THE JOURNEY TO RESILIENCE

A GLC4HSR Learning Series

Peer to Peer Learning Series, Session 3:

Policy Decision-Making During and After Public Health Emergencies

27rd August 2026

2:00 – 3:30 PM IST

GLOBAL LEARNING COLLABORATIVE FOR HEALTH SYSTEMS RESILIENCE

THE JOURNEY TO RESILIENCE

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Public health emergencies test health systems in ways that routine governance rarely does. Decisions must often be taken with incomplete information, competing priorities, limited resources, and little time to assess the consequences. At the same time, the decisions made during a crisis can have implications far beyond the immediate emergency, shaping public trust, economic stability, health outcomes, and the future preparedness of institutions.

The third session of The Journey to Resilience, the learning series convened by the Global Learning Collaborative for Health Systems Resilience (GLC4HSR), examined this critical dimension of governance: how health systems make decisions during emergencies, how those decisions are coordinated across institutions and levels of government, and how the experience of crisis can be translated into stronger preparedness and resilience afterwards.

The session built on the first two webinars in the governance series. The inaugural session examined assessment, monitoring, and surveillance as governance functions that help systems understand their current situation. The second session moved from intelligence to action, exploring policy formulation, priority-setting, evidence-informed decision-making, and implementation. The third session moved into a more demanding environment: what happens when the normal policy cycle is disrupted by a public health emergency?

The central question:

How can governance systems make timely, evidence-informed decisions when the evidence itself is incomplete, and the consequences of delay are potentially enormous?

From Routine Governance to Crisis Decision-Making

Opening the session, Dr. N. Krishna Reddy, CEO of ACCESS Health International, reflected on the broader purpose of the governance series. The COVID-19 pandemic had demonstrated that leadership, governance, and public trust could significantly influence how health systems absorbed shocks and protected populations. Yet, despite the prominence of these concepts, there remained limited clarity about what governance actually looks like in operational terms.

The governance series therefore seeks to move beyond abstract definitions and examine the institutional mechanisms through which governing functions are performed.

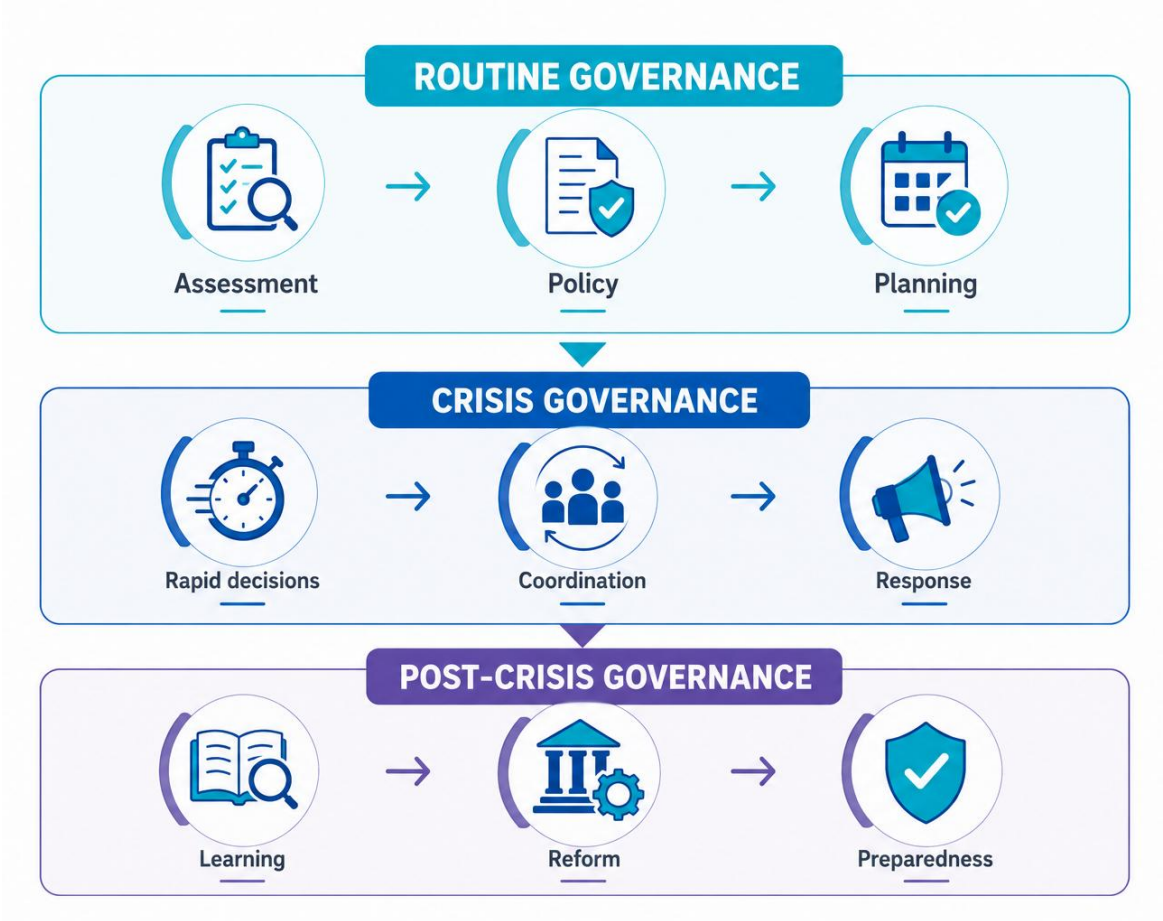
"Resilience is built before the crisis, tested during it, and strengthened afterwards."

