







# ‘This is not our mandate’: a qualitative case study on the resilience of a humanitarian health programme in Lebanon

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## Abstract

Decision-making in humanitarian crises is rarely based on evidence and often constrained by uncertainty. Humanitarian health organizations such as the International Committee of the Red Cross (ICRC) operate in conflict settings, characterized by multi-layered, complex crises. Understanding how their decision-making processes influence the continuity of humanitarian health operations can provide insight to inform the development of resilience-oriented interventions in these contexts. We conducted a qualitative case study on the ICRC health operations in Lebanon, with the objective of exploring the elements shaping decision-making and understanding how different organizational factors influenced absorptive, adaptive, and transformative capacities in response to disruptive events in a hospital programme. Twenty semi-structured interviews were conducted with ICRC decision makers. Data were analysed through qualitative content analysis. Three themes emerged, describing how decisions were shaped by people and the trust they were able to develop in internal and external relationships; political considerations often overriding public health priorities; and unresolved tensions around the institutional identity and mandate. Resilience capacities were sustained by different factors. Absorptive capacities were primarily sustained by the availability of material resources, as well as operational contingency plans allowing for flexibility in their allocation. Adaptive capacities were strengthened by cohesive social networks among committed team members. Transformative capacities were limited, promoted by the ability to innovate while at the same time constrained by a rigid organizational culture. Our findings suggest that health governance and local leadership need to be strengthened to enable transformative capacities within humanitarian organizations. Through this, accountability and legitimacy can be enhanced, especially amid growing critiques and dramatically contracting funding.

**Keywords** health systems resilience, health governance, conflict, crisis, Lebanon, humanitarian aid

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### Key messages

- Organizational governance can influence the resilience of health systems and services through the decision-making process adopted. In situations characterized by fragility and volatility of the operating environment, such as complex humanitarian crises, making informed decisions can be particularly challenging.
- Considering the scarce evidence on what can strengthen health systems resilience through health service continuity, we conducted a qualitative case study of a 10-year hospital programme implemented by the International Committee of the Red Cross in Lebanon.
- Our findings have shown that public health evidence was not the main driver for decision-making. Managers tended to prioritize relational elements, such as interpersonal trust, as well as institutional and external political factors.
- Understanding social networks, institutional controversies, as well as broader contextual considerations related to humanitarian health operations is key to ensure the resilience of health programmes. In the current landscape of decreasing funding and increasing criticism towards the humanitarian sector, strengthening humanitarian leadership for health is key to sustain the resilience of health systems affected by conflict and fragility.

## Introduction

The current funding crisis of the aid sector has exposed the shortcomings of a humanitarian system that has long been under scrutiny (Colombo and Pavignani 2017, Spiegel 2017). Humanitarian health operations, in particular, face challenges to maintain continuity of essential service provision through crises increasingly protracted in nature (Cavalcanti et al. 2025, O'Leary 2025). One of the key areas of criticism in the aid sector has been decision-making, acknowledged as complex under uncertain circumstances, yet described as inefficient and poorly informed by evidence (Knox Clarke and Campbell 2020, Khalid et al. 2023, McGill et al. 2023). In humanitarian settings, evidence is loosely defined and may encompass formal operational research, routine data analysis, professional knowledge, and mechanisms of information flow (McGill et al. 2023). These blurred boundaries in conceptual definitions mirror the intrinsic uncertainty in which humanitarian operations occur. Such uncertainty makes it difficult to prioritize health operations when limited information is available on both existing needs and effectiveness of interventions (Pierson and Verguet 2023).

Knox Clark and Campbell described two pathways for decision-making that could be of use in humanitarian contexts: a 'naturalistic' approach, based on experience and intuition, and a 'rational' approach, based on the a systematic analysis of available information, highlighting that the two approaches can coexist and can be complementary and of different utility in different phases of humanitarian crises (Knox Clarke and Campbell 2020). Understanding how decision-making processes unfold in humanitarian health operations and improving them to support critical service delivery in the short term is critical to ensure that interventions do not

have unintended, harmful consequences in the medium to long term and ultimately contribute to health systems resilience strengthening (Cochrane and Wilson 2023). The concept of resilience, defined as the capacities of a system to absorb, adapt, and transform in response to acute shocks and chronic stressors, provides a useful lens to analyse how humanitarian health organizations can respond to increasingly complex systemic challenges (Lokot et al. 2022, Thu et al. 2022, Truppa et al. 2024).

Governance is pivotal to the resilience of health systems and health operations, both globally (Blanchet et al. 2017, Saulnier et al. 2023) and specifically in fragile and conflict-affected settings (Truppa et al. 2024). Within the health sector, governance includes the organizational values that influence collective priority setting and decision-making, as well as the policies and processes adopted to ensuring continuity of essential health care services (Barasa et al. 2018, Jarrett et al. 2021). In humanitarian settings, health governance functions become focused on operational urgency and continuity of health service implementation, with uninterrupted health care provision emerging as a central objective for health systems resilience (Truppa et al. 2024).

The current funding constraints and increasing complexity of geopolitical dynamics are posing a threat to the continuity of humanitarian programmes, and cosmetic adjustments—such as short-term funding reallocation or cuts—will arguably be insufficient to enact operational resilience.

Despite the increasing use of concepts related to resilience in the humanitarian and health systems discourses, there is a persistent gap in operational examples and metrics of how resilience can be enacted (Truppa et al. 2024). The present situation offers therefore an opportunity to rethink how humanitarian organizations can build and sustain resilience, not only in terms of continuity of the health operations they implement but also ensuring that through them they contribute to strengthen the health system in which they operate.

Within this landscape, this study offers an opportunity to reflect on how a humanitarian organization has absorbed shocks, adapted to stressors, and transformed through the lessons learned from its experience in a specific context. We focused on one of the major global humanitarian health actors, the International Committee of the Red Cross (ICRC). With over 20 000 staff in more than 100 countries, the ICRC provides protection and assistance to populations affected by armed conflict and other situations of violence. Within the ICRC, we were interested in describing how decision-making was influencing continuity of health operations during a period of compounded crises in Lebanon. The assumption was that, through making a specific health service available where it would not otherwise be, the ICRC, as a sub-system operating within the country's health system, can contribute to its resilience. This assumption roots in the current health systems resilience theories, which see health systems as composed by multiple sub-systems contributing both vertically and horizontally to the resilience of the broader system in which they intervene (Barasa et al. 2018, Saulnier et al. 2023).

For this research, the sub-system under analysis was limited to the ICRC operations within a long-term health programme in Lebanon. Drawing on the widely used frameworks that see governance as key driver of health systems resilience (Blanchet et al. 2017), this study conceptualizes decision-making as key governance function of the ICRC as humanitarian organization and refers to resilience as continuity of health operations within a hospital-based operation in Lebanon.

The primary aim of this research was therefore to understand how decision-making processes influenced the resilience of the ICRC hospital operations, operationalized as sustained continuity of programme implementation through contextual disruptions.

The secondary objectives were as follows:

- To describe the governance-related elements that shaped decision-making processes from the perspective of ICRC managers.
- To analyse which organizational factors influenced the absorptive, adaptive, and transformative capacities enacted in response to disruptive events.

