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I hereby declare that I have read and understood the regulations governing the submission of LLM dissertations, including those relating to length and plagiarism, as contained in the rules of the University, and that this dissertation conforms to those regulations.

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CHAPTER I

INTRODUCTION

'You let a doctor take a dainty, helpless baby, and put that stuff from a cow, which has been scratched and had dirt rubbed into her wound, into that child. Even, the Jennerians now admit that infant vaccination spreads disease among children. More mites die from vaccination than from the disease they are supposed to be inoculated against.'

(George Bernard Shaw, 1929)

1.1 Introduction

Public perceptions of vaccination have changed greatly since George Bernard Shaw unleashed his diatribe against the practice. Today it is recognised that, far from spreading disease, vaccination is one of the cheapest and most effective public health interventions. Immunization against infectious diseases has drastically reduced mortality and morbidity, particularly among children, and has diminished the disease burden caused by poliomyelitis, rubella, measles, tetanus, diphtheria and whooping cough, amongst others. By one estimation, paediatric immunization worldwide prevents approximately 3 million child deaths each year, and saves 750 000 more from disability.[1] In addition to alleviating suffering, prevention of infectious diseases by vaccination is also more cost-effective than treatment of infectious diseases once contracted.[2] It is no exaggeration to say that '[w]ith the exception of safe water, no [other] modality, not even antibiotics, has had such a major effect on mortality reduction and population growth.'[3]

Ironically, it seems immunization has become a victim of its own success. In many developed countries, most parents have little or no memory of the devastating effects of vaccine-preventable diseases such as measles, poliomyelitis, pertussis and so on. Since vaccine coverage remains at significant levels, disease burdens are low and the effects of vaccine-preventable diseases are rarely felt. The reduction in the incidence of

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[1] P Bonanni 'Demographic impact of vaccination: a review' (1999) 17(3) *Vaccine* 5120.
[2] J Ehreth 'The value of vaccination: a global perspective' (2003) 21 *Vaccine* 4105.
[3] S and S Plotkin 'A Short History of Vaccination' in S Plotkin et al (eds) *Vaccines* 2ed (1994) at 1.

vaccine-preventable diseases has altered public perceptions regarding the severity of diseases such as measles: whereas 55% of mothers considered measles a 'serious' illness in the UK prior to the introduction of the MMR vaccine, more recently only 20% agreed on the severity of the disease.[4] Even in less-developed countries such as South Africa, where factors such as poverty and high HIV infection rates keep vaccination coverage at comparatively low levels, outbreaks are less frequent, and less severe than they would be in the absence of vaccination.[5] In short, parents have grown less fearful of vaccine-preventable diseases and, instead of focussing on the potentially fatal effects of infectious diseases, have shifted their attention to the safety of vaccines.[6]

1.2 The problem of vaccination refusals

The focus on vaccine safety has given rise to a well-organized anti-vaccine movement that plays on concerns regarding the safety of vaccines using sensationalized and biased information[7] to link vaccines to a variety of side-effects. Anti-vaccine crusaders allege that vaccines cause adverse effects beyond the known vaccine-related risks.[8] Some critics focus on the number and variety of vaccines recommended, arguing that the antigens they contain may interact dangerously in ways not recognised by the mainstream medical community.[9] Others concentrate on the timing of administering the vaccines, while yet others focus on vaccine components or specific vaccines that they regard as harmful to children.[10] The anti-vaccine lobby continues to command significant attention from the media despite the deficiencies in the credibility and composition of the faction, which claims negligible support

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[4] N Begg et al 'Media dents confidence in MMR vaccine' (1998) 316 *British Medical Journal* 561.
[5] M S Blecher et al 'Financing vaccinations – the South African experience' (2012) 30 Vaccine 79.
[6] G Cunliffe 'Deciding on MMR' (2004) 16(4) *Paediatric Nursing* 25.
[7] See Social Market Foundation 'Science, Risk and the Media— Do the Front Pages Reflect Reality?' (2006) Available at: http://www.smf.co.uk/files/6613/2317/4941/SMF_science_and_risk.pdf [Accessed 3 January 2013]; and A Moore 'Bad science in the headlines. Who takes responsibility when science is distorted in the mass media?' (2006) 7(12) *EMBO Report* 1193.
[8] J L Schwartz 'Vaccination Refusal: ethics, individual rights, and the common good' (2011) 38(4) *Primary Care* 717.
[9] P A Offit et al 'Addressing parents' concerns: do multiple vaccines overwhelm or weaken the infant's immune system?' (2002) 109 *Pediatrics* 124.
[10] Ibid.

from the medical and scientific establishments,[11] and which continues to rely on the now-discredited theory of Dr Andrew Wakefield linking autism to the MMR vaccine.[12] Faced with the media's coverage of sceptics' fervent, emotional rhetoric, some parents have voiced concerns regarding the safety of vaccines.[13]

The increased public concern regarding the real or perceived risks associated with vaccination has created a concomitant increase in the number of persons refusing vaccination.[14] Though the number of parents who refuse vaccination remains small in absolute terms, an upward trend in the number of non-medical exemptions from school vaccination requirements has been noted in the US.[15] This rise in refusals is linked to the debate concerning vaccine safety, which persists, fuelled by a vocal cohort of activists who reject the significant growing body of scientific evidence demonstrating the safety and efficacy of vaccines.

It should be noted that whilst the refusal to consent will generally be made by the parent acting on behalf of the child, situations may arise where a child is competent to refuse consent herself. Because of the age at which children are generally vaccinated,[16] the first situation is far more likely to occur. It is possible, however, that the second situation could occur if adolescents are vaccinated as part of a mass vaccination campaign in response to an outbreak. In such a case only the conflict between individual and community interests, considered in chapter four, would be relevant (there being no parent refusing consent on the child's behalf). This dissertation uses the term vaccination refusal to refer to both these situations where a person refuses vaccination – be it the parent acting on behalf of the child, or the adolescent child herself.

