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Government Responses During Covid 19: A Study from India

Uday Shankar and Shubham Pandey

Abstract. From the beginning of 2020 onward, the Government of India was faced with an unprecedented challenge to control the spread of the Covid-19 pandemic and manage the health crisis that was rapidly growing. By the time lockdown was imposed on 24 March 2020, the number of cases of positive Covid-19 patients was steadily rising, within India's the borders. In order to curb the rapid growth of the disease and prevent community spread, the Ministry of Home Affairs (MHA), Government of India, published the official notification and invoked lockdown under relevant provisions of the law. This gave overarching powers to the government to enforce stringent lockdown measures, suspend all transport services, and the closing of government offices, commercial and industrial establishments. Exceptions were specially crafted for services, like police and emergency services, essential services like electricity, water and sanitation, postal, banking and insurance services, manufacture, sale and transportation of essential goods such as food, medicines, telecommunication and internet services including print and electronic media.
The paper examines the Government of India (GoI) responses during Covid-19. It identifies the legal basis of the measures adopted by the government to contain the pandemic and highlights the steps taken up by the executive to deal with crisis.

Keywords: *COVID-19, Pandemic, Horizontal Federalism, Epidemic, Disaster Management, Government Response, Migrant Labors, Health*

1. Introduction

The Government of India was faced with an unprecedented challenge to control the spread of epidemic Covid-19 and manage the health crisis that was growing at a rapid pace. At the time when the Pandemic first hit Indian shores, there were hardly few reported cases in the Month of January and February 2020. By the time lockdown was imposed on 24th March 2020, the cases had grown to 500 positive Covid-19 patients within the borders of India. In order to curb the rapid growth of the disease and prevent the community spread, the Prime Minister of India, Mr Narendra Modi announced a national lockdown for a period of 21 days. He announced that "a total ban be imposed on people, from stepping out of their houses for a period of 21 days."[1]

The Ministry of Home Affairs (MHA) published the official notification and invoked lockdown under section 6 of the Disaster Management Act.[2] This gave overarching powers to the government to enforce stringent lockdown measures, suspend all transport services, closing of government offices, commercial and industrial establishments. Exceptions to activities, like police and emergency services, essential services like electricity, water and sanitation, postal, banking and insurance services, manufacture, sale and transportation of essential goods such as food, medicines, telecommunication and internet services including print and electronic media, were granted. Under the order of the Ministry of Home Affairs, any person who was found to be violating the norms of containment or lockdown measures were held liable under the provision of the Disaster

[1] Press Information Bureau, Government of India, 'PM calls for complete lockdown of entire nation for 21 days' (*PIB Delhi*, 24 March 2020) <https://pib.gov.in /Pressreleaseshare.aspx?PRID=1608009> accessed 20 September 2021.

[2] Ministry of Home Affairs, Government of India, 'Government of India issues Order prescribing lockdown for containment of Covid-19 Epidemic in the Country' (*PIB Delhi*, 24 March 2020) <https://www.pib.gov.in /PressReleasePage.aspx?PRID=1607997> accessed 20 September 2021.

Management Act, 2005, with an imprisonment of up to 2 years, with or without fine.

The paper examines the government responses during Covid 19. It identifies the legal basis of the measures adopted by the government to contain the pandemic. The paper highlights the steps taken up by the executive to deal with crisis.

2. Legal Responses to Covid: Law of Lockdown

The Constitution of India provides for exercise of right to free movement and assemble peacefully in the territory of India under Article 19(1)(b) and (d)[3]. This right however can be restricted, under Article 19(3)[4] and Article 19(5)[5] respectively, in order to maintain public order and in the interest of general public of India. In India, there are laws under which the Union Government has the power to impose 'lockdowns' and 'curfew' and enforce 'quarantine' and 'isolation'. However the terminology so used do not find mention anywhere in any statute, but the essence is captured under various different laws. Let us first have a quick glance over what the respective terms means and later locate where they find legal authority.

2.1. Lockdown, Curfew, Quarantine and Isolation

'Lockdown' The term is used by government officials and others to describe a situation where free movement of goods is restriction, with only essential items, as declared by the Union Government, are allowed. Such restriction is imposed under section 2 and 2A of the Epidemic Diseases Act, 1897 (EDA). Under EDA power is granted to State and Union Government to take necessary steps to control the outbreak of pandemic. Also under the Indian Penal Code 1860, provisions similar to enforcement of lockdowns are provided under section 188 (disobedience of the directions given by a public servant)[6], section 269 (negligent act likely to spread infection of diseases dangerous to life) and section 270 (malignant act likely to spread infection of disease dangerous to life).

'Curfew' The term is used to denote the executive power, available to District Magistrate, Sub-divisional Magistrate or any other executive magistrate under section 144 of Code of Criminal Procedure, 1973. The executive authorities are empowered by law to issue orders under section 144 to prevent imminent threat to human life, health or safety, disturbance of public tranquility, or a riot or an affray. The major difference between lockdown and curfew is that under curfew, the executive authorities like police or magistrates, can detain and/or arrest the person for violating the norms whereas in cases of lockdown, their is no such powers of arrest and detention.

'Quarantine' means separating and restricting the movement of people who were exposed to contagious disease to see if they become sick.[7] It is further defined as a restraint upon the activities or communication of persons or the transport of goods designed to prevent the spread of disease of pests.[8] 'Isolation' means separating sick people with a contagious disease from people who are not sick.[9] This is done to ensure that disease is not spread and the chain of infection is broken at the early possible stage.

[3] The Constitution of India, 1950, Art. 19(1): All citizens shall have the right (b) to assemble peaceful and without arms; (d) to move freely throughout the territory of India.

[4] The Constitution of India, 1950, Art. 19(3): Nothing in sub clause (b) of the said clause shall affect the operation of any existing law in so far as it imposes, or prevent the State from making any law imposing, in the interests of the sovereignty and integrity of India or public order, reasonable restrictions on the exercise of the right conferred by the said sub clause.

[5] The Constitution of India, 1950, Art. 19(5): Nothing in sub clauses (d) and (e) of the said clause shall affect the operation of any existing law in so far as it imposes, or prevent the State from making any law imposing, reasonable restrictions on the exercise of any of the rights conferred by the said sub clauses either in the interests of the general public or for the protection of the interests of any Scheduled Tribe.

[6] S. 188, *The Indian Penal Code*, 1960: Disobedience to order duly promulgated by public servant.—Whoever, knowing that, by an order promulgated by a public servant lawfully empowered to promulgate such order, disobeys such direction, shall, (A) if such disobedience causes or tends to cause obstruction, annoyance or injury, or risk of obstruction, annoyance or injury, to any person lawfully employed, be punished with simple imprisonment for a term which may extend to one month or with fine which may extend to two hundred rupees, or with both; and (B) if such disobedience causes or trends to cause danger to human life, health or safety, or causes or tends to cause a riot or affray, shall be punished with imprisonment of either description for a term which may extend to six months, or with fine which may extend to one thousand rupees, or with both.

[7] Centers for Disease Control and Prevention, 'Quarantine', Covid-19, Centre for Disease Control (*CDC*) <https://www.cdc.gov/coronavirus/2019-ncov/your-health/quarantine-isolation.html> accessed 20 September 2021.

[8] Merriam Webster Dictionary, 'Quarantine' <https://www.merriam-webster.com/dictionary/quarantine> accessed 20 September 2021.

[9] Centers for Disease Control and Prevention, 'Isolation', Covid-19, Centre for Disease Control (*CDC*) <https://www.cdc.gov/coronavirus/2019-ncov/your-he health/quarantine-isolation.html> accessed 20 September 2021.

