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COVID-19 Pandemic and Legal Response: A Review of Punjab Infectious Diseases Law

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ABSTRACT

COVID-19 emerged as an infectious disease and was later declared as global pandemic by the World Health Organization. With its ongoing spread COVID-19 carries severe threat to public health across the globe, the gravity of situation has been multiplied by the economic implications of the pandemic, which is causing more pressure on the funding and resources required for running any public health system at national and domestic levels in a jurisdiction. In containing the impact of COVID-19, strong pandemic preparedness and response strategies with supportive public health laws are more desperately required densely populated regions. This paper reviews the legislative framework on control and containment of infectious diseases in the province of Punjab, which is the most populated province of Pakistan and has lately gone through a significant legislative development in the form of Infectious Diseases (Prevention and Control) Act, 2020. The paper seeks to address the main question whether this Act adequately addresses the current challenges in the Punjab province? For this purpose, the Act is analyzed in this paper to examine its legal response framework in dealing with COVID-19. The findings of this study reveal that the Act is inadequate and insufficient, and does not meet the needs of present health crises. It concludes that there is need a comprehensive public health legislation to defeat the challenges and an impact of COVID-19 pandemic. These findings aim to assist policy and law makers to establish practicable pandemic preparedness strategies, translating preparedness 'on paper' to 'in practice'. For conduct of research doctrinal method has been employed with analytical and comparative approach.

1. Introduction

Punjab is the most densely populated province of Pakistan, which according to the 6th Population and Housing Census, 2017 by Pakistan Bureau of Statistics had a population of 110,012,442.[i] Which due to its geographically centered positioning on the country's map and long-established agricultural and industrial economy is comparatively more developed. Due to its population density and the ubiquity of movement for economic needs from one place to the other makes Punjab vulnerable to outbreak of any infectious disease. Corona Virus Disease 2019 (COVID-19) poses a serious threat to this highly populated federating unit of Pakistan. Population density in the capital city of the Punjab province at the rate of more than 6300 people per square meter is alarming, making the city a welcoming spot for spread of any infectious ailment like COVID-19.

Started in China, the Covid-19 was declared as a public health emergency of global concern by the World Health Organization (WHO) on January 31, 2020.[ii] As of date, there are 40,465,956 confirmed cases of infected persons and 1,117,046 deaths caused by the COVID-19 around the globe.[iii] The pandemic with its far reaching impact is a serious threat to public health, national and global economy, directly and indirectly, in the developed and under developed countries around the world.[iv] Pakistan as a member of today's global and inevitably-linked-together international community is not immune to the impact of the COVID-19. As of date, there are total 324,744 cases and 6692 deaths reported in Pakistan as of 21st October 2020. Number of reported cases and deaths caused by the pandemic in different provinces and regions of Pakistan are provided below:[v]

Table: Statistics on Infections and related Deaths in Pakistan[vi]

Province/Region	Number of Reported Cases	Deaths Caused
Azad Jammu & Kashmir (AJK)	3564	84
Baluchistan	15717	148
Gilgit-Baltistan	4091	90
Khyber Pakhtunkhwa	38779	1265
Punjab	101,936	2319
Sindh	142,348	2587
Islamabad (Capital Territory)	18309	199

In light of the above statistics, the number of cases in Punjab are second to Sindh Province only where the very first case was reported. High number of cases in Punjab, a problem which is aggravated by the higher population density in the province, is making it relatively more vulnerable to the threat posed by COVID-19.

Intervention and Response Strategies

The response or intervention strategies to deal with the present situation in any region sharing the footprints of COVID-19 in Punjab, can be classified into four categories:

a) Biological: simply put, it concerns development of a vaccine for the pandemic;

b) Behavioral: it is about modeling of public behaviour in responding to the outbreak;

c) Political: it about response strategies at the level of political leadership; and

d) Structural: it concerns the legislative response in the form of law making.[vii]

In the discussion below, this study will explore the structural response to COVID-19 in the province of Punjab by examining the existing legal framework on control of infectious diseases. It is argued that the structural response works as part of the overall response comprising of biological, behavioral and political strategies. These intervention categories are not mutually exclusive but supplementary to each other as they work engagement of legislative, administrative and community level involvement for making the response efficient. Emergency response, with a combination of these strategies, is a primary need for effective health disaster management, preparedness and response.[viii] These methods necessarily require inclusive plans and policies. To strengthen these plans, there is need of comprehensive legal framework at national and provincial levels.

