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Pandemic Exposes Weaknesses in India's Disaster Management Response



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Migrant workers from other States, desperate to return to their homes, walk through rail tracks towards a train station in Ahmedabad, India, on May 11, 2020. File Photo: AP

Disasters are testing times for institutions and individuals, processes and procedures, and policies and their implementation mechanisms. When COVID-19 struck India, the country already had in place legal and administrative instruments to empower and enable the state to contain and manage the several crises that would arise from the pandemic. Two of the most important legal instruments are the Disaster Management Act and the Epidemic Diseases Act.

In this article, Sumit Chaturvedi, independent journalist and researcher, analyses India's response to COVID-19 through the administrative lens. "India's disaster management response", he concludes, "has brought to light severe inadequacies and ambiguities in India's disaster management framework".

I.

On March 24, 2020, India first imposed a national lockdown to contain the spread of the COVID-19 pandemic. This was lifted after two months. The hope expressed by the political leadership then was that the spread of the disease would be checked within 21 days. Uplifting gestures were performed by the people, led by the political leadership, and slogans were carried across sections of the social media by enthusiasts. Such symbolism apart, the lockdown was considered as an important measure to prevent the rapid spread of the disease, to avoid overwhelming of the existing health infrastructure and to give time to these institutions and policy makers to prepare themselves to handle the pandemic.

India's lockdown has been termed as one of the most strictly imposed in the world.¹ Yet, the curve of spread of the disease has neither declined nor flattened even after the restrictions were eased in phases by the end of May. Italy and Spain, which implemented their lockdowns a few weeks before India, witnessed peaking of daily count of cases around the 13th day of the lockdown². In sharp contrast, the cumulative and daily number of cases continue to rise in India and the number of deaths has also increased rapidly. India has a total number of 37,53,406 confirmed COVID-19 cases and has reported 67,376 deaths as on September 3, the highlight being a record single day jump of 83,883 cases on that day³.

The health infrastructure in many cities has been completely overwhelmed. Bigger cities like Delhi, Mumbai⁴ and Chennai⁵ have faced problems in

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accommodating COVID-19 patients, especially during periods of significant surge in number of cases. The World Bank, in a presentation to the 15th Finance Commission, said that the COVID-19 pandemic has exposed "large, persistent health gaps among States". It has highlighted that non-COVID-19 healthcare has also suffered as only 40 per cent have reported seeking medical advice during the lockdown instead of the 90 per cent who do so in normal times. The pandemic has also adversely impacted the trend of hospitalisation through the PM-Jan Arogya Yojana programme, deliveries at hospitals, and cancer care⁶.

This article will discuss why the Indian response to the pandemic has not yielded the desired results as intended through the lockdown strategy from the outset. Central to this analysis would be the manner in which the Disaster Management Act was invoked and the key features of the Union Government's response to the pandemic thereafter. In the process, the article will also take a look at the country's disaster management framework, analysing its efficacies and shortcomings and how the government implemented the same.

II.

As the world was gearing up to usher in a new year, on December 31, 2019, the WHO picked up a report of multiple cases of an unusual kind of pneumonia in Wuhan, China. This unprecedented health crisis, declared a "global emergency" a month later by the WHO on January 30, 2020, is what the world now knows as the Novel Coronavirus Disease or COVID-19 pandemic⁷. India's first case of the disease was also reported from the State of Kerala on January 30: a student who had returned from Wuhan was found to be infected by the virus⁸. As the disease

spread globally due to international travel, the number of global cases kept mounting, so did the number of deaths.

