Overcoming Parental Consent: How can International Human Rights Law be used to Protect a Child's Right to Health in Childhood Immunization Cases?

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I hereby declare that I have read and understood the regulations governing the submission of Master of Laws in International Law dissertations/ research papers, including those relating to length and plagiarism, as contained in the rules of this University, and that this dissertation/ research paper conforms to those regulations.

Date: 12 September 2019 **Signature:** Signed by candidate

DEDICATION

To my loves: Wamaka and Zaithwa.

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ABSTRACT

Children have the right to preventive medical treatment and interventions that serve their best interests. In the case of minors, this right is exercised by the parent or legal guardian with hopes that they will exercise their responsibility positively. Over the years however, this right has been challenged by an increasing number of parents withholding consent to immunize their children against some deadly diseases for one reason or another. This has led to a conflict between parental consent and the child's right to health and resolving this conflict is an issue of law. Childhood immunizations are the first line of defence for a child and as such, should be considered a basic human right that needs to be protected. By denying this right to the child, it infringes on that child's right to health and right to life. This should not be the case as international human rights law demands the protection of society's most vulnerable members, especially children.

LIST OF ACRONYMS

AAAQ	Availability, accessibility, acceptability, and quality
ACRWC	African Charter on the Rights and Welfare of the Child
AU	African Union
CEDAW	Convention on the Elimination of all Forms of Discrimination Against Women
CESCR	Committee on Economic, Social and Cultural Rights
CRC	Committee on the Rights of the Child
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
MMR	Measles, mumps, and rubella
NGOs	Non-Governmental Organisations
OAU	Organisation of African Unity
RSA	Republic of South Africa
UDHR	Universal Declaration of Human Rights
UN	United Nations
UNCRC	United Nations Convention on the Rights of the Child
UNESCO	United Nations Educational, Scientific and Cultural Organisation
UNGA	United Nations General Assembly
UNICEF	United Nations Children's Fund
USA	United States of America
WHO	World Health Organization

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CHAPTER ONE

INTRODUCTION

Childhood immunisation policy… contemplates numerous complex, contentious, and controversial themes: a state's interest in protecting public health must be balanced against an individual's medical treatment considerations; concepts of informed consent and personal autonomy must be balanced against state mandates; minor-patients' rights and public interests must be balanced against parental rights; and religious and personal philosophies must be balanced against science and medicine. … The prospect of harmoniously resolving all of these concerns appears daunting.[1]

I INTRODUCTION

The right to health is a basic human right afforded to all regardless of age, race, or gender. It has been enshrined in key international law instruments including the International Covenant on Economic, Social and Cultural Rights (ICESCR), and the Universal Declaration of Human Rights (UDHR), and other regional instruments such as the African Charter, and the African Charter on the Rights and Welfare of the Child (ACRWC). A child's right to health is specifically enshrined under Art. 24 of the United Nations Convention on the Rights of the Child (UNCRC). It states in part that 'States Parties recognise the right of the child to the enjoyment of the highest attainable standard of health…State Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.'

Yet, children's health is regarded as 'the most neglected segment' in healthcare.[2] This is especially true in developing countries where access to health is regarded as more of a luxury than a right. The World Health Organization (WHO) estimates that 15, 000 children die every day across the globe.[3] In Sub-Saharan Africa alone, one (1) child in thirteen (13) dies before his or her fifth birthday, fourteen (14) times higher than in developed countries.[4] What is worst, 'more than half of under-5 child deaths are due to diseases that are preventable and treatable through simple, affordable interventions.'[5] That being said, immunization rates have seen a significant decline in the last decade. For instance, 12.9 million infants were unvaccinated in 2016, and 'the percentage of children who received their full course of routine immunizations has stalled at 86% (116.5 million infants)' since 2010.[6] These are startling statistics considering

[1] Ross D. Silverman 'No More Kidding Around: Restructuring Non-Medical Childhood Immunization Exemptions to Ensure Public Health Protection' (2003) 12 *Ann Health L* 277, 278.
[2] R. N. Srivastava 'Right to Health for Children' (2015) 52 *Indian Pediatrics* 15.
[3] UNICEF/WHO '1 in 10 infants worldwide did not receive any vaccinations in 2016' available at https://www.who.int/mediacentre/news/releases/2017/infants-worldwide-vaccinations/en/, accessed on 4 April 2019.
[4] Ibid.
[5] Ibid.
[6] Ibid.

that immunisations 'prevent between 2 – 3 million deaths every year from diphtheria, tetanus, whooping cough, and measles,' and an additional 1.5 million deaths could be prevented if global vaccination rates around the world improved.[7] In fact, immunization is considered to be one of the most cost-effective public health interventions.[8]

Given the role immunizations have played in relieving pain and suffering, and in the eradication of some infectious diseases, why is access to readily available vaccines not considered a human right? Learned colleagues are of the opinion that it should be, arguing that it is 'hard to imagine a more basic infringement of children's rights than to deliberately put them at risk of dying.'[9] Yet, that is exactly what happens every day when children are exposed to deadly diseases that are avoidable through immunizations. The risk of exposure to such diseases is exacerbated by parents who exercise their right to withhold consent to have their children immunized. In 2019, the WHO ranked "vaccine hesitancy" as one of the top ten threats to global health.[10] Be it for philosophical or religious reasons, the anti-vaccination movement has seen an increase in popularity, including receiving support from the current President of the United States of America (USA), Mr. Donald Trump.[11] This movement has contributed to previously eradicated diseases such as measles seeing a comeback in the USA, and across the globe.[12]

The question then becomes, how can a child's right to health be protected in childhood immunization cases where parents withhold consent? At the heart of answering this question is a discussion on the balancing of parental and children's rights when they conflict, and most importantly, determining when it is appropriate for the state to intervene. Furthermore, what role can international human rights law play in this debate?

II PROBLEM STATEMENT

[7] Ibid, WHO/Rada Akbar 'Ten threats to global health in 2019' available at https://www.who.int/emergencies/ten-threats-to-global-health-in-2019, accessed on 4 April 2019.
[8] Ibid.
[9] Mary Robinson 'Immunization is all about human rights' *Chicago Tribune* 28 August 2005 available at https://www.chicagotribune.com/news/ct-xpm-2005-08-28-0508280357-story.html, accessed on 4 April 2019.
[10] Ibid.
[11] On 28 March 2014, President Trump tweeted: 'Healthy young child goes to doctor, gets pumped with massive shot of many vaccines, doesn't feel good and changes – AUTISM. Many such cases!' Quote from Dan Janison 'Trump neither recants nor follows up on his anti-vaccine tweets' *News Day* 11 February 2019 available at https://www.newsday.com/amp/long-island/columnists/dan-janison/measles-trump-anti-vaccine-1.27190465, accessed on 4 April 2019.
[12] Kaja Damnjanovic et al. 'Parental Decision-Making on Childhood Vaccination' (2018) 9 *Frontiers in Psychology* 1, 2.

Sometimes, doctors and parents will disagree on a course of medical treatment of a child. This is normal, and can usually be resolved through information sharing and frank discussions between the disputing parties. But, what if the dispute arises from the stern belief that truly the course of action is not in the best interests of the child? Converting philosophical beliefs is a lot more challenging.

The anti-vaccination movement has seen an increase in popularity over the years. Several factors can be attributed to this, but the most common one is the belief that vaccinations 'specifically the measles, mumps, and rubella (MMR) vaccine, or vaccines thimerosal – a mercury-based preservative in vaccines' cause autism.[13] Though this 'autism link theory' has been debunked by the medical community, it has not deterred the conspiracy theorists from claiming a correlation between the MMR vaccines and the increased number of autism cases.[14] The medical community argues that 'correlation is not the same as causation' and it has to be noted that the creator of the autism link theory, Andrew Wakefield acknowledged in his published findings that 'no association between autism and the MMR vaccine were found.'[15] Wakefield explained the autism link theory by stating that 'the inflamed intestines released toxins in the bloodstream which reached the brain thus resulting in the neurological disorder.'[16] It was later discovered that Wakefield was paid handsomely by an attorney to embellish the results of his study so that they could be used in a class action suit against manufacturers of the MMR vaccine.[17] He was later 'charged for scientific misconduct' by the General Medical Council.[18] With that brief history, we find ourselves in this legal conundrum of competing interests.

The law grants parents and guardians (in circumstances where the biological parents are not around) the right to make medical choices for their child (i.e. a minor) on their behalf. This is because the law and courts believe that the minor is too young to comprehend the complexity of making medical decisions, some of which could be life-altering. So, the faith is placed in the parents or guardians to use their knowledge and better judgment and make a decision in the best interests of the child. This decision-making power is not unlimited though.

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[13] Stephanie Jablonsky 'The Right to Refuse Vaccination: Revisiting Vaccination Exemptions and the Best Interests of the Child Standard' (2016) 733 *Law School Student Scholarship* 1, 9.
[14] Ibid.
[15] Ibid.
[16] Ibid, 9 - 10.
[17] Ibid.
[18] Ibid.

There have been instances where parents have been brought before courts to answer for failing to act in the best interests of the child.

The challenge with anti-vaccination is that not only does it pose a threat to the health of the child, and infringe on his/her right to access to health, it also poses a global health threat to the community at large. Vaccination hesitancy which is 'the resistance to be vaccinated or to delay vaccination despite having available vaccination services' has been on a steady rise.[19] Everyday parents are making a conscious decision not to vaccinate their children.

The problem statement is how can international human rights law be used to protect a child's right to health in childhood immunisation cases where parental consent is withheld? To this end, there will be a discussion on how the UNCRC, the International Bill of Human Rights and soft law can be used to protect a child's right to health in childhood immunisation cases. Additionally, the following sub-questions will be addressed; what is the role of the courts in balancing parental and children's rights in immunisation cases? Does the child have any say in childhood immunisation cases?

III AIM OF STUDY

With the WHO listing vaccine hesitancy as one of the top threats to global health, now more than ever should we take a keen interest in improving vaccination numbers across the globe. It is no longer a "them" problem but an "us" problem as the increasingly globalised world makes transmission of previously eradicated diseases among continents more likely as has been seen with the measles outbreak. So, the first aim of the dissertation is to critically analyse the principle of parental consent in immunization cases with regards to minors. Here, a comparative analysis will be conducted on the different approaches in the application of this principle in the United States of America (USA), and the Republic of South Africa (RSA) (i.e. the test countries). The balancing act that the various actors and decision-makers face when dealing with the rights and best interests of the child versus the parental rights will also be explored. The two test countries have been selected for comparison based on their geographical location (i.e. one is in North America and the other in Africa); their economic status (i.e. developed country versus developing country); the ratification of the UNCRC (i.e. one has ratified, the other has not); and the legal maturity of the subject matter in their jurisdiction (i.e.

[19] Ibid, 10.

USA has more extensive legal commentary, while RSA is still developing its commentary on the same).

Secondly, the paper will address how the UNCRC should be applied in cases concerning minors where parental consent is denied, and will explore circumstances that can trigger state-mandated vaccinations. To this end, the dissertation will explore the international children's rights legal framework and will assess how it envisions the protection of the child's right to access to health. It will include a comparative analysis of the two test countries' existing laws and policies to help the reader gain a better understanding of the laws governing vaccination of children, minors in particular.

Lastly, it will conduct an analysis on when and how the law can intervene to vaccinate the child contrary to parental wishes. To achieve this, an analysis of jurisprudence of the two test countries will be conducted, even though reference may be made to other countries.

IV RESEARCH METHODOLOGY

The research methodology will be limited to desktop research. This will consist of an application of the relevant literature (i.e. international and regional children's rights framework, General Comments, case law, legislation, journals, electronic sources and textbooks) to the issue at hand.

V LITERATURE REVIEW

(a) Introduction

Vaccines are the first line of defence for children (especially infants and toddlers) and are arguably one of the most important preventive measures in paediatric healthcare. Yet, vaccinations have seen a steady decline over the years due to parents withholding consent based on a study that purported that some vaccines may cause permanent harmful side effects on their children. This is despite the fact that the impugned study has been debunked and its author stripped of his medical licence. The problem with parents withholding consent is that it is extremely dangerous not only for the un-immunized child whose life is put at risk, but also for the community at large whose lives are also put at risk. Vaccination delays and refusals cause communities to fail 'to reach thresholds of vaccine uptake that confer herd immunity; thus raising the possibility of an outbreak should a vaccine-preventable organism start circulating

in that community.'[20] Furthermore, denying immunisation for the child infringes on that child's right to health.

The anti-vaccination movement has garnered popularity in the Western world, so there is diverse literature on the subject, but it remains a relatively new concept in Africa and not much has been written about it. However, over the years, there has been significant literature and interest in vaccine hesitancy due to the WHO identifying it as a priority issue in global health. As such, every continent is under scrutiny and going forward, there will be more literature on Africa as well.

Vaccinations and a child's right to health are closely interlinked. Under Art. 24 of the UNCRC, a child has a right to health including access to preventive healthcare such as vaccines. Furthermore, Art. 24 (1) places an obligation on States Parties to 'strive to ensure that no child is deprived of his or her right of access to such healthcare services.'[21] Article 24 (2) goes on to list the measures States Parties must take in order to ensure a child's right to health and these measures include development of preventive healthcare, diminishing of infant and child mortality and provision of necessary medical assistance.[22] Regionally, the ACRWC under Art. 14 (2) entrenches a child's right to health including access to preventive healthcare services. Chirwa argues that this demonstrates that international law has recognised access to essential medicine as a 'fundamental component' of the right to health.[23] As will be demonstrated in the discussion below, not only are immunizations beneficial to the child's healthy development, but the fact that it prevents child mortality also serve the best interests of the child. This literature review shall explored the reasons behind vaccine hesitancy, its effects, and how to address it.

(b) Why are parents so hesitant to vaccinate their children?

A review of the literature demonstrates that there are a myriad of reasons why parents are hesitant or refuse to immunise their children. They show that vaccination hesitancy is not as simple as black and white plain parental refusal to vaccinate their child. There are factors that heavily influence that decision, be it religious or philosophical beliefs, or medical concerns

[20] Sara Cooper et al. 'Vaccine hesitancy – a potential threat to the achievements of vaccination programmes in Africa' *Taylor & Francis Online* 22 May 2018 available at https://www.tandfonline.com/doi/full/10.1080/21645515.2018.1460987, accessed on 20 April 2019.
[21] Art. 24 (1) UNCRC.
[22] Art. 24 (2) UNCRC.
[23] Danwood Chirwa 'The Right to Health in International Law: Its Implications for the Obligations of States and Non-State Actors in Ensuring Access to Essential Medicine' (2003) 19 *SAJHR* 541 at 42.

(whether real or imagined). While some parents will outright refuse to vaccinate their child, others will opt to delay the vaccination until the child is older or explore alternative medicine.