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[11] Schwartz op cit note 8 at 718.
[12] F Godlee et al 'Wakefield's article linking MMR vaccine and autism was fraudulent' (2011) 346 *BMJ* 7452.
[13] A Visser and A Hoosen 'Combination vaccines in the South African setting' (2012) 30 *Vaccine* 38 at 39.
[14] S B Omer et al 'Nonmedical exemptions to school immunization requirements: secular trends and association of state policies with pertussis incidence' (2006) 296 (14) *JAMA* 1757.
[15] Ibid.
[16] South Africa's vaccination schedule recommends children be vaccinated for oral polio vaccine and BCG at birth, and recommends various other vaccinations until the age of 12. South African vaccination schedule Available at: www.pntonline.co.za/index.php/PNT/article/download/679/958 [Accessed 02 February 2013].

Individuals may remain unvaccinated for various reasons. Some cannot be vaccinated for medical reasons, for instance individuals whose immune system is compromised, and those for whom the vaccination is contraindicated. Many, however, remain unvaccinated for non-medical reasons, such as their concerns regarding the vaccine's safety, or because they have religious or philosophical objections to vaccination. This increase in the numbers of parents refusing to vaccinate their children is concerning as refusals to vaccinate can be detrimental, both to the individual and to the community of which the individual is a part. Falling vaccination rates have led to outbreaks of vaccine-preventable diseases, such as the measles epidemic in South Africa in 2009, where over 18 000 cases were recognised, leading to several hundred deaths and disabilities.[17] The occurrence of such epidemics raises the question as to whether the state may be justified in imposing compulsory vaccinations in the face of parental refusal. Possible circumstances are twofold:

First are situations where refusal poses so great a risk of harm to the child that it justifies state intervention to protect the child's best interests. Whether a sufficiently serious risk is posed will depend on several factors, including the morbidity and mortality associated with infection, and the probability of the child contracting the disease if unimmunized.[18] The prevalence of the disease in the child's community will also affect the seriousness of the risk posed. Even in a well-immunized community, where the risk assumed by refusing to vaccinate is low, it is likely that the risk of the child developing an adverse reaction to a vaccine is lower still. If this is the case, then from a medical perspective it will be preferable to be vaccinated, since there is less chance of suffering harmful side-effects than of contracting the disease.

Second are circumstances where refusal poses a risk of harm to other individuals, such that state intervention may be justified. Immunization is justified on the basis of its beneficial effects – the most obvious of which is the development of immune protection in the individual who is vaccinated. Another significant, though less obvious, benefit is the indirect protection of

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[17] B D Schoub 'Lessons from the 2009 measles epidemic in South Africa' (2011) 101(8) *South African Medical Journal* 519.
[18] D S Diekema 'Responding to parental refusals of immunization of children' (2005) 115 *Paediatrics* 1429.

unvaccinated persons, attributable to the presence and proximity of vaccinated, immune persons.[19] Because of this phenomenon, known as herd immunity, the case for compelled vaccination can be couched not only in terms of the individual, but by reference to society at large too.

Herd immunity ensures that important sectors of society who are unable to be vaccinated are protected. Such groups include: children too young to be vaccinated, immunocompromised persons (such as AIDS sufferers, the elderly, or those undergoing chemotherapy), persons with contraindications to vaccination, persons whose vaccine-induced immunity has waned over time, and persons who are unvaccinated, either by choice or because they lack access to vaccines.[20] For such indirect protection to arise, the prevalence of immune persons in the community must reach a threshold which varies by disease, but generally falls between 85%-95% of the population.[21] When the requisite proportion of the population is immune, the transmission of the disease is inhibited, allowing the minority of nonvaccinated individuals to enjoy the protection provided by the vaccinated majority. Under conditions of high immunization coverage, then, refusals to vaccinate are generally unproblematic – the unimmunized child (or adult) does not pose a risk to the vaccinated population, and that unimmunized person benefits from herd immunity so is unlikely to contract the virus from other persons in the community. Difficulties arise, however, where rising numbers of refusals lead to falling rates of vaccination. In such cases the vaccination coverage may drop below the threshold level required for herd immunity, putting at risk those segments of the population which cannot be vaccinated. In short, where there are high rates of vaccine coverage and herd immunity operates to protect unimmunized persons, the community can accommodate a small minority of parents who refuse to vaccinate their children.[22] In cases where community immunity is impaired, however, vulnerable groups who are unable to be vaccinated are put at risk and the legitimacy of the refusals to vaccinate should be interrogated.

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[19] K R Malone and A Hinman 'Vaccination Mandates: The Public Health Imperative and Individual Rights' in Law in R A Goodman et al (eds) *Public Health Practice* (2007) at 264.
[20] P E M Fine and K Mulholland 'Community immunity' in S Plotkin et al (eds) *Vaccines* 2ed (1994) at 1395.
[21] Ibid.
[22] Ibid at 1427.

1.3 Aim of study

The aim of this dissertation is twofold. First, I hope to draw attention to an issue that has received little (if any) attention in the South African context. Though there is considerable academic commentary concerning the state's ability to overturn vaccination refusal in foreign jurisdictions (particularly the United States and Canada), the subject has been neglected in the South African literature. Given the medical significance of vaccination programs and the controversies surrounding state-mandated vaccination which have been covered by the media, this neglect is surprising, though perhaps attributable to the fact South Africa, unlike the US, does not have a policy of compulsory vaccination at present.