## Materials and methods

### Setting

In 2016, the ICRC initiated a partnership with the main Lebanese governmental hospital located in Beirut, Rafik Hariri University Hospital (RHUH). This facility was selected for support as it was the last resort provider for the most vulnerable populations in the country, affected by the Syrian refugee crisis and the compounding shocks and stressors that in the following years put additional strain on the public health services (The International Committee of the Red Cross 2016). This partnership was initially funded by a private Swiss donor, the Avina Foundation (The International Committee of the Red Cross Lebanon 2017), and since 2019 by the Agence Française de Développement (AFD) (Agence Française de Développement 2019).

The partnership was extended on several occasions, to account for the multiple disruptions and nested crises RHUH—and the broader public hospital system in Lebanon—was confronted with (Abouzeid et al. 2020, Kawa et al. 2022, Nuwayhid et al. 2024). Box 1 provides an overview of the scope and evolution of the programme over the period 2016–25 (see Box 1).

### Study design

We conducted qualitative research using a single, holistic case study approach (Grey 2022). We focused on a programme that was unique at the time of inception and that subsequently became the blueprint of the so-called multi-year, multi-partner (MYMP) programmes. This model was scaled through a series of partnerships developed by the ICRC in situations of protracted crises in collaboration with multiple donors, international development banks, and local actors. The value of adopting a case study approach in health research has been described by Crowe and colleagues (Crowe et al. 2011) and is increasingly recommended in global health research to evaluate complex interventions (Paparini et al. 2020). Given that the model of the ICRC programme in Lebanon can be considered a complex operation, the case study approach allowed us to analyse in-depth the dynamics at play in its implementation, as well as to unpack the complexity of the decision-making processes based not on theoretical constructs but on a real-life scenario.

## Data collection

In-depth semi-structured interviews with key informants were conducted between 5 December 2023 and 11 March 2024. Twenty out of the 40 ICRC staff members invited accepted to participate in the study. These staff members had occupied middle and senior management positions and been involved in decision-making processes on different aspects and phases of the programme, ranging from technical matters, budget overview, and human resources supervision, to security and humanitarian diplomacy at country level.

Interviews were conducted in English through Microsoft Teams or Zoom, depending on the technical possibilities and preferences of each interviewee. With the agreement of the participants, interviews were recorded and transcribed.

## Theoretical framework

To describe decision-making, we drew upon Blanchet's governance-centred framework, which defines resilience in terms of three capacities (absorptive, adaptive, and transformative) unfolding across four dimensions that are interrelated: knowledge, uncertainty, interdependence, and legitimacy (Blanchet et al. 2017). To understand how these capacities and dimensions manifest operationally, we adopted a second theoretical framework, drawn on the organizational resilience theory defined by Barasa et al., identifying the factors influencing the resilience capacities of organizations: these factors include preparedness and planning, material resources, collateral pathways, information management, governance processes, leadership practices, organizational culture, human capital, and social network and collaboration (Barasa et al. 2018). These frameworks were used to develop the interview guide and to derive categories from the code groups during data analysis.

## Data analysis

Data analysis took the form of qualitative content analysis (QCA) (Graneheim and Lundman 2004), conducted using Atlas.ti (ATLAS.ti Scientific Software Development GmbH for Windows), version 25.0.1. QCA was chosen for its structured approach to analysing manifest and latent content meanings and its flexibility in allowing for both deductive and inductive category development, while also allowing for quantification of occurrences where appropriate (Vaismoradi et al. 2013).

The first author led the analysis, sharing interim findings with the second and last author to validate the coding approach and the construction of categories, sub-themes, and themes. After conducting open coding on the transcripts, codes were grouped deductively into categories based on Barasa's factors of organizational resilience (Barasa et al. 2018) and their influence on the resilience capacities described by Blanchet (Blanchet et al. 2017). Sub-themes and themes were drawn inductively from the categories, through high-level abstraction and identification of meanings. A co-occurrence analysis explored the interactions between categories across the two frameworks used as theoretical framing for the study.

### Box 1. Overview of the RHUH partnership programme

In 2016, the ICRC and the RHUH started a partnership triggered by the availability of philanthropic funding from a Swiss private donor, the Avina Foundation. The initial strategic objective of the programme was that of supporting emergency care for the most vulnerable populations in Lebanon in the biggest public hospital in the country. With its over 400 beds, RHUH was the last resort for populations affected by the Syrian conflict who were in a situation of vulnerability and for whom access to emergency care was not affordable, including Syrian refugees, Lebanese, and migrant workers.

With the withdrawal of the Swiss private foundation, in 2019, the French Agency for Development (AFD) stepped in granting multi-year funding for the already established programme, as this aligned with its vision of strengthening the resilience of local institutions in Lebanon.

The long-term availability of funding allowed to shift the focus of the programme from emergency response to enhancing the hospital capacity to cope not only with the increased demand for services but also with any future disruption. From the onset, the partnership was designed as a systemic support to the hospital, embedding the ICRC teams directly into the RHUH clinical, managerial, and support structures. This systems perspective shaped both the design and the evolution of the programme, with a holistic approach supporting:

1. Clinical workflows and nursing practices in different departments: emergency room, operating theatre, medical and surgical wards, obstetric services, neonatal and paediatric wards, intensive care, outpatient care, mental health and psychosocial support (MHPSS) services, and physical rehabilitation services.
2. Infection prevention and control.
3. Logistics and material management.
4. Infrastructure rehabilitation and critical systems support.
5. Hospital administration.
6. Hospital leadership.

The partnership was extended in terms of both duration and budget on several occasions, spreading until end of 2025: in 2020, additional budget was needed for the emergency response to the COVID-19 pandemic and the explosion of the Beirut port on August 4; in 2022, another budget extension was granted to implement projects that were delayed due to the emerging needs triggered by the pandemic; and between 2023 and 2024 following the spillover effect of the conflict between Israel and Hamas in Gaza following 7 October 2023, as well as the subsequent conflict between Israel and Hezbollah in late 2024. The total budget implemented through the 10-year project was ~35 million EUR, which allowed key achievements in terms of:

1. Ensuring access to, quality of, and continuity of care for populations in a situation of vulnerability throughout a period of compounded crises.
2. Enhancing leadership roles within medical care, nursing, social work, MHPSS, rehabilitation, and material management.
3. Strengthening emergency preparedness and surge capacity, through the establishment of a training centre for the entire country as part of a sustainable exit strategy.

Besides the support to RHUH, the partnership between the ICRC and AFD extended also in terms of scope and geography, as new agreements were signed to scale the model of support to additional governmental hospitals in the country: in 2022 Tripoli Governmental Hospital and in 2024 Marjayoun Governmental Hospital.

## Results

The characteristics of the 20 ICRC middle and senior managers who were interviewed are shown in [Table 1](#).

The QCA was conducted on two levels. At the individual level, it aimed at identifying the governance elements influencing decision-making. At the programme level, it explored how different organizational factors supported or hindered the resilience capacities—absorptive, adaptive, and transformative.

### Relational, political, and institutional influences on decision-making

Three themes emerged from the analysis of the interviews' transcripts, highlighting how decision-making within the ICRC programme in Lebanon was influenced by individuals and their relationships, shaped by the interplay between knowledge and politics, and constrained by unresolved tensions around the institutional identity ([Table 2](#)).

### People matter: the power of individuals and their relationships

This theme describes how interpersonal relationships and trust shape institutional networks and partnership development. The ICRC hospital programme remained useful over time due to having the right staff with appropriate skills, but staff and programme sustainability was challenged when interpersonal and institutional field-headquarter relationships were difficult to navigate. Over the course of the programme, a new approach to local partnerships developed. This approach was characterized by co-creation and largely driven by trust built through interpersonal relationships and emotional connection. This helped sustain the programme and its relevance over the years.