On March 11, the WHO declared the outbreak a global pandemic with the total number of people infected in the world having climbed to over 1.15 lakh and more than 4,000 people having died. By then, India's tally of infected patients had reached up to 60⁹. Within a fortnight, however, the number of cases in India increased by about nine times to a total of 564 by March 24, while globally, more than 3.34 lakh people had been infected and over 14,000 having died.¹⁰ (The Hindu Net Desk 2020)

On March 25, 2020, the Disaster Management Act 2005¹¹ (DM Act) was invoked in India for the first time since it was passed almost a decade and a half ago, to tackle the COVID-19 pandemic that was then in its initial stages of spreading, albeit rapidly¹². The National Disaster Management Authority (NDMA), which was created by the Ministry of Home Affairs (MHA) in pursuance of the DM Act, issued an order on March 24, 2020 under Section 6-(2)-(i) of the DM Act. The order directed the ministries and departments of Government of India and State Governments along with State Disaster Management Authorities to take measures for "ensuring social distancing so as to prevent the spread of COVID-19 in the country".

III.

The need to invoke the Act at the national level was felt to ensure

"consistency in the application and implementation of various measures across the country while ensuring maintenance of essential services and supplies, including health infrastructure".¹³

This legal move put the NDMA in charge of handling the COVID-19 pandemic. The chairperson of NDMA as per Section 3-(2)-(a) of the DM Act is the Prime Minister of India. The decision for a national lockdown was taken in a meeting of the

NDMA chaired by PM Narendra Modi, who announced the same via a televised address to the nation at 8 p.m. on March 24.

This author filed an application under the Right to Information Act 2005 (RTI Act) with the Prime Minister's Office (PMO) on April 1, 2020, seeking the minutes of the meeting in which the decision for the lockdown was taken. On April 27, the PMO responded saying that the application had been transferred to the Ministry of Home Affairs (MHA).

On June 8, the Disaster Management Division (DMD) of the MHA communicated to the author-applicant that it did not have the information sought. The response did not mention if the application had been forwarded to any other public authority that may have the information sought, as mandated under Section 6-(3) of the RTI Act. A first appeal was filed to this response under the RTI Act on June 8, with the MHA. In compliance with the directions of the First Appellate Authority (FAA) the CPIO of the DMD sent a response dated July 24, 2020. The response, however, does not provide the minutes of the meeting in which the decision for the lockdown was taken, as was requested through the RTI application. It only provides the details of the orders given by NDMA and the Home Secretary regarding the guidelines for the lockdown after the decision had already been taken. A subsequent appeal has been filed via email with the FAA asking for the requested information. The FAA's response is awaited.

IV.

With no respite in terms of flattening of the curve of the disease outbreak, it is pertinent to evaluate both the disaster management framework and the incident response in context of the current crisis. This analysis is important both for controlling the present spread as well as preparing for fresh waves of the disease in the future. Therefore, it becomes vital that the Union government proactively releases information regarding decision making behind its response strategy and opens it up for critical scrutiny.

For instance, New Zealand, which has achieved considerable success in controlling the outbreak, has been proactively releasing information regarding its response to the pandemic on its website, including minutes of cabinet meetings.¹⁴ The Indian government, in contrast, has not been forthcoming about various aspects of its response strategy, including lockdown, disaster funding, and surveillance parameters.

The DM Act was enacted after the 2004 tsunami disaster hit the southern coasts of India killing over 10,000 people and causing massive devastation. It was the initial step towards installing an elaborate legal and policy framework to deal with a wide variety of disasters, both in terms of immediate response and long-term preparedness. The Act itself does not specifically mention examples of disasters. It defines a disaster as a

"catastrophe, mishap, calamity or grave occurrence in any area, arising from natural or man-made causes, or by accident or negligence which results in substantial loss of life or human suffering... and is of such a nature or magnitude as to be beyond the coping capacity of the community of the affected area"¹⁵.

As per the Act, the NDMA is responsible for "laying down the policies, plans and guidelines for disaster management for ensuring timely and effective response to disaster"¹⁶. The entire disaster management framework has been created by the NDMA in pursuance with the DM Act, which includes policy, plans, and guidelines to deal with a wide range of disasters.

Biological Disaster Management Guidelines, Surveillance and Social Distancing

The NDMA has devised guidelines to deal with various types of disasters. In July 2008, it brought out a document comprising Biological Disaster Management (BDM) guidelines. The document almost prophetically highlighted the increase in international travel as a factor that "exposes the whole world to epidemics" and

acknowledges the ever-looming threat of spreading of such diseases to disastrous levels¹⁷.