Secondly, I aim to consider the challenges inherent in balancing the rights and interests of children, their parents, and the community in the context of refusals to vaccinate children. To this end, this dissertation outlines the current legal framework for vaccination of minors in South Africa, and examines the way in which the existing laws and policies deal with immunization against the wishes of the parent or child. South Africa does not have a single comprehensive piece of legislation for administering medical treatment to young persons. Instead, the Constitution, various pieces of national legislation (such as the Children's Act[23] and the National Health Act),[24] policy guidelines and international practice cover different facets of children's medical treatment. Understanding the legislative landscape governing vaccination of children and the circumstances in which the state can justifiably overturn a parent's vaccination refusal requires knitting together these disparate elements into a cohesive structure.

This dissertation focuses on whether the state may intervene to vaccinate a child contrary to the wishes of the parent and, if so, in what circumstances this will be justifiable. In considering this question, this dissertation will critically and comparatively consider how South Africa's laws attempt to reconcile public health considerations with a parent's objections to

[23] Act 38 of 2005.
[24] Act 61 of 2003.

vaccination. Though the primary focus will be on South African law, international, regional and foreign jurisprudence will be considered, in accordance with the Constitution's injunction that, when interpreting the Bill of Rights, a court is required to consider international law and is permitted to consider foreign law.[25] Parallels are drawn with the experiences of other countries, and the varied immunization policies which they have adopted.

1.4 Chapter outline

This dissertation comprises of five chapters. The second chapter reviews the extant literature, providing an overview of the two central conflicts that flow from a refusal to vaccinate. Each forms the basis of a chapter: chapter three considers the conflict between the child's right to healthcare and the parent's right (and responsibility) to make choices for her child, in accordance with the right to dignity and the obligation to make decisions in the child's best interest (s 28). Chapter four discusses the tension between the individual's autonomy right to make decisions about her health, and the community's interest in promoting public health by preventing the spread of infectious diseases that are easily avoided by vaccination. The final chapter synthesises the preceding discussions, and suggests how South Africa could learn from other jurisdictions when dealing with vaccination refusals. This chapter concludes by providing a summary of the key arguments developed in the preceding chapters.

[25] Constitution of the Republic of South Africa, 1996, section 39(1)(b) and (c).

CHAPTER 2

LITERATURE REVIEW AND ETHICAL FRAMEWORK

2.1 Introduction

Refusals to vaccinate are addressed in the literature concerning the United States and Europe, where a growing trend of parents who refuse to vaccinate their children is causing concern.[26] Several commentators address whether vaccination should be compulsory; most conclude that current vaccine coverage would not justify such a move. In other words, coverage is still sufficient to maintain the community's immunity, in general terms. The South African context has received comparatively little attention, however. In addition, the ethical principles which underpin the controversy are seldom articulated, with many writers failing to acknowledge the assumptions which animate their arguments. This chapter sketches briefly the historical context informing the problem of vaccination refusal, before reviewing the literature concerning vaccination refusal.

2.2 Background to vaccination refusal

During the second half of the twentieth century, the value of vaccination in controlling and even eliminating infectious diseases was demonstrated many times over. Most famously, the massive global immunization campaign pursued from 1967 to 1977 resulted in the eradication of smallpox, a disease which previously killed one in four persons infected and claimed two million lives annually until its elimination in 1979.[27] Building on this success, the World Health Organization (WHO) launched the Expanded Program on Immunization (EPI), targeting diphtheria, tetanus, whooping cough, measles, polio, and tuberculosis through the promotion of immunization policies in WHO member states. The EPI increased vaccination coverage against these

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[26] See A Chatterjee and C O'Keefe 'Current controversies in the USA regarding vaccine safety' (2010) 9(5) *Expert Rev. Vaccines* 497; Schwartz op cit note 8 at 719.

[27] World Health Organization 'The Expanded Programme on Immunization' (2011) Available at http://www.who.int/immunization_delivery/benefits_of_immunization/en/index.html [Accessed $ January 2013].

diseases amongst children from 5% prior to 1974 to over 70%.[28] As a result, many high risk countries have eliminated maternal and neonatal tetanus, several regions have set targets for eliminating measles, and the eradication of poliomyelitis is within reach.[29] Since the EPI's launch, the number of reported measles deaths has plummeted from 6 million to less than 1 million a year,[30] and the WHO reports that polio infections have fallen by 99%.[31]

Despite these clear success stories, the rapid rise in vaccination coverage that characterised the 1970s and 1980s has stalled since the 1990s. This is partially attributable to a decline in funding: UNICEF vaccination program funding, for instance, was reduced from $182 million to $51.4 million between 1990 and 1998.[32] The effect on coverage statistics has been noted.[33] Worldwide coverage of the diphtheria, tetanus, and pertussis (DTP3) vaccine has hovered at 74% since 1990,[34] and coverage of the measles, mumps, and rubella (MMR) vaccine has slid following claims (now discredited) positing a link to autism.[35] Full routine coverage of children has not yet been achieved in many countries, and it has been estimated that at least 9.2 million additional infants must be immunized to achieve this level of coverage.[36]

The global decrease in vaccination coverage has also affected South Africa. Whilst official figures for vaccination coverage in South Africa are high, the accuracy of the Department of Health's figures for childhood vaccination has been questioned.[37] EPI-SA[38] has stated that 96% of children have received

