Submission to NHRC committee to assess "impact of the COVID epidemic on people's human rights"

Thematic Group on "HEALTH"

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[1] (2017) 10 SCC 1

1. Respect for human rights must be central to the law and policy response to epidemic control

1.1 The COVID-19 pandemic has witnessed countries undertaking legal and policy changes that are increasing and normalizing mass surveillance, measures to monitor movements of individuals across the world, assumption of extraordinary emergency powers that may extend beyond the pandemic itself, large scale quarantine and isolation, and unprecedented lockdowns in national and security interests. Further, the pandemic is witnessing a scramble to use digital health technologies for a whole host of tracking, tracing, surveillance and containment measures.[2] New applications for digital contact tracing and artificial intelligence (AI) using Big Data and machine learning (ML) for screening of the population and assessing infection risks have been developed.

1.2 These measures have fuelled a global debate on the need to balance emergency powers of the State with civil liberties and fundamental freedoms of the citizens. The UN High Commissioner for Human Rights has stated that **protection of human rights must be central to the COVID-19 response.**[3] The UN Special Rapporteur on the Right to Privacy has warned that invasive digital surveillance could "cause lasting damage to the right to privacy" across the world; and stressed on checks and balances as "dictatorships and authoritarian societies often start in the face of a threat."[4] Protecting rights and empowering individuals advances the health of the whole population. Ensuring consent, confidentiality and non-discrimination, promoting dignity and non-stigmatization of patients, and improving access to affordable and quality treatment and diagnostics, has positive impacts on the health and well-being of all. People's confidence in the health system increases, they themselves are keen to engage with it, and seek out health information and services.

1.3 As enhanced powers of the State and steps undertaken during public health emergencies encroach upon rights of citizens, the law as laid down in the landmark judgment in ***Justice K. S. Puttaswamy (Retd.) v Union of India*** requires that (a) The action must be rooted in and sanctioned by law, (b) The proposed action must be necessary for a legitimate aim, (c) The extent of such interference must be proportionate to the need for such interference, and (d) There must be procedural guarantees against abuse of such interference.

[2] COVID-19, Information Problems, and Digital Surveillance. March 20, 2020. Centre for Global Development. https://www.cgdev.org/blog/covid-19-information-problems-and-digital-surveillance

[3] United Nations Policy Brief on COVID19 and Human Rights: We are all in this together. April 23, 2020. https://www.un.org/en/un-coronavirus-communications-team/we-are-all-together-human-rights-and-covid-19-response-and

[4] Coronavirus surveillance poses long-term privacy threats, U.N. expert warns. March 31, 2020. https://in.reuters.com/article/health-coronavirus-privacy/coronavirus-surveillance-poses-long-term-privacy-threat-u-n-expert-warns-idINKBN21I1WU

1.4 A legal framework for disease control in the interest of public health security is essential to provide: authority to the State to take necessary measures to control an epidemic which would otherwise be illegal, enhance the public health capacities to respond proactively to threats of epidemics; provide substantive guidance to the states to determine 'when' and 'how' to act; provides checks and balances for exercise of the authority; protect rights of citizens; and increase transparency and accountability of the State towards the public.

1.5 As a culmination of a decade long process which got accelerated by the SARS epidemic, WHO revised the ***International Health Regulations*** (IHR) in 2005 to align it with the changing public health priorities in a globalized world, taking into account different types of threats to public health, varied information systems available and the need to enhance health systems capacities in developing countries to tackle existing and emergent epidemic prone diseases. The IHR 2005 mandates states to revise their legislation to align with the IHR 2005, including development of the necessary public health capacities and legal and administrative provisions. Further, it categorically states that the **implementation of IHR shall be with full respect for the dignity, human rights and fundamental freedoms of persons** in accordance with the Charter of the United Nations and the principles of international law.

2. Rights violations in response to COVID-19

(limited to instances of violation of confidentiality and privacy, police excesses, conditions on quarantine/isolation facilities etc.)

The Indian response to control the spread of COVID19 has focused more on police powers of the state and little on ensuring protection of the rights of citizens (civil, political and socio-economic). This is chiefly because India's legal framework to deal with epidemics – ***Epidemic Diseases Act 1897*** (EDA) – mentions only the *powers* to be exercised by the State but does not describe the government's *duties* in preventing and controlling the epidemic, does not explicitly state the *rights* of the citizens, does not provide substantive and procedural safeguards to prevent excesses, and does nothing to ameliorate the impact of epidemics on people's lives, for instance, loss of livelihoods. This gives rise to unreasonableness and arbitrariness in state action, aggravates the existing structural inequities in our society, and disproportionately impacts the weakest socio-economic groups and other marginalized sections of our society, which is antithetical to our constitutional values.