In terms of immediate response for handling the outbreak of a pandemic, the guidelines suggest that the affected persons shall be quarantined and put under observation¹⁸. The document also mentions that surveillance is to be strengthened at all airports, seaports, and border crossings, in case of disasters¹⁹. The contacts of infected individuals and those possibly exposed to them would also need to be quarantined and vaccinated in case secondary spread is anticipated, as per the guidelines²⁰. Most of these measures had been adopted prior to the lockdown when the number of cases were relatively low, with only 564 positive cases recorded till March 24.

The testing strategy, as directed by the Indian Council of Medical Research (ICMR), for initial few weeks was focused only on those who had come from affected areas abroad or have

been in contact with such persons.

On March 20, 2020, the testing criteria was expanded to include all hospitalised patients with

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severe acute respiratory illness, shortness of breath and fever and cough²¹. Since then, the testing criteria has undergone multiple revisions depending on the spread of the disease. The testing was ramped up in the few preceding weeks with an increase in the total number of tests conducted. However, the number of tests conducted per-1,000 population remained relatively low²². On June 23, 2020, the ICMR announced that the IgG (Immunoglobulin G) Antibody Test would be made available to all symptomatic individuals in every part of the country, but only for surveillance and not diagnosis²³.

The gradual expansion of testing parameters runs counter to the suggestion of the BDM guidelines that state that the guiding principle for surveillance is to identify as many suspect cases as possible and, if needed, to employ active house-

to-house surveillance, especially if the "strategy is to stamp out the disease in the formative stages of the epidemic"²⁴.

The quarantine measures can be extended not only to the affected persons, as per the BDM guidelines, but also the healthy population beyond defined geographical area or unit, a step considered important to contain communicable diseases²⁵. The guidelines also mention social distancing measures that include closure of places such as schools, cinemas and offices and ban on cultural events etc. to prevent gathering of people at one place. It is also mentioned that social distancing measures, if required, could also be legally mandated²⁶. The BDM guidelines state:

"There is evidence to suggest that social distancing measures, if properly applied, can delay the onset of an epidemic, compress the epidemic curve and spread it over a longer time, thus reducing the overall health impact."²⁷

These provisions have also been incorporated in the overall lockdown strategy as reflected in the MHA guidelines released by the Home Secretary on March 24, 2020, in his capacity as the chairperson of the National Executive Committee (NEC), as per the Section 8 of the DM Act²⁸.

The BDM guidelines mention that "[c]entral to the success of quarantine will be making available all essential services in the quarantined area"²⁹. Yet, it took five days after the lockdown for the MHA to issue an order which provided for measures that included adequate arrangements of food for the poor and needy, including migrant workers stranded due to lockdown in their respective areas. The order dated March 29, 2020, had belatedly taken cognisance of violation of the lockdown measures in maintaining social distance because of the movement of a large number of migrants in some parts of the country to return to their hometowns. It also directed payment of wages of the workers by all employers without any deduction, ensuring that rent is not demanded from workers for one

month, and an effective embargo on eviction of workers or students by their landlords³⁰.

Even so, the supply of essential items was deficient in many States that created severe stress and survival crisis among the working class, more so for those belonging to the lower economic strata, especially the migrant workers. The reverse migration of workers continued in large numbers and the suspension of all transport facilities led them to face tremendous ordeals. Visuals of thousands of migrant workers walking hundreds of miles across the country, often with children in tow, carrying whatever they considered valuable, exposed what economist K. Nagraj had called the "extremely fragile survival game" for the migrant workers, as quoted by P. Sainath in his 1996 book *Everybody Loves a Good Drought*. Sainath further quotes Nagraj saying, "This sort of footloose migrant lives in a permanent zone of very low income and very high insecurity"³¹. More than two decades later, the observation still remains relevant as, according to a database that has recorded all reported non-COVID deaths between March 14 and July 4, as many as 971 migrant workers died due to various factors like starvation, exhaustion, dehydration, accidents, police brutality, or duress. Till March 24, there were only 11 non-virus deaths, as recorded by the same database.³²