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[28] Ibid.
[29] Ibid.
[30] D E Bloom et al 'The Value of Vaccination' (2005) 6(3) *World Economics* 15 at 19.
[31] WHO op cit note 27.
[32] V Gauri and P Khaleghian 'Immunization in Developing Countries: Its Political and Organizational Determinants' (2002) 30(12) *World Development* 2109.
[33] Bloom op cit note 30 at 21.
[34] Global Alliance for Vaccines and Immunization 'Progress towards global immunization goals 2011: Summary presentation of key indicators' (2012) Available at http://www.who.int/immunization_monitoring/data/SlidesGlobalImmunization.pdf [Accessed 19 December 2012].
[35] M J Smith et al 'Media coverage of the measles-mumps-rubella vaccine and autism controversy and its relationship to MMR immunization rates in the United States' (2008) 121 *Pediatrics* 836.
[36] GAVI op cit note 34 above.
[37] N Dyosop 'Flawed data undermines SA claims on vaccination coverage' Available at: http://www.africacheck.org/reports/flawed-data-undermines-sa-claims-on-vaccination-coverage/ [Accessed 27 January 2013]
[38] A government programme established under the auspices of the WHO but now forming part of the Department of Health.

the vaccinations required for their age,[39] however, this diverges substantially from the figures published by the WHO and Unicef, which estimate vaccination coverage to be at just 64%.[40] This is significantly worse than countries with less developed healthcare systems and lower gross national income.[41] By way of comparison, the WHO estimates that in South Africa only 72% of children under one year have received the recommended three doses of DTP3 for diptheria, tetanus and pertussis, whereas Angola and Malawi have 86% and 87% coverage respectively.[42] South Africa's coverage is thus far from optimal.

International movements for universal vaccination such as the Global Alliance for Vaccines and Immunization (GAVI) have attempted to respond to vaccination challenges in other countries by encouraging take-up of vaccinations. Despite this, there remains serious concern amongst academics and health practitioners that significant numbers of parents are electing either not to vaccinate their children, or to vaccinate selectively against only certain diseases.[43]

It is in this context that the debate concerning compulsory vaccination has taken place. Before considering the legal issues posed by state intervention in vaccination and the arguments posed by commentators, however, it is important to understand the ethical framework informing the debate.

2.3 An ethical framework for considering vaccination refusal

The focus on individualism and autonomy in bioethics is argued to have led to the emergence of liberal autonomy as the dominant ideology, which has

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[39] J van den Heever (head of EPI-SA) 'What is the South African vaccination coverage?' Conference presentation delivered at Hermanus on 15 October 2012. Available at: http://www.africacheck.org/wp-content/uploads/2012/11/S-Africans-Immunization-Coverage-ppt-EPI-Manager3.pdf [Accessed 27 January 2013].

[40] World Health Organization 'Immunization profile – South Africa' Available at: http://apps.who.int/vaccines/globalsummary/immunization/countryprofileresult.cfm?C=zaf [Accessed 27 January 2013].

[41] Dyosop op cit note 37 above.

[42] Ibid.

[43] See P Bradley 'Should Childhood Immunisation Be Compulsory?' (1999) 25(4) *Journal of Medical Ethics* 330; P Rosenthal 'Skepticism to vaccines: enough already?' (2010) 4(2) *Pediatric Health* 121.

caused communitarianism to be largely overlooked.[44] This is despite the latter theory's emphasis on the common good and public interest, which renders it particularly well-equipped to deal with medical issues affecting our collective lives.[45] Liberal autonomy stresses the distinction between private and public spheres; highlights the individual's right to make their own decisions in matters falling within the private sphere, but fails to recognise the permeable nature of the division between the 'public' and the 'private'. It also ignores the fact that the 'private sphere' is a fluctuating construct, with little intrinsic content.[46] In contrast, communitarianism recognises the constructed nature of the private/public divide. Notions of what is 'public' and 'private' are not seen as immutable and independent but as existing in response to social pressures. In the context of healthcare, communitarianism recognises that new medical technologies often have consequences which are socially coercive or culture-shaping.[47] Medical treatment is thus not simply the preserve of the individual decision maker, but is also a social issue with ramifications for the wider community.

The communitarian perspective is particularly apposite in the context of immunization, where the tension between the rights of the individual and the interests of the community has become a locus of debate, as will be discussed in chapter four.[48] The communitarian approach allows the reasons motivating the refusal (often religious or philosophical in nature) to be acknowledged, whilst at the same time situating these reasons in the context of community interests. The importance of vaccination is recognised without marginalizing religious or philosophical beliefs which may inform the refusal of a parent to consent to vaccination. As will be discussed in chapter five,[49] this recognition is important to encourage adherence to vaccine schedules.

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[44] D Callahan 'Individual Good and Common Good: A Communitarian Approach to Bioethics' (2003) 46(4) *Perspectives in Biology and Medicine* 496.
[45] Ibid at 500.
[46] Ibid at 503.
[47] Ibid at 500.
[48] See page 33 below.
[49] See page 42 below.

2.4 Reasons for refusal

The reasons behind parents' refusal to vaccinate their child might vary widely, but can be grouped into three general categories: medical reasons, safety concerns and religious or philosophical objections.

As noted in the introduction,[50] for various medical reasons some groups of people are unable to be vaccinated. In certain people a particular vaccine may be contraindicated, as in the case of the measles vaccine, which should not be given to persons with congenital immunodeficiency disorders or those who suffer from leukaemia, lymphoma or serious malignant disease.[51] Where one particular vaccine is contraindicated, the individual will have to rely on the protection provided by the vaccinated community in respect of that particular disease, but will be able to be vaccinated against other diseases. However, whilst this group is discussed under the heading of reasons for refusal, parents who do not vaccinate their child for such medical reasons should not strictly be viewed as 'refusing' the vaccination, since vaccination is not recommended to persons for whom it is contraindicated. There is accordingly no choice for the parent but to 'refuse' the vaccination.