Though these words are not defined anywhere in the law, there are seminal provisions in the Disaster Management Act and Epidemic Disease Act which give effect to such actions.

2.2. The Epidemic Disease Act, 1896

The law of Epidemic Diseases was enacted to prevent the spread of bubonic plague in erstwhile Bombay, in the year 1896, which forced people to migrate out of the city. It is the shortest Act with only four provisions. Section 2 of the Act empowers the State government to take necessary steps, if it is satisfied that there is a real or imminent threat or an outbreak of dangerous epidemic disease, in any part of that state, and that the ordinary provisions of the law for the time being in force are insufficient to prevent the outbreak of such disease or the spread.[10] The government then by issuing a public notice, may take measures and prescribe regulations for inspection of persons travelling by railway or otherwise, and the segregation and temporary accommodation of persons suspected by the inspecting officer of being infected with any such disease (quarantine and isolation).[11] Similar power is extended to the Central Government under section 2A of the Act, if there is a real or imminent threat of an outbreak of dangerous epidemic disease in India or any part thereof. The Central government also has power to detain persons of vessels, if it is necessary to give effect to the provisions of the law.[12]

The Act also provides for concurring penalty on any person who disobeys any regulation or order made under this Act, similar to that of an offence punishable under section 188 of IPC, 1860.[13] The Epidemic Disease Act of 1897 is an archaic law that was curated to encompass the urgent demands of late 19th century. The law grants sweeping powers to both the State and Central government to take necessary steps to control the spread of epidemic disease. However the law on Epidemic Diseases fails to define what is an 'Epidemic Disease' or 'Dangerous Epidemic Disease' and leaves it entirely on the Government of such determination. The government also has not furnished any list of diseases that are considered as Epidemic, neither it has laid down any criteria for determining the same. In absence of such standards, there is a possibility of the law to be misused or wrongly used by the governments. Further, the law bars any legal proceedings or suits against such persons who act in good faith, to implement the provisions of said Act and prevent the spread of disease.[14] The absence of judicial review makes the judgments of official of the government machinery opaque and raises issues of accountability and transparency in the system. In the ensuing situation, the Epidemic Disease Act has been used in tandem with the Disaster Management Act 2005, which provides for lockdown, containment measures, contact tracing, testing and isolation guidelines[15], restrictions on travel, prohibition on gathering and various other measures to contain the outbreak.

2.3. The Disaster Management Act 2005

The Act provides for administrative framework, rules and regulations, providing measures to deal with the disasters.

The term Disaster has a wide amplitude of meaning which covers any catastrophe, mishap, calamity or grave occurrence in any area, arising from natural or man-made causes, or by accident or

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[10] S. 2, *The Epidemic Diseases Act*, 1897, Act No. 3 of 1897: Power to take special measures and prescribe regulations as to dangerous epidemic disease.—(1) When at any time the State Government is satisfied that the State or any part thereof is visited by, or threatened with, an outbreak of any dangerous epidemic disease, the State Government, if it thinks that the ordinary provisions of the law for the time being in force are insufficient for the purpose, may take, or require or empower any person to take, such measures and, by public notice, prescribe such temporary regulations to be observed by the public or by any person or class of persons as it shall deem necessary to prevent the outbreak of such disease or the spread thereof.

[11] S. 2(b), *The Epidemic Diseases Act*, 1897, Act No. 3 of 1897.

[12] S. 2A, *The Epidemic Diseases Act*, 1897, Act No. 3 of 1897: Powers of Central Government.—When the Central Government is satisfied that India or any part thereof is visited by, or threatened with, an outbreak of any dangerous epidemic disease and that the ordinary provisions of the law for the time being in force are insufficient to prevent the outbreak of such disease or the spread thereof, the Central Government may take measures and prescribe regulations for the inspection of any ship or vessel leaving or arriving at any port in 2[the territories to which this Act extends] and for such detention thereof, or of any person intending to sail therein, or arriving thereby, as may be necessary.

[13] S. 3, *The Epidemic Diseases Act*, 1897, Act No. 3 of 1897: Penalty.—Any person disobeying any regulation or order made under this Act shall be deemed to have committed an offence punishable under section 188 of the Indian Penal Code (45 of 1860).

[14] S. 4, *The Epidemic Diseases Act*, 1897, Act No. 3 of 1897: Protection to persons acting under Act.—No suit or other legal proceeding shall lie against any person for anything done or in good faith intended to be done under this Act.

[15] Directorate General of Health Services, Ministry of Helath and Family Welfare, Government of India, 'Guidelines for Home Quarantine' (*EMR Division*) <https://www.mohfw.gov.in/pdf/Guidelinesforhomequarantine.pdf> accessed 20 September 2021.

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.[16]

The Act provides for integrated process of planning, organising, coordinating and implementing measures which are necessary for preventing disaster situations, mitigating harms[17] and capacity building.[18] The term capacity building implies identification of existing resources and acquiring or creating such resources. It also includes organisation and training of personnel and coordination of such training for effective management of disasters.[19]

The intent of the makers of the statute was to include natural calamities, like cyclones, tsunamis, heat waves, landslides, urban floods, earthquakes & floods, and man-made hazards, like chemical, biological or nuclear. The Act did not provide for disease like pandemics or epidemics. However, due to lack of any other law, for the time being in force, the Union Home Ministry was compelled to notify the Coronavirus outbreak in 2020 as a 'disaster' thus bringing into effects the provisions of the Disaster Management Act.[20] Declaration of Covid-19 pandemic as a 'notified disaster' was one of a kind measure taken by the government to ensure quick administrative actions and decisions to fight the disease. Despite lacking the necessary frameworks and guidelines, to control the pandemic, the governments at both the State and Union level had to take unprecedented steps, like the lockdown, to stop the spread of the pandemic, which do not find any legal backing.

The Ministry of Home Affairs (MHA) published the official notification and invoked lockdown under section 6 of the Disaster Management Act.[21] The Home Secretary issued several guidelines for lockdown under section 10 of the Disaster Management Act, as the Chairman of the National Executive Committee constituted under section 8 of the Act. In furtherance of the nation-wide lockdown, the MHA issued guidelines under section 10(2)(I) of the Disaster Management Act[22] to restrict all types of transport services (air, train and road travel), commercial and private activities. Activities like educational institutions, industrial activities, hospitality services, cinema halls, social/political/sports/entertainment/academic/cultural/religious functions and gathering, place of worship were closed during the period of lockdown, except the essential services like ration-shops, medical shops, banks, ATMs, media and telecommunication services, which were up and running.[23] The order also provided for punishment and penalties in case of violation of lockdown, under section 51 to 60 of the Disaster Management Act, 2005.[24]

There is no comprehensive framework in India to combat with the pandemic of this nature. The

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[16] S. 2(d), *The Disaster Management Act*, 2005 Act No. 53 of 2005: Disaster.

[17] S. 2(i), *The Disaster Management Act*, 2005 Act No. 53 of 2005: Mitigation means measure aimed at reducing the risk, impact or effects of a disaster or threatening disaster situation.

[18] S. 2(e), *The Disaster Management Act*, 2005 Act No. 53 of 2005: Disaster Management activities includes: (i) prevention of danger or threat of any disaster; (ii) mitigation or reduction of risk of any disaster or its severity or consequences; (iii) capacity building; (iv) preparedness to deal with any disaster; (v) prompt response to any threatening disaster situation or disaster; (vi) assessing the severity or magnitude of effects of any disaster; (vii) evacuation, rescue and relief; (viii) rehabilitation and reconstruction.