The lockdown strategy, which effectively suspended most economic activity, seems to have been completely neglected the economic impact, especially on the vulnerable population. Considering how quickly the crisis escalated for the daily wage earners and migrant workers, the economic fallout of the lockdown strategy should have been factored in and remedies provided for in the initial guidelines issued for the lockdown.

As COVID-19 differs from other disasters that last for a shorter period of time, the response to it also lasts longer: like a complete or partial suspension of economic activity and complete or partial restrictions on movements. The economic duress is continuing to affect not only those migrant workers who have

returned to their hometowns but also those who have stayed back in the cities, since economic activity either remains suspended or is slow to take off. Existing cash disbursement and employment schemes such as Pradhan Mantri Jan Dhan Yojana and Mahatma Gandhi National Rural Employment Guarantee Scheme can be instrumental in rebuilding lives and enabling sustenance in the wake of the continuing crisis. Yet these schemes have not been incorporated into the recovery response for disasters in the entire disaster management framework, including the national plans and policies. The government, too, did not pay adequate attention to these schemes in its initial strategy of dealing with the pandemic.

National Disaster Management Policy and Plan

As was mandated by the DM Act, the NDMA came out with the first National Policy for Disaster Management (NPDM) in 2009. However, the first National Disaster Management Plan (NDMP) came out only in 2016, and its updated and revised version was released in November 2019. The policy's vision is

"to build a safe and disaster resilient India by developing a holistic, proactive, multi-disaster oriented, and technology driven strategy through a culture of prevention, mitigation, preparedness and response"³³.

It outlines the disaster risks in India as earthquakes, floods and river erosion, cyclones and tsunamis, droughts, and landslides and avalanches specifically in hilly areas. It also mentions disasters and emergencies of chemical, biological, radiological, and nuclear origin. The only reference to epidemics and disease outbreaks is found in the post-disaster scenario and not in the context of them being disasters themselves³⁴. Similarly, there is no specific mention of measures to deal with epidemic outbreaks in National Disaster Management Guidelines-Incident Response System that were brought out in 2010 by the NDMA despite BDM guidelines having already suggested the same.³⁵

The NDMP 2016 categorises disasters into various types, including those belonging to biological family that are caused due to "biological vectors" including viral epidemics³⁶.

It also registers a critical note regarding the DM Act. It mentions that the High-Power Committee on Disaster Management, which was constituted in 1999, in its report brought out in 2001, categorised disaster situations into three levels: L1, L2 and L3. These levels correspond to the magnitude of disaster with regards to the capabilities and resources of the district, the State, and the central levels of administration to handle it. This categorisation does not find mention in the DM Act, neither does it have a provision of notifying any disaster as a 'national calamity' or a 'national disaster', the plan notes³⁷.

However, the updated NDMP brought out in November 2019, is more detailed and includes Biological and Public Health Emergencies (BPHE) as a sub-category of disasters. Like the BDM guidelines, the description of BPHE also suggests that "the likelihood of fast global spread of epidemics has increased dramatically making localised outbreaks into national epidemics and global pandemics" due to increase in travel within and across national boundaries³⁸.

Conflicts in Delegation of Responsibilities

The government's response to COVID-19 pandemic has highlighted some discrepancies in the disaster management legal and policy framework. The NEC, as per section 8(2)(a) of the DM Act, is chaired by the Secretary to the Government of India, in charge of the Ministry or Department of the central government having administrative control over disaster management. The order for guidelines for the lockdown was issued by the Home Secretary in his capacity as the chairperson of the NEC, as per section 10 (2)(i) of the DM Act that makes the MHA as the ministry in charge of the Covid-19 disaster. Yet, as per the Government of India's Allocation of Business Rules (ABR), 1961 amended up to January 31, 2017, the MHA is mandated to look after "matters relating to loss of

human life and property due to all natural and man-made calamities other than drought or epidemics"³⁹.