Mistrust of vaccines is not new, in fact Poland and Jacobson note that 'since the 18th Century, fear and mistrust have arisen every time a new vaccine has been introduced.'[24] Some scholars argue that in many ways, vaccines have become victims of their own success, such that parents do not see the need to immunize their children when most of those diseases they are trying to protect their child from have already been eradicated.[25] Furthermore, the increased number of publications on the side effects of vaccinations (whether real or perceived) have caused parents to focus on the negative than the positive, forgetting that 'the benefits of vaccination greatly outweigh the risks, and many more illnesses and deaths would occur without vaccines.'[26] It is pretty evident that the effects of Wakefield's falsified study are still being felt today as he continues to enjoy a large following.[27]

The literature shows that the increase in parental mistrust in the safety of vaccinations has contributed to increased vaccine hesitancy in the USA, with more and more parents opting for non-traditional medicines and "natural products."[28] The reasons why vaccine hesitancy is on the rise in Africa remain unknown. While 'academic publications on vaccine hesitancy quadrupled during the first few years of this decade', these are primarily focused on the research conducted in Western countries.[29] The challenge with these findings is that 'vaccine hesitancy is highly variable and context specific' and so the reasons cannot simply be generalised and applied to the African context.[30] For instance, inaccessibility to vaccination stations or lack of knowledge on the importance of vaccines are some of the primary barriers to vaccines in most African countries.[31] However, most research suggests that 'the drivers of vaccine hesitancy include confidence, complacency, convenience, risk calculation, and collective responsibility ("5C model").'[32] These are based on data collected in the 'WEIRD (Western, Educated, Industrialised, Rich, and Democratic) societies' and there is insufficient

[24] Catherine C. McClure et al. 'Vaccine Hesitancy: Where We Are and Where We Are Going' (2017) 39 *Clinical Therapeutics* 1550, 1552.
[25] Jablonsky op cit (n 13) 1.
[26] Claire Felter 'Measles and the Threat of the Anti-Vaccination Movement' *Council on Foreign Relations* 12 March 2019 available at https://www.cfr.org/article/measles-and-threat-anti-vaccination-movement, accessed on 4 April 2019.
[27] McClure et al. op cit (n 24).
[28] Ibid at 1553.
[29] Cooper et al. op cit (n 20).
[30] Ibid.
[31] Ibid.
[32] Ibid.

empirical data to suggest how this model applies to Africa. There is a clear knowledge gap in this field, and there is a need to develop models that respond to 'the context-specific causes and implications of vaccine hesitancy within different African settings, and differentiate hesitancy from other reasons why individuals are not (completely) vaccinated in the region.'[33] This will require further research and Africa-specific interventions for better results. Otherwise, we might not have a definite response as to why vaccine hesitancy is on the rise in Africa.

(c) Effects of Vaccine Hesitancy

The Disneyland measles outbreak that occurred between 2014 and 2015 was the first major outbreak that demonstrated the link between vaccination hesitancy and disease outbreak.[34] Measles outbreaks have increased by 30% globally and kill 90, 000 people annually.[35] 2017 was the worst case of measles outbreak with 21, 315 cases and 35 deaths reported globally.[36] An additional 275 cases have been reported in 2019 in eight American States, Washington alone reported at least 70 cases.[37] In Africa, Madagascar is currently combatting one of its worst outbreaks in decades.[38] As of 14 February, 2019, the WHO has estimated that nearly 1, 000 children have died a result of the outbreak that began in October, 2018.[39] The measles outbreak caused 70 deaths in the Philippines in 2019 and decreasing vaccination rates have been a major contributing factor.[40] It has been reported that measles coverage has been steadily declining since 2014 'from a high of 88% to just above 50% in 2018.'[41]

The WHO has linked these outbreaks to low vaccination rates.[42] Approximately 1 in 10 infants (12.9 million children) were unvaccinated in 2016.[43] In fact, 27 million children 'miss out on vaccines against common disease such as measles and whooping cough.'[44]

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[33] Ibid.
[34] Ibid.
[35] WHO/Rada Akbar op cit (n 7), BBC 'New York County declares measles outbreak emergency' *BBC* 27 March 2019 available at https://www.bbc.com/news/world-us-canada-47715169, accessed on 4 April 2019.
[36] Damnjanovic et al. op cit (n 12).
[37] Felter op cit (n 26).
[38] Ibid.
[39] Amy Green 'How strong are the anti-vaxxers in SA?' *Daily Maverick* February 2019 available at https://www.dailymaverick.co.za/article/2019-02-18-how-strong-are-the-anti-vaxxers-in-sa/amp/, accessed on 22 April 2019.
[40] Ibid.
[41] Ibid.
[42] Laura Williamson, Hannah Glaab 'Addressing vaccine hesitancy requires an ethically consistent health strategy' *BMC Medical Ethics* available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6201581/, accessed on 20 April 2019.
[43] UNICEF/WHO op cit (n 3).
[44] Robinson op cit (n 9).

Consequently, 1.4 million children – three every minute – die annually from infectious diseases that could have been easily prevented through immunisations.[45]

(d) Addressing Vaccine Hesitancy

Efforts have been made to address the declining vaccination numbers across the globe, to no avail. Evidence reveals that the vaccination numbers continue to decline regardless. Many theories have been raised as to why this may be. Some argue that the efforts are not targeting the main problem. Most interventions are based on the fact that parents or guardians are misinformed and if they are provided with more information, then they will be coerced and change their minds. However, this is easier said than done. In the words of Corace, 'while knowledge is a necessary first step, it is not sufficient to tip the scales of behaviour change.'[46] In fact, failure of the medical community to change the minds of vaccine-hesitant parents is well documented. For instance, increased knowledge on the human papillomavirus (HPV) did not translate to more HPV vaccinations.[47] In Africa, traditional medicine and cultural beliefs contribute to misinformation.[48] Generally, the literature shows that correcting the misinformation is not enough to reduce vaccination hesitancy. What is required is a reiteration of the facts in simple language with little to no repetition of the misinformation.

The literature also identified healthcare workers as an integral part in influencing the decision of parents to vaccinate their child. [49] As such, they need to be equipped with excellent communication skills to be able to articulate the facts and information in a simple, informative, and unbiased manner. Medical practitioners have to be able to build a rapport with the parents in order for them to trust them and influence a positive decision. Other documentations also show that parents appreciate an open-minded and engaged discussion with the medical practitioners.

The legal strategies that have been developed and are currently in practice in the USA to curb vaccine hesitancy are aimed at removing non-medical exemptions or making exemptions difficult to require. The hope is that this will cause an increase in vaccination rates, but the opponents point out the ethical and political violations of such a decision. They argue

[45] Ibid.
[46] McClure et al. op cit (n 24) 1554.
[47] Ibid.
[48] WHO 'SAGE Working Group on Vaccine Hesitancy – Literature Review' 21 March 2013 available at https://www.who.int/immunization/sage/meetings/2013/april/2_Systematic-lit_Review.pdf, accessed on 20 April 2019.
[49] Ibid.

that ‘making vaccination compulsory removes the element of choice and personal liberty, which may provoke political advocacy by those who oppose vaccination and government regulation.’[50] The best legislative approach on this is yet to be determined.

However, web-based tools and information have been designed by researchers to combat misinformation online. This was after research showed that most parents obtain their anti-vaccine information online. There has been significant success in information dissemination though it will be difficult to analyse the full impact of these campaigns at the moment.

Finally, the importance of community engagement in curbing vaccine hesitancy cannot be understated. These two are interlinked such that face-to-face interactions is essential in order to build trust and respect with the hopes of enacting changes in perception. Here, international human rights law can play an important in informing both state and non-state actors (including parents and children) of their rights and duties in immunization cases.

VI CHAPTER OUTLINE

This dissertation has six Chapters.

Chapter One discussed how withholding of parental consent infringes on the child’s right to health and highlighted the pertinent questions to be answered in this paper. It further conducted and in-depth review of the literature exploring among other themes; the importance of vaccinations, the reasons behind vaccine hesitancy and its effects, and concluded with a brief discussion on how to address vaccine hesitancy.

Chapter Two focuses on the international legal framework that governs children’s rights. To this end, it will begin with a brief historical background of children’s rights and then proceed into an in-depth discussion of the four general principles of the UNCRC and their relation to the topic at hand. Following that, the regional treaties governing children’s rights shall be briefly examined, and the Chapter will conclude with a discussion of how a child’s right to health is governed under international human rights law.

Chapter Three discusses the balancing of competing rights between the parent and child. It will analyse the extent to which the best interests of the child are weighed against parental rights

[50] McClure et al. op cit (n 24) 1556.

and responsibilities. Other areas of analysis will include the role of informed consent, child autonomy and evolving capacity in immunisation cases.

Chapter Four analyses how the domestic courts in the two test countries protect a child's right to health in instances where parental consent is withheld. Specifically, it will address when courts are likely to intervene. Furthermore, it will also analyse the extent international human rights law has influenced the domestic law in the test countries in relation to a child's right to health in immunisation cases.

Chapter Five discusses how international human rights law can be used to overcome parental consent. It will analyse the interaction between international human rights law with domestic law in the two test countries, and address the gaps contributing to vaccine hesitancy in the two test countries.

Chapter Six is the final Chapter. It will conclude by summarising all the main arguments made in the previous Chapters.

VII CONCLUSION

Vaccine hesitancy is not a new concept, though the number of parents opting out of vaccinating their children is alarming. There are several gaps in the literature especially with regards to Africa. What has been written about Africa has been based on research and modules designed for Western countries and neglected some unique features found in Africa that play a pivotal role in influencing the decisions of parents. What is evident is that all countries need to develop strategies on addressing this gap and they should incorporate open dialogue and community engagement between parents and the community at large. While forced vaccinations may reach the target of increasing vaccination rates, they raise ethical and political violations that will only reinforce the mistrust that is already brewing amongst vaccine-hesitant parents. Either way, this should be a priority concern for every human being as it has the potential of affecting us in one way or the other.

CHAPTER TWO

INTERNATIONAL LEGAL FRAMEWORK FOR CHILDREN'S RIGHTS

I INTRODUCTION

Children, as legal subjects under international law, have rights that are entrenched in the UDHR, ICESCR, and the International Covenant on Civil and Political Rights (ICCPR) (known collectively as the International Bill of Human Rights). One of the rights that features in these three documents as well as in the UNCRC is the right to health. The right to health is an inalienable right which the WHO describes as 'our most basic and essential asset.'[51] In fact, the former UN High Commissioner for Human Rights, Navi Pillay opined in her report that 'the right to health is the foundation for all other rights.'[52] Due to the importance of this right, great responsibility has been placed on states to ensure that this right is not infringed upon. The most comprehensive example of this is found under Art. 12 of the ICESCR which calls on States Parties to undertake specific measures to ensure full realisation of the right to health.

The UNCRC also safeguards various rights relating to children, and under Art. 4, States Parties bear the responsibility of undertaking 'all appropriate legislative, administrative, and other measures for the implementation of the rights recognised in the… Convention.' More specifically, the right to health is governed under Art. 24 of the UNCRC. In part, this Article calls on States Parties to take 'appropriate measures' in ensuring that every child enjoys 'the highest attainable standard of health' by ensuring that 'no child is deprived of his or her right of access to… health care services.'[53] Despite all these mechanisms in place, the right to health seems but a fairy tale for some, be it due to lack of resources, or lack of access to healthcare as is the case when parental consent is denied for some medical procedures.

This Chapter seeks to analyse the legal framework that governs a child's right to health under international law. First, it will begin with a historical background of the development of child rights under international law. Secondly, it will provide a brief overview of the international and regional legal instruments that govern children's rights. More specifically, it

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[51] UN Office of the High Commissioner for Human Rights (OHCHR) *Fact Sheet No. 31, The Right to Health*, June 2008, 1.

[52] Office of the United Nations High Commissioner for Human Rights *Report in preparation to the Day of General Discussion on Human Rights on the right of the child to the enjoyment of the highest attainable standard of health* (4 March 2013). The right to housing, food, life, non-discrimination, and human dignity complement the right to health.

[53] Art. 24 (1) UNCRC.

will examine the UNCRC and its four general principles, as well as the ACRWC. Thirdly, it will examine the right to health under international human rights law, this will also include a brief discussion on the soft law governing the right to health. It will also specifically address what international law means by the 'highest attainable standard of health.' Lastly, it will conclude with an analysis of the right to health under the UNCRC, in relation to other rights. It will evaluate how the UNCRC addresses the evolving capacities of the child, focusing on the balancing of the right of the child to be heard against the right of the child to be protected. This Chapter will inform the upcoming discussion on addressing the conflict of rights between parents and children in Chapter Three.

II HISTORICAL BACKGROUND OF CHILDREN'S RIGHTS

The past ninety-five years have seen a legal evolution of children's rights. What initially began as perceiving children as "small adults" has gradually progressed to their fully-fledged recognition as persons deserving of equal rights and protection under the law.[54] As the post-World War II human rights instruments were enacted, they took special care to afford minors legal protection with regards to human and socio-economic rights[55] that cumulated to the establishment of the United Nations Children's Fund (UNICEF) in 1953. However, it would take another thirty-six years before the United Nations General Assembly (UNGA) would adopt a specific instrument that governs the rights of a child, the UNCRC. This document has become one of the most important legal texts in our time with a wide ratification by 196 countries by 2015, with the USA being the only exception.[56] In as much as there has been progress in child rights law, children all over the world continue to face several hurdles that infringe on their basic human rights in various sectors of their lives.[57]

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[54] Humanium 'Children's Rights History' available at https://www.humanium.org/en/childrens-rights-history/, accessed on 9 May 2019.

[55] These are rights that ensure that people have the basic necessities in order to live a dignified life. These include the right to food, water, housing, and health.

[56] Humanium op cit (n 54).

[57] For example, the right to access to health remains a challenge in most parts of the world. The WHO estimated that 6.3 million children under the age of 15 died in 2017 from preventable diseases, translating to 1 child death every 5 seconds: WHO 'Maternal, newborn, child and adolescent health' *WHO* 20 November 2018 available at https://www.who.int/maternal_child_adolescent/child/en/, accessed on 26 July 2019. Aside from health, the right to education remains unattainable for millions of children. Statistics reveal that over 72 million children are deprived of a primary education and 759 million adults 'are illiterate and do not have the awareness necessary to improve both their living conditions and those of their children': Humanium 'Right to Education: Situation around the world' available at https://www.humanium.org/en/right-to-education/, accessed on 15 May 2019. Additionally, child marriages remain prevalent with an estimated 650 million child brides globally, and 12 million females being married off before the age of 18: Girls Not Brides 'New Global Estimates of Child Marriage' 15

The concept of "children's rights" began in 1924 following the League of Nation's adoption of the Geneva Declaration on the Rights of the Child which has been heralded as 'the first effort to address the rights of the child on an international level.'[58] The Preamble of the Declaration recognises that 'mankind owes to the child the best it has to give.'[59] To that end, several rights for children key to their development including 'priority for relief and economic relief, and protection from exploitation' were recognised by the Declaration.[60] This was followed by the establishment of an organisation specifically designed to cater to every aspect of a child's life called the International Children's Emergency Fund in 1946 (later known as UNICEF).[61] All these efforts gradually demonstrated the international community's willingness to recognise children's rights and give children's rights their own platform on the international law scene. That being said, children's rights were not explicitly entrenched in their own legal instrument.

Instead, inferences of such rights were drawn from other prominent human rights instruments such as the UDHR, ICESCR and the ICCPR. For instance, the UDHR under Art. 25 (2) confers the right to 'special care and assistance' and 'social protection' to mothers and children. While the ICCPR is a general instrument affording equality of rights amongst all human beings, it also makes specific reference to children. For example, Art. 6 (5) forbids the death penalty for any person under the age of 18, the right to life for all is conferred under Art. 6 (1), the prohibition of pre-arranged marriages is found under Arts. 22 and 23, Art. 24 confers the right to non-discrimination for every child and juvenile offenders are protected under Arts. 10 and 14. The ICESCR makes some references to the protection of children's economic, social, and cultural rights. For instance, the right to education is entrenched under Art. 13, furthermore, children are entitled to 'special measures of protection and assistance… without discrimination' under Art. 10 (3), while Art. 12 regulates the right to health, and calls on States Parties to reduce stillbirth rates, infant mortality and the improvement of healthy development

March 2018 available at https://www.girlsnotbrides.org/wp-content/uploads/2018/03/CM_burden_release_webinar_15Mar18_final_.pdf, accessed on 15 May 2019.