It is pertinent to highlight that efficient public health structure is developed, inter alia, on a framework devised through legislation, and plays an important role to downplay the impact of an pandemic disease like COVID-19.[ix] Such legislation also plays a vital role in emergency situation through appropriate guidance on rights and obligations of the public as well as the degree of concerned authorities' response to public health issues at international and national level.[x] Legal response does not work in isolation of other measures taken during a pandemic as Martin argues that in addition to law, as a vital tool to contain transmissible and untransmissible diseases, social measures authorized by regulatory framework are not less important than medical interventions.[xi]

According to a report of WHO in 2016 on assessment of core capabilities of Pakistan under the International Health Regulations (IHR), different infectious diseases out broke from time to time in the country and its health system failed to respond appropriately to most of them.[xii] It is argued that such failure is not solely attributable to the public health framework as de facto reality, but is also linked with legal framework. Even in case of biological and behavioral interventions, still there will be need of having appropriate legal framework

governing response strategies for efficient working of a public health system in the form of 'structural intervention'.

In view of the above argument for having a coherent response strategy to deal with outbreak of an infectious disease, the infectious diseases law in the province of Punjab will be analyzed after an historical overview of the statute on the subject.

Historical Survey of the Infectious Diseases Laws in Punjab

Before passing of 18th Amendment to the Constitution, the subject of infectious diseases, being part of the federal legislative list, was under the legislative domain of the Parliament of Pakistan, comprising the National Assembly and the Senate. Federation of Pakistan, after its independence from British rule in 1947, inherited a plethora of statutes enacted during the colonial era. Some of these laws are too old, even dating back to the second half of 19th century. On control of infectious diseases, the first footprints of legislation on the subject is found in the Epidemic Diseases Act of 1897, which came into force on February 4, 1897 to provide for a basic legal framework for dealing with outbreak of plague in Bombay, now part of India.[xiii] At time of independence, Pakistan did not have a legal framework of its own in the field after the independence in 1947. The country facing challenges in relation to dealing with migrants from eastern borders, distribution of assets and a feeble administrative system had no other option except to adopt the laws enacted in British India.[xiv] This said Act of 1897 was adopted by Pakistan in 1958. The only change effected into the Act by way of adoption was substituting the word 'India' with 'Pakistan' and it was renamed as the West Pakistan Epidemic Diseases Act, 1958.[xv]

After passing of 18th Amendment in 2010, when the health-related legislation became a subject of provincial legislature, the West Pakistan Epidemic Diseases Act, 1958 was adopted by the Provincial Assembly of Punjab and its title was changed to the Epidemic Diseases Act, 1958 through Epidemic Diseases (Amendment) Act, 2011. The only changes to the Epidemic Diseases Act were concerning its extent of application as it was tailored to apply to the province of Punjab alone.[xvi] Previously it was a federal statute. Given the history of this one of the oldest pieces of legislation hailing from 19th century and its sheer briefness, the Act should have been amended earlier, ideally in 1958 at the time of its enactment by the West Pakistan Assembly, which did not happen. Later in 2011, at the time of its adoption and passing by the Provincial Assembly of Punjab also no changes or update was considered by the legislators, ignoring the importance of this law as the only legal tool at the disposal of Provincial Government of Punjab to employ structural intervention strategy.