Similarly, as per ABR, the Department of Health and Family Welfare of the Union Ministry is accorded the responsibility to manage matters relating to epidemics

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but only in a post-disaster scenario⁴⁰. The department is also responsible for national health programmes relating to

control and eradication of communicable diseases and for prevention of their spreading from one State to another. But this responsibility is limited to a "legislative capacity only for the Union". According to the BDM guidelines and NDMP, however, the MHFW is designated as the nodal ministry in charge of biological disasters that include epidemics. Thus, MHFW is expected to coordinate the disaster response to disease outbreaks, which contradicts the provisions of ABR.

As per section 6.1 of the Containment Plan for Large Outbreaks to manage Novel Coronavirus Disease 2019 brought out by the MHFW, the MHA has also delegated powers under the DM Act to the Union Health Secretary under Section 10 (2) (i) and (l)⁴¹. These powers enable the Secretary to undertake evaluation of preparedness at all governmental levels for responding to any disaster and for laying down guidelines for ministries and departments under central and State governments to that end.

The framework of delegation of responsibilities for BDM seems to lack coherence and the responsibilities accorded to various authorities do not correspond with the provisions mentioned in both the ABR as well as the DM Act and its framework. Similarly, the delegation of responsibilities during the COVID-19 pandemic does not adhere to the disaster management legal and policy framework.

The lack of clarity in leading the response to the pandemic also reflects on the actual surveillance of the disease undertaken during the current crisis. The BDM guidelines mention that National Centre for Disease Control (NCDC) (which works under the MHFW), formerly known as the National Institute of Communicable Diseases, is the nodal agency for outbreak investigations.⁴² The Indian Council for Medical Research (ICMR) is the apex body for biomedical research, including facets such as control and management of communicable diseases and drug and vaccine research as per the guidelines⁴³. The Integrated Disease Surveillance Programme (IDSP), launched in 2004, has been responsible for detecting early warning signals of impending outbreaks and helping initiate effective response in a timely manner⁴⁴.

While disease surveillance has always been the prerogative of NCDC through the IDSP, since the emergence of COVID-19 in January 2020, the ICMR also began the same⁴⁵. The NCDC continued to collect data on COVID-19 through its own network of State government staff who work in the field, whereas the ICMR sourced data directly from the laboratories designated for testing Covid-19. The ICMR has been frequently revising protocols and processes for collecting data as well as the basic form that it has ordered the labs and States to use. Many discrepancies have been found in the ICMR database, such as duplicate and wrong names and other data-collection and data-entry flaws. Yet, according to the Union government, the ICMR data prevails and is also used for making decisions regarding lockdowns and easing of restrictions⁴⁶.

As 'Health' is a State subject, the primary responsibility of managing biological disasters are vested with the State governments⁴⁷. However, for diseases that threaten to spread across States and make an epidemic out of an endemic situation, it is the MHFW that decides on the approach for controlling or eliminating the same⁴⁸. The NDMP 2019 has also made the MHFW as the nodal ministry and its responsibilities include responding to biological emergencies and operating epidemiological surveillance systems. It is also assigned the role of supporting States in management of public health logistics, immunisation,

disinfection, vaccination and vector control measures, and providing laboratory support⁴⁹.

While the disaster management framework had accorded the NCDC the responsibility of investigating disease outbreaks, it had also made the MHFW the nodal authority for dealing with pandemics. Now, the NCDC has been running the IDSP—a decentralised State based surveillance system for detecting epidemic prone diseases—for almost two decades. However, the MHFW gave precedence to ICMR data over NCDC during the current crisis. This situation exposes the inherent contradictions in the federal delegation of responsibilities by the disaster management framework in the case of biological emergencies.