[58] UNICEF 'History of child rights' available at https://www.unicef.org/child-rights-convention/history-child-rights, accessed on 9 May 2019, Osifunke Ekundayo 'Does the African Charter on the Rights and Welfare of the Child (ACRWC) only Underlines and Repeats the Convention on the Rights of the Child (CRC)'s Provisions?: Examining the Similarities and the Differences between the ACRWC and the CRC' (2015) 5 (7) *International Journal of Humanities and Social Science* 143 at 145.

[59] Ekundayo op cit (n 58).
[60] Ibid.
[61] Ibid.

of the child. However, while these instruments covered some of the pertinent rights owed to children, they were primarily seen as human rights instruments.

Realising the obvious legal gap, the UNGA attempted to remedy it through the adoption of the 1959 Declaration of the Rights of the Child. In its Preamble, the Declaration notes that mankind owes a child 'special safeguards and care, including appropriate legal protection, before as well as after birth.'[62] As such, this document was pivotal in shaping the way for the UNCRC and other regional child rights treaties. There was a shift in the language used in the 1959 Declaration that was more authoritative, and entitlement or rights-giving as compared to the 1924 language which was more persuasive.[63] For instance, the 1924 Declaration uses phrases like 'the child must be given' while the 1959 Declaration states that 'the child shall enjoy all the rights set forth in this Declaration.'[64] This language shift, Fitzgibbon argues 'reflects a change in the treatment of children from being viewed as objects of international law to being perceived as subjects of international law.'[65] It has been credited as being the 'conceptual parent' for the UNCRC and so, in that respect the 1959 Declaration is considered as 'ground-breaking.'[66]

While the 1959 Declaration was definitely a positive step, it was not until the adoption of the UNCRC in 1989 that children's rights were exclusively recognised in a binding international legal instrument. This codified legal document has been 'widely acclaimed as a landmark achievement for human rights, recognising the roles of children as social, economic, political, civil, and cultural actors.'[67] The consequence of the adoption of the UNCRC is that it 'guarantees and sets minimum standards for protecting the rights of children in all capacities.'[68] Furthermore, being a living instrument, this has allowed for the area of children's rights to expand and adapt to the modern times. For instance, the post-UNCRC adoption era has focused on the domestication of the UNCRC with a lot of success (as previously stated, only the USA is yet to ratify the document); and has also led to the adoption of other treaties aimed at

[62] Brian K. Gran 'An International Framework of Children's Rights' *Annual Reviews* 31 July 2017 available at https://www.annualreviews.org/doi/full/10.1146/annurev-lawsocsci-110615-084638, accessed on 9 May 2019.

[63] Ekundayo op cit (n 58) 146.
[64] Ibid.
[65] Ibid.
[66] Ibid.
[67] UNICEF op cit (n 58).
[68] Ibid.

combatting some modern-era human rights infringements such as child labour,[69] early and/or forced marriages,[70] and juvenile justice.[71]

III AN OVERVIEW OF THE UNITED NATIONS CONVENTION OF THE RIGHTS OF THE CHILD

The adoption of the UNCRC in November, 1989 by the UNGA marked a pivotal moment in the international protection of children's rights. The UNCRC is arguably 'the most prominent treaty on children's rights' and has enjoyed wide support from UN Member States.[72] It comprises of 54 Articles based on four general principles namely; non-discrimination,[73] best interests of the child,[74] the right to life, survival and development,[75] and the right to be heard.[76] Also, under Art. 43, the UNCRC established the Committee on the Rights of the Child (CRC) as a monitoring body for the implementation of the UNCRC by States Parties. The Committee is comprised of 18 independent experts 'of high moral standing and recognised competence in the field covered by this Convention' elected by States Parties.[77] As part of its monitoring duties, the Committee receives and reviews state reports submitted by States Parties, (an initial report submitted by the state two (2) years after ratification), and a periodic report (every five years after that).[78] Lastly, the UNCRC is unique in that it allows for non-governmental organisations (NGOs) and other specialised agencies a direct role in monitoring implementation under Art. 45 (a) of the UNCRC.[79]

(a) The General Principles of the UNCRC

The next four principles to be discussed in this subsection were identified by the CRC not only as mere rights but also as 'general principles to be considered in the implementation of all other

[69] Worst Forms of Child Labour Convention adopted in 1999 by the International Labour Organisation (ILO).
[70] The Optional Protocol to the Convention on the Rights of the Child on the Sale of Children, Child Prostitution, and Child Pornography (OPSC) adopted in 2000.
[71] Manual for the Measurement of Juvenile Justice Indicators published in 2007.
[72] Gran op cit (n 62).
[73] Art. 2 UNCRC.
[74] Art. 3 UNCRC.
[75] Art. 6 UNCRC.
[76] Art. 12 UNCRC.
[77] Art. 43 (2) UNCRC.
[78] United Nations Human Rights Office of the High Commissioner 'Monitoring Children's Rights' *OHCHR* available at https://www.ohchr.org/en/hrbodies/crc/pages/crcintro.aspx, accessed on 10 May 2019.

[79] Gran op cit (n 62).

rights.'[80] These general principles are non-discrimination, best interests of the child, the right to life, survival and development, and the right to be heard as discussed below:

(i) Non-Discrimination

The principle of non-discrimination is a hallmark of international human rights law instruments, and it calls for equal protection of rights for all regardless of racial, gender, religious, ethnic, and any other differences. It was adopted into the UNCRC under Art. 2 and it speaks to non-discrimination in relation to children. The Article calls on States Parties to ensure that the rights set out in the Convention are enjoyed by every child without discrimination.[81] This Article was drafted on the basis that children are vulnerable and will face discrimination be it in the form of 'reduced levels of nutrition; inadequate care and attention; restricted opportunities for play, learning and education; or inhibition of free expression of feelings and views… [and] harsh treatment.'[82] As such, the CRC calls on States Parties to confer protection from discrimination children or groups of children 'whose rights may demand special measures.'[83] This is why the UNCRC makes reference to non-discrimination in other Articles, like Art. 22 in reference to refugee children, Art. 23 in reference to disabled children, and Art. 30, in reference to indigenous children.[84] Regardless, Art. 2 is unique as compared to other non-discrimination clauses because the prohibition not only applies to discrimination towards the child, but also discrimination aimed at the parents or legal guardians of the child.[85] So, this non-discrimination principle serves to protect both the child and the child's family.[86]

With regards to the right to health, Art. 2 has been described by some academics like Kasper as one of the key contributors in ensuring the realisation of this right by children without facing discrimination.[87] Kasper bases her argument on the fact that the prohibition outlined in Art. 2 places an obligation on states to ensure protection and realisation of children's rights without discrimination and to refrain from discriminatory policies.[88] This obligation, in her

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[80] Gerison Lansdown *See Me, Hear Me: A guide to using the UN Convention on the Rights of Persons with Disabilities to Promote the Rights of Children* (2009) 83.
[81] Art. 2 UNCRC.
[82] Committee on the Rights of the Child, General Comment No 7, 'Implementing Child Rights in Early Childhood' (20 September 2006) CRC/C/GC/7/Rev.1 para 11 (b).
[83] Committee on the Rights of the Child, General Comment No 5, 'General measures of implementation of the Convention on the Rights of the Child' (27 November 2003) CRC/GC/2003/5 para 12.
[84] Samantha Besson 'The Principle of Non-Discrimination in the Convention on the Rights of the Child' (2005) 13 *The International Journal of Children's Rights* 433, 446.
[85] Trynie Boezaart *Child Law in South Africa* (2009) 316.
[86] Ibid.
[87] J. Kasper 'The Relevance of U.S. Ratification of the Convention on the Rights of the Child for Child health: a Matter of equity and Social Justice' (2010) 5 (89) *Child Welfare* 21 at 27.
[88] Ibid.

purview has resulted in active efforts by states to ensure fulfilment of children's rights without discrimination.[89]

(ii) The Best Interests of the Child

The best interests principle gained prominence following its entrenchment in Art. 3 (1) of the UNCRC. While the CRC in General Comment 14 traced this principle's origins to the 1959 Declaration, the text only references it on two occasions. The first is in reference to enactment of laws, that the best interests of the child shall be of "paramount consideration" (Principle 2), and the second is in reference to upbringing, that parents shall use the best interests as the "guiding principle" when raising their children (Principle 7).[90] Nonetheless, by the time the UNCRC came into force, the CRC had been tasked with developing yardsticks for States Parties to monitor compliance and implementation of the Convention in their respective jurisdictions. The best interests principle was listed as one of those general principles and it soon gained prominence as one of the key principles, even though it was not the CRC's intention for the principle to garner that much attention.[91] It is therefore unsurprising that the best interests principle has received both criticism and adulation from the legal fraternity. Some academics have hailed it as 'one of the most significant accomplishments of the CRC' while others have critically referred to it as 'a formula for unleashing state power, without any meaningful reassurance of advancing children's interests.'[92]

Article 3 (1) states that in all matters concerning the child, the best interests of the child shall be "a" primary consideration. The wording of Art. 3 (1) suggests that the best interests principle is one of the factors to be considered in the decision-making process, but not necessarily the dominant one. However, the UNCRC has demonstrated that in certain situations (adoption for example), the best interests of the child shall be "the" paramount consideration.[93] This demonstrates that in certain circumstances what is best for the child will determine the course of action in relation to that child.[94] For example, in cases of abusive parents, the courts may rule that the best interests of the child would be to remove the child from the custody of

[89] Ibid.
[90] Committee on the Rights of the Child, General Comment No 14, 'The right of the child to have his or her best interests taken as a primary consideration' (1 February 2013) CRC/C/GC/14, para 2, Nigel Cantwell 'The concept of the best interests of the child: what does it add to children's human rights?' in Milka Sormunen (ed) *The Best Interests of the Child - A Dialogue between Theory and Practice* ed (2016) 19.
[91] Cantwell op cit (n 90) 20.
[92] Boezaart op cit (n 85) 319.
[93] Art. 21 UNCRC.
[94] Boezaart op cit (n 85) 319.

his/her parents and place the child in the custody of the state.[95] In that case, the best interests will guide the action.

The ACRWC on the other hand, takes on a stronger approach of the best interests principle. Article 4 of the ACRWC states that in all matters concerning the child, the best interests of the child shall be "the" primary consideration. The ACRWC arguably places the best interests principle on a higher standard than the UNCRC.[96] Given the mild contradiction, it begs the question of which Article to apply if a state has ratified both the UNCRC and the ACRWC. According to Boezaart, the answer is quite simple, whichever instrument carries the higher protection supersedes the UNCRC because the end goal is to attain the highest protection and realisation of children's rights.[97]

The most difficult interpretation of this principle arises when dealing with parental decision-making in medical cases. In such cases, determining the best interests involves a multitude of factors including the evaluation and balancing of both long-term and short-term interests which at times are in conflict. In explaining how these interests are balanced, Freeman states that 'current interests tend to be formulated in relation to experiential considerations, whereas future-oriented interests focus on developmental considerations.'[98] Such considerations would arise in an instance where a child had to undergo an operation to cure a life-threatening illness. While the child may suffer short-term post-surgery consequences such as pain, discomfort and immobility, but in the long-term, the child stands a chance of living a longer and healthier life.[99] Similarly, in vaccination cases, a child's fear of needles has to be balanced against the benefits of immunizations.[100]

Furthermore, the best interests of the child must be balanced against the child's right to participation. For instance, where an anorexic child refuses food, the best interests of the child would be to insert a feeding tube. However, the child has a right to have his or her views heard as their right to participation. So, the question becomes, whether or not to consider the child's views considering that the child's life is at stake. Here, Fortin has argued that 'there are respectable jurisprudential arguments for maintaining that children's rights do not prevent

[95] Ibid, Art. 9 read with Art. 20 UNCRC.
[96] Boezaart op cit (n 85) 319.
[97] Ibid, 342.
[98] Michael Freeman *A Commentary on the United Nations Convention on the Rights of the Child, Article 3: The Best Interests of the Child* (2007) 3.
[99] Sarah Ida Spronk *The right to health of the child: an analytical exploration of the international normative framework* (unpublished PhD thesis, Leiden University, 2014) 57.
[100] Ibid.

interventions to stop children making short-term choices, thereby protecting their potential for long-term autonomy.'[101] This perspective is pivotal especially when deciding the level of participation children should be allowed in their medical treatments.[102]

(iii) Life, Survival, and Development

This principle is closely linked to the right to life which is prominently featured in various international human rights instruments.[103] Additionally, this principle is significant in obligating states to 'reduce infant mortality and increase life expectancy' in order to ensure fulfilment of this right.[104] The wording of Art. 6 of the UNCRC is such that it does not only guarantee the right to life for the child but also places an obligation on States Parties to ensure the survival and development of the child. A lot of factors contribute to the survival and development of the child including access to food, water, sanitation, shelter and medical services – factors governments have been tasked with providing. So, where parents are lacking, states are to ensure access to clean water and sanitation, free medical services, government housing and school feeding programmes, in order to ensure that children are able to realise this right. In fact, some legal scholars argue that the states are obligated to provide such survival and developmental services, and children are entitled to demand them.[105]

The right to life and the right to health are intrinsically linked. In fact, Riedel argues that 'without an effective guarantee of the right to life, all other rights would be meaningless.'[106] Furthermore, the right to survival is not only about ensuring the right to health, but also includes a myriad of factors including the child's mental, psychological and social development, which are vital to a child's healthy development.[107] This means that states are tasked with developing programmes that target the long-term health, survival, and development of the child. In terms of the focus of this paper, this means that children should have access to preventive healthcare, more specifically, access to vaccines, regardless of parental wishes. When a parent refuses to immunize their child, this refusal is in direct conflict with the child's

[101] Jane Fortin 'Children's Rights: Are the Courts taking them More Seriously?' (2004) 15 *King's College Law Journal* 253 at 270.
[102] Spronk op cit (n 99) 58.
[103] Art. 3 UDHR and Art. 6 ICCPR.
[104] Rachel Hodgkin, Peter Newell *Implementation handbook for the Convention on the Rights of the Child* ed (2007) 84.
[105] Boezaart op cit (n 85) 320.
[106] Eibe Riedel 'The Right to life and the Right to health, in particular the obligation to reduce child mortality' in Antonella Invernizzi and Jane Williams (eds.) *The Human Rights of Children: From Visions to Implementation* (2011) 351–369.
[107] General Comment op cit (n 82) para 12.

right to health. This is because the entire purpose of Art. 24 of the UNCRC is not merely to protect children from existing diseases but under Art. 24 (2) (f), this includes protection from potential threats to their health, which vaccines are designed to counteract.

(iv) The Right to be Heard

The child's right to be heard, also known as the right to participation, is entrenched under Art. 12 of the CRC. The concept of this principle is rooted in the idea of recognising the child as an active participant whose views are to be considered on matters concerning them.[108] Even though people have dubbed this as the right to participation, it is important to note that nowhere in the CRC's interpretation of this Article is it referred to it as that.[109] However, what is clear in the CRC's interpretation is that the primary objective of Art. 12 is to allow child participation, hence the association of the term with this right/Article.[110] For ease of reference, Art. 12 of the UNCRC states as follows:

1. States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.
2. For this purpose, the child shall in particular be provided the opportunity to be heard in any judicial and administrative proceedings affecting the child, either directly, or through a representative or an appropriate body, in a manner consistent with the procedural rules of national law.

There are three components to Art. 12 namely; the right to express views freely, the right to be 'given due weight in accordance with the age and maturity of the child' and 'the right to be heard in any judicial and administrative proceedings affecting the child.' If properly executed, this Article is crucial to initiating 'dialogue between children and adults based on mutual respect, and in which children can learn how their views and those of adults are taken into account to shape the outcome of such processes.'[111] Of course this right to be heard is not limited, and applies to both private and public forums.