It was only when COVID-19 started spreading across the country in February 2020 that the need of a better legislation was felt in Punjab. Given the urgency of the situation and mounting pressure on the provincial health structure due to

increasing number of cases, the new law was issued in the form of an 'Ordinance' by the Governor of the Punjab, titled the Punjab Infectious Diseases (Prevention and Control) Ordinance ("PIDO" or "Ordinance") on March 27, 2020. It is worth highlighting that the law was not issued as an Act of Provincial Assembly of Punjab, but as an 'Ordinance' which is a special piece of legislation under the Constitution of the Islamic Republic of Pakistan which allows promulgation of an 'Ordinance' by the President of Pakistan at Federal level and by the Governor a Province at provincial level in special circumstances. According to Article 128(1) of the Constitution:

"The Governor may, except when the Provincial Assembly is in session, if satisfied that circumstances exist which render it necessary to take immediate action, make and promulgate an Ordinance as the circumstances may require."

An Ordinance so issued by the Governor is deemed to have effect of an Act of the Provincial Assembly, though in order to be permanently treated as an Act, it has to be laid before the Provincial Assembly as a bill and then be approved after debate. Constitutionally, the above Ordinance issued by the Governor in March, 2020 was not a permanent piece of law, as it was bound to stand repealed after a period of ninety days from the date of its promulgation, or even before that if the Provincial Assembly passed a resolution disapproving the Ordinance.[xvii] However, the Provincial Assembly by its resolution, within the constitutional limitation of ninety-days, passed the said Ordinance as an Act on July 15, 2020 to save it from lapse, naming it as Punjab Infectious Diseases (Prevention and Control) Act 2020 ("PIDA" or "Act").

It is noted that despite the contents of the PIDO were supposed to be presented as a bill pursuant to Article 178 of the Constitution. However, despite having been tabled as a bill in the Provincial Assembly and passed so, no changes were made to the Ordinance except of nomenclatural nature to amend the title of the law. For the purpose of analysis, the content of the PIDA will be discussed in the upcoming section:

For "prevention and control of infectious diseases and matters ancillary and connected thereto". Thus, review of public health systems preparedness does not complete without evaluating the current legal framework which needs more deliberations and warrant a relook at significant issues including: definition of pandemic disease, quarantine and its area, territorial boundaries, ethics and human rights principles, authorization, duties and liabilities of officials, immunity/ protection of officials and penalties. So, this study is conducted in this perspective.

The Punjab Infectious Diseases (Prevention and Control) Act, 2020

The objective of the Act is "prevention and control of infectious diseases in the Punjab and matters ancillary and connected thereto".[xviii] It comprises of six Parts, each dealing with a specific subject within the Act. Below will be

analyzed various aspects of PIDA to highlight the issues covered and missed out in this latest piece of legislation on infectious diseases amid COVID-19.

Definitional Issues in the Preliminary Part 1

Part 1 of the Act provides introduction and definitions under section 1 and 2 respectively. In any legislation on a particular subject like infectious diseases is expected to provide a definition of what an infectious disease is. Such definitions primarily provide for a constituent element which cause for application of such law. For example, legislation on the subject of media will be deficient without an articulate definition of what is media. In case of the PIDA, it is noted that it does not provide a definition of 'infectious disease' or an epidemic.

It is normal for infectious diseases laws to provide for a definition of its main subject, the infectious disease. Numerous examples can be quoted from different jurisdictions to support this argument that a law like PIDA should have provided a clear definition of infectious diseases, infection or epidemic. While these terms are particular to the field of biology and its specialized branch virology, they are equally important to be defined in the legal context in the laws aimed at control of such diseases. To reinforce the need of avoiding such definitional lapses, it is pertinent to quote examples from outside Pakistan.