[19] S. 2(b), *The Disaster Management Act*, 2005 Act No. 53 of 2005: Capacity building.

[20] The Economic Times, 'India declares Covid-19 a 'Notified Disaster' (*Economic Times*, 14 March 2020) <https://economictimes.indiatimes.com/news/politics-and-nation/india-declares-covid-19-a-notified-disaster/articleshow/74631611.cms> accessed 20 September 2021.

[21] Ministry of Home Affairs, Government of India, Order No. 40-3/2020, 'Guidelines on the measure to be taken by Ministries/Departments of Government of India, State/Union Territory Governments and State/Union Territory Authorities for containment of Covid-19 Epidemic in the Country' (*MHA*, 24 March 2020) <https://www.mohfw.gov.in/pdf/Annexure_MHA.pdf> accessed 20 September 2021.

[22] S. 10(2)(I), *The Disaster Management Act*, 2005 Act No. 53 of 2005: The National Executive Committee may lay down guidelines for or give direction to, the concerned Ministries or Departments of the Government of India, the State Government and the State Authorities regarding measure to be taken by them in response to any threatening disaster situation or disaster.

[23] Ministry of Home Affairs, Government of India, Order No. 40-3/2020-DM-I(A), Lockdown measures (*MHA*, 15 April 2020) <https://www.mha.gov.in/sites/default/files/MHA%20order%20dt%2015.04.2020%2C%20with%20Revised%20Consolidated%20Guidelines_compressed%20%283%29.pdf> accessed 20 September 2021.

[24] *The Disaster Management Act*, 2005 Act No. 53 of 2005: The punishment includes punishment for obstruction (s.51), punishment for false claims (s.52), punishment for misappropriation of money or materials, etc (s.53), punishment for false warning (s.54), offences by departments of the Government (s.55), failure of officer in duty or his connivance at the contravention of the provisions of this Act (s.56), offence by companies (s.58).

laws on Disaster Management and Epidemic Diseases do not provide for methodological and operative framework to tackle the spread of present and future pandemics.

3. Executive Responses to COVID-19

3.1. Surveillance

The Government of India launched the Integrated Disease Surveillance Programme (IDSP) which aimed at strengthening/maintaining a decentralised model of laboratory based, IT-enabled, disease surveillance system.[25] This system was implemented in epidemic-prone areas to monitor disease trends, detect and respond to outbreaks during the early phases. This was done with the help of the Rapid Response Teams (RRTs), who were trained to execute such purpose.

To ensure integrated response to the growing threat of pandemic, the Government established decentralised surveillance units at the Centre, State and District levels. The State Surveillance Officers, District Surveillance Officers, RRT's and other Medical and Paramedical staff were trained to administer quick response to the disease through a three-tiered training model. The State and District Surveillance Officers and RRT members were trained at recognised National Institutes. The Medical Officers and District Lab Technicians were trained by Master Trainers at the State level. The Health Workers and Lab Technicians/ Assistants at peripheral institutions were trained by District Surveillance Officer/Medical Officers at the District Level.

The government ensured that information and communication technology (ICT) was optimally used for collection, collation, compilation, analysis and dissemination of data. Under the IDSP, data was collected from epidemic prone areas on a weekly basis. The weekly data provided relevant information about the disease trends, its seasonality, the rapidity of its spread and the total infected people in the district or state. On the basis of the data, wherever the trends related rising of illness, additional resources along with RRTs were deployed in the area to control the spread.

Regular monitoring and data analysis were undertaken by the respective State/District Surveillance Units.

3.2. Active Surveillance

For active surveillance, the Government of India issued Guidelines on Containment plans for large outbreaks of novel Corona Virus Disease (Covid-19) on 16th May 2020.[26] As per the guidelines, the residential areas were divided into sectors, each covering 50-100 households. Each sector was allotted to field workers coming from ASHAs/Anganwadi Workers/ANMs to perform active house-to-house surveillance, daily in the containment zone. All influenza like illness (ILI)/ severe acute respiratory illness (SARI) cases were reported to the supervisory officer, who in turn conducted house visit to confirm that the diagnosis made is as per the required norms and ensure that the suspect cases are shifted to the nearby designated treatment facility. The supervisory officer also was duty bound to collect data from the health workers under him/her, and provided daily updates to the respective control rooms, for further updating in the IDSP system. This data was used State officials for policy formulation and actions.

In addition to collection of Covid related data, record of potential co-morbidities, antenatal history as well as immunisation was maintained during the surveillance process. Advisories were issued to all pharmacists and single practitioners to share data about customers and patients who were purchasing medicines related to ILI or fever. List of such case were forwarded to respective Primary Health Centre (PHCs) for framing quarantine and isolation guidelines in respective areas. Also such data was used for better understanding of infection trends and ensuring the availability of medical facilities in the territory.

3.3. Contact Tracing

The Government of India guidelines also provided for tracing and tracking those individuals who had been in touch with the laboratory confirmed case/ suspected case of Covid-19.[27] All Covid-19 confirmed and suspected cases were listed, tracked and kept under surveillance at home for 28 days, by designated field worker. The supervisory officer was entrusted with the duty to inform the Control room about all the contacts and their residential addresses, and keep surveillance of all the primary and secondary contacts, with the help of field

[25] National Centre for Disease Control, Directorate General of Health Services, Ministry of Health and Family Welfare, Government of India, 'Integrated Disease Surveillance Programme' <https://idsp.nic.in/index4.php?lang=1&level=0&linkid=313&lid=1592> accessed 20 September 2021.

[26] Ministry of Health and Family Welfare, Government of India, 'Updated Containment Plan for Large Outbreaks Novel Coronavirus Disease 2019 (COVID-19)' (*MoHFW*, 16 May 2020) 3, 7 <https://www.mohfw.gov.in/pdf/UpdatedContainmentPlanforLargeOutbreaksofCOVID19Version3.0.pdf> accessed 20 September 2021.

[27] Containment Plan n. 26.

workers. In case the residential address of the contact lay outside the jurisdiction of the a particular district or state, then the officer informed the IDSP to relay the necessary information to concerned supervisory officer of that district or state. The follow-up of contact were done for a period of 14 days, by a dedicated health worker.

The Government of India also launched a Covid-19 dedicated mobile application that had features which enabled for early identification of potential risk of infection and contact tracing.[28] Individual states also developed their contact tracing protocols on the basis of data collected from PHCs and IDSP and in-depth interviews with the patients.

3.4. Containment Zone/ Cluster Management

The Government of India recommended the States to evolve/develop a strategic approach for containing the spread of Covid cases and manage the existing cases. To achieve effect containment and management of Covid, the Government laid down several element that the State were obliged to follow: (a) Inter-ministerial coordination group for Centre-State co-ordination. (b) Early detection through Point of Entry (PoE) screening of passengers, coming from Covid affected territories, on airports, ship ports, land crossing. (c) Surveillance and contact tracing through IDSP of those affected with influenza like illness. (d) Early diagnosis and testing through network of laboratories certified by Indian Council of Medical Research (ICMR). (e) Creating buffer stock of Personal Protective Equipment (PPEs) including N-95 masks, surgical gloves and full body protective suits. (f) Creating awareness among the citizens of the risks associated with Covid-19 and how to avoid them.

Treatment facilities for Covid related cases were readied in the district and many private hospitals were designated as Covid dedicated hospitals. Along with free-of-cost Institutional quarantine centres, several paid Institutional quarantine centres were developed on the basis of public-private partnership (PPP) model. The District Administration took various positive steps to ensure that people living in hotspot areas and containment zones do not face scarcity of essential items including food and medicinal supplies. E-passes were issued to food and medicine suppliers to carry on with their routine business and door-step distribution services were set-up for delivery of essential supplies.