The first two sessions followed the policy cycle from understanding the current state of a health system to formulating policy responses. Crisis decision-making introduces a fundamentally different set of conditions. Policymakers must act despite uncertainty, while simultaneously balancing scientific evidence, political considerations, operational feasibility, economic consequences, and public expectations.

The discussion also distinguished between three related but different governance tasks:

- Decision-making during a crisis — responding rapidly to an immediate threat.
- Decision-making for preparedness — building capacities before the next crisis occurs.
- Learning after a crisis — ensuring that experience is translated into institutional reform rather than being forgotten once the emergency subsides.

This framing positioned resilience not as something that can be switched on when an emergency begins, but as a capability that must be developed during routine times.



Rethinking What Counts as a Public Health Emergency

Dr. Sohel Saikat began by placing emergency decision-making within the broader landscape of population health. The conventional understanding of an emergency often centres on infectious disease outbreaks and sudden catastrophic events. Yet the global burden of disease increasingly demonstrates that the threats confronting health systems are much broader.

Non-communicable diseases, mental health conditions, climate change, displacement, conflict, antimicrobial resistance, ageing populations, economic pressures, and infectious disease outbreaks increasingly interact with one another. What constitutes an "emergency" can therefore vary considerably across countries and contexts.

In some settings, infectious disease outbreaks may remain the dominant concern. In others, climate-related events, non-communicable diseases, nutrition, mental health, or the consequences of conflict and displacement may pose equally significant threats.

This changing risk landscape has an important implication for governance: health systems cannot build resilience around individual diseases or isolated emergencies. Instead, resilience requires baseline capacities that allow health systems to absorb routine shocks before they escalate into major emergencies.

“We cannot build resilience around individual diseases or isolated emergencies. We need to strengthen the system so that routine shocks do not become major emergencies.”