Though in some cases there are valid medical reasons for not immunizing a child, many parents are hesitant to vaccinate their children on the basis of fears concerning the safety of vaccines. This second category of reasons underpins most parents' decisions not to vaccinate their child. Some parents are concerned about the number and variety of vaccines recommended, citing theories that the antigens they contain may interact dangerously or act to overwhelm or weaken the child's immune system.[52] Others worry that certain vaccine components are harmful, or that specific vaccines are linked to dangerous sequelae, such as encephalopathy, paralysis, or neurodevelopmental problems.[53] These fears have been decisively answered in the medical literature[54] but despite the overwhelming scientific

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[50] See page 5 above.
[51] National Institute for Communicable Diseases 'Frequently Asked Questions about Measles Vaccine for Health Care Professionals' Available at: http://www.kznhealth.gov.za/measlesfaq1.pdf [Accessed 03 February 2013].
[52] Offit op cit note 9.
[53] Ibid.
[54] See R T Chen and F DeStefano 'Vaccine adverse events: causal or coincidental?' (1998) 351 *Lancet* 61; F DeStefano 'Vaccines and autism: evidence does not support a causal association' (2007) 82 *Clinical Pharmacology and Therapeutics*756; and S B Omer 'Vaccine

evidence to the contrary, media reports continue to fuel parents' fears, and to erode public confidence in vaccination. Parental concerns about perceived vaccine safety issues were 'vindicated' following the media attention surrounding Hannah Poling, a 9-year-old girl who developed severe neurodevelopmental problems subsequent to receiving an MMR vaccine and whose parents were successful in their litigation under the Vaccine Injury Compensation Progam.[55] This second category of reasons for refusal thus continues to motivate many parents to refuse vaccination for the children.

Finally, some parents refuse vaccination for their children based on religious grounds. For many religious objectors their moral opposition stems from the fact that the initial cell lines in which the vaccine viruses are grown are obtained from voluntarily aborted foetuses.[56] Other religious objections are based on the belief that the body is sacred and should not be healed through 'unnatural' means, but rather through prayer. Whilst religious opposition in South Africa is not marked, it has been a major factor in the failure of the polio immunization programs in Nigeria, Afghanistan and Pakistan.[57] It has been recognised that the family unit is the 'crucible for the transmission of religious and cultural beliefs'[58] and that religious beliefs embrace a strong measure of parental choice.[59] In South Africa parents have discretion in deciding how and whether their children will worship, since the religious beliefs which parents adopt, and in accordance with which they raise their children, are intimately connected with the parents' rights to human dignity, and with their sphere of parental authority, in which the state should not arbitrarily interfere. Though careful to avoid unwarranted judicial interference in this sphere of parental authority, courts have shown special solicitude for

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Refusal, Mandatory Immunization, and the Risks of Vaccine-Preventable Diseases' (2009) 360 *N Engl J Med* 19 in this regard.

[55] PA Offit 'Vaccines and autism revisited — the Hannah Poling case' (2008) 358 *N Engl J Med* 2089.

[56] Chatterjee and O'Keefe op cit note 26 at 498.

[57] See H J Warraich 'Religious opposition to polio vaccine' (2009) 15 *Emerging Infectious Diseases* 978; and A S Jegede 'What led to the Nigerian boycott of the polio vaccination campaign?' (2007) 4 *PLOS Medicine* 417.

[58] D Brown 'Freedom from or freedom for? Religion as a case study in defining the content of Charter rights' (2000) 33 *U.B.C. L. Rev.* 551 at 579.

[59] B Bekink 'Parental religious freedom and the rights and best interests of children' 2003 (66) *THRHR* 246 at 248.

protecting children from what they have regarded as the potentially injurious consequences of their parents' religious practices.[60]

2.5 Conceptions of the family

The nature of parental responsibility in the context of children's health care treatment has received extensive attention, particularly in the context of parents exercising their right to practice their religion in circumstances where this does not serve the child's best interests. Though this will not be discussed at length in this dissertation it is necessary to outline the different conceptions of the family which are drawn on in discussing the right to family life.

Conflicting views of the family abound. The difficulty of giving a conceptual account of the family is compounded by its contemporary sociology: divorce, gamete donation, surrogacy, homosexual relationships, single parenting and extended families mean that 'the family' should no longer be read as the nuclear family comprised of a monogamous, heterosexual married couple and their children.[61] This dissertation therefore uses 'family' not to denote any particular set of biological relationships. Instead, a nominalist view is adopted: the family arises out of the agreement of its constitutive members, and is thus a social structure created and reinforced by its members.[62] In addition to this terminological difficulty, various accounts of the family's moral and ontological standing can be adopted. On the view this dissertation adopts, the family possesses some authority over its constituent members, and can use this to demand justification from the state where there is state intervention into family life and parental decision-making.[63]

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[60] *Christian Education South Africa v Minister of Education* 2000 10 BCLR 1051 (CC) at [41]. Hereafter referred to as *Christian Education.*

[61] H T Engelhardt 'Beyond the Best Interests of Children: Four Views of the Family and of Foundational Disagreements Regarding Pediatric Decision Making' (2010) 35 *Journal of Medicine and Philosophy* 499.

[62] Ibid at 508.

[63] Ibid at 507.

2.6 Conclusion

The problem of vaccination refusal has received much attention in the US and Europe, though little attention has been paid to the ethical principles informing the debate. The emphasis on the liberal autonomy of the individual over the community's interests has been largely unremarked. Communitarianism would thus serve as a useful framework for analysing vaccination refusals, particularly given its recognition of the social consequences of an individual's healthcare decisions, such as the decision to refuse vaccination. Such vaccination refusals, which are frequently motivated by safety concerns, and occasionally by religious objections, place the child's interests in tension with the parents' interest in raising their children in accordance with the discretion afforded them in terms of the right to family life, as will be examined in the following chapter.