3.5. Testing and Isolation Management

The Government of India issued in the guidelines a series of tests for routine surveillance and monitoring of Covid-19 in containment zones and other point of entry screening.[29] These test included a Rapid Antigen Test, RT-PCR, TruNat or CBNAAT test, to be conducted in order of priority, for all symptomatic cases and asymptomatic contact cases of individuals with high risk. A provision for testing on demand was introduced, which was monitored by the respective State governments. All the testing was done free-of-charge, and the charges were borne out by the Government. In the State of Gujarat, help from specialists were sought to train laboratory personnel on identification of virus. The Ahmedabad Municipal Corporation deployed mobile testing vans across the city for frequent testing and monitoring of the citizens.[30] In the State of Jharkhand, TruNat testing machines were installed in Community Health Centres (CHCs) across the state, which made the centres self-sufficient for detection of Covid-19.[31] This has made local testing quick, easy and reliable for emergency and serious cases.[32] The State of Uttar Pradesh also has employed a similar TruNat and antigens detection assay, in all the PHCs and CHCs for quick, easy and reliable testing of Covid-19. King George Medical University, Lucknow has applied the principle of pooled sampling, which has led to

[28] Ministry of Human Resource Development, Government of India, 'Aarogya Setu App' (*MHRD,* 3 April 2020) <https://www.mohfw.gov.in/pdf/DOSecyHRD.pdf> accessed 20 September 2021.

[29] Ministry of Health and Family Welfare, Government of India, 'Updated Containment Plan for Large Outbreaks Novel Coronavirus Disease 2019 (COVID-19)' (*MoHFW*, 16 May 2020) Version 3, Chapter 8. <https://www.mohfw.gov.in/pdf/UpdatedContainmentPlanforLargeOutbreaksofCOVID19Version3.0.pdf> accessed 20 September 2021.

[30] Ranjan Kumar Ghosh and others, 'Management of the COVID-19 Pandemic in Gujarat' (*IIM Ahmedabad*, 24 July 2020) <https://www.iima.ac.in/c/document_library/Gujarat%20Covid%20Response%20Report-2020.pdf> accessed 20 September 2021.

[31] National Disaster Management Authority, Coalition for Disaster Resiliente Infrastructure (CDRI), 'Response to Covid-19, Jharkhand' <https://ndma.gov.in/sites/default/files/PDF/covid/Jharkhand-eng.pdf> accessed 20 September 2021.

[32] National Disaster Management Authority, Government of India, 'COVID-19 Case Studies' <https://ndma.gov.in/covid/Covid-19CaseStudies>; Government of Sikkim, 'Best Practices by Sikkim for COVID-19 Management and Mitigation' (*Sikkim Herald*, 15 May 2020) Vol. 63, No. 27 <https://sikkim.gov.in/uploads/SikkimHerald/May_15_0_20200515.pdf> accessed 20 September 2021.

reduction of cost by one-third and an increase in laboratory testing capacity by three times.[33]

The Government of India also issued various isolation modalities for Covid-19 positive patients, depending upon the resource availability in each State and Districts.[34] The positive patients were ideally to be shifted to individual isolation wards or accommodated with others in a single ward with good ventilations. Similarly, all the suspected cases were to be accommodated in a separate wards for constant monitoring and medication purposes. In the State of Chhattisgarh, Railway bogies were converted into Covid isolation and care wards for accommodating hundreds of patients. In the city of Raipur, an Indoor stadium was converted into self-sufficient isolation-cum-treatment facility with a capacity of at least 3,000 patients. [35]

3.6. Boosting of Health Infrastructure and Medical Supplies

a. Health Infrastructure

The Government of India in its guidelines provided for three-tier arrangement for managing suspect/confirmed cases will be implemented.[36] For mild and very mild cases, temporary makeshift hospital facilities were made as Covid Care Centres by repurposing hotels/hostels/guest houses/stadiums near a Covid hospital. For moderate to serious cases, dedicated Covid Health Centres were created in existing hospitals. These Centres were equipped with isolation beds with oxygen support from managing moderate cases. For severe cases requiring intensive/critical care, the Government determined Dedicated Covid Hospitals which were equipped with oxygen support and ventilator systems for treatment of severe cases.

The State of Gujarat presented a unique model of Public Private Partnership in terms of management of suspect/confirmed Covid-19 cases.[37] In every District of Gujarat there was at least one hospital which was dedicated for treatment of Covid patients. A two part-pricing arrangement, was adopted in the municipality of Ahmedabad, between the private hospitals and the government for augmenting health infrastructure in the State. Half of the beds in the private hospitals were blocked by the government for providing treatment and care to government referred patients. The cost of treatment was borne, totally be the State government at negotiated rates. In case the designated beds remained vacant or unoccupied at any stage, the Government compensated the hospitals by paying a fixed sum of money to the hospitals. The remainders of 50% of beds in the private hospitals were available to the hospitals at their disposal, to be given to patients, on a payment basis, the upper ceiling limit of which was specified by the Government, under the Essential Commodities Act, 1955.[38]The private hospital employees were designated as Covid employees under the Epidemic Act, and they were not allowed to leave their jobs during the said period. Their service conditions could not be changed adversely and their salaries and allowance were increased proportionally for the services they rendered during such period.

b. Medical Supplies

Several State governments took it upon themselves to ensure that free flow of essential medical supplies is maintained even in times of surged demands. In the State of Goa, during the National lockdown period,[39] liquor manufacturers were

[33] Government of Uttar Pradesh, 'COVID-19 Management and Mitigation in Uttar Pradesh' (Covid-19 Prevention, Control and Treatment) <http://dgmhup.gov.in/documents/Compedium_DOMHFW.pdf> accessed 20 September 2021.

[34] Ministry of Health & Family Welfare, Government of India, 'Updated Containment Plan for Large Outbreaks Novel Coronavirus Disease 2019 (COVID-19) (*MoHFW*, 16 May 2020) Chapter 13 <https://www.mohfw.gov.in/pdf/UpdatedContainmentPlanforLargeOutbreaksofCOVID19Version3.0.pdf> accessed 20 September 2021.

[35] Department of Health and Family Welfare and Medical Education, 'Covid-19 Management and Mitigation in Chhattisgarh, Best Practices' <http://www.cghealth.nic.in/cghealth17/> accessed 20 September 2021.

[36] Ministry of Health & Family Welfare, Government of India, 'Updated Containment Plan for Large Outbreaks Novel Coronavirus Disease 2019 (COVID-19)' (*MoHFW*, 16 May 2020) Chapter 9 <https://www.mohfw.gov.in/pdf/UpdatedContainmentPlanforLargeOutbreaksofCOVID19Version3.0.pdf> accessed 20 September 2021.

[37] Ranjan Kumar Ghosh and others, 'Management of the COVID-19 Pandemic in Gujarat' (*IIM Ahmedabad*, 24 July 2020) <https://www.iima.ac.in/c/document_library/Gujarat%20Covid%20Response%20Report-2020.pdf> accessed 20 September 2021.

[38] National Disaster Management Authority, Government of India, 'COVID-19 Case Studies, State of Maharashtra and Odisha' (*NDMA*) <https://ndma.gov.in/covid/Covid-19CaseStudies> accessed 20 September 2021.

[39] Ministry of Home Affairs, Government of India, 'Government of India issues Orders prescribing lockdown for containment of Covid-19 Epidemic in the country' (*PIB Delhi,* 24 March 2020) <https://pib.gov.in/PressReleseDetail.aspx?PRID=1607997> accessed 20 September 2021.

permitted to produce hand sanitizers to full-fill the local demands. Other Government departments like the health, police and disaster management were given the task of ensuring that there is a free flow of distributions without any illegal activities of hoarding and black-marketeering in the State. The surplus of production was exported to other State to full-fill their own demands.

