LEGAL FRAMEWORK FOR COMBATING COMMUNICABLE DISEASES IN INDIA

A Dissertation submitted to the National University of Advanced Legal Studies, Kochi in partial fulfilment of the requirements for the award of L.L.M Degree in Public Health Law

THE NATIONAL UNIVERSITY OF ADVANCED LEGAL STUDIES

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CERTIFICATE

This is to certify that **Reg No. LM0320016** has submitted her dissertation titled, "**LEGAL FRAMEWORK FOR COMBATING COMMUNICABLE DISEASES IN INDIA"** in partial fulfillment of the requirement for the award of Degree of Masters of Laws in Public Health Law to the National University of Advanced Legal Studies, Kochi under my guidance and supervision. It is also affirmed that the dissertation submitted by her is original, bona fide, and genuine.

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DECLARATION

I declare that this dissertation titled, "LEGAL FRAMEWORK FOR COMBATING COMMUNICABLE DISEASES IN INDIA" researched and submitted by me to the National University of Advanced Legal Studies in partial fulfilment of the requirement of the for the award of Degree of Master of Laws in Public Health Law, under the guidance and supervision of Prof Abhayachandran K. is an original, bonafide, and legitimate work, and it has been pursued an academic interest. This work or any type thereof has not been submitted by me or anyone else for the award of another degree of either this University or any other University.

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LETTER OF APPROVAL

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ABBREVIATIONS

BPHE	Biological and Public Health Emergencies
CCTV	Circuit Television
COVID-19	Coronavirus Disease 2019
CoWIN	Covid Vaccine Intelligence Work
CrPC	Criminal Procedure Code
HIV AIDS	Human Immunodeficiency Virus
ICCPR	International Covenant on Civil and Political Rights
ICESCR	Covenant on Economic, Social and Cultural Rights
IDSP	Integrated Disease Surveillance Programme
IHR	International Health Regulations
IPC	Indian Penal Code
NCDC	National Centre for Disease Control
NDMA	National Disaster Management Authority
NHP	National Health Policy
PIL	Public Interest Litigation
T.B.	Tuberculosis
UDHR	Universal Declaration of Human Rights
UHC	Universal Health Coverage
UN	United Nations
WHO	World Health Organisation

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CHAPTER I: INTRODUCTION

Transmission of infectious diseases is a threat to public health as is evident from the coronavirus COVID-19 pandemic and the immense toll it is taking on human lives. Corona is the latest in the list of communicable diseases the world has faced. Tuberculosis, leptospirosis, influenza, hepatitis, dengue, H1N1 etc. are few examples of communicable diseases that wreak havoc in different parts of the globe. India, too, suffers the brunt of various communicable diseases. 26 per cent of the Tuberculosis cases in the world is in India[1], a highly disproportionate number. Endemic diseases like Kala Azar, Leprosy, Kyasanur Forest Diseases, Nipah etc. creates panic and fatalities in many regions of the country.

The large-scale possibility of death, disability and economic ruin caused by such scares of communicable diseases makes it the duty of the state to prevent the spread of such diseases in the interest of the greater public good. State undertakes many methods to combat communicable diseases according to the nature, extent and urgency posed by each disease. The lockdown imposed over COVID-19 is an example of such a preventive measure.

Through provisions of law there can be improvement in access to treatment, limit contact and spread of diseases, facilitate screening, counseling and education, immunization etc. yet such actions, however effective, would conflict with the freedom of movement, right to control of one's body and health, right to privacy, property rights etc. Ineffective implementation or non-implementation of preventive measures will result in greater violation of the right to life, health etc. of individuals.

[1] WHO, https://www.who.int/news-room/fact-sheets/detail/tuberculosis (last visited Sept. 30, 2008).

Laws, in action during public health emergencies should be ethical and transparent, in line with principles of public health necessity, reasonable and effective means, proportionality and distributive justice to minimize the violation of individual's rights[2].

The principle of public health necessity means that the coercive powers of the State to contain public health threats to be employed only on the basis of demonstrable threat to public health and that mandatory provisions of examination, treatment, isolation etc. to be conducted only upon reasonable suspicion. Principle of reasonable and effective means provides measures to be appropriate to prevent particular threats or to reduce its spread. This is because different communicable diseases require different standards of care and caution. Measles and polio, once very feared diseases, are prevented by immunization drives whereas ravages of tuberculosis and malaria can be successfully treated by early detection and strict treatment protocols and monitoring by health authorities.

Proportionality principle requires that there needs to be a balance between coercive measures undertaken as preventive steps against the communicable disease and the public health benefit borne out of such measures. The principle of distributive justice provides that risks, benefits and burden of interventions to be shared fairly. This is to safeguard the interests of the vulnerable populations. Public health laws to be based on trust and transparency. The implementation of such laws must be with public participation. Restriction of individual freedoms to be reasonable and must be after ensuring public trust and cooperation.

It is in the light of such principles that the laws in force in India are to be examined. The reasonableness, necessity and apparent consequences of the relevant statutory provisions needs to be seen in comparison to the rights of the individual. The provisions empowering coercive measures need to be seen in the light of the safeguards, if any, built into the statutes against violations of basic rights vested in the individual and recognized human rights.

The Constitution of India Schedule Seven divides the subject matter of legislation between centre and state governments. The Union list has entries for port quarantine (Entry 28), inter-state

[2] WHO, Advancing the right to health: the vital role of law, (2017), http://apps.who.int/iris/bitstream/handle/10665/252815/9789241511384-eng.pdf;jsessionid=D7F2ECA1725B47FDA6379258AA5EAF2A?sequence=1.

quarantine (Entry 81) whereas the provision for public health and sanitation, hospitals and dispensaries are contained in Entry 6 of the State list. The concurrent list where legislation can be done by both centre and state governments contains Entry 29 which provides for prevention of extension from one state to another of infectious diseases or contagious diseases or pests affecting men, animals or plants. India does have multiple statutes dealing with outbreaks and epidemics of communicable diseases. The Epidemic Diseases Act, 1897 is a central statute whereas the states have legislated into force separate state laws. A short legislation vests the central government with broad powers to face outbreaks of communicable diseases and provides penal provisions against violators. Relevant provisions of IPC, CrPC, Disaster Management Act are also employed in prevention of spread of communicable diseases.

The state governments have within their legislative powers enacted various state laws to combat spread of communicable diseases, these include Karnataka Epidemic Diseases Act of 2020, Rajasthan Epidemic Diseases Act of 2020, Epidemic Diseases (Bombay Amendment) Act of 1953, Epidemic Diseases (Punjab Amendment) Act of 1944, Epidemic Diseases Act, 1977 of erstwhile Jammu and Kashmir, Tamil Nadu Public Health Act, 1955 and many more. With a few exceptions most of the statutes in existence in India are limited to providing penal provisions for non-disclosure of disease, violation of any isolation or social distancing norms, attack on health providers etc. There is a dominance of states power over the rights of individuals with little safeguards against any deprivation that may be caused. The statutory safeguards to ensure access to treatment, sanitation, immunization, counseling etc. to the benefit of the patient are lacking. To what extent, are the laws in India proactive in dealing with disease outbreaks as simple penal provisions in health laws are reactive and not enough to effectively deal with infectious diseases.

1.1. Objectives of study

The study aims to examine the nature of statutes dealing with prevention of communicable diseases. It tries to see how far the legislations in force in India are proactive in dealing with public health risks and providing basic rights of people affected- patients infected with the disease, people who are prone to or under threat of infection and otherwise adversely affected by the social or economic consequences of an outbreak or epidemic. There also needs to be studied provisions of

the statute that provide for coercive measures by the State to prevent spread of communicable diseases which may inexplicably cause annoyance to the public. There may be mandatory screenings, compulsory treatment, isolation, quarantine, destruction of property enforced by the State to prevent spread of diseases. As there are multiple statutes in force in different areas of the country dealing with public health, there will be undertaken a comparison of the provisions, the similarities and contrasts they provide with respect to the various facets of disease control and prevention.

Hence, the objectives of the study can be stated as under:

1. To analyze the existing statutes regarding their effectiveness in containing communicable diseases and the extent of protection given to the freedoms of movements right to life, liberty, dignity and property of the individuals while the said statues are implemented.

2. To provide suggestions and solutions to combat outbreaks of communicable diseases without disproportionate violation of the rights of the individuals.

1.2 Research questions

1. Whether the statutes in force in India provide safeguards against violation of an individual's right to health while combating communicable disease?
2. Whether the statutes in force in India provide safeguards against violation of an individual’s right to life and liberty while combating communicable disease?
3. Whether the statutes in force in India provide safeguards against violation of an individual's right to privacy while combating communicable disease?

1.3 Hypothesis of study

The hypothesis, the study is based on is that the present statutory framework to combat communicable diseases in India is not providing enough safeguards to protect the individual’s rights to health, life, dignity, property, liberty etc.

1.4 Methodology of study

The method of study to be followed is doctrinal research by the analysis of existing statutes along with case laws, articles and other publications related to the subject of study.

1.5 Outline of study

Chapter 1: Introduction, seeks to introduce the subject of study while outlining the preliminary requirements of scope, research problem, method adopted etc.

Chapter 2: Law in India regarding communicable diseases, follows the history of legislation on communicable disease, its control and prevention. It enumerates and examines the many central and state legislations in force and their provisions. The state legislations on epidemic control and public health legislations with provisions on prevention and control of infectious diseases are both examined separately. Especially focusing on the provisions of the legislation that empowers restrictions on individual's rights and otherwise, providing for certain rights like right to health, privacy, access to medical care etc.

Chapter 3: Powers of state and rights of individuals, focuses on the exercise of restrictive measures adopted by States to prevent and control the spread of communicable diseases and the soundness of the measures and legislative provisions against the touchstone of human rights, rights under the Constitution and against ethical principles like proportionality, necessity etc. The chapter also enumerates the essential rights of the persons affected by such disease situations including right to health, right to livelihood, right to movement, right to dignity, right to access to health care etc. The chapter seeks to illuminate the need to balance the powers of the state under emergency situations of communicable disease outbreaks and the basic rights of the individual under such restrictive actions. The existence of an emergency situation like disease spread must not be an absolute reason to deny the rights of the individual.

Chapter 4: Recommendations/ Suggestions, the concluding chapter seeks to summarise and enumerate the findings of the study and suggests recommendations to remedy and improve the issues observed.

1.6 Literature Review

1. Tobey, in his book *Public Health Law*[3] lays the foundational principles of public health law and ethics. He defines the concept and role of public health law, especially the policing powers of the State in regards to disease control and the need to limit the same powers.

2. Gostin in his work, *Public Health Law: Power, Duty, Restraint*[4], theorized expansively on the definition and role of public health law, significantly on the ethical principles of proportionality, effective means, distributive justice, transparency and human rights norms to be applied to public health regulation. The book enumerates the various public health measures that come in conflict with civil liberties like isolation, quarantine, restriction on movement etc. and the powers and duties of the State in contrast to the rights of the individual.

3. *Communicable Diseases and Human Rights*[5]: The article in the European Journal of health by Joseph Dute, talks about how communicable diseases require an effective surveillance system, timely application of control measures and increased public health resources to be mobilized. The associated rights of the affected individuals like the right to health care ,right to education, right to work and right to social security etc. Compulsory public health powers involve massive infringement of individual human rights, civil liberty, physical integrity and privacy. Surveillance methods should safeguard privacy. The article focuses on the need for an international approach to tackle communicable diseases, especially on the roles of WHO and EU as a region.

4. Setsuko Aoki, in the article *International Legal Cooperation to Combat Communicable Diseases: Increasing Importance of Soft Law Frameworks*[6] , set up in the context of the SARS outbreak of 2003, talks of the importance of the International Health Regulations and the need for adoption of its provisions by the sovereign States for the prevention of

[3] James A. Tobey, PUBLIC HEALTH LAW 9 (The Commonwealth Fund, 3 ed. 1947).
[4] Lawrence O. Gostin, PUBLIC HEALTH LAW: POWER, DUTY, RESTRAINT 2 (Zinta Saulkalns et al. ed., 2nd ed. 2008).
[5] Joseph Dute, *Communicable Diseases and Human Rights,* 11 Eur. J. Health L. 45 (2004).
[6] Setsuko Aoki, *International Legal Cooperation to Combat Communicable Diseases: Increasing Importance of Soft Law Frameworks,* 1 Asian J. WTO & Int'l Health L & Pol'y 543 (2006).

transnational spread of communicable diseases. The IHR provides for certain tasks for states regarding enhanced national capacity to detect, notify and report events or disease outbreaks. There is outlined a need for appropriate infrastructure to detect, prevent and contain a severe infectious disease and for standardized processes and measures. The article emphasizes that the implementation of the IHR shall be with full respect for human rights and fundamental freedoms of persons.

5. David P. Fidler , David L. Heymann, Stephen M. Ostroff & Terry P. O'Brien,in the article, *Emerging and Reemerging Infectious Diseases: Challenges for International, National, and State Law*[7] focuses on the American situation against communicable diseases. The common thread is the emphasis on the need for surveillance, research on disease, training to scientists and epidemiologists and importance of public health infrastructure in surveillance, treatment, control, prevention etc. The article cites the 1994 pneumonic plague in India which was reported to WHO according to international health regulations. The economic disruption on trade, restriction on air travel, limitation of imported food in the country etc. The instance was seen as a failure to apply International Health Regulations properly.

6. Aruna Kumar Malik in her article *Health Sector Governance and Reforms in India*[8], views health and healthcare through the provision of the Alma Ata Declaration Of 1978 which recommends that primary health care should include education concerning health problems, identifying, preventing and controlling the problems, promotion of food supply and proper nutrition and adequate supply of safe water and basic sanitation, maternal and Child health care immunization against major infectious diseases, prevention and control of locally endemic diseases etc. It seeks to see whether the approach of Indian policy makers is in line with the above mentioned holistic concept. It argues that India suffers from an insufficient health infrastructure

[7] David P. Fidler et. al., *Emerging and Reemerging Infectious Diseases: Challenges for International, National, and State Law*, 31 Int'l L. 773 (1997).
[8] Aruna Kumar Malik, *Health Sector Governance and Reforms in India*, 2 Liberal Stud. 85 (2017).

CHAPTER II : LAW IN INDIA REGARDING COMMUNICABLE DISEASES

The bubonic plague epidemics in Europe led to development of practices of isolation of the afflicted, restrictions on movement, bills of health and quarantine regulations for travellers and shipping[9] etc and the development of the body of sanitation laws. Whereas in India the idea of diseases within the indigenous medicine system was entwined with religious beliefs[10]. The subcontinent was the source of the cholera pandemics and itself suffered millions of deaths from the disease during the nineteenth and early twentieth centuries[11].

Chapter II of the Bhore report traces the history of the health administration in India. Before the rise of modern health systems, there was the recognition that disease spread from the patient to those in association with him and there arose the practices of segregation of the sick and quarantine even when the population was unaware of the cause of such diseases.

While under the British colonial rule the Royal Commission of the year 1859 enquired into the conditions of health in the army in India and its recommendations led to the establishment of the Public Health in provinces of Madras, Bombay and Bengal in the year 1864. Officers designated as sanitary commissioners were appointed to oversee sanitation issue, vaccination drives against small pox in the provinces. The Contagious Diseases Act was passed in 1868 to enforce regular inspection, and forceful confinement of Indian sex workers, so as to prevent European men from being exposed to venereal diseases[12].

The outbreak of plague in India in 1896 and the toll it took on the population led to an enquiry by a commission known as the Plague Commission. The Report submitted in 1904 recommended the strengthening of the public health services, establishment of laboratories for research and for the preparation of vaccines and sera. A Medical Research Department was established under the Central Government, posts of Deputy Sanitary Commissions in Provinces and Health offices in

[9] Paul Slack, *Responses to Plague in Early Modern Europe: The Implications of Public Health* , 3 Soc. Res. 433, 433 (1988), PubMed, PMID: 11650270.
[10] David Arnold, *Cholera and Colonialism in British India*, 113 Past & Present 118, 119 (1986), PubMed, PMID: 11617906.
[11] *Id* at 119.
[12] Burton Cleetus, *Tropics of Disease: Epidemics in Colonial India* ,55 Econ. Pol. Wkly. (May 23, 2020), https://www.epw.in/engage/article/tropics-disease-epidemics-colonial-india.

local governments were created following the report. The plague outbreak saw the legislation of Epidemics Act of 1897, which gave sweeping powers to the colonial government to prevent spread of diseases.