For instance, in Vietnam, the Law on Prevention and Control of Infectious Diseases, 2007 (Vietnamese Law) defines an infectious disease as 'a disease that transmits directly or indirectly from humans or animals to humans due to agents of infectious disease…'.[xix] It is interesting to note that Vietnamese Law not only define an infectious disease but also goes on to categories infectious diseases into three categories: A, B and C. Each category puts together certain infectious diseases into one category in view of the level of risk posed by them. For example, Class A infectious diseases are those 'extremely dangerous' and can 'spread rapidly' with 'high mortality rate'.[xx] The Vietnamese Law is admirably comprehensive and reflects a progressive approach mainly due to its formulation in relatively recent past as it includes post-2000 infectious diseases like SARS which emerged in 2003. It also caters to an epidemic situation like the one caused by COVID-19 by providing a definition of what constitutes an epidemic. It defines when an infectious disease can become an epidemic by defining it as 'the occurrence of an infectious disease in a number of persons exceeding the normal projected number of persons during a particular period and in a given area.'[xxi]

China applies a similarly comprehensive approach through the Law on Prevention and Treatment of Infectious Diseases, 1989 (Chinese Law) by proving a classification of the infectious diseases by categorizing them into Class A, B and C.[xxii] The apparent reason for such classification seems to the detailed approach which enables adopting of appropriate measures corresponding to the severity of the infectious diseases. It is noted that though classification of infectious diseases under Vietnamese and Chinese laws may

differ. For example, influenza is categorized under Class B in Vietnamese Law and the same is classified under Class C in the Chinese Law. However principally, the legislative approach is similar.

On the other hand, the drafters of PIDA seemed to be content with not having a definition of an 'infectious disease', 'epidemic' and the classification of infectious diseases. It is an unignorable lapse in the Act, which may have significant impact on the application of response strategies. For example, a response strategy dealing with a Class C (assuming not an extremely dangerous infection), will not recommend employment of measures recommended for tackling an extremely dangerous disease. The same way, it will be difficult to identify when an infectious disease will reach the level of an epidemic unless it has been articulated within the legislation, like in Vietnamese Law.

In addition to the above, even on response measures the definitional issue is very much there. Quarantining is an important response measure under the Act, however, the expressions 'quarantine' and 'quarantine area' have not been defined. In fact, it is silent about quarantine specifications, procedures etc. According to Saqlain *et al*, this shortcoming is having severe impact in practice as major difficulties faced in controlling COVID-19 are concerning quarantine.[xxiii] The Act employs the term 'place of retention' but does not define it. This issue is particularly relevant not only in terms of response measures but also as a human rights concern for the reason that retention of person is exceptional measure that curtails his freedom of movement. It is perhaps this concern that some critics see it as a problem for government to handle it.[xxiv]

The definitional issues in the PIDA are not only absence of important definitions like the one discussed in the above paragraphs, but also vagueness and lack of clarity. For example, a 'medical officer', under the Act has been entrusted with several powers and functions. Under section 2(e) of the Act, a "notified medical officer" has been defined vaguely as somebody "notified for the purpose of the Act by the Secretary". Eligibility criterion has not been specified concerning issuance of notification for skills, experience, salary package, scale grade an academic credentials of the medical officers.

Human Rights Concerns

It is noted that PIDA is an emergency legislation, which like any other emergency laws is likely to give rise to doubts as to its implications in a post-emergency scenario. Jonathan observes that COVID-19 has led to imposition of strict measures by the governments which include restrictions on freedom of movement and doing business and even placing infected persons in isolation centers.[xxv] These concerns are not unfounded and ethical concerns have been raised by concerned quarters like the European Group on Ethics in Science and Technologies (EGE) which highlighted a 'significant danger of any emergency legislation' that is likely to establish a new 'normal' of shattered rights and liberties in a post-emergency world.[xxvi]

In view of the above concerns, it is observed that PIDA, an emergency legislation now made an act of Provincial Assembly, does not make any reference to the protection of human rights. However, it appears that in terms of restricting movement or retention of an infected person, while the Act seems to have reserved discretionary powers for the Provincial Government, its health representatives and those exercising executive authority under thereunder, it has also placed some limitations on the time of retention. For example, under Section 10(3) of the Act, a medical practitioner has authority to retain a potentially infected person for not more than 48hour period in the beginning. However, such limitation can be qualified and a person can be retained for a period beyond 48 hours if in the opinion of the concerned medical officer, such person is required to be retained. In such case, there is no limitation and the patient can be retained for an indefinite period of time subject to assessment of the medical officer.[xxvii] The basis of authority to retain a person is premised on the assessment of medical officer. Such retention is primarily a restriction on right to freedom of movement under Article 15 of the Constitution of Pakistan which reads:

"Every citizen shall have the right to remain in, and, subject to any reasonable restriction imposed by law in the public interest, enter and move freely throughout Pakistan and to reside and settle in any part thereof."