Similarly in Uttar Pradesh, the Government tasked itself of providing safety equipment's like mask, sanitizers and gloves, to its ASHAs/Anganwadi Workers/ANMs field workers. The demand was estimated at two re-usable masks and a bottle of hand sanitizer for every field worker in the State.[40] The Uttar Pradesh State Rural Livelihood Mission along with National Health Mission, played instrumental role in manufacturing and distribution of masks and sanitizer to not only the field workers but also the community members. In West Bengal, the State government took the onus of manufacturing and providing Personal Protective Equipment (PPE) to its hospital staff and medical workers. It entered into a partnership with the leading textile manufacturer under the West Bengal State Handloom Weavers Cooperative to reconfigure the existing textile machinery, and manufacture PPE kits at the required scale to fulfill the surging demands.[41]

3.7. Medical Waste Management

Apart from the growing pandemic in the country, one the biggest cause of concerns was the handling, treatment and disposal of waste generated during the treatment/diagnosis/quarantine of Covid-19 patients. The Government of India issued guidelines for treatment of such waste in accordance with the Biomedical Waste Management Rules.[42] The Central Pollution Control Board provided extensive guidelines for segregation of bio-medical waste, which included installing separate colour-coded bins/bags/containers in every Covid ward.[43] The State administrative bodies also issued specific directions to every household in their jurisdiction to store medical waste like strings, masks, gloves, medicines, tissues as well as other item that could be contaminated with virus, in a separate bin.[44] The State Pollution Control Board further laid down guidelines for handling, collection, transportation, treatment and disposal of bio-medical waste generated from potential or confirmed Covid cases.[45] The waste is then collected by door-to-door waste collection services provided by the civic body and sent to Common Bio-Medical Waste Treatment facility. In order to ensure stricter implementation of the rules, a nominal fine of $7 has been imposed.[46]

3.8. Delivery of Essential Services

The Government of India issued recommendation to the State to establish dedicated teams within the State and each District to ensure availability of Covid and non-Covid essential services to the citizens.[47] In its recommendations the GoI laid impetus on (a) Mapping all the existing health facilities, including all private and public and not-for-profit institutions within the States. (b) Determine their level of preparedness for dealing with the Covid outbreak and allocate essential resources to them, where necessary. (c) Create dedicated first-level 24*7 hospital emergency units at suitable CHCs/Sub-District Hospitals to provide for non-Covid care, including provision for obstetric

[40] Swaniti Initiative, 'COVID-19 Best Practices Manual for Parliamentarians' <http://www.swaniti.com/wp-content/uploads/2020/08/COVID-19-Best-Practices-List.pdf> accessed 20 September 2021.

[41] Anil Urs, 'Central Government shares 8 best practices followed by States to tackle Coronavirus outbreak' (*The Hindu Business Line*, 2 April 2020) <https://www.thehindubusinessline.com/news/central-government-shares-8-best-practices-followed-by-states-to-tackle-coronavirus-outbreak/article31233171.ece> accessed 20 September 2021.

[42] Central Pollution Control Board, Ministry of Environment, Forest & Climate Change, Government of India, 'Revision 1: Guidelines for Handling, Treatment and Disposal of Waste Generated During Treatment/Diagnosis/Quarantine of COVID-19 Patients' (*CPCB*, 25 March 2020) <https://www.mohfw.gov.in/pdf/63948609501585568987wastesguidelines.pdf>accessed 20 September 2021.

[43] Central Pollution Control Board, Ministry of Environment, Forest & Climate Change, Government of India, Revised Guidelines for Common Bio-medical Waste Treatment and Disposal Facilities' (*CPCB*, 21 December 2016) <https://jspcb.nic.in/upload/uploadfiles/files/Guidelines%20for%20CBWTF.pdf> accessed 20 September 2021.

[44] National Disaster Management Authority, Government of India, 'COVID-19 Case Studies, State of Maharashtra' (*NDMA*) <https://ndma.gov.in/covid/Covid/Covid-19CaseStudies> accessed 20 September 2021.

[45] National Disaster Management Authority, Government of India, 'COVID-19 Case Studies, State of Telangana' (*NDMA*) <https://ndma.gov.in/covid/Covid-19CaseStudies> accessed 20 September 2021.

[46] *Ibidem.*

[47] Ministry of Health & Family Welfare, Government of India, 'Guidance Note for Enabling Delivery of Essential Health Services During the COVID 19 Outbreak' (*MoHFW*, 13 April 2020) <https://www.mohfw.gov.in/pdf/EssentialservicesduringCOVID19updated0411201.pdf> accessed 20 September 2021.

services. (d) Provide for Mobile Medical Units for delivery of services, especially services related to care for reproductive, maternal, new born and child health service, chronic communicable and non-communicable diseases. (e) Patients requiring medical facilities like immunisation, antenatal care, non-communicable disease etc must be encouraged to take prior appointment telephonically, and make visit to peripheral facilities (SHCs/PHCs/UPHCs/HWCs/Urban Health Posts) at the designated time/place to prevent contact with other Covid infected patients. (f) States were encouraged to deploy field workers (ASHAs/ANMs/Anganwadi workers) to pay home visits for providing follow-up care to all beneficiaries. (g) Ministry of Health and Family Welfare (MoHFW) under the GoI issued guidelines for augmenting health workforce availability in the States, by expeditiously filling up existing vacancies, redeploying staff from non-affected areas or facilities, utilising the services of fit retired personnel for non-Covid serves and utilising Human Resource from non-profit organisations and institutions.[48]

In pursuance of the guidelines issued by GoI, many of the Sates took positive steps in the same regard. In the State of Gujarat, the Ahmedabad Municipal Corporation (AMC) developed the concept of providing non-Covid essential health services to the doorsteps of the people in the city (Dhanwantari Rath).[49] The concept proved fruitful, as majority of hospitals in the city were dedicated to the treatment of Covid, hence the State devised the idea of utilising mobile vans for delivering non-Covid essential services, like those, related to diabetes, bold pressure, cardiac ailments, for people who cannot visit hospital at this time. Some Sates also initiated home delivery services of drugs and other essential non-Covid items to the citizens under National Health Programmes like NTEP, NACP.[50]

3.9. Digital Health

The GoI sought amendment to the telemedicine practice guidelines which enabled registered Medical practitioners to provide healthcare using telemedicine.[51] The purpose of the telemedicine guidelines was to restructure and re-model the existing structure of health care services in the country and to encourage the doctors as well as other health care members to use telemedicine services as a part of their routine activity. The guidelines aim to (a) Assist the medical practitioner in delivering effective and safe medical care to the patients in need over the telephone and other virtual mediums. (b) To utilize the full potential of latest advancements in the field of Heath care related technologies.

The guidelines also provide for norms and regulations relating to physician-patient relationship, mitigating issues of liability and negligence, timely evaluation and treatment, prior-informed consent, continuity of care over virtual mediums, virtual referrals for emergency services, digital generation of medical records, maintaining patient's privacy and security during exchange of records and information, online reimbursements, health education and counselling.

The guidelines further providing relevant information of how to integrate latest technologies to provide health care services. These technologies should be used in conjunction with other clinical standards, protocol, policies and procedures established by the government. Various other modalities of appropriateness, safety and effectiveness of telemedicine are also laid down in the guidelines, so that the practitioners feel confident about using them in their day to day practice..