The Government of India Act of 1919, decentralized the power of health administration to provincial legislatures including medical administration of hospitals, dispensaries, asylums, for medical education, public health and sanitation. Provincial ministers for the department of health among others like health, education etc of health among others like health, education etc was made responsible to the legislature.

The Government of India Act,1935 divided the subjects of legislation between the centre and provincial legislatures by three lists- federal legislative list, provincial legislative list and the concurrent legislative list. The power to legislate on prevention of the extension of infectious and contagious diseases from one unit of Federation to another was contained in Part II of the concurrent legislative list. In those subjects under part II of the Concurrent List the executive power vests in the provincial government while the central government reserves the power to give directions to the provinces if necessary.

2.1 Constitution of India

Part IV of the Constitution[13] provides that it is among the primary duties of the State to raise the level of nutrition, standard of living of the people and the improvement of public health. The right to life under Article 21 and its expanded judicial interpretation has cast varied obligations on the State to ensure dignity, privacy and health of the people. This obligation is further reinforced under Article 47, it is for the State to secure health to its citizen as its primary duty[14]. Right to health to be constituted within right to life[15].

Under Article 245, the parliament can make laws for the whole or any part of the territory of India whereas the State legislatures may make laws for the whole or any part of the state. Article 246 provides that the Parliament has exclusive law making powers regarding subjects

[13] India Const. art. 47.
[14] *State Of Punjab & Ors vs Ram Lubhaya Bagga,* (1998) 1 SCR 1120.
[15] *Parmanand Katara v. Union of India,* AIR 1989 SC 2039.

enumerated in the union list of the Seventh Schedule and states have the corresponding exclusive legislative power with respect to the subjects in the state list. Subjects within the concurrent list can be the legislative purview of either the Parliament or State legislatures. Port quarantine, including hospitals connected therewith(entry no 28), inter-state migration and inter-state quarantine (entry no 81) etc. form part of the union list whereas public health and sanitation, hospitals and dispensaries (entry no 6), including water supply and prevention of communicable diseases are the purview of the states. The concurrent list has subjects including medical profession(entry 26), prevention of the extension from one State to another of infectious or contagious diseases or pests affecting men, animals or plants (entry 29).

2.2. Central statutes relating to communicable diseases

2.2.1 Indian Penal Code

The substantive legislation providing for offences and punishments, the IPC[16], relates to the control of spread of communicable diseases vide sections 269,270, 271, 188 etc. Section 269 makes the unlawful or negligent spreading of infection of any disease dangerous to life punishable with imprisonment for term which may extend to six months or with fine or with both. The section is framed in order to prevent people from doing acts which are likely to spread infectious diseases[17]. Unlawful or negligent act likely to spread disease dangerous to life is essential to constitute the offence[18].Section 270 penalises any malignant act likely to spread infection of any disease dangerous to life with imprisonment, either simple or rigorous, for a term which may extend to two years or with fine or both. The offence under Section 270 is an "aggravated form[19]" of the offence punishable under Section 269. In *X v. Hospital Z*[20], the Supreme Court had held that a person suffering from HIV- AIDS knowingly marries a woman thereby transmitting the disease to her would be guilty of offences under sections 269 and 270 of IPC. Anyone knowingly disobeying any rule made and promulgated by the Government for quarantine of any vessel, or for regulating

[16] PEN.CODE § 3
[17] Ratanlal Ranchhoddas & Dhirajlal Keshavlal Thakore, THE INDIAN PENAL CODE, 1145 (V.R. Manohar ed., 32 ed. 2011).
[18] *Cahoon v. Mathews*, (1897) 24 Cal 494 ; In Re Kandaswami, AIR 1920 Mad 420.
[19] Ratanlal & Dhirajlal *supra* note 17, at 146.
[20] AIR 1999 SC 495.

the intercourse between places where an infectious disease prevails and other places, shall be punished with imprisonment upto six months or with fine or with both[21]. The offences under Section 269 and 270 are cognizable whereas offence under Section 271 is non-cognizable but all three offences are bailable and non-compoundable.

Section 3 of the Epidemics Diseases Act, 1897 provides that any person disobeying any regulation or order made under the Act shall be deemed to have committed an offence punishable under section 188 of the Indian Penal Code. Section 188 punishes the disobedience of any order duly promulgated by a public servant with imprisonment, simple or rigorous, for a term up to six months or with fine which may extend to thousand rupees or with both if such disobedient act causes or tends to cause danger to human life, health or safety. the offence is cognizable, bailable and non-compoundable.

2.2.2 Code of Criminal Procedure, 1973

By an order under Section 144 of the Code of Criminal Procedure[22], a District Magistrate or any other Executive Magistrate in circumstances requiring immediate prevention or speedy remedy, direct any person or persons in particular or the public in general to abstain from certain acts. Such directions to be made only when it is likely to prevent or tends to prevent , obstruction, annoyance or injury to any person lawfully employed or danger to human life, health or safety or a disturbance of the public tranquility.

2.2.3 Epidemics diseases Act, 1897

The Epidemics Diseases Act was enacted for the prevention of the spread of dangerous epidemic diseases in the country[23]. Section 2 empowers the State government to take such measures and after public notice prescribe the necessary temporary regulation to arrest the spread of dangerous epidemic disease. In particular, such measures may include inspection of persons travelling by railway or otherwise, and the segregation, in hospital, temporary accommodation or otherwise, of persons suspected by the inspecting officer of being infected with any such disease. Section 2A

[21] PEN.CODE § 271.
[22] CODE CRIM. PROC. § 144.
[23] *M. Vijaya vs. Chairman and Managing Director, Singareni Collieries Co., Ltd., Hyd. and Ors*, AIR 2001 AP 502.

provides that in case of outbreak of any dangerous epidemic disease in any part of the Country the Central Government, has power to take measures and prescribe regulations for inspection of any ship or vessel leaving or arriving any port and for detention of any person sailing or intending to sail in such vessels or ships.

The Epidemic Diseases (Amendment) Ordinance was promulgated to amend the Epidemics Diseases Act. Section 2-A was amended to empower the Central government to inspect any train or buses in addition to ships and vessels and to detain any person travelling therein. section 2B prohibits any person from indulging in acts of violence[24]against healthcare personnel or cause any damage or loss to any property during an epidemic. Any person committing or abetting the commission of such act of violence against healthcare professionals or abets or causes damage to property is to be punished with imprisonment for a term not less than3 months but which may extend to 5 years and with fine not less than 50000 rupees, but which may extend to 2 lakh rupees[25]. Causing grievous hurt under section 320 IPC to such professional then the imprisonment may extend to a term between 6 months to 7 years and a fine not less than 1 lakh rupees, but going upto 5 lakh rupees[26]. The offences so mentioned are to be in the nature of cognizable, bailable[27] and compoundable[28]. Section 3-C of the Ordinance introduced a presumption of guilt until the contrary is proved in trial of offences provided for under the Act. Section 3-D directs the Court to presume a culpable mental state of the accused unless the defence proves otherwise. Section 3-E also provides that the accused once convicted shall also be liable to pay compensation for acts of violence or damaging property. The Ordinance was repealed and Epidemic Diseases(Amendment) Act, 2020 was enacted with similar provisions.

The Supreme Court recognized the Disaster Management Act, 2005 and the Epidemic Diseases Act, 1897 amended in the year 2020 as two of legal and administrative instruments to empower and enable the State to contain and manage the COVID-19 pandemic.

The Epidemic Act is a vestige of colonial times and views the individual as subject rather than citizen. The short Act gives unqualified power to the governments to arrest the spread of

[24] Epidemic Diseases (Amendment) Ordinance, 2020 § 1 A (April 22, 2020).
[25] *See Id.* § 3(2).
[26] *See Id.* § 3(3).
[27] *See Id.* § 3-A
[28] *See Id.* § 3-B

communicable diseases. The Amendment to the Act in COVID-19 pandemic times also seeks to focus more regulatory powers to the Central and State Governments. The Act is silent on the ethical aspects and human rights principles, which deserve to be protected even during an epidemic outbreak[29].

The long in force legislation fails to define or enumerate what constitutes dangerous epidemic diseases. The law is silent on the steps to categorise an epidemic as "dangerous" based on variables like the scale of the disease, the distribution of the affected population across age groups, the possible international spread, the severity of the malady, or the absence of a known cure[30].The provisions of the Act consist largely of penal provisions and immunity for state action. The statute fails to provide for a particular situation of disease spread like bioterrorism which when intertwined with national security cannot be governed by individual states. The Act being the primary legislation on the subject also fails to include the changes in the global situation since its inception. The increased connectivity and intercourse has given rise to pandemics and the law is still restricted to the concept of epidemic control.

Prior to its application and amendment during the COVID-19 pandemic the central legislation was held to be redundant and recommended for repeal.The Report of the Commission on Review of Administrative laws constituted by the Department of Administrative Laws, Ministry of Personnel, Public Grievances and Pensions in September, 1998 chaired by P.C. Jain and the Law Commission 248th Report both recommended repeal of the Act.

[29] Parikshit Goyal, *The Epidemic Diseases Act, 1897 Needs An Urgent Overhaul*, 55 Econ. Pol. Wkly. (Nov. 7, 2020), https://www.epw.in/engage/article/epidemic-diseases-act-1897-needs-urgent-overhaul?0=ip_login_no_cache%3D88708d385cd8c2a7f61f3c9c1c2d9305.
[30] Manish Tiwari, *India's fight against health emergencies: In search of a legal architecture,* Observer Rsch. Found. (March 31, 2020), https://www.orfonline.org/research/indias-fight-against-health-emergencies-in-search-of-a-legal-architecture-63884/.

2.2.4 Disaster management Act, 2005

The Act aims at providing for the effective management of disasters and matters connected or incidental to such disasters[31]. The Act aims at providing for the effective management of disasters and matters connected or incidental to such disasters.The central Act has also found application during the current COVID-19 pandemic in India. The definition of the term disaster in the Act is "a catastrophe, mishap, calamity or grave occurrence in any area, arising from natural or man-made causes, or by accident or negligence which results in substantial loss of life or human suffering or damage to, and destruction of, property, or damage to, or degradation of, environment, and is of such a nature or magnitude as to be beyond the coping capacity of the community of the affected area[32]". This is a very broad definition that does not limit in any way the nature of disaster covered by the Act. The Government of India citing the lack of uniformity in the measures adopted as well as in their implementation by the State governments and union territories evoked the provisions of the Act. The National Disaster Management authority has by the Order dated 24th March 2020 directed effective measures to prevent spread of COVID-19 inorder to mitigate the threatening disaster situation The Order envisioned enforcement of social distancing in India under the provision Section 6 (2)(i) of the Act.

The Act establishes a National Disaster Management Authority with the Prime Minister as its Chairperson[33] in the national level, State Disaster Management Authorities with Chief Ministers as ex-officio chairperson[34] for each States and District Disaster Management Authorities[35] for each district within the States to be headed by the Collector or District Magistrate. The Act also envisions the formulation of National plan for disaster management for the entire country[36], State Disaster Management Plans[37] and District Disaster Management Plans[38].National plan provided for under Section 11 of the Act for disaster management for the entire country, it includes

[31] In Re: Distribution of Essential Supplies and Services During Pandemic, AIR 2021 SC 2356.
[32] Disaster Management Act, 2005, § 2(d).
[33] *See Id.* § 3.
[34] *See Id.* § 14.
[35] *See Id.* § 25.
[36] *See Id.* § 11.
[37] *See Id.* § 23.
[38] *See Id.* § 31.

preventive measures, mitigation measures for various disasters, capacity building for effective response to disasters etc.

Chapter X of the Act contains penal provisions in relation to the enforcement of the Act. Any person found not complying with any direction provided under the Act or obstructs the any officer functioning under the Act is liable to be punished with an imprisonment for a term which may extend to one year or with fine or both and if such non-compliance or obstruction results in loss of life the term of imprisonment which may extend to two years.

The Act also provides for relief in its Section 12 with guidelines for minimum relief. It provides that the national authority is to recommend guidelines for minimum relief to persons affected by disasters including but limited to food, shelter, drinking water, medicine and sanitation in relief camps, special provisions for widows and orphans, ex gratia payment for loss of life, damage to houses or to livelihood due to the disaster. The National authority may also recommend loan relief or fresh loans for affected persons under Section 13. It is a discretionary provision. The Supreme Court opined that "Human suffering and loss of livelihood that has accompanied this pandemic, NDMA may consider laying down minimum standards of relief in this regard[39]." It was clarified that this was in no way a direction of the Court. In a later case, the petitioner claimed relief of ex gratia payment for the deceased due to COVID-19, under Section 12 of the Act as COVID-19 is a notified disease under the Act[40]. The petitioner argued that financial constraints cannot be a reason to disregard statutory obligations of the government. The Court directed the NDMA to issue guidelines under Section 12 as to minimum relief on account of loss of life due to COVID-19 but refused to state a particular sum as ex-gratia leaving it to the discretion of the authority.

Section 34 measures depending upon the ground reality, action is required to be taken by the authorities and no mandamus can be issued to the District Management Authority, to take action to cover all the things mentioned in Section 34[41].

The National Plan under Section 11 of the Act formulated by the NDMA includes Biological and Public Health Emergencies as a type of disaster. Biological emergencies and epidemics, pest

[39] In *Re: Distribution of Essential Supplies and Services During Pandemic*, MANU/SC/0366/2021.
[40] *Gaurav Kumar Bansal vs. Union of India and Ors.,* MANU/SC/29585/2021.

[41] *Nasih K.K. vs. Union of India and Ors*., MANU/KE/1601/2021.

attacks, cattle epidemics and food poisoning are included in BPHEs. Biological emergency is one caused due to natural outbreaks of epidemics or intentional use of biological agents (viruses and microorganisms) or toxins through dissemination of such agents in ways to harm human population, food crops and livestock to cause outbreaks of diseases. This may happen through natural, accidental, or deliberate dispersal of such harmful agents into food, water, air, soil or into plants, crops, or livestock. Zoonotic diseases capable of infecting humans, pest and animal diseases capable of affecting the food security of the nation and biological terrorism forms part of the plan against BPHEs. Further, the Supreme Court observed that in the present COVID-19 crisis, the "National Plan, 2019 can be supplemented by the issuance of additional guidelines to tackle any aspect of disaster management including the issue of admission to hospitals and access to essential drugs and vaccines[42]."

National Disaster Management Guidelines Management of Biological Disasters[43]

The National Guidelines prepared by the NDMA defines communicable diseases as "an infectious condition that can be transmitted from one living person or animal to another through a variety of routes, according to the nature of the disease." And epidemics as "the outbreak of a disease affecting or tending to affect a disproportionately large number of individuals within a population, community, or region at the same time.'' In Chapter 3 the Guidelines recommends the repeal and replacement of the Epidemics Act of 1897 with a new framework providing more power to the Centre government in matters of biological emergencies, bioterrorism etc.

2.2.5 Live-Stock Importation Act, 1898

The Act aims at regulation of the importation of live-stock and live-stock products which are liable to be affected by infectious or contagious disorders. Section 3 empowers the Centre Government in restricting the import of live-stock liable to spread contagious or infectious diseases like anthrax, scabies or any other diseases notified by the Centre government. No suit, prosecution or other legal proceeding shall lie against any person for anything in good faith done or intended to be done

[42] In *Re: Distribution of Essential Supplies and Services During Pandemic*, MANU/SC/0366/2021.
[43] National Disaster Management Authority, National Disaster Management Guidelines- Management of Biological Disasters, (issued in July 2008).

under this Act[44]. The Law Commission 248th Report recommended repeal of the legislation after introduction of new law on the subject. The Report observed that the legislation has not kept pace with modern developments.

