EPIDEMIC LAWS AND MENTAL HEALTH IN INDIA

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I. Introduction

The Coronavirus pandemic has emerged as an event that portends a colossal impact in nearly every imaginable aspect of human life. The outbreak has already marked its name in history books and this has happened much before we can think of putting this calamity behind our backs. As the world grapples with Covid-19, a host of new measures in the form of policies, guidelines, rules and social norms are being implemented globally and much of this new way of life has become a part of our common sense. There has been no shortage of laws being put in full force to ensure the achievement of the much-desired common purpose. Notably, India has witnessed the emergence of a 123-year old law which has risen to the fore like a phoenix emerging from its ashes. Thus, it becomes imperative and necessary to take a renewed look at the Epidemic Diseases Act 1897 (hereinafter also referred to as ‘the principal act’ / ‘the act’) and its amendment from a decolonized lens with a purpose of assessing its role in the current scenario from a perspective of mental health issues of police personnel during the Covid-19 pandemic.

II. Historical Background

Prior to examining the principal act and its amendment, a critical analysis of the act must be capacious enough to accommodate its historical background. Hence, with such a view in mind, this section attempts to answer the following questions.

i. Why was the Epidemic Diseases Act 1897 enacted by the colonial government?
ii. Did a law exist at the time in England with a similar purpose?
iii. What criticism was the act subjected to?

i.

In 1896, Bombay (present day Mumbai), saw the outbreak of the Bubonic Plague, creating major panic in the region. The matter reached the heads of the colonial
government in England and post the speech of Queen Victoria on January 19, 1897 in both houses of the British parliament it was decided that measures needed to be taken for the eradication of the epidemic. Subsequently, a bill was introduced in the Council of the Governor-General of India in Calcutta (present day Kolkata) with the agenda of “better prevention of the spread of dangerous epidemic diseases”. Interestingly, the final act never went on to even provide a definition of “dangerous epidemic diseases”. John Woodburn, introducing the bill, admitted that certain provisions of the bill appeared prima facie extraordinary, however, the masses must “trust the discretion of the executive in grave and critical circumstances”. Woodburn also believed this measure was necessary “to take steps to allay the fears of other nations”. During that period, Russia was believed to have taken notice of the outbreak and hence it had become all the more instructive for the English to ensure no harm was done to their commercial interests. Unsurprisingly, the bill was passed unanimously. It must also be remembered that the discussion on the bill lasted for a gigantic sum total of one day.

Although some of Woodburn’s claims suggested the colonial government’s interest lay in the greater good of the natives, we cannot paint the entire picture in isolation. Other laws existing in the contemporary time must be placed alongside this particular act to determine the reasonability of the powers residing with the government. In England, at the time, the law dealing with spread of infectious diseases was the Public Health Act 1875. There is a striking difference in the provisions. Section 264 of this act dealt with the notice that could be served against a local authority acting under the act. Notably the law did not forbid a writ against the authority. The sole requirement was that “a writ or process shall not be sued out against…. until the expiration of one month after notice in writing has been served on such local authority”. Similarly, the scope of immunity to authorities, under section 265 was diluted. A simultaneous reading of the Epidemic Diseases Act 1897 and the Public Health Act 1875, highlights the explicit divergence in the rights of the public provided to them by the act.
iii.

The implementation of the act certainly did not go down without facing scathing criticism. As officials searched for suspected cases, there were reports of forcible segregation of masses and destruction of infected places. Public gatherings, meetings and festivals too were banned. As authorities ruthlessly cracked down on the cases, there were alleged instances of public humiliation in the form of strip searching and even violence at times. Nationalist, Activist and Teacher, Lokmanya Tilak was also a part of those who fiercely opposed the manner in which act was being implemented. In a memorandum published by residents of Pune against the workings of the Plague Committee, they highlighted the state of a ‘…reign of terror’. Along with carrying the infected patients to hospitals, the troops would also carry their family members and there was a forcible opening of housing and business premises for inspection and a merciless demolition of property. Thus, the enforcement was far from smooth sailing and individual liberty rights were the last priority of the authorities.