In view of Article 15, the objective criterion of imposing a limitation on freedom of movement is 'reasonable restriction imposed by law in the public interest'. What may constitute 'reasonable restriction' has to be seen in view of the case law developed in Pakistan. The Lahore High Court held a reasonable restriction under the Constitution and the prohibitions under the law, has to be scrutinized. The Court provided an objective test for a restriction to be qualify as reasonable that it must be "substantive, real, proximate, tangible and immediate and not remote, conjectural or far-fetched."[xxviii]

Thus, it can be argued that a restriction imposed on a potentially infected person based on the opinion of a medical officer is reasonable, as only a qualified medical practitioner can assess the condition of an infected person, which is rightly considered by the drafters of the PIDA and further qualified by 'pre-conditions' in Section 15 of the Act recognizing the principle of proportionality, the interest of the infected person and public at large. However, it is also noted that in addition to the medical officers, the Secretary of the Provincial Government under Section 10(3)(b) of the PIDA with the approval the Chief Minister can order a retention beyond 48 hours in view of 'circumstances related to' infectious diseases. The does not explain what those circumstances could be, in addition to the risks assessed by a qualified medical officer? The Secretary to the Provincial Government is representative of the executive authority of the Government, and unless exercise of his authority in restricting a person is reasonably qualified, i.e. based on assessment of a medical officer, cannot be justified.

In case of persons posing 'significant risk', a medical officer may place restrictions on such person for a maximum period of 14 days, which can be extended based on the assessment of the concerned medical officer. However, at the same the power to extend such period of time has been reserved for the Secretary who can order extension of restrictions beyond 14 days with the approval of the Chief Minister under Section 12(3)(b) of the Act with ditto text found in Section 10(3)(b). These powers of extension of retention and restraint period reserved for the Provincial Government without objective qualifications does not inspire confidence of reasonability. Therefore, it is argued that such powers vested in the Secretary, that is executive authority of the Provincial Government, under Section 10(3)(b) and 12(3)(b) of the Act cannot be justified as 'reasonable' within the spirit of Article 15 of the Constitution.

Another important aspect missing from the text of PIDA is the issue of discrimination against the infected persons and publishing their identities and images. In Vietnam, the issue has been approached with more sensitivity as Article 9(5) of the Vietnamese Law provide that it is prohibited to:

"Discriminat[e] against and publishing negative images of and information on persons suffering from an infectious disease." (Clarification added)

Person infected with an infectious disease are already vulnerable to discrimination due to a medical condition which is not their choice. The trauma of suffering from a viral disease can be added by the trauma of being discriminated against by publishing of their images and reporting on them in the media. Though PIDA provides for confidentiality of the information concerning an infected person in Section 27, however, it is important the PIDA should have expressly provided against discriminatory treatment of people suffering from an infectious disease especially keeping in the view the media hype that is surrounding the present epidemic. The issue is so sensitive that New York based Covid-19 Working Group has issued specific guidelines on Media Communications so that the infected people are not discriminated by media and thus stigmatized.[xxix]

Concept of use of 'Reasonable Force' and Police Powers

In addition to the powers under Sections 10 and 12, the Act also provides for 'ancillary powers' for a medical officer or a police officer under its Section 16, which allows a police officer to use 'reasonable force'. The Act itself does not elaborate the concept of reasonability. In order to understand what should be reasonable, one has to look into the case law developed by the superior courts in Pakistan. As per Supreme Court's observations in *Maudoodi v. Government of Pakistan*, 'the reasonableness of the mode of application of the restriction whether such mode be prescribed by the statute or not'.[xxx] Apparently in view of this precedent, the concept of reasonableness of use of force should have been provided within the Act. Not only the power to use reasonable force has been vested in the police officers but also power to apprehend an individual has also been ordained by the PIDA under Section 16(4). This combination of

powers has been supplemented by more questionable power, vested in a police officer of Sub-Inspector level, to enter any premises while exercising his authority under the PIDA.