2.2.6 Drugs and Cosmetics Act, 1940

The central government is empowered to regulate or restrict, manufacture, etc., of drugs in public interest, if the central government is satisfied that a drug is essential to meet the requirements of an emergency arising due to epidemic or natural calamities and that in the public interest, it is necessary or expedient so to do, then, that Government may, by notification in the Official Gazette, regulate or restrict the manufacture, sale or distribution of such drug[45]. In *Panacea v. Union of India*[46], though it was not a relief asked for by the applicant, the Delhi high Court had directed the government to consider the emergency authorization under Section 26-B of the Russian Sputnik vaccines for the Indian population in the wake of COVID-19 pandemic.

2.2.7 Indian Ports Act, 1908

The provisions of the Act empowers the government in making rules for the prevention of danger arising to the public health by the introduction and the spread of any infectious or contagious disease from vessels arriving at, or being in, any such port[47]. The section provides for signals and anchorage for suspected ships, compulsory medical inspection of such ships and persons in such ships. The Government is also empowered to detain ships with suspected cases of infectious diseases, removal of infected persons to hospitals, disinfection of ships etc.

Under the rule making power the Central Government has formulated the India Ports Health rules, 1955. Rule 2(14) held quarantinable diseases plague, cholera, yellow fever, smallpox, typhus and relapsing fever are held as quarantinable diseases[48]. Rule 46 provides that the Health officer has the power of not only medical examination but also to direct isolation of persons and putting on

[44] Live Stock Importation Act,1898, § 5.
[45] Drugs And Cosmetics Act, 1940, § 26-B.
[46] MANU/DE/1038/2021
[47] Indian Ports Act, 1908, § 6(p).
[48] India Ports Health Rules, 1955. Rule 2(14).

surveillance on persons disembarking the ship for a period of incubation of the infectious diseases. Rule 50 directs that a person proposing to embark on a ship departing India, refusing to undergo medical examination be prohibited for disembarking and Rule 51 provides that the Health Officer shall prohibit the embarkation or re-embarkation on any ship of any person showing symptoms of any quarantinable disease.

The Ministry of Ports, Shipping and Waterways had circulated the draft Indian Ports Bill 2020 for seeking inputs from all stakeholders viz. State Governments, State Maritime Boards, major ports, General Public etc[49]. The draft bill seeks to repeal the Indian Ports Act,1908 vide Section 95. Section 30 of the draft Bill envisions of appointment of health officers by the central government with the powers to inspection of vessels, to board vessels and medically examine medically examine all or any of the seafarer or apprentices on board the Vessel, inspect documents, log books etc. while enquiring into the health and medical condition of the persons on board the Vessel.

2.2.8 The Essential Services Maintenance Act, 1968

The Act aims to provide for the maintenance of certain essential services and the normal life of the community. The Act empowers the Central Government, by orders, to prohibit strike in essential services including postal services, railway, defence services and more[50]. Any such strike shall be punishable with imprisonment for a term which may extend to six months, or with fine which may extend to two hundred rupees, or with both[51]. Section 5 penalises instigation of illegal strike with imprisonment up to a year or with a fine of 1000 rupees or both. Any person giving financial aid to illegal strikes is also liable to the same quantum of punishment[52].

[49] Press Information Bureau, https://www.pib.gov.in/PressReleasePage.aspx?PRID=1739059, (last visited Aug 18, 2021).
[50] The Essential Services Maintenance Act, 1968, § 2(a)
[51] *See Id.* § 4.
[52] *See Id.* § 6.

2.2.9. Aircraft act, 1934

Section 8A provides the power to the Central Government to make rules under the Act for protecting the public health from danger arising by the introduction or spread of any infectious or contagious disease from aircraft arriving at or being at any aerodrome. Section 8B provides emergency powers for the Central Government upon outbreak or threat of outbreak of any dangerous epidemic disease to make temporary rules with respect to aircraft and persons traveling or things carried therein and aerodromes as it deems necessary in the circumstances. The Indian Aircraft (Public Health) Rules, 1954 was superseded by the Indian Aircraft (Public Health) Rules, 2015.

Rule 4 holds the Airport Health officers responsible for surveillance[53] and application of public health measures[54] at the airports, including health screening and medical examination of the travelers, if necessary; and inspection of baggage, cargo etc. during public health emergencies can require an aircraft to land in an airport not being the destination airport[55], direct travellers to medical examination, isolation, quarantine for a period not exceeding the incubation period of the disease, require documentation as to vaccination[56], prohibit persons suspected of suffering from infectious disease from embarking on an aircraft[57] etc.

2.3 State Legislation relating to communicable diseases

Health being a State list subject there are a plethora of state legislations relating to epidemic diseases and in prevention of spread of communicable diseases. The provisions are spread across particular epidemic diseases Acts or state public health legislations.

[53] The Aircraft Act, 1934 § 2 (38).
[54] Indian Aircraft (Public Health) Rules, 2015, Rule 2(22).
[55] *Id.* Rule 6.
[56] *Id.* Rule 7.
[57] *Id.* Rule 10.

State Epidemic diseases Acts include:

A. State Epidemic Diseases Acts

2.3.1 Karnataka Epidemic Diseases Act,2020

The law legislated with the objective to "unify and consolidate laws relating to regulation and prevention of epidemic diseases in Karnataka." Section 3 of the Act empowers the State government to declare epidemic diseases. Section 4 provides power of the state government to take special measures and specify regulations on outbreak of an epidemic disease. It delegates the power to make temporary regulations or orders to be observed to the deputy commissioner or municipal commissioner. The regulations particularly include prohibition of gatherings, celebrations etc., restrictions on public and private transport ; quarantining of persons entering the state; imposition and enforcement of social distancing; sealing of state borders etc.

Any act of contravention or obstruction of a public servant or acts of violence against public servant or any act of disobeying the regulations in force under section 4, shall be punishable with imprisonment for a term not less than 3 months which may extend to 5 years with a fine not less than Rs 50000/ under Section 5. Any damage to property attracts punishment under Section 6 including imprisonment. Upon conviction such offender shall also become liable to pay compensation the quantum of which is to be decided by the competent Courts[58].

2.3.2 Rajasthan Epidemic Disease Act, 2020

The Act repeals[59] the Rajasthan Epidemic Diseases Ordinance, 2020 and the Rajasthan Epidemic Diseases (Amendment) Ordinance, 2020. Section 3 of the Act confers the power to notify epidemics diseases to the State government. Section 4 is similar to the Karnataka epidemic legislation in it being the purview of the State government to seal state borders, restrict gathering etc. The penalty for contravention of the Act provided in section 5 includes an imprisonment up to 2 years and fine not less than Rs 10,000/. Abatement of any offence under the Act also attracts the

[58] Karnataka Epidemic Diseases Act, 2020, § 7.
[59] Rajasthan Epidemic Diseases Act, 2020, § 16.

same punishment under Section 6 of the Act. Section 14 provided that the State Government may by order in the Gazette make provisions not inconsistent with the provisions of this Act as may appear to be necessary for removing any difficulty in giving effect to the provisions of the Act.

2.3.3 Epidemic Diseases (Bombay Amendment) Act, 1953

The state amendment to the Epidemic Act,1897 adds that powers under the Act be delegated to Collectors under Section 2B.

2.3.4 Epidemic Diseases (Punjab Amendment) Act, 1949

The state amendment allows delegation of powers under Section 2 of the central Act to deputy commissioners to exercise within their local jurisdiction.

2.3.5 Epidemic diseases act, 1977

The Act was legislated into force in the erstwhile State of Jammu and Kashmir. Section 2 provides to the State the powers to take special measures including inspection of travellers, segregation of infected persons etc. and penalty for contravention under Section 3 is as under the State Penal Code Section 183.

2.3.6 Kerala Epidemic Diseases Act, 2021

The Act seeks to unify and consolidate the laws relating to regulation and prevention of epidemic diseases. Section 3 empowers the State Government to notify, by Official Gazette, any disease as an epidemic disease throughout the territory of the State or any specified part thereof.

Section 4 vests the government with the power to take necessary measures upon outbreak of any epidemic disease and specify temporary regulations including but not limited to

a. prohibition of any usage or act capable of spreading disease in a gathering

b. inspection of persons arriving in the State or in quarantine or isolation

c. seal state borders

d. restrict public and private transport

e. prescribe social distancing norms

f. restrict or prohibit congregation in public places and religious places

g. regulate or restrict functioning of Government and private offices

h. restrictions on functioning of shops, commercial establishments etc.

i. restrict the duration of services like banks, electricity, food supply etc.

Contravention[60] of the provisions under the Act or its abetment[61] is punishable by a term of imprisonment extending up to two years or with fine up to ten thousand rupees or both. Section 10 protects from legal proceedings or prosecution any act done in good faith under this Act.

The state epidemics legislations that have been in force for long unilaterally allow for power of state governments in the prevention and control of epidemic diseases. These legislations too fail to provide the benchmark for an epidemic disease, merely providing for the power of the state governments to declare the state to be visited or threatened with an epidemic disease. The power of regulation and prevention of spread of disease is conferred on district executives without qualifying the extent and limits of the exercise of power along with penalty for non-compliance.
The state epidemics acts legislated during the pandemic times are providing for tailor-made regulations for control of COVID-19. These statutes providing for social distancing, restrictions of gathering etc. relevant in the present times may fall redundant in the control of another communicable disease threat whose mode of spread, infectivity, treatment and control may differ from that of COVID-19.

[60] Kerala Epidemic Diseases Act, 2020, § 5.
[61] *See Id.* § 6.

B. State Public health acts

Public health Acts have a broader consensus than epidemics Acts, which only comes to play at outbreak or threat of outbreak of diseases. Public health Acts deals with matters of water supply, drainage, sanitation, hygiene, vector control, building safety, food sanitation, abatement of nuisance etc. along with measures for preventing and controlling the spread of communicable diseases.

2.2.7 Model Public Health Act

The model public health act to be adopted by the Centre and States was first recommended by the Report of the Health Survey and Development Committee, published in 1946. The Government of India appointed a Model Public Health Committee which produced a draft of the Act in 1955. The Model Public Health Draft was revised in 1987. The object of the model Act is to make provision for health services in the States and Union Territories. Section 5 of the Model act envisioned the setting up of the Board of Health in the States and Union Territories with the Minister of health as its President overlooking functions related to health services and health campaigns.

The local authorities are made responsible for preventing the occurrence of any communicable diseases and dealing with it in the event of an outbreak according to section 13. The responsibility of the local authorities to provide services like immunization centres, public health laboratory services, isolation hospitals and facilities , ambulance services were made conditional upon the availability of financial resources.

To control and prevent spread of diseases the following measures are provided

1. Removal of persons: According to section 120, health officer may remove any person suffering from a communicable disease, while without proper lodging or accommodation, or lodged in a place with more than one family or is without medical supervision or when his presence is a danger to the neighbourhood, to any hospital or place for treatment. no one so removed shall leave such a facility without the permission of the health officer. any

obstruction to such removal or taking away of the removed person is liable for punishment of imprisonment for a term of 3 months or fine or both.

2. Prohibition of exposure of other persons to infectious diseases in public places under section 121 and prohibition of use of public conveyance by infected persons under section 136.

3. Prohibition on infected persons engaging in certain trades relating to food for human consumption under Section123.

4. Every medical practitioner, manager of any factory or public building, keeper of lodging houses, heads of family, owner and occupier of houses etc to report or give information in cases of notified infectious diseases to health officer.

5. Health officers and other officials have powers of inspection and to take such measures to prevent spread of the disease.

6. Restrict persons from entering a house or otherwise contact a person suffering from cholera, plague or other dangerous disease and direct isolation for violators.

7. Magistrates are empowered to close down places where food is manufactured in case of occurence of of notified diseases in the premises in the interest of the public.

8. Restrictions on infected clothing and articles.

9. Prohibition of use of public libraries or use of books from libraries.

10. Magistrate to prohibit assemblage of over 50 people in private or public when such assemblages are likely to spread diseases.

11. upon declaration in the official Gazette, of any place to be visited by or threatened with outbreak disease the collector will be empowered to evacuate houses in infected areas, make vaccination and preventive inoculation compulsory, compulsory medical examination of persons arriving from outside, disinfection, destruction of infected articles etc. the power includes the direction to restrict movement of infected persons, power to

close markets etc. any breach of such regulation under Section 140 is punishable with imprisonment of term of 3 months or with fine or both.

There is a lack of uniformity in adoption of public health laws by States. Legislation like the Tamil Nadu Public health Act, 1939 have been in force before the Constitution , whereas there are States and Union Territories with no public health legislations.

State public health legislations include:

2.2.8 Tamil Nadu Public Health Act, 1939

An outbreak of infectious diseases[62] empowers the health officer with the local authorities to appoint additional medical staff, provide medicines, equipments etc. as needed[63]. The duty to set up isolation wards and hospitals to treat affected persons is upon the respective local authorities in the areas of outbreaks[64]. Section 56 binds the medical practitioner to inform on any case of tuberculosis and enteric fever specifically. The health officer can affect the removal of any infected person, without lodging or medical care or living in such situation as to be dangerous to any person living with them, to a hospital or such place infectious persons are lodged[65]. Such removed person is prohibited from leaving such place without leave of the health officer[66] and any person obstructing such removal or takes away such removed person in liable for imprisonment which may extend to three months, or with fine, or with both[67]. Persons suffering from infectious diseases is prohibited from knowingly exposing other persons in public places like markets, theatre, factory, shops[68] etc., or use public conveyance[69] and such persons, likely to spread diseases, are also prohibited from carrying on trade related to food for human consumption or such other trades requiring special permits from the health officer[70]. The power of the health officer relating to

[62] Tamil Nadu Public Health Act, 1939, § 52.
[63] *See Id.* § 53.
[64] *See Id.* § 54.
[65] *See Id.* § 58(1)
[66] *See Id.* § 58(3)
[67] *See Id.* § 58(4).
[68] *See Id.* § 59.
[69] *See Id.* § 69.
[70] *See Id.* § 72.

infectious diseases among animals is limited to recommendations to the local authority to adopt[71]. The health officer with the sanction of the district collector, may enter upon, occupy and use any premises for the purposes related to control and prevention of any notified diseases. The owner or occupier is entitled to a 36 hour notice and compensation for damages and reasonable rent[72]. The health officer and such person so deputed also has power to inspect and take such preventive measures as required for control of the notified infectious diseases[73] including destruction of any hut or shed[74], closing down of lodging houses[75]. Magistrates in local areas are empowered under section 75 to prohibit gatherings and assembly of more than fifty persons.

2.2.9 Madhya Pradesh Public Health Act, 1949

The Act seeks the constitution of a Public Health Board[76] to advise the government on matters of public health including measures against epidemics[77]. The Government shall have power to inspect, control and superintend the operations of local authorities under the Act and define the powers to be exercised by the Director of Health[78]. This power of the Director of Health and staff to advise and recommend necessary measures to local authority[79]. The local authority is to appoint a Health inspector to carry out the duties under the Act, upon the direction of the State Government[80].

Section 50 enumerates specific diseases as infectious diseases, the definition is inclusive of such diseases the state government may by notification declare to be an infectious disease in the state or any part thereof. Section 51 provides that certain diseases and such others as the state government may notify as Notified infectious disease.

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[71] *See Id.* § 61.
[72] *See Id.* § 63.
[73] *See Id.* § 65.
[74] *See Id.* § 66.
[75] *See Id.* § 67.
[76] Madhya Pradesh Public Health Act, 1949, § 4.
[77] *See Id.* § 5.
[78] *See Id.* § 6.
[79] *See Id.* § 7.
[80] *See Id.* § 9.

