Article

To Vax or Not? A Human Rights Review of the Implications of Mandatory Vaccination as a Response to COVID-19

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Abstract

The COVID-19 pandemic precipitated the largest public health emergency so far experienced in the twenty-first century. As the world frantically pursues a sustainable solution, several vaccines have been tested and approved by the World Health Organization (WHO) under the Emergency Use Listing procedure. On the heels of this development have been moves by some States to adopt mandatory vaccination policies. Several private firms have also required their employees to be vaccinated as a pre-condition for resuming work. This fast-evolving situation brings into sharp focus the tensions between the rights to health, privacy, bodily autonomy and the right to consent to medical treatment on the one hand, and the public health and safety imperatives of protecting global populations against a ravaging pandemic on the other hand. This article argues that aggressive mandatory vaccination policies being propagated globally violate human rights by strengthening prejudices, and stereotypes, and furthering discrimination against those who may be unwilling to take the vaccines for one reason or another. Ultimately, therefore, there will be a need for States to adopt their own tailor-made vaccination frameworks that ensure the respect of individual rights on the one hand, but also ensures that it does not prejudice public safety in the wake of a ravenous pandemic.

Keywords: Mandatory vaccination; compulsory vaccination; informed consent; right to refuse medical treatment; right to health

UNISA university of south africa PRESS
South African Yearbook of International Law
https://unisapressjournals.co.za/index.php/SAYIL
Volume 46 | 2021 | #10360 | 16 pages
https://doi.org/10.25159/2521-2583/10360
ISSN 2521-2583 (Online), ISSN 0379-8895 (Print)

Introduction

The COVID-19 pandemic has precipitated the largest public health emergency so far experienced in the twenty-first century, occasioning not only loss of lives, but also social and economic losses due to containment measures set up by governments across the globe.

As the world continues to ride the COVID-19 wave and frantically pursue a sustainable solution, several vaccines have been tested and approved by the World Health Organization (WHO) under the Emergency Use Listing procedure.[1] On the heels of this development, there have been moves by some States to adopt mandatory vaccination policies.[2] For instance, United States President, Joe Biden, has rolled out proposed regulations for mandatory vaccination for federal workers and contractors.[3] Colleges, businesses and local governments in the US are also following suit with their versions of mandatory vaccination regulations.

In Kenya, the Head of Public Service and Secretary to the Cabinet circulated a memo dated 5 August 2021 to all public servants requiring them to undergo mandatory COVID-19 vaccinations, failure to which they would be subjected to disciplinary proceedings. Several institutions and private firms are also requiring their employees to be vaccinated as a pre-condition for resuming work.

This fast-evolving situation brings into sharp focus the tensions between the rights to health, privacy, bodily autonomy and the right to consent to medical treatment on the one hand, and the public health and safety imperatives of protecting global populations against a ravaging pandemic on the other. This article considers these emergent issues through the lens of the Constitution of Kenya and international human rights standards and norms, and argues that the overall effect of mandatory vaccination would be to exclude those who dissent/do not accept to be vaccinated from crucial economic and social activities, thereby rendering the full enjoyment of their rights in equality with others nugatory. Mandatory vaccination policies would also promote the segregation

1 See World Health Organisation (WHO), 'Emergency Listing Use Procedure' <https://cdn.who.int/media/docs/default-source/medicines/eulprocedure_a63b659c-1cdc-4cee-aa2d-ef5dd9d94f0b.pdf?sfvrsn=55fe3ab8_7&download=true> Also see <https://www.who.int/news/item/03-11-2021-who-issues-emergency-use-listing-for-eighth-covid-19-vaccine> accessed 17 November 2021.

2 As discussed elsewhere in this article, mandatory vaccination is the requirement that individuals be vaccinated as a pre-condition to accessing some socio-economic benefit. Compulsory vaccination on the other hand is the requirement that all individuals be vaccinated under the threat of criminal or other sanctions.