#### *Having the right people with the right skills*

Throughout the programme implementation, participants described an increasing recognition of the value of individual skills and continuity of team composition rather than the typical high

**Table 1** Characteristics of the 20 participants interviewed.

Participants characteristics	Value
Gender	
Woman	9
Man	11
Department <sup>a</sup>	
Management	9
Health	7
Water and habitat	5
Assignment	
Field/Beirut	13
Headquarters/Geneva	3
Both	4
Duration of assignment	
Range	4 months to 8 years
Average	3 years
Interview duration	
Range	27'–72'
Mean/median	51'/53'

<sup>a</sup>One person changed department overtime and is counted twice.

turnover that characterizes the ICRC hospital projects. In fact, at the inception of the programme in Lebanon, participant stated that the high turnover of key staff members represented a key obstacle to the development of the programme, as people were shortening their contract and leaving the assignment due to the frustration of not being able to provide care in the way they were used to in other hospital projects. With the progressive increase in length of field assignments of professionals having the right balance of clinical leadership, contextual understanding, and public health knowledge, the development of a coherent vision became possible. The coherent vision led to continuous adaptations of the programme itself, expanding beyond the traditional areas of health interventions of the ICRC (i.e. war surgery), to encompass medical care for both paediatric and adult medical emergencies, obstetric care, and psychosocial interventions:

It was also because we had the right people from, you know, the health coordinator to the head of project, to the... to the people at the hospital. So, we adapted. I think we adapted quite... quite naturally in an environment that was new in terms of the type of problem that we were facing. (KI09, field)

### *Negotiating field-headquarters relationships*

Besides the increased length of assignment, participants explained that the transition of specific profiles from the field to the headquarters, or within headquarters from senior leadership to executive positions, strengthened the continuity of strategic vision and enhanced institutional sponsorship towards the programme itself. However, such institutional support was for some respondents the reflex of a strong individual sponsorship towards the programme, which created a deepening fracture between the concrete challenges faced by professionals working in the field on one side, and the celebrative tone of polished institutional narratives on the other.

The institutional support for the programme from headquarters emerged as a double-edged sword: on one side, it helped resolving tensions within the field delegation to ensure continuity of implementation, and on the other, it deepened tensions whenever the delegation would claim their own decision-making space:

There was, you know, the usual kind of tensions between the so-called field and Geneva, thing that was... there was certainly palpable frustration on the side of the field that Geneva was not listening and the other way around, that Geneva was not informed enough. (KI11, headquarters)

### *The role of emotions and interpersonal dynamics in trust building*

Besides individual characteristics and career trajectories, interpersonal dynamics also contributed to shape decision-making processes. Having shared personal experiences in different contexts before the Lebanon field assignment or having worked together on an emotionally challenging moment in Beirut, supported the establishment and reinforcement of professional trust.

This cohesion at field level allowed managers in the field to create a safe decision-making space for them to shape the programme in the direction they foresaw for it, shielding it from the tensions arising from conflicting views between field and headquarters:

There was a trust, you know, I have been in [another Delegation] with [them] in complex, dangerous situations, and I really trusted [them] as a person. So, this was a very strong bond. And then we also hoped that the project would allow for something different in the ICRC, a response that's not just in emergency, but really ties together the long-term response with the short-term response, and we both thought it was missing. (KI02, field)

### *A new approach to partnership*

Building trust with the local partners required, according to the interviewees, a substantial shift in programmatic and professional approaches. The ICRC staff had to learn how to work in an integrated fashion with the RHUH hospital staff, without decision-making independence, and how to co-develop the programme in response to evolving population health needs. Participants highlighted how the traditional, substitutive approach the ICRC used to have in hospital projects could not fit the reality and needs of a complex urban tertiary hospital in a country with an advanced health care system and very skilled health care professionals. Adopting a different approach entailed learning to integrate within existing local teams, supporting and complementing their work rather than substituting for it, and co-developing interventions:

One that we certainly got to know through this project is... is kind of partnership, right? Kind of being at each other's eye's heights, understanding that you're not here to solve or to teach or to come as a preacher, but rather to... to see how... how, yes, certainly you can improve things and influence, but also learn and really become part of... of that hospital life. (KI11, headquarters)

**Table 2** Themes, categories, and sub-categories describing the organizational dimensions of resilience for the RHUH project.

Theme	Sub-theme	Category
People matter: The power of individuals and their relationships	Having the right people with the right skills	The challenges of high turnover The added value of specific skills
	Negotiating field-headquarters relationships	Field towards headquarters: between continuity of roles and divergence of narratives Headquarters towards field: between sponsorship and control
	The role of emotions and interpersonal dynamics in trust building	The role of emotions in shaping the programme The role of interpersonal dynamics in shaping the programme
Blurred lines: The role of knowledge and politics in shaping governance practices	A new approach to partnership	Building trust with external partners through co-creation Shifting from substitution to support
	Inconsistent information and knowledge management practices	Unstructured information sharing processes Challenges in knowledge integration
	Politics above public health in decision-making	The downside of a weak health leadership Politics above evidence in prioritization and decision-making
Negotiating identities: unresolved tensions within the organization	Situation-dependent leadership style	Command-and-control leadership style with short shocks facilitates rapid decision-making Inclusive leadership style with long shocks and chronic stressors delays decision-making A careful decentralization of decision-making
	Weak governance structures	Gaps in accountability Limited project management culture
	Interpretations of the institutional mandate	A traditional view of the mandate A transformative view of the mandate
	Controversies around the humanitarian–development–peace nexus	Lack of clarity on the position of the ICRC along the humanitarian–development–peace nexus Funding flexibility as key driver of programme resilience 'Too big to fail'
	The challenges of operationalizing interdisciplinary collaboration	The need for a systems view of programmes The institutional quest for complexity
	The ambition of a learning organization	Piloting without scaling The challenges of learning in uncertainty

### Blurred lines: the role of knowledge and politics in shaping governance practices

This theme highlights how governance practices relative to decision-making processes were influenced by emerging tensions between knowledge and politics. Fragmented information management led to uneven information use, which in turn created space for politically driven rather than evidence-based decision-making. These processes were described as influenced by individual—rather than institutional—approaches to leadership and management, which generated gaps in accountability.

#### *Inconsistent information and knowledge management practices*

Participants described information flow as person- and team-dependent, rather than a standardized process. While written documents were produced, they did not become an instrument used to share and generate knowledge:

There is something really interesting in our organisation, is that people don't read. But nevertheless, they have an

opinion on things. You know, and as the project goes after a year or two, people talk about something which is actually not what it is. (KI14, field and headquarters).

In other occasions, e.g., when deciding whether to rehabilitate the central sterile services department (CSSD), non-health managers could not comprehend the need and urgency for this as data were not available or not shared:

I request data of... of infections, no for example, when you say let's do a CSSD, is... is super urgent to do CSSD, and I... and I don't... I don't disagree at all. I say OK well, how many... how many infections did we record since...? And there's no data. No one could tell me. No, no one could... could actually give me number of cases. (KI18, field).

Respondents also highlighted not only the lack of data on specific operational priorities identified by other colleagues but also inconsistent pathways for sharing written information where available. This contributed to deepen gaps in the understanding

of the programme vision, leading to decision-making practices based on personal intuition rather than structured documentation.