The provision for additional medical staff, medicines and equipment in case of emergencies[81], provision for hospitals, isolation wards[82], ambulances[83] etc., are the responsibility of the local authorities. The Act also directs mandatory intimation of information on those affected by notified infectious diseases[84] and removal of such infected persons to hospitals[85]. The penalty for obstructing such removal or leaving from such facility without permission of the health officer entails an imprisonment which may extend to three months or with fine, or with both.[86]Apart from compulsory removal such persons suffering from infectious diseases is prohibited from exposure of other persons in public places[87], restrictions are placed on using public conveyance and taking part in certain trade related to food for human consumption[88] etc.

No person shall, while suffering from, on in circumstances in which he is likely to spread, any infectious disease bath, wash, wash clothes in or near or lake water from any public well, tank, pond, pool, spring, stream, or water-course or other sources of public water-supply; or wilfully touch any article of food, drink, medicine or drug exposed for sale by others.

The health officer has the power to occupy any house or building without the consent of the owner or occupier, for any purpose connected with the prevention or control of infection and such owner is entitled to 36 hour notice and adequate compensation.[89] Such officers shall also have the powers of taking preventive measures against spread of disease including entry and inspection of any house, factory, workplace etc.[90], destruction of huts or sheds[91], closure of lodging houses.[92] Under Section 71 the Government has the power to confer special powers on health officers in local areas visited or threatened with infectious diseases. Such special powers include the power to order the evacuation of infected house and houses adjoining them or in their neighborhood, or generally of all houses in any infected locality, power to make vaccination and preventive inoculations compulsory, power to direct persons arriving from outside, or those residing adjacent to infected

[81] *See Id.* § 52.
[82]*See Id.* § 53.
[83]*See Id.* § 54.
[84] *See Id.* § 55.
[85] *See Id.* § 57.
[86]*See Id.* § 57(3).
[87]*See Id.* § 58.
[88] *See Id.* § 59.
[89] *See Id.* § 61.
[90]*See Id.* § 62.
[91]*See Id.* § 63.
[92] *See Id.* § 64.

persons to undergo medical examination, power to close down markets or assign special areas for market, power to prohibit fairs, festivals etc. It is in the discretion of the local authority to give compensation to any person who has sustained substantial loss by the destruction of any property due to exercise of such powers but no claim for compensation shall lie for any loss or damage caused by any exercise of the said powers.

Under Section 70, any Magistrate not being a Magistrate of the third class, having local jurisdiction shall have power to prohibit assemblages consisting of any number of persons exceeding fifty, in public or private which is likely to become a means of spreading the disease or of rendering it more virulent.

The one provision ensuring treatment of affected persons is included in the section 77 of the Act which binds the local authority to provide free diagnosis and treatment of persons suffering from or suspected to be suffering from leprosy and take steps to prevent the spread of the disease. The provisions of the Act that required Medical Certificates to certify that a person is free from leprosy, restrictions on diseased persons to accept employment as teachers, personal attendants etc., or attend schools, colleges or public libraries and their detention in segregated accommodations were repealed. Such a beneficial provision is restricted to only leprosy alone and not to other communicable diseases.

2.2.10 Assam public health act, 2010

The legislation aims to provide for the protection and fulfillment of rights in relation to health and well being, health equity and justice. Communicable diseases is defined as any "illnesses caused by microorganisms and transmissible from an infected person or animal to another person or animal[93]." Public health emergency means any unusual or unexpected occurrence or imminent threat of illness which affects or is likely to affect a large population which needs immediate public health intervention to prevent death or disability to a large number of people.[94]Apart from the duties of ensuring access to health services[95], sanitation, basic housing, adequate food and nutrition[96], the specific duty to take effective measures to prevent, treat and control epidemic and

[93] Assam public health act, 2010, § 2(c).
[94] *See Id.* § 2(r).
[95] *See Id.* § 3(1)(b).
[96] *See Id.* § 3(2).

endemic diseases falls on the government and the department of Health and Family Welfare[97]. Section 4 empowers the Government in the health department to take appropriate legal steps through amendment or review of the public health law or through rules and orders under the Act to fix responsibility and accountability to concerned departments and agencies in case of repeated outbreaks or recurrence of communicable, viral and waterborne diseases found to be due to failure to improve sanitation and safe drinking water facilities.

Chapter III of the Act provides for collective and individual rights in relation to health. Section 5 provides that every person shall have the right to appropriate healthcare and essential drugs[98], right to effective measures for prevention, treatment and control of epidemic and endemic diseases and the right to effective mechanisms in public health emergencies. Outside the management of communicable diseases a user has the rights to information about healthcare, their health status[99], right to access to medical records[100], right to autonomy and exercise of prior and fully informed consent[101] and the right to confidentiality[102] of his health status and medical information. The section 20 of the Act provides for immunity for the Government or any of its personnel acting under the Act from liability due to death or injury to any individual or property while complying with the provisions of the Act. No action for damages shall lie against actions done by its servants in good faith purported to be done under the Act. No provision exists for penalty or criminal liability for contravention of the Act.

The Assam Act moves away from the existing public health legislations. It binds the government and departments with responsibility for control of communicable disease spread. The Act also enumerates the rights of the diseased and affected persons making it a first of its kind rights based legislation on the subject. The Act eschews the coercive penal provisions against non-compliance.

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[97] *See Id.* § 3(3)(b).
[98] *See Id.* § 5(a).
[99] *See Id.* § 6.
[100] *See Id.* § 7.
[101] *See Id.* § 8.
[102] *See Id.* § 9.

2.2.11 The Goa, Daman and Diu Public Health Act, 1985

The Act aims to make provision for advancing public health in the union territory of Goa, Daman and Diu. Chapter VII of the Act exclusively deals with prevention, notification and treatment of diseases. The diseases under the infectious disease includes acute influenza, anthrax, chicken pox and any other diseases notified by the Government[103].

The local authority in such localities is obliged to provide isolation wards, hospitals etc. for reception treatment of patients with infectious diseases[104]. According to section 50 of the Act it is the duty of the Director of health services of the Government to provide and maintain suitable conveyances, with sufficient attendants and other requisites, for free carriage of persons suffering from any infectious diseases and to make available proper places and apparatus and establishment, for the disinfection of conveyances, clothing, bedding or other articles which have been exposed to infection to be used by the public for free or for a fixed fee.

Every registered medical practitioner who becomes cognizant or suspects the existence of any case of the infectious diseases is duty bound to inform the specified authority which could be the local authority or the health inspector or sanitary inspector[105]. Similar provision of removal of persons[106], prohibition of exposure[107], engaging in trade [108], like the model act is also enforced.

The health officer is empowered, with the sanction of the Collector enter upon, occupy and use, or depute any person to enter upon, occupy and use, without having recourse to the provisions of the Land Acquisition Act, 1894, any building or place for any purpose related to the prevention or control of infection from a notified disease[109]. The person who may be occupying such a building or place is entitled to a 36 hour notice to be given by the health officer and also, entitled to receive compensation for any damage or expenses incurred and to a reasonable rent for the period of occupation. Health officers or other authorized persons are empowered to conduct inspection of any place with reported cases of notified disease or where there is a suspicion of such diseases and take appropriate preventive measures. Such authority is not bound to give notice of such inspection

[103] Goa Public Health Act, 1987, § 57.
[104] *See Id.* § 48.
[105] *See Id.* § 51.
[106] *See Id.* § 53.
[107] *See Id.* § 54.
[108] *See Id.* § 55.
[109] *See Id.* § 58.

except in case of dwelling houses[110]. Preventive measures may include destruction of house or shed which the health officer may direct if he reasonably feels it necessary to prevent the spread of any notified disease after giving previous notice to the owner and occupier of his intention to destroy such premises[111]. The owner or any person suffering loss due to such destruction is entitled to receive such compensation as the local authority may decide but he is barred from otherwise claiming compensation for loss or damage under section 61(3).

2.2.12 Public health law in Kerala

There exists in force two public health legislations for the territory in Kerala- the Travancore-Cochin Public Health Act, 1955 and the Madras Public Health Act, 1939.

The Travancore- Cochin Public Health Act has similar regulatory measures as the Model Public health Act, in section 50 to 72. The Madras Public Health Act legislated for the erstwhile Malabar region of Kerala have provisions for the establishment of a public health Board, otherwise confers similar power on local authorities to prevent spread of infectious diseases like removal of persons, restriction on movement, restrictions on assembly etc. The Kerala Public Health Ordinance, 2021 sought to unify the existing laws to enhance the public health administration in the State and repealed and ceased the operation of the Travancore- Cochin public health Act and Madras public health act.

Section 2(b) of the Ordinance defines communicable diseases as "a clinically manifest disease of man or animal resulting from an infection" and clause (g) defines epidemics "the sudden and rapid increase in the number of cases of a disease or other condition of public health importance in a population." The Ordinance establishes the State Public Health Authority, District Public Health Authority and Local Public Health Authority responsible for implementation of the provisions of the Ordinance[112].

[110] *See Id.* § 60.
[111] *See Id.* § 61(1).
[112] The Kerala Public Health Ordinance, 2021, § 3 (Feb. 23, 2021).

2.2.13 The Uttar Pradesh Public Health and Epidemic Diseases Control Act, 2020

The power to declare[113] epidemics and regulations[114] to control and prevent vests with the State Government. Section 5 of the Act established the State Epidemic Control Authority and District Epidemic Authorities to implement the provisions of the Act. The government and authorities will have power to order lockdown under Section 7.

The Act specifically has more restrictive measures relative to the above mentioned legislations. Some of the restrictive measures that the Government and Epidemic Authorities are empowered exercise under the Act include:

a. declaration of reward for tracing an afflicted person or a person likely to be afflicted due to contact with an afflicted person,who is evading detection

b. require to trace and bring an afflicted person to the treatment centre[115]

c. issue a proclamation in respect of an afflicted person to airport authorities or other State Governments to take appropriate steps in respect of such person

d. taking such a person traced to a treatment facility. Section 10 clarifies that such action not to amount to arrest under Criminal Procedure Code

e. authorized persons to enter any place to search and trace any person in compliance of a requisition[116]

f. order that expenditure incurred by the Government or loss or damage caused by the deliberate or negligent conduct or behaviour of any individual or an organisation be recovered from such individual or organisation under Section 13

g. section 14 prohibits voluntary help or material assistance to be given to afflicted persons independently by individuals, the same must be done through agency of the State

[113] Uttar Pradesh Public Health and Epidemic Diseases Control Act, 2020, §3.
[114] *See Id.* § 4.
[115] *See Id.* § 9.
[116] *See Id.* § 11.

h. section 15 punishes concealment or evasion of detection with imprisonment for a term not be less than one year but may extend to three years and with fine which shall not be less than fifty thousand rupees but which may extend to one lakh rupees

i. Section 16 punished travel by public conveyance of afflicted persons with imprisonment for a term which shall not be less than one year but may extend to three years and with fine which shall not be less than fifty thousand rupees but which may extend to two lakh. rupees

j. Section 17 punished violation of quarantine with rigorous imprisonment for a term 'which shall not be less than one year but may extend to three years and shall also be liable to be punished with fine which shall not be less than ten thousand rupees tbut which may extend to one lakh rupees.

k. Section 18 punishes persons running away from epidemic disease treatment with rigorous imprisonment for a term which shall not be less than one year but may extend to three years and shall also be liable to be punished with fine which shall not be less than ten thousand rupees but which may extend to one lakh rupees.

l. section 19 punishes obscene or vulgar or act or indecent act or gesture shall be punished with imprisonment for a term which shall not be less than one year but may extend to three years and shall also be liable to be punished with fine which shall not be less than fifty thousand rupees but which may extend to one lakh rupees

m. section 20 punishes incitement of violation of provisions under the Act shall be punished with rigorous imprisonment for a term which shall not be less than two year but may extend to five years and shall also be liable to be punished with fine which shall not be less than fifty thousand rupees but which may extend to two lakh rupees

n. section 21 penalises malicious propaganda with rigorous imprisonment for a term which shall not be less than six months but may extend to three years and shall also be liable to be punished with fine which shall not be less than ten thousand rupees but which .may extend to one lakh rupees

o. attack and obstruction of officers authorized under that Act is punished under Section 22 with imprisonment for a term which shall not be less than three months, but which may extend to five years and with a fine, which shall not be less than fifty thousand rupees but which may extend to two lakh rupees.

p. section 23 punishes malignant conduct with intention or knowledge that it may spread contagion or disease to others with rigorous imprisonment for a term which shall not be less than one year but may extend to three years and shall also be liable to be punished with fine

The Act disproportionately penalises non-compliance and does not contain elaboration on what can possibly constitute malignant conduct or malicious propaganda. Upon such a situation, the provisions of the Act are liable to abuse. In effect the Act enforces requisitioning and compulsory treatment of afflicted persons and enforces restrictions with penal sanction essentially making falling sick a potential criminal activity.

Conclusion

An Approach Paper on Public Health Act Task Force on Public Health Act[117] observed that the existing public health legislations in India are coercive based rather than rights based. The Constitution casts a duty upon the State to preserve the life and health of the citizens yet the plethora of legislations undertake to penalise and restrict the rights and freedoms. A health emergency like the spread of communicable diseases poses grave threat to the life of the individual and the society but such an emergency must not be an avenue for the State to abrogate unto itself wide powers.

The central Epidemic Act and the statutes legislated by the states mirror the tendency to vest elaborate and unqualified powers on the functionaries of the government and penalize any contravention. The Public health Acts, except the Assam public health Act, speaks of penal provisions for contravention of regulatory measures rather the rights of persons afflicted with such

[117] NHRC, https://nhsrcindia.org/sites/default/files/2021-03/Task%20Force%20on%20Public%20Health%20Act_2012_approach%20paper.pdf, (last visited Aug 18,2021).

diseases or suffering incidental loss of livelihood, property etc. due to such situations. The provisions of the public health Act of the last century, it is evident that the outbreak situations they envisage were more localized than the pandemic of the present times.

A threat of outbreak of diseases requires the State to restrict and regulate aspects of ordinary life of the community but the "inherent prerogative of the state to protect public's health, safety and welfare is limited by individual rights to autonomy, privacy, liberty, property, and other legally protected interests[118]."

[118] *Id*

"What, then, is the rightful limit to the sovereignty of the individual over himself? Where does the authority of society begin? How much of human life should be assigned to individuality, and how much to society?" - John Stuart Mill, On Liberty

CHAPTER III: POWERS OF STATE AND RIGHTS OF INDIVIDUALS

Since disease is as old as mankind itself, society has realized from its earliest beginnings that organized efforts by the sovereign power are necessary to cope with plague and pestilence.[119] Early public health law employed a legal maxim that symbolized the intrinsic purposes of a sovereign government- *Salus populi est suprema lex*, the welfare of the people is the supreme law[120]. Thus, the intervention of the State into the health of the people is not a new phenomenon.

3.1 Health, public health and law

The preamble to the WHO Constitution defines health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. Good Health confers on a person or group freedom from illness and the ability to realize one's potential.

Around the world, health care is provided through many diverse public and private mechanisms. However, the responsibilities of public health are carried out in large measure through policies and programs promulgated, implemented and enforced by, or with support from, the State[121]. Public health emphasizes the health of populations[122].Public health has a distinct health- promoting goal and emphasizes prevention of disease, disability and premature death[123]. Public health is primarily concerned with the health of the entire population, rather than the health of individuals. Its features include an emphasis on the promotion of health and the prevention of disease and disability- the collection and use of epidemiological data, population surveillance, and other forms of empirical quantitative assessment; a recognition of the multidimensional nature of the determinants of health; and a focus on the complex interactions of many factors- biological, behavioral, social, and

[119] James A. Tobey, PUBLIC HEALTH LAW 9 (The Commonwealth Fund, 3 ed. 1947).
[120] Lawrence O. Gostin, *Public Health Theory and Practice in the Constitutional Design*,Health Matrix 265, 282 (2001), https://scholarlycommons.law.case.edu/cgi/viewcontent.cgi?article=1559&context=healthmatrix.
[121] Jonathan M. Mann et al., *Health and Human Rights*, 1 Health Hum. Rights J. 7, 13(1994), https://cdn1.sph.harvard.edu/wp-content/uploads/sites/2469/2014/03/4-Mann.pdf.
[122] *Id.* at 8.
[123] *Id.* at 8.

environmental-in developing effective interventions[124]. While medicine focuses on the treatment and cure of individual patients, public health aims to understand and ameliorate the causes of disease and disability in a population[125]. Public health focuses on populations[126]. Contrary to the practice of medicine , public health " contemplates the relationship between states and populations rather than between individuals and health care providers.[127]"

Law has long been considered an important tool of public health[128]. The law provides for the financing and the administration of public health agencies; suggests what the work- force is and what its role should be; and creates the powers and duties of agencies to protect the public health. The law also should define the missions, functions and essential services of public health agencies[129].Public health law may be defined as that branch of jurisprudence which treats of the relation and application of the common and statutory law to the principles.and procedures of hygiene, sanitary science: and public health administration[130]. Government has a unique role in public health because of its responsibility, grounded in its police powers, to protect the public's health and welfare, because it alone can undertake certain interventions, such as regulation, taxation, and the expenditure of public funds.[131].

