Independent Commission on UK Public Health Emergency Powers Questions on Legislative Options David Nabarro 22nd May 2023		
No	Question	Comment
1 - 6		I regret I am not in a position to answer these questions.
7	Where is the balance to be drawn between the use of a pre-existing legal framework and responsive legislation made as a specific public health emergency occurs?	In general, I favour the development of a legal framework when there is not a health emergency. The framework needs to be flexible enough to apply to the range of potential health emergencies that might be expected to emerge. It can be supplemented by responsive action during the emergency if necessary. Members of the public could be informed about the Framework and be given opportunities (and encouraged) to discuss its relevance to them and application in practice.
8	Is it possible to pre-identify before a specific public health emergency: the types of non-pharma interventions that could be used, how they might be applied and enforced including the types of powers that it might be necessary and appropriate for ministers to adopt; and appropriate levels of parliamentary scrutiny over ministerial powers.	The selection of the spectrum of non-pharma interventions depends on the anticipated transmission route (eg contact with a patient's body fluids vs droplet spread vs airborne) and I believe that it should be possible to pre-identify both the interventions and the powers in general terms. It should also be possible to pre-identify the appropriate levels of parliamentary scrutiny. It would always be feasible to build into the legislative instrument the capacity for arrangements to be adapted during an outbreak if the circumstances warrant it.
9	Is it practical to have a tiered approach within public health emergency legislation with distinctions in the extent of powers available to ministers, and the balancing factors to which they are subject (including sunset provisions) based on the nature and level of the risk and the need for urgency?	YES: The WHO approach is all about encouraging decision-makers to establish policies and then change the stringency of responses based on assessments of the nature and level of risk for different population groups (as well as the need for urgency): WHO secretariat is 100% focused on providing strategic guidance on a) how risk should be determined and b) how data on risks should be used to identify appropriate actions (taking the specific needs of different population groups into account)
10	What factors should determine the use of guidance vs legislation to impose public health restrictions?	My position on this is based on experience with a range of infectious diseases including influenza, Ebola virus disease, cholera and COVID-19. In all these conditions, it is the pathogen that is the problem and people who provide the solutions. This means that people (meaning *all* people) need to be able to perceive that they are seen, by authorities, as partners in outbreak responses always. Communication must reflect that. Communicators need to be honest (about why specific decisions are being made, especially explaining why alert levels are changing), humble (about what is not known as well as what is known), humane (paying attention to the interests of all people especially those who have the least resources),) and hopeful (as appropriate, but without offering false hopes). Trust is stretched if people are criticised by leaders and is broken if decision makers appear to follow a different set of rules. From my perspective, mandates (for how people behave or for

		specific preventive interventions like vaccination) should only be used as a last resort. In my experience people within WHO did not recommend the use of lockdowns as a primary means for controlling an outbreak of COVID-19. A lockdown should only be applied as a temporary measure while the essential systems for containing infectious disease outbreaks [viz isolation - when illness is suspected, confirmatory testing, contact tracing and quarantine for contacts] are being established and then put in place. As I saw it (without evidence) the UK public proved to be much more willing to make sacrifices "to fo the right thing" than decision-makers initially expected.
11	To what extent would it be possible to ensure that there is clarity as to what is guidance and what are legal rules during a public health emergency? (The experience of other countries shows that while a number had similar problems to the UK in this regard during Covid-19, some – e.g. Germany – did not)	If the partnering approach is used – above – then it should be relatively straightforward for District Public Health officials to engage with people's representatives – especially in local jurisdictions – and for there to be a shared understanding of what is guidance and what is a legal requirement. In my view the German experience reflects on the collective approach which was exemplified by the leader of the Robert Koch Institute. As I understand things, such an approach – locally integrated action supported by a combination of guidance and regulations from decision makers in the centre – did emerge in the UK as the pandemic evolved.
12	During Covid-19, scientific advice used to inform policy was dominated by evidence about the disease. How can the other societal impacts of the containment measures be weighed against the spread of disease?	It seemed to me that in many countries, the scientific advice that had the greatest influence on those exploring the trade-offs associated with alternative policy decisions, was based on models produced using epidemiological science - especially in the earlier months of the COVID-19 pandemic. In my work on Ebola in West Africa, on supporting people through Cholera epidemics more broadly, and on vaccine hesitancy, I have come to appreciate the importance of always complementing the numerical models with the results of social science studies (esp sociology, anthropology, geography and economics) in helping to identify societal groups whose experiences might be different from the majority. For them the trade-offs might be different, and both strategies and operational priorities should be adapted (as feasible) to where they really are (rather than where policymakers might wish them to be). This particularly applies when identifying the groups of people in different societies who are likely to feel alienated with regard to guidance on offer, and to find it hard to comply with it. Their noncompliance could well be for very good reasons - because of concerns about losing their (already low) incomes, their sense that "guidance is not for them", or aspects of their working conditions. One example that seemed relevant in several countries relates to the dilemmas faced by workers in meat packing plants not wanting to declare that they had COVID because they would be expected to remain at home receiving a weekly allowance that was about a quarter of what they would expect to earn at work. For me an appreciation of the potential disadvantages of not drawing on social science data became clearer as the inequities related to people's COVID19 experiences became more evident.

13	What steps should be taken to engage the public in their understanding of public health emergencies and the control measures?	This is an absolute priority as it is the only way to reduce the risk of anger and frustration building up to a point where it can be exploited within political discourse: once that happens, the practise of public health becomes very difficult indeed. So… my recommendation to all involved in controlling infectious diseases is to establish opportunities everywhere for people to be listened to and heard, for them to have dialogue about what is being proposed, and for questions to be answered promptly and with respect: prioritize people in high risk groups or high dependency settings (eg care homes). In addition, establish similar opportunities for engaging front-line health care, security, customer relations and similar personnel who are on lower incomes (as they may have a higher risk of infection and challenges with accessing care).
14	Do you have any further views on how the UK can better prepare its law-making for the next public health emergency?	As the Independent Commission on UK Public Health Emergency Powers develops its recommendations, I would be delighted to engage with the Chair (or someone deputed by him to speak with me) and comment on them if that would be helpful. I could also check specifics with the legal experts at WHO Secretariat.