3 See 'The White House: Executive Order on Requiring Coronavirus Disease 2019 Vaccination for Federal Employees' (September 9 2021) <https://www.whitehouse.gov/briefing-room/presidential-actions/2021/09/09/executive-order-on-requiring-coronavirus-disease-2019-vaccination-for-federal-employees/> accessed17 November 2021.

and stratification of society into the 'vaccinated' and the 'non-vaccinated' thereby strengthening prejudices, and stereotypes and furthering discrimination. Ultimately, therefore, there will be a need to carefully navigate the minefield of possible scenarios in which violations would occur that are clearly traceable to mandatory vaccination policies.

The first part of this article examines the concept of the right to health, and in particular, the protections against forced medical treatment in the Kenyan Constitutional context. The second part of the article will then distinguish between compulsory vaccination and mandatory vaccination and explore whether mandatory vaccination policies amount to a violation or a reasonable limitation of the right to health as espoused both in the Kenyan Constitution and international human rights instruments. The last part of the article will attempt to decipher a possible middle ground, in particular, within the COVID-19 context, which would encourage the uptake of the vaccines, as well as ensure the respect and protection of the rights to health as well as bodily autonomy.

Revisiting the Right to Health in the Context of the COVID-19 Pandemic

Article 43 of the Constitution of Kenya declares that everyone has the right to the highest attainable standard of health, which includes the right to health care services. Article 21 proceeds to stipulate that the State shall take legislative, policy and other measures to ensure the progressive realisation of socioeconomic rights, including the right to health, protected in article 43. Part of the legislative measures enacted by the State in this regard is the Health Act of 2017 which provides that every person has the right to the highest attainable standard of health which shall include progressive access for the provision of promotive, preventive, curative, palliative and rehabilitative services. Section 5(2) of the Act further enacts that every person shall have the right to be treated with dignity, and respect and have their privacy respected in accordance with the Constitution and the Act.

In addition to the direct and explicit Constitutional protection of the right to health, article 2 of the Constitution incorporates general principles of international law, as well as international treaties ratified by Kenya as part of the domestic legal framework.

In this regard, Article 12 of the International Covenant on Economic Social and Cultural Rights (ICESCR) provides that every person has the right to the highest attainable standards of health. At the regional front, Article 16 of the African Charter on Human and Peoples' Rights (ACHPR) declares that every individual shall have the right to enjoy the best attainable state of physical and mental health and requires States to take such measures as are necessary to ensure the realisation of this right.

In explaining the normative content of the right to health, the Committee on Economic Social and Cultural Rights (CESCR) in General Comment No. 14 clarifies that health

services must be available, accessible, acceptable and of reasonable quality.[4] In addition, States are required to ensure that these are delivered in a manner that is not discriminatory and is alive to the specific requirements and circumstances of women, children and adolescents, older persons, persons with disabilities as well as indigenous communities and other minorities.

The Committee details a list of core State obligations in paragraph 43 of the General Comment to include accessibility to and distribution of health facilities, goods and services in a non-discriminatory and equitable manner; access to essential food and ensuring freedom from hunger, provision of essential drugs as well as the development and adoption and implementation of national public health strategies and plan of action.

Of course, the right to health cannot be realised in isolation, as emphasised in the 1993 Vienna Declaration and Platform for Action that all human rights are universal, indivisible and interdependent. Thus, the Committee observes that:

> The right to health is closely related to and dependent upon the realization of other human rights, as contained in the International Bill of Rights, including 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. These and other rights and freedoms address integral components of the right to health.