2.1 Rights violations related to confidentiality/ privacy of health information & status

The Indian response has seen varied measures that have serious implications for rights to consent, privacy and confidentiality and have caused stigmatization and harassment of affected people, which are not only violation of their individual rights but also detrimental to the control of the pandemic. The government has allowed stamping of

hands of home quarantined people with indelible ink.[5] In **Karnataka**, the government mandated all those quarantined to send selfies every hour throughout the day [6] and made public the names and personal details of quarantined persons.[7] In **Rajasthan**, the government made public the personal details of those under home-quarantine.[8] In **Kerala** the personal details of all patients in isolation and quarantine, along with details of all their contacts, was hacked into and made public.[9] **Tamil Nadu** is using a facial recognition app to track quarantined people.[10] In **Delhi and Haryana** government officials plastered posters on home-quarantined patients' houses that revealed their names and those of their family members.[11]

2.2 Rights violations related to police excesses and abuses

There have been numerous reports of heavy handedness of the police while enforcing lockdowns and social enforcing. In several states, photos and videos show police beating people who are trying to get essential supplies. In West Bengal, police allegedly beat a 32-year old man to death, after he stepped out of his home to get milk.[12] A video from Uttar Pradesh shows police forcing migrant workers, who were trying to walk home, to hop on the street to humiliate them.[13] Police in Maharashtra allegedly beat homeless people to evict them from streets.[14] Police have targeted daily wage workers, such as vegetable and fruit vendors, milk sellers, auto rickshaw and taxi drivers, and others delivering essential goods. Police have also allegedly harassed doctors and health workers. Police in several states, including Punjab, Rajasthan, Haryana, Uttar Pradesh, Maharashtra, and Andhra Pradesh have arbitrarily punished people[15] or publicly shamed them,[16] forcing them to

[5] https://economictimes.indiatimes.com/news/politics-and-nation/election-commission-allows-use-of-indelible-ink-for-stamping-home-quarantined/articleshow/74820647.cms?from=mdr
[6] https://www.indiatoday.in/india/story/all-those-home-quarantined-in-state-need-to-send-selfies-to-govt-every-hour-karnataka-minister-1661517-2020-03-30
[7] https://thefederal.com/states/south/karnataka/covid-19-karnataka-does-a-china-puts-quarantine-data-in-public-domain/
[8] https://www.theweek.in/news/india/2020/03/22/privacy-of-covid-19-suspects-violated-names-addresses-made-public.html
[9] https://www.deccanherald.com/national/south/did-kerala-government-compromise-health-data-privacy-for-coronavirus-surveillance-825229.html; https://timesofindia.indiatimes.com/city/thiruvananthapuram/data-on-covid-19-patients-and-suspects-in-kerala-hacked/articleshow/74821713.cms
[10] https://www.medianama.com/2020/04/223-face-recognition-tamil-nadu-quarantine-coronavirus/
[11] https://timesofindia.indiatimes.com/city/delhi/home-quarantine-posters-put-up-to-prevent-spread/articleshow/74801174.cms
[12] https://thewire.in/rights/west-bengal-police-curfew-man-thrashed-dies
[13] https://twitter.com/Zebaism/status/1243084378751651841; https://www.youtube.com/watch?v=24SwcmdwqTw
[14] https://thewire.in/rights/homless-persons-coronavirus-mumbai
[15] https://economictimes.indiatimes.com/news/politics-and-nation/coronavirus-sit-ups-squats-murga-punishment-police-try-new-ways-to-keep-people-at-home/articleshow/74811310.cms
[16] https://www.ndtv.com/india-news/enemy-of-society-uttarakhand-police-shame-those-defying-coronavirus-curfew-2200140

hold posters saying "I am an enemy of society because I will not stay at home." In MP a policeman wrote "I Violated Lockdown Orders" on a person's forehead.[17]

2.3 Rights violations in quarantine and isolation facilities

Lack of procedural safeguard and basic information

There have been plethora of reports about unacceptable conditions in quarantine facilities and complete absence of procedures to carry out quarantine and isolation of individuals. People have not been provided any information about why they are being quarantined, where and for how long.