At the time, the necessity of combating the outbreak ensured that the provisions of the act trumped all other civic rights. However, it is also true that there was a striking variance in the yardstick used to measure the importance of individual rights in England and those in colonial India. The discrepancies in the provisions of the two acts made this very evident. Hence, it comes as no surprise when historian David Arnold regarded the act as “one of the most draconian pieces of sanitary legislation ever adopted in colonial India.”

III. The Epidemic Diseases (Amendment) Ordinance 2020

Since its use under the colonial government, the Epidemic Diseases Act, hasn’t been invoked too often but neither has it completely gone under the carpet. Recently, it has been enforced to prevent multiple outbreaks. In 2018 it was invoked with the spread of cholera in a Gujarat village, in 2015 it was invoked in Chandigarh to combat the malaria outbreak and in 2009 Pune needed the act to contain the spread of swine flu. But only under the current circumstances of Covid-19 has the law and its new amendment been a serious part of public discourse.
As this paper progresses, I will narrow the scope on examining the various facets of the aforementioned act and its amendment. But before that it is crucial to understand why and how the said amendment has been made. This will lay the groundwork for a more enhanced analysis of the changes brought in by the central government with the intent of effectively dealing with the coronavirus pandemic.

Globally, doctors, nurses and other essential health workers have been at the forefront of this battle. The onus of their protection and security has shifted on the community at large to ensure they face no hindrance in performance of their tasks. In light of this, in *Jerry Banait v. Union of India*¹³, a writ petition filed under article 32, the Supreme Court took cognisance of two distinct issues. (1) Availability of Personal Protection Equipment (PPEs), medical masks and other necessary equipment for healthcare workers; (2) Provision of security to healthcare workers. For the purposes of this paper, I will focus on the latter issue due its contribution to the amendment of the Epidemic Diseases Act. In its judgement the court threw light on the reported incidents of violence against health workers in Indore and Ghaziabad in the early days of April 2020. Due to this, it issued a 4-point directive to the central government and the respective states and union territories. Point 2 directed the authorities to provide police security to healthcare workers and point 3 directed the state to take necessary action against those who are found in violation of these rules.

Hence, the directives issued in the court’s response to the writ petition have catapulted the insertion of new provisions in the principal act, with an intent of effectively dealing with the contemporary issues that have arisen.

**IV. Analysis**

This part of the paper shall include an analysis of the various sections of the principal act and the newly inserted provisions through the amendment ordinance declared in the gazette on April 22, 2020. However, prior to that, we must also understand the basis on which this ordinance has been promulgated.

Article 123 of the constitution deals with the power of the President to promulgate ordinances during parliament recess. In essence, this particular ordinance has been promulgated under Article 123 (1) which states, “*If at any time, except when both Houses
of Parliament are in session, the President is satisfied that circumstances exist which render it necessary for him to take immediate action, he may promulgate such Ordinances as the circumstances appear to him to require.xiii

A key amendment has been with respect to Section 1, with the insertion of Section 1A. It lays down the important definitions the act lacked previously. The ambit of “acts of violence” against healthcare service personnel is inclusive of acts of harassment, causation of hurt/ injury, obstruction in duty and loss of or damage to property. But more importantly, this section provides the very definition of a “healthcare service personnel” and notably, it is not limited to a doctor, nurse or other medical worker.

Section 2A, originally gave the central government the power to prescribe regulations for inspections at ports. Evidently, this section excluded alternative modes of transport. Thus, the inclusion of other modes of transport like buses, trains and aircrafts was necessary. Section 2B is a new addition prohibiting “acts of violence” against healthcare service personnel or causing damage to property.