Governance Is the Architecture Behind Public Health Action

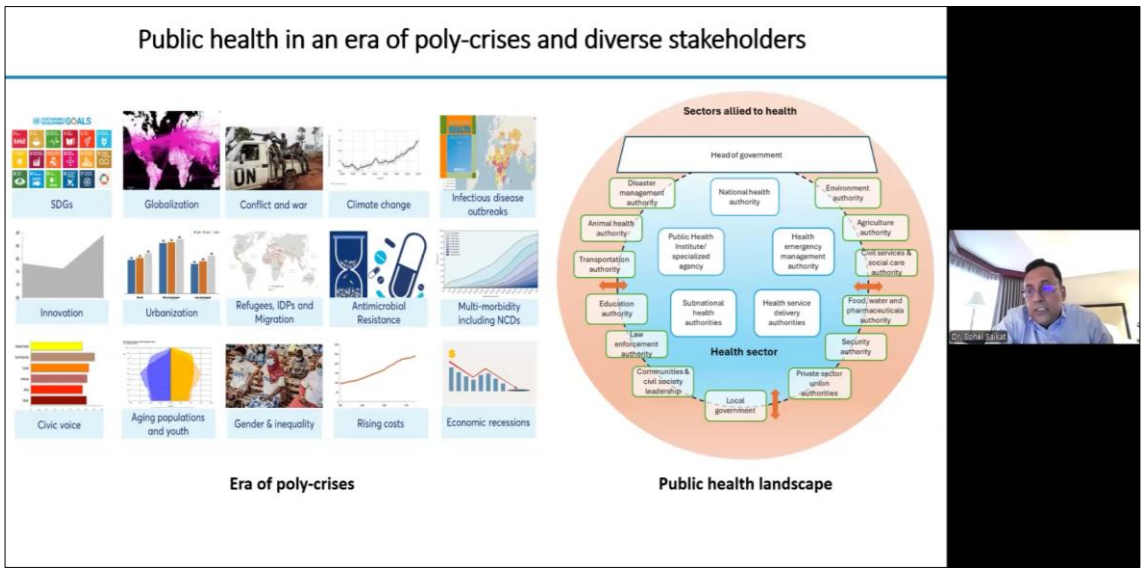
Dr. Saikat's presentation moved from the changing risk landscape to a more fundamental question: what does governance for public health actually mean?

He described governance as encompassing the processes, structures, and mechanisms through which decisions are made, and oversight is exercised to guide, coordinate, and ensure accountability for collective public health action.

Importantly, this governance architecture must include more than the Ministry of Health.

Public health outcomes are shaped by decisions relating to water and sanitation, food safety, environmental protection, urban planning, transport, housing, social protection, education, finance, and other sectors. During a crisis, weaknesses in these interconnected systems can rapidly become health-system vulnerabilities.

The implication is that public health governance must operate across institutional boundaries



Six Foundations for Crisis-Ready Governance

The discussion presented governance as a system with several interconnected components rather than a single institutional structure.

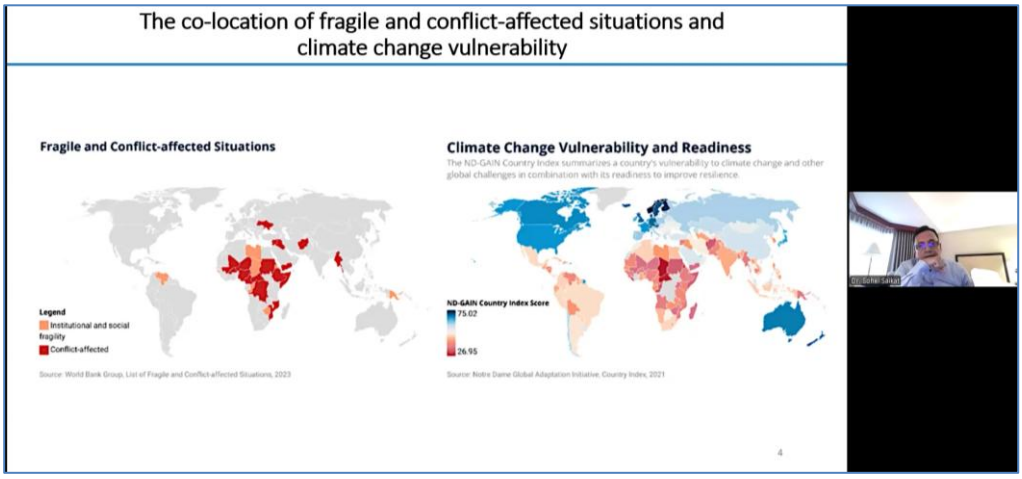
These included:

- **Strategic Direction:** Clear authority to establish priorities and provide policy direction.
- **Oversight & Partnership:** Mechanisms that allow institutions and sectors to work together and maintain accountability.
- **Legal Authority:** Legislation and mandates that establish responsibilities before a crisis occurs.
- **Resource Stewardship:** Protected and appropriate financing for public health and emergency preparedness.
- **Monitoring & Accountability:** Systems for tracking performance, identifying gaps, and enabling self-correction.
- **Institutional Coordination:** Structures that define who leads, who supports, and who is accountable across different levels.