The first component of free expression of views simply means that children should be able to communicate their thoughts without manipulation or pressure. With regards to health, this

[108] Boezaart op cit (n 85) 321.
[109] Ibid.
[110] Committee on the Rights of the Child, General Comment No 12, 'The right of the child to be heard' (20 July 2009) CRC/C/GC/12.
[111] Ibid.

could mean a number of things. For example, it could mean that a child is entitled to private counselling with a health professional where they can express themselves and ask questions freely. It could also mean that the parent must accept a course of treatment the child has decided on regardless of whether or not the parent agrees with that particular decision. The second scenario is where the potential conflict between Art. 3 (1) (i.e. best interests of the child) and Art. 12 arises, with some scholars treating the two Articles as "oppositional."[112] The tension can be attributed to the fact that Art. 3 was designed to determine the best interests of the child which 'is in contrast with the shield-like mechanism of Article 12 requiring non-interference with the child's right to participate in matters affecting him or her.'[113] States Parties have made efforts to remedy the conflict in the UNCRC through their domestic laws.[114] Lastly, it is important to note that in some contexts, Art. 12 has been limited by cultural practice. For instance, African children are taught from a young age to respect the views of their elders. This thinking affects the extent to which an African child is allowed to express their views in matters concerning them, and also the extent to which adults will take those views into consideration.[115]

The second component of giving due weight to the age and maturity of the child refers to the evolving capacities of the child. In essence, as the child ages and/or matures, their capacity will develop along with it, hence this growth must be taken into account when considering their views.[116] Research has revealed that children who undergo long-term medical treatments are more likely to mature quicker than those who do not suffer from long-term illnesses.[117] Other studies revealed that 4 to 5 year olds who had been undergoing long-term medical treatment were more medically mature (i.e. able to understand their course of treatment) than 9 year olds who rarely fell ill.[118] This finding affirmed that in some instances, experience is vital to developing competency, as such, putting an age limit as to when a child would attain competency would be misguided, as age might not reflect capacity in some cases.[119] Furthermore, this element of giving due weight also means that when a child

[112] Susan Moses 'Children and Participation in South Africa: An Overview' (2008) 16 *International Journal of Children's Rights* 327, 337.
[113]Boezaart op cit (n 85) 322.
[114] Ibid.
[115] Ibid.
[116] Art. 5 UNCRC and General Comment op cit (n 82).
[117] Mary Donnelly, Ursula Kilkelly *The Child's Right to be Heard in the Healthcare Setting: Perspectives of Children, Parents and Health Professionals* (2006) 3.
[118] Myra Bluebond-Langner *The Private Worlds of Dying Children* (1978) 135.
[119] Ibid.

communicates their feelings (e.g. pain, sorrow or depression), parents, guardians, and/or medical professionals should employ measures to treat the child.[120]

The last component concerns the child's right to be heard in judicial and administrative proceedings. In a healthcare setting, this could mean the child has a right to participate in a disciplinary hearing against a medical professional who infringed on that child's right to health. For Art. 12 to have any effect, it is important for the child to be well informed about their medical treatment in order for them to participate fully in the decision-making processes.[121]

IV REGIONAL TREATIES GOVERNING CHILDREN'S RIGHTS

Several regional bodies have adopted their own instruments to safeguard children's rights. These treaties bear resemblance to the UNCRC in that they afford children protection of rights similar to those stipulated in the UNCRC. However, they also bear some differences influenced by social, cultural and traditional practices as will be discussed below. African member states through the Organisation of African Unity (OAU) (now the African Union (AU)) adopted the ACRWC in 1999 and it has been ratified by 48 African states as of February, 2019.[122] European states followed suit the following year with the adoption of the European Convention on the Exercise of Children's Rights in 2000, and as of May 2019, it has been ratified by 20 European states.[123] The European Convention is similar to the UNCRC in that it deals with the best interests of the child, but unlike the UNCRC, it places a majority of its emphasis on the rights of the child during court proceedings relating to family disputes.[124] Also important in this Convention is the provision of assistance to European States to implement the UNCRC which demonstrates Europe's commitment to ensuring that children's rights are universal and attainable throughout its continent.[125] However, for the purpose of this research paper, the discussion will be limited to the African treaty.

(a) An Overview of the African Charter on the Rights and Welfare of the Child

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[120] Spronk op cit (n 99) 65.
[121] General Comment op cit (n 82).
[122]Global Initiative to End All Corporal Punishment of Children 'African Charter on the Rights and Welfare of the Child (ACRWC)' November 2018 available at https://endcorporalpunishment.org/human-rights-law/regional-human-rights-instruments/acrwc/, accessed on 10 May 2019. The African States that have not ratified the ACRWC include Tunisia, Democratic Republic of Congo, Morocco, Sahrawi Arab Democratic Republic, Somalia, South Sudan and Sao Tome & Principe.

[123] Gran op cit (n 62).
[124] Ibid.
[125] Ibid.

In 1999, African member states adopted the region's child-specific legally binding instrument known as the ACRWC. As already alluded to before, this treaty is different to the UNCRC in that it takes into account the 'social and cultural values of Africa, including those relating to family, community and society… virtues of cultural heritage, historical background, and values of the African civilization.'[126] In fact, one of the driving forces behind the development of this Charter was to ensure that the African culture and values would not be lost in translation as the founders considered them pivotal to the foundation of these rights.[127] This fear of being lost in translation was not unfounded. First, only four[128] of the fifty-five African member states actively participated in the drafting process of the UNCRC.[129] This side-lining of the African states during the UNCRC's drafting process led to the 'exclusion of Africa-specific issues from the [UNCRC].'[130] This viewpoint is shared by other scholars such as Muyilla who described the UNCRC as 'a western phenomenon' that barely involved the participation of African member states.[131] Secondly, there was the belief that there was a need for an instrument that 'reflected the specifics of the African context' because the UNCRC did not articulate 'issues pertinent to African children… in as strong and enforceable terms as deserving of problems of such magnitude.'[132] The Preamble itself notes that it was important to develop this Africa-specific Charter due to "unique factors" that African children face.[133] Consequently for these reasons, the ACRWC was developed to protect children's rights 'not only founded upon the UNCRC, but also reflective of, and informed by African cultural values and heritage,' thereby adding 'a meaningful African influence' to this area of law.[134]

The ACRWC is comprised of 48 Articles that mirror those found in the UNCRC. In fact, there are more similarities between the ACRWC and the UNCRC than there are differences. This is unsurprising given that the ACRWC was based on UNCRC principles, and the two instruments are generally viewed as 'wholly complementary, though there may be instances where one will provide more protection to children than another.'[135]

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[126] Ekundayo op cit (n 58) 147.
[127] Ibid.
[128] Algeria, Morocco, Senegal and Egypt.
[129] Ekundayo op cit (n 58) 147.
[130] Ibid, Frans Viljoen 'Why South Africa Should Ratify the ACRWC' (1991) 16 *South Africa Law Journal* 660 at 661.
[131] Ekundayo op cit (n 58) 147.
[132] Ibid, Priscilla Ankut *The African Child: Linking Principle with Practice* (2006) 8.
[133] Preamble of the ACRWC.
[134] Ekundayo op cit (n 58), 148.
[135] Ibid.

The ACRWC like the UNCRC recognises the four general principles. It identifies 'the best interests of the child' principle as the primary consideration (Art. 4), which unlike in the UNCRC means that it is the overriding consideration in all matters concerning the child. The principle of non-discrimination is also entrenched in the treaty (Arts. 3 and 26); as well the right to life, survival, and development (Art. 5); and the right to be heard and participate (Arts. 4, 7, 8, 9, 12 (2), and 13 (1)). Lastly, similar to the UNCRC, the ACRWC also establishes a Committee of experts to monitor implementation of the instrument in States Parties (Arts. 32 to 45).

V THE CHILD'S RIGHT TO HEALTH IN INTERNATIONAL HUMAN RIGHTS LAW

(a) The Child's Right to Health under International Human Rights Law

The right to health is a fundamental human right that has been enshrined in customary international law, entrenched in several human rights treaties, and is recognised and upheld by states, and international and regional human rights bodies across the world. This right was first officially acknowledged in international law after 'the [United Nations] formally mentioned the international human right to health in connection with other economic, social and cultural rights in the UDHR, which is the basis of all human rights.'[136] Under Art. 25 (1) of the UDHR:

> Everyone has the right to a standard of living adequate for the health and wellbeing of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.[137]

Since the UDHR was a non-binding Declaration, this right was not legally enforceable on states. It was not until the ICESCR under Art. 12 gave the right to health an "authoritative" definition under international law.[138] Now, the 'right to the highest attainable standard of health' or the 'right to health' is regarded as one of the core human rights norms that warrants special protection.[139] It embodies two primary objectives, that is, the global protection of one's health on an individual level, and the assurance of equal health rights for all on a national

[136] Universal Declaration of Human Rights, GA Res 217A (III), UN Doc A/810 at 76 (1948).
[137] Art. 25 (1) UDHR.
[138] Olubayo Oluduro, Ebenezer Durojaye *The Normative Framework on the Right to Health under International Human Rights Law* in Litigation the Right to Health in Africa (ed) (2015) 19.

[139] Brigit Toebes 'International Health Law: an emerging field of public international law' (2015) 55 (3) *Indian Journal of International Law* 299 at 308.

level.[140] The concept of the right to health was first developed by the WHO and the recognition of this right is found in the Preamble of the Constitution of the WHO. The Preamble of the Constitution of the WHO defines health as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.'[141] Furthermore, the Preamble goes on to identify the right to the highest attainable standard of health as a fundamental right of every human being and even goes on to recognise that a child's health is of 'basic importance.'[142]

The WHO's recognition of the right to health paved way for other health or health-related provisions in consequent international law instruments including Art. 12 of ICESCR which recognises 'the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.'[143] However, the 'highest attainable standard of health' remains a debatable concept because there is no actual definition for the term nor is there a universal standard that applies across the board. It varies from state to state and is dependent on other factors. However, in General Comment 3, the highest attainable standard of health encompasses the provision of minimal requirements in basic healthcare. [144] This would mean access to primary healthcare services (free, where necessary), including access to essential medications, skilled healthcare workers, immunizations and nutritional programmes (where necessary).[145] The ICESCR under the same Art. 12 goes on to identify four cornerstones (i.e. availability, accessibility, acceptability, and quality (AAAQ)) for states to follow for this right to be realised.

Furthermore, the Committee on Economic, Social and Cultural Rights (CESCR) produced an explanatory note (i.e. General Comment 14) which while not legally binding and considered as 'soft law,' carries a persuasive and in some cases an authoritative value for several legal jurists and scholars operating in the international human rights field.[146] General Comment 14 is often referred to and applied when discussing the right to health by 'human rights scholars, NGOs, and increasingly so by judicial bodies and State authorities.'[147] General

[140] Ibid.
[141] Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19 – 22 June, 1946; signed on 22 July 1946 by the representatives of 61 States.
[142] Ibid.
[143] Ibid, Art. 12 ICESCR.
[144] Committee on Economic, Social and Cultural Rights (CESCR), General Comment No 3, 'The Nature of States Parties' Obligations (Art. 2, Para 1, of the Covenant)' (14 December 1990) E/1991/23 para 10.
[145] Ibid.
[146] Toebes op cit (n 139) 309.
[147] Ibid.

Comment 14 is of significant relevance to a child's right to health as it specifically calls on states to ensure 'the provision for the reduction of the stillbirth rate and of infant mortality and for the healthy development of the child' under Art. 12 (2) (a). Furthermore, reference is made to the UNCRC with regards to children's and adolescent's right to health with particular emphasis on the right to information, what it termed 'child-friendly' information.[148] This is aimed at promoting essential health information on preventive and health-promoting information and practices.[149]

Lastly, is important to note that General Comment 14 makes a distinction between the right to health and the right to be healthy. The two are not one in the same. The right to be healthy is not a right to health, 'but rather a broad human right extending not only to access to healthcare services, but also to the underlying determinants of health.'[150] These determinants include access to clean and safe running water, proper sanitation, health-related knowledge and information, environmental factors, and occupational hazards.[151] Therefore, not only is the right to health twofold (i.e. access to healthcare services and underlying determinants of health), but it is also interlinked with other pertinent rights such as the right to clean water and sanitation, the right to education, and the right to housing, to name a few.[152] Additionally, apart from the four principles mentioned in this Chapter, States are further legally obligated to 'respect, protect and fulfil' human rights including those related to the right to health.[153]

(b) The UNCRC and the Child's Right to Health

The UNCRC sets out several rights ranging from fundamental human rights and freedoms to those dealing with the welfare of a child. The right to health and other health related rights are featured prominently throughout the Convention.[154] However, it is Art. 24 (1) of the UNCRC that specifically recognises 'the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health.'[155] In ensuring the full realisation of this right, 'States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.'[156] Article 24 (2) (f) makes

[148] General Comment op cit (n 83) para 22.
[149] Ibid.
[150] Toebes op cit (n 139) 310.
[151] Ibid.
[152] Ibid.
[153] Committee on Economic, Social and Cultural Rights (CESCR), General Comment No 14, 'The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant)' (11 August 2000) E/C.12/2000/4 para 33 – 37.
[154] Arts. 3, 17, 23(4) and 32 UNCRC.
[155] Art. 24 (1) UNCRC.
[156] Art. 24 (1) UNCRC.

reference to the development of preventive healthcare by States Parties, and Art. 24 (3) calls on States Parties to take measures aimed at 'abolishing traditional practices prejudicial to the health of children.'[157] The CRC in General Comment 15 explained the nature of the obligations Art. 24 has placed on States Parties. According to the Committee, the child's right to access to health as guaranteed under Art. 24 is 'an inclusive right':

> extending not only to timely and appropriate prevention, health promotion, curative, rehabilitative and palliative services, but also a right to grow and develop to their full potential, and live in conditions that enable them to attain the highest standard of health by implementing programmes that address the underlying determinants of health.[158]

As such, the Committee urged 'States Parties to adopt a holistic approach to advancing children's right to health' because 'the realisation of the right to health is indispensable for the enjoyment of all the other rights in the Convention.'[159]

VI CONCLUSION

It is evident that children's rights have evolved over the years and have gained recognition by states as one of the fundamental human rights in international human rights law. The adoption of the UNCRC by 196 states, as well as the adoption of other regional instruments such as the ACRWC, have helped in entrenching these rights both internationally and regionally. Furthermore, the international legal framework has been instrumental in entrenching the right to health, particularly the child's right to the highest attainable standard of health under Art. 24 of the UNCRC. This means that denying a child access to vaccines would amount to infringement of this right as that is the opposite of the highest attainable standard of health. As has been demonstrated in this Chapter, the UNCRC has ensured a child's right to health by increasing the child's autonomy guaranteeing that the child's voice is heard during medical decisions and weighing the parental rights against the best interests of the child to ensure the best possible outcome. This will contribute to the full realisation of this right.

[157] Arts. 24 (2) (f), 24 (3) UNCRC.
[158] Oluduro et. al op cit (n 138) 21, Committee on the Rights of the Child, General Comment No 15, 'The right of the child to the enjoyment of highest attainable standard of health' (17 April 2013) CRC/C/GC/15.
[159] Ibid, General Comment op cit (n 158) para 7.

CHAPTER THREE

BALANCING COMPETING RIGHTS: PARENTAL RIGHTS VS. CHILDREN'S RIGHTS

I INTRODUCTION

The crux of the immunization debate lies in the balancing of the rights of the parents and the rights of the child. This is because the parent's right to refuse vaccination for the child so long as it is in the best interests of the child conflicts with the child's right to access to healthcare. Infringement of this right affects other related rights of the child such as the right to life.[160] On the other hand, under Art. 18 of the UNCRC, parents bear responsibility for the upbringing and development of the child, which means that they have autonomy over their children and this autonomy should not be arbitrarily interfered with. And so lies the delicate balance – ensuring the promotion and protection of one right without interfering with the enjoyment of the other.