CHAPTER 3

THE CONFLICT BETWEEN PARENT AND CHILD

3.1 Introduction

As noted in chapter one,[64] vaccination refusals pit the right of the child to access healthcare against the right of a parent to make choices for her child according to her discretion, as long as the choice is in the best interests of the child. Couched in rights-based terminology, this may be described as a conflict between the child's right to access to healthcare and the parent's right to human dignity. In addition, the child's rights to life, human dignity and family care are implicated, and 'the common law rights of parents to parental authority and care for their children, state and medical paternalism, social and public opinion and even aspects of self determination for the child' are relevant.[65] Whilst these rights and issues all have significant bearing on the parent/child relationship, the focus of this chapter is the conflict between the parents' right to family life and the child's right to access healthcare.

Before examining these conflicting rights, it is necessary to understand why the informed consent of the parent is needed, and what this informed consent entails. To this end, the first part of this chapter examines the importance of consent in the healthcare context, situating it within the South African constitutional setting and establishing, firstly, the requirements for informed consent; secondly, the circumstances in which informed consent is not required; and, thirdly, the position of children who consent to medical treatment. Having outlined the South African law governing consent of children to medical treatment, the chapter turns to consider the child's right to healthcare, the importance of the family, and the relationship between parental authority and the best interests of the child.

Thereafter, this chapter discusses the rights which conflict when parents refuse to consent to vaccination of their child. The remainder of the chapter focuses on these rights. The discussion examines the parents' concerns, in particular the right to family life, before moving on to consider the child's right

[64] See page 4 above.
[65] Bekink op cit note 60 at 247.

to healthcare. The conflict between the rights must be resolved in pursuance of the child's best interests. Finally, the chapter considers the best interests standard and its application to vaccination.

3.2 Informed consent

Informed consent entails 'a process of information sharing and decision making based on mutual respect and participation,'[66] which allows the patient to participate in choices about her healthcare. This safeguards the person's dignity by acknowledging them as an autonomous agent capable of rational deliberation and able to decide on what is in their own best interests. It is also an important element of ensuring the medical intervention is ethically and legally defensible, as it is through consent that physical invasion is made lawful and ethical.[67] As will be seen, however, such consent must be voluntarily given in light of sufficient information so as to make a responsible choice.

Historically, medical ethics have been dominated by the Hippocratic principles of beneficence and non-maleficence. Provided that the healthcare practitioner acted in furtherance of the patient's best interests, and did not intentionally harm the patient, it was permissible for treatment to be imposed irrespective of the patient's wishes.[68] This paternalistic stance has now been tempered by the recognition of patient autonomy. If patients are autonomous, rational agents capable of formulating their own opinions, it follows that their choices should be respected and their actions should not be hindered, unless clearly detrimental to others.[69] A legally competent adult therefore has the right to determine what shall be done with her own body, and her decision to seek treatment (or refuse it) should be respected by the healthcare practitioner as an exercise of this right. This strong moral conviction that every person has the right of self-determination with regard to her body explains the seriousness with which the law views any invasion of

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[66] D McQuoid Mason and A Dhai (eds) *Bioethics, Human Rights and Health Law: Principles and Practice* (2011) 70.
[67] J K Mason and RA McCall Smith *Law and Medical Ethics* 5ed (1999) 245.
[68] Ibid at 69.
[69] Ibid at 70.

physical integrity.[70] Respect for autonomy therefore forms the ethical bedrock upon which informed consent is based.[71]

3.2.1 South Africa

In the South African context, section 12(2) of the Constitution affirms that '[e]veryone has the right to bodily and psychological integrity, which includes the right...to security in and control over their body.' Patient autonomy is not, however, absolute, as the Constitution permits limitation of rights in terms of a law of general application and only to the extent that it is reasonable and justifiable in an open democratic society based on human dignity, equality and freedom.[72] In assessing the limitation, the courts must take into account several factors, including the nature of the right, the importance of the purpose of the limitation, the nature and extent of the limitation, the relationship between the limitation and its purpose, and the availability of less restrictive means to achieve the limitation's purpose. The right to bodily integrity can therefore be limited, provided such limitation complies with the constitutional requirements.

The National Health Act 61 of 2003 stipulates that informed consent must be obtained prior to any healthcare intervention, subject to certain exceptions discussed below.[73] Patients must have full knowledge of the procedure to which they are consenting.[74] As part of informed consent, patients are entitled to know their health status, and should be informed by their healthcare provider of the range of diagnostic procedures and treatment options available to them, and the benefits, risks, costs and consequences generally associated with each of these options.[75] Moreover, the patient should be informed of her right to refuse health services and the healthcare

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[70] Mason op cit note 69 at 245.
[71] R Thomas 'Where to from Castell v De Greef? Lessons from recent developments in South Africa and abroad regarding consent to treatment and the standard of disclosure' (2007) 124 *SALJ* 188 at 203.
[72] Section 36.
[73] National Health Act 61 of 2003 at section 7.
[74] Section 6.
[75] Section 6(1)(a)(b)(c).

practitioner must explain the implications, risks and obligations of such refusal.[76]

Section 7 of the Act states that treatment cannot be provided without informed consent, but this requirement is waived in exceptional circumstances as outlined. For example, where the person is unable to consent personally, but has mandated another person in writing to consent on their behalf or where a law or a court has authorised a person to give consent on behalf of the person.[77] The National Health Act also provides for proxies in a specified order of preference.[78] Informed consent may be waived where the medical treatment is authorised in terms of any law or court order.[79]

3.2.2 Consent of children

South African law distinguishes between persons with and without decision-making capacity when determining whether a person may personally consent to medical treatment. Children below a certain age are deemed to be legally incapable of providing consent, and therefore a proxy (usually a parent) must provide consent to medical treatment on their behalf. Despite being incapable of consenting, a child's opinion should not be disregarded. International legal instruments mandate that even very young children should be included in the decision-making process insofar as this is possible. Article 12 of the United Nations Convention on the Rights of the Child,[80] and article 7 of the African Charter on the Rights and Welfare of the Child,[81] provide that a child who is able to form and communicate her own views has the right to express these views and that they will be taken into consideration.

