post-amputation care pathway that begins before hospital discharge and includes wound care, infection prevention, neuropathic and phantom pain management, nutrition, physical and occupational therapy, psychological support, and social follow-up.
- Secure antibiotics, painkillers, bandages, and wound care supplies free of charge and regularly, with home follow-up and an early warning system for infection, gangrene, and risk of losing an additional limb.
- Restart and expand prosthetic services, providing raw materials, personnel, maintenance, adjustment, and periodic replacement, and adopt an individual assessment that takes into account the limb, environment, and work, education, and care needs.

- Give special priority to children and adolescent girls in providing prosthetics and assistive devices and replacing them in line with their growth.
- Provide wheelchairs, crutches, walkers, and other assistive devices, and adapt shelters, toilets, transport, and access routes to ensure accessibility and autonomy. The absence of an accessible environment not only affects mobility, but also may aggravate the impact of injury and limit the ability to access services and participate, turning the injury into a broader and more enduring disability.
- Accelerate medical evacuation for cases facing risk of additional amputation or needing reconstructive surgery or specialized treatment unavailable locally, according to a clear clinical time limit, while ensuring travel of companions and continuity of the medical file.
- Provide long-term psycho-social, and gender-sensitive services that take into consideration trauma, body image, stigma, sexual and reproductive health, protection from violence, and privacy, while ensuring continuity of education, work, and livelihoods.
- Establish a secure and confidential national registry of amputation cases and rehabilitation needs, disaggregated by sex, age, amputation level, location, need for prosthesis or assistive device, and follow-up outcomes.

Operational recommendations on congenital anomalies and disorders

- Restore the regular and free antenatal care package, including examinations, imaging, high-risk pregnancy follow-up, chronic disease medicines, iron, folic acid, supplements, and nutritional counselling.
- Provide nutritional support for pregnant and breastfeeding women and infants, monitor anaemia, weight, fetal growth, and milk production, and secure safe feeding alternatives when breastfeeding is not possible.
- Rehabilitate safe delivery services and incubators, and secure beds, oxygen, ventilators, surfactant, antibiotics, cardiac medicines, intravenous nutrition, blood, electricity, water, and specialized personnel.
- Establish expedited referral channels for cardiac, neurological, surgical, and rare cases, link them to pre-designated receiving centers, so that a medical decision sets the maximum acceptable waiting time, and ensure that the mother or caregiver accompany the child during travel.
- Establish a unified and confidential registry of congenital anomalies, neonatal outcomes, prematurity, and pregnancy loss, using unified diagnostic definitions and disaggregated data, and conduct independent epidemiological studies before concluding any causal relationships.

- Provide early intervention, physical and occupational therapy, speech, hearing, and vision therapy, and assistive devices for children with long-term impairment, and link this to inclusive education and social protection.
- Develop home follow-up services for at-risk children after discharge from the incubator, including follow-up of growth, nutrition, breathing, seizures, medicines, and danger signs, with a rapid referral line in case of deterioration.
- Integrate psycho-social support for families, and adopt a health communication protocol that clearly distinguishes between confirmed diagnosis, suspicion, and hypothesis, and prevents blaming the mother or holding her responsible for the child's health condition.
- Provide financial and social support for families caring for children with long-term needs, including costs of transport, treatment, rehabilitation, assistive devices, nutrition, and alternative care when needed.

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Annex 1: list of statements (by codes)

Statements of older women:

1- Statement of (K.B) on 3/2 /2026.
2- Statement of (K. J) on 4 /2 /2026.
3- Statement of (K.D) on 25 /1 /2026.
4- Statement of (K.H) on 30 /1 /2026.
5- Statement of (K.W) on 4/2 /2026.
6- Statement of (K.Z) on 9/2 /2026.
7- Statement of (K. HH) on 5/2 /2026.
8- Statement of (K.T) on 25/1/2026.
9- Statement of (K.Y) on 4/2/2026.
10- Statement of (K. L) on 25/1/2026.
11- Statement of (K.M) on 9/2/2026.
12- Statement of (K.N) on 3/2/2026.
13- Statement of (K.A) on 11/3/2026.
14- Statement of (K.F) on 2/2/2026.
15- Statement of (K.S) on 27/1/2026.
16- Statement of (K.Q) on 24/1/2026.
17- Statement of (K.R) on 30/1/2026.
18- Statement of (K.Sh) on 8/3/2026.

Statements of women and girl amputees

1- Statement of (B.A) on 5/2/2026.
2- Statement of (B.B) about her child sister Asmaa on 6/1/2026.
3- Statement of (B.J) on 4/2/2026.
4- Statement of (B.D) on 26/1/2026.
5- Statement of (B.H) on 3/2/2026.
6- Statement of (B.W) on 10/3/2026.
7- Statement of (B.Z) on 2/2/2026.
8- Statement of (B.H) on 14/2/2026.
9- Statement of (B.T) on 27/1/2026.
10- Statement of (B.Y) on 1/2/2026.
11- Statement of (B.K) on 3/2/2026.
12- Statement of (B.L) on 1/1/2026.
13- Statement of (B.M) on 28/1/2026.
14- Statement of (B.N) on 8/3/2026.
15- Statement of (B.S) on 2/9/2026.
16- Statement of (B.A) on 26/1/2026.

Statements of mothers who gave birth to infants with congenital anomalies or disorders

1- Statement of (T.A) on 24/1/2026.
2- Statement of (T.B) on 3/2/2026.
3- Statement of (T.J) on 9/3/2026.
4- Statement of (T.D) on 8/2/2026.
5- Statement of (T.H) on 26/1/2026.
6- Statement of (T.W) on 8/2/2026.
7- Statement of (T.Z) on 2/2/2026.
8- Statement of (T.HH) on 3/2/2026.
9- Statement of (T.T) on 2/2/2026.
10- Statement of (T.Y) on 24/1/2026.
11- Statement of (T.K) on 26/1/2026.
12- Statement of (T.L) on 2/2/2026.
13- Statement of (T.M) on 9/2/2026.
14- Statement of (T.N) on 10/3/2026.
15- Statement of (T.S) on 4/2/2026.
16- Statement of (T.A) with the name appearing in another format on 6/2/2026.
17- Statement of (T.F) on 8/2/2026.

Statements of the health personnel

1- Statement of Dr. (S.A), Oncologist and head of oncology department on 29/1/2026.
2- Statement of Dr. (S.B), head of Neonatal Nursery Department at Nasser Hospital on 8/2/2026.
3- Statement of Dr. (S.J), consultant in Nephrology and Internal Medicine at Nasser Medical Complex on 1/2/2026.
4- Statement of Dr. (S.D), General practitioner who worked at several hospitals and medical clinics, on 8/3/2026.
5- Statement of Dr. (S.H), Emergency and Coordination Officer and Health Sector Coordinator at the World Health Organization, on 4/2/2026.
6- Statement of Dr. (S.W), Specialist in Internal Medicine and Emergency Medicine, and Head of the Internal Medicine Department at Nasser Hospital, on 30/1/2026.
7- Statement of (S.Z), Psychologist and Rehabilitation Specialist, on 8/2/2026.
8- Statement of Dr. (S.HH), Head of the Physiotherapy Department at the Prosthetics Center in Gaza City, on 7/2/2026.
9- Statement of Dr. (S.T), Pediatric surgeon, the date appeared in the analysis file as 30/1/2026.