Although the amendments in the previous sections were necessary, it is section 3 of the principal act that has been under the spotlight of legal debate for a host of reasons, as I shall be exploring. The amendments made under the umbrella of this section are linked to the directives issued by the Supreme Court in Jerry Banait v. Union of Indiaxlv. Firstly, it must be noted that this particular section of the principal act laid down the penalty for a person found in violation of the orders made under the act. The person would be deemed to have committed an offence under section 188 of the IPC. This section provides a punishment of imprisonment extending to one month or a fine extending to two hundred rupees or both. In case disobedience to the order endangers human life, health or safety then the term of punishment could extend to six months or a fine extending to one thousand rupees. This section is expected to serve the purpose of a deterrent. Now, given the gravity of the current situation of the pandemic and the reported cases of violence against medical workers, any argument in favour of leaving section 3 unamended appeared to find itself on shaky grounds.
The newly added sub-section (2) of Section 3, penalises an individual who commits an “act of violence” against a healthcare service personnel or causes damage to property with a minimum imprisonment of 3 months, that could extend to 5 years and a minimum fine of 50000 rupees extendable to 2 lakh rupees. Also, if the act of violence causes grievous hurt, then, the punishment is a minimum jail term of 6 months extendable to 7 years and a fine of not less than 1 lakh rupees that could go to 5 lakh rupees. However, the ordinance has made offences under sub-section (2) and (3) cognizable, whereas, it doesn’t mention anything on the existing penal provision in sub-section (1). Hence, there is potential for conflict in the provisions of the act and the criminal procedure code 1973.xv

However, these insertions do not call for much scrutiny. Rather, it is the application of sub-section 3 and 4 w.r.t section 3A, section 3C and section 3D that needs to be placed under a microscopic lens.

Leaving aside the substantive aspects of section 3A (3), the procedural application invites practical issues. The ordinance states that the investigation of cases under the act shall be completed within a time period of thirty days from which the FIR was filed. Given the fact that the police force already finds itself working 24x7 in ensuring the lockdown guidelines are enforced and given that the coronavirus is reported to be increasingly spreading among police personnel, it begs the question whether it is practically possible to adhere to the mandated time period of investigation.xvi Moreover, section 3A (4), directs the judiciary to hold the inquiry/ trial “as expeditiously as possible” and the provided time frame is one year, but extendable. Again, it is not clear how the judiciary can expeditiously adjudicate on the issues before it, given the current circumstances and the plethora of backlog cases it will be forced to take up once normal service resumes.

Section 3C and 3D deal with presumption to offences and mental state of accused. For purposes of analysis, I will read the two sections together. Section 3C enables the court to presume the commission of an offence, under sub-section (3) of section 3, on part of the accused. Interestingly, the two parts of section 3D appear to contradict each other. For prosecution of offence, under sub-section (3) of section 3, the court shall presume existence of culpable mental state in sub-section (1) of section 3D. But, in the subsequent sub-section this fact of a “culpable mental state” is only declared to be proved when it is beyond reasonable doubt and not on the basis of preponderance by probability. Thus, on
one hand there is an assumption of a culpable mental state but on the other the condition is that it ought to be beyond reasonable doubt.

Last but by no means the least, is the debate on Section 4. The section provides absolute immunity to any person doing anything in accordance with the act. While some may argue that this is a “necessity” in exceptional circumstances, as I have noted earlier in the paper this argument appears outrightly ludicrous when one compares section 4 with section 264 and section 265 of the Public Health Act. The colonisers’ yardstick to measure the level of immunity was very different when it came to their own people. We need to ask ourselves whether after 123 years we want to be held prisoners to a section that is the epitome of a legislation once criticised by Myron Echenberg for its “… potential for abuse was enormous.”

The Epidemic Diseases Act (Amendment) Ordinance 2020, certainly possesses a list of much needed changes. The Prime Minister of the nation has hailed it as a symbol of “…commitment to protect each and every healthcare worker who is bravely battling Covid-19 on the frontline…” The insertion of definitions and list of contemporary modes of transport requiring inspection has taken into account the criticisms previously faced by the act. Moreover, the insertion of stricter penal provisions will facilitate in the purpose of deterrence of acts of violence against healthcare personnel. However, this doesn’t take away from the fact that there are certain practical issues, in the current scenario, that the provisions may not be able to obviate. Also, the act still doesn’t define what the phrase “dangerous epidemic diseases” encompasses.

