Conflict and Health

COMMENT

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When the system fails, the community leads: field insights from the self-efficacy and knowledge (SEEK) trial during Lebanon's 2024 active conflict

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Abstract

Background Adolescent girls and young women affected by conflict experience persistent sexual and reproductive health challenges along with poorer mental health and wellbeing. Among Syrian adolescent girls and young women living in Lebanon, these challenges are exacerbated by displacement, economic challenges, and barriers to accessing needed health services. Community-based interventions are being increasingly adopted to address these gaps, however evidence remains limited on how these interventions can be effectively implemented while preserving fidelity and quality during periods of active conflict, especially when centralized delivery models are not feasible.

Main body This paper presents a comment on implementation insights from the Self-Efficacy and Knowledge (SEEK) trial, a community-based integrated intervention conducted in two primary healthcare centers in Lebanon to improve sexual and reproductive health service uptake and psychosocial wellbeing among Syrian adolescent girls and young women aged 15–24. Specifically, during implementation, escalating conflict severely restricted mobility and on-site supervision by the central team, threatening intervention continuity. As a result, the team shifted the implementation model from a centralized structure to a decentralized one, emphasizing co-leadership with local communities. To that end, local and affected community members were recruited, trained, and supervised to assume responsibility for field coordination, management of logistical procedures, and decision-making in real time, supported by remote supervision. Subsequent outcome evaluations identified positive effects on some outcomes, and limited effects on others, indicating that SEEK's effectiveness varied across outcomes. Beyond these findings, the experience highlighted how adaptive approaches that shift power to affected communities during implementation amid active conflict can transform contextual constraints into opportunities for culturally responsive and resilient implementation.

Conclusion The implementation of SEEK demonstrates that community-led models may not be merely emergency substitutes when traditional delivery systems fail, but foundational strategies for effective humanitarian programming during conflict. Shifting power to local and affected communities as co-implementers can strengthen ownership,

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adaptability, and sustainability during active conflict. Community leadership, supported by flexible planning and agile decision-making may be essential for building resilient health interventions.

Keywords Conflict, Community-led implementation, Adolescent girls and young women, Sexual reproductive health, Wellbeing

Introduction and problem statement

Adolescent girls and young women (AGYW) affected by conflict continue to experience poor sexual and reproductive health outcomes (SRH) [1], alongside compromised mental health and wellbeing [2]. These challenges are particularly pronounced among Syrian AGYW living in Lebanon, who face harsh living conditions, and structural barriers to access healthcare [3]. Community-based interventions have emerged as practical approaches to promote their SRH and psychosocial wellbeing through ensuring services are accessible and appropriate [4–6]. Engaging community members not only as participants but also as facilitators, can contribute to a more culturally aligned intervention [7]. Despite their potential, there is limited evidence on their effectiveness, and on how they are implemented during active conflict [8].

The Self-Efficacy and Knowledge (SEEK) trial, a WHO-developed community-based intervention, was conducted at two primary health care centers (PHCs) in the Beqaa governorate of Lebanon. It focused on enhancing SRH service utilization and wellbeing among Syrian AGYW aged 15–24. During implementation, the escalating conflict in Lebanon led to unforeseen disruptions, necessitating immediate adaptation of operational processes. The model switched from centralized to localized community-driven co-leadership approach, whereby both local and affected communities shared responsibility for implementation. Active engagement of local and affected communities, along with flexible planning, was essential for effective and contextualized implementation. Based on findings of the Randomized Controlled Trial (RCT) which are under review at the time of writing this manuscript, SEEK significantly improved SRH knowledge and key psychosocial factors such as coping, perceived social support, self-efficacy, and overall wellbeing [9, 10].

This perspective paper draws on findings from the overall SEEK process evaluation [11] but also from the authors' implementation experiences, field observations, and collective team reflections. Accordingly, this paper argues that community-led models are a significant step forward in humanitarian responses, extending beyond traditional models to achieve greater ownership, cultural relevance, and sustainable impact. The SEEK's implementation suggests that this approach can turn contextual challenges into opportunities for promoting intervention fidelity and continuity particularly during active conflict.