3.10. Welfare of Labours, Migrant Worker and other Vulnerable Groups

Migrant workers are the most marginalised groups of the society who live on daily wages for their subsistence and living. During the time of lockdown, as the industrial establishments were shut and other avenues of income also ceased, the migrant workers faced immediate crisis related to food, shelter, loss of wages, healthcare, concerns of the family, fear of getting infected or spreading the infection. This called for urgent social protection measure to reduce the hardships faced by the

[48] Department of Health and Family Welfare, Ministry of Health and Family Welfare, Governemnt of India (20 April 2020) <https://www.mohfw.gov.in/pdf/MeasuresUndertakenToEnsureSafetyOfHealthWorkersDraftedForCOVID19Services.pdf> accessed 20 September-2021.

[49] Ministry of Health & Family Welfare, Government of India, 'Dhanwantari Rath: Taking Non-COVID Healthcare Services to Peoples Doorsteps in Ahmedabad' (*MoHFW*, 4 July 2020) <https://pib.gov.in/PressReleasePage.aspx?PRID=1636359> accessed 20 September 2021.

[50] Government of Sikkim, 'Centralised Information System for Covid-19' <https://www.covid19sikkim.rog> accessed 20 September 2021.

[51] Board of Governors In Supersession of the Medical Council of India, 'Telemedicine Practice Guidelines, Enabling Registered Medical Practitioners to Provide Healthcare Using Telemedicine' (25 March 2020) <https://www.mohfw.gov.in/pdf/Telemedicine.pdf> accessed 20 September 2021.

migrant workers. The GoI issued recommendations for addressing the psycho-social issues faced by the Migrants during the Covid-19 pandemic.[52] The basic requirement listed by the government included (a) Establishing community shelter and kitchens for migrant workers by the respective state governments where they are located. (b) Providing adequate relief materials to them along with emphasising the need for social distancing. (c) Identify Covid-19 suspected and infected cases and take appropriate steps for mitigating the same, as per the protocols issued by the government. (d) Install mechanism for migrant workers to connect with the family member in distress through means of telephone or video call services.

The Ministry of Labour and Employment issued an advisory appealing to all employers' association not to terminate their employees or cut wages of its workers in view of the lockdown.[53] The advisory also stated that all employers of public/private establishments must extend their cooperation to the governments by not terminating their employees, particularly casual or contractual workers or reduce their wages during the entire period of lockdown. However, the Supreme Court of India allowed the employers to negotiate with the employees on the payment of wages.[54]

All the State government took upon themselves to provide protection and adequate services to the migrant workers living in their jurisdiction or domiciled in the state but have migrated to other State for subsistence. The State Government of Odisha was the first state to announce that it will take care of migrant workers living in its jurisdiction and provide services free of cost during Covid-19.[55] The Odisha government announced a comprehensive welfare package of Rs. 2,200 crores to address the food and security issues of Migrant labours and other vulnerable sections of the society. The measures included distribution of free ration for a three-month period, advance payment of pension under various social security schemes as well as, special financial assistance for construction workers in the State. The State Government of Assam implemented several initiatives for migrant labours returning to Assam, like issuance of job cards, supply of food rations for three months (free of cost), enhancement of daily wages from Rs. 182 to Rs. 202 under the Mahatma Gandhi National Rural Employment Guarantee Act (MGNREGA), allocating 5 kg rice per month to poor families living in the State without a ration card.[56] The State of Chhattisgarh implemented the scheme of providing free ration of rice, gram, jaggery and salt, during the entire period of lockdown, to Below Poverty Line (BPL) households and highly subsidised ration to Above Poverty Line (APL) households in the State.[57] The State of Gujarat distributed free food grains to migrant labours without ration cards under the Anna Brahma Yojana, whereas those labours and migrant workers who possessed ration cards received Direct Benefit Transfers under the Mukhya Mantri Garib Kalyan Yojana. [58]

4. Critical Evaluation of Efforts of the Government

From the beginning of 24th March, India saw one of the severest lockdowns in the world, which was imposed on 1.3 billion people.[59] The first phase of the lockdown was followed my more phases of lockdown, continuing up till 31st May 2020. After that, the government gradually allowed opening of economic, social, cultural and political activities, during the phase of 'unlock'.[60] In this period, people were allowed limited economic activities of sale and

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[52] Ministry of Health & Family Welfare, Government of India, 'Psychosocial Issues Among Migrants During Covid-19' <https://www.mohfw.gov.in/pdf/RevisedPsychosocialissuesofmigrantsCOVID19.pdf> accessed 20 September 2021.

[53] Ministry of Labour and Employment, Government of India (20 March 2020) <https://labour.gov.in/sites/default/files/Central_Government_Update.pdf> accessed 20 September 2021.

[54] See Ficus Pax Private Ltd. and *Ors v. Union of India*, Writ Petition No. 10983 of 2020 <https://main.sci.gov.in/supremecourt/2020/10983/10983_2020_36_1502_22526_Judgement_12-Jun-2020.pdf> accessed 20 September 2021.

[55] National Disaster Management Authority, Government of India, 'COVID-19 Case Studies, State of Odisha' (NDMA) <https://ndma.gov.in/en/media-public-awareness/covid-19-case-studies.html> accessed 20 September 2021.

[56] Government of Assam, 'Best Practices for Covid-19 Management and Mitigation' <https://nhm.assam.gov.in/portlet-innerpage/covid-19-documents-govt-of-assam> accessed 20 September 2021.

[57] Department of Health and Family Welfare and Medical Education, 'Covid-19 Management and Mitigation in Chhattisgarh, Best Practices' <http://www.cghealth.nic.in/cghealth17/> accessed 20 September 2021.

[58] Ranjan Kumar Ghosh and others, 'Management of the COVID-19 Pandemic in Gujarat' (*IIM Ahmedabad*, 24 July 2020) <https://www.iima.ac.in/c/document_library/Gujarat%20Covid%20Response%20Report-2020.pdf> accessed 20 September 2021.

[59] Partha Chatterjee, Soma Dey and Shweta Jain, 'Lives and Livelihood: An Exit Strategy from Lockdown' (*Economic and Political Weekly*, 30 May 2020) 55(22) <https://www.epw.in/journal/2020/22/special-articles/lives-and-livelihood.html> accessed 20 September 2021.

[60] Ministry of Home Affairs, Government of India, 'New Guidelines to fight Covid-19 to be effective from 1st June 2020' (*PIB Delhi*, 30 May 2020)

purchase, based on the guidelines of 'social distancing' issued by the government on the basis of this assessment of the local Covid-19 situation.

Despite the relaxation in the restrictions, travel and economic activities remained dormant in the months following the 'unlock'. The impact of complete lockdown was devastating for both human beings and the economy. The consumption of electricity went down to 30% below the normal, in the entire region of India, till August, highlighting the intensity of the lockdown.[61] The Pandemic had unprecedented effects on public health, livelihood, economy and or ways of living. These effects were exacerbated by the lockdown measures. The Government hastily announced the lockdown, only in the evening before it was to be announced. With the announcement of lockdown and subsequent shutting of economic activities, the government poor mismanagement came to the front and also exposed the vulnerabilities of the working class. From haphazard suspension on of transportation, to mismanagement of information with regards to lockdown, poorly funded public health facilities and inadequate fiscal stimulus packages, it was the 'responses of the government' or 'the govern-mentality associated with the pandemic' has been at the heart of challenges initiated by the lockdown.[62] Let us look at some of the consequences of the responses of the government.