In addition, and more relevant to the COVID-19 pandemic, the Committee in its General Comment No. 14 observes that the freedoms attendant to the realisation of the right to health include inter alia, the right to 'control one's health and body … and the right to be free from non-consensual medical treatment.'[5]

Furthermore, the Committee acknowledges that in instances of public emergencies certain restrictive/derogation measures may be employed by States for the benefit of the general public. However, it notes that such limitations must be 'in accordance with the law, including international human rights standards, compatible with the nature of the rights protected by the Covenant, in the interest of legitimate aims pursued, and strictly necessary for the promotion of the general welfare in a democratic society.'[6]

Protection Against Forced Medical Treatment in Kenya

The right to health includes the right to be protected from forced medical treatment, or put another way, the right to refuse medical treatment. This is underpinned by the doctrine of informed consent, that people have the right to make their own decisions

4 See Paragraph 12 of the CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health Art 12.

5 See para 8 of the General Comment.

6 See para 28 of the General Comment as well as Arts 4 and 5 of the ICESCR.

about medical treatment after being informed of the risks, benefits and any reasonable alternatives.

The right to refuse medical treatment is enshrined in section 8 of the Health Act, which requires health care providers to provide information on the nature and type of medical intervention proposed, and to inform the user of their right to refuse the recommended options, and explain the implications, risks and legal consequences of such refusal.

Furthermore, section 9 of the Act provides that no specified health service may be provided to a patient without their informed consent.

Indeed, courts have upheld the right to refuse medical treatment in a variety of scenarios. For instance in *Fosmire v Nicoleau*, the Court of Appeals in New York held that a patient who was a Jehovah's Witness had the right to refuse blood transfusion despite the physician's belief that she was likely to die without the transfusion.[7] And in Kenya, the High Court has held that the subjection of an individual suspected to have committed a sexual offence to forced DNA testing by the Police without his consent, and without a prior court order was a violation of, among others, his rights to privacy and bodily autonomy.

The protection against forced medical treatment is supported by both national and international human rights standards including the protection from torture and cruel, inhuman and degrading treatment, the rights to security of the person as well as the rights to privacy and bodily autonomy.

Nonetheless, like most others, this right is not absolute; it may be overridden, for example, where the patient lacks the mental capacity to provide informed consent and the treatment would be in their best interest.[8] In addition, non-consensual treatment may be authorised if it is necessary to protect the safety of others; for instance, the sedation of violent patients in emergency situations where there is an imminent danger to the patient or others. Lastly, individuals may be compelled to submit to medical interventions as part of the investigatory process in a criminal or judicial process; for instance, physical examinations or collection of DNA samples such as saliva or blood, thus any such interventions would be sanctioned by a court of law, after careful consideration of the particular circumstances justifying the limitation of the right.

Article 4 of the ICESCR provides a general limitation clause to the rights contained in the Convention. However, any such limitations should be determined by law, and should be compatible with the nature of the rights protected and solely for the purpose of promoting the general welfare in a democratic society. The CESCR Committee emphasises in its General Comment that:

7 144 A.D.2d 8 (N.Y. App. Div. 1989)/ 536 N.Y.S.2d 492.

8 *Steele v Hamilton City*. Community Mental Health Bd. 2000.

> the Covenant's limitation clause, article 4, is primarily intended to protect the rights of individuals rather than to permit the imposition of limitations by States. A State party… has the burden of justifying such serious measures in relation to each of the elements identified in article 4…such limitations must be proportional, i.e., the least restrictive alternative must be adopted where several types of limitations are available. Even where such limitations on grounds of protecting public health are basically permitted, they should be of limited duration and subject to review.[9]

Within the Kenyan context, article 24(1) of the Constitution provides an analytical framework for the limitation of rights in a similar manner to the provisions of Article 4 of the ICESCR.

> 24. (1) A right or fundamental freedom in the Bill of Rights shall not be limited except by law, and then only to the extent that the limitation is reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom, taking into account all relevant factors, including—
>
> (*a*) the nature of the right or fundamental freedom;
>
> (*b*) the importance of the purpose of the limitation;
>
> (*c*) the nature and extent of the limitation;
>
> (*d*) the need to ensure that the enjoyment of rights and fundamental freedoms by any individual does not prejudice the rights and fundamental freedoms of others; and
>
> (*e*) the relation between the limitation and its purpose and whether there are less restrictive means to achieve the purpose.