The focus of this Chapter shall be on the specific rights and responsibilities of the parents weighed against the best interests of the child, in relation to immunization cases. The Chapter will begin with a discussion on the role of informed consent, evolving capacity and child autonomy and their relevance to the dissertation topic, the second part of this Chapter will discuss the conflict between parental and children's rights in immunization cases, and will conclude with a brief discussion of the best interests principle.

II INFORMED CONSENT, EVOLVING CAPACITY, AND CHILD AUTONOMY

The rules stipulated in various international human rights instruments, doctrine, jurisprudence and international bioethics declarations dictate that medical treatments cannot be administered without prior informed consent.[161] This was following the Nuremberg Code of 1947 which codified this principle under international law in order to prevent scientific experimentation on unwilling or unsuspecting human test subjects.[162] Under the first principle of the Nuremberg Code, consent must be granted voluntarily prior to any medical procedure and this right has been reflected in other human rights instruments.[163] Informed consent though difficult to

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[160] Art. 6 (1) UNCRC, Art. 5 (1) ACRWC. Art. 6 ICCPR, Art. 3 UDHR.

[161] Juana I. Acosta 'Vaccines, Informed Consent, Effective Remedy and Integral Reparation: an International Human Rights Perspective' (2015) 131 *Vniversitas* 19, 23.

[162] Ibid.

[163] Ibid. For instance, Art. 6 of the Universal Declaration on Bioethics and Human Rights (UNESCO Declaration) states that:

Any preventive, diagnostic and therapeutic medical intervention is only to be carried out with the prior, free and informed consent of the person concerned, based on adequate information. The consent should, where appropriate, be express and may be withdrawn by the person concerned at any time and for any reason without disadvantage or prejudice.

define, requires an open exchange of information and active participation in decision-making processes between the medical professional and patient, in order to ensure that the healthcare provided is aligned with the patient's core values.[164] In the case of vaccination, this means that the patient must not only possess 'information about the general inherent risks of vaccines, but also information of risks related to the individual characteristics of each patient.'[165] In light of all the information at hand, such consent must be given by the patient, and in the case of minors, by the parents or legal guardians.

The end goal of informed consent is to make a wise decision for the betterment of one's health. If the contrary is suspected or proven, then medical professionals and courts could impose medical intervention against the patient's wishes, provided it was in the best interests of the patient, and prevented further harm.[166] However, it is important to note that consent recognises patient autonomy in that if a person is of legal age, and of sound mind, and makes an informed decision against medical advice, then that decision must be respected because every human being has a right over their bodies.[167]

Informed consent in children is more complicated due to their lack of maturity to grasp the full extent of the medical intervention. Furthermore, children lack the capacity to make legally binding decisions, and instead have to rely on their parents or legal guardians to act in their best interests. Regardless, under Art. 12 of the UNCRC, a child has the right to be heard if that child is capable of making an informed decision on all matters affecting him or her.[168] Furthermore, the fact that Art. 12 does not limit the child's age or form of communication to formal language means that every child is capable of expressing their view be it through 'emotions, drawing, painting, singing, [or] drama.'[169] The only difference is that the older or more mature the child, the higher the consideration of their views.[170] Ultimately, even though Art. 12 allows for a child's views to be expressed and considered, the final decision lies with the adult, often times, the parent.

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[164] Acosta op cit (n 161).
[165] Ibid.
[166] Jessica Blignaut *Calling the shots on vaccination: when is the state justified in overturning a refusal to vaccinate?* (unpublished LLM thesis, University of Cape Town) 18, J.K. Mason and R.A. McCall Smith *Law and Medical Ethics* 5ed (1999) 70.
[167] Ibid, 18 – 19.
[168] The ACRWC has a similar provision under Art. 7.
[169] Gerison Lansdown *The Evolving Capacities of the Child* (2005) 4.
[170] Ibid.

Furthermore, under Art. 5 of the UNCRC, states shall respect the rights of parents to provide for their children 'in a manner consistent with the evolving capacities of the child.' In theory, as a child grows, so does the capacity, as such, parents have a responsibility to adjust their guidance on their child as the child evolves. This Article is vital in not only recognising children's autonomy but also important in creating a barrier to prevent children from incurring unnecessary adult responsibility.[171] It is important to note that the evolving capacities of the child go hand-in-hand with participation rights of the child. However, in as much as the child has a right to be autonomous, they also have to possess the desire, capacity and opportunity to exercise this right.[172] This simply means that a child will not be forced to make a decision that they are either incompetent or unwilling to make because the UNCRC is designed to protect the child from such scenarios.[173]

III BALANCING PARENTAL AND CHILDREN'S RIGHTS

Regarding parental rights and responsibilities, the general rule is that states will not interfere with family life and with the rights of parents. This is because parents have the primary responsibility for the upbringing and development of the child.[174] It is important to note that this is a responsibility and not a right. Regardless, this responsibility is usually exercised in a family setting. The importance of a family setting is paramount to the child's full enjoyment of rights. While the state rarely interferes in the family setting, there are international law provisions that impose an obligation on states to protect the family should the need arise. For instance, Art. 16 of the UDHR states that 'the family is the natural and fundamental group unit of society and is entitled to protection by society and the state.' The ICCPR has a similar provision under Art. 23 (1) which mirrors the UDHR provision. Likewise, under Art. 18 of the African Charter, 'the family shall be the natural unit and basis of society [that] shall be protected by the state.' The obligation imposed on states to protect the family setting demonstrates that the importance of family under international law, and most importantly the need to protect the family setting from unwarranted judicial or legislative interference that would negatively impact the upbringing and development of the child. Additionally, the parent's right to raise their children without interference as stipulated under Art. 18 of the UNCRC demonstrates that international law respects the rights of parents as decision makers

[171] Ibid.
[172] Ibid.
[173] Arts. 5 and 12 when read together emphasise the importance of offering encouragement and support to children as they exercise their wishes.
[174] Art. 18 UNCRC, Art. 20 ACRWC.

on fundamental matters concerning their children, and aims to protect those rights from being arbitrarily interfered with by states, without good reason.

On, the other hand, there is a duty to protect children as rights holders. International law balances the competing rights of the parents and children through the best interests principle.[175] Though there is no definition for "best interests of the child" under international law, it is a term that has been frequently used in international law instruments including the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) and ACWRC.[176] However, this principle gained traction after it was recognised in the UNCRC under Art. 3 (1) which provides that:

> In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration.

The purpose of this Article is to ensure that children are fully able to realise their rights in all matters concerning them. This is especially so where there is a conflict of rights (e.g. parental rights versus children's rights). Where such conflict arises, the interests of the child are a primary consideration, even though they are considered on a case-by-case basis.[177] This means that states are obligated 'to clarify the best interest of all children.'[178] However, since the best interests principle is applicable on an individual case basis, this means that it is flexible, and adaptable to our ever-changing world. That is not to say that the best interests principle is without flaws, as it has sometimes been criticised as 'self-defeating, individualistic, unknowable, vague, dangerous, and open to abuse.'[179] Furthermore, some legal scholars have argued that the idea that a determination for the best interest of the child can be made, even when tailored to individual cases is flawed. According to Mnookin and Szwed, the best interest principle is flawed in that 'what is best for any child or even children in general is often indeterminate and speculative, and requires a highly individualised choice between

[175] Committee on the Rights of the Child, General Comment No 14, 'The right of the child to have his or her best interests taken as a primary consideration' (1 February 2013) CRC/C/GC/14, para 36, Art. 3 (1) UNCRC, Art. 4 ACRWC.
[176] Arts. 5 (b), 16 (1) (d) CEDAW, Art. 4 ACRWC.
[177] Committee on the Rights of the Child, General Comment No 14, 'The right of the child to have his or her best interests taken as a primary consideration' (1 February 2013) CRC/C/GC/14, para 32.
[178] Ibid, para 33.
[179] Blignaut op cit (n 166), 28, L. Kopelman 'The best interests standard as threshold, ideal, and standard of reasonableness' in M Freeman *Children, Medicine and the Law* (2005) 436.

alternatives.'[180] Regardless of the criticisms, this legal principle remains one of the fundamental principles in children's rights.[181]

As previously stated, the purpose of Art. 3 (1) of the UNCRC is to ensure full realisation of rights by children, hence the phrase "in all actions." This is not merely limited to acts, but also includes omissions.[182] The CRC defines "actions" in Art. 3 (1) to mean 'decisions, all acts, conduct, proposals, services, procedures, and other measures.'[183] The phrase "shall be a primary consideration" also has its own legal meaning and interpretation. The Committee explained that the words "shall be" impose 'a strong legal obligation on states.'[184] Simply put, 'states may not exercise discretion as to whether children's best interests are to be assessed and ascribed the proper weight as a primary consideration in any action undertaken.'[185] Meanwhile, "primary consideration" has been interpreted by the Committee to mean that children's rights are not on par with other rights due to the nature of the subject (i.e. age, lack of maturity, dependency), they cannot exercise their own interests effectively, as such, their interests have to be explicitly highlighted by their representatives or risk being overlooked. However, the phrase "**a primary** consideration" (emphasis added) means that while best interests are of "high priority," they are not the determining factor.[186] Therefore, where harmonization of rights is impossible due to conflicting rights:

> the decision-makers will have to analyse and weigh the rights of all those concerned, bearing in mind that the right of the child to have his or her best interests taken as a primary consideration means that the child's interest have high priority and not just one of several considerations. Therefore, a larger weight must be attached to what serves the child best.[187]

Lastly, the words "primary" indicate that in all circumstances, children's interests must come first 'especially when an action has an undeniable impact on the children concerned.'[188]

With regards to immunization cases, the best interests standard can be used to balance the conflicting rights between the parents and the child. If proven that immunization would be in the best interests of the child, then the child's rights will outweigh parental rights. It has been

[180] Blignaut op cit (n 166) 28 - 29.
[181] Ibid, 29.
[182] General Comment op cit (n 177) para 17.
[183] Ibid.
[184] Ibid, para 36.
[185] Ibid.
[186] Ibid, para 38.
[187] Ibid, para 39.
[188] Ibid, para 40.

stated by the WHO that immunizations 'prevent between 2 – 3 million deaths' annually and have decreased measles mortality rate by 80%.[189] For this reason, they are regarded as the most cost-effective public health intervention.[190] However, as is the case with all medical interventions, vaccinations also carry 'minute but measurable' risks.[191] Nonetheless, the benefits of immunisations outweigh the risks.[192] For instance, '1 to 3 in 1, 000 children will develop encephalitis concurrent with the measles infection.'[193] Of those children infected, between '10 to 15% will die and a further 25% will be left with permanent neurological damage.'[194] On the other hand, '1 to 2 in 1 million children' who received the MMR will develop encephalitis from the vaccine which is 'less than the incidence of all types of encephalitis.'[195] Despite the demonstrably low risk, some parents remain hesitant to vaccinate their children for fear of the safety of the vaccine or due to religious and/or personal beliefs.[196] However, deciding what is in the best interests of the child requires equal examination of both sides. In this case, the risk of adverse effects is lower than if the child were left unvaccinated. As such, immunisation would be in the best interests of the child, therefore, the child's right to be immunised outweighs the parent's right to refuse consent.

IV CONCLUSION

This Chapter has discussed how the rights of the child are balanced against the parents' rights in immunization cases. Specifically, it has been demonstrated that parents have decision-making rights on all matters concerning their children and such rights are not to be interfered with by the state unless it is in the best interests of the child. Therefore, the best interests principle exists to reconcile these conflicting rights with the aim of having an outcome that best serves the child, as the child's interests are of the highest priority. The next Chapter will proceed to discuss how the law attempts to resolve this conflict through examination of case law in the chosen test countries.

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[189] WHO/Rada Akbar op cit (n 7), WHO 'Immunization Coverage' *WHO* 15 July 2019 available at https://www.who.int/news-room/fact-sheets/detail/immunization-coverage, accessed on 5 September 2019.
[190] Ibid.
[191] Jessica Kerr 'Immunisation and the Law: Slippery Slope to a Healthy Society' (2006) 37 *VUWLR* 93, 96.
[192] Ibid, 97.
[193] Natasha Crowcroft 'Measles Infection and Encephalitis' *Encephalitis Society* available at https://www.encephalitis.info/measles-infection-and-encephalitis, accessed on 5 September 2019.
[194] Ibid.
[195] Ibid.
[196] McClure et al. op cit (n 24).

CHAPTER FOUR

DOMESTIC LAW PROTECTING A CHILD'S RIGHT TO ACCESS TO CHILDHOOD IMMUNISATION IN THE UNITED STATES OF AMERICA AND THE REPUBLIC OF SOUTH AFRICA

I INTRODUCTION

As alluded to in the foregoing Chapters, the right to health for all is an inalienable right that is enshrined by international, regional, and domestic framework. Furthermore, a child's right to access to preventive healthcare, vaccines in particular, is protected under the domestic law of the test countries. In the USA for example, the Supreme Court in the landmark case of *Jacobson v. Massachusetts*[197] confirmed mandatory childhood vaccination, even if that were contrary to parental wishes.[198] In coming to its decision, the court held in that matter that the state has authority to override an individual citizen's freedom in instances where the exercise of that citizen's freedom would jeopardize the health of other citizens on a large scale.[199] Jacobson alleged that his freedom was being violated when he was being forced to vaccinate himself even though it was against his religious beliefs.[200] The court disagreed and instead reiterated that 'persons and property are subjected to all kinds of restraints and burdens in order to secure the general comfort, health, and prosperity of the state.'[201] *Jacobson v. Massachusetts* remains good law in the USA.[202]

Meanwhile, South Africa has comprehensive domestic laws that protect various rights of the child. A child's right to health (including preventive healthcare) is guaranteed under s 27 (1) of the South African Constitution which provides for the right to health for all, and under s 28 (1) (c) which protects a child's right to access to healthcare services. Furthermore, under s 7 (2) of the South African Constitution, as per the Bill of Rights, the state has an obligation to respect, promote, and fulfil all rights including the right to health. Moreover, over the years, there have been some cases that have discussed the right to access to health,[203] even though those dealing with a child's right to health have been limited.[204]

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[197] 197 U.S. 11 (1905).
[198] Lois A. Weithorn, Dorit Rubinstein Reiss 'Legal approaches to promoting parental compliance with childhood immunization recommendations' (2018) 14 (7) *Human Vaccines & Immunotherapeutics* 1610, 1611.
[199] Ibid.
[200] Ibid.
[201] Ibid.
[202] Ibid.
[203] *Soobramoney v Minister of Health, KwaZulu Natal* (1998) 1 SA 765 (CC), *B v Minister of Correctional Services* (1997) (6) BCLR 789, *Treatment Action Campaign v Minister of Health* (2000) BCLR (4) 356 (T).
[204] Mariana Buchner-Everleigh 'Children's rights of access to health care services and to basic health care services: a critical analysis of case law, legislation and policy' (2016) *De Jure* 307 at 308.

The aim of this Chapter is to discuss how domestic law in the test countries protects a child's right to access to health in childhood immunization cases.[205] In particular, this Chapter will analyse the domestic legislation regulating immunization with specific attention to how international human rights law instruments have influenced domestic law. The Chapter will also include an examination of case law in order to ascertain the standard courts have used in order to overrule parents who opted against immunising their child.