4.1. Migrant Crisis

The most visible impact of the sudden announcement of the nation-wide lockdown was the migrant labour crisis that began in the early months of the lockdown. Due to complete restrictions on the economic activities, daily wagers especially migrants, were rendered jobless overnight. A survey among migrant workers conducted in the month of April-May 2020, revealed that 90% of them did not receive wages from their employers, in various states; 96% did not get rations from the government outlets; and 70% did not get cooked food during lockdown 1.0.[63] The lack of government security compelled the workers to leave their places of work and return to their villages, in order to obtain social security. They however, found themselves in the lurch, as all the means of transport were temporarily shut and there was no alternative arrangements put in place, immediately after the commencement of lockdowns. This led the Migrant labours to undertake long and arduous journeys, on foot, back to their homes. This unexpected eventuality highlighted the vulnerabilities of the working class of the society.[64] The Migrant crisis arose mainly due lack of foresight on part of the GoI which had announced lockdown without any prior deliberation with the States or the employers. It affected the livelihood of around 4 crores internal migrants and around 104 lakh migrant workers had to move from urban areas to rural areas, via means of Shramik trains, busses, trucks and walking thousands of kilometers.[65] Many of whom lost their lives in the process.

In order to mitigate the effects of loss of livelihood of the labours and workers, the government issued relief measure such as the Pradhan Mantri Garib Kalyan Yojana. Under this Yojana, the people who had Jan Dhan accounts were entitled to receive Rs. 500 and Rs. 333 to migrant labours & women and pensioners respectively, per month. However this measure taken by the Finance Ministry was severely criticised by many as sheer tokenism and mockery of the poor.[66] In fact, with the rise in inflation during the period of lockdown and high cost of essential commodities, the amount was meager which did not adequately provided for labours from unorganised sectors, small and medium enterprises, pregnant and lactating women and those suffering from critical ailments.[67] This was in addition to the frequent inclusion and exclusion errors in the official databases, regarding the Public Delivery System (PDS) and Direct Benefit Transfer

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<https://pib.gov.in/PressReleasePage.aspx?PRID=1627965> accessed 20 September 2021.

[61] Editorial, 'Pandemic in the Eyes of the World Bank and the IMF' (*Economic and Political Weekly*, 31 October 2020) 55(44) <https://www.epw.in/journal/2020/44/editorials/pandemic-eyes-world-bank-and-imf.html> accessed 20 September 2021.

[62] Abraham Samuel, Gorky Chakraborty and K. J Joy, 'Emerging Govern-mentality and Bio-politics of Covid-19 in India' (*Economic and Political Weekly*, 12 September 2020) 55(37) <https://www.epw.in/journal/2020/37/commentary/emerging-governmentality-and-biopolitics-covid-19.html> accessed 20 September 2021.

[63] Vibhuti Patel and others, 'Reverse migration of labourers amidst Covid-19' (*Economic and Political Weekly*, 8 August 2020) 55(32-33) <https://www.epw.in/journal/2020/32-33/commentary/reverse-migration-labourers-amidst-covid-19.html> accessed 20 September 2021.

[64] S. Irudaya Rajan, 'Covid-19 led migrant crisis: A critique of Policies' (*Economic and Political Weekly*, 5 December 2020) 55(48) <https://www.epw.in/journal/2020/48/commentary/covid-19-led-migrant-crisis.html> (accessed 20 September 2021).

[65] *Ibidem*.

[66] Sangeeta Ghosh, 'Examining the Covid-19 relief packages for MSMEs' (*Economic and Political Weekly*, 30 May 2020) 55(22) <https://www.epw.in/journal/2020/22/commentary/examining-covid-19-relief-package-msmes.html> accessed 20 September 2021.

[67] *Ibidem*.

(DBT) mode. The inadequacies in official database have been highlighted time and again. The Economic Survey of 2016-17, showed in respect to MGNREGA, that two-fifth of bottom 40% of the population was still not registered as beneficiary for the PDS.[68] As per the Periodic Labour Force Survey (PLFS), there were nearly 55 million construction workers in 2017-18, out of which 20 million workers were left out of the benefits entitled to them under the DBT mode.[69] It is not far-fetched to assume, that the same trend also caught-up several thousands of migrant labours and workers who were not registered as beneficiaries of the DBT and PDS benefits, even after being qualified for the same.

4.2. Impact on Livelihoods and Economic Shutdown

The impact of pandemic and the subsequent lockdowns has inestimable effect on the jobs and livelihood of small and medium enterprises resulting in job losses. In one of the Survey conducted on assessing the impact of Covid-19 on vulnerable workers, it was found that more than 43% of the national workforce was severely affected.[70] The follow up survey, which was taken again after six months, showed 20% of those who lost their jobs during lockdown were still unemployed.[71] The study also picked up the trend in rising self-employment and casual labour (informal) among the previously salaried workers, who were returning to the labour market.[72] According to the study, the most affected were women and younger workers, who lost their jobs very easy and were less likely to recover.[73]

Along with the adverse impacts on livelihoods, the economy also slowed down due to lockdown. In the first half of the year 2020, from Jan- June, the economy shrunk by 15.7% due to closure and shutdown of industries and other economic activities.[74] This slowing down of economy, however had un-equal effects on different sections of the society. With the lockdowns, there has been a rise in savings inequalities among the higher income households and lower income households. Households of higher income groups have seen their income protected and saving rates forced up during the lockdown, ensuring long term future consumption security. Meanwhile the households of lower income groups have witnessed permanent hit to jobs and incomes, leading to degradation in long term future consumption.[75]

In the midst of this crisis, the financial stimulus rolled out by the Finance Ministry has not been able to curb the crisis and restore equilibrium in the market. In fact the GoI did not acknowledge the millions of job losses in both, the informal and formal, sectors and also failed to mention about the plight of migrant workers in their budgets speech in the Parliament.[76] On the contrary, there has been a cut down upon the overall subsidies by 43% and for the outlay of MGNREG employment programme has been cut by 34.5% from the previous budget.[77]

4.2. Public Health

Public health in India falls under the jurisdiction of individual states rather than under the central government, yet the Central Government unilaterally imposed lockdown on the grounds of placing 'life' and 'health' over 'livelihood' and other economic or legal concerns. The model adopted by India in the initial days of the pandemic comprised of macro-lockdown with micro-testing, which was bound to fail to impose a check on the spreading of the disease. In a report published by the World Bank, it was shown that the total number of infection in India, by the end of September 2020, as meander by total Covid-19 cases per million people

[68] Ajit Jha, 'Covid-19 relief package: Will central largesse help construction workers?' (*Economic and Political Weekly*, 25 April 2020) 55(17) <https://www.epw.in/journal/2020/17/commentary/covid-19-relief-package.html> accessed 20 September 2021.

[69] *Ibidem.*

[70] Amit Basole, 'Labour, livelihood and employment in the 2021-22 Union Budget' (*Economic and Political Weekly*, 27 February 2021) 56(9) <https://www.epw.in/journal/2021/9/budget-2021–22/labour-livelihoods-and-employment-2021–22-union.html> accessed 20 September 2021.

[71] Mahesh Vyas, 'Job losses in white and blue collar workers' (*Centre for Monitoring Indian Economy Pvt. Ltd*, 2020) <https://www.cmie.com/kommon/bin/sr.php?kall=warticle&dt=2020-09-14%2021:47:53&msec=416> accessed 20 September 2021.

[72] *Ibidem.*

[73] M. Govinda Rao, 'A budget for pandemic times: Implementations Question' (*Economic and Political Weekly*, 24 February 2021) (56)9 <https://www.epw.in/journal/2021/9/budget-2021–22/budget-pandemic-times.html> accessed 20 September 2021.