In the recent case of *Law Society of Kenya v Hillary Mutyambai Inspector General National Police Service*[10] challenging the constitutionality of some of the COVID-19 restriction measures by the government, the Court while explaining the test provided in article 24(1), cited with approval the reasoning of the judges in the decision of the Constitutional Court of the Republic of Kosovo in *President of the Republic of Kosovo (Applicant) v Constitutional Review of the Decision No. [Government] 15/01*, 23 March 2020[11] in the following terms:

> …In this regard, it follows that the substance of the constitutional test of Article 55 of the Constitution is a four (4) step test which should be done in all cases when it is necessary to confirm whether we are dealing with a constitutional limitation of freedoms or rights……Before describing in detail all four steps of the test in question and how to apply them, it should be noted that the test in question is not cumulative. This means that in all instances where the condition or the first step of the test is not passed, the

9 See para 28 and 29 of ICESCR Committee General Comment No. 12.
10 [2020] eKLR.
11 Case No. KO54/2020.

> constitutional analysis ends there and it is not necessary to analyze the applicability of three, two, or another remaining step of the test. This interpretive approach……is also used by the ECtHR itself in interpreting the limitations on freedoms and rights guaranteed by the ECHR.
>
> In the abovementioned context and in the summary, the Court emphasizes that the test of Article 55 of the Constitution stipulates that the limitation of a right or freedom: (i) may be done only by "law" of the Assembly; (ii) there should be a "legitimate aim"; (iii) it should be "necessary and proportional"; (iv) it should be "necessary in a democratic society.

Within the Kenyan legal framework, the requirement for informed consent under sections 8 and 9 of the Health Act is not absolute. Section 9(1) provides that the requirement for informed consent may be waived in instances which include where the health service is authorised by an applicable court order, or where failure to treat the user, or a group of people which includes the user, will result in a serious risk to public health. In such circumstances, therefore, it follows that to pass the constitutional threshold, any non-consensual medical interventions that are performed on an individual, including compulsory vaccination, must pass the four-step process as outlined above. It must be grounded in law; it must pursue a legitimate aim; it should adhere to the tenets of necessity and proportionality and it must be justifiable in a democratic society.

In addition to the Health Act of 2017, the Public Health Act (as amended in 2012) provides guidance in relation to the regulation, maintenance and preservation of the overall public health framework, including the management of epidemics and infectious diseases such as smallpox, leprosy and tuberculosis, some of which have been retooled and applied to the control of the COVID-19 pandemic.

For the purposes of our analysis, sections 26, 27 and 28 of the Public Health Act are instructive in relation to the management of infectious diseases as well as the provisions pertaining to the control of smallpox in sections 106–112 as well as the Public Health (Port, Airport and Frontier Health) Rules 1959 which were enacted pursuant to section 73 of the Act. Furthermore, section 164 which provides a general penalty for non-compliance would be instructive. Section 2 of the Act defines an infectious disease as 'any disease (not including any venereal disease except gonorrhoeal ophthalmia) which can be communicated directly or indirectly by any person suffering therefrom to any other person.' Part IV of the Act which provides for infectious diseases enacts a raft of measures which may be implemented to treat, manage and suppress the spread of such diseases. In particular, section 26 provides for the possibility of 'detention' by the order of a medical practitioner, of someone suffering from an infectious disease in a hospital or other suitable location for purposes of treatment until he no longer poses a threat to the public. Section 27 also allows the detention and isolation of someone suffering from an infectious disease by an order of a magistrate to an isolation facility for such a time

as may be necessary until they are cured or no longer certified to be infectious or a danger to the public.

