The Predicaments of Unbridled Quarantine Legislation in India: A Peril to Constitutional Rights

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The COVID-19 pandemic has precipitated unprecedented use of quarantine and isolation measures globally, raising critical questions about the balance between public health imperatives and fundamental constitutional rights. This article examines the legal and constitutional challenges posed by quarantine legislation in India, analysing their implementation through individual liberty, due process, and federalism frameworks.

The study critically evaluates quarantine application criteria, constitutional validity of such measures, and tensions between collective health security and individual rights. Drawing from comparative international perspectives and constitutional jurisprudence, this research identifies significant gaps in India's quarantine framework, particularly regarding vulnerable populations, jurisdictional ambiguities between central and state authorities, and absence of robust safeguards against arbitrary detention.

The article argues that while quarantine measures may constitute reasonable restrictions during health emergencies, their unbridled application without clear statutory frameworks, adequate procedural safeguards, and constitutional oversight poses serious threats to civil liberties. The study concludes by proposing a balanced legal framework that harmonizes public health objectives with constitutional imperatives, advocating for potential constitutional amendments to address health emergencies while preserving individual rights.

Keywords: Quarantine, Constitutional Rights, Public Health, Individual Liberty, Emergency Powers, Health Emergency

I. Introduction

India's recent experience with large-scale outbreaks of emerging and re-emerging infectious diseases has underscored the critical role of legal frameworks in managing public health emergencies[1]. These frameworks serve as essential mechanisms for defining the scope of

[1] Rakesh Ps, *The Epidemic Diseases Act of 1897: Public Health Relevance in the Current Scenario*, IJME (2016),http://ijme.in/articles/the-epidemic-diseases-act-of-1897-public-health-relevance-in-the-current-scenario/?galley=html.

governmental responses while establishing corresponding duties and rights of citizens during crisis situations. India's response to the COVID-19 pandemic exemplified the global challenge faced by legal systems in adapting existing frameworks to address unprecedented public health emergencies. Like many nations worldwide, India initially relied on colonial-era legislation, primarily invoking the Epidemic Diseases Act of 1897 alongside the Disaster Management Act of 2005 to manage the crisis. Multiple Indian states declared COVID-19 an epidemic under these provisions, implementing widespread measures such as educational institution closures, prohibitions on mass gatherings, visa cancellations, and travel restrictions. However, this patchwork approach highlighted significant gaps in India's legal preparedness, particularly when compared to more comprehensive frameworks adopted by countries like Australia[1], and Singapore[2].

The constitutional and legal foundations for COVID-19 measures in many jurisdictions demonstrate a more comprehensive approach to pandemic governance than India's framework. Where the constitution explicitly guarantees free healthcare services as a fundamental right and public health laws establish mandatory governmental duties for epidemic prevention, the resulting legal architecture provides both stronger institutional accountability and clearer citizen protections. This constitutional entrenchment creates enforceable obligations that transform pandemic responses from discretionary administrative actions into legally mandated governmental duties. Such frameworks ensure that emergency measures operate within a rights-based paradigm where citizens can claim healthcare access and epidemic protection as constitutional entitlements rather than governmental favours[3]. This article argues that India's quarantine framework suffers from a fundamental structural deficit: legislative obsolescence compounded by executive overreach in a fragmented federal system. The core problem is not merely outdated laws, but the absence of constitutionally-mandated procedural safeguards that enable arbitrary restrictions on liberty. While the Epidemic Diseases Act of 1897 and ad-hoc pandemic measures may satisfy the test of 'procedure established by law' under Article 21, they

[1] Anthony Gray, *The Australian Quarantine and Biosecurity Legislation: Constitutionality and Critique*, 22 J LAW MED 788 (2015).

[2] Dale Fisher & Kenneth Mak, *Exiting the Pandemic: Singapore Style*, 19 BMC MED 238 (2021), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8445738/.

[3] RESTRICTION OF HUMAN RIGHTS AND FREEDOMS IN HEALTH EMERGENCIES: THE EXAMPLE OF COVID-19 (AACC ed., 2020).

fail the deeper constitutional requirement of substantive due process, proportionality, and federal accountability that modern emergency governance demands.