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[76] Section 6(1)(d).
[77] Section 7(1)(a).
[78] Section 7(1)(b).
[79] Section 7(1)(c).
[80] UN General Assembly, *Convention on the Rights of the Child*, 20 November 1989, United Nations, Treaty Series, vol. 1577, p. 3, available at: http://www.unhcr.org/refworld/docid/3ae6b38f0.html [Accessed 12 November 2012]. Hereafter referred to as the CRC.
[81] Organization of African Unity, *African Charter on the Rights and Welfare of the Child*, 11 July 1990, CAB/LEG/24.9/49 (1990), available at: http://www.unhcr.org/refworld/docid/3ae6b38c18.html [Accessed 24 November 2012].

The international position is reflected in South Africa's domestic legislation. The Children's Act[82] provides that in major decisions involving a child, the person making the decision 'must give due consideration to any views and wishes expressed by the child, bearing in mind the child's age, maturity and stage of development.'[83] Where the child is of an age, maturity and stage of development so as to be able to participate in any matter concerning that child, the Act provides that the child 'has the right to participate in an appropriate way and views expressed by the child must be given due consideration.'[84]

In addition to this guarantee of child participation, section 129 of the Act lists the circumstances in which a child may consent to medical treatment,[85] and outlines the various persons who may give consent on the child's behalf where the child cannot do so herself.

The Act states that consent to medical treatment may be given by a child over the age of 12 years, who is of sufficient maturity and has the mental capacity to understand the benefits, risks, social and other implications of the treatment.'[86] Where the child is either younger than 12 or does not have the requisite maturity or mental capacity, then the parent, guardian or care-giver must consent on the child's behalf.[87] If the medical treatment is necessary to save the child's life or to prevent serious injury or disability and the urgency is such that treatment cannot be deferred to obtain consent, the superintendant of the hospital may consent.[88] Particularly pertinent here, the Act also provides for situations where consent to medical treatment is unreasonably withheld. Where the child's parent or guardian unreasonably refuses to give consent or to assist the child to give consent, the Minister must assist the child.[89] Where it is the child herself who refuses to give consent, the Minister may override this refusal and give consent.[90] Moreover, in terms of section 46 of the Children's Act, a children's court is empowered

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[82] Children's Act 38 of 2005.
[83] Section 31(1)(a) read with s 31(1)(b)(iv).
[84] Section 10.
[85] Which should be understood as including preventative healthcare, such as vaccination. See page 22 below for further discussion of this interpretation.
[86] Section 129(2).
[87] Section 129(4).
[88] Section 129(6).
[89] Section 129(7).
[90] Section 129(8).

to make a child protection order, which includes an order 'giving consent to medical treatment of, or to an operation to be performed on, a child.'[91] Of course, all these decisions must be made in accordance with giving effect to the child's best interests.

Where more than one person holds parental rights and responsibilities towards a child, the co-holders may act independently of each other in exercising those responsibilities and rights, except where this is prohibited by law or an order of court.[92]

In general, then, before a child younger than 12 may be treated the informed consent of at least one parent is required on the child's behalf. Though the child is not competent to give consent herself, her views must be taken into account, having regard to the child's maturity and ability to understand the risks, benefits and consequences of treatment. If the treatment is required in order to prevent serious harm to the child, and the urgency is such that it cannot be postponed in order to obtain parental consent, the consent of the parents can be dispensed with. Finally, where consent is unreasonably withheld by either the parent, or by the child, the Minister is empowered to consent in their place.

Having examined the South African law governing consent of children, I turn now to examine the rights in conflict when a parent refuses to vaccinate her child. The discussion examines the parents' concerns, in particular the right to family life, before moving on to consider the child's right to healthcare. The final part of the chapter considers the best interests standard and its application to vaccination.

3.3 Parents' concerns

Over past decades, the focus of the parent-child relationship has shifted from rights and powers of parents to rights of children.[93] A parent is no longer perceived to have almost absolute power over her child. This shift of focus is reflected by changed terminology: 'parental power', that emphasises the

[91] Section 46(1)(h)(ii).
[92] Section 30(2).
[93] D S P Cronje and J Heaton *South African Family Law* 2ed 2004 Durban: LexisNexis Butterworths at 257.

parents' dominance over the child, has given way to 'parental responsibilities.'[94] Despite this emphasis on rights of children rather than those of parents, the latter continue to exercise rights insofar as their responsibilities may require actions. This fact may cause tension between the rights. Thus, although the child's right to healthcare has received recognition, it does not operate in isolation.

3.3.1 Right to family life

In international and domestic law, the family is the foundational unit of society. It functions as the primary and most important support system for individuals, and usually provides financial, emotional and material support for its members, particularly children.[95] However, the family unit has a complex relationship with societal structures. On the one hand, traditionally, legal recognition and protection of the family unit has implied a private zone exempt from state interference, save for in exceptional circumstances. On the other, respect for the family unit must consider the rights of the individuals who constitute that family unit. In some cases, state interference is necessary to ensure respect for the rights of particular individuals. For example, in the case of a child that is neglected, the state is obliged to intervene in order to protect her interests.