Thus, in *Daniel Ngetich v Attorney General*,[12] the petitioners, who were suffering from tuberculosis, had defaulted in adhering to their treatment regimen. They were subsequently arrested and committed to serving eight months in prison by a magistrate's court under sections 26 and 27 of the Public Health Act. The High Court declared their incarceration unconstitutional on among other grounds, that the correct procedure for committal was not followed, and further, that prisons were not envisaged as the appropriate detention facilities for such patients. However, given that the Court did not question the constitutionality of the provisions of sections 26 and 27 of the Public Health Act, their provisions would be presumed to be in the Court's mind, a reasonable limitation under article 24 of the Constitution. Indeed, in Kenya's 2019 report to the Human Rights Council under the Universal Periodic Review mechanism, the State report acknowledges that the High Court's decision 'led to the development of a rights-based Tuberculosis Isolation Policy in 2018.'[13]

Notably, however, nothing in part IV of the Public Health Act provides for the forced uptake of medication. Sections 26 and 27 only provide for detention and isolation until such time as the person is cured or no longer infectious. In the *Ngetich* case, the Court relied extensively on sections 25 and 26 of the Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights (Siracusa Principles) which outline that any measures taken by a State to deal with a serious threat to public health must be taken in accordance with the World Health Organization's regulations.[14] It is instructive that the Court made reference to the WHO's Guidance on Ethics of Tuberculosis Prevention, Care and Control 2010**,** which emphasises that:

> TB treatment should be provided on a voluntary basis, with the patient's informed consent and cooperation…engaging the patient in decisions about treatment shows respect, promotes autonomy, and improves the likelihood of adherence … Detention should never be a routine component of TB programmes. However, in rare cases, despite all reasonable efforts, patients will not adhere to the prescribed course of treatment, or will be unwilling or unable to comply with infection control measures. In these cases, the interests of other members of the community may justify efforts to isolate or detain the patient involuntarily … involuntary isolation and detention must be carefully limited and used only as a very last resort. [15]

12 (2016) eKLR.

13 See para 60 of Kenya's State Report to the UPR Working Group A/HRC/WG.6/35/KE1.

14 Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights <https://www.icj.org/wp-content/uploads/1984/07/Siracusa-principles-ICCPR-legal-submission-1985-eng.pdf> accessed 6 November 2021.

15 WHO, 'Guidance on Ethics of Tuberculosis Prevention, Care and Control 2010**'** <https://www.who.int/publications/i/item/9789241500531> accessed 6 November 2021.

More significantly, the guidance notes also observe that individuals who have been properly counselled about the risks and benefits of TB treatment rarely refuse care, and adherence is not usually a problem if appropriate support is provided.

In conclusion therefore, from a legal and constitutional standpoint, in the context of COVID-19, forced medical treatment, including forced vaccination, is only permissible under very stringent conditions, and should only operate as a last resort, after having passed the constitutional threshold set out in article 24 of the Constitution of Kenya.

Mandatory Vaccination, Compulsory Vaccination and the Human Rights Risks in the COVID-19 Pandemic

As the COVID-19 pandemic continues to scour the globe, scientists and researchers have been working tirelessly to pursue safe and effective vaccines with the hope of stemming its spread. As of the writing of this article, several vaccines have been tested and approved by the WHO under the Emergency Use Listing procedure.[16] States have on the heels of this development, been racing against time to procure the vaccines and inoculate their populations, hoping to achieve some level of herd immunity, thus slowing down the pandemic. It is in this context that debates around mandatory vaccinations have arisen, in particular in the wake of several mandatory vaccination directives by a number of States.

The concept of mandatory vaccination is related to but distinct from compulsory vaccination. Compulsory vaccination is the requirement that all persons, within a given locality, undergo vaccination against an identified illness. It would typically be invoked in emergency situations and would be an exception to the right to refuse medical treatment. Non-compliance would typically attract criminal and other sanctions. In Kenya, part VIII of the Public Health Act provides for a raft of restrictive measures, including penal sanctions for refusal to be vaccinated against smallpox. Sections 104 and 105 provide for the compulsory vaccination of children and adults including persons entering Kenya. In section 106(c), any person who refuses to be vaccinated, or prevents a child from being vaccinated commits a criminal offence punishable by a fine of at least six months imprisonment or a fine of fifty thousand Kenya Shillings (approximately USD500). Under section 112, no child may be admitted to or permitted to attend any school until they provide sufficient proof of having been vaccinated. Obviously, since the formal eradication of smallpox, no person has been subjected to these provisions and they are thus largely redundant in Kenya's legal framework.