II UNITED STATES OF AMERICA

(a) Background of Childhood Immunisation and the Law

Though the USA is the only country in the world to not have ratified the UNCRC, some steps have been taken in their domestic law to ensure that children's rights to health are not infringed upon.[206] This is especially so when it comes to childhood immunisation cases. For instance, 1855 marked a landmark year for Massachusetts as it became the first state to issue mandatory immunisation for children against communicable diseases such as small pox as a condition for studying in a public school.[207] It did not take long for other states to jump on the bandwagon, and by 1963, twenty more states had followed suit requiring evidence from parents or guardians that their children had undergone immunisation for specific diseases.[208] By 1980, all fifty states required mandatory vaccinations for entry into public schools.[209] In fact, as the years progressed, more detailed school vaccination policies were developed across the country, and technological and scientific advancements led to the development of safer and more effective vaccines.[210] As it stands currently, all states in the USA require mandatory immunisations prior to admission in both public primary and secondary schools, although the requirements may differ from state to state.[211] Similarly, some day care centres and private schools will require proof of immunisation though most private schools are prone to exemptions.[212]

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[205] The two test countries were selected for comparison based on their geographical location (i.e. one is in North America and the other in Africa); their economic status (i.e. developed country versus developing country); the ratification of the UNCRC (i.e. one has ratified, the other has not); and the legal maturity of the subject matter in their jurisdiction (i.e. USA has more extensive legal commentary, while RSA is still developing its commentary).
[206] While the right to access to health is not enshrined in America's Constitution, the Supreme Court in *Roe v. Wade* 410 U.S. 113 (1973) ruled that individuals have the right to access to healthcare from willing medical practitioners at their own expense.
[207] Weithorn and Reiss op cit (n 198) 1611.
[208] Ibid.
[209] Ibid.
[210] Ibid.
[211] Ibid.
[212] Ibid.

There are legal exemptions to the mandatory immunisation requirements that have been categorised into three: medical, religious and personal/philosophical. In all fifty states, children can be medically exempted 'if the parents can provide certification by a licensed physician documenting that specified vaccines are medically contraindicated for that particular child.'[213] This medical exemption is specifically reserved for children with 'a health condition or prior adverse vaccine reaction rendering administration of the vaccine to that child medically unsafe.'[214] Mere parental concerns or fear of immunisation or of a particular vaccine and its effect will not qualify the child for a medical exemption.[215]

The child may be granted religious exemption from immunisation (to varying degrees) in forty-seven of the fifty states, with the exception of Mississippi, West Virginia, and California.[216] The way religious exemptions are granted varies from state to state. In some states, it can be as easy as ticking a box on a form, while in other states such as New York, parents have to undergo stringent requirements, often times ending in litigation in order 'to prove that their views are indeed religious in nature (rather than the product of secular, medical, philosophical, or moral considerations).'[217]

The last legal exemption is on the ground of personal or philosophical beliefs. Seventeen states as of October 2017 adhere to this exemption which affords parents the option of not immunising their children if proven that the immunisation is contrary to the parent's "personal beliefs" or it 'conflicts with … [the] philosophical beliefs of the parent or guardian.'[218] Though the beliefs need not be necessarily religious. As with the case with religious exemptions, granting of philosophical exemptions vary from state to state, in some states, parents need only check a box on a form while in other states, parents have to undergo serious vetting as some parents have requested for this exemption simply out of convenience and void of any deeply rooted views against immunizations.[219] This has led to states like Oregon and Washington to tighten their laws and develop strict requirements for the philosophical exemption in order to reduce non-vaccination rates.[220] The next sub-section will look at the domestic law governing immunisation at the Federal level.

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[213] Ibid.
[214] Ibid.
[215] Ibid.
[216] Ibid.
[217] Ibid.
[218] Ibid.
[219] Ibid.
[220] Ibid.

(b) Federal Law Governing Childhood Immunisation

The Federal constitutional law of the USA governs mandatory childhood vaccination which encompasses a balancing act between preservation of constitutional rights and the state's duty to regulate behaviour.[221] As already mentioned in this Chapter's introduction, *Jacobson v. Massachusetts* was the first case in the USA that confirmed mandatory vaccination and it remains good law.[222] The majority of today's mandatory vaccination cases deal with children and the Supreme Court has reiterated that 'the government's authority to regulate the lives of children far exceeds its authority to intervene in the lives of adults .'[223] So, while parents hold significant discretion on how to raise their children, the state's duty to protect children in all sectors of their lives can sometimes override that obligation.[224] Examples of the state's authority overriding parental upbringing include mandatory education and anti-child labour policies to name a few.[225] In the healthcare setting, the courts have been known to overrule parental decisions on healthcare if the court deems those decisions will endanger the welfare of the child.[226]

This notion was underscored in *Prince v. Massachusetts*[227] where parents tried to claim religious exemption and the court found that parents 'cannot claim freedom from compulsory vaccination for the child more than for himself on religious grounds.'[228] The court held that while parents are at liberty to make unwise healthcare choices for themselves, this discretion does not extend to their children.[229] It went on to state that the First Amendment right to religious freedom has limitations in that it 'does not include liberty to expose the community or the child to communicable disease or the latter to ill health or death.'[230] Essentially, while parents can sacrifice their health in the name of their beliefs 'they are not authorized to sacrifice their children's well-being in the name of such principles.'[231] As such, there are provisions in several state statutes that permit state intervention in cases where the child's health is at risk.[232] In

[221] Ibid.
[222] Ibid.
[223] Ibid, 1612.
[224] Ibid.
[225] Ibid.
[226] Ibid.
[227] *Prince v. Massachusetts* 321 U.S. 158 (1944), Ibid.
[228] Cristian Farias 'Yes, the Government Can Make You Vaccinate Your Child' *The New Republic* 3 February 2015 available at https://newrepublic.com/article/120950/courts-have-upheld-governments-constitutional-right-vaccine-laws, accessed on 15 July 2019.
[229] Weithorn and Reiss op cit (n 198) 1612.
[230] Ibid.
[231] Ibid.
[232] Ibid.

essence, it has been seen that while parents have discretion on how to raise their children, this discretion can sometimes be limited by the state. An example of such a limitation is that of mandatory vaccination where the courts have at times overruled parental wishes and granted childhood immunisations in order to protect the child's welfare.

The notion that a court can overrule parental wishes in childhood immunisation cases has caused a legal tug-of-war, so to speak, between the rights of the parent and the rights of the child. It has long been established in American law that patients ought to give consent before any medical treatment is administered by a physician. This law gained recognition in 1891 following the American Supreme Court decision in *Union Pacific Railway Company v. Botsford*[233] where the court held that 'no right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others.'[234] This position was later reaffirmed in *Cruzan v. Director, Missouri Department of Health* where the court held that 'a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment.'[235] Therefore, obtaining informed consent is crucial prior to any medical treatment and failure to do so amounts to battery under American law, which attracts either civil or criminal liability for the physician.[236] However, informed consent is only reserved for those persons who are competent to give consent, and where one cannot exercise this right, this right has to be exercised for them on their behalf.[237] In the case of minors in America, this right is exercised by their parents or guardians who have been legally empowered to make decisions on behalf of their children 'and the law has respected those decisions except where they place the child's health, well-being, or life in jeopardy.'[238] As previously stated, parents are presumed to care about their children and as such are more likely to make decisions in their children's best interests.[239] Furthermore, parents are at liberty to raise their children according to their own values and standards, and the upbringing of their children is not to be interfered with arbitrarily by third parties.[240] Henceforth, the beginning assumption in the USA is that 'parents are the persons best suited and most inclined to act in the best interests of their children, and

[233] 141 U.S. 250 (1891).
[234] Douglas S. Diekema 'Parental Refusals of Medical Treatment: The Harm Principle as Threshold for State Intervention' (2004) 25 *Theoretical Medicine* 243.
[235] *Cruzan v. Director, Missouri Department of Health* 497 U.S. 261 (1990), Ibid.
[236] Diekema op cit (n 234) 243 – 244.
[237] *Cruzan* supra (n 235).
[238] See *Meyer v. Nebraska* 262 U.S. 390 (1923), *Pierce v. Society of Sisters* 268 U.S. 510 (1925), and *Wisconsin v. Yoder*, 406 U.S. 205 (1972).
[239] Diekema op cit (n 234) 244.
[240] Ibid.

that in most cases they will do so.'[241] As such, parents are afforded great latitude when it comes to decision making on their children's behalf, although this autonomy is not absolute.[242] The law makes it clear that whenever a parent fails to act in the best interests of the child, the state has the authority to intervene through the *parens patriae* doctrine which holds the state as a '"surrogate parent" when necessary to protect the life and health of those who cannot take care of themselves, including children.'[243] The court in *Prince v. Massachusetts* confirmed this notion when it found that '…neither rights of religion nor rights of parenthood are beyond limitation.'[244] Where the parent refuses medical intervention for the child, for instance refusal to grant consent for childhood immunisation, the state is justified to intervene by claiming the "best interests" principle.[245] In fact, the state's intervention in such matters is vital in safeguarding the rights, and sometimes life of the child.

(c) The Threshold: When are Courts likely to intervene?

The general rule of thumb is that parents have the freedom to raise their children in the manner they see fit without third party interference.[246] This was reiterated by the United States Supreme Court when it held in *Troxel v. Granville*[247] that the American Constitution protects 'the interest of parents in the care, custody, and control of their children.'[248] The court went on to further describe this parental freedom as 'perhaps the oldest of the fundamental liberty interests recognised by [the] court.'[249] The court concluded by stating that parental decisions ought to receive great deference because they are based on the presumption that 'fit parents make decisions in their children's best interests.'[250] So, in the court's opinion, any court that presumes a contrary opinion fails 'to provide protection for the [parent's] fundamental constitutional right to make decisions concerning the rearing of [their] own [children].'[251] However, this parental autonomy is limited by state authorities who have been granted the power to intervene in parental decisions that will likely bring harm, injury or affect the

[241] Ibid.
[242] Ibid.
[243] Ibid, *re Phillip B.*, 92 Cal. App. 3d 796 (1979).
[244] *Prince* supra (n 227).
[245] Diekema op cit (n 234) 245.
[246] See *re Phillip B*. supra (n 243).
[247] 530 U.S. 57, 66 (2000).
[248] Ibid, Adeline Sulentich 'Do Parents Who Choose Not to Vaccinate Their Children Open Themselves Up to Liability?' *The John Marshall Law Review* 9 January 2019 available at https://lawreview.jmls.edu/do-parents-who-choose-not-to-vaccinate-their-children-avail-themselves-to-legal-punishment/#_ftn1, accessed on 17 July 2019.
[249] Ibid.
[250] Ibid.
[251] Ibid.

wellbeing of the child – this is known as the doctrine of *parens patriae*. Under this doctrine, the state is constitutionally justified to intervene in order to protect the rights of the child because the right the state is trying to safeguard is the right to life, which is an inalienable human right recognised by all.

Over the years, the judiciary has developed several standards aimed at determining the appropriate course of treatment for persons who are otherwise incompetent to make such medical decisions on their own.[252] Such decisions are usually deferred to the incompetent person's medical proxy, in the case of children, their parents or guardians, who are entrusted 'to make decisions that most faithfully reflect the patient's wishes or, if those wishes cannot be known, the best interest of the patient.'[253] There are two standards that are applied in order to determine what is in the best interests of the patient. The first is known as a subjective or "pure autonomy" standard that is applied for those patients who were previously competent based on previously expressed medical wishes.[254] However, in order for this standard to be effective, the previously competent person should not only have made medical decisions in the past, but s/he must have 'expressed sufficiently specific preferences regarding future medical care that surrogate decision-makers can apply' in the current situation that would resemble their own wishes had they been competent.[255] The second standard is based on self-determination and is known as "substituted judgement," and is reserved for individuals who have never been competent.[256] It is a somewhat controversial standard as heavy reliance is placed on the surrogate decision-maker to 'don the mental mantle of the incompetent' and decide what 'the incompetent person would have wanted regarding the proposed treatment if he or she were capable of making a decision.'[257] Arguably, both standards are difficult to apply to children as they do not possess the competency or capacity to decide what procedures they would prefer if a complicated medical situation would arise.[258] However, the appropriate standard to apply in such situations would be one rooted in safeguarding the welfare of the patient, i.e. the best interests principle.[259]

[252] Diekema op cit (n 234) 244.
[253] Ibid.
[254] Ibid.
[255] Ibid.
[256] Ibid.
[257] Ibid.
[258] Ibid.
[259] Ibid.

The best interests principle has 'become the prevailing standard used to judge the adequacy of medical decision-making on behalf of children.'[260] As such, where the state adjudges that a parental decision is contrary to the best interests of the child, it shall be justified in intervening in order to protect the child. This best interest standard is one that is well known by medical practitioners and parents alike, and on which most medical decisions are made on behalf of children. Brock and Buchanan have described best interests as 'acting so as to promote maximally the good of the individual.'[261] While Beauchamp and Childress determined that best interests is 'the highest net benefit among the available options, assigning different weights to interests the patient has in each option and discounting or subtracting inherent risks or costs.'[262] In both descriptions, the decision-maker is to act in a manner that favours the child.[263]

The court *In the Matter of Christine M.*[264] held that the father's refusal to vaccinate his daughter against measles was not in the best interests of the child, finding that his personal and religious beliefs cannot overrule the child's health and safety especially 'when parental conduct poses some substantial threat to public safety.'[265]

Meanwhile the case of *Archer v. Cassel*[266] involved divorced parents, the mother who was anti-immunisation and the father who was pro-immunisation. Instead of making a ruling on whether the child should be immunised or not, the court instead found that the best interests of the child would be to vest "superior" decision-making powers in the hands of one of the parents, in this case, the father.[267] The court in coming to its decision stated:

> [T]he court does not question [Mother]'s religion, moral convictions or the sincerity of her [anti-vaccination religious] beliefs. The court is focused instead on the best interest of the children and which parent is best suited to make health decisions for them. There is no need for the court to assert its authority when a parent can act in the best interests of their children.[268]

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[260] Ibid.
[261] Ibid.
[262] Ibid.
[263] Ibid.
[264] 157 Misc. 2d. 4 (1992).
[265] Rachel Vankoughnet, Rebecca Rodriguez 'Court-Ordered Medication/Vaccination of Children and the Role of the Attorney for the Child' *Semantic Scholar* 2006 available at https://pdfs.semanticscholar.org/8fb5/e45bc3da47ec4745dd77cc6a7a56ddb82346.pdf, accessed on 17 July 2019.

[266] (2015 WL 1500447).
[267] Ibid.
[268] Ibid, Eugene Volokh 'Family Court gives pro-vaccination father decision making authority over children's medical care' *The Washington Post* 6 April 2015 available at https://www.washingtonpost.com/news/volokh-

What is observed in the cases above is that the state has to balance several factors unique to every case in order to make a determination on whether or not to intervene in the best interests of the child. As evidenced by the cases above, different facts will cause the court to arrive at different conclusions. For instance, the court is less likely to intervene in cases where a child's life is not at risk even though they have been known to intervene at times, albeit with controversial reception. One such instance was in the case of *Kou Xiong*[269] where the court ordered a six year old boy to have corrective surgery to fix his clubfoot against his parent's wishes who objected on cultural grounds. Most famously in *re Sampson*[270] the court ordered a blood transfusion for Kevin Sampson during a surgery to correct a deformity on his face as a result of his severe neurofibromatosis.[271] The court ordered this despite the boy's mother (a Jehovah's Witness) objecting to it.[272] The court found that his mother's wishes amounted to neglect and that the blood transfusion during the surgery was in his best interests in order to save his life.[273] With regards to vaccines, with the exception of rubella, all diseases children are being inoculated against have the potential of being life-threatening.[274] Yet in that same vein, most of those diseases have been eradicated. So, opponents of vaccination argue that their child is at low risk to contract any of those diseases, so the decision against immunisation is therefore not life-threatening.[275] In such circumstances, the court has ordered the child to be vaccinated against a specific disease as was the case *re Christine M*. where the court found that the parents' failure to immunise their child against measles during a measles outbreak was tantamount to neglect, finding that such a decision 'clearly places that child's physical condition in imminent danger of becoming impaired.'[276]

With regards to whether a child can exercise autonomy and demand to be immunised, American law does not recognise child participation rights, and since the UNCRC is not ratified, it is highly unlikely for such rights to be exercised by the child.[277] However, there are

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conspiracy/wp/2015/04/06/family-court-gives-pro-vaccination-father-decisionmaking-authority-over-childrens-medical-care/?utm_term=.906e31aef83d, accessed on 17 July 2019.