Lack of basic facilities re sanitation, hygiene and food

People in quarantine have complained of overcrowding, lack of social distancing and unhygienic conditions, for example 40 people camped in a facility with 3 dirty washrooms and 5 beds.[18] People have complained of lack of food, water, soap and sanitizers in quarantine centres.[19] There have been reports of people being treated poorly and in an undignified manner by police or people in charge of the facilities, especially where returning migrant workers were housed. Due to poor management and bad treatment people are fleeing quarantine centres.[20] In Latehar, Jharkhand over 100 migrants escaped from a quarantine facility and in Nalanda, Bihar 17 people escaped from a facility.

A central Ministry of Home Affairs official said there had been reports of 27 clashes in quarantine centres since 16 April. "Mounting frustration and anxiety were the main causes," the official said. "People are getting angry."[21]

Lack of safety of women

A woman was allegedly assaulted while under quarantine in a centre in Mumbai.[22] A man was arrested in Patna, Bihar for allegedly raping a minor inside an isolation facility.[23] A 14-year old was sexually assaulted at a Delhi COVID-19 centre.[24]

[17] https://indianexpress.com/article/coronavirus/i-violated-lockdown-orders-stay-away-from-me-mp-police-writes-on-migrants-forehead-6337019/

[18] https://economictimes.indiatimes.com/news/politics-and-nation/poor-conditions-of-quarantine-facilities-come-into-focus/articleshow/74738682.cms

[19] https://www.npr.org/sections/goatsandsoda/2020/03/25/821431916/quarantined-in-india-no-soap-dirty-toilets-not-enough-coronavirus-tests

[20] https://timesofindia.indiatimes.com/india/covid-19-why-people-flee-quarantine-centres/articleshow/75783193.cms?utm_source=contentofinterest&utm_medium=text&utm_campaign=cppst; https://qz.com/india/1819659/why-are-patients-fleeing-indias-coronavirus-isolation-wards/

[21] https://www.aljazeera.com/news/2020/04/indians-flee-unsanitary-coronavirus-quarantine-centres-200424123723059.html

[22] https://timesofindia.indiatimes.com/city/navi-mumbai/maharashtra-woman-sexually-assaulted-at-panvel-civic-covid-care-centre/articleshow/77021129.cms

[23] https://timesofindia.indiatimes.com/city/patna/minor-raped-in-covid-ward-guard-arrested-in-patna/articleshow/76990268.cms

[24] https://www.bbc.com/news/world-asia-india-53522998

Abuse of quarantine facilities for illegal detention

In Maharashtra, police detained a trade union president in a quarantine facility because they did not like his food distribution activity during the lockdown. A habeas corpus petition was filed before the Bombay High Court for the release of K Narayanan, President of the Centre of Indian Trade Unions (CITU), Mumbai District Committee, who had been placed under quarantine on the instructions of the police for over 14 days, although he had tested negative for COVID-19. The Bombay High Court was constrained to observe that COVID-19 quarantine facilities should not be misused by the police to keep away people, who according to them, were of nuisance value. The court observed that "Quarantine cannot be used for preventive detention."[25]

3. India lacks a comprehensive legal framework to deal comprehensively with epidemics, and public health emergencies

3.1 India's ability to deal with epidemics proactively has long been hampered by the absence of a legal framework that could support its public health activities and capacities. The EDA was enacted in 1897 and implemented vigorously to control the plague epidemic that broke out in the 1890s and was criticized even then for being excessive and draconian. The powers it conferred were invoked to search for suspected plague cases in homes and among passengers. There was forcible segregation of affected persons, disinfections, evacuation, and demolition of infected places.[26] Alleged humiliation (including public stripping) of and violence against women gave rise to concerns among the citizens, and riots were reported in some areas. In many places, military powers were used to ensure the proper implementation of the preventive measures.[27] Historian David Arnold called the Act **"one of the most draconian pieces of sanitary legislation ever adopted in colonial India"**[28] and Myron Echenberg reported in his book that **"the potential for abuse was enormous"**[29].

3.2 The limited purpose of the EDA is to allow states to take extraordinary measures at the time of a dangerous epidemic disease. It is antiquated and wholly inadequate to provide support to state in controlling an epidemic informed by current public health practices and does not incorporate accountability standards. The main deficiencies of EDA include:

[25] http://timesofindia.indiatimes.com/articleshow/75559599.cms?utm_source=contentofinterest&utm_medium=text&utm_campaign=cppst

[26] https://ijme.in/articles/the-epidemic-diseases-act-of-1897-public-health-relevance-in-the-current-scenario/?galley=html

[27] Arnold D. Science, technology and medicine in colonial India. United Kingdom: Cambridge University Press; 2000: p143

[28] Ibid.