3.2 .Police powers

The police power is the most famous expression of the natural authority of sovereign governments to regulate private interests for the public good[132]. Gostin defines police powers as "the inherent authority of the state (and, through delegation, local government) to enact laws and promulgate regulations to protect, preserve, and promote the health, safety, morals, and general welfare of the people. To achieve these communal benefits, the state retains the power to restrict, within federal and state constitutional limits, private interests-personal interests in autonomy, privacy,

[124] James F. Childress et al., *Public Health Ethics: Mapping the Terrain*, 30 J.L. Med. & Ethics 170, 173(2002).
[125] *Id.* at 170
[126] Lee Breckenridge et al., *The Role of Law in Improving Public Health*, 23 J. Pub. Health Pol'y, 195, 198 (2002).
[127] *Id.* at 198.
[128] Lawrence O. Gostin et al., *The Model State Emergency Health Powers Act: Planning for and Response to Bioterrorism and Naturally Occurring Infectious Diseases*, 288 J. Am. Med. Ass'n 622, 624(2002).
[129] Beckridge, *supra* note 126, at 198.
[130] Tobey, *supra* note 119, at 8.
[131] Chidress, *supra* note 124, at 170.
[132] Gostin, *supra* note 120, at 282.

association, and liberty as well as economic interests in freedom to contract and uses of property[133]."

Gibbons v. Ogden[134] Chief Justice Marshall conceived of police powers as an "immense mass of legislation, which embraces every thing within the territory of a State, not surrendered to the general government. . . .Inspection laws, quarantine laws, health laws of every description ... are component parts of this mass." The power inherent in the State, or sovereignty, to enact and enforce, to protect and promote the health, safety, morals, order, peace, comfort, and general welfare of the people is known as the police power[135]. It means the power of advancing the public welfare by restraining and regulating the use of liberty and property.

State power to restrict private rights is embodied in the common law maxim *sic utere tuo ut alienum non laedas*- use your own property in such a manner as not to injure that of another.The maxim supports the police power, giving government authority to determine safe uses of private property to diminish risks of injury and ill-health to others[136].

3.3 State power restricting rights of the individuals

The outbreak of communicable diseases forces the governments to undertake measures to arrest the spread of diseases. Such interventions may include restriction on movement, isolation, regulations on livelihood of the people etc.

3.3.1 Restriction on movement

Restrictions on travel are employed to limit the geographic range of an epidemic. Restrictions on travel can affect the lives, livelihood of individuals and the life of the economy at large. The strategy followed is one of containment of the disease. WHO Pandemic Influenza Draft Protocol for Rapid Response and Containment,[137] provides that in the containment strategy that "all non-essential movement of persons in and out of the containment zone is discouraged as much as possible." The restrictions on movement should be mindful of the needs of the population, especially their medical, livelihood needs. Restrictions must be placed on movement only after

[133] Gostin, *supra* note 120, at 283.
[134] *Gibbons v. Ogden*, 22 U.S. (9 Wheat.) 1 (1824).
[135] Tobey, *supra* note 119, at 40.
[136] Gostin , *supra* note 120, at 284
[137] WHO, *Interim Protocol: Rapid operations to contain the initial emergence of pandemic influenza,* (October 2007), https://www.who.int/influenza/resources/documents/RapidContProtOct15.pdf.

ensuring availability and accessibility of resources like food, medicines and other necessities to the persons so confined.

Travel restrictions placed during outbreaks of diseases are commonplace but not advised under the IHR or by the WHO. The COVID-19 travel advice by the WHO holds that "Evidence on travel measures that significantly interfere with international traffic for more than 24 hours shows that such measures may have a public health rationale at the beginning of the containment phase of an outbreak, as they may allow affected countries to implement sustained response measures, and non-affected countries to gain time to initiate and implement effective preparedness measures. Such restrictions, however, need to be short in duration, proportionate to the public health risks, and be reconsidered regularly as the situation evolves[138]." In the short term, travel restrictions prevent supplies from getting into affected areas, slow down the international public health response, stigmatise entire populations, and disproportionately harm the most vulnerable among us[139].

3.3.2 Isolation and quarantine

Isolation as a means of disease prevention separates one thing from another; it is inherently a spatial and material as well as a social and medical practice[140]. One of the earliest uses of quarantine - and isolation-type measures to control the movement of sick persons is said to have taken place in 532 C.E., when the Emperor Justinian of the Eastern Roman Empire commanded that persons arriving into the capital city of Constantinople from "contaminated localities" be housed in separately till cleansed. The term quarantine is derived from the Italian words *quarantina* and *quarantagiorni*, which were used during the fourteenth and fifteenth centuries and referred to a 40-day period in which certain ships that entered the port of Venice were obliged to wait in isolation before any person or good was permitted to go ashore.

[138] WHO, *Key considerations for repatriation and quarantine of travellers in relation to the outbreak of novel coronavirus 2019-nCoV,* (February 2020), https://www.who.int/news-room/articles-detail/key-considerations-for-repatriation-and-quarantine-of-travellers-in-relation-to-the-outbreak-of-novel-coronavirus-2019-ncov/.
[139] Roojin Habibi et. al., *Do not violate the International Health Regulations during the COVID-19 outbreak,* 395, Lancet, 664, 665 (2020).
[140] Jeanne Kisacky, *Restructuring Isolation: Hospital Architecture, Medicine, and Disease Prevention*, 79 Bull. Hist. Med., 1 (2005).

Quarantine separates persons who have been potentially exposed to an infectious agent and thus at risk for disease, from the general community[141]. Gostin defines it as the restrictions of activities of a healthy person who have been exposed to communicable diseases, during its period of communicablity, to prevent transmission during the incubation period if infection should occur. Isolation is the separation, for the period of communicability of known infected persons in such a place and under such conditions as to prevent or limit the transmission of the infectious agent.

Persons placed in quarantine have their freedom restricted to contain transmissible diseases. This takes a considerable toll on the person[142]. The potential benefits of mandatory mass quarantine need to be weighed carefully against the possible psychological costs. Successful use of quarantine as a public health measure requires us to reduce, as far as possible, the negative effects associated with it[143].Quarantine and isolation should be voluntary whenever possible[144]. When mandatory containment is necessary, governments should first apply the least restrictive measures followed, when necessary, by a graded application of more restrictions[145]. When quarantine and isolation are necessary, the principle of reciprocity obliges society to provide those affected with the necessities of life during the period of quarantine, including safe and humane housing, as well as high quality medical care and psychological support[146].

In deciding on the Human rights aspect of detention of persons under public health law to prevent spread of contagious diseases, the European Court of Human rights held that any such detention must be in compliance with both the principle of proportionality and the requirement that there be an 'absence of arbitrariness[147].

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[141] Hawryluck et.al., *SARS control and psychological effects of quarantine, Toronto, Canada*, 10 *Emerg Infect Dis*.1206, 1206 (2004).
[142] *Id.* at 1209
[143] Samatha K. Brooks et.al.,*The psychological impact of quarantine and how to reduce it: rapid review of the evidence*, 395 Lancet, 912, (2020).
[144] Benjamin E. Berkman et. al., *Pandemic Influenza:Ethics, Law and Public's Health*, 59 Admin. L. Rev. 121, 173 (2007), http://www.administrativelawreview.org/wp-content/uploads/2014/04/Pandemic-Influenza-Ethics-Law-and-The-Publics-Health.pdf.
[145] WHO, *supra* note 138, at 11-12.
[146] Berkman, *supra* note 144, at 174.
[147] Robyn Martin,*The Exercise of Public Health Powers in cases of infectious diseases: Human Rights Implications*, 14 Med. L. Rev.132, 134 (2006).

3.3.3 Surveillance

Surveillance serves as the eyes of public health[148]. It is essential for planning, intervention, and prevention. Surveillance has the potential to "trigger the imposition of public health control measures, such as contact tracing, mandatory treatment, and quarantine[149]." Surveillance is the backbone of public health, providing essential data to understand the epidemic threat and inform the public. Surveillance strategies include rapid diagnosis, screening, reporting, case management reporting, contact investigations, and monitoring[150].Early identification of case clusters, contact tracing, reporting etc. are crucial for disease control.

In India, the IDSP is a decentralized State based surveillance system launched in 2004[151] which tracks the incidence of a host of diseases like Bacillary Dysentery, Viral Hepatitis, Enteric Fever, Malaria,Chikungunya, Typhoid, cholera etc. the system establishes surveillance units at central, state and district levels with weekly outbreaking reporting to the Central system. Disease surveillance systems aggregate data and there is anonymity and de-identification of patients in the information disclosed to the public. Notifiable diseases provided under the Indian statutes mandates their disclosure and surveillance by the government.

More unprecedented disease outbreaks, such as the current pandemic, have seen governments adopting contact tracing methods. Techniques deployed in the emergency situation included recognition of contacts by CCTV, mobile locations, social media tracking etc. The information passed on to the public domain carried essential information capable of identifying individual persons leading to stigma and unwanted attention to such persons. Surveillance by large scale deployment of technology is inevitable in a public health emergency, but it must be based on respect for privacy and anonymity of individual persons. The collection of health information that identifies individuals carries the risk of discrimination and loss of privacy. The management of these risks, through legal requirements to maintain the security, privacy, and confidentiality of personal information, and through legal protection from discrimination, provide the foundation for

[148] Amy Fairchild et. al., *Privacy and Public Health Surveillance: The Enduring Tension,* 9 Am. Med. Ass'n J. Ethics 132, 137 (2007).
[149] *Id*. at 138
[150] Gostin, Supra note 120, at 154.
[151] IDSP, https://idsp.nic.in/index1.php?lang=1&level=1&sublinkid=5778&lid=3707, (last visited Sept. 6, 2021).

effective control of communicable diseases[152]. Measures undertaken like surveillance, tracing etc. amplified by use of technology etc. measures must incorporate meaningful data protection safeguards, be lawful, necessary, and proportionate, time-bound and justified by legitimate public health objectives[153].

Early in the course of the AIDS epidemic, public health officials recognized that mandatory screening for human immunodeficiency virus would simply help drive the epidemic underground, where it would spread faster and wider. Likewise, draconian quarantine measures would probably have the unintended effect of encouraging people to avoid public health officials and physicians rather than to seek them out.[154]

3.3.4 Penalty on non-compliance

The Indian statues examined in the previous chapter increasingly employ a deterrent approach based on criminal and civil penalty to ensure compliance. A deterrent approach is based on the principle that people can be persuaded from violating a law if they believe that non-compliance will be detected and punishment will be severe and swift[155]. The stringent penalties exclude the possibility of cooperation, self regulation etc. by individuals facing spread of communicable diseases. The imposing of fines as penalties at times of restrictions on movement and livelihood, adds extra burden on a population, which leads to unrest and dissatisfaction towards the government.

Criminal penalties though intended as a deterrent, can in turn cause stigma and persecution of the population already reeling under the effects of disease outbreak. An illustrative example is the case of Tablighi Jammat in Delhi at the beginning of the spread of COVID-19 in India. The gathering flouting lockdown restrictions acquired notoriety on a communal basis and saw widespread arrests across the country. In a related case before the Bombay High Court, held the media coverage as

[152] WHO, *Advancing the right to health: the vital role of law*, (2017),http://apps.who.int/iris/bitstream/handle/10665/252815/9789241511384-eng.pdf;jsessionid=D7F2ECA1725B47FDA6379258AA5EAF2A?sequence=1.
[153] UN OHRC, *Emergency Response and COVID-19: Guidance*, (April 2021), https://www.ohchr.org/Documents/Events/EmergencyMeasures_Covid19.pdf.
[154]George J. Annas, *Bioterrorism, Public Health, and Civil Liberties*, 346 N Engl J Med. 1337, 1340(2002).
[155] WHO, *Enforcement of Public Health Legislation*, (2006), https://iris.wpro.who.int/bitstream/handle/10665.1/5543/9290612231_eng.pdf.

propaganda and as virtually persecution. The Court found malice and discrimination in charging the various peanl provisoins relating to epidemics and quashed the same[156].

The SC was less inclined to quash criminal proceedings under Section 188 of the IPC and dismissed a PIL seeking the same under Article 32 of the Constitution. This PIL, *Vikram Singh v. Union of India* sought the relief citing the indiscriminate suffering of the poor leading to lockdown violations and instances of police high handedness during the lockdown period[157].

3.3.5 Destruction of property

Governments are empowered to mandate destruction of personal articles, possessions, of infected premises and structures etc. to prevent spread of communicable diseases. Especially, in cases where threats of spread of infection from poultry and other animals to animals and human population culling is undertaken officially to preempt any outbreak or arrest the spread. The method of culling is undertaken especially under threat of avian influenza, swine fever etc. Culling and other activities of destruction of articles carries with it a huge economic burden to the owner and economy. A massive culling of birds can have a devastating economic toll on the poultry industries of the affected nations and the livelihoods of all classes of poultry owners, producers and their employees[158]. For culling decisions to be justified, the public benefit should outweigh the personal and economic burdens placed on individuals[159].

Indian statutory law also provides wide powers to the administrators to close down workplaces, close markets, restrict usage of conveyance and public gathering, on usage of public library, carry on employment at certain establishments etc.

In respect to the coercive power of the State, it is to be understood that "Law has the potential to be a very useful tool for the attainment of public health. Bad law, however, can serve to create obstacles to public health"[160]. Some compulsory powers are necessary for those who will not comply, provided those powers are bounded by legal safeguards, individuals should be required to yield some of their autonomy, liberty or property to protect the health and security of the

[156] *Konan Kodio Ganstone And Others vs The State Of Maharashtra,* 2020 SCC Online Bom. 869.
[157] Lee Brown, *India police punish coronavirus lockdown evaders with sit-ups,* NEW YORK POST,(March 31, 2020, 12:53 PM), https://nypost.com/2020/03/31/india-police-punish-coronavirus-lockdown-evaders-with-sit-ups/.
[158] Berkman, *supra* note 144, at 158.
[159] *Id*.
[160] Martin, supra note 147, at 143.

community[161].When the government acts to preserve the public's health, it can interfere with property rights (e.g., freedom of contract, to pursue a profession, or to conduct a business) or personal rights (e.g., autonomy, privacy, and liberty). [162]Public health work requires both ethics applicable to the individual public health practitioner and a human rights framework to guide public health in its societal analysis and response[163].

3.4 Health and human rights

Human rights "they are human; they apply to all people around the world; and they principally involve the relationship between the state and the individual[164]."The main sources of human rights law are the Universal Declaration of Human Rights and two international covenants on human rights: the International Covenant on Civil and Political Rights (ICCPR) and the International Covenant on Economic, Social and Cultural Rights (ICESCR), as well as an optional protocols[165]. The UN Charter seeks to reaffirm faith in fundamental human rights, in the dignity and worth of the human person.

3.4.1 UDHR

The Preamble to the UDHR[166] touches on the inherent dignity and inalienable rights of all of the human family as the foundation of freedom, justice and peace. While Article 1 decalres the equality in dignity and rights of all, the second Article reaffirms the entitlement to equaltiy without distinction of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.