II. International Standards and Comparative Analysis

The United Nations Committee on Economic, Social and Cultural Rights has established that the right to health is closely related to and dependent upon other human rights as contained in the International Bill of Human Rights. These include the rights to food, housing, work, education, human dignity, life, non-discrimination, equality, the prohibition against torture, privacy, access to information, and the freedoms of association, assembly and movement. The Committee mandates that health facilities, goods, and services should be available, accessible, acceptable, and of good quality. The Siracusa Principles, adopted by the UN Economic and Social Council in 1984, provide authoritative guidance on emergency measures[1]. These principles establish that any population protection measures limiting rights and freedoms must be lawful, necessary, and proportionate. States of emergency must be limited in duration, with any rights curtailment considering disproportionate impacts on specific populations or marginalized groups. A rights-respecting society, as defined by the United Nations Charter and the Universal Declaration of Human Rights, must ensure that any government restrictions on individual freedoms even for legitimate public health purposes like quarantine must meet strict criteria established under Article 1(B) of the International Covenant on Civil and Political Rights (ICCPR) that they must be legally based, absolutely necessary in a democratic society, non-discriminatory, time-limited, and subject to regular review. The critical concern highlighted is that indefinite quarantine measures violate international law by failing the time-limitation requirement established in the ICCPR and disproportionately restricting multiple fundamental rights simultaneously. This framework emphasizes that even during health emergencies, governments cannot impose unlimited restrictions and must continuously balance individual freedoms against public health necessities through legally justified, proportionate, and regularly reviewed measures in accordance with international human rights law[2].

[1] *Human Rights Dimensions of COVID-19 Response | Human Rights Watch*, (Mar. 19, 2020), https://www.hrw.org/news/2020/03/19/human-rights-dimensions-covid-19-response.

[2] Jamal Barafi et al., *Quarantine Regulations during the Coronavirus Pandemic: A Study in Light of National and International Legislation*, 11 JGR 277 (2022), https://virtusinterpress.org/Quarantine-regulations-during-the-coronavirus-pandemic-A-study-in-light-of-national-and-international-legislation.html.

II.A Comparative Operationalization of Rights-Based Quarantine.

Australia's Biosecurity Act 2015 demonstrates constitutional compliance through specific mechanisms: mandatory judicial review within 72 hours of any quarantine order, statutory compensation for economic losses, and explicit proportionality assessments requiring officials to document why less restrictive alternatives are inadequate. Singapore's Infectious Diseases Act requires daily medical assessments, provides free accommodation and meals during quarantine, and establishes an appeals tribunal with 48-hour response requirements. These frameworks transform abstract Siracusa Principles into enforceable procedural rights, precisely what India's ad-hoc approach lacks.

A state of emergency is a temporary situation in which exceptional powers are granted to the executive and exceptional rules apply in response to and with a view to overcoming an extraordinary situation posing a fundamental threat to a country[1].

III Constitutional Framework for Health Emergency Powers in India

India's historical experience with emergency powers reveals a troubling pattern of extraordinary governmental authority during crises, often with insufficient constitutional safeguards. The colonial legacy, established through legislation like the Epidemic Diseases Act of 1897, created precedents for state-centric emergency responses that prioritized administrative control over individual liberties. The COVID-19 pandemic continued this pattern, with states invoking colonial-era and modern legislation to implement nationwide restrictions without adequate constitutional oversight[2]. The only legitimate aim and legitimate ground for adoption of emergency measures is to help the State overcome an exceptional situation. Emergency measures should respect certain general principles which aim to minimize the damage to fundamental rights, democracy and rule of law[3]. In light of legal precedent, it has been determined that the combination of Article 21 of the Constitution and the Directive Principles of State Policy guarantees that all individuals possess a fundamental

[1] Nicos Alivizatos et al., *RESPECT FOR DEMOCRACY, HUMAN RIGHTS AND THE RULE OF LAW DURING STATES OF EMERGENCY : REFLECTIONS*.

[2] Kiran Kumar Gowd, Donthagani Veerababu & Veeraiahgari Revanth Reddy, *COVID-19 and the Legislative Response in India: The Need for a Comprehensive Health Care Law*, 21 J PUBLIC AFF e2669 (2021), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8250373/.

[3] Alivizatos et al., *supra* note 7.

right to health and healthcare. Thus, health is widely regarded as a fundamental aspect of the right to life.