Adaptive planning amid active conflict

The escalating conflict on Lebanon restricted the central (Beirut) team's ability to travel, provide on-site supervision, logistical support, and resource management, as originally planned. As the conflict intensified, concerns about travel risks and the intervention's delivery became paramount. The unpredictable situation prompted the project to be at risk of suspension. Thus, multiple contingency strategies were considered, including moving operations to other governorates, or switching to full online delivery. After a thorough assessment, the central team adopted a decentralized strategy that shifted on-site leadership and field-level decision-making to local and affected-community actors. The primary change in the leadership structure was the recruitment and training of two field coordinators from the local host communities, who assumed on-site operational leadership and coordination. They served as the main link between the PHCs, the locally based implementation team, and the remotely based core team. They coordinated staff and participants, managed intervention materials and logistical requirements, and responded to emerging site-level challenges.

Although participant communication, attendance monitoring, and rescheduling were part of the research assistants' initial roles, conflict-related disruptions required them to exercise greater autonomy. They made real-time decisions about reallocating participants to alternative session times or groups in response to rapidly changing attendance constraints and relayed participant and implementation needs to the field coordinators. Syrian refugee paraprofessionals continued to lead session delivery but assumed greater initiative in adapting how content was communicated and providing peer coverage when a colleague was unable to attend. Psychologists and midwives from the local host communities supported them through session preparation, responses to technical questions, and post-session feedback. Syrian refugee members of the LWCs complemented these roles by supporting communication with participants and assisting with implementation activities [11]. These actors worked through a coordinated structure in which emerging operational, participant-related, and technical issues were communicated across the implementation team. This decentralized shift, supported by remote monitoring from the core team, enabled local and affected community members to assume leadership of field operations and sustain intervention delivery amid active bombardment and ground occupation. Additional details on field

operations during the conflict are reported in the published SEEK process evaluation [11].

The strategic value of community-led implementation

The SEEK experience reveals how genuine adaptive involvement of local and affected communities preserved the intervention, particularly during active conflict. While studies rarely identified considerable community engagement in planning, implementation, and assessment phases of community-based interventions [12], SEEK provided a contrasting model. It presented community members as co-implementers, not merely recipients of externally delivered knowledge. The intervention's delivery became entirely dependent on the initiative of trained community members under remote supervision of the core team. As described above, field coordinators, research assistants, paraprofessionals, psychologists, midwives, and LWCs participated at different stages and contributed different forms of operational, technical, cultural, and community-based knowledge.

During implementation, the field coordinators provided locally situated operational leadership. Their proximity to the implementation settings enabled emerging logistical and participant-related challenges to be identified and managed more rapidly than through remote coordination alone. Regular communication between research assistants and participants allowed field arrangements to be adapted in response to participants' circumstances. These experiences indicated that on-site coordination and immediate decision-making were most effectively situated with local actors who understood the implementation context and could respond promptly to emerging needs.

Affected-community leadership was particularly evident in intervention delivery and cultural adaptation. As members of the affected community, Syrian refugee paraprofessionals drew on shared language, lived experience, and familiarity with participants' social and cultural contexts. This allowed them to recognize discomfort or disengagement, respond sensitively to participants' concerns, and use familiar vocabulary and relatable examples when communicating complex or sensitive sexual and reproductive health and psychosocial content [11]. Beyond delivering the materials provided during training, the paraprofessionals took the initiative to use additional visual aids, including images illustrating relevant health conditions, and examples drawn from their own lives and surroundings to make complex information more understandable. These additions were discussed with the psychologists and midwives to ensure technical accuracy and consistency with the intervention's objectives. The paraprofessionals also shared session experiences and challenges with one another and provided peer coverage when a colleague was unable to attend. This peer support contributed to the continuity and flexibility of intervention delivery. Psychologists and midwives provided continuous technical mentorship rather than only periodic supervision. They proactively established a WhatsApp group with the paraprofessionals to support Session preparation, respond to questions, and clarify mental health and sexual and reproductive health content. They also provided feedback following each session, creating an ongoing cycle of reflection that helped paraprofessionals strengthen subsequent delivery. The LWCs served as a link between the local implementation team and the affected communities. Their established relationships within the refugee community helped the team understand participant's concerns, facilitated communication through trusted and acceptable approaches, and helped respond to barriers that might not have been immediately apparent to staff outside the affected community.

Overall, the contributions of these different actors were complementary, bringing together locally situated operational knowledge, affected-community perspective, and professional expertise.

Thus, the intervention maintained fidelity while gaining cultural and contextual depth as a result of local leadership. The SEEK experiences suggests that local communities may be better positioned to lead field coordination than the central team given their close alignment with the communities being served.

