A Legal Analysis of India's Legislative Response to Covid-19 Pandemic

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Introduction

As of 26th of May 2020, the world has witnessed 5,370,375 confirmed cases of Covid-19 and 344,454 deaths due to this highly contagious viral pneumonia. India's share of these figures are 138,845 confirmed cases and 4,021 deaths ("WHO Corona virus Disease (COVID-19)

The legal bedrock for tackling COVID-19 in India are The Disaster Management Act, 2005(DM Act) and The Epidemics Diseases Act of 1897 (ED Act). The DM Act, 2005 has its genesis in the aftermath of the tsunami (2004) when India realised the need to have a separate legislation for disaster management. The ED Act, 1897 is a pre-independence law enacted for dealing with the bubonic plague that led to enormous loss of lives and deserted villages (Home Department, Government of India 1898, 11-14). The ED Act, 1897 delegated law-making powers on the State administration empowering them to enact rules and regulations for inspection, restricting movement or modifying behaviour to prevent the spread of any dangerous epidemic disease. [1]

Questions of suitability and effectiveness test the forte of this legal framework. In this paper, the researcher endeavours to ascertain the suitability of these legislations, their recent amendments Vis –a- Vis Covid-19.An attempt to examine certain provisions of these legislations and their amendments through the lens of

pandemic preparedness and response is undertaken.

Disaster Management Act, 2005 *Vis-a-Vis* Pandemic Response

DM Act, 2005 covers both manmade and natural disasters as indicated by the definition of "disaster" [2] and the various disaster specific guidelines released by the National Disaster Management Authority (NDMA) post 2005. [3] The Ministry of Home Affairs on the 24th of March 2020, notified Covid-19 as a disaster on the recommendation of the NDMA [4]

The DM Act, 2005 formulates a four tier administrative structure at the National, State, District, and Local levels by establishing the National Disaster Management Authority, State Disaster Management Authority, and District Disaster Management Authority respectively. The Act lays down the composition of these authorities and details the functions of each authority. The three tiers have functions of planning, policy formulation, inter-sectoral and ministerial cooperation; the functions for the local bodies get a brief mention.[5] This Act has been critiqued on the grounds of implementing a top down approach to disaster management where decision-making power is centralised leaving very little role in decision making by local authorities. Other grounds of deliberation were absence of community participation in decision-making, focus on financial mitigation and rehabilitation rather than development of the disaster prone area (Sarkar and Sarma 2006, 3760-763). Lack of capacity building in communities, the inability of the Act to garner active civil society support, exclusion of non-governmental organisations, private sector, local volunteers, and lack of coordination at the local levels are other fissures in the current legislation (Ray 2005, 4881)

With a hierarchal bureaucratic structure and centralised nodal agencies, skilled to deal with natural disaster like tsunamis and cyclones, dealing with a pandemic poses challenges on three major fronts. Firstly, is the top down decision making model suitable in condition of a pandemic? As per the seventh schedule of the Indian constitution, health is a State subject and every State has a different health

infrastructural setup, individual State legislations, disparity in population resulting in dissimilar capacities of pandemic preparedness and response. Secondly, the Act focuses on response, mitigation, and relief in disasters whereas in case of a pandemic the objective is prevention of a health infrastructural collapse. The third challenge is generating capacity building in response forces and rapid response teams to prevent spread of a pandemic in a community with community co-operation. A weak fourth tier due to non-specification of local bodies, their roles, and composition makes a bottom up approach to any disaster problematic. The absence of community health centres and lack of their integration in the disaster management plans at local levels is an oversight in the legislation. (John 2020, 14)

The Biological Disaster Management Guidelines

NDMA in 2008 released "The Biological Disaster Management Guideline" (BDM); these guidelines detail the role and functions of various authorities in situations of bio-terrorism, biological warfare, biological disasters (natural and accidental) and epidemics (National Disaster Management Authority of India 2008, 11-29). These guidelines make it clear that management of biological disasters requires specialists such as medical experts, epidemiologists, virologists, etc. hence the nodal ministry for management for biological disasters is the Ministry of Health and Family welfare (MoH &FW).

Epidemics are categorised as biological disasters and via these guidelines, the authorities created under the DM Act, 2005 turn into consultative bodies. The MoH &FW and the crisis management group becomes the policy making body with technical advisory committee under the Director General of Health Services providing the technical inputs (22). During a Biological disaster, the Emergency Medical Relief Division (EMRD) is the focal point for coordination and monitoring at the central level. A striking lacuna is the absence of a similar nodal agency at the State level. Most of the States have a regional office for Health and Family Welfare and regional health directors' laisses with State Governments for management of biological disasters (21).Many States have till date not established the State Disaster Management Authority and their disaster management plans are pending.