The Constitution of India acknowledges the importance of health and ensures that its fundamental aspects are protected. This aligns with the widely embraced global perspective and has also found recognition from the judiciary. For instance, the Supreme Court emphasised that the right to life encompasses the right to live with dignity in the following words: the right to life includes the right to live with human dignity and all that goes along with it, namely, the bare necessities of life such as adequate nutrition, clothing and shelter...[1]" India's federal structure creates complex authority distribution for health emergencies. The Seventh Schedule grants states primary responsibility for public health under Entry 6 of the State List ('Public health and sanitation; hospitals and dispensaries'). However, Entry 81 of the Union List covers 'inter-state migration; inter-state quarantine,' while Entry 29 of the Concurrent List addresses 'prevention of the extension from one State to another of infectious or contagious diseases.' This multi-level authority creates coordination challenges during health emergencies[2]. The Supreme Court has interpreted this to include the right to health and medical care, recognizing it as essential for a life with dignity[3].

The Supreme Court's evolving proportionality doctrine, from Modern Dental College (2016)[4] to Anuradha Bhasin (2020)[5], establishes a four-step test: (i) legitimate goal, (ii) rational nexus, (iii) necessity (no less restrictive alternative), and (iv) balancing (proportionality stricto sensu). India's COVID-19 quarantine measures—implemented through executive orders without legislative debate—arguably satisfied steps (i) and (ii) but failed rigorous scrutiny under steps (iii) and (iv). No systematic assessment determined whether mass quarantine was less restrictive than targeted isolation, no cost-benefit analysis weighed liberty deprivation against epidemiological benefit, and no sunset clauses ensured temporal limitation

Additionally, Article 47 of the Directive Principles of State Policy places a duty upon the state to raise the level of nutrition and standard of living and to improve public health. In response to public health emergencies such as epidemics, the Epidemic Diseases Act of 1897

[1] *Francis Coralie Mullin v. Administrator, Union Territory of Delhi*, AIR 1981 SC 746, para 8.

[2] *Consumer Education and Research Centre v. Union of India*, AIR 1995 SC 922, para 25.

[3] *State of Punjab v. Mohinder Singh Chawla*, (2007) 12 SCC 1.

[4] *Modern Dental College and Research Centre and Ors. v. State of Madhya Pradesh and Ors.* (2016) 7 SCC 353

[5] *Anuradha Bhasin v. Union of India and Ors*. (2020) 2 SCC 57

serves as the primary legal instrument. Despite its brevity and antiquated language, it has been invoked repeatedly during public health crises, including the COVID-19 pandemic.[1]

IV **Statutory Quarantine Framework and Constitutional Deficiencies**

Quarantine, derived from the Italian phrase "quaranta giorni" meaning forty days, represents one of humanity's oldest public health interventions designed to prevent disease transmission through the systematic separation of potentially exposed individuals or animals from the general population. Quarantine represents one of public health's fundamental interventions, involving systematic separation of potentially exposed individuals from the general population to prevent disease transmission. This practice differs from isolation, which separates confirmed infected individuals. Historically, isolation was practiced even in biblical times to separate visibly ill individuals, such as leprosy patients. Quarantine has evolved from medieval port management to modern epidemic control, yet continues to raise questions about balancing collective health protection with individual liberty[2]. COVID-19's emergence prompted unprecedented quarantine measures globally. In India, the pandemic renewed attention to quarantine as a critical tool, leading to widespread implementation under existing legislation despite constitutional concerns.[3] Though often used interchangeably in public discourse, these terms carry distinct legal implications, especially since quarantine may restrict liberty without confirmed infection, demanding careful legal and ethical scrutiny[4]. Quarantines cannot stop pandemics immediately, but they can slow down their progression. This can provide precious time to learn more about the disease and hopefully develop a vaccine able to contain the virus[5]. India's quarantine provisions derive primarily from the Epidemic Diseases Act of 1897 and regulations issued under the Disaster Management Act of 2005. The Epidemic Diseases Act empowers Central and State Governments to take special measures during dangerous epidemic

[1] Shri M Karunanithi & Raka Arya, *A COMPREHENSIVE REVIEW OF THE EPIDEMIC DISEASES ACT. 1897*, Report No. 286 February,2024

[2] Kaushik Chatterjee & V.S. Chauhan, *Epidemics, Quarantine and Mental Health*, 76 MEDICAL JOURNAL ARMED FORCES INDIA 125 (2020), https://linkinghub.elsevier.com/retrieve/pii/S0377123720300551 .

[3] Md Mahbub Hossain, Abida Sultana & Neetu Purohit, *Mental Health Outcomes of Quarantine and Isolation for Infection Prevention: A Systematic Umbrella Review of the Global Evidence*, EPIDEMIOL HEALTH e2020038 (2020), http://e-epih.org/journal/view.php?doi=10.4178/epih.e2020038.