16 See WHO, 'WHO Issues Emergency Use Listing for Eighth Vaccine' (3 November 2021) <https://www.who.int/news/item/03-11-2021-who-issues-emergency-use-listing-for-eighth-covid-19-vaccine> accessed 17 November 2021.

Nonetheless, this does not rule out the possibility of them being retooled and applied in the context of an epidemic of similar proportions.

Mandatory vaccination, on the other hand, refers to situations where vaccination would be required as a pre-condition to accessing any economic, social or other premises, or obtaining a specified service or benefit. The distinction between mandatory and compulsory vaccination, however, is that mandatory vaccination gives the individual a choice of whether to take up the vaccine or not. Should the individual opt not to take the vaccine, then they are denied access to a specific service or premises or benefit. Prior to the COVID-19 pandemic, mandatory vaccination was already a requirement, for instance, the requirement for yellow-fever vaccination as a pre-condition for international travel to certain destinations.

At first glance, it may be arguable that mandatory vaccination, is a relatively harmless device, respects the rights to privacy, bodily autonomy, and freedom from torture and upholds the individual's right to refuse medical treatment as provided in both national and international instruments. However, when the concept of mandatory vaccination is examined in the context of the current responses to the COVID-19 pandemic, a more concerning side of the narrative begins to emerge where the element of 'choice' or the 'right to refuse' is left hollow given the nature of services, and benefits being withheld or denied as a consequence of refusal to be vaccinated. Three American cases are instructive in this context.

In 1905, at the height of the smallpox epidemic, the United States Supreme Court had the occasion to address itself to the question of compulsory vaccinations in the case of *Jacobson v Massachusetts.*[17] The State authorities passed a law that allowed a city, if 'necessary for the public health or safety,' to enforce the vaccination of its citizens. If a person refused, he could be fined USD5.00. Relying on this statute, the city of Cambridge ordered its citizens vaccinated for smallpox. Mr Jacobson refused the vaccine and after trial, a jury found him guilty of refusing the vaccine. He was sentenced to jail until he paid the USD5.00 criminal fine. On appeal, he argued that the Massachusetts law authorising the vaccine mandate violated his Fourteenth Amendment rights. In rejecting his challenge, the Supreme Court observed that a State's police power 'must be held to embrace, at least, such reasonable regulations established directly by legislative enactment as will protect the public health and the public safety.' [18] This power included the 'authority of a state to enact quarantine laws and health laws of every description;' and such power extended to 'all laws that relate to matters completely within its territory and which do not by their necessary operation affect the people of other states.'

Thus, a court should only intervene 'if a statute purporting to have been enacted to protect the public health, the public morals, or the public safety, has no real or

17 *Jacobson v Massachusetts*, 197 U.S. 11 (1905).
18 Paragraph 25.

substantial relation to those objects, or is beyond all question, a plain, palpable invasion of rights secured by the fundamental law.'[19]

A more recent case involving mandatory vaccination is *Jennifer Bridges v Houston Methodist Hospital*.[20] In April 2021, the Houston Methodist Hospital announced a policy requiring its employees to be vaccinated against COVID-19 by 7 June 2021, or else they would lose their jobs. The plaintiffs, who were employees at the hospital sued to block the mandatory injections and the termination. In dismissing her claim, the court held that the vaccine requirement was neither coercive nor amounted to unlawful termination and that she should accept or refuse the vaccine, but should she refuse, then she would need to work somewhere else.