**Deficiencies in the law**

Through the previous sections, I have traced the history of the Epidemic Diseases Act. I have also analysed the legal points from the current amendment ordinance that have not failed to invite scrutiny. The amendment’s intention to address the urgent issue of rampant acts of violence and hostility against frontline workers cannot be ignored. But, is it the only problem encountered during the pandemic?

In a developing country like India, the plight of migrant labourers- forced to make the arduous journey back to their hometowns- poses some uncomfortable moral questions.
There are other issues including unemployment, schooling, sick pay, food supply chain disruption, health insurance and lack of medical facilities, which have proliferated during the Covid-19. While there may be separate legislations that could be modified to address these concerns, it does not diminish the need for an epidemic/pandemic law comprehensively dealing with a multitude of matters. Given the absence of such a legislation in India, it is imperative for the government to import ideas from other countries that have enacted laws.

UK Coronavirus Act 2020

The legislation was enacted in the UK on March 25, 2020, with the intention of making various provisions in connection with the Covid-19.

Although an analysis of the act is beyond the scope of this paper, a few provisions must be noted.

i. Section 10 of the act focused on modifying the Mental Health Act 1983 to relax certain statutory requirements for patient detention, in anticipation of the potential rise in number of patients during the lockdown.

ii. Sections 25-29 were concerned with matters of potential disruption in the food supply chain during the pandemic. Hence, the provisions gave authorities powers to gather information from entities at various points within the food supply chain and to determine status of food supply throughout the UK.

There were other provisions on temporary closure of educational institutions, public gatherings, statutory sick pay and vaccination.

There is another concern that has gone relatively unnoticed. It is of the dead bodies’ disposal in a dignified and humane manner. The UK Coronavirus Act 2020 made provisions on the matter. Similarly, in India, the Ministry of Health & Family Welfare released guidelines dated March 15, 2020, on the management of dead bodies.

However, evidence points out to the startling and undignified manner in which dead bodies in some of the cases were disposed of. The burden on the Covid-19 hospitals and municipal authorities is unfathomable. However, it is imperative that they make every effort to fulfil the procedural requirements and ensure no dead body is abandoned or disposed of in a degrading manner.
V. Perspective on Mental Health: Police Personnel

We have witnessed a plethora of discussions on the Epidemic Diseases Act. A lot has been written on the origins of the law, its provisions, recent amendment etc. I have illustrated some of these points in this paper too. As the law has been under scrutiny, it has helped lawmakers to take into account concern of the frontline workers, albeit a lot more remains to be accomplished. Arguably, we require a new epidemic law or a legislation akin to the Public Health Bill 2009.

In this section of the paper, I will put policing during Covid-19 under the spotlight. However, it will be for a different purpose. The aim here is to make a case for the inclusion of mental health provisions as part of an epidemic/pandemic law for police personnel, who are a vital component of frontline workers.

The effectiveness with which the police force can perform its duties will go a long way in determining our capability to combat the coronavirus. But the police force has its own set of obstacles. We are also aware of issues that plague the institution. It faces severe criticism for instances of brutality and hostility. For instance, the case of Jayaraj and Bennicks during the Covid-19 lockdown in Tuticorin. However, as has been highlighted in the Second Administrative Reforms Commission’s report\textsuperscript{xxv}, a lot of these issues, which potentially dehumanise the force, stem from much more complex problems like stress and harsh working conditions. Owing to the increased probability of such problems to intensify during frontline work in the pandemic, it is necessary for us to focus on this aspect.

I have divided this section into three elements, (1) How has the nature of the police’s duty changed? (2) What are the new issues faced by police personnel? (3) How can the existing practices and policies be reformed?