These components need to exist during routine conditions, but they must also be capable of being activated or scaled up during a crisis.

> **"The emergency should activate governance mechanisms, not create them from scratch."**

There Is No Single Model of Crisis Governance



One of the important lessons from Dr. Saikat's presentation was that countries organize public health governance in different ways.

Some place public health and emergency preparedness primarily within the ministry of health. Others use a national public health institute, while some rely on multisectoral coordinating bodies or combinations of these structures.

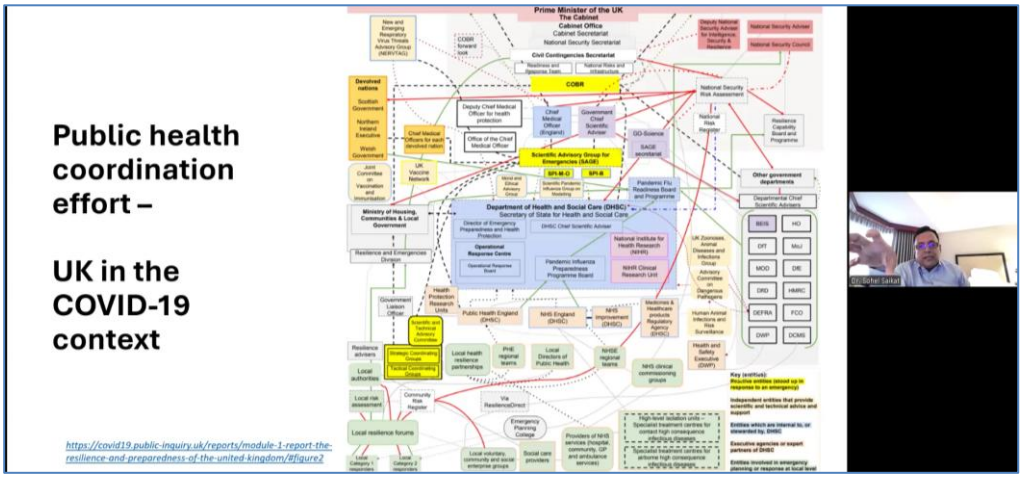
The appropriate institutional model therefore depends on the country's political, administrative, legal, and health-system context.

What matters is not whether a country follows one particular organizational model, but whether the arrangement provides:

- clear ownership;
- defined mandates;
- authority to act;
- access to resources;
- coordination across sectors;
- mechanisms for scientific and technical advice; and
- accountability for decisions and outcomes.

The discussion highlighted examples from the United Kingdom, Saudi Arabia, Finland, and Thailand to demonstrate how different countries have approached these challenges.

From Crisis Response to Routine Preparedness



The country examples discussed by Dr. Saikat demonstrated an important distinction: some governance systems are designed primarily to respond to emergencies, while others build preparedness into routine government processes.

Finland: Health Across Government

Finland was presented as an example of institutionalizing health considerations across government. Its approach includes intersectoral accountability and mechanisms that bring health considerations into wider government decision-making.

A particularly relevant example is the use of Health Impact Assessment in government proposals. Rather than waiting for health consequences to emerge, the process allows potential risks and vulnerabilities to be considered before policies and development decisions are implemented.

Thailand: Bringing Multiple Voices into Decision-Making

Thailand's National Health Assembly provides another model. Government, academia, and civil society participate in a structured process in which different stakeholders contribute to public health decision-making. The broader lesson is that governance becomes stronger when participation and coordination are institutionalized rather than convened only when a crisis occurs.