Furthermore, in *Ryan Klaassen v The Trustees of Indiana University*,[21] the University passed a policy in May 2021 requiring all students, faculty, and staff to be fully vaccinated before returning to campus between 1 August to 15 August for the fall 2021 semester. Those refusing the vaccine would not be permitted on campus, their emails and university accounts would be suspended, and their access cards deactivated. Faculty and staff who refuse vaccination would also face termination. Several students filed a suit challenging the constitutionality of the mandatory vaccine policy and seeking a preliminary injunction against the implementation of the policy.

In denying their application, and upholding the mandatory vaccination policy, the Court, relied on among others, the precedent set in *Jacobson*. It held that the Fourteenth Amendment permitted Indiana University to pursue a reasonable and due process of vaccination in the legitimate interest of public health for its students, faculty, and staff.

Meanwhile, in Kenya, by a circular dated 5 August 2021, the Head of Public Service issued a blanket mandatory vaccination directive to all civil servants or risk being subjected to disciplinary processes. The directive was spurred by the low uptake of vaccines among civil servants. It remains to be seen whether similar directives would be issued with regard to learning institutions, private businesses, or even as pre-conditions for accessing public amenities, domestic air travel and so on. As of the writing of this article, a Constitutional Petition has been filed at the High Court challenging the validity of the said government circular. It is anticipated that the decision in *Jacobson* will feature prominently at the hearing of the suit.

It is evident from the cases above, that the debates surrounding mandatory vaccination policies will require a delicate balancing between the rights sought to be limited, and the rights sought to be protected through the proposed limitation. It, therefore, becomes

19 Paragraph 31.

20 *Bridges et al v Houston Methodist Hospital et al* 21-1774.

21 Cause No. 1:21-CV-238 DRL.

increasingly urgent at this stage of the pandemic, to ensure that any vaccination policies being developed or allowed are consistent with international and national human rights obligations and standards. That the right to refuse medical treatment is not rendered hollow. That human rights are not sacrificed at the altar of fear and misinformation.

Human Rights Risks Associated with Mandatory/ Compulsory Vaccinations

The foregoing sections of this article have demonstrated that compulsory and mandatory vaccination policies may be allowed within certain limited parameters as set by the Constitution and international law. Despite this, there are still, in the author's view, a number of 'human rights risks' associated with compulsory and mandatory vaccination policies, which policymakers must be alive to.

To begin with, mandatory and compulsory vaccination robs the individual of the right to choose. In the case of mandatory vaccination such as in the case of Indiana University discussed above, individuals are 'coerced' to either vaccinate or forego their right to education. And in the Houston Medical Hospital case, mandatory vaccination was used as a pre-condition to work, with those who choose to remain unvaccinated ultimately losing their employment. The downstream effects of loss of education opportunities or loss of livelihood would be catastrophic for many struggling individuals, families, and communities. Ultimately, individuals are left to choose between two evils, ie, loss of livelihoods, or the likelihood of adverse reactions from the vaccines, which are then not covered by most health insurance schemes.

Secondly, mandatory and compulsory vaccination pose the risk of the erosion of democracy at a fundamental and structural level. Democracy implies the right to dissent, to ask questions, to be different, and to say no if the answers given are unsatisfactory, and to have that decision respected, of course within reasonable bounds. The foundations of democracy are weakened when individuals and communities are arbitrarily and subtly 'threatened' with the withdrawal of crucial services and opportunities if they do not submit to vaccination. Thus, the hard-won gains in most emergent and established democracies are under serious threat of a return to some form of authoritarianism.

Furthermore, the use of terms such as 'the vaccinated' and 'the unvaccinated' risks stratifying communities into an 'us versus them' scenario. The immediate and longer-term effects of this classification set the foundation for discrimination on the basis of vaccination status. As illustrated by the cases above, there are documented instances of individuals having been denied access to employment, education and other services on the basis of their vaccination status. If not properly managed, such mandatory vaccination policies would run counter to the very foundation of the international human rights framework, that all are born free and equal in dignity and rights.