The role of the Disaster Management Response Force[6] is limited in case of epidemics as the National Institute of Communicable Diseases (NICD) and Indian Council of Medical Research (ICMR) train and send Rapid Response Teams (RRT's) for field management of the biological disaster. As per the report "Disaster Management in India" (Ministry of Home Affairs 2011, 98), "In the larger cities (say with population exceeding 2.5 million ... the Mayor assisted by the commissioner of the Municipal Corporations and the police commissioner are directly responsible for crisis management." The National Institute of Disaster Management has the primary function of training, but for biological disasters, NICD and ICMR are the training bodies, the police and municipal workers, however, receive their training from the NDRF.[7] Biological disasters response force needs special training and exposing untrained police forces and municipal workers can result in shortage of staff in these essential services.

As per these guidelines, Biological Disaster Management Plans (BDMP's) are mandatory at the national, state and district levels. These guidelines also mandate that all ministries at the national and State level should have standard operating procedures (SOP's) for dealing with biological disasters. At the State level, the state health department is responsible for preparation of these SOP's and at the District level the District Disaster Management Authority of which the Chief Medical Officer is a member, should draft, and circulate SOP's to all concerned authorities. Most of these SOP's are at present being issued in the form of circulars and guidelines by the Central Ministries.

BDM guidelines are peripheral touching nearly all aspects of management of a biological disaster but lack precision and depth. They fail to create a clear line of command and the inter-ministerial coordination network needs further definition.

The Epidemic Disease Act, 1897 *Vis –a-Vis* Pandemic Response

The ED Act, 1897 enacted to prevent the spread of dangerous epidemic diseases is a brief law made up of just four sections. Concisely it provides blanket powers

to the State Government to take all measures to prevent the spread of an epidemic. These measures include curtailment of travel, inspection of vessels, and promulgation of temporary legislations binding on the public or class of persons.[8] Disobeying any such temporary law or obstructing any public servant is punishable under sec. 188 of the Indian Penal Code, 1860. An attempt to have a separate enactment for biological disasters including epidemics came through The Public Health (Prevention, control and Management of Epidemics, Bioterrorism and Disasters) Bill, drafted by the MoH & FW in 2017.

This Bill clubbed epidemics with bioterrorism and biological disasters and defined a number of terms essential to manage biological disasters[9] Sec 2 of this Bill detailed all the measures that a State or local authority could take when faced with a public health emergency such as tracing, isolation, quarantine, and containment. This Bill was criticised for vagueness and transfer of excessive power to the State in case of health emergencies, like compulsory treatment, detention etc. (Verma 2017).

This bill was skeletal and extremely generic, apart from a detailed enumeration of the actions, which a State government could take, it was silent on identifying the nodal agencies, and assigning precise functions to them, it followed the same hierarchal structure like the DM, Act, 2005.[10] It did however; give States the power to amend any rules enacted under it to suit State specific circumstances.[11] One of its objective was repealing The Epidemic Disease Act, 1897, this law was however, not enacted for unknown reasons.

The Epidemic Diseases (Amendment) Ordinance, 2020 promulgated on April 22, 2020 amends the ED Act, 1897 in four areas.[12] Firstly, it expands the power of the Central Government for inspection of vehicles, aircrafts, and vessels, the government can now detain people who use or intend to use these modes of transport.[13] Secondly, this ordinance expanded the definition of Healthcare service personnel by including any person coming in contact of the infected patient during the course of his duty to prevent spread of the epidemic.[14] Thirdly, the Ordinance endeavours to protect health care personnel against violence by making acts of violence against health personnel cognisable, non- bailable offences. Lastly, the Ordinance gives an inclusive definition of property and makes

the destruction of such property a punishable offence.[15]

Promulgated with the intention of protection of healthcare personnel against violence and protection of property essential to the functioning of hospitals, facilities and clinics this Ordinance overlooks some fundamentals of criminal jurisprudence. In most of the offences under the Indian Penal Code, 1860, the abettor receives a lesser punishment than the offender does whereas under the amended ED Act the abettor is entitled to the same punishment as the offender.[16] Criminal law distinguishes between offences against person and property on grounds of gravity; offences against property have lesser punishments. The definition of "acts of violence" given in this ordinance blurs this boundary by including within its ambit both bodily harm and loss or damage to property in the custody of the health care personnel. The reversal of burden of proof in a case of causing grievous hurt goes against the generally established principle of proving beyond reasonable doubt of culpability in criminal cases. The presumption of mental state of culpability includes vague concepts such as "belief in" or "reason to belief" and "motive".[17] If the Court can presume the existence of such vague notions, it can do away with the need of a trial as well. Recovery of damages that are twice the fair market price of the property-destroyed merge the concept of liquidated damages usually utilised in civil cases with a criminal action.