[4] Khan Ia, *Quarantine: Concept, Origin and Impact on COVID-19 Pandemic*, 3 J BIOMED RES ENVIRON SCI 198 (2022), https://www.jelsciences.com/articles/jbres1422.pdf.

[5] Vera Lúcia Raposo, *Quarantines: Between Precaution and Necessity. A Look at COVID-19*, PUBLIC HEALTH ETHICS phaa037 (2021), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7928590/.

outbreaks, including authority to inspect and detain persons for quarantine or isolation. However, these provisions lack constitutional safeguards required under Article 21's due process standards[1]. Quarantines remain more controversial than isolation because they restrict liberty of many uninfected individuals, raising fundamental questions about the balance between public health imperatives and individual constitutional rights[2]. Articles 19(2) through 19(6) of the Indian Constitution allow reasonable restrictions on fundamental freedoms including speech, assembly, association, and movement, provided the interventions are aimed to protect specific values including public health. Article 21 permits deprivation of life and liberty through procedure established by law, while Article 47 mandates state duty to improve public health. In spite of the aim to protect an arguably higher constitutional value, such measures must be proportional, reasonable, and necessary as established by Supreme Court precedents[3]. However, the constitutional boundaries are frequently contravened during health emergencies.

V. Emergency Powers vs. Procedural Justice: The Due Process Deficit

Involuntary confinement of an individual for any reason, is a deprivation of liberty which the State cannot accomplish without due process of law[4]. For instance, quarantine imposed under belief of severe public health threat may prevent normal life activities including school, work, medical appointments, and socialization, justified as legitimate means to safeguard public health. However, if the threat proves null or minimal, consequences extend beyond economic loss to include educational deficits for children, family income loss affecting basic needs, undiagnosed medical conditions, and mental health impacts leading to domestic violence or suicide. The state bears the burden of proving compelling interest for quarantine, as needless measures waste scarce resources, may cause people to flee and spread infection, and undermine public trust. Public health crises reveal the apparent conflict between collective good and individual rights. However, this conflict may be more apparent than real, as public health has critical obligations regarding individual rights, and only by respecting individual liberties can prevention be promoted and common good achieved. Both involuntary quarantine and isolation

[1] Karunanithi and Arya, *supra* note 12.

[2] Raposo, *supra* note 17.

[3] *Gajendra Sharma v. State of Uttarakhand* (2020), Supreme Court of India.

[4] Wendy K Mariner & Michael Ulrich, *Quarantine and the Federal Role in Epidemics*.

constitute obvious deprivations of liberty requiring justification, necessitating a delicate balance between collective health interests and individual rights.

These deficiencies emerge from deeper institutional failures that have developed over decades. First, Parliament has increasingly avoided making hard choices about health emergency powers, preferring instead to delegate broad authority to executive officials through vague enabling provisions. Second, bureaucratic agencies have cultivated a preference for discretionary decision making over clear legal rules, since discretion maximizes administrative flexibility while minimizing political accountability. Third, courts have been reluctant to scrutinize health emergency measures rigorously, deferring to claimed medical expertise even when basic procedural protections are violated. Fourth, India's federal structure creates jurisdictional ambiguity where both central and state governments can claim authority over quarantine measures, yet neither bears clear responsibility when rights violations occur. This institutional architecture creates perverse incentives: governments favor improvised emergency responses over comprehensive legal frameworks because ad hoc measures allow maximum flexibility with minimum accountability. The result is a governance system structurally biased toward executive overreach during health crises.

Emergency legislation poses an inherent threat to the rule of law due to the dangerous precedent it establishes for fundamental rights derogation, creating a pathway for future authoritarian overreach disguised as crisis management. Once governments successfully restrict constitutional freedoms under the banner of emergency—whether for public health, national security, or other purported crises—the legal and political infrastructure for such restrictions becomes normalized, making it exponentially easier to reactivate similar measures during subsequent emergencies, real or manufactured. The COVID-19 pandemic has demonstrated how quickly democratic governments worldwide can suspend fundamental liberties in the name of public welfare, raising critical questions about the reversibility of such measures and the long-term constitutional implications of normalized emergency governance. Therefore, the protection of public health during genuine emergencies must be carefully balanced with vigilant safeguarding of the rule of law, ensuring that emergency measures include robust sunset clauses, judicial review mechanisms, and democratic oversight to prevent the virus of authoritarianism from infecting constitutional democracy itself. This requires constant vigilance from civil society, judiciary, and democratic institutions to ensure that temporary emergency measures do not become permanent features of governance, thereby

preserving both the right to health and the fundamental architecture of constitutional democracy for future generations[1].