Without providing for an objective criterion for exercise of police powers within the Act, it is argued that such powers are not unlikely to be misused. This issue, outside the statute, needs to be examined in view of the police attitude towards public and use of violence. There have been numerous incidents of police manhandling, beating and inhuman treatment of persons. For not wearing masks, people were tortured by police on public places. In the second largest city of Faisalabad in Punjab Province, police were reported using shock-wave gadgets, stun-guns, on adults and minors alike. The stun-guns inflicted on the victims not wearing masks were reported to cause, for few seconds, loss of balance, muscle control, mental confusion and disorientation.[xxxi] It is noted that this incident in Faisal Abad, reported in international media, took place after promulgation of PIDA coming into force as an Ordinance. The question of reasonability hanging between the concept of use of 'reasonable force' and the on-ground reality looms over the provisions of PIDA. In the provincial capital, Lahore, police were reported issuing fines for violation of SOPs, while the figures of fines for such violations were not yet approved by the relevant authority.[xxxii]

Under Section 22 of PIDA, the Deputy Commissioner as administrative officer of the district is empowered to issue an order to his subordinates or police officers and for enforcement of such order, the Deputy Commissioner, his subordinates or police officers can:

(a) Enter any premises;

(b) Detain a person for up to 24 hours; and

(c) Use 'reasonable force' to ensure compliance.

It is noted that while the Act allows filing of a revision petition against an order, instruction or restriction imposed by a medical officer or a police officer may be filed against a board comprising of the concerned Commissioner and the medical officer notified by the Secretary of the Ministry of Health, Punjab. It appears that any grievance arising out of an ill imposed order or restriction has been kept out of the judicial purview under the PIDA by creating a forum within the executive and keeping out of the judicial purview. While this can be argued that the in an emergency situation like COVID-19, providing for the revision or appeal forum within the executive structure is more plausible approach as it might be time-effective since judicial recourse is more likely to take time. However, this argument is implausible for the reasons: first that it violates the principle of separation of executive and judicial authority; and second that summary procedures are available in action before normal court of law.

Public Responsibility vs. Government Responsibility

From overall scheme of the PIDA, it appears that the Act is more focused on creating obligations for the citizens. For instance, the duty to inform has been imposed on the public, however, the Act does not provide for sharing this duty with the part of the Government to inform and educate public as is the case in Vietnam. On a closer look into Section 4 to 6, 11, 12 and 14, it appears that the Act extravagantly focuses on layers of duties imposed on the public, sometimes directly terming those as *duties*, and at times creating their effect through the powers reserved for Government officials. For example, Section 11 of the PIDA places duty to inform on the following persons:

(a) Head of family

(b) Healthcare services provider

(c) In-charge of an educational institution

(d) In-charge of services like transport, hotel, hostel etc.

(e) In-charge of place of worship

However, no corresponding duty has been ordained for the Government and its functionaries that it will be their primary duty to inform and educate public concerning an infectious. As compared to the persons who under duty to inform, the Government machinery is better-positioned to inform public. No doubt, in circumstances of spread of a viral disease, these persons enjoined with the duty to inform play an important role in identifying the trail of virus and to curb its spread at places of public gathering, however, it is also a principle in dealing with infectious diseases that information management is actively undertaken by the authorities in-charge of combating the disease. We can see its example in the Vietnamese Law which provides a mechanism for dealing with an infectious disease through express provisions on information management, and not simply imposing a duty on the public.