United Kingdom: Defining Roles Before the Emergency

The UK's civil contingencies framework was highlighted as an example of defining the responsibilities of different responders, including health services, police, fire and rescue, and environmental agencies, before emergencies occur. This creates a common operating architecture that can be activated when a crisis emerges.

Egypt: Building Preparedness Before COVID-19

Dr. Hala Zaid brought the discussion from global frameworks to the practical experience of leading a national health system through COVID-19.

Her central message was that preparedness for COVID-19 did not begin when the pandemic arrived.

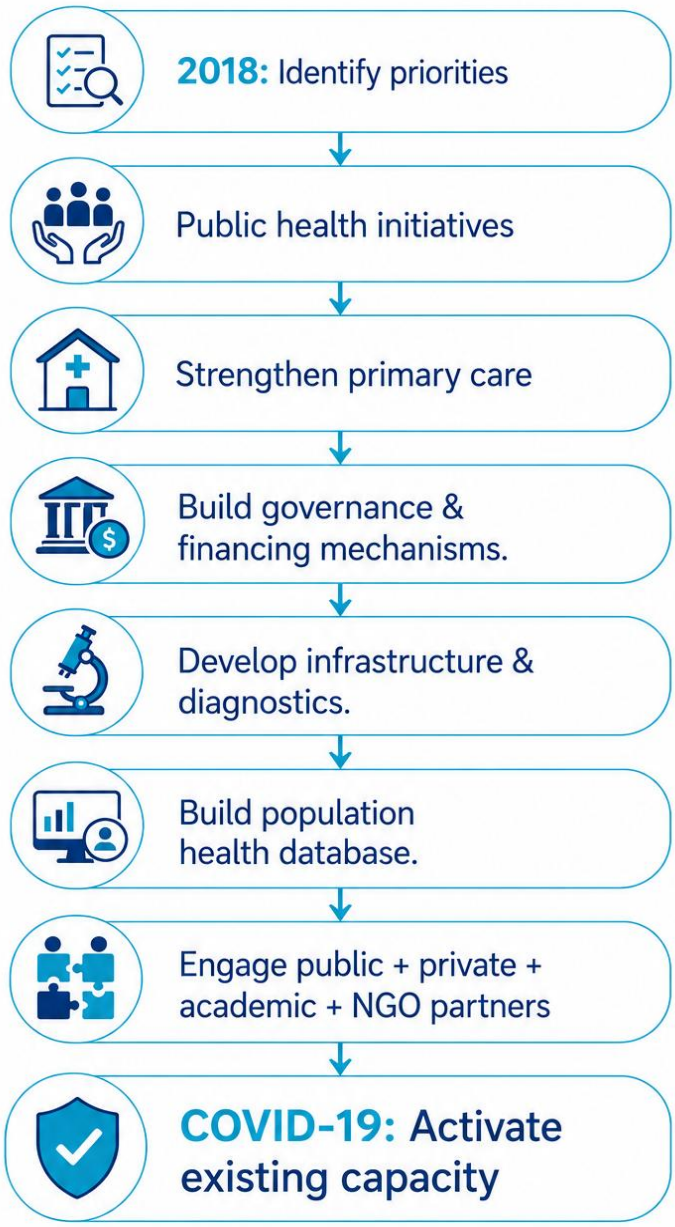
When Dr. Zaid assumed leadership of Egypt's Ministry of Health and Population in 2018, she described establishing two major priorities: strengthening public health and prevention, while simultaneously restructuring the health system to support Universal Health Coverage.

"The investments we made before COVID-19 became the capabilities we relied on during the pandemic."

The government began by identifying the country's major disease burdens. Hepatitis C was a major priority, alongside non-communicable diseases, breast cancer, childhood malnutrition and other population health challenges.

The resulting public health initiatives were not designed as isolated programmes. They were linked to stronger primary care, governance structures within the ministry, annual budget allocation, infrastructure development, human-resource capacity, and engagement across public, private, academic, and civil society organizations.