VI. Socio-Economic Dimensions and Vulnerable Populations

Governments should take policy measures to buffer the economic impacts of COVID-19, which will affect lower-wage workers first and hardest. Social distancing, quarantine, and the closure of businesses may have enormous economic consequences. The most vulnerable people are low-wage workers in low-income households.

The differential impact of quarantine on informal workers implicates Article 14's substantive equality guarantee. The Supreme Court's recognition in Navtej Singh Johar (2018)[2] that formal equality is insufficient when laws have disparate impact on vulnerable groups applies with equal force to public health measures. When quarantine orders impose catastrophic economic consequences on daily wage earners while salaried employees work remotely with minimal disruption, the measure—though facially neutral—violates substantive equality unless accompanied by compensatory mechanisms. This aligns with the constitutional vision in Olga Tellis (1985)[3], recognizing that deprivation of livelihood implicates the right to life itself. Governments should create mechanisms so that workers affected by COVID-19 do not suffer loss of income that might deter them from self-isolating to contain the spread of the virus.

Quarantine measures impose disproportionate economic burdens on vulnerable populations, particularly affecting low-wage workers, informal sector employees, and marginalized communities. The COVID-19 pandemic demonstrated that social distancing and quarantine policies create cascading economic consequences that affect society's most vulnerable members first and hardest[4]. Workers in essential services—retail, restaurants, personal care, and the gig economy—face unique challenges during quarantine periods, as remote work is not an option for millions in these sectors.

India's current legal framework lacks comprehensive compensation mechanisms for individuals subjected to quarantine orders. While the Employees' State Insurance (ESI) scheme provides limited protection for formal sector workers, it fails to address the broader economic

[1] Nicola Canestrini, *Covid-19 Italian Emergency Legislation and Infection of the Rule of Law*, 11 NEW JOURNAL OF EUROPEAN CRIMINAL LAW 116 (2020), https://journals.sagepub.com/doi/10.1177/2032284420934669.
[2] *Navtej Singh Johar v. Union of India*, AIR 2018 SC 4321
[3] *Olga Tellis & Ors v. Bombay Municipal Corporation & Ors*, AIR 1986 SC 180
[4] Human Rights Dimensions of COVID-19 Response | Human Rights Watch, *supra* note 5.

hardships faced by quarantined individuals, particularly those in informal employment. Travel restrictions were particularly cruel for migrants during COVID-19, as many were dismissed from their jobs and became unable to support themselves or return home. The absence of uniform compensation policies creates additional challenges for public health compliance, as individuals may avoid testing or fail to report symptoms when quarantine measures threaten economic survival.

Providing compensation for quarantined individuals would financially protect those subjected to quarantine and increase compliance. Because public health crises disproportionately affect poor and working class individuals, special efforts should be considered to protect against unnecessary vulnerabilities. A uniform act with a compensation mode would be the simplest and most effective method given India's dual public health system.

VII. Conclusion

This analysis reveals that India's quarantine legislation framework suffers from fundamental structural deficiencies that threaten both public health objectives and constitutional rights. While genuine public health imperatives necessitate quarantine measures, current laws pose grave threats to individual liberty and civil rights due to inadequate legal safeguards and arbitrary implementation. The investigation establishes that the distinction between quarantine and isolation remains legally ambiguous, leading to violations of due process rights, while the federal structure's inadequacies in health emergency governance create enforcement gaps that undermine both public health objectives and individual rights protection.

This research advocates for a paradigm shift from the current ad-hoc emergency response model to the comprehensive, rights-protective legal framework. The proposed framework—incorporating definitional clarity, proportionality assessments, temporal safeguards, procedural due process, compensation mechanisms, federal coordination, independent oversight, and vulnerable population protections—demonstrates that effective public health governance and robust civil liberties protection are complementary objectives requiring careful institutional design rather than competing interests necessitating trade-offs.

India's response to future health emergencies must be grounded in constitutional values, procedural fairness, and respect for human dignity. Mass quarantine measures generate multidimensional social consequences that disproportionately exacerbate existing inequalities across diverse socioeconomic contexts, making the reduction of social disparities a critical

priority for building pandemic resilience and strengthening future emergency preparedness[1]. Only through protecting both collective health and individual rights can the nation build resilient public health systems that are both effective and respectful of the constitutional principles that form the cornerstone of democratic governance.