Complementing this, the central team played an essential role in promoting unity and a shared sense of purpose, strengthening capacity, and facilitating a gradual transfer of power to local actors. While community actors managed implementation, the central team's dedication to listening, validating input, and sharing strategies and techniques generated a respectful and collaborative learning environment for local communities. By constantly emphasizing that the intervention's success relied on cooperation and co-leadership, the central team nurtured a shared dedication and purpose. This combination of relational accountability and distributed leadership was reinforced through open communication, whereby local and affected-community actors were encouraged to raise concerns, propose adaptations, and seek support when challenges emerged. The central team maintained regular contact and worked collaboratively to address concerns arising within the implementation team rather than withdrawing after responsibilities were decentralized. In informal conversations during implementation, locally based team members repeatedly expressed appreciation for the central team's availability, continuous communication, and confidence in their abilities. Although these perceptions along with the factors supporting the remote supervision model were not formally assessed, this feedback suggested that continued

support, responsive communication, shared problem-solving, and trust-based power sharing helped sustain the remote coordination, and reduced the risk of decentralization being experienced as abandonment or the imposition of centrally determined decisions.

Overall, these implementation experiences indicate that the decentralized model supported both culturally and contextually appropriate delivery as well as continuity during conflict. These process lessons should be considered alongside the effectiveness results of the RCT reported separately [9, 10]. Although the available findings do not quantitatively account for shifts in leadership and implementation, they do suggest that positive outcomes were achieved while SEEK was delivered through a collaborative, locally grounded, and adaptable implementation model such as improvements in SRH knowledge and improvements in key psychosocial variables. These SEEK-specific experiences informed the recommendations presented below regarding community involvement, capacity strengthening, peer learning, contingency planning, digital readiness, and sustainability.

Key recommendations

Based on this experience, future community-based interventions implemented in conflict settings could:

- **Include local and affected communities as co-implementers from the outset**: Local host-community actors should participate in operational planning, field coordination, and implementation decision-making. This enables smoother implementation through supporting with logistics and ensuring the continuity of operations under acute stress. Affected-community members should contribute to the adaptation of intervention content, examples, communication approaches, and delivery strategies. Their lived experiences and cultural knowledge are essential to provide culturally sensitive insights, enhancing trust, minimizing stigma, and establishing a safe environment for sharing of experiences [11]. In SEEK, this collaborative structure supported locally responsive decision-making, culturally sensitive delivery, and continuity of implementation during acute disruption. More broadly active involvement of both local and affected communities may enhance project credibility, promote retention, and encourage a sense of ownership.
- **Strengthen community members' competencies via strategic investment**: Empowering community members to take on a leadership role when needed requires early targeted recruitment, tailored capacity building, and continuous monitoring and support. This approach is especially critical in situations where the central team is unable to be physically present at sites.
  This was reflected in SEEK, where role-specific training and ongoing support enabled the on-site team to ensure complementary operational, decision-making, and intervention-delivery responsibilities as implementation needs evolved.
- **Establish and promote peer-to-peer learning mechanisms**: Develop peer-to-peer learning environment, including reflective sessions, case sharing, and supportive mentorship groups. These enable community members to exchange best practices, manage challenges, and support each another. In SEEK, informal exchanges among paraprofessionals, together with continuous feedback from psychologists and midwives, created opportunities for collective reflection and improvement. Future interventions should formalize such approaches to enhance shared learning and the quality of delivery.
- **Develop contingency plans from inception**: Incorporate comprehensive contingency planning to ensure flexibility and rapid adaptation when needed. Also, clearly defined responsibilities and a structured communication strategy are crucial for preventing miscommunication and facilitating smoother transitions during emergencies. In SEEK, several contingency responses were considered before the team adopted the decentralized option. This underscored the importance of defining alternative implementation approaches before disruptions occur.
- **Enhance digital readiness**: Digital readiness could be enhanced by equipping community members with the necessary tools, guidance, and strategies for effective remote monitoring. In the absence of physical presence, digital tools are essential. In SEEK, for instance, WhatsApp groups supported communication and session preparation, as well as coordination between the field-based and central teams. Future interventions should establish accessible and secure messaging, virtual meeting platforms, shared implementation trackers, and remote reporting systems with clear guidance on their use and confidentiality.
- **Develop a comprehensive sustainability plan**: A sustainability plan ensures that community engagement continues even after the closure of the project. The SEEK experience highlighted the value of trained paraprofessionals and their collaboration with PHCs during implementation. Future programmes should build on such investments by defining future roles for trained paraprofessionals, connecting them to PHCs, or enabling them to maintain peer-led initiatives.