The risks set out in this section are not exhaustive but are merely illustrative so as to demonstrate the levels of vigilance required to safeguard mandatory or compulsory vaccination policies from morphing into instruments of discrimination and oppression. Accordingly, this study proposes the adoption of softer approaches that would run parallel to and mitigate the adverse effects of any mandatory vaccination requirements. These are outlined below.

De-Stigmatisation of COVID-19

From the outset of the COVID-19 pandemic, at least in Kenya, there was a high degree of social stigma associated with the disease. In its earlier days, those who contracted the virus were kept in prison-like detention and isolation centres, sometimes at their own expense. The disease was and is still being referred to severally by policymakers as the 'unseen enemy'. Unfortunately, the negativity associated with the disease is then projected onto the COVID-19 patients who are then seen as the agents or the carriers of this 'unseen enemy'. They are implicitly blamed for 'catching the virus', 'not adhering to relevant guidelines' and possibly 'spreading it'. This has then led to the discrimination and stigmatisation of COVID patients, largely due to a mix of misinformation or lack of information. There is therefore a need for sustained campaigns targeted at the de-stigmatisation of COVID-19 at all levels of governance.

Public Information and Awareness on Vaccinations

We operate in the era of fake news and misinformation, especially with the increased uptake of social media which is readily available on most mobile devices. The WHO Guidance on Ethics of Tuberculosis Prevention, Care and Control 2010 provides a useful template which may be retooled to provide relevant information to the public and increase their confidence levels in voluntary vaccination.[22] The argument here is that if the public is well informed, voluntary vaccination would follow and there would be little or no requirement for mandatory or compulsory vaccination policies. These guidelines provide that: 'TB treatment should be provided on a voluntary basis, with the patient's informed consent and cooperation … engaging the patient in decisions about treatment shows respect, promotes autonomy, and improves the likelihood of adherence.'

It proceeds to observe that: individuals who have been properly counselled about the risks and benefits of TB treatment rarely refuse care, and adherence is not usually a problem if appropriate support is provided.[23]

Thus, learning from the TB framework, it is proposed that States emphasise adequate information and counselling to the public about the various vaccines available, their

22 See (n 15).

23 See Principle No.7 of the World Health OrganiZation, 'Guidance on Ethics of Tuberculosis Prevention, Care and Control 2010' <https://www.who.int/publications/i/item/9789241500531> accessed 6 November 2021.

benefits, the risks and side effects as well as those who may need to get medical clearance before vaccination. This could follow the model of the Voluntary Counselling and Testing (VCT) services offered in the context of the HIV/AIDS response.

Provide Incentives to the Public

States should put in place appropriate frameworks and incentives to encourage the uptake of vaccinations. This would include cushioning and financial or other support for those who may have negative vaccine reactions, provision of testing and counselling or advice to those who may have pre-existing conditions that would render them unfit as candidates for vaccination, tax incentives to employers who give their employees time off to get vaccinated, etc.

Development of a Vaccine Exemption Framework

Instead of issuing blanket mandatory vaccination policies, States should also invest in the development of a vaccine exemption framework. Such a framework would include guidelines on grounds for vaccine exemption, the documentation required, and who may qualify for such exemptions. For example, organ transplant recipients, those with pre-existing autoimmune conditions, lactating mothers, patients with already compromised immunity eg, cancer patients and so on.

Pursuit of Reasonable Alternatives to Mandatory Vaccinations

Closely related to the foregoing, would be the development and implementation of alternatives to vaccination tailored for the workplace or learning institutions, for instance, promoting online learning, remote working for those unwilling or who do not qualify to get vaccinated, the requirement to provide COVID-19 negative test results every seven to fourteen days or any other reasonable alternative mutually agreed between the employer and employee after a thorough evaluation of what would be workable within the specific work context.

Conclusion

The COVID-19 pandemic is not yet over. The disease still continues to ravage communities and stretch the public health systems globally. As the vaccination drives gain momentum, States must seek to pursue vaccination policies that are not coercive, do not unduly prejudice human dignity, but strike the delicate balance between the rights of the individual and the rights of the public to be protected from the pandemic.

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