[29] Echenberg M. Plague ports: the global urban impact of Bubonic plague, 1894-1901. London: New York University Press; 2007: p 58.

- It has not kept pace with changing factors leading to the emergence and spread of communicable diseases. Some of the factors that need to be addressed now are more extensive use of air travel compared to sea travel, greater migration within states for earning a livelihood, the transition from agrarian to industrial societies, increased urbanization, grossly increased density of populations in certain areas, increasing intensity of contact with animals and birds, man-made ecological changes, changing climatic conditions, technologies of mass food production and biosafety lapses.[30]
- It does not respond to the changed public health realities of today and does not keep pace with the knowledge and practices in the field of epidemic management and control. For instance, it does not provide for comprehensive preparedness and response for controlling epidemic diseases and establishment of early warning systems and its components - regulation of public health surveillance, notification, information systems, laboratory samples, assessment of risk, reporting etc.
- There are no provisions on the necessary preparations for a response to an epidemic - stockpiling of drugs/vaccines, ensuring adequate PPE for health care workers, ensuring pre-designated quarantine and isolation facilities etc.
- It fails to define "dangerous", "infectious", or "contagious diseases", let alone an "epidemic". There is no elaboration in the Act on the extant rules and procedures for any criteria to determine that a particular disease needs to be declared as an epidemic.
- The role of the union government is also negligible (such as port quarantine) under this law. It also does not establish any coordination mechanism between states and the union government at the time of a dangerous epidemic outbreak.
- There is no authority to declare a state of public health emergency, neither at the Central nor at the State level and no 'criteria' for determining one.
- There are no substantive provisions for minimum standards of quarantine and isolation facilities – procedures to be followed, minimum standards pertaining to accommodation, hygiene, sanitation, food, water etc.
- The Act emphasizes only the *powers* of the central and state governments during the epidemic, but it does not describe the government's *duties* in preventing and controlling the epidemic, nor does it explicitly state the *rights* of the citizens during the event of a significant disease outbreak.
- There is no underlying delineation of the fundamental principles of human rights that need to be observed during the implementation of emergency measures. While, it may be important that the state should have powers to quarantine and isolate, quarantine and isolation orders must be conducted in accordance with substantive and procedural due process, and any restrictions of civil liberties should be legal and as least restrictive as possible. To this end, states

[30] https://ijme.in/articles/the-epidemic-diseases-act-of-1897-public-health-relevance-in-the-current-scenario/?galley=html#six

should ensure that the following five threshold requirements are met: a) the individual must pose an actual threat to the public; b) the intervention must be reasonable and effective; c) it must be conducted in a manner that comports with equal protection and due process; d) individuals must be provided with safe and comfortable conditions; and e) reasonable compensation for loss of income must be ensured.

- There is no provision to regulate use of personally identifiable health information in keeping with rights of confidentiality, privacy and in conformity to established data protection standards.

3.3 The Law Commission Report considered the EDA under '*Central Acts identified for re-enactment or review thereof*'.[31] The P.C. Jain Commission has recommended for its repeal at Sl. No. 133 of Appendix A-1 (166 Central Acts recommended for repeal). The Commission deliberated on the repeal of this Act and felt that it needs to be re-enacted to relate to current contexts.

3.4 The *National Disaster Management of Biological Disasters Guidelines 2008* also recommend that the Ministry of Health & Family Welfare replace the EDA with a more relevant and comprehensive law to deal with different threats to public health proactively and effectively.[32]

4. Data Protection and Privacy

4.1 COVID-19 has provided a fresh impetus to digital health surveillance, most prominent being digital contact tracing. On 2 April 2020, the Government of India launched the *Aarogya Setu* app.[33] State governments have also launched contact tracing apps on similar lines, such as *Corona Watch* (Karnataka), *Mahakavach* (Maharashtra), *COVA Punjab* (Punjab), *Corona Mukt Himachal* (Himachal Pradesh), *Covid Locator* (Goa), etc.[34]

4.2 These contact tracing apps collect substantial information about individuals, including personal information, as well as real-time location data through GPS and Bluetooth technologies. In the absence of a comprehensive data protection law, these apps have led to concerns about abuses, including real-time surveillance, misuse of information for unlawful purposes by government and private players, ransomware attacks, data breaches and identity theft.