Egypt's Preparedness Pathway:



The Hepatitis C Program as a Preparedness Platform

The hepatitis C elimination program emerged as a particularly powerful example of how a disease-specific intervention can create broader health-system capabilities.

The program required large-scale screening, diagnostics, treatment, referral, follow-up, infrastructure, data systems, and coordination across different actors.

According to Dr. Zaid, these investments created capabilities that subsequently proved valuable during COVID-19.

The program also generated a large population health database, strengthened diagnostic infrastructure, including PCR capacity, and created experience in coordinating government institutions with universities, NGOs, and private-sector actors.

Perhaps most importantly, it helped establish public trust.

When COVID-19 emerged, the population had already experienced large-scale public health initiatives delivered through the health system. This existing relationship of trust helped make government communication and public health guidance more effective during the pandemic.

"Preparedness is not only about emergency stockpiles and response plans. It is also about building trusted institutions, capable infrastructure, usable data, strong primary care, and relationships between stakeholders during normal times."

COVID-19 and the Shift from National to Regional Governance

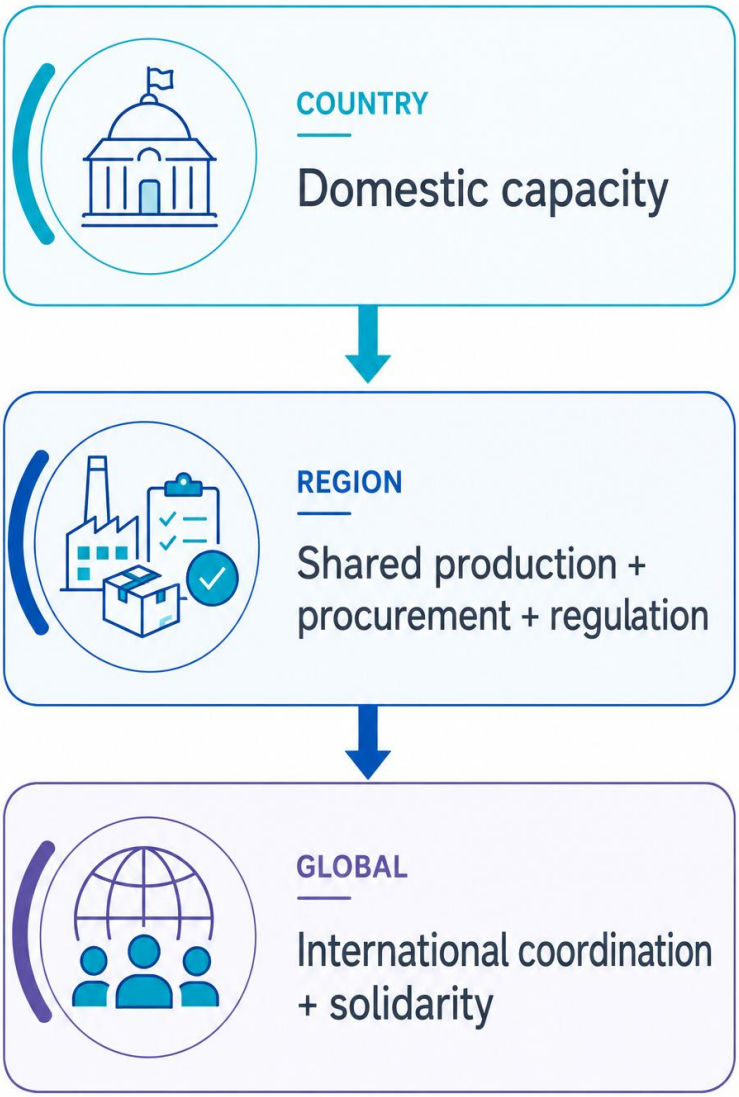
The discussion also highlighted how crises expose vulnerabilities that cannot be solved by individual countries acting alone.

Dr. Zaid described Egypt's experience of working with regional institutions during and after COVID-19, including efforts around vaccine access, African health cooperation, pharmaceutical regulation, and procurement.