Conclusion

The successful implementation of SEEK during conflict demonstrated that community actors are not only the most accessible option in humanitarian response initiatives, but also capable of leading them. Their close alignment with affected populations enabled them to manage field operations and respond to emerging needs. Resilience and sustainability of community-based interventions during crises lie in adaptive strategies rooted in community leadership and intentional redistribution of power to those most affected. Community-led implementations are not merely contingency plans when traditional models fail, but they are rather core strategies for building resilient and contextually responsive interventions.

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Data availability
No datasets were generated or analysed during the current study.

Declarations

Ethics approval and consent to participate
This study was approved by the Institutional Review Board at the American University of Beirut and by the Ethics Review Committee at the World Health Organization. All participants provided informed written consent prior to participation. For participants under 18, their parents or guardians were required to sign a consent form on their behalf.

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Consent for publication
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Competing interests
The authors declare no competing interests.

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References

1. Soeiro RE, de Siqueira Guida JP, da-Costa-Santos J, Costa ML. Sexual and reproductive health (SRH) needs for forcibly displaced adolescent girls and young women (10–24 years old) in humanitarian settings: a mixed-methods systematic review. Reproductive Health. 2023;20(1):174.
2. UNFPA. The impact of conflict on women and girls: A UNFPA strategy for gender mainstreaming in areas of conflict and reconstruction. 2002.
3. Fahme SA, Sieverding M, Abdulrahim S. Sexual and reproductive health of adolescent Syrian refugee girls in Lebanon: a qualitative study of healthcare provider and educator perspectives. Reproductive Health. 2021;18(1):113.
4. Chutiyami M, Cutler N, Sangon S, Thaweekoon T, Nintachan P, Napa W, et al. Community-Engaged Mental Health and Wellbeing Initiatives in Under-Resourced Settings: A Scoping Review of Primary Studies. J Prim Care Community Health. 2025;16:21501319251332723.
5. Banerjee A, Glewwe P, Powers S, Wasserman M. Expanding access and increasing student learning in post-primary education in developing countries: A review of the evidence. Abdul Latif Jameel Poverty Action Lab; 2013.
6. Hallfors D, Cho H, Rusakaniko S, Iritani B, Mapfumo J, Halpern C. Supporting adolescent orphan girls to stay in school as HIV risk prevention: evidence from a randomized controlled trial in Zimbabwe. Am J Public Health. 2011;101(6):1082–8.
7. Joshi R, Alim M, Kengne AP, Jan S, Maulik PK, Peiris D, et al. Task shifting for non-communicable disease management in low and middle income countries–a systematic review. PLoS ONE. 2014;9(8):e103754.
8. Durrance-Bagale A, Marzouk M, Tung LS, Agarwal S, Aribou ZM, Ibrahim NBM, et al. Community engagement in health systems interventions and research in conflict-affected countries: a scoping review of approaches. Glob Health Action. 2022;15(1):2074131.
9. Saleh S, Naal H, El Dakdouki A, Chamseddine Z, Govender V, Abou Haidar H, Bosqui G, Tamim T, Fouad H, F., Say L. Outcome Evaluation of the Self-Efficacy and Knowledge (SEEK) Randomized Community-Based Trial for Syrian Refugee Adolescent Girls and Young Women: Family Planning and Sexual Reproductive Health. n.d.
10. Naal H, El Dakdouki A, Chamseddine Z, Govender V, Bosqui T, Haidar Honein A, Tamim G, Fouad H, Say F, L., Saleh S. Evaluating Mental Health and Psychosocial Support Outcomes of the Self-Efficacy and Knowledge (SEEK) Community-Based Randomized Controlled Trial in Lebanon During Active War. n.d.
11. Saleh S, Naal H, Dakdouki AE, Chamseddine Z, Govender V, Sarieddine D, et al. Process evaluation of an integrated community-based intervention to improve family planning, sexual reproductive Health, and wellbeing among Syrian refugee women and girls in Lebanon during active conflict. Confl Health. 2026;20(1):13.
12. Siddiq H, Elhaija A, Wells K. An Integrative Review of Community-Based Mental Health Interventions Among Resettled Refugees from Muslim-Majority Countries. Commun Ment Health J. 2023;59(1):160–74.

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