[31] Law Commission of India, Report no. 248th (5 November 2014) available at https://www.pmindia.gov.in/wp-content/uploads/2015/01/Extracts-of-the-Committee-of-the-Report-Vol.I-.pdf?query

[32] *NDMA Management of Biological Disasters Guidelines 2008*, available at https://ndma.gov.in/images/guidelines/biological_disasters.pdf

[33] https://www.livemint.com/technology/apps/govt-launches-aarogya-setu-a-coronavirus-tracker-app-all-you-need-to-know-11585821224138.html

[34] https://sflc.in/our-analysis-indian-covid19-apps

4.3 According to a new Data Security Council of India (DSCI) report, India has been the second most cyber-attacks affected country between 2016 to 2018.[35] There have also been several instances of glaring data breaches of confidential patient health information. In February 2020, over a million medical records and 121 million medical images of Indian patients, were leaked online including personally identifying details of them as well as their treating doctors.[36] In August 2019, hackers broke into a leading India-based healthcare website, stealing 68 lakh records containing patient and doctor information.[37] A technical error led to the records of 12.5 million pregnant women being publicly accessible earlier this year, as well as information about practitioners.[38][39] This amounts to a patent violation of rights to confidentiality and privacy, makes data security and protection health care's biggest concern today and calls for stringent laws to regulate its use.

4.4 In May 2018, the World Health Assembly Resolution on Digital Health acknowledged the potential of health technology to enhance health service capabilities; however, it squarely calls upon member states to develop legislation around issues such as data access, sharing, consent, security, privacy and inclusivity consistent with international human rights obligations.[40]

4.5 In August 2017, a nine-judge bench of the Supreme Court in *Justice K. S. Puttaswamy (Retd) Vs Union of India,* emphatically held that Indians have a constitutionally protected fundamental right to privacy that is an intrinsic part of life and liberty under Article 21 of the Constitution. The judgment emphasizes informational privacy in the age of digitization, and in the specific context of health data it stressed the need to have a comprehensive data protection law. Several countries have adopted comprehensive laws to regulate ehealth, such as the General Data Protection Regulations in the EU.

4.6 In India, while the government is aggressively promoting digital health, there is no concurrent law to regulate its use. The current legal and regulatory landscape that governs digital health is scattered, ambiguous and grossly inadequate to effectively steer the use of technologies to serve public good, regulate digital health technologies and protect the fundamental rights to privacy and confidentiality, and data security. The *Data Protection Bill 2019* is still pending and falls short in serving these goals. Further, there is

[35] https://inc42.com/buzz/cyber-attacks-india/
[36] https://inc42.com/buzz/india-healthcare-data-leak-over-120-mn-medical-images-exposed/
[37] https://ciso.economictimes.indiatimes.com/news/hackers-attack-indian-healthcare-website-steal-68-lakh-records/70782910
[38] https://www.healthissuesindia.com/2019/04/02/in-major-error-millions-of-pregnant-womens-data-leaked-online/
[39] https://www.healthissuesindia.com/2019/04/02/in-major-error-millions-of-pregnant-womens-data-leaked-online/
[40] https://apps.who.int/gb/ebwha/pdf_files/WHA71/A71_R7-en.pdf

none or very little legal scholarship in the area of Digital Health in India. This lacuna in regulatory landscape coupled with application of *Puttaswamy* judgment, places a big question mark on the legality of the entire gamut of digital health initiatives of the GOI and also offers no protection to rights of privacy and data protection to the people.

5. Recommendations

- *Rights-based approach to disease control* – **(MoHFW – Dept. of Health and Family Welfare, National Centre for Disease Control - NCDC; MHA)**
  A rights-based approach should inform any response to disease control and should imbue the entire gamut of public health measures – from access to adequate information, consent, confidentiality (esp. pertaining to surveillance, notification and contact tracing), protection of personally identifiable health information, balancing police powers of quarantine and isolation with rights, ensuring minimum conditions at facilities, access to treatment and other health services, measures to mitigate socio-economic impact of epidemics on the most marginalized. Closely related to and complimentary to rights-based approach is the issue of transparency mentioned below.