The challenge was particularly visible in countries that lacked the cold-chain infrastructure required for some vaccines. The availability of a vaccine did not necessarily translate into the ability to deliver it.

This highlighted the importance of regional production capacity, regulatory cooperation, pooled procurement, and supply-chain resilience.

Post-pandemic initiatives such as the African Medicines Agency and African procurement mechanisms were discussed as examples of attempts to institutionalize some of the lessons emerging from COVID-19.


COUNTRY
Domestic capacity
REGION
Shared production + procurement + regulation
GLOBAL
International coordination + solidarity

The Next Crisis May Not Look Like the Last One

The discussion broadened the concept of preparedness beyond pandemics.

Dr. Zaid identified climate change as one of the major long-term threats that health systems need to prepare for. Unlike an acute infectious outbreak, climate-related health risks can develop over longer periods and affect populations through multiple pathways.

Heat, environmental disruption, changing disease patterns, displacement, food insecurity, and pressure on health infrastructure require sustained cross-sectoral action.

The implication is important: health ministries cannot address climate change alone. Their role is to understand and prepare for its health consequences while working with other sectors to address underlying drivers.

The speakers also discussed the emerging governance challenge presented by artificial intelligence. AI could support prediction, diagnosis, and health-system decision-making, but without appropriate regulation and safeguards, it could also introduce new risks, particularly in settings where regulatory capacity is still developing.

Preparedness cannot be built around yesterday's emergency. The governance system must be capable of adapting to risks that are still evolving.

Bringing Governance Down to the Local Level

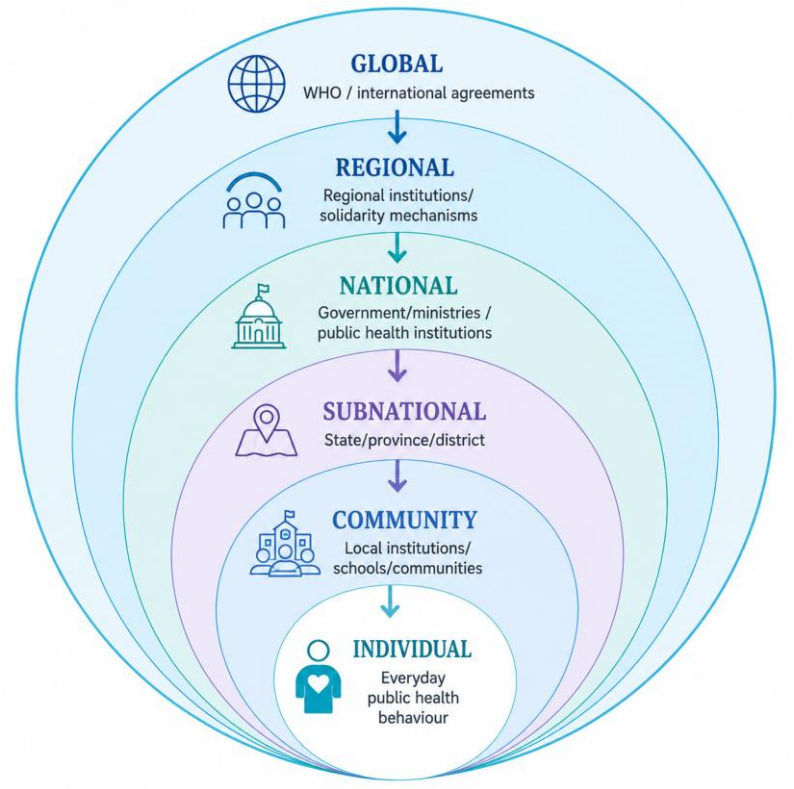
A key question during the discussion was whether governance frameworks designed at global and national levels can effectively reach communities.

Dr. Saikat argued that governance needs to be considered as an ecosystem extending down to district and local levels.

At district level, health authorities interact with primary care facilities, laboratories, veterinary services, food-safety systems, local government and other actors. These institutions need to be connected before a crisis occurs.