Article 3 holds that everyone has the right to life, liberty and the security of a person. Right to freedom of movement[167], freedom of peaceful assembly and association[168] are also recognised as

[161] Lawrence O. Gostin et al., *The Model State Emergency Health Powers Act: Planning for and Response to Bioterrorism and Naturally Occurring Infectious Diseases,* 288 J. Am. Med. Ass'n 622, 624(2003).
[162] *Id.* at 624.
[163] Jonathan M. Mann, *Medicine and Public Health, Ethics and Human Rights,* 27 : The Hastings Cent. Rep. 6, 10(1997).
[164] Mann, *supra* note 121 at 10.
[165]Benjamin E. Berkman et. al., *Pandemic Influenza:Ethics, Law and Public's Health,* 59 Admin. L. Rev. 121, 142(2007).
[166] G.A. Res. 217 (lll) A, Universal Declaration of Human Rights (Dec. 10, 1948).
[167] *Id. at Article 13.*
[168] *Id. at* Article 20

human rights under the UDHR. Article 25 specifically declares that "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control." The Declaration prohibits cruel, inhuman or degrading treatment[169], arbitrary arrest and detention[170], arbitrary interference with his privacy, family, home[171]

Restrictions to the rights are provided under Article 29(2) to be as "determined by law solely for the purpose of securing due recognition and respect for the rights and freedoms of others and of meeting the just requirements of morality, public order and the general welfare in a democratic society."

The United Nations' General Assembly has declared that the principles embodied in the Universal Declaration "constitute basic principles of international law."[172]

3.4.2 ICCPR

ICCPR[173] declares that right to life[174] not be deprived off arbitrarily. It holds that no one shall be subjected to cruel, inhuman or degrading treatment or punishment[175]. Article 4 allows derogation of rights under the Convention in cases of public emergency which threatens the life of the nation but the rights above mentioned cannot be derogated even in such circumstances.

ICCPR also protects persons against arbitrary arrest or detention in deprivation of their right to liberty and security of person[176]. Any person so deprived of liberty is to be treated with humanity and with respect for the inherent dignity of the human person, according to Article 10. The right to liberty of movement is secured to everyone lawfully present within the territory of a State[177] so is the right not be subjected to arbitrary or unlawful interference with his privacy[178].

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[169] *Id. at* Article 5
[170] *Id. at* Article 9
[171] *Id. at* Article 12
[172] Berkman, *supra* note 165 at 143.
[173] International Covenant on Economic, Social and Cultural Rights, Dec. 16, 1966, 993 U.N.T.S. 3.
[174] *Id. at* Article 6
[175] *Id. at* Article7
[176] *Id. at* Article 9
[177] *Id. at* Article 12(1)
[178] *Id. at* Article 17

ICCPR recognizes the right of peaceful assembly to be restricted only by law, necessary in a democratic society in the interests of national security or public safety, public order, the protection of public health or morals or the protection of the rights and freedoms of others. Hence, according to Article 21 of ICCPR, public health is a valid ground to restrict assembly of individuals.

3.4.3 ICESCR[179]

Article 4 provides that restriction be placed on the rights under the Covenant only by law, for the welfare of general public[180]. Article 12 recognizes the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. Improvement of environmental hygiene, prevention, treatment and control of epidemic, endemic, occupational and other diseases and assurance of medical service and medical attention in case sickness[181] are the duty of the State in attainment of the right under Article 12.

General Comment no 14[182] on the ICESCR underlines that right to health is not merely the right to be healthy but includes certain freedoms and entitlements. The notion of health under Article 12 includes the individual's biological and socio-economic preconditions and a State's available resources broadening the scope of health as given by the WHO Constitution.

The General Comment no 14 holds that the right to treatment under Article 12(c) includes the creation of a system of urgent medical care in cases of accidents, epidemics and similar health hazards, and the provision of disaster relief and humanitarian assistance in emergency situations.

The right to medical services under Paragraph 17 of the Comment "includes the provision of equal and timely access to basic preventive, curative, rehabilitative health services and health education; regular screening programmes; appropriate treatment of prevalent diseases, illnesses, injuries and disabilities, preferably at community level; the provision of essential drugs; and appropriate mental health treatment and care."

The right to health, like all human rights, imposes three types or levels of obligations on States parties: the obligations to respect, protect and fulfil. In turn, the obligation to fulfil contains

[179] International Covenant on Economic, Social and Cultural Rights, Dec. 16, 1966 993 U.N.T.S. 3.
[180] *Id*. at Article 4
[181] *Id*. at Article 12(2)
[182] UN Committee on Economic, Social and Cultural Rights, *General Comment No. 14: The Right to the Highest Attainable Standard of Health,* U.N. Doc.E/C.12/2000/4(2000).

obligations to facilitate, provide and promote. The obligation to respect requires States to refrain from interfering directly or indirectly with the enjoyment of the right to health. The obligation to protect requires States to take measures that prevent third parties from interfering with Article 12 guarantees. Finally, the obligation to fulfil requires States to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards the full realization of the right to health. However, Paragraph 34 provides that treatment of mental illness or the prevention and control of communicable diseases as an exception to prohibition of coercive medical treatment.

3.4.4 Restrictions on Human rights

State duties encompass the obligations to not interfere directly or indirectly with the enjoyment of human rights, to prevent private actors from interfering with human rights, and to take positive measures to enable and assist individuals and communities to enjoy their rights[183].

The International documents aforesaid, provide a number of rights that are relevant to the implementation of public health interventions including the right to freedom from cruel, inhumane, or degrading treatment or punishment; the right to freedom of movement and residence; the right to freedom from arbitrary detention; and most notably the right to health.

The Paragrapgh 3 of the General Commnent recognizes that the right to health is closely related to and dependent upon the realization of other human rights, as contained in the International Bill of Rights, including the rights to food, housing, work, education, human dignity, life, non-discrimination, equality, the prohibition against torture, privacy, access to information, and the freedoms of association, assembly and movement

The General Comment 14, sets conditions for restraints on civil and political rights are that they must be prescribed by law, enacted within a democratic society and necessary to achieve public order, public health, public morals, national security, public safety, or the rights and freedoms of others. State parties may not impose restrictions aimed at the destruction of rights or their limitation to a greater extent than provided in the Covenant.

The ICCPR Article 12 requires states to take steps aiming at "prevention, treatment and control epidemic, endemic, occupational and other diseases."Thus, compulsory measures such as vaccination, treatment, or isolation would be permitted only if necessary. International tribunals

[183] GOSTIN, *supra* note 50 at 142.

have relied on the Siracusa Principles to require states to use the least restrictive measure necessary to achieve public health[184].

According to the Siracusa principles[185], limitations on rights to be justified and provided by law[186]. No limitation is to be administered in an arbitrary[187] or discriminatory[188] manner and must be subject to challenge and reedy in case of abuse[189].

A necessary limitation under the Covenant must be according to Article 10

1. based on grounds justifying limitations recognized by the relevant article of the Covenant
2. in response to a pressing public or social need
3. In pursuance a legitimate aim
4. proportionate to that aim.

By virtue of Article 25 of the Siracusa Principles Public health may be invoked as a ground for limiting certain rights in order to allow a state to take measures dealing with a serious threat to the health of the population or individual members of the population. These measures must be specifically aimed at preventing disease or injury or providing care for the sick and injured and due regard shall be given to the international health regulations of the World Health Organization[190].

Human rights offers a societal-level framework for identifying and responding to the underlying societal determinants of health. It is important to emphasize that human rights are respected not only for their instrumental value in contributing to public health goals but for themselves, as societal goods of pre-eminent import[191]. The times of necessity under a disease outbreak must be the time to reaffirm the values of human rights and forgo them. The public health measures Public health officials have, two fundamental responsibilities to the public: to protect and promote public health, and to protect and promote human rights[192].

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[184] *Enhorn v. Sweden*, [2005] E.C.H.R. 56529/00.
[185]UN Commission on Human Rights,U.N. Doc. E/CN.4/1985/4, *The Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights*, (1984).
[186]*Id,* Article 5
[187]*Id,* Article 7
[188]*Id,* Article 9
[189] *Id*, Article 8
[190]*Id,* Article 26
[191] Mann, *supra* note 121, at 10.
[192] Mann, *supra* note 121 at 27.

3.4.5 IHR, 2005

The WHO Constitution Article 21 empowers the World health Assembly to adopt regulations to provide for sanitary, quarantine and other procedures to control the international spread of communicable diseases. This was aimed at a uniform and coordinated regulation of health crises. Unequal development in different countries in the promotion of health and control of disease, especially communicable disease, was recognized as a common danger in the WHO constitution. Public health emergency of international concern was held to mean an extraordinary event which is determined, as provided in the IHR as constituting

(i) a public health risk to other States through the international spread of disease

and

(ii) to potentially require a coordinated international response;

Article 3 of the IHR Regulations recognises the need to respect the dignity and human rights in the implementation of its provisions. IHR while formulating duties of surveillance and reporting on States also allows adoption of health measures to prevent and control diseases, provided such measures are based on scientific evidence . Such health measures may include collection of information on travellers, including their itinerary, require travellers to undergo a non-invasive medical examination which is the least intrusive examination that would achieve the public health objective, inspection of baggage, postal parcels, isolation etc. Article 23(3) provides that no medical examination, vaccination, prophylaxis or health measure under these Regulations shall be carried out on travellers without their prior express informed consent or that of their parents or guardians, as a general rule with exceptions. Under Article 31 at risk of imminent threat to public health, a State Party may deny entry to such refusing traveller or compel such medical examination, vaccination or prophylaxis. Such travellers offered vaccination or prophylaxis or their parents or guardians must be informed of the risks of vaccination or non-vaccination, quarantine, isolation or such other health measures. Such health measures need to follow international and national law and safety norms.

Article 32 requires State Parties to deal travellers with courtesy and respect with considering the gender, sociocultural, ethnic or religious concerns of travellers and with adequate provision for food and water, appropriate accommodation and clothing, protection for baggage and other

possessions, appropriate medical treatment, means of necessary communication and other appropriate assistance for travellers who are quarantined, isolated or subject to medical examinations etc. State Parties are not precluded from taking additional health measures not provided in the IHR but Article 43 requires that such measures be taken not be more restrictive of international traffic and not more invasive or intrusive to persons than reasonably available alternatives. IHR requires States to protect personal data collected during health measures.

IHR is a "treaty meant to herald a new era of global cooperation to make the world more secure[193]"It recognizes the importance of travel and commerce, the IHR contains a "balancing dynamic," comprising public health, commerce and human rights. States Parties must, though, have sufficient scientific evidence of the risk posed and of whether the measure adopted is likely to ameliorate that risk before taking restrictive travel or trade measures or impinging on human rights.[194] In India, the NCDC, under the Ministry of Health and Family Welfare acts as the IHR focal point.

3.5 Public Health ethics

3.5.1Public health necessity

Public health powers are exercised under the theory that they are necessary to prevent an avoidable harm[195]. Government, to justify the use of compulsion, therefore, must act only in the face of a demonstrable health threat[196]. Public health officials must be able to prove that they had "a good faith belief, for which they can give supportable reasons, that a coercive approach is necessary[197]." The standard of public health necessity requires, at a minimum, that the subject of the compulsory intervention must actually pose a threat to the community. In the context of infectious diseases, for example, public health authorities could not impose personal control measures (e.g., mandatory physical examination, treatment, or isolation) unless the person was actually contagious or, at least,

[193] Gostin, Lawrence et.al., T*he International Health Regulations: The Governing Framework for Global Health Security,* 94 The Milbank quarterly 264, 313(2016), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4911720/.
[194] *Id.* at 300.
[195] Berkman, *supra* note 165, at 147.
[196] *Id.*
[197] Childress, *supra* note 124, at 173.

there was reasonable suspicion of contagion.[198] Police powers must be based on the "necessity of the case" and could not be exercised in "an arbitrary, unreasonable manner" or go "beyond what was reasonably required for the safety of the public.[199]

3.5.2 Reasonable and Effective Means

Under the public health necessity standard, the government may act only in response to a demonstrable threat to the community. The methods used, moreover, must be designed to prevent or ameliorate that threat. In other words, there must be a reasonable relationship between the public health intervention and the achievement of a legitimate public health objective. Even though the objective of the legislature may be valid and beneficial, a public health intervention must be an effective means of combating the public health threat[200].“ It is essential to show that infringing one or more general moral considerations will probably protect public health. For instance, a policy that infringes one or more general moral considerations in the name of public health but has little chance of realizing its goal is ethically unjustified[201].”

3.5.3 **Proportionality**

The public health objective may be valid in the sense that a risk to the public exists, and the means may be reasonably likely to achieve that goal - yet a public health regulation is unethical if the human burden imposed is wholly disproportionate to the expected benefit. Public health authorities have a responsibility not to overreach in ways that unnecessarily invade personal spheres of autonomy. It is essential to show that the probable public health benefits outweigh the infringed general moral considerations — this condition is sometimes called proportionality. For instance, the policy may breach autonomy or privacy and have undesirable consequences. All of the positive features and benefits must be balanced against the negative features and effects[202].

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[198] Berkman,*supra* note 126, at 148.
[199] *Jacobson v Massachusetts* , 197 U.S. at 28.
[200] Berkman, *supra* note 126, at 147.
[201]Childress, *supra* note 121, at 173.
[202] *Id.*

Balance between public good and personal invasion: In Puttaswamy case wherein right to privacy was declared a part of right to life under Article 21, it was held that Right to privacy cannot be impinged without a just, fair and reasonable law: It has to fulfill the test of proportionality i.e.

(i) existence of a law;

(ii) must serve a legitimate State aim; and

(iii) proportionality[203].

In *Om Kumar v. Union of India*[204] proportionality means the question whether, while regulating exercise of fundamental rights, the appropriate or least restrictive choice of measure has been made by legislature or the administrator so as to achieve the object of the legislation or the purpose of administrative order as the case may be. Coercive measures may be justified in certain situations, they can backfire if applied in a heavy-handed, disproportionate way, undermining the whole pandemic response itself[205].

3.5.4 Distributive Justice

The ethical principle requires that the risks, benefits, and burdens of public health action be fairly distributed, thus precluding the unjustified targeting of already socially vulnerable population[206]. All persons are equally responsible for sharing the burdens as well as the benefits of protection against death and disability, except where unequal burdens result in greater protection for every person and especially potential victims of death and disability[207]. . In a medical context, this requires patients with similar cases to be treated in a similar manner, and for there to be overarching equality of access to finite health resources[208].The work of public health is always challenged by inadequate resources, raising the question of how best to allocate limited resources[209]. Understanding the landscape of justice will enable actors within public health systems both to

[203] *Justice K.S. Puttaswamy v. Union of India,* (2017) 10 SCC 1.
[204] (2001) 2 SCC 386.
[205] UN, *COVID-19 and Human Rights:We are all in this together, (*April 2020), https://www.un.org/victimsofterrorism/sites/www.un.org.victimsofterrorism/files/un_-_human_rights_and_covid_april_2020.pdf.
[206] Berkman,supra note 48, at 148.
[207]Dan E. Beauchamp, *Public Health as Social Justice*, 13 Inquiry 3, 8 (1976).
[208] Oliver M. Fischer et. al., *Distributive justice during the coronavirus disease 2019 pandemic in Australia* , 10 ANZ J. Surg. 961,961, (2020).
[209] Anna C. Mastroianni et. al., *Public Health Ethics: an Introduction and Overview,* THE OXFORD HANDBOOK OF PUBLIC HEALTH ETHICS, *3(*Anna C. Mastroianni, Jeffrey P. Kahn, and Nancy E. Kass ed., 2019*).*

evaluate the merits of different public health choices and to compare public health interventions with interventions outside of public health[210].