The battle with Covid-19 has broadened the scope of duties of police personnel across India. Enforcement of epidemic and disaster management laws added new dimensions to an officer’s tasks. Subsequently, public perception of the police has also reshaped.
In addition to their primary duties of enforcing the lockdown, maintaining social distancing and prohibiting mass gatherings, police officials have stepped in to fill the void that was created during lockdown. They assist in provision of essential services including medical supplies to ‘at-risk’ citizens and food and transportation to hapless migrant workers. For instance, in Indore, police personnel spread awareness on women security coordinating with representatives under the URJA Trust.

In Jabalpur, a constable coordinated with an NGO to provide basic food supplies to starving slum dwellers.

D V Guruprasad, a former DGP of Karnataka Police remarked on the application of provisions of the Karnataka Police Act to combat spread of the coronavirus. He noted the domino effect of certain measures. In a lockdown, most roads will be deserted; hence, there is a heightened risk of rash driving, criminal activities, and theft in isolated areas. Thus, road safety becomes a priority for the police.

Moreover, as more people will tend to interact on the internet, the police need to be vigilant to prevent cyber-crimes.

The role of technology has enhanced by a remarkable degree. Officials in the Delhi Police have employed new technological methods to receive and record complaints. Interrogations for petty crimes can be done by video-conferencing. They also hailed communication apps like WhatsApp, which has significantly cut down on working hours and manpower deployment.

Interestingly, in midst of the pandemic, soft skills have received their due in the police force. Hitherto, the emphasis lay on hard skills like physical activities, crowd control, law and order maintenance. However, now they’ve had to adapt and adopt a more community friendly approach, wherein they disseminate information on Covid-19 and resolve conflicts with unruly citizens through communication. This is a welcome development in the institutions’ functioning and ushers a dawn of a 21st century people friendly police.

For instance, Pune Police is considering launching a ‘virtual appointment system’ to address grievances of residents (in a one-on-one interaction) as an increase in criminal cases was observed since the relaxation of the lockdown.
We have witnessed instances reflecting the dynamism and adaptability of the police. While circumstances for policing to evolve do exist, one cannot turn a blind eye towards the evident drawbacks. Although, there is no dearth of negative consequences, I will narrow the scope on the mental health issues, which have made themselves visible.

Firstly, I will illustrate the most common causes of mental health issues for the police and other frontline workers.

A report by the National Institute of Mental Health & Neurosciences noted the central cause to be “burnout” among frontline workers. A study conducted in the United States laid down four broad reasons for a burnout. (1) Occupational Hazards, (2) Inefficient Processes, (3) Financial Instability and (4) Comparisons between responses scaled on national and local level.

Moreover, the list of risk factors for frontline workers appear to be endless. Yet, there are some issues that have dominated discourse on the topic.

i. Availability and quality of PPE rank high among the concerns. Also, it is an arduous job for an officer to wear a PPE kit for 8-10 hours a day when on outside duty.

ii. Increased overburdening of daily tasks.

iii. Separation from family due to the risk of potentially transmitting the disease to a loved one.

A study was conducted on the plight of personnel in the Maharashtra Police, which evaluated the individual experiences of a few police officers during Covid-19.

Although, the study provides a detailed and comprehensive analysis, I will only note the issues faced by officers that had a psychological impact on their well-being.

Similar problems have been noted in this study. (1) Lack of PPE availability and concerns over quality, (2) The matter of migrant labourers added an unprecedented complexity to the matter. But the issue that has directly impacted mental health is separation from family. Consequently, in addition to their service-related work, officers have been forced to complete daily chores on their own. For instance, washing their uniforms on a regular
basis as part of the disinfection process. As a result, they've no time to focus on their physical, mental and spiritual well-being in midst of arguably the most severe crisis of this era.

The numbers reflect this, with half of the personnel in the study affirming mental disturbance due to Covid-19. Furthermore, more than two-thirds officers did not have the means and the time to focus on their personal well-being.

(3)

This component of the paper is divided into two parts. Firstly, I will illustrate measures, which can be implemented by police officers to alleviate mental health concerns. Followed by a suggestion on how policy makers can address the matter.