[74] *Ibidem.*

[75] Sajjid Chinoy and Toshi Jain, 'Fiscal policy and growth in a post Covid-19 world' (*Economic and Political Weekly*, 27 February 2021) 56(9) <https://www.epw.in/journal/2021/9/budget-2021–22/fiscal-policy-and-growth-post-covid-19-world.html> accessed 20 September 2021.

[76] Editorial, 'A bonanza for corporates' (*Economic and Political Weekly*, 6 February 2021) 56(6) <https://www.epw.in/journal/2021/6/editorials/bonanza-corporates.html> accessed 20 September 2021.

[77] *Ibidem.*

was 4,574 while it was only 2,207 in Bangladesh, 2,670 in Nepal and 1,416 in Pakistan.[78]

What could India have done instead was, that, it could have emulated the South Korean model of mass testing, tracing and isolating without a lockdown.[79] Or it could have developed a sui-generics model, like the Kerala State model, of region specific micro level lockdown with aggressive health measures to control the spread.[80]

The public health delivery system is severely starved with resources and investments, which became amply clear during the pandemic 2020. Even after more than seven decades of Independence, the Centre and States have not been able to co-operate effectively with themselves to establish a robust public health infrastructure in the country. It would not be appropriate to put the entire blame on any one respective government and especially not the one who is in majority during the pandemic. The responsibility of not improving public health standards in India has to be attributed on all the preceding government, who has not done their share of works when they were in the majority. In all this, the most pertinent question that is raised is whether 'public health' be made a responsibility of the centre alone or should the responsibility be shared between the Centre and States, so that the uniformity in health care services are to be maintained.[81]

As we have witnessed, in the preceding year that public health emergencies have the potential to bring down nationals a global economies, and imposing long-term lockdown and other emergency responses cannot be a standard way or the only way to deal with them.[82] India needs to re-think its legal-economic-political responses towards future pandemic and make efforts to develop and improve the public health infrastructure.

4.3. Fabric of Federalism

Apart from exposing the vulnerability of the weaker and marginalised sections of the society, the Covid-19 pandemic has brought to light the GoI's lack of communication and consultation with the State on matters pertaining to legislative competence of the State, (i.e. public health which falls under List II of the Constitution). The situation was made worse by lack of communication amongst the States also, which has aggravated the sufferings of the common people.

There exists a strong vertical relationship between the Centre and the States, which allows the Centre to collaborate with the States in order to pursue a common objective. For instance, in the current pandemic of 20202, the GoI had announced several guidelines to curb the epidemic and had left the substantive part on the state to strategize and develop means to fight the pandemic. However, owing to the nature of pandemic (it spreads rapidly and across borders), it requires a horizontal collaborative and cooperative effort between the states to effectively contain the spread and effectively deal with the existing cases of Covid-19. The question then arises, how can the horizontal relationship between the States be strengthened? Is there any institutional arrangement given by the Constitution of India to deal with issues amongst the States? Can these arrangements be used to contain the epidemic and also create a new governance model for the country?

The horizontal model of Federalism envisages a strong relationship between the constituent units, i.e. the States, with the supervisory power of the Central Government. This framework facilitates effective coordinating between the states on matters of common economic-social-political importance.

The makers of the Constitution of India envisaged the possibility of differences and subsequent dialogue between the States with the support of the Centre. They carved an institutional framework of Inter-State Council, provided under Article 263 of the Constitution of India.[83] The design of Inter-State Council was borrowed from section 135 of the Government of India Act 1935 which was

[78] Rajan, n.64.

[79] Editorial, 'A dilemma for the government' (*Economic and Political Weekly*,13 June 2021) 55(24) <https://www.epw.in/journal/2020/24/editorials/dilemma-government.html> accessed 20 September 2021.

[80] *Ibidem*.

[81] Uday Shankar, Shubham Pandey and Simi Mehta, 'New India? A case for urgent transfer of public health from State to concurrent list' (*Counterview*, 29 April 2020) <https://www.counterview.net/2020/04/new-india-case-for-urgent-transfer-of.html> accessed 20 September 2021.

[82] Editorial, 'Covid-19 Crisis and the centre-state relations' (Economic&PoliticalWEEKLY, 24 April 2021) 56(17) <https://www.epw.in/journal/2021/17/editorials/covid-19-crisis-and-centre–state-relations.html> accessed 20 September 2021.

[83] The Constitution of India, 1950, Art. 263: If at any time it appears to the President that the public interests would be served by the establishment of a Council charged with the duty of —(a) inquiring into and advising upon disputes which may have arisen between States; (b) investigating and discussing subjects in which some or all of the States, or the Union and one or more of the States, have a common interest; or (c) making recommendations upon any such subject and, in particular, recommendations for the better co-ordination of policy and action with respect to that subject, it shall be lawful for the President by order to establish such a Council, and to define the nature of the duties to be performed by it and its organisation and procedure.

known as Inter-Provincial Council, which was responsible for inter-governmental consultations on matters of agriculture, forestry, education, etc.[84] The Constitutional body is provided with the powers to inquire and advise upon issues relating to inter-state disputes, investigate and discuss among States and Centre the issues of common importance, and make recommendations for better coordination of policy and action with respect to such subject, among the States and Centre.

The Inter-States Council remained dormant until 1990, i.e. for four-decades since the Constitution of India came into force, and only came into existence on the recommendations of Sarkaria Commission.[85] Today the Council consists of the Prime Minister along with Union Misters and the Chief Ministers of all States. The Council has also framed guidelines and identified issues to be deliberated upon. It precludes topics that fall under the purview of National Development Council, Finance Commission, and other areas that related to the statutory or constitutional responsibility of the Union. It has further not been assigned the responsibility to resolve disputes, as envisaged under Article 263(a). These normative guidelines have severely restricted and weakened the functioning and autonomy of the Council, which has been time and again also re-iterated by various Commissions.[86]

The Council is one such body that ensures meaningful participation of the States in order to coordinate and develop policy and actions. The Standing Committees notification on re-composition of Inter-State Council suggests that invitations must be extended to experts in the domain, on the issues of vital importance which requires technical guidance and expertise.[87] The Council has huge potential to deal with the problem posed by the pandemic, with require co-ordinate policy efforts and cooperative actions to deal with the same. The futuristic approach of the provisions of the Council provides for a strong alternative forum for collective consideration, deliberations and discussion with the heads of Centre and States, to resolve the problem of large magnitudes, such as the one presented to us in the form of pandemic.[88]

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[84] Uday Shankar, 'Strengthening Horizontal Federalism in India: Role of the Inter-State Council' (*Bar and Bench*, 13 June, 2020) <https://www.barandbench.com/columns/strengthening-the-horizontal-federalism-in-india-need-of-the-hour> accessed 20 September 2021.

[85] Government of India, 'Sarkaria Commission' (*Inter-State Council Secretariat, Ministry of Home Affairs*) <http://interstatecouncil.nic.in/sarkaria-commission/> accessed 20 September 2021.

[86] Inter-State Council Secretariat, Ministry of Home Affairs, Government of India, 'Punchihi Commission' (The Punchhi Commission has stressed that functional independence is must for effective and efficient discharge of roles and responsibilities. The Inter-State Council, being a constitutional body, must be conferred necessary attributes so that it may take up matters of national and urgent importance and engage vibrantly on policy development and conflict resolution) <http://interstatecouncil.nic.in/punchhi-commission/> accessed 20 September 2021.

[87] Ministry of Home Affairs, Government of India, 'Standing Committee, Inter-State Council' (*MHA*) <http://interstatecouncil.nic.in/standing-committees/> accessed 20 September 2021.

[88] See Uday Shankar (2020) note 89.