Similar challenges were reported for oral communication, where information sharing tended to occur in a loosely structured fashion, which contributed to generating fractures in the understanding of the programme vision and objectives:

I would say that maybe at a certain stage we were having a political dialogue, or not political, strategic dialogue (...). And then there was the... the level of... the working level. But there's a tactical level in between where maybe the information flow was not as good as it should have been, or it could have been. So that's what I would say. I would... I would revisit and maybe rethink something around a more (...) regular flow of information to make sure that... the different levels have well understood. (KI09, field)

Some respondents highlighted that the perceived dysfunctionality in information flow is to be imputed to an excessive production of unfocused information, which does not allow to generate and integrate knowledge:

Sometimes I feel the way we share information is heavy, cumbersome and very iterative (...). We describe a lot, but we are not to the point, which makes it complicated to transfer information, to absorb information, to get inspired by information and to uh, to multiply, you know, to have this multiplication factor. (KI11, headquarters)

### ***Politics above public health in decision-making***

As a consequence of these challenges in compiling and communicating information, many participants underlined how political considerations often took precedence over public health concerns. The weight of political matters in shaping programmatic decisions is intensified by emerging tensions and contradictions within the health department, with different viewpoints being shared with operations managers. Some participants imputed this to a weak leadership within the health department, which contributed to creating space for multiple, conflicting contributions shared with decision makers in situations when rapid decisions were needed, such as at the onset of the COVID-19 pandemic.

During the interviews, some operations managers shared the ethical dilemmas they faced when having to make decisions on technical matters without having the necessary knowledge nor a coherent view shared by technical teams. One respondent gave an example with regards to internal discussions on the validation of specific types of medical supplies for surgery:

I don't know if it's the right way to do it, ethically, you know when... when you're talking about standards, professional standards, and in the end the decision is taken by a non-professional. I mean it's... it's perhaps something one could... one could question as a baseline. Umm, but that was a consequence somehow of the inability within... among experts to actually take a position and move things forward. (KI11, headquarters)

### ***Situation-dependent leadership styles***

Decision-making is reported by participants as influenced by leadership styles that tend to vary based on the circumstances. When responding to sudden-onset disruptive events, i.e., in the 'traditional' operating environment of the ICRC, managers adopt a command-and-control approach to ensure rapid responses, which often overlooked inclusive communication. In less typical situations, characterized by slow onset, converging chronic stressors, managers appear to be less equipped to make effective decisions, and deliberations tend to be slower, impacting efficiency and effectiveness. For example, during the cholera outbreak in 2022, some participants reported lengthy consultations with local health authorities, due to disagreements over the prioritization of water sanitation interventions and the structure of a dedicated cholera unit within the hospital:

It was like a lot of agitation and by the time we were ready... by the time we were ready, we went into another crisis. (KI06, field)

Some participants pointed out that complex organizational hierarchies also contributed to delayed decision-making, as they created barriers to effectively decentralize decision-making, both between headquarters and field and within field operations. While expressing frustration with the existing structures, some managers reported that they were able to claim an autonomous decision-making space to overcome operational challenges:

I was always trying to make the least worst decision. So umm, it wasn't the decision I really wanted because of the organizational constraints, but then I... yeah, I tried to make decisions that were keeping the space open. So, you keep the relationship with Rafic Hariri (hospital) like positive and you keep it more or less open with the headquarters, also the health unit. (KI02, field)

### ***Weak governance structures***

Such governance structures reflect, for some respondents, a limited project management culture within the organizations, which in turn creates gaps in accountability.

In fact, despite the substantial efforts in defining and enacting accountability structures, and the clear guidance provided by the institution, a pervasive sense of lack of accountability is described by the participants, both at the individual and at the organizational level.

For some respondents, the root cause is to be recognized in weak project management capabilities among managers, which do not allow to adopt standard practices that would enable monitoring, evaluation, and clear attribution of responsibilities and accountabilities within the programme:

We don't have a project management mindset, therefore accountability mindset. I mean, it works, doesn't work, there would be no consequences for you, for me, for anybody. (KI14, field and headquarters)

### ***Negotiating identities: unresolved tensions within the organization***

This theme describes how decision-making is constrained by unresolved tensions around the institution's specific mandate to

alleviate the suffering and protect affected people in conflict and how it reconciliates with its developing role in protracted crises where operations are part of a continuum of interventions along the humanitarian–development–peace nexus. The difficulties of remaining true to the institutional identity while understanding the complexity in which the organization intervenes imply limitations in the learning process, particularly when learning indicates the need for a transformative view of the organization and how it interprets its role.

### *Interpretations of the institutional mandate*

Participants in the study identify in the interpretation of the institutional mandate a source of complexity, as this defines which type of responses and operations fit within its scope or not:

And then the narrative, the political narrative inside the ICRC was to say: no, this is not our mandate. We're not going to focus on women and children and expand. Our focus really has to be on war wounded and weapon wounded, and there was a whole debate about that. (KI02, field)

Such interpretation is non-univocal, often ambiguous, and influenced by personal, relational, and contextual considerations. One position within the organization is that the ICRC should focus on its core mandate of alleviating human suffering in conflict, hence limiting the scope of its action to emergency response. At the other end of the spectrum, there is a growing sense that today's crises need a shift in approach and that the challenges of protracted conflict require adaptations in the interpretation and operationalization of the mandate, as the historical perspective does not allow to provide suitable responses for the evolving needs of civilian populations affected by conflicts.

### *Controversies around the humanitarian–development–peace nexus*

Participants explained how the tensions around the interpretation of the mandate translated into tensions around the role that the organization should have within the humanitarian–development–peace nexus. Those who were involved in the RHUH programme envisioned a new role for the organization in this area. In fact, they see the ICRC as uniquely positioned in contexts of protracted crises to leverage its in-depth knowledge of the country and proximity to both the population and the state and non-state actors and to build the foundation for system strengthening interventions. For these participants, such investment in system strengthening would allow a more effective emergency response whenever a sudden-onset disruptive event occurs:

Yes, we do it and we are convinced and this demonstrate that it makes sense because building long term resilience—and this takes years through which you build contextual knowledge, you have the network of relationships, you build trust, you build working mechanisms—because of this, then the moment you need to respond in an emergency, you are much stronger. And so, the two are really part of the same response. (KI07, field and headquarters).

The partnership established between ICRC, AFD, and the hospital allowed to develop over time such in-depth contextual knowledge, as well as fiduciary agreements that granted flexibility in funding allocation whenever disruptive events occurred, as it was the case during the COVID-19 pandemic or in the aftermath of the Beirut port blast. Such flexibility allowed for more rapid responses in the wake of shocks and stressors, solidified the commitment of the three instances involved—the ICRC, AFD, and RHUH—to the partnership. This in turn strengthened the conviction that the investment done by all sides to operationalize the humanitarian–development nexus was 'too big to fail':

I think there was definitely a strong common sentiment that this project is not allowed to fail, right? That we have invested too much, and it had shown a certain level of success that was very promising, that we had to do that extra mile of... of whatever it takes to make sure that it's... it moves forward. (KI20, field)

At the same time, many staff members based in the field expressed doubts with regards to the long-term sustainability of the ICRC approach, particularly at the time when the programme started progressively scaling down with the end of the agreement approaching:

There is no one... Now we are withdrawing slowly from this project (...) and the areas we left are still empty (...), there is nobody supporting. (...) So this is a concern, it's not our... it's not our job, we finalise our project and khalas, OK, we wasted 25 million. (KI12, field)

### *The challenges of operationalizing interdisciplinary collaboration*

Some managers underlined that understanding the complexity of the operating environment in which the organization acts would require going beyond the traditional modalities of intervention and adopting a systems view to capture interdependencies within and between sub-systems across scales, from the infrastructural to the programmatic to the policy level.