However, it is imperative to note the symptoms of mental health issues in police personnel before I address the aforementioned points.

A review paper published in the Indian Journal of Mental Health laid down the common symptoms in police personnel that manifest due to stress at the workplace.

i. Signs of fatigue and impulsive behaviour with sudden outbursts of varying emotions.

ii. Hypertension and cardiovascular irregularities.

iii. Tendency to overindulge in alcohol or other addictions.

The paper also cited a couple of contributing factors to the malaise. (1) Lack of support from the community and (2) lack of appreciation for the service they perform.

A lot of these factors stem from the public’s perception of the police as an uncompassionate state functionary.

The solutions can be further divided into categories, (1) Reshaping the work schedule and (2) Introducing mental health friendly policies.

i. Staff Rotation: The schedule ought to be divided into varying tasks based on stress levels. For instance, a few hours can be spent outside (high stress work) where they have to strictly maintain social distancing and other personal protection requirements. They can also spend some time within premises of their workplace to engage in relatively less stressful work.
ii. Supervisors should also try to arrange for short breaks and holidays from a busy work schedule\textsuperscript{xlv}.

In a webinar conducted by the Indian Police Foundation on mental health of police officers during the pandemic, heads of a few police institutions discussed the idea of a buddy project for police personnel\textsuperscript{xlv}. Such initiatives are regularly taken in other institutions like universities. Police personnel in a particular unit could also be divided into teams\textsuperscript{xlvi}, in which they openly communicate and discuss the mental health problems they’ve encountered during the pandemic. They can also stage regular Yoga sessions and encourage personnel to use mediation apps.

Departments can also coordinate with NGOs or other mental healthcare specialists who can arrange for helpline numbers, conduct interactive sessions and routinely circulate FAQs.

**Interventionist Approach**

While there are existing legislations and policies on mental health in India, there is an absence of an epidemic legislation addressing this— at times inconspicuous— but serious issue. The state of frontline workers discussed in the previous components, calls for an interventionist approach by the government.

Provisions on mental health of police and other frontline workers must be incorporated in an epidemic legislation. It should focus on certain points including, (1) role of police departments, (2) possible setting up of mental healthcare state commissions akin to the accountability state commissions mentioned the Model Police Bill, 2015\textsuperscript{xlvii}.

However, any reforms are conditional on the budget allocation. In 2019, the budget allocated to the National Mental Health Programme reduced from 50 cr. to 40 cr. (estimated to be 0.05% of the total healthcare budget)\textsuperscript{xlviii}. Furthermore, there is a paucity of resources. According to WHO estimates, there are only 4000 mental healthcare professionals in India, translating to about 1 for every 4,00,000 in the population\textsuperscript{xlix}.

Thus, a mechanism of psychological crisis intervention must be a priority. The pandemic has merely thrown light on existing predicaments. Now, these circumstances ought to be
perceived as an opportunity for us to address those concerns of police personnel at the frontline, which continue to be brushed under the carpet in public discourse.

VI. Conclusion

In this paper, I have discussed the Epidemic Diseases Act, 1897 and its intricacies in depth. I have also introduced provisions from the Coronavirus Act in the UK to remark on the evident deficiencies of an epidemic legislation in India. While there are a multitude of concerns in current policies and laws in India, I have narrowed this paper’s focus on the relatively unnoticed predicament of mental health problems among frontline workers—police personnel in particular. In an attempt to discuss the issue, certain critical questions on the subject were introduced. As statistics show, mental healthcare has not received its due in India. Unfortunately, it appears to be a subject burdened with a stigma in our society. But merely ignoring a concern does not diminish its significance. Circumstances, especially of police personnel, during Covid-19 have brought the matter to fore and we have been presented with an opportunity to reshape our perception on mental health. It presents a challenge requiring an interventionist approach, which our lawmakers must welcome; otherwise, we may be guilty of neglecting those who work tirelessly for our safety.
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