3.5.5 Trust and transparency

Public health officials have the responsibility to involve the public in the process of formulating public health policies as well as to explain and justify any infringement on general moral considerations. Public health officials should honestly disclose relevant information to the public[211].

public health agents should offer public justification for policies in terms that fit the overall social contract in a liberal, pluralistic democracy. This transparency stems in part from the requirement to treat citizens as equals and with respect by offering moral reasons, which in principle they could find acceptable, for policies that infringe general moral considerations. Transparency is also essential to creating and maintaining public trust; and it is crucial to establishing accountability[212]. Public education important in preventing panic and flight, protecting against discrimination, and promoting sanitary practices and adherence to quarantine.

The best way to maintain public support for the measures is for governments to be open and transparent and involve people in making the decisions that affect them[213]. Informed cooperation and active participation of the population necessary for the success of public health measures. Battling HIV, T.B. and now COVID-19 has seen the need for information dissemination by the Government through awareness campaigns, public messaging etc.

3.5.6 Least infringement

Least infringement is a broad principle that implies corollary principles for each kind of moral cost, such as least restriction of liberty, least infringement of privacy, least infringement of justice, and so on[214].Least infringement requires that public health agents should seek to minimize the

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[210] Govind Persad, *Justice and Public Health*, THE OXFORD HANDBOOK OF PUBLIC HEALTH ETHICS, 33-46(Anna C. Mastroianni, Jeffrey P. Kahn, and Nancy E. Kass ed., 2019).
[211] Berkman, *supra* note 45, at 149.
[212]Childress, *supra* note 48, at 173.
[213] UN, *Human rights and covid*, (April, 2020) (https://www.un.org/victimsofterrorism/sites/www.un.org.victimsofterrorism/files/un_-_human_rights_and_covid_april_2020.pdf.
[214] Timothy Allen et. al., *Necessity and least infringement conditions in public health ethics*, 20 Med Health Care and Philos 525, 526 (2017).

infringement of general moral considerations[215]. The policy must impose the least restrictions on freedom necessary to promote the public health goals[216].

3.6 Constitutional restraints

The overarching ideals of individual autonomy and liberty, equality for all sans discrimination of any kind, recognition of identity with dignity and privacy of human beings constitute the cardinal four corners of our monumental Constitution[217].Reasonable restriction on the ground of the interest of general public, is found in Articles 19(1)(g) of the Constitution of India and Article 19(6) of the is of wide import comprising grounds of public order, public health, public security[218] etc.

3.6.1 Protection against discrimination

Article 14 guarantees equality. Equality was held to be "one of the magnificent corner-stones of Indian democracy[219]." Article 15 prohibits discrimination by the State solely on the grounds of religion,race, caste, sex, place of birth. Article 14 guarantees against arbitrariness[220] in State action, legislative or executive as any action that is arbitrary must necessarily involve the negation of equality[221]. Article 14 also protects against unfettered discretion in administrative action. The statute conferring such discretion must be confined by standards, principles, guidelines etc. While the mere likelihood of abuse of discretion is not enough to declare a statutory provision unconstitutional[222], the actions taken under it can be invalidated. Reasonableness an Essential element of equality[223].

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[215] *Id.*
[216] David Resnik, *Trans fat bans and human freedom*, 10 Am.J. Bioethics 27, 32 (2010).
[217] *Navtej Singh Johar and ors. v. UOI*, LNIND 2018 SC 45.
[218] *Municipal Corpn., Ahmedabad v. Jan Mohammed,* AIR 1986 SC 1205.
[219] *Indra Swahney v. Union of India,* AIR 1993 SC 477.
[220] *Naraindas v. State of M.P.,* AIR 1974 SC 1232.
[221] *A.L. Kalra v. P&E Corporation of India Ltd.,* AIR 1984 SC 1361.
[222] *Government of Andhra Pradesh v. P. Laxmi Devi,* AIR 2008 SC 1640.
[223] *Maneka Gandhi v. Union of India,* AIR 1978 SC 597.

3.6.2 Reasonable restrictions

Statues seeking to restrict freedoms under Article 19 must conform to the test of reasonableness. There is 'no abstract standard or general pattern of reasonableness[224]'. In *Chintaman Rao v. State of Madhya Pradesh*[225], reasonableness was held to be dependent on the nature of right infringed, the underlying purpose of restriction imposed, extent and urgency of evil sought to be remedied etc.In applying the test of reasonableness, the Court has to consider the question in the background of the facts and circumstances under which the order was made, taking into account the nature of the evil that was sought to be remedied by such law, the ratio of the harm caused to individual citizens by the proposed remedy, to the beneficial effect reasonably expected to result to the general public[226].

3.6.3 Procedure established by law

Right to life and liberty to be curtailed by only procedure established by law[227] and the procedure so established must be fair, just and reasonable[228]. In *Shakuntala P. Devlekar vs. Surat Municipal Corporation*[229] during the Plague outbreak in Surat in 1994 the municipal services were declared as essential services with immediate effect and all municipal workers ordered to report for duty, defaulters to be dismissed under the epidemics diseases act,1897. The dismissal was held to be proper, and following proper procedure.

3.7 Rights of the individual

3.7.1 Autonomy

Autonomy, derived from the Greek *autos* ("self") and *nomos* ("rule," "governance," or " Iaw"). self governance, liberty, rights, privacy, individual choice, freedom of the will, causing one's behavior, and being one's own person[230]. Beauchamp holds that there is two essential conditions to autonomy:

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[224] *State of Madras v. V.G. Row*, AIR 1952 SC 196.
[225] AIR 1951 SC 118.
[226] *Narendra Kumar v. Union of India*, AIR 1960 SC 430.
[227] INDIA CONST. art. 21.
[228] *Maneka Gandhi v. Union of India*, AIR 1975 SC 775.
[229] (2003) 4 GLR 154.
[230] Tom L. Beauchamp & James F. Childress, PRINCIPLES OF BIOMEDICAL ETHICS 120(4th ed. Oxford university Press 1994).

1) liberty : independence from controlling influences

2) agency :capacity for intentional action

Respect for autonomy is a part of principles of bioethics.As a principle of biomedical ethics, autonomy provides for informed consent of an individual. Kant argued that respect for autonomy flows from the recognition that all persons have unconditional worth, each having the capacity to determine his or her own destiny[231].

Informed consent is a foundation of autonomy. An informed consent is an autonomous authorization by an individuals of a medical intervention or of involvement in research[232]. Informed consent is dependent on elements including competence to give consent, disclosure of information, understanding, voluntariness and consent. The statutory provisions of compulsory treatment and removal from the home of infectious persons etc. deeply affects the autonomy of individual persons. Though necessary to prevent spread of communicable diseases there needs to be avenues of hearing and notice and remedy in case of abuse for persons so removed forcibly and treated.

3.7.2 Privacy

Nissenbaum[233] underlines that the deliberation on the concept of privacy is based on three principles, which are:

(1) Limiting surveillance of citizens and use of information about them by agents of government,

(2) Restricting access to sensitive, personal, or private information, and

(3) Curtailing intrusions into places deemed private or personal.

Protection of privacy and confidentiality of a patient in medicine is part of the principles of bioethics. “Breaches of privacy and confidentiality not only may affect a person’s dignity, but can cause harm. When personally identifiable health information, for example, is disclosed to an employer, insurer, or family member, it can result in stigma, embarrassment, and discrimination. Thus, without some assurance of privacy, people may be reluctant to provide candid and complete disclosures of sensitive information even to their physicians. Ensuring privacy can promote more

[231] *Id.* at 125.
[232] *Id.* at 143.
[233] Helen Nissenbaum, *Privacy as Contextual Integrity*, Wash. L. Rev. 101, 139 (2004).

effective communication between physician and patient, which is essential for quality of care, enhanced autonomy, and preventing economic harm, embarrassment, and discrimination[234]."

Allen[235] holds that informational privacy calls for the protection of the health information that is provided by the patient to a health care provider, a physician, nurse etc. and confidentiality is defined as restricting information to persons belonging to a set of specifically authorized recipients. Confidentiality can be achieved through professional silence and secure data management. The guarantee of secrecy and confidentiality form the basis of open and honest disclosures from the patient.

In India, Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002,[236] section 2.2 the physician is duty bound to protect the confidence of information entrusted to him by the patient but the same provision mandates disclosure in order to prevent spread of infectious diseases to healthy persons.

Right to privacy however, is not absolute. In *Central Public Information Officer, Supreme Court of India v. Subhash Chandra Agarwal*[237], the Court recognized that the right to information of one could be at the cost of the right to privacy of another. The requirement of proportionality is satisfied when the nature and extent of the abridgement of the right is proportionate to the legitimate aim being pursued by the State. The test is to see whether the release of information would be necessary, depending on the information seeker showing the 'pressing social need' or 'compelling requirement for upholding the democratic values'. Privacy is considered as a subset of personal liberty thereby accepting the minority opinion in *Kharak Singh* v. *State of U.P. & Ors* Privacy is the constitutional core of human dignity, where the information/data is necessary, for exercising the right of freedom of expression and information, for compliance with legal obligations, for the performance of a task carried out in public interest, on the grounds of public interest in the area of public health, for archiving purposes in the public interest, scientific or historical research purposes or statistical purposes, or for the establishment, exercise or defence of

[234] Samuel D. Warren et. al., *The Right to Privacy*, 4 Harv. L. Rev. 193, 220 (1890).
[235] THE STANFORD ENCYCLOPEDIA OF PHILOSOPHY, http://plato.stanford.edu/archives/spr2011/entries/privacy-medicine/, (last visited 13 June, 2021).

[236] NATIONAL MEDICAL COMMISSION, https://www.nmc.org.in/rules-regulations/code-of-medical-ethics-regulations-2002, (last visited June 13, 2021).
[237] AIROnline 2019 SC 1449

legal claims. Such justifications would be valid in all cases of breach of privacy, including breaches of data privacy[238].

Activities such as contact tracing, creation of route maps etc. undertaken to discover persons exposed to infectious agents, carry much scope for intervention into the privacy of the individual. The availing digital services like COWIN for vaccination disbursal, Aarogya Setu app etc. collects significant amounts of data on personal information requiring firm data protection norms to ensure right to privacy and confidentiality of the individual.

3.7.3 Right to dignity

In *Francis Corallie Mullin v. Delhi*[239] , right to life under Article 21 was interpreted to include "right to live with human dignity and all that goes with it, namely, the bare necessity of life like adequate nutrition, clothing, shelter"

In *P. Rathinam v. Union of India*[240], right to life was held to mean, " right to live with human dignity and the same does not connote continued drudgery."

In *Chameli Singh v. State of Uttar Pradesh*[241], the Supreme Court observed that "right to life guaranteed in any civilised society implies the right to food, water, decent environment, education, medical care and shelter."

The Right to dignity also extends to the dead. In the COVID pandemic, dignity was violated by practices of mass burials, improper burial[242] etc.

3.7.4 Right to health

Health is a fundamental human right indispensable for the exercise of other human rights. Health is essential for ensuring life with dignity. Health care is an essential concomitant to quality of life. Its demand and supply cannot therefore be left to be regulated solely by the invisible hands of the

[238] *Justice K.S. Puttaswamy v. Union of India,* (2017) 10 SCC 1.

[239] AIR 1981 SC 746.
[240] AIR 1994 SC 1844.
[241] AIR 1996 SC 1051.
[242]NHRC,,https://nhrc.nic.in/sites/default/files/NHRC%20Advisory%20for%20Upholding%20Dignity%20%26%20Protecting%20the%20Rights%20of%20Dead.pdf, (last visited Sept. 23, 2021).

market. The State must strive to move towards a system where every citizen has assured access to basic health care, irrespective of capacity to pay[243]. Article 21 of the Constitution of India casts an obligation on the State to preserve life[244].The Courts have also held that an obligation to provide medical care was an obligation of the welfare state[245]. Failure to provide medical aid on a fair, reasonable, equitable and affordable basis for rare diseases was held to be a breach of constitutional obligation by the Government.

In *Vincent Panikulangara v. Union of India*[246], the Court held that right to maintenance and improvement of public health as one of the fundamental rights falling under Article 21 of the Constitution.

3.7.5 Right to information

In *PUCL v. UOI*[247], the Supreme Court had held that the right of the citizens to obtain information on matters relating to public acts flows from the fundamental right to speech and expression enshrined in Article 19(1)1(a). Reasonable restrictions[248] have been placed on the right including national security, international relations, privacy of individuals etc. The right and its exemptions are embodied in the Right to Information Act, 2005.

Accountability is conceived in such a way as to enable the democratic process of establishing respect for those values, whether of efficiency or independence, efficacy in achieving objectives, or impartiality in the treatment of citizens[249].

Disseminating health information is of particular importance during a health emergency[250].key types of information that should be released proactively during a public health crisis include information about: the progression of the disease, broken down as granularly as possible; steps governments are taking to protect individuals and how to maximise the effectiveness of those steps; decision-making around responding to the crisis; allocation of emergency funding;

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[243] *All India Lawyers Union, Delhi v. Govt. of NCT, Delhi*, LNIND 2009 DEL 1197.
[244] *Mohd. Ahmed (Minor) vs Union Of India & Ors*, 2014 SCC On Line Del 1508.; Pt. Parmanand Katara Vs. Union of India and Others, (1989) 4 SCC 286.
[245] *Paschim Banga Khet Mazdoor Samity and Others,* AIR 1996 SC 2426.
[246] (1987) 2 SCC 165
[247] AIR 2002 SC 2362
[248] *PUCL v. UOI*, AIR 2004 SC 1442.
[249] Mark Bovens, *Analysing and Assessing Accountability: A Conceptual Framework*, 13 Eur. L.J.l 447, 448 (2007).
[250]UNESCO, *The Right to Information in Times of Crisis: Access to Information – Saving Lives, Building Trust, Bringing Hope*, (Sept 24, 2020), https://en.unesco.org/sites/default/files/unesco_ati_iduai2020_english_sep_24.pdf.

procurement of emergency equipment; the allocation of grants; and how to access government programmes and benefits introduced in response to the pandemic[251]. The constitutional Court had to intervene to direct the Government of Gujarat to take such measures to sensitize and make aware the residents of the suburban, semi-rural, rural and tribal areas of this pandemic and the precautionary measures they need to take[252], such is the essentiality of information and awareness in a public health crisis situation.

3.7.6 Right to livelihood

For more than 2.2 billion people in the world, washing their hands regularly is not an option because they have inadequate access to water. For 1.8 billion who are homeless or have inadequate, overcrowded housing, physical distancing is a pipe dream. Poverty itself is an enormous risk factor[253]Restrictions directly affect the avenues of employment and livelihood of people. In the case of the *Board of Trustees of the Port of Bombay v. Dilipkumar Nandkarni*[254], the Supreme Court overruled its previously held contrary position[255] and held that the right to life under Article 21 would encompass the right to livelihood. No person can live without the means of living[256].

3.7.7 Right to movement

The most common public health measure taken by States against COVID-19 has been restricting freedom of movement: the lockdown or stay-at-home instruction. This measure is a practical and necessary method to stop virus transmission, prevent health-care services becoming overwhelmed, and thus save lives .Restrictions on free movement should be strictly necessary for that purpose, proportionate and non-discriminatory. The availability of effective and generalised testing and tracing, and targeted quarantine measures, can mitigate the need for more indiscriminate restrictions[257].

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[251] *Id*.
[252] *Suo Motu vs. State of Gujarat and Ors*, MANU/GJ/0737/2020.
[253] Human rights and COVID, *supra* note 95.
[254] AIR 1983 SC 109.
[255] *Re Sant Ram*, AIR 1960 SC 932; *A.V. Nachane v. Union of India*, AIR 1982 SC 1126.
[256] *Olga Tellis v. Bombay Municipal Corporation*, AIR 1986 SC 180.
[257]UN, *supra* note 213.