Participants highlighted the growing complexity of conflicts, which are increasingly characterized by extended duration, lower intensity, urban warfare, and shifting epidemiological features of the population affected. They explained how intervening in this type of setting requires a systemic view and understanding of issues at stake, and a longer time frame:

Now I think by the nature of the operational environment in which we act, we need to think system if we want to be efficient and relevant, OK? I'm not sure we made this choice. I don't.... I'm not sure that in our mind we are there. I'm not sure about that. We are still too short-termism organisation. And I regret this, but deeply. (KI14, field and headquarters)

### *The ambitions of a learning organization*

Managers who have been part of the programme in Lebanon acknowledged that the intervention offered an opportunity to strengthen operational models, conceptualizing what was learned at programme level, and replicating it within the same country.

For example, several respondents mentioned the rehabilitation of the emergency room as an example to capitalize learning on infrastructural rehabilitation in hospitals: the design of the renovated RHUH emergency room spanned over several years, from 2016 to the beginning of 2020, with lengthy internal negotiations over the technical standards to apply. The success of the COVID-19 response in RHUH was imputed to the configuration of services in terms of triage, patient flow, gas distribution, and other technical elements, which allowed to timely respond to the unexpected pandemic without the need for further adjustments. The same considerations were therefore applied to Tripoli Governmental Hospital and are now being scaled to other public hospitals across the country.

However, despite the learning opportunities offered, the institutional learning appears constrained by the uncertainty in which the organization operates, which limits the opportunities to scale innovations at the organizational level:

Well, the question is if mechanisms are now in place that would allow us, you know, to... to have this business continuity kind of predefined. I think it's not, I think, yeah, in that sense we could have, we could have done more. But then it's also a very challenging environment, a delegation that has to downscale dramatically today etcetera, so. Even if there were lessons learned, they could probably simply no longer be... be observed. (KI01, field and headquarters)

## Organizational factors shaping resilience capacities

The participants described different shocks and stressors throughout the 10-year period of implementation under study. These were categorized following the most recent recommendations elaborated by the health policy and systems research community, which distinguish—on the basis of both their time extension and their predictability—short, recurring, and long shocks, chronic health system stressors, and chronic system dysfunctions (Witter et al. 2023). However, based on the respondents' replies, an additional category emerged, related to organizational disruptions. These include internal deadlines and rigid project cycles, funding contractions, changes in governance structures, and internal disagreements on the strategic orientation of the programme (Table 3; Fig. 1).

The participants described how different organizational factors had differential influence on the three resilience capacities at the programme level. Figure 2 shows the co-occurrence analysis of the code groups used in the analysis.

Absorptive capacities were primarily sustained by the availability of key material resources such as supplies and funding, along with an operational contingency plan rapidly allowing the flexible reallocation of these. The pre-existing agreements with the partners in the programme, as well as the trust established through the years of collaboration, enabled rapid and effective response, particularly at the onset of short shocks. For example, at the onset of the COVID-19 pandemic, the AFD allowed to repurpose a part of its funding to enable the emergency response in RHUH, which was the first hospital admitting COVID-19 patients in the country. Subsequently, it granted additional funding to allow the resumption of projects that had been

**Table 3** Shocks and stressors reported by the participants in the study.

Type of disruption (number of respondents) <sup>a</sup>	Specific disruption
Short shocks ( <i>n</i> = 4)	Beirut port blast
Short, repeated shocks ( <i>n</i> = 2)	Strikes by hospital personnel
Long shocks ( <i>n</i> = 13)	COVID-19 pandemic
	Cholera outbreak
	Israel–Hamas conflict
Chronic health system stressors ( <i>n</i> = 1)	Demographic pressure of Syrian refugees
Chronic system dysfunctions ( <i>n</i> = 5)	Financial crisis
	Electricity crisis
Organizational disruptions ( <i>n</i> = 7)	Changes in internal governance structures
	Changes in funding landscape
	Internal disagreement on strategic direction

<sup>a</sup>Multiple respondents referred to multiple shocks and stressors; therefore, the sum of the total number of times a specific shock or stressor was mentioned exceeds the total number of respondents.

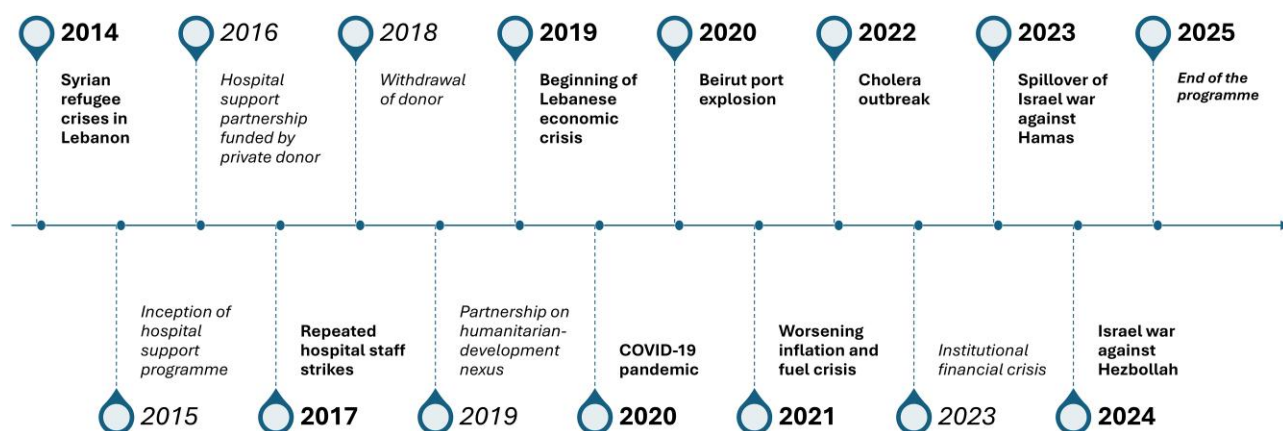
suspended to enable the response to the pandemic. As one participant noted:

We have an operational agreement in place and it's just a matter of opening a new document and all the procedures are known, all the requirements are known, and it will take a few days to sign off whatever funding they would channel together through the ICRC. We didn't have that capacity few years ago. (KI07, field and headquarters)