[269] *People v. Kou Xiong*, 764 N.W. 2d 15 (Mich. 2009).

[270] 317 N.Y.S. 2d 641 (Fam. Ct. 1970).

[271] Ibid.

[272] Ibid.

[273] Ibid.

[274] Dorit Rubinstein Reiss 'Rights of the Unvaccinated Child: Vaccinating over the Parents' Will' *Shot of Prevention* 4 March 2014 available at https://shotofprevention.com/2014/03/04/rights-of-the-unvaccinated-child-vaccinating-over-the-parents-will/, accessed on 17 July 2019.

[275] Ibid.

[276] *re Christine M.* supra (n 264).

[277] Elizabeth Bartholet 'Ratification by the United States of the Convention on the Rights of the Child: Pros and Cons from a Child's Rights Perspective' (2011) 633 *The ANNALS of the American Academy of Political and Social Science* 1 at 10.

some states that allow for child autonomy. For instance, Oregon allows for children aged 15 and above to be immunised without parental consent.[278] In Washington minors can be immunised without parental consent so long as their doctor deems them to be a "mature minor."[279] In making this determination, a child's 'age, ability to understand the treatment and self-sufficiency' is taken into account.[280]

The above case law demonstrates that the court intervenes when proven that refusal to vaccinate would be life-threatening especially in times of an outbreak as was seen in *re Christine M*.[281] It has also been seen that in instances where parents disagree on whether their child should be immunised, the court has ruled in favour of the pro-immunisation parent to make medical decisions in the best interests of the child. The child may also exercise autonomy and choose to be immunised if the state laws provide for such. Overall, court-mandated vaccination is an extreme act and should only be carried out as the last resort in situations that pose 'direct, immediate risk to the child or where parental rights to make such a decision are already called into question.'[282] Only in such circumstances is intervention justified.

III REPUBLIC OF SOUTH AFRICA

(a) South Africa's Domestic Laws relating to Immunizations

Unlike the USA, South Africa has not had mandatory vaccination laws since 1987. Before 1987, children had to receive compulsory vaccinations for Bacillus Calmette Guerin (BCG) and polio, but that law has since been abolished, and only those persons travelling from high risk yellow fever areas have to receive mandatory yellow fever vaccinations prior to admission into South Africa.[283] There are also other domestic immunisation regulations relating to communicable diseases and school policy admissions. For instance, s 90 of the National Health Act[284] deals with the regulation of some communicable diseases such as measles, which upon diagnosis require notification within seven days, to the proper authorities in either local or provincial governments.[285] Furthermore, the regulations state that if there is scientific evidence

[278] Jose Luis Pelaez 'Can teenagers get vaccinated without their parents' permission?' *New Scientist* 14 February 2019 available at https://www.newscientist.com/article/2193937-can-teenagers-get-vaccinated-without-their-parents-permission/amp/, accessed on 6 September 2019.
[279] Ibid.
[280] Ibid.
[281] *re Christine M.* supra (n 264).
[282] Reiss op cit (n 274).
[283] Blignaut op cit (n 166), 38.
[284] 61 of 2003.
[285] Regulations Regarding Communicable Diseases GNR 27 GG 30681 of 25 January 2005.

that the population at large may be at risk of contracting a disease that is easily preventable through vaccines, the state may call for compulsory immunisations by placing a notice in the Government Gazette.[286] The state is also authorised to place individuals who refuse the compulsory immunisations under quarantine.[287]

Regulation 12 stipulates that where the head of an institution (e.g. a school) possesses knowledge or has reasonable suspicion that an individual at the institution is suffering from one of the communicable diseases listed in Annexure 1 or was in recent contact with a known carrier of the disease, he or she must report to local government authorities immediately through written and verbal communication.[288] The head is also to place the individual under quarantine unless otherwise authorised by the relevant authorities.[289] In that same vein, parents or legal guardians of children are to report to the head of the school if their child has contracted a communicable disease and place that child under quarantine until instructed otherwise by the relevant authorities.[290] Furthermore, under Regulation 12 (3), the parent or legal guardian may be required to provide proof to the school of the immunisations that their child has received, or written proof of treatment of a disease that is curable through vaccines. Echoing Regulation 12 is s 16 of the Admission Policy for Ordinary Schools[291] which states that:

> On application for admission, a parent must show proof that the learner has been immunised against the following communicable diseases: polio, measles, tuberculosis, diphtheria, tetanus and hepatitis B. If the parent is unable to show proof of immunization, the principal must advise the parent on having the learner immunised as part of the free primary health care programme.

Unlike Regulation 12 (3), s 16 requires parents to provide proof of immunization of their children and provides for mandatory immunisation for the communicable disease the child has not been vaccinated for. However, the Policy falls of short of stating the consequence of failing to immunise the child, even after being mandated to do so by authorities. Even more, the courts have yet to be tested on this.

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[286] Ibid, s 8.
[287] Ibid.
[288] Ibid, s 12(1)(a).
[289] Ibid, s 12(1)(b).
[290] Ibid, s 12(2).
[291] GNR 2432 GG 19377 of 19 October 1998.

(b) A Child's Right to Healthcare in South Africa

South Africa has comprehensive domestic child protection laws that have been heavily influenced by international law instruments and principles.[292] In 1995, South Africa ratified the UNCRC and thereafter in 1996, it adopted its Constitution which protects a child's right to access to healthcare through sections 27 and 28. Section 27 (1) guarantees the right to healthcare for all citizens and s 27 (2) places an obligation on the state to take measures (legislative or otherwise), to ensure the realisation of this right. Meanwhile s 28 (1) (c) specifically affords every child the right to basic healthcare services – this, despite s 27 affording every South African citizen the very same right. Furthermore, under s 39 of South Africa's Constitution, the courts are obligated to consider international law in their decisions.[293] This provision essentially guarantees the court's consideration of international law principles regarding cases concerning children's healthcare and wellbeing.

South Africa has three primary legislative pieces that regulate the healthcare rights of children namely; the National Health Act, Mental Care Act,[294] and Children's Act.[295] For the purposes of this discussion, the focus will be on the National Health Act and Children's Act. The National Health Act was enacted in 2005 and it provides the legal framework for health rights in South Africa.[296] The purpose of this Act is 'to protect, respect, promote and fulfil' peoples' constitutional right to healthcare services through regulation of national healthcare systems, services, service providers and users.[297] With regards to children, the Act provides for a child's right to healthcare and further recognises children as a vulnerable group.[298] The Act further recognises child autonomy by affording children older than 14 years to consent to their own medical treatment without parental consent.[299] However, since the Act neglected to define the terms 'health care services' or 'basic health care services,' and since these terms are not known in international law, there is uncertainty and ambiguity as to what amounts to the constitutional fulfilment of this right for children.[300]

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[292] Buchner-Everleigh op cit (n 204).
[293] Pravania Reddy *The Best Interests of the Child: A Perspective into the Refusal of Necessary Medical Care for Children, By Parents, on the Basis of Religious Beliefs* (unpublished LLM thesis, Howard College, 2014) 71.
[294] 17 of 2002.
[295] 38 of 2005, Buchner-Everleigh op cit (n 204) 315.
[296] Buchner-Everleigh op cit (n 204) 315.
[297] Ibid.
[298] Ibid.
[299] The National Health Act refers to s 39 (4) of the Child Care Act, 1983 (Act. No. 74 of 1983) for the age of consent.
[300] Ibid.

The Children's Act was also enacted in 2005 with the primary purpose of giving 'effect to children's rights already guaranteed in the Constitution, and sets out principles relating to their care.'[301] Most notably, s 4 of the Act places an obligation on the state to ensure full realisation of these rights by children, and ss 7 and 9 provide that in all decisions pertaining to the child, the best interests are of paramount consideration.[302] Furthermore, the child's right to autonomy is recognised under s 129 of the Act. This states that a child can consent to medical treatment so long as that child is over 12 years old, demonstrates 'sufficient maturity and has the mental capacity to understand the benefits, risks, social and other implications of the treatment.'[303] However, the Act has been criticised for being ambiguous and providing children with 'limited protection in respect of health care services.'[304] For instance, the Act makes no specific reference to a child's right to healthcare services, nor does it define what it means by 'basic health care services' or the standard of healthcare for children.[305]

(c) The Threshold: When are Courts likely to intervene?

As is customary elsewhere in the world, South African law states that parents or legal guardians are legally empowered to make medical decisions on behalf of their children.[306] However, such responsibility should be exercised with due diligence and at all times must be in the best interests of the child.[307] As such, where parents or guardians fail to make decisions in the best interests of the child (e.g. parents refusing to grant consent to immunize their child), the court as the "upper guardian" has been granted powers to intervene.[308] It was held in *Hay v B* 'that the High court was the upper guardian of all minors, and such courts will have the authority to order any decision over that of the parents if such decision would be in the best interests of the child.'[309] Furthermore, pursuant to the *parens patriae* doctrine, s 129 (9) of the Children's Act states:

> A High Court or Children's court may consent to the medical treatment of or a surgical operation on a child in all instances where another person that may give consent in terms of this section refuses or is unable to give such consent.

[301] Ibid, Preamble of the Children's Act.
[302] Buchner-Everleigh op cit (n 204) 320.
[303] s 129 (2) Children's Act.
[304] Ibid.
[305] Ibid, The Act makes reference to s 28 of the Constitution in the Preamble.
[306] s 18 (3) (c) Children's Act.
[307] Reddy op cit (n 293) 49.
[308] *Hay v B and Others* 2003 (3) SA 492 (W).
[309] Ibid.

The *parens patriae* doctrine provides the justification for the court's intervention in what would otherwise be a private decision in relation to the child's care in order to serve the best interests of the child, and preserve the child from imminent harm or danger. In *Hay v B,* the court in deciding whether the blood transfusion was in the best interests of the child, balanced the child's right to life and healthcare services against the parent's right to religion.[310] The court found that 'the child's right to life was most important as his chances of survival without the treatment was minimal,' therefore, the child's rights overrode the rights of the parents.[311]

South African domestic courts have held s 28 (2) of the Constitution which states that 'a child's best interests are of paramount importance in every matter concerning the child,' to be of high importance in relation to the rights of the child.[312] In fact, this provision is 'the paramount factor that is to be considered when weighing up conflicting rights between the parents and the child.'[313] Furthermore, s 7 of the Children's Act provides a list of factors that the court considers when making the best interests determination which are applied on a case-by-case basis. These factors as contemplated in *M v S*[314] include 'decisions affecting their health; protection against any harm; prevention of harm to the child and provision to have their rights met and protected.' [315] It is essential that all these factors are weighed and 'applied collectively to ensure proper determination of the standard.'[316] As already recognised by the courts, the best interests standard 'should be flexible as individual circumstances will determine which factors secure the best interests of a particular child.'[317] In summary, when courts are attempting to balance the interests of the parent and child, they will always look at what will serve the best interests of the child. What this means can vary from case to case but what is consistent is that in all interpretations, the court will favour a child-centred approach that focuses on what will serve the child's interests best in the specific situation.

There is no case law on immunisations in South Africa. However, if a parent were to refuse to immunise their child due to non-medical reasons, it is evident from the cases above that the courts would apply the best interests principle to assess whether the child's rights will

[310] Ibid, 495.
[311] Ibid.
[312] Ibid.
[313] Ibid.
[314] 2007 (12) BCLR 1312 (CC).
[315] Ibid, Reddy op cit (n 293) 53.
[316] Ibid.
[317] *Minister of Welfare and Development v Fitzpatrick* 2000 (3) SA 422 (CC), para 18.

override the parent's rights. Refusal to vaccinate interferes not only with the child's right to access healthcare but also with the child's right to life. As such, it is likely that where parental rights interfere with the child's right to life, the child's right to life will supersede parental rights. Furthermore, where the child is 12 years and older, they can exercise autonomy and request to be immunised without parental consent as stipulated under s 129 (2) of the Children's Act. The courts as per the requirements under s 129 need to be satisfied that the child is mentally competent to understand the risks and benefits of the medical treatment. Alternatively, in the event that both the parent and child choose not to consent to immunisations, the courts as *parens patriae* will intervene and make a determination using the best interests standard.

IV CONCLUSION

In this Chapter, the domestic laws of the two test countries in relation to immunization laws has been discussed. It has been demonstrated that both test countries have been influenced by international law by applying the "best interests" standard in circumstances where there is a conflict between parental and children's rights. In ascertaining whose rights take priority over the other, the courts, exercising their powers provided to them through the *parens patriae* doctrine, will make this determination on a case-by-case basis.

CHAPTER FIVE

OVERCOMING PARENTAL CONSENT

I INTRODUCTION

Vaccines are regarded as one of the safest and cost-effective preventive medical interventions on the planet. They save at least 2.5 million lives every year according to WHO estimates, and have been credited for eradicating several diseases like polio for instance.[318] The health benefits aside, vaccines also have positive cost benefits for both individuals and the state. A recent survey of ten vaccines revealed that '94 low- and middle-income countries estimated that an investment of US$34 billion for the immunization programs resulted in savings of US$586 billion in reducing costs of illness and US$1.53 trillion when broader economic benefits were included.'[319] Additionally, the survey also revealed that vaccination would prevent 100 million people globally from going into poverty due to medical bills arising from vaccine-preventable diseases.[320] Yet, some parents remain hesitant to vaccinate their children due to misleading information about the negative risks of vaccines. This is despite those risks being quite miniscule. Regardless, more and more parents are opting to withhold consent to immunize their children resulting in an increased number of unvaccinated children as well as an increased number of outbreaks of vaccine-preventable diseases. This is because low immunization rates means that the community is vulnerable to contracting diseases as herd immunity (i.e. the population's ability to resist infectious diseases) is low, while high immunization rates have the opposite effect.[321]

The purpose of this Chapter is to address how to overcome parental consent in childhood immunisation cases. Part II will discuss why vaccine hesitancy matters in relation to this dissertation's topic. Part III will suggest areas for reform in order to overcome parental consent in the two test countries. Finally, Part IV will provide the conclusion.

II WHY VACCINE HESISTANCY MATTERS

[318]John Hewko 'Why Vaccines Matter in 2019' *Medium Health* 01 May 2019 available at https://medium.com/@JohnHewko/why-vaccines-matter-in-2019-9d458a89367f, accessed on 14 August 2019.
[319] Ibid.
[320] Ibid.
[321] H. Cody Meissner 'Why is herd immunity so important?' *American Academy of Pediatrics* 27 April 2015 available at https://www.aappublications.org/content/36/5/14.1, accessed on 6 September 2019.