3.8 Conclusion

Outbreaks of diseases, epidemics and pandemics are times of intense pressure for the health system, for the governments and for the individuals. Epidemics and pandemics like the one we are living through are not a novel occurrence nor are they a thing of the past. Threats of zoonotic diseases and bioterrorism threats makes the future occurrence of diseases of pandemic potential a reality that nations should prepare for, if they have not already. Such preparations, along with the aim of prevention or eradication of such diseases must also be in tune with the needs and rights of the very population it seeks to protect. The COVID-19 pandemic has since its emergence put strain on not just the health infrastructure of nations but also brought to fore the social, political and economical challenges in the existing structure. The UN document on the effects of COVID-19 pandemic has found that "for more than 2.2 billion people in the world, washing their hands regularly is not an option because they have inadequate access to water. For 1.8 billion who are homeless or have inadequate, overcrowded housing, physical distancing is a pipe dream. Poverty itself is an enormous risk factor[258]." There are added burdens of loss of livelihood, inadequacy of healthcare etc. on vulnerable populations, disproportionately women, informal workers et

Amidst all such ravages, the law plays a fundamental role in management and control of such disease situations. When there is a public health crisis, the chief variable for determining how a community fares is the responsiveness of its legal system[259]The acts of the government for preventing, controlling or managing such a situation should not add to the burdens on the individuals. The violation of any right has measurable impacts on physical, mental, and social well- being; yet these health effects still remain, in large part, to be discovered and documented[260]. Pandemics can be deeply socially divisive, and the political response to these issues not only impacts public health preparedness, but also is important to a good and decent society.It is for this reason that it is particularly important to show respect for public health ethics and international law, particularly human rights law, when developing national policy for pandemic influenza[261].

[258] *Id.* at 7.
[259]*WHO, supra note 39.*
[260] Mann, *supra* note 163, at 9.
[261] Berkman, *supra* note 165, at 142

The law aimed at public health protection must be dynamic, keeping in tune with the changing paradigms of rights and responsibility. The traditional public health paradigm and strategies developed for diseases such as smallpox, often involving coercive approaches and activities which may have burdened human rights, are now understood to be less relevant today. For example, WHO's strategy for preventing spread of the human immunodeficiency virus (HIV) excludes classic practices such as isolation and quarantine and explicitly calls for supporting and preventing discrimination against HIV-infected people[262]. The Public health and epidemics legislation in India in particular are vestiges of a time long past. The restrictive measures and actions provided for does not recognise the human rights principles or public health principles. The necessity of emerging communicable diseases should not be a reason to forgo the rights of the individuals nor shall the wide and unregulated statutory powers be an avenue of misuse or abuse.

[262] Mann, supra note 4 at 16.

CHAPTER IV: CONCLUSIONS AND SUGGESTIONS

In a welfare state, disease is not the concern of the affected alone, communicable disease is an added threat due to the social, economical and political disruptions it can cause. The loss of life, livelihood and attending disabilities can negatively affect the health and welfare of a population and can have lasting effects on the present and future generations. It is essential, thus, to have governmental measures to prevent and control the spread of communicable diseases or any threat thereof.

The Indian response to communicable diseases is governed by multiple statutes, fragmented between the central and state levels. The Epidemic Diseases Act, the primary legislation, provides the powers of the central government in relation to control of communicable diseases. The Disaster Management Act has been employed to deal with the COVID-19 pandemic based on which the disease has been declared a disaster adds another dimension of government action. The state legislations in force in the respective territories empowers the state government and its functionaries to deal with communicable diseases.

The legislation provides for restrictive measures to be placed on those affected or exposed to communicable diseases to prevent the danger to themselves and the public at large. The restrictive measures statutorily provided in the examined statutes include inspection of vehicles, mandatory removal of exposed persons to health facilities, compulsory treatment, restrictions on travel and movement, sealing of state borders. The compliance is ensured by providing varying amounts of penalties including imprisonment and fines. The quantum of punishment for non-compliance varies with the statute.

The research study has observed that such coercion based legislations fails to recognize the principles of public health law like proportionality, least infringement etc. Nor are the statutory provisions in line with the human rights norms as discussed in chapter 3.

Findings of the study include:

1. The Constitution does not provide an express right to health and the obligation of the state to ensure health and well-being is declared by judicial decisions.

2. The legislative powers relating to communicable diseases are spread non-uniformly through the Seventh Schedule of the Constitution. The power to legislate on public health and control of communicable diseases being State subjects and the Central list primarily to deal with port quarantine while prevention of inter-state spread of contagious diseases being in the concurrent list. The disjointed legislative powers bring conflict and prevent a national action especially in cases of epidemics and pandemics which may have greater reach than endemic diseases.

3. The Epidemic Diseases Act, 1897 the Central legislation has limited application and empowers Central Government only on matters relating to persons travelling by vessels, trains etc. The Act fails to define dangerous epidemic diseases and fails to thus provide wholesome exercise of powers in cases of pandemic diseases. The Act is one which has been recommended for repeal yet still in force.

4. The enactment of State epidemics and public health Acts are not uniform. Such enactments are wholly absent in some states. Such a situation results in conflict between states, confusion to the population and disjointed control measures against spread of communicable diseases.

5. The state legislations are still based on experiences of endemic diseases of limited local extent and effect. The legislation as a whole fails to comprehend pandemics and outbreaks with national security implications like bioterrorism. The Central government needs to be empowered to take a more responsible and coordinated action in such situations.

6. The central and state statutes provide for expansion of the state policing powers in the wake of communicable diseases. Statutory provisions in varying degrees provide for devolution of powers to executive authorities like District Magistrates, Deputy magistrates etc. to take

prevention and control measures the list of which is not exhaustive. Such powers so provided are wide reaching and not limited expressly.

7. The statutory provisions so examined employ restrictive measures such as quarantine, isolation, inspection etc. the non-compliance of which attracts criminal liability. The COVID-19 pandmeic has seen the inclusion of heavy penalties especially for offences against health care workers and destruction of hospital property. Deterrence via penalties must not lead to added burden in case of its limited effectiveness.

8. The Livestock importation Act deals separately with disease outbreak potential from animals to humans. The emergence of zoonotic diseases like COVID-19, Nippah, Kyasanur forest disease etc. is not comprehended under the provisions of the Act. The Act provides for control and restriction on import of cattles etc, which is a limited understanding of the origin and spread of zoonotic diseases.

9. State public health acts are in most cases comprising provisions unrelated to the present state of affairs. Most public health statutory provisions still provide for measures such as restriction of use of public libraries, restriction on conveyance etc. The public health Acts provides the local government with the duty of prevention and control of communicable diseases subject to financial constraints of local governments. The Statutes, with exception of Assam Public health Act, fails to provide any binding duty to the Government in terms of health services, sanitation, provision for food and nutrition.

10. Except the Assam Public health Act there is no positive enumeration of rights of individuals affected with communicable diseases. There is a dearth of rights-based health legislations in India.

Suggestions

1. Need for a Rights- based approach: The 15th Finance Commission High Level Group recommended that public health and hospitals be brought under the Concurrent list and also recommended declaration of right to health as a fundamental right. The recommendation included amendment to the Constitution to provide for free and quality healthcare to all citizens in a manner as the state may determine by law. National health

policy, 2017 recognizes the interrelationship between communicable disease control programmes and public health system strengthening. For prevention and eradication of T.B., the policy calls for access to free drugs complemented by affirmative action to ensure that the treatment is carried out, dropouts reduced and resistant strains are contained. For HIV/AIDS the NHP,2017 calls for support in treatment and care. Coming so far in such rights based recommendations the NHP,2017 derogates on the question of a rights based health care law for India citing the need for levels of finances and infrastructure as a precondition for an enabling environment. It advocates a progressively incremental assurance based approach, with assured funding to create an enabling environment for realizing health care as a right in the future. The Ayushman Bharat initiative, proposals for UHC are all part of incremental assurance based approaches. Such assurance based approach though a welcome development over the prevalent system, the COVID-19 pandemic along with coinciding disease outbreaks such as Nippah in Kerala, Kala Azhar in Bihar creates heavy burden on the population. The reasoning of financial constraints should not prevent the rights of the affected individuals.

There is a need to incorporate the human rights protection and ethical principles of public health into the statutory framework relating to communicable diseases to ensure that government action aimed at prevention does not lead to abuse and unnecessary violation of the individual's rights. Towards this end, the National Health Bill, 2009 a draft legislation submitted to the parliament by the Ministry of Health and Family affairs, envisaged a health legislation which at the outset recognised the right of the individual to the highest attainable standard of health intrinsic to the attainment of all other rights and the need to set a broad legal framework for providing essential public health services and functions, including powers to respond to public health emergencies.

The features of the Health Bill include:

a) The draft Act provided for certain definitions to the terms epidemic, communicable diseases etc. Section 2(e) defines communicable diseases as illnesses caused by microorganisms and transmissible from an infected person or animal to another person or animal. Any disease “endemic” means diseases prevalent in or peculiar to a particular locality, region, or people and “epidemic” means occurrence of cases of disease in excess

of what is usually expected for a given period of time, and includes any reference to disease outbreak. Hence, the Bill seeks to give a uniform definition lacking in existing legislations.

b) Chapter II of the Draft solely focuses on the Obligation of the state in relation to health. transparency and equity in the allocation, planning and rational allocation and distribution of resources for health, ensure the enjoyment of right to health and well-being of every person, equally and without any discrimination, universal healthcare, ensuring proportionality when limiting the rights of persons.Section 4 provides that the core obligation of government include provision of equitable distribution of health facilities, food, water, sanitation, housing and specific obligation upon central government regarding public health relating to prevention and control of communicable diseases, Public health emergencies of international concern and so on. Section 6(2) puts obligation upon state governments in relation to disease outbreaks, public health emergencies.

c) Section 7 incorporates the duty of Governments to respect, fulfil and protect. The obligation to respect requires the Government to refrain from interfering or denying the right to health. The Obligation to protect requires the Government to prevent interference from third parties on the right to health. Under the third obligation to fulfil pro-actively facilitate, provide and promote the health rights of persons.

d) Chapter III enumerates individual and collective rights The Draft Bill confers the right to health, right to access, use and enjoy facilities to ensure right to health including food, sanitation, housing etc, right against discrimination, right to dignity and privacy, right to information, right to justice in the form of redressal in case of any violation, right to autonomy and so on.

e) The Bill provides for the establishment of the National Public Health Board as a nodal authority to formulate and implement national health policy and other functions and State Public Health Boards.

f) The Bill envisages redressal mechanism through public hearings, District forums etc. with provision for compensation for violations of rights.

2. Rationalisation of health statutes and need for a national Public health Act

The control and prevention of communicable diseases, especially ones that transcends state boundaries and national boundaries, needs coordinated and uniform action. The multiple health legislations, epidemics Acts, public health Acts, separate legislations for various points of entry like ports, airports etc. results in a fractured and disjointed response that may inadvertently result in spread of disease, which in turn burdens the public. Being governed by different statutes, the efforts of individual states to deal with communicable diseases which know no borders, results in failed attempts at containment, confusion and panic among populations that are in transit like migrant labourers, students, workers etc. There is a need to rationalise the number of legislation relating to communicable diseases with proper devolution and division of powers between the centre and states.

The Ministry of Health and Family Welfare had notified the Draft Bill, the Public Health (Prevention, Control and Management of Epidemics, Bio-Terrorism and Disasters) Bill, 2017 for comments from stakeholders on 13 February, 2017[263].

The features of the Draft Bill that makes it a desired legislation in the present context includes:

- The Draft has its for its object provision for the prevention, control and management of epidemics, public health consequences of disasters, acts of bio terrorism etc. and a scope extending to all of India.
- The Draft Bill section 14 seeks to repeal the Epidemic Diseases Act, 1897 and to override any existing provision in any other law for the time being in force.
- Section 3 of the Draft Bill devolves the power to states, union territories and respective district administrations to prevent, control and manage any public health emergency. States are empowered to restrict activities inimical to public health, quarantine, isolation, medical

[263] MOHFW, https://main.mohfw.gov.in/sites/default/files/Inviting%20Comments%20on%20Draft%20Public%20Health%20Bill%2C%202017.pdf, (last opened Sept 28, 2021).

examination, treatment of those affected such diseases, disinfection, decontamination, inspection of vehicles, detention of persons travelling, dissemination of information, closure of markets etc. Section 4 of the Draft Bill allows the Central government to give directives to the States and Union territories in the implementation of the provisions of the Act and the Central government can intervene and assume the powers under Section 3 where it would be expedient and in public interest to do so[264]. Section 3 and 4 provides clear division of powers between central, state and district governments in the management of epidemics diseases, potentially doing away with multiplicity of legislation on the subject.

- Unlike the existing Epidemics Diseases Act, the draft bill provides definition for Epidemics[265],epidemic prone disease[266], public health emergency[267], public health emergency of international concern[268]. The Draft Bill in its Schedule I lists epidemic prone diseases including HIV/AIDS, Kala azar, Influenza etc.

- The Draft Bill still relies on penal provisions. The contravention of the provisions under the Act invites heavy monetary fine and imprisonment of up to two years under Section 5 yet Section 6 provides avenue for appeal for any person aggrieved by any order under Section 3, 4 and 5 to an Authority to be constituted under the Bill. The Appellate authority envisaged underSection 6 is an added protection against abuse of powers by authorities in an epidemic situation, which is unavailable in the existing regime.

- The Draft Bill recognises the threat of bioterrorism to public health. Section (b) defines bio-terrorism to include "intentional use of biological agents to cause disease or death of human beings or any animal or plant through dissemination of microorganisms or toxins

[264] *Id*,§ 4
[265] *Id*,§ 2 (m) epidemic means the occurrence in a community or region of cases of an illness, specific health related behavior, or other health related events clearly in excess of normal expectancy;
[266] *Id*,§ 2(n) "epidemic prone disease" means a disease as listed in the First Schedule of this Act as may be notified by Central government from time to time;
[267] *Id*,§ 2 (y) "public health emergency" means any sudden state of danger to public health including extension or spread of any infectious or contagious disease or pests affecting humans, animals or plants, occurrence of or threat of dangerous epidemic disease, epidemic prone disease, disaster or bio-terrorism or potential public health emergency requiring immediate action for its prevention, control and management which cannot be dealt with by any law other than this Act
[268] *Id*,§ 2(aa) "public health emergency of national concern" means a public health emergency as declared or notified by Central government from time to time

in and by any medium or any means." Second Schedule of the Draft Bill provides potential bioterrorism agents of bacteria, fungus, virus, toxins kind.

The Draft is not without deficits. Apart from the provision for Appellate authority there is an absence of enumeration of any rights of the individual to health and other needed protections in an epidemic situation. The inclusion of disaster into the object of the Act overlaps with the scope of the existing specific legislation of the disaster management Act, 2005. The definition of disaster[269] under Section 2(g) mirrors the definition under the Disaster Management Act. The Draft Bill does not deviate from applying criminal penalty as the major mode of enforcement of the provisions of it. The elements of coercion, lack of informed consent in treatment and testing etc still prevail in the proposed legislation.

The problem of legislating such national legislations lies in the conundrum of the Seventh Schedule of the Constitution. Such proposed legislations are seen as encroachment on the sphere of the states.Though public health and prevention of communicable diseases comes under the state list, the union list empowers legislation on prevention of inter state spread of communicable diseases only. The High level Group on Health of the 15th Finance Commission had recommended amendment to the Seventh schedule to move the subject of public health to the concurrent list allowing legislation on the matter by both parliament and state legislatures. Proper heed must be paid to the recommendation in the light of experience of the pandemic.

Further, even without such an amendment, the Article 253 of the Constitution allows for the parliament to legislate for the whole or any part of the country to implement the international obligation of India. The need to incorporate the International human rights obligations especially the obligations under the IHR, 2005 can allow for a national legislation on the subject especially when the nation is reeling under a communicable disease of pandemic proportion.

[269] *Id*,§ 2(aa)(g) "disaster" means a catastrophe, mishap, calamity or grave occurrence in any area, arising from natural or man-made causes, or by accident or negligence which results in substantial loss of life or human suffering or damage to, and destruction of, property, or damage to, or degradation of, environment, and is of such a nature or magnitude as to be beyond the coping capacity of the community of the affected area;

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APPENDIX

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