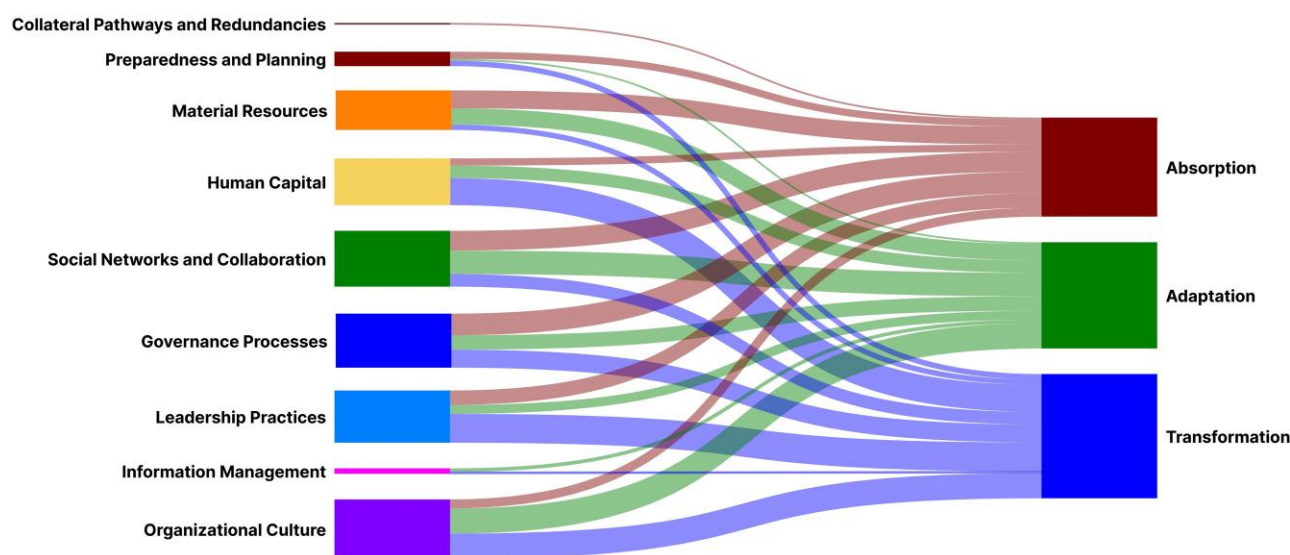
A key role for both absorptive and adaptive capacities was played by the commitment and motivation of the ICRC staff involved in the programme, as well as their ability to navigate the intricacies of the local health system and establish mutual trust. An example frequently reported by the participants was again the COVID-19 pandemic, throughout which the ICRC teams, both from the Health and Engineering departments, supported the smooth running of clinical and infrastructural activities. The continued support did not go unnoticed and strengthened the collaboration and coordination between the ICRC and the RHUH teams.

So, they... everyone, even in the circumstances of COVID, where everyone was really scared because it was a new thing, my team went to the hospital in those days, and they were not afraid. So, I think the high commitment of the team made the response of the ICRC effective in the short term. (KI04, field)

Another key element central to both absorption and adaptation was the partnership model between the ICRC, the AFD, and RHUH. Building and sustaining such partnership was an endeavour that took time and that required intense efforts of both internal and external persuasion:



**Figure 1** Timeline of events throughout the ICRC programme implementation (created by the author) (*organizational events; external disruptive events*).



**Figure 2** Organizational factors' (Barasa et al. 2018) differential influence on resilience capacities (created by the author with SankeyArt.com).

I think we shouldn't underestimate how much it took to start it. Because there's a lot of elements that had to align for the project to start, at the inception phase. (...) It was not easy, and so I think there was a big lesson around perseverance, and... and really having a vision and following it through and... And patience, and that with time we could, if we continue to knock on the door, we can make something happen with the right allies. (KI20, field).

Transformative capacities are primarily sustained instead by the capacity of documenting and conceptualizing the learning from the response to different disruptive events. These unfold through the progressive improvements in the knowledge management system and through exploring innovation opportunities to scale at the institutional level initiatives established, thanks to the insight and creativity of single individuals. Some participants highlighted how the new partnership model established with this programme—based on co-creation between a development actor, a humanitarian actor, and a local health institution—became a new way of working for the ICRC. This model did not exist prior to the RHUH programme and was established and

supported by key people in positions of leadership within the delegation and in headquarters:

And I would say that a figure of reference also for all this not only was (colleague in the field), but I would say it was (colleague in headquarters), because \*they\* were certainly big believers in this project. And I think \*they\* gave a very clear direction. \*They\* were never dwindling. \*They\* were never swinging on this. \*They\* were always very confident on the... on the impact of the MYMP projects and on their functioning. (KI08, headquarters)

Central to the three capacities, and enabling the continuum across them, we found governance processes and leadership practices, profoundly shaped and informed by what emerges as a complex organizational culture.

The institutional governance model in fact allows for decentralized decision-making at the delegation level. This decentralization operates within a complex matrix in which technical managers from the Health and Engineering departments can escalate controversies around decisions either towards their

hierarchy at the field level in the Operations Department (the 'red line') or towards their technical counterpart in headquarters (the 'blue line'). This model has been described by some participants as a powerful instrument to create space for a long-term vision, as it was the case at the inception of the programme:

The way we were able to do that is to be more cohesive, (colleague), (colleague), and I, so the three people, you know, in the field. And then there were these conflict lines with the headquarters (...). And then there was this big political pressure. So, the way we created the space to be able to move forward was by just protecting each other probably. And then (...) it was very difficult then from the headquarters to just disrupt that. So, we... yeah, we built a small coalition and protected the project in ourselves, because (we) really believed in it. (KI02, field)

As for leadership practices, resilience appeared to be sustained by a strong individual sponsorship of the programme:

So, you know, it kind of became a baby that we were all kind of wanting to save. And so... So, I think it, yeah, the personal involvement and interest of key colleagues, that was, you know, on the one hand side, the head of Delegation who kind of... was open at continuing the project. (KI11, headquarters)

Some organizational factors appeared to be less central to the experience of the respondent, as they were mentioned comparatively less than others. Among these, collateral pathways and redundancies were marginally cited by only few respondents, mostly referring to the expansion of procurement capacity of the organization:

You have a framework agreement ready, and you have like most of the paperwork ready, can be fairly fast. I mean, there's been a couple of times that we... we needed to procure fuel for the hospital, (...) and it was done almost in one day (...). That was quite... quite satisfying to see. Whereas if you go for other type of... of procurement (...), or if... there is more than one item, (...) a small purchase can take weeks and months. (KI18, field)

Information management was also mentioned less compared to other factors and was highlighted as unstructured, and as such a missed opportunity for institutional learning:

I think that's to be... to be... to be defined as lessons learned was... would be to say OK, maybe from the onset, what type of information flow is required? Who's responsible of what? Defining clearly the accountability framework and maybe fit... fixing it in a... in a... in a more structured and systemic way, and not having it floating a bit too much, sometimes in the air. (KI09, field)

The cumulative impact of the different events reported by the respondents on the programme prompted absorptive and adaptive actions that often overlapped, in iterative learning loops that led to structural transformations for the whole organization, which in turn strengthened absorptive capacities in crises. For example, some participants reported how the beginning of the programme was challenging from a financial point of view, as

there were no mechanisms in place to follow up on a multi-year budget for a programme, due to the constraints of the traditional annual planning cycle. Several cycles of administrative adaptations took place, which, over time, made the programme a blueprint for developing a separate financial structure for projects and programmes conceived at the humanitarian-development-peace nexus, structured over multiple years. Similarly, the adaptations in human resources allocation to the programme, shifting from the short-term deployment of international staff to the recruitment of national staff on a permanent basis, allowed to strengthen the trust with local partners, leading to the rapid deployment of key ICRC health professionals at the southern border at the onset of the Israeli attack in 2023, which for some respondents contributed to strengthen the national hospital system's absorptive capacity:

The hospital is one of the pillars of the crisis preparedness plan right now of the Ministry of Public Health, as well as the ICRC, of course. But we went to the extent of even allowing some of our staff to be embedded into the team of the Minister of Public Health to really build this crisis preparedness plan. (KI07, field and headquarters)

## Discussion

This study provides insights into what some scholars have defined as the 'black box' of the ICRC decision-making, intrinsically tied to a mandate enshrined in the Geneva Conventions, extensively debated within the organization, but very seldomly leaking out to the public domain (Forsythe 2024a).