VIII. Toward a Rights Protective Quarantine Framework: Essential Legislative Elements

India's future pandemic preparedness requires moving beyond ad hoc emergency measures toward a comprehensive statutory framework that protects both public health and constitutional rights. Such legislation must balance the legitimate need for swift action during health emergencies with robust safeguards against arbitrary state power. The following elements represent the minimum constitutional requirements for any quarantine law that seeks to reconcile collective health security with individual liberty.

A. Clear Legal Definitions

The law must clearly distinguish between quarantine and isolation. Quarantine applies to individuals who may have been exposed to infection but show no symptoms, while isolation applies to confirmed infected persons. This distinction matters because restricting the liberty of healthy individuals requires stronger justification and more rigorous procedural protections than isolating confirmed cases. Each category should trigger different legal procedures, with quarantine requiring higher standards of proof and more frequent review.

B. Proportionality Requirements

Health authorities must be required to document their reasoning before imposing quarantine orders. Specifically, officials should demonstrate three things: the scientific basis for the quarantine duration being imposed, why less restrictive alternatives such as symptom monitoring or voluntary isolation would be inadequate, and how they considered the individual circumstances of the person being quarantined. This documentation requirement ensures accountability and enables meaningful judicial review.

[1] Isaac Yen-Hao Chu et al., *Social Consequences of Mass Quarantine during Epidemics: A Systematic Review with Implications for the COVID-19 Response*, 27 JOURNAL OF TRAVEL MEDICINE (2020), https://academic.oup.com/jtm/article/doi/10.1093/jtm/taaa192/5922349.

C. Time Limits and Oversight

Quarantine orders should not be indefinite. Initial orders should be limited to 72 hours, after which judicial review becomes mandatory if quarantine continues. The maximum duration of any quarantine period should correspond to the known incubation period of the disease in question, with medical justification required for any extension. Emergency regulations authorizing quarantine powers should contain automatic sunset clauses expiring after 30 to 45 days, requiring fresh parliamentary debate and renewal if continued powers are necessary. This prevents emergency measures from becoming permanent features of governance.

D. Procedural Safeguards

Every person subjected to quarantine must receive written notice in a language they understand, explaining why they are being quarantined, how long the quarantine is expected to last, and how they can challenge the order. Quarantined individuals should have access to legal representation and the right to request an independent medical examination. Health authorities should be required to review each quarantine order every seven days to determine if continued restriction remains necessary. Courts should provide expedited review, deciding quarantine challenges within 48 hours of petition filing.

E. Economic Protection

Quarantined individuals should receive statutory compensation equal to at minimum the prevailing minimum wage for each day of quarantine. Employers should be prohibited from terminating employees solely because of quarantine status. The state should bear the cost of accommodation, food, and necessary medical care during quarantine periods. Special provisions must address informal sector workers and daily wage earners who lack employment protections, ensuring they do not face economic catastrophe simply because of public health measures taken in the collective interest.

F. Federal Coordination Mechanisms

The law should clearly demarcate responsibilities: state governments handle quarantine within their borders, while the central government manages interstate and international quarantine measures. Mandatory consultation protocols should require coordination between levels of government, preventing conflicting orders that confuse citizens and undermine compliance.

Consideration should be given to establishing a National Health Emergency Authority with constitutional status, empowered to set uniform national standards while permitting state flexibility in implementation based on local conditions.

G. Independent Monitoring

A Health Emergency Review Board comprising judicial officers, medical experts, and civil society representatives should oversee quarantine implementation. This body should receive monthly reports during declared emergencies and possess authority to investigate complaints and recommend corrective action. Transparency requirements should mandate publication of data on quarantine orders, their duration, demographic patterns, and outcomes. Civil society organizations should be granted formal monitoring roles, ensuring that vulnerable communities have advocates watching for discriminatory enforcement.

H. Protecting Vulnerable Populations

Before implementing mass quarantine measures, authorities should conduct impact assessments specifically examining effects on marginalized communities, persons with disabilities, pregnant women, the elderly, and other vulnerable groups. The law should mandate special accommodations addressing the specific needs of these populations. Information and appeal procedures must be accessible across linguistic and literacy barriers. Where medically appropriate, authorities should consider community based quarantine alternatives that respect cultural practices and family structures while achieving public health objectives.

This framework represents not merely a set of policy recommendations but the constitutional minimum required to render quarantine powers compatible with India's commitment to liberty, equality, and human dignity. Only by institutionalizing these protections can India ensure that future health emergencies strengthen rather than undermine its constitutional democracy.