Conclusion

This brief encapsulation of the DM Act, 2005 and BDM guidelines is enough to bring to light that managing a pandemic is fraught with challenging issues. Some of which are; lack of nodal agencies at all levels ; lack of training of civil servants manning the municipal authorities and the police forces ; multitude of authorities at horizontal level and the vertical integration of parallel ministries and most importantly the lack of SOP's. The BDM guidelines are extremely generic whereas a biological disaster is of a highly specialised nature, the effective management of which requires clearly demarcated nodal agencies, strong vertical and horizontal integration of nodal agencies, role demarcation with clear SOP's for every stakeholder along with trained response forces. The DM Act, 2005 and

the BDM guidelines fails in assigning specific roles and functions to mentioned authorities. Role sharing by authorities created under the DM Act, 2005 with health departments and institutes leaves a trail of confusion delaying the swift response that a pandemic requires.

Protection of doctors against violence is a growing concern that needs a well-drafted and just law. The Amended provisions of the ED Act, maybe defensible in the face of a pandemic, but overlooks the fact that offences need to be well defined and an accused deserves a fair trial without presumption of culpability. The existing legal framework is being utilised as best as possible but post the pandemic, legislative action is required both at the Central and State levels to strengthen the legislative shield against future biological disasters.

NOTES

1. Section 2 of the Epidemic Diseases Act, 1897devolves rule making power to the State Government in case of spread of an epidemic and gives the flexibility to the state to make regulations for the purpose of inspection, prevention of travel , quarantine and all other measures to deal with the epidemic.

2. Sec. 2 of the DM Act, 2005 Sections 2(d) of the DM Act, 2005 is a wide definition that includes a manmade, natural, or accidental happening that results in the loss of human lives or property or the environment and is not manageable by the community.

3. The NDMA has released 30 guidelines specific to floods, cyclones, heat wave, hospital safety, tsunamis and various other disasters.

4. Ministry of Home Affairs, GOI. 2020. "Order No.40-3/2020-DM-I (A)". New Delhi, 24th March 2020: Government of India.

5. Sections 3, 14, 25 and 41 set up the National disaster management authority, State Disaster Management Authority, District Disaster Management Authority. Sec. 41 lays down the functions of the local authority without detailing its composition. Training and response for disaster is emphasised as its main function subject to the directions of the district administration.

6. The Disaster Management Response Force constituted under section 44 of the Disaster Management Act, 2005. The control of this force vests in the Central Government, there is no mention of setting up similar response forces at the state and district levels.

7. Sec 42 of the DM Act, 2005 sets up the National Institute of Disaster Management and details out the specific functions of training and education in disaster management. The Act does not mention similar institutes at state or local levels. A disaster is local correspondingly; the lowest rung should be the strongest.

8. Section 2A of the Epidemic Disease Act, 1987 under which the Central Government has the power to prescribe regulations pertaining to inspection of means of transportation and detaining people intending to use these modes of transport or who are arriving in India.

9. Section 2 of the bill defined public health emergency, disinfection, deratting, ground crossing, social distancing, and outbreak. At present, there is no law that defines these terms.

10. Section 8, which gave precedence to the decisions taken at the centre over the state and those taken by the state precedence over the decisions taken by the district and local authorities.

11. Section 13 focused more on rules for furnishing reports, officers who would grant sanctions and compound offences.

12. The Epidemic Diseases Amendment Ordinance, 2020 borrows heavily from the draft of The Healthcare Service Personnel and Clinical Establishments (Prohibition of violence and damage to property) Bill, 2019.

13. Sec.2A Epidemic Disease Act, 2020 has added the inspection of aircrafts and aerodromes and the power to detain persons who intend to use these modes of transport. The detention of a person is thus legally justified as it is for the prevention of spread of the epidemic.

14. Sec. 1A (b) of The Epidemics Disease Act, 2020 - The definition of health care personnel is wide enough to include non- medical personnel like the police, municipality workers, and members of a response team or any one empowered by the government to take measures for preventing the spread of the epidemic.

15. Sec. 1A(c) of the Epidemics Disease Act, 2020 defines property and includes four types of property the last subsection is widely worded to include any other property in which a health service care personnel has direct interest in relation to an epidemic.

16. Sec. 3(2) of the Epidemic Diseases Act, 2020 meets out same punishment for the person committing the act and the abettor.

17. Sec. 3D of the Epidemics Disease Act, 2020 presumes not only mens rea,a culpable mental state, but also motive, knowledge and reason to believe. The accused is allowed to take the defence of absence of such mental state but he has to prove it beyond reasonable doubt.

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