The lived experience of the ICRC middle and senior managers involved in the Lebanon hospital programme shows that its resilience was influenced by individual, relational, political, and institutional factors, rather than purely driven by public health evidence.

It has long been suggested that one of the main barriers to the use of evidence in humanitarian settings is the scarcity and poor quality of public health information available to decision makers (Turner et al. 2011). Over the past two decades, multiple initiatives have emerged aiming at addressing this gap and strengthening the use of evidence in humanitarian crises (Khalid et al. 2019, Doocy et al. 2022). However, the uptake of the evidence produced has been fragmented and inconsistent. Our findings suggest that scaling up the production of evidence is only one pillar of improving decision-making, and a comprehensive frameworks should include also data literacy in humanitarian leaders (ALNAP 2022, RedR UK 2024), political aspects (Colombo and Checchi 2018), and an ethical dimension (Simm 2021, Cuthbertson and Penney 2023). Moreover, the uncertainty that humanitarian leaders have to navigate in decision-making requires dynamic and customizable tools, as suggested in the context of the COVID-19 pandemic (Odlum et al. 2021).

Over the past years, there has been a flourishing production of decision-making support tools, including through the adoption of artificial intelligence to allow for a more flexible and dynamic analysis of emergent data (Garcia et al. 2023, Burkle et al. 2025). However, in most cases, these tools have been based on quantitative information and have not accounted for social networks and political factors. The prioritization of standard epidemiological quantitative data over context-specific qualitative data

reflects an epistemic hierarchy that is often unsuitable or unattainable in humanitarian settings (McKay et al. 2022). This suggests the need of developing new knowledge systems that move beyond 'the reasoning of individuals or rationale of institutions' and are able to account for the multifaceted complexity of fragile contexts (Abimbola et al. 2024).

Despite the growing call for evidence-informed decision-making, individual experience and relational elements appear to have played a key role in the programme under study. This finding confirms what was already described by Leresche et al. on primary health care interventions in Lebanon and on physical rehabilitation operations in Myanmar. This study showed how uptake of operational research-informed recommendations was more likely to happen if relationships between field and headquarters were more dense and when transitions of roles between the two were reciprocal (Leresche et al. 2023). Social network analysis is increasingly used in humanitarian policy research, as relational elements can play a key role in shaping decision-making and policy development in the humanitarian sector. Their analysis can support the identification of the most influential nodes—be it individuals, teams, or institutions—that can enable the uptake of specific recommendations, hence bridging the policy-to-practice gap (Clark-Ginsberg et al. 2022).

While the weak evidence available in crisis situations is already in itself sufficient for under-informed decision-making, the specific organizational culture of the ICRC reinforces the tendency to define priorities based on unverified assumptions and personal experience rather than on documented needs. For example, the internal debate on whether intervening in obstetric emergency care was within the scope of the mandate or not constrained decision-making and jeopardized programme continuity at the onset of the intervention. The tension could be circumvented by an individual initiative supported by the professional trust granted by managers. These coalitions were able to shield the programme from headquarters influences and claim a decentralized decision-making space, in which saving the lives of pregnant women who were unable to access care as they were fleeing an armed conflict was considered in line with the institutional mandate. Controversies around the interpretation of the mandate are not new to the ICRC, with many having criticized the organization over the last years due to a perceived expansion of its scope of action beyond its core area of expertise and legitimate action, which is humanitarian assistance and protection in the acute phase of the crises (Forsythe 2024b, 2024c). However, given the increasingly protracted nature of modern conflicts, a narrow interpretation of the mandate is for many others inadequate to effectively address the needs of affected people (Forsythe 2024b).

Our findings resonate with the global literature on the role of organizational factors in sustaining health systems resilience in humanitarian settings, as they show how different resilience capacities can be influenced simultaneously by different elements. For example, Alameddine et al. have investigated the resilience capacities of the United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA) in ensuring continuity of service provision for Palestinian refugees in Jordan and Lebanon throughout the Syrian conflict and identified contingency planning as key to absorption, similarly to our findings. At the same time, the cohesion among staff member was also highlighted as a critical element for adaptive capacities (Alameddine et al. 2019). Transformative capacities remain

underutilized in humanitarian settings (Bou-Orm et al. 2023, Yamout et al. 2025).

While there is a tendency to consider the resilience capacity consecutive along a continuum, our study confirms what has been suggested by other scholars: resilience capacities are non-time-bound and non-hierarchical, and they can develop simultaneously rather than consequentially in relation to cumulative shocks and stressors (Alameddine et al. 2019, Truppa et al. 2026).

It has been suggested that resilience should be analysed through a learning lens, rather than focusing on processes and outcomes (Fortnam et al. 2024, Thu et al. 2025). The limited examples available on the capacity of humanitarian organizations to transform their structures and meanings are in this sense the reflex of the limited learning space available in humanitarian organizations (Leresche et al. 2024).

For the ICRC in Lebanon, the availability of long-term funding from a development actor created space for long-term engagement with local actors. It shifted working modalities from the substitution of the local workforce to the support of the local hospital system. The progressive empowerment of Lebanese health care workers and managers allowed for in-depth contextual dialogue and understanding. However, this appeared to emerge organically rather than intentionally, leading to the deepening controversies around whether long-term system strengthening in a protracted crisis falls within the scope of the mandate or not. In fact, despite the successful responses that the programme allowed the hospital to have in responding to shocks and stresses, a tension emerged as to whether resilience—intended as continuity of programme implementation—can translate into longer-term sustainability of the programme. In fact, once the financial and operational setup provided by international actors is withdrawn, service provision often becomes unsustainable. In this sense, resilience of humanitarian health operations supported by international actors might fail to strengthen local health system resilience. This aspect of the dependency—created by a programme operating in a broader, fragile system—is often overlooked in an environment where life-saving interventions need to be prioritized, as the focus of the analysis remains at the operational level rather than the project's contributions to the broader system in which it is delivered (Truppa et al. 2026). This partnership, established between a local institution, a humanitarian organization, and a development actor, allowed to circumvent the dilemma on whether to address short-term, acute needs or to invest in long-term system strengthening, as it created space—financially and operationally—for both. However, as highlighted by other scholars in the Lebanese context, a longer timeframe for health interventions often fails to translate into a cross-scalar effect that ultimately strengthens the local health system. This is particularly the case if the intervention is delivered by international organizations, as their departure often creates a void that cannot be replenished as the structural conditions that created it are not addressed (Gilmour and Bou-Orm 2025). External financing renders sustainability dependent on continued international presence. In order to sustain service provision beyond the short-term humanitarian planning cycles and even beyond the medium-term development funding availability, it is important to integrate interventions in national institutions, and ideally also in national financing mechanisms (Witter et al. 2025).

Our findings suggest that resilient humanitarian operations can support the resilience of the health system in which they intervene, if they do so in partnership with local actors and ensuring mutual learning rather than unidirectional capacity building. This approach can help strengthening accountability through anchoring humanitarian health operations in locally driven priorities, hence shifting decision-making power to people affected and humanitarian health leaders coming from the same communities (El Doukhi 2025, Mohamud 2025, Truppa et al. 2026).

In the case of the ICRC programme in RHUH, resilience was sustained by individual initiatives, trust-based collaboration, and decentralized decision-making within a constraining organizational culture, but there was little integration in national budgets, primarily due to the complex economic crisis the country was going through. In the present context of shrinking humanitarian funding, prioritizing financial integration over service integration can be more critical for strengthening long-term system resilience.