The last decade has witnessed an outbreak of vaccine-preventable diseases due to an increased number of unvaccinated children. While the anti-vaccination movement is far much stronger in the USA than in South Africa, that is in no way an attempt to undermine the movement and its growing influence in South Africa. However, the statistics in the USA are staggering. Between January and June 2019, 1, 022 measles cases were reported with 90% of those cases being unvaccinated, demonstrating the link between the unvaccinated and outbreaks.[322] The statistics are unsurprising as a study published in 2018 revealed that 70% of parents in the USA refused to immunize their children born in 2013, compared to those born in 2010.[323]

On the other hand, South Africa reported three measles outbreaks in 2017, a twelve fold increase from the previous year which prompted questions of the anti-vaccination movement in the country.[324] This is because research revealed that the outbreaks were from largely unvaccinated areas in the country.[325] However, it is difficult to ascertain whether the increase in outbreaks in South Africa is due to the anti-vaccination movement or due to lack of state resources. This is because there is a discrepancy on the immunization statistics between the government of South Africa and the WHO. While the Department of Health states that 96% of South African children have received essential vaccinations, the WHO claims that only 64% of children have received this.[326] Nonetheless, studies have revealed two pertinent points; the first is that there is a link between the unvaccinated and an increase in outbreaks of vaccine-preventable diseases (as has been discussed above); and the second is that the less stringent the laws governing vaccination, the lower the vaccination rates.[327] For instance, a study revealed that more than thirty-three percent of parents in the USA refused to vaccinate their child on either philosophical or religious grounds in jurisdictions that do not have stringent requirements on obtaining the exemptions.[328] This has also contributed to the increase in outbreaks. These findings support the argument that stronger immunization laws are needed in order to curb vaccine hesitancy.

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[322] Melissa Jenco 'CDC: Measles cases rise to 971; disease elimination status threatened' *AAP News* 30 May 2019 available at https://www.aappublications.org/news/2019/05/30/measles053019, accessed on 14 August 2019.
[323] Hewko op cit (n 318).
[324] Health-e News 'Anti-vaxxers & the return of measles: Is SA immune?' *Health-E News* 18 February 2019 available at https://www.health-e.org.za/2019/02/18/anti-vaxers-is-sa-immune/, accessed on 11 August 2019.
[325] Ibid.
[326] Ntombi Dyosop 'Flawed data undermines SA claims on vaccination coverage' *Africa Check* 16 January 2018 available at https://africacheck.org/reports/flawed-data-undermines-sa-claims-on-vaccination-coverage/, accessed on 11 August 2019.
[327] Lois A. Weithorn, Dorit Rubinstein Reiss 'Responding to the Childhood Vaccination Crisis: Legal Frameworks and Tools in the Context of Parental Vaccine Refusal' (2015) 63 *Buffalo Law Review* 881, 931.
[328] Ibid.

III POSSIBLE AREAS OF REFORM

The UNCRC states in Art. 4 that 'States Parties shall undertake all appropriate legislative, administrative, and other measures for the implementation of the rights recognized in the present Convention.' This provision means that the state has an obligation to develop legislative and policy interventions targeted at protecting a child's right to health. In terms of legislature, the two test countries could develop mandatory childhood immunization laws when it has been proven that voluntary measures are unsuccessful. This has been done in the USA where public schools require proof of immunisation before admission. However, this requirement is limited by parental rights, medical and non-medical exemptions which parents have used as an excuse to circumvent the requirement as will be addressed below.

Arguably the concept of mandatory immunization laws brings about other contentious legal issues such as the state's interference with the right to individual freedom, with potential debates about the constitutional validity of such laws. The argument being that people have the freedom to do to their bodies whatever they desire. While this may be true for say the decision not to undergo a surgery, the same cannot be said about vaccines. This is because the individual choice to not vaccinate can affect the entire community as other community members are forced to live in an environment prone to infectious diseases.[329] Simply put, if some parents are allowed to not vaccinate their children, then they are infringing upon the rights of those parents who desire their children to grow in societies without certain vaccine-preventable diseases. Additionally, where the child's life is at risk, the best interests standard is put to the test and the court has opted to preserve the child's life than to honour parental wishes that interfere with that right.

The legal debate aside, mandatory immunizations are the easiest way to improve childhood immunization rates and parental compliance, simply because the element of choice is revoked. Indeed, case law exists in the USA where courts ordered forced immunizations during outbreaks against parental wishes as was the case in *re Christine M.*[330] In South Africa, there are legislative requirements for heads of institutions such as a head of a school and parents alike, to notify the state if there are suspicions of an outbreak. While seeking mandatory vaccinations for every disease imaginable may not be practical, it would be advisable to follow

[329] Ben Balding 'Mandatory Vaccination: Why we still got to get folks to take their shots' *Harvard Law School* 27 April 2006 available at https://dash.harvard.edu/bitstream/handle/1/8852146/Balding06.html?sequence=2&isAllowed=y, accessed on 14 August 2019.
[330] *re Christine M.* supra (n 264).

the recommended list of vaccinations as determined by the WHO as mandatory, and adding any region specific vaccinations as required.[331]

On the other hand, South Africa does not have any mandatory immunization laws except for the Yellow Fever vaccination as discussed in Chapter Four. Furthermore, while s 16 of South Africa's Admission Policy for Ordinary Schools requires parents to show proof of their child's immunizations, it falls short of providing a penalty or consequence for failing to immunise the child even after being mandated to do so by authorities. Having no criminal liability for failing to immunize a child provides no incentive for the parent to immunize the child, despite the possible risk to the child's life. As already discussed, Art. 18 of the UNCRC states that parents have the primary responsibility for the upbringing and development of the child which entails all aspects of that child's life, including access to healthcare. Surely, depriving the child access to medical care that is essential to the healthy development of that child should be a crime that is punishable by law. It falls on the state to enforce this right.

In the USA, *Jacobson v. Massachusetts* criminalised non-vaccination though the state has not imprisoned parents who refuse to vaccinate their children.[332] In fact, the state's only form of redress is to prevent the child from attending public school during an outbreak until after the outbreak and infection risk period has ended (i.e. forced quarantine). [333] This forced quarantine only punishes the child whose right to education is infringed upon as s/he is exempted from studies for an undetermined period of time causing them to fall behind.[334] This is in sharp contrast to other jurisdictions. In France for instance, parents who fail to immunize their children against the mandatory vaccinations for diphtheria, tetanus and polio, face fines or imprisonment.[335] The fact that in the USA, children are the ones punished because of their parents' decision not to vaccinate is indicative of the consequences of not domesticating the UNCRC to further enshrine the rights of the child in their jurisdiction. Current law in the USA places heavy reliance on parental rights believing that they are capable of making sound decisions in the best interests of the child, with little to no consideration of children's rights. Furthermore, while the law allows for states to protect the child in some instances, there is no

[331] These are BCG, Polio, Hepatitis B, Measles, Rotavirus, Rubella, HPV, DTP, Haemophilus influenzae and Pneumococcal.
[332] Weithorn and Reiss op cit (n 327) 968.
[333] *Anderson v. State*, 65 S.E.2d 848, 852 (Ga. Ct. App. 1951); *State v. Drew*, 192 A. 629, 632 (N.H. 1937).
[334] This demonstrates how the right to immunisation is interlinked with other rights. As such, failure to immunise can adversely affect other rights the child is entitled to, in this case, the right to education.
[335] Art. L.31116-4 of the French Code of Public Health imposes a 3, 750 Euro fine and a jail term of up to six months.

constitutional mandate to do so, and the state's powers are limited by parental rights.[336] In fact, the law in the USA 'forbids any consideration of children's interests until adults' interests have been addressed and given priority.'[337] This just demonstrates that children's rights are not the primary consideration during decision-making on matters concerning them. Therefore, ratification of the UNCRC in the USA would develop children's rights by forcing policy-makers to take into account the provisions of the UNCRC with regards to the child's right to be heard and having their views given due consideration depending on the age and maturity of the child.

The final possible area for reform concerns non-medical exemptions. As the law stands in both test countries, parents can obtain exemptions to medical procedures based on medical, philosophical or religious grounds. Obtaining such exemptions can vary from ticking a box on a form to fulfilling more stringent requirements. It is proposed that all non-medical exemptions should be determined on a case-by-case basis rather than providing blanket protection especially in jurisdictions that require a simple check in a box. The courts should determine whether the exception is based on true beliefs and weigh it against the best interests of the child. Here, the onus would be on the parents to prove to the court that their non-medical reasons for exemptions are legitimate. In the instance where the affirmative is proven, then the court should issue an order that includes a warning to the parents about the health consequences for non-vaccination.

Additionally, during the court proceedings, it is important to have the child heard in accordance with Art. 12 of the UNCRC. This is extremely vital in the American context as current law in the USA does not provide for child participation rights be it in the public or private arena. The only recognised child participation rights concern the right to legal representation in court proceedings. Aside from that, the law gives great deference to parental rights in all matters. In terms of health rights, parents have the right to make most medical decisions on behalf of their children even if the child is of relative age and maturity to be consulted on the medical decision or even if the parental rights conflict with the child's rights.[338] The only exception to this right is if it is proven that the parents' decisions place the

[336] Bartholet op cit (n 277) 6.
[337] Ibid, 7.
[338] Ibid, 10. As of 1 September, 2019 '30 states and the District of Columbia allow all parents, regardless of age, to consent to medical care for their child.' The remaining '20 states have no explicit policy or relevant case law': Guttmacher Institute 'An Overview of Consent to Reproductive Health Services by Young People' *Guttmacher Institute* 1 September 2019 available at https://www.guttmacher.org/state-policy/explore/overview-minors-consent-law, accessed on 6 September 2019.

child's life in jeopardy.[339] This is in contrast with South Africa where child participation rights are enshrined in the South African Constitution.[340] The importance of child participation rights in relation to this topic is that it presents an opportunity for the court to hear the child's views on vaccination. This will best highlight the position of the vulnerable party (i.e. the child) and ensure that their interests are seriously considered before a decision is made.

IV CONCLUSION

The foregoing aimed to discuss how to overcome parental consent in childhood immunization cases. To that aim, this Chapter has demonstrated that there is a link between low vaccination rates and the increase in outbreaks. Even more, a majority of those outbreaks have been linked to unvaccinated populations who are hesitant or reluctant to vaccinate for one reason or another resulting in poor herd immunity. These vaccine hesitant parents either use the law (i.e. through exemptions) or ignore the law all together to not vaccinate their children and suffer no legal consequences. As such, the Chapter has proposed several areas for reform in order to overcome parental consent in the two test countries. These mainly involve the state exercising its authority to introduce mandatory vaccinations in line with constitutional law, criminalise non-vaccination, and remove the award of non-medical exemptions without the courts hearing the case and weighing it against the best interests of the child. Lastly, it has also been proposed that the child's right to be heard in such proceedings needs to be given due consideration by the courts especially in the USA where no such right exists.

[339] *In re Guardianship of Phillip Becker* 139 Cal. App. 3d407 (1983).
[340] See s 28 (1) (h).

CHAPTER SIX
CONCLUSIONS

I INTRODUCTION

A child's right to health is an inalienable right that is governed by international human rights law. More specifically, under Art. 24 of the UNCRC, a child is guaranteed the right to the highest attainable standard of health. Despite this right being indisputable, it has been seen that children across the globe fail on a daily basis to attain this right when they are denied access to childhood immunizations. It has been demonstrated throughout this paper that vaccine hesitancy is on the rise and has had negative consequences on public health with the WHO labelling vaccine hesitancy as one of the top ten threats to global health.[341] This has been evidenced by the steady decline in global childhood immunizations and the increase in outbreaks of previously eradicated infectious diseases. Nonetheless, some parents still choose to not vaccinate their children either out of religious or philosophical beliefs or out of fear of the negative side effects of vaccines. However, those negative side effects seem minute when weighed against the risk non-vaccination poses to the child's life and healthy development.

The introductory Chapter aimed to establish a background of the problem statement and set out to answer how a child's right to health can be protected in childhood immunization cases where parents withhold consent. To this end, a literature review was conducted focusing on the history of vaccine hesitancy, its effects and how to address it. It also looked at the role of the best interests standard when balancing between parental and children's rights in childhood immunization cases. The purpose of this final Chapter is to synthesise the findings of this paper, and present the final conclusion.

II SUMMARY OF FINDINGS

The objective of this paper was to address how to protect a child's right to health where parental consent is not granted in immunization cases. In determining this objective, the paper began by examining the international and regional framework that govern children's rights in Chapter Two. In particular, special emphasis was drawn on the UNCRC with regards to its four underlying principles and their relation to a child's right to health. It also addressed a child's right to health both under international human rights law and the UNCRC.

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[341] WHO/Rada Akbar op cit (n 7).

Chapter Three explored how the competing rights between parents and children are balanced. Here, it was found that the best interests standard plays a critical role when determining whose rights to prioritise. Specifically, the best interests standard attempts to strike a balance between parental autonomy and child autonomy. It was found that in instances where the child's life is at risk, parental autonomy will be discarded in favour of the child's best interests. Finally, Chapter Three also addressed the evolving capacities of the child and explained how the child has a right to be heard in all matters concerning them, and this includes having their views taken into consideration depending on their age and maturity.

Chapter Four considered the domestic immunization laws in the two test countries and similarities were observed between the two legal systems. It was found that in matters where there was a conflict between parental and children's rights in immunization cases, the courts applied the best interests standard to determine whose rights will take priority. The application of the best interests standard was in line with the provisions of the UNCRC which South Africa ratified. However, it was found that despite the USA not ratifying the UNCRC, it still applied the best interests standard because it is an enshrined principle under common law. Henceforth, the best interests standard is also a valid principle under American domestic law. It was also found that the USA has some limited mandatory vaccination laws that are sometimes circumvented by vaccine hesitant parents, while South Africa does not have mandatory immunization laws. Furthermore, it was observed in Chapter Four that the USA's domestic law has been tested on immunization laws more than South Africa, so, the position in the USA came out more clearly in that where the child's life is at risk, the courts will order the immunization of that child, regardless of parental wishes. Now, that is not to say that South African courts would also not do the same, it is just that it has not been tested in the domestic arena.

In Chapter Five, recommendations were made on how to address the legal gaps and overcome parental consent in the two test countries. Three possible areas for reform were suggested namely: introduction of mandatory vaccination laws in line with constitutional law; criminalization of non-vaccination; and awarding non-medical exemptions after the matter is heard before the courts, and weighed against the best interests of the child. It was also suggested that the USA would heavily benefit from the ratification of the UNCRC as it would strengthen children's rights domestically – in particular, the child's participation rights in matters concerning them.

III CONCLUSION

The primary question of this paper was how international human rights law can be used to protect a child's right to health in childhood immunization cases where parental consent is not granted. From the research, it is concluded that first and foremost, states need to ratify and adhere to international and regional human rights instruments relevant to the realization of the highest attainable standard of health for children. In particular, the UNCRC needs to be ratified not only because it specifically addresses the rights of children, but because it embraces other novel concepts pertaining to the child. An example of such a concept is that of child autonomy which is crucial in childhood immunization cases as it speaks to consent of the patient. Once these international human rights instruments have been ratified, it is the responsibility of both the state and non-state actors to ensure their compliance in fulfilment of this right to health. Where the right is contravened upon, it is up to the court to rectify it by weighing the best interests of the child against the wishes of the parent in order to determine whose rights take priority.

It has also been suggested that pursuant to Art. 4 of the UNCRC, States Parties shall adopt legislative, administrative and other measures in pursuit of the rights stipulated under the UNCRC. To this end, states can develop mandatory vaccination laws thus eliminating the need for parental consent, or, the state can opt to criminalize non-vaccination which would also give parents an incentive to vaccinate their children or face legal consequences, and lastly, states can introduce more stringent requirements for parents who wish to apply for non-medical exemptions. It is believed that these proposed methods would go a long way in overcoming parental consent in childhood immunization cases and thus protect the child's right to health.

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