- *Transparency for accountability and public trust* – **(MoHFW – Dept. of Health & Family Welfare, NCDC, ICMR; MHA)**
  Recent scholarship in the field of public health ethics and pandemic influenza planning has emphasized the importance of transparency in managing infectious disease outbreaks.[41] Transparency not only provides individuals and communities with information needed to survive an emergency, it is also an element of procedural fairness in decision-making and for the promotion of public trust. Most measures for managing public health emergencies rely on public compliance for effectiveness. Measures ranging from hand washing to quarantine require public acceptance of their efficacy, as well as acceptance of the ethical rational for cooperating with instructions that may even temporarily limit individual liberty so as to protect the broader public from harm. But instead of forcing this limitation, it informs, empowers and encourages cooperation.

- *Repeal and replace the Epidemic Diseases Act with a new comprehensive law on epidemic control* – **(MoHFW – Dept. of Health & Family Welfare, National Health Systems Resource Centre - NHSRC; MHA)**
  A good public health law infrastructure establishes not only the powers of the government, but also shapes the government's role in preventing and controlling diseases holistically. A new central law should be introduced (entry 29 of List III) which respects the federal structure and establishes appropriate division of power and cooperation between centre and states; aligns with the IHR 2005;

[41] https://www.who.int/bulletin/volumes/87/8/08-056689/en/

respects the reflects the current public health realities and threats to public health from existing and new diseases irrespective of source; establishes components of core public health capacities of public health surveillance and early warning systems; builds capacity to detect, assess, notify and report events; incorporate legal measures to ensure preparedness (e.g. stockpiling of drugs and equipment and PPE kits); sets up authorities with well-defined powers and functions; incorporates human rights principles and substantive and procedural safeguards against abuse and excesses.

- *Avoid use of criminal law in dealing with public health challenges* – **(MoHFW, MHA)**
  Criminal law must be used extremely sparingly in infection control. Criminalization and prosecution in cases of disease transmission must be limited to only those exceptional cases of intentional and willful spread of disease, where it can be proved beyond reasonable doubt that there was intent to spread the disease. Barring that, restraint needs to be shown in deploying criminal law/ punitive measures to deal with public health challenges. The World Health Organization, as well as other key public health experts and actors,[42] have highlighted the importance of voluntary, non-coercive measures in addressing infectious diseases. Community-level activities – such as appropriate, rights-aligned quarantine and social distancing measures – can be more effective for compliance with public health interventions in the COVID-19 response than the threat of criminal sanctions. Clear, transparent and consistent public health communications can help persuade people to comply with public health measures. Provision of support services, fulfillment of basic needs (e.g., food, water), as well as financial, social and psychosocial support, can also strengthen compliance.

- *Data Protection Bill 2019* – **(Parliament - Department Related Parliamentary Standing Committee on Information Technology)**
  The Department Related Parliamentary Standing Committee on Information Technology, which is examining the *Data Protection Bill 2019,* should expedite the submission of its report and recommendations to the Parliament. It should also examine and in fact seek fresh public consultations on whether the provisions of the bill are adequate to regulate digital contact tracing tools and other health technology reliant on personal data, deployed by the central and state governments. The experience of the responses to COVID-19 in terms of use of personally identifiable health data in a manner that compromises the right to confidentiality and privacy of citizens and does not conform to established data protection principles and standards, should most certainly inform the development of the *Data Protection Bill*.

[42] https://www.who.int/healthsystems/topics/health-law/chapter10.pdf?ua=1; http://opiniojuris.org/2020/04/03/covid-19-symposium-the-use-of-criminal-sanctions-in-covid-19-responses-enforcement-of-public-health-measures-part-ii/

- *Specific Law to regulate digital contact tracing* – **(MoHFW, MeitY, National Health Authority, Ayushman Bharat/ PMJAY)**
  As there is still time for the *Data Protection Bill* to become law, and as it will be an omnibus law, a health data sector specific law, should be passed providing the legal basis for and regulating the use of digital contact tracing, as it is currently operating in a legal vacuum.

- *Health Technology Assessment* – **(MoHFW – Dept. of Health Research, Dept. of Health & Family Welfare, NHSRC; MHA)**
  The Government of India should develop a comprehensive legal framework for health technology assessments (including for digital health technologies), prior to, during and post-deployment of any new health technology. The law should be governed under an ethical framework and assess safety, cost and cost-effectiveness, social and organizational implications, legal and ethical considerations, equity considerations, clinical efficacy and effectiveness of a health tech solution.

- *Workplace safety* – **(MoL&E)**
  Healthcare settings should be included in the proposed *Occupational Safety, Health & Working Conditions Code*.