## Limitations and strengths

This study presents some limitations. First, only ICRC decision makers working in a specific programme were invited and interviewed. This constrained the possibilities of understanding how decisions were perceived by frontline workers, both within and outside the organization. A causal loop analysis of decision-making processes based on purposive analysis of the interviews is being performed, displaying the dynamic ways in which the individual and organizational factors influence continuity of health operations. The causal loop analysis will be reviewed through group model building with ICRC staff members having experience with different health programmes, to understand to what extent these findings are specific to the RHUH programme or more generalizable within the organization.

Secondly, we did not include the perspectives of external partners, such as RHUH staff, the local Ministry of Public Health, and AFD representatives, which would have provided a more nuanced understanding of how the continuity of programme implementation has contributed to the Lebanese hospital system's resilience during times of compounded crises. However, as the primary focus of the study was understanding organizational dynamics, the selection of participants was influenced by the need to derive as a comprehensive view as possible of decision-making processes from the perspective of those making decisions. Considering the specificities of the ICRC, and the limited evidence available on its governance processes, we privileged a narrow but in-depth qualitative focus to generate hypothesis to be tested through additional case studies and to be validated through participatory research.

Thirdly, through the study, the terms project and programme are used interchangeably by the respondents. We as authors refer to the partnership between RHUH, ICRC, and AFD as a programme, referring to standard definitions that define programmes as the coordination of multiple projects with different specific outputs, managed as a concerted effort to achieve the same overarching outcome (Weaver 2010, Pellegrinelli 2011). The words of respondents were not modified, to preserve the semantic integrity of their account, as well as to reflect the conceptual ambiguity when using project management terminology in practice.

Additionally, a strong element emerged in the analysis as a key driver of resilience for the project, that is the complex configuration

of personal relationships often trespassing into professional relationships, career pathways between field and headquarters, and informal alliances among colleagues sharing similar views. Due to the methodological approach chosen in the analysis, it was not possible to explore these aspects more in-depth, but as shown by previous research conducted within the ICRC (Leresche et al. 2023), it might be worthwhile for the organization to include formal social network analysis (Blanchet and James 2012) in complex programmes conceptualization and development.

Finally, the lead author of this research performed data collection and part of data analysis and interpretation as an embedded researcher while employed by the ICRC, including as manager of the health department in the Lebanon delegation. While this approach has possibly led to unconscious and conscious biases throughout the process, its value is widely recognized in that it allows for a more thorough understanding of organizational dynamics at play and a deeper reflexivity on explicit and implicit meanings conveyed during the interviews (Olivier et al. 2017, Ward et al. 2021, Akintola et al. 2024). The scientific rigour of the process was ensured by the involvement of external academic researchers with significant experience with the methods adopted.

## Conclusion

Decision-making within the ICRC emerged to be relational, political, and driven by organizational identity, rather than evidence based. Complex social dynamics shape institutional behaviours, and informal structures often override technical evidence in prioritization of actions.

The human factor emerges as crucial in sustaining resilience. Besides allowing rapid absorption of shocks during crises, interpersonal trust and informal networks within and outside the organization appear to be a powerful driver of adaptations at the organizational level over time.

Strengthening health governance and leadership is key to enhancing transformative capacities at the organizational level and requires investment in organizational learning systems to enact resilient humanitarian operations.

## HIC authorship

The authors acknowledge that there is no representation of the local Lebanese context among the co-authors of this paper. The reason for this absence is due to the fact that the case study was proposed by a non-Lebanese, white female physician who appears as the first author of this manuscript, who worked in Lebanon between September 2016 and May 2018, and again between July 2019 and July 2022. Her position as manager of the portfolio of the ICRC health programmes in the country raised some profound reflections that led ultimately to the choice of starting a doctoral programme in an Italian university at the end of her work in Lebanon. The focus of this study is not intended to be on the Lebanese context itself, but rather on taking the Lebanon health programme as a case study to explore how an international organization whose headquarters are in Geneva validates or makes decisions around programmes to be implemented in another country. The lack of representation of the local context is a reflex of the structural lack of diversity among decision makers in the organization, rather than a

deliberate exclusion from the side of the authors, which is important to make visible so that it can be addressed in the future.

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## Author contributions

Conception and design of the work: C.T. and D.D.S. Data collection: C.T. Data analysis and interpretation: C.T. (lead), D.D.S. (support), and M.V. (support). Drafting the article: C.T. Critical revision of the article: D.D.S., M.V., G.C., L.R., and C.S. Final approval of the version to be submitted: C.T., M.V., G.C., C.S., L.R., and D.D.S.

## Supplementary material

Supplementary material is available at [Health Policy and Planning](#) online.

## Conflicts of interest

None declared.

## Funding

None declared.

## Ethical approval

Ethical approval was obtained from the Ethical Review Board of the Center for Operational Research and Experience of the ICRC (protocol number 2322\_NOV) and from the Interagency Ethics Committee in Novara (protocol number CE271/2023).

## Reflexivity statement

The lead author, Claudia Truppa (C.T.), is a white Italian female physician, with a MD degree in Infectious Diseases from the University of Florence, a MSc in Epidemiology from the London School of Hygiene and Tropical Medicine, and is in the final year of her PhD at the CRIMEDIM Center for Research and Training in Global Health, Disaster Medicine and Humanitarian Aid of the University of Eastern Piedmont. She was employed

by the International Committee of the Red Cross and assigned to a field mission in the Lebanon delegation from September 2016 to May 2018 as Primary Health Care Program Manager and from August 2019 to July 2022 as Health Coordinator. She recognizes that her direct involvement as middle manager in the programme under study has given her the privilege of conducting embedded research and hence to access data and people that would have been largely inaccessible to external researchers, as she personally knew each and every person who was involved as decision maker in the programme. She also acknowledges that her interpretation of the data collected might have been biased by her own views on the programme itself and more broadly on the institution. The co-authors Giulia Celentano (G.C., white Italian female) and Catherine Savoy (C.S., white Swiss female) have also been employed by the ICRC. G.C. has been postdoctoral research fellow deployed to Lebanon in several occasions between 2023 and 2025 within a research partnership between the ICRC and her university, ETH Zurich, while C.S. is currently Deputy Head of the Health Unit of the ICRC in the Geneva headquarters. Our collective experience as embedded researchers in the ICRC has given us the unique opportunity of an in-depth understanding of the meanings of specific statements from the participants, as the ICRC jargon is very specific to the organization. We acknowledge that this might have also led to a biased interpretation of some of the meanings extracted from the interviews. We balanced these potential biases through the continuous engagement with academic researchers, who have ensured a rigorous approach to data analysis and interpretation. Luca Ragazzoni (L.R., white Italian male) and Dell D. Saulnier (D.D.S., white Swedish American female) are C.T.'s co-supervisors, while Martina Valente (M.V., white Italian female) is the coordinator of the PhD programme at CRIMEDIM. They all have extensive experience with qualitative research methods and a track record of peer-reviewed publication adopting them in fragile and conflict-affected settings. We acknowledge our privilege as embedded and academic researchers working in Europe and that this reflects a colonial heritage in the hierarchical structures of both academia and humanitarian organizations of the Global North. We are aware that our experience and views might not reflect those of non-white staff from the Global South who have been part of the programme and have not had the opportunity of having managerial positions.

## Data availability

The data underlying this article will be shared on reasonable request to the corresponding author, conditional upon approval from the Ethical Review Board of the International Committee of the Red Cross.

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