It is observed the overall scheme and focus of the PIDA is more on reserving extensive powers for the persons acting under the Act and to protect them from any proceedings in case any loss or damage is caused to the person or property of a citizen as is evident from Section 26. It seems police as law enforcement apparatus has been vested with extensive powers when examined in the light of incidents and historical evidence of police excesses in Pakistan. This power-oriented approach of the Act is evident from the Ancillary Powers under Section 16 and the provisions concerning Offence and Penalties in Chapter V of the Act.

Unattended Questions

In addition to the above issues, there are certain unattended questions popping out of perusal of the PIDA. Under the Act, a medical practitioner has extensive

authority in handling the patient, which may result in suffering for the patient. This discretion can create problems if he conducts a medical checkup wrongly or refuses to do. There is no remedy for the patient suffering either due to medical negligence and denied treatment. For example, whether there is legal remedy available to them if they cause any damage? The issue is unanswered under this law. The central point feature of this law is to mitigate the COVID-19 pandemic. So, its enforcement can be very hard if it does not succeed to establish a mechanism or is applied wrongly. In reality, the objective of the current law itself defeats if it does not address the virus infected people.[xxxiii] In the absence of these measures, there is also immunity clause 26 which protects medical practitioner from being liable saying that "no order made under the Act shall be called in question in any court and no civil or criminal proceedings shall be instituted against any person for anything done in good faith against any person for any loss or damage caused to, or in respect of any property whereof possession has been taken under this Act". According to this section, medical practitioner escapes from the liability even duty exercised by him negligently, as it is very hard to prove particularly in emergency circumstances such as COVID-19 pandemic.

The PIDA under sections 17-20 categorize penalty according to the level of offence committed by the offender. It is mentionable here that although Government has articulated other regulations, but have not been incorporated in this Act. Section 4(a) of PIDA, provides authority to the Secretary, by the approval of Chief Minister, to give directions to medical practitioners handling victims of the virus. The responsibility to treat the victims is very risky for their own lives also, so it is probable they may refuse to comply with directions. Can a practitioner leave his job? If yes, then what should be the basis? These issues have not been included expressly. For these reasons, practitioners are being excused for not following the said directions.[xxxiv]

Safety of practitioners as well as health workers is very important to deal with an epidemic spread, especially, the current situation. But these have not been included in PIDA, particularly for staff working in emergency wards. The essential precautions for doing their duties have also not been stated. The question here is: should not the higher authorities have any duty for this purpose? Similarly, under sub-clause (c) of section 4, the medical practitioner has responsibility to wear protective dress while on duty. It is not stipulated, who will provide the necessary protective dress. In this regard, the duty of Government to provide complete protective kits to the practitioners and staff has not been fixed. As a result, if the practitioner or worker suffers, whether the Government is responsible for any loss?

Under this backdrop, it is stated here that the current PIDA is silent on the responsibility of the Government amid public health emergency like COVID-19, which leads to plausible questions like: whether the steps taken by the Government functionaries will be evidence-based. Duration of any restrictions is suitable and in which circumstance breach into the privacy of a citizen can

be considered proportional. Similarly, the economic implications of pandemic have not been taken into consideration by the drafters of PIDA.[xxxv] For instance, whether a daily wager infected and quarantined will be provided with any relief in terms of any discount in his house rent or food for his dependents?

2. Conclusion

Under the above careful review, this research finds that PIDA is inadequate and insufficient, policing in nature and does not cover all aspects of current public health crises caused by Covid-19 in the province of Punjab. This paper concurs with the view of Arshad that despite promulgation of this Act, the question of wellbeing of infected patients has not been settled and is still controversial issue in Punjab.[xxxvi] It concludes that Punjab government needs an inclusive and single public health legislation with more deliberations and warrant a relook at issues highlighted in this paper as well as practical implications and challenges faced on the ground by the Government in implementing the mandate of PIDA.

Conflict of Interest

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