Disaster Management Laws and the Persistent "Good Faith" Clause

The BDM guidelines also suggest the need for modifications in existing legal framework to deal with biological disasters that include giving power to central and State governments and local authorities to "act with impunity, notify the affected area, restrict movements or quarantine the affected area"⁵⁰. These provisions had already been made under Section 73 of the DM Act, which states that no legal action can be taken against any government or authority at Central, State, District, or Local levels or any person working on their behalf for any work "done in good faith".⁵¹

Many States additionally invoked the Epidemic Diseases Act 1897 (EDA) to deal with the COVID-19 crisis. Enforceable by the State Government, this Act mainly prescribes temporary regulations to be observed by the public that the government deems necessary for the prevention of the outbreak or spread of an epidemic. It also provides for the power for inspection of people travelling by railway or other modes and their segregation in hospitals or temporary accommodation if suspected to be infected.⁵² The Act also empowers the Central Government to inspect people aboard or about to board ships or vessels leaving or arriving at any port and detain them if necessary⁵³. Violations under the Act

are liable for action under Section 188 of IPC and any action taken in "good faith" under this Act also could not be challenged via any suit or legal proceeding⁵⁴.

This Act was also amended via an ordinance in April 2020. The main impetus of this amendment was to make provisions for punishment or legal action against those who committed any acts of violence against healthcare professionals who were discharging their duties in tackling the epidemic.

The clause for "good faith" has been a persistent feature in all the Acts and BDM guidelines related to disasters that has not been clearly defined and is open to vague interpretations. Similarly, the insistence on impunity for officials, especially in an epidemic situation where response includes mass surveillance and restriction of movement, is also a reason for worry for civil liberties and rights scenario. The onslaught of cases of police brutality during the COVID-19 lockdown has raised concerns regarding the tendency of "over-policing" in India and its inadequacy in general, let alone a public health crisis like the COVID-19 pandemic⁵⁵.

Controversies regarding Disaster Management Funding

The multiplicity of funds for disaster response has created grounds for fresh controversy. The DM Act provides for the National Disaster Response Fund (NDRF) as per Section 46 (2), for meeting expenses for emergency responses, relief, and rehabilitation in accordance with the guidelines laid down by the Central Government in consultation with the NDMA⁵⁶. The Act also provides for the creation of National Disaster Mitigation Fund under Section 47(1). There is also the Prime Minister National Relief Fund that was established more than 70 years ago in January 1948 in pursuance of an appeal by the then PM Jawaharlal Nehru to assist displaced persons from Pakistan. Now the fund is utilised to deal with emergencies, calamities, and emergency medical expenses.⁵⁷ In addition to these funds, the Centre on March 28 announced the establishment of PM CARES fund that would be available during a public health emergency and other

emergency and calamities. Questions have been raised regarding the need for a new fund when multiple funds exist already with similar objectives⁵⁸.

An important measure mentioned in the NDMP is to strengthen the "monitoring mechanisms for fund utilisation and progress of implementation".⁵⁹ In the context of PM CARES fund, the refusal of the government to include it under the ambit of the RTI Act has made the achievement of this objective unlikely.

Paradigm Shift in Disaster Management

The NDMP 2019 has added a separate section specifically for BPHE in the chapter on Disaster Risk Resilience (DRR)-Responsibility Framework. This framework lists the responsibilities accorded to various agencies at the central and the state levels, which are divided into four categories based on the timelines in which they have to be completed—Recurring or Regular (day to day), Short Term (until the end of 2022), Medium Term (until the end of 2027) and Long Term (until the end of 2030)⁶⁰.

The plan refers to a paradigm shift in the approach to addressing disasters from one focused on relief and response to one that emphasises DRR and preparedness; from one focused on disaster management to one on disaster risk management⁶¹. Both these shifts emphasise long-term preparedness and do not lay out a definite plan of action in case of immediate response to an outbreak as the BDM guidelines do.