The discussion also emphasized that individuals and communities have an important role in public health governance. Behavioral changes observed during COVID-19, such as greater attention to hygiene, infection prevention, and respiratory etiquette, can become lasting public health assets when they are reinforced through education and community engagement.

School health and public health education can therefore form part of the longer-term governance architecture.



The Hardest Part: Making Reform Stick

The discussion then turned to one of the most persistent problems in health governance: what happens when the emergency is over?

Crises often generate new institutions, committees, funding mechanisms, partnerships, and ways of working. But once the immediate threat recedes, attention and resources can shift elsewhere.

Dr. Zaid emphasized the importance of institutionalizing emergency preparedness through high-level, multisectoral structures rather than leaving responsibility exclusively with the Ministry of Health.

During COVID-19, Egypt's national response involved senior government leadership and multiple ministries. Dr. Zaid argued that such mechanisms should increasingly become institutionalized because emergency preparedness requires decisions relating to finance, investment, energy, procurement, manufacturing, and other sectors, not health alone.

The African experience also demonstrated the value of creating permanent institutions and mechanisms for medicines, procurement, and regional cooperation.

It is to identify what worked, what should be retained, and what needs to change, and then embed those lessons into normal governance.

Key Insights

The third session of The Journey to Resilience brought together global and national perspectives to examine how governance systems make decisions under conditions of uncertainty, and how they can become stronger as a result.

- **Resilience is built before the emergency:** The most important preparedness investments are often made during routine periods. Strong primary care, public health functions, data systems, infrastructure, workforce capacity, supply chains, and public trust provide the foundation from which emergency response becomes possible.

- **Crisis governance cannot depend on improvisation:** Emergencies require rapid decisions, but rapid does not have to mean improvised. Clear mandates, legal authority, leadership structures, coordination mechanisms, and predefined responsibilities allow institutions to act more effectively when pressure is highest.

- **Public health governance extends beyond the health ministry:** Health emergencies affect - and are affected by - finance, education, environment, infrastructure, food, energy, social protection, and other sectors. Effective governance therefore requires mechanisms that bring these actors together.

- **Evidence remains essential even when evidence is incomplete:** Crisis decisions rarely come with perfect information. The challenge is not to wait for certainty, but to identify the best available evidence, understand its limitations, make proportionate decisions, and adapt as new information emerges.

Overarching Insights

- **Primary care is a foundation for resilience:** The discussion repeatedly returned to the importance of building resilience into primary health care and public health systems. Systems that rely predominantly on hospitals to absorb crises are likely to face greater disruption.

- **Trust is a governance asset:** Egypt's experience demonstrated how investments in public health programmes can build trust before a crisis occurs. That trust can become critical when governments need populations to accept difficult decisions and follow public health guidance.

- **Regional and global solidarity are essential:** Vaccines, medicines, technology, manufacturing, procurement, data, and expertise cannot always be secured independently by every country. Regional and global mechanisms are therefore an important complement to domestic resilience.

- **The real test is what remains after the crisis:** A crisis should leave behind stronger institutions, clearer responsibilities, better preparedness, and greater capacity; not simply memories of what happened.

A Final Reflection

The conversation ultimately reframed emergency decision-making as more than a question of responding quickly when a crisis occurs. It is a question of how health systems are governed before, during, and after the crisis.

Before an emergency, governance determines whether institutions have the authority, resources, information, relationships, and capacity needed to act.

During an emergency, governance determines how rapidly different actors can come together, interpret uncertain evidence, make decisions, communicate with populations, and protect essential services.

After an emergency, governance determines whether the experience becomes institutional learning, or gradually disappears as systems return to business as usual.

The experiences shared by Dr. Sohel Saikat and Dr. Hala Zaid therefore point towards a broader understanding of resilience: resilient health systems are not simply systems that survive crises. They are systems that learn from crises and use that learning to become better prepared for what comes next.

As the Journey to Resilience continues, this provides an important bridge from understanding how health systems are governed to examining how those governance capabilities can be strengthened, sustained, and translated into action across every level of the health system.