The NDMP 2019 suffers from shortcomings of the 2016 Plan in that it

"fails to lay down a clear and practical roadmap. It is too generic in its identification of the activities to be taken by the central and State governments for disaster risk mitigation, preparedness, response, recovery, reconstruction, and governance"⁶².

Conclusion

The unprecedented crisis of the COVID-19 pandemic has provided the sternest test for Disaster Management response in most countries, including India. India's Disaster Management Framework has evolved over the past many years with a dedicated legal and policy framework. Yet, it suffers from ambiguity. The provisions mentioned in the guidelines, policy, and plans of the Disaster Management Framework not only lack coherence with each other but also with the official delegation of responsibilities to various ministries. It also suffers from contradictions in federal delegation of responsibilities in case of biological emergencies. Over the years the focus has been shifted from immediate response to long term preparedness. While BDM guidelines specifically laid down elaborate measures to deal with disease outbreaks, epidemics, and pandemics, the subsequent plans and policies focused mostly on preparation of risk resilience.

Although the initial response of the Government of India aligned closely with the BDM guidelines, as reflected in the lockdown and social distancing guidelines, many of its provisions were not implemented optimally. The most important among them were those specifically related to disease surveillance guidelines and provision of essential supplies and services to ensure successful social distancing. Both these measures were important in early containment of the disease outbreak, an objective that India failed to achieve. The parameters of disease surveillance and the key agency to coordinate it have remained mired in controversy and ambiguity throughout the crisis. The provision of essential supplies and services was not ensured from the beginning and suffered from inadequacy later as well, which resulted in the massive exodus of migrant workers from cities to their hometowns and villages.

There have also been inadequacies in the Disaster Management Framework itself, including the BDM guidelines. The nature and lifecycle of a pandemic is different from all other disasters and, thus, its response differs as well. A

pandemic is far more unpredictable and long-lasting than other disasters. While the BDM guidelines, in order to ensure social distancing, made provisions for suspension of economic activity, a measure strictly implemented as part of the lockdown, it did not focus on the repercussions of the same, especially on the economically vulnerable, including migrant workers. Adequate measures to ensure economic sustenance, such as employment generation and cash transfer schemes, have not been incorporated in the Disaster Management Framework. Neither was the fallout anticipated by the government and the response to the disaster itself became a crisis and wreaked havoc, especially for the economically vulnerable population.

The suspension of economic activity was tantamount to the denial of the basic right to livelihood. Civil liberties were also compromised through several other restrictions as part of what has been

called one of the strictest lockdowns in the world and this compounded the crisis. The heavy-handed attitude of

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the police was only aided by the impunity granted to them through various Acts and guidelines constituting the Disaster Management Framework. This resulted in several cases of police brutality, many of which resulted in fatalities.

Even with so many hardships, the number of infected people has rapidly increased and the healthcare facilities have been overwhelmed resulting in 67,376 COVID-19 deaths till September 3; interestingly, as many as 971 non-Covid deaths were recorded between March 14 and July 4, which include fatalities due to starvation, duress due to long distance travel, or accidents, according to the independent database mentioned earlier in the article. The crisis borne out of the response to the disaster has still not subsided with economic uncertainty and struggles for sustenance still being reported from both urban and rural areas, especially among the migrant workers.

Transparency in both the decision-making process and the disaster response has been an important feature of some of the most successful strategies adopted worldwide in handling of the pandemic. Free flow of information and accountability are of utmost importance to ensure course-correction where desired objectives have not been achieved, besides being prepared in case of re-emergence of the disease in the near future. Yet, there has been a great degree of opacity in the government's decision-making processes in response to the pandemic. For instance, the establishment of PM CARES fund despite the existence of several emergency funds meant for relief disbursement during calamities, and the refusal of the government to include it within the ambit of public auditing or the RTI Act 2005 has only strengthened the perception of opacity.

India's disaster management response has brought to light severe inadequacies and ambiguities in the Disaster Management Framework, especially in dealing with a unique crisis like the COVID-19 pandemic. The response itself has become a disaster in many ways as India still struggles to arrest the spread of the disease.

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