The state's obligation to protect the family is recognised in international human rights law. Article 16 of the Universal Declaration of Human Rights[96] provides that 'The family is the natural and fundamental group unit of society and is entitled to protection by society and the State.' The wording of this provision is echoed verbatim in article 23(1) of the International Covenant on Civil and Political Rights,[97] which South Africa has ratified. In the same vein,

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[94] B Van Heerden et al (eds) *Boberg's Law of Persons and the Family* 2ed (1999) at 313.
[95] E Patterson and A Andrews 'Protecting the child against separation from the family environment: Articles 9 and 25 of the UN Convention on the Rights of the Child' (1996) 16(3) *Children's Legal Rights Journal* 2.
[96] UN General Assembly, *Universal Declaration of Human Rights*, 10 December 1948, 217 A (III), available at: http://www.unhcr.org/refworld/docid/3ae6b3712c.html [Accessed 12 November 2012].
[97] UN General Assembly, *International Covenant on Civil and Political Rights*, 16 December 1966, United Nations, Treaty Series, vol. 999, p. 171, available at: http://www.unhcr.org/refworld/docid/3ae6b3aa0.html [Accessed 24 November 2012].

the African Charter on Human and Peoples' Rights,[98] also ratified by South Africa, states in article 18:

> '1. The family shall be the natural unit and basis of society. It shall be protected by the State....
>
> 2. The State shall have the duty to assist the family which is the custodian of morals and traditional values recognized by the community.'

Unlike these international instruments and many other national constitutions, South Africa's Bill of Rights does not expressly protect the right to family life. Though the Constitutional Court has affirmed that the family is a social institution of 'vital importance', which provides for the 'security, support and companionship of members of our society' and has 'an important role in the rearing of children,'[99] no explicit right to family life is included in the Constitution. Despite its omission from the Bill of Rights, the right to family life can be inferred from the foundational right to human dignity, enshrined in section 10 of the Constitution. The Constitutional Court recognised this in *Dawood v Minister of Home Affairs,*[100] where it stated that the right to family life is safeguarded by the right to dignity, which encompasses and protects the rights of individuals to 'enter into and sustain permanent intimate relationships.' This follows from the reasoning of the court in *Ex parte Chairperson of the Constitutional Assembly: In re Certification of the Constitution of the Republic of South Africa, 1996*[101] where it was stated that the right to dignity 'would clearly prohibit any arbitrary State interference with the right to marry or to establish and raise a family.' The state's international obligation to protect the family unit and constitutional injunction to respect the dignity of the members of a family therefore entails that families be protected from unwarranted executive, legislative and judicial acts that thwart the development of a healthy parent-child relationship.

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[98] Organization of African Unity, *African Charter on Human and Peoples' Rights ("Banjul Charter")*, 27 June 1981, CAB/LEG/67/3 rev. 5, 21 I.L.M. 58 (1982), available at: http://www.unhcr.org/refworld/docid/3ae6b3630.html [Accessed 24 November 2012].

[99] *Dawood v Minister of Home Affairs; Shalabi v Minister of Home Affairs; Thomas v Minister of Home Affairs* 2000 8 BCLR 837 (CC) at pars [30] and [31]. Hereafter referred to as *Dawood.*

[100] Ibid at par [36].

[101] 1996 10 BCLR 1253 (CC) at par [100].

In keeping with the respect afforded the family unit and its members, the courts are ordinarily reluctant to interfere with the exercise of parental authority, affording parents a wide discretion in directing their children's development.[102] This is supported by the view that the family is better suited to accommodating the child's specific and ever-changing needs than the state, which may of necessity only deal with generalities.[103] Thus, though the courts have both common law and statutory power to intrude on the parent-child relationship and interfere with parental authority,[104] this power is rarely employed. Mere disagreement with a parent's decision does not suffice for the court to intervene. As Broome J held in *Martin v Mason*:[105]

> 'Unless good cause was shown, [the court] did not arrogate to itself functions which ought normally to be performed by one or other of the parents. The duty to care for the child devolved in the first instance upon the custodian parent, and it was only where that duty was not being properly performed that the Court would interfere.'

The right of parents to guide the upbringing of their children is also internationally acknowledged. The CRC recognises the rights of parents in its injunction that states must 'respect the responsibilities, rights and duties of parents or guardians [...] to provide, in a manner consistent with the evolving capacities of the child, appropriate direction and guidance.'[106]

To sum up, both international and domestic law recognise the importance of the family structure within society and the obligation incumbent on the state to protect the family. In the South African context, the importance of the family unit has been recognised by the courts, and the family structure is protected by the foundational constitutional right to human dignity, despite the absence of an explicit right to family life. Parents are accordingly afforded a considerable measure of discretion in their decision-making regarding their child, and may appeal to the right to dignity and the importance of the family as protecting their parental decision-making powers from being arbitrarily

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[102] B Clarke 'A "golden thread"? Some aspects of the application of the standard of the best interest of the child in South African family law' (2000) 11 *Stellenbosch Law Review* 3 at 15.
[103] J Goldstein, A Freud and A J Solnit *Beyond the Best Interests of the Child* (1979) at 9.
[104] Cronje and Heaton op cit note 95 at 281.
[105] 1949 1 PH B9 (N) at 24.
[106] CRC op cit note 82 articles 5, 14.

countermanded by the state. However, where individual rights are exercised so that the herd immunity is diminished and the community's interests are negatively affected, this discretion may be curtailed. This tension between individual and community interests is addressed at length in chapter four.

3.4 Children's concerns

Having examined the importance of the family unit and the discretion parents have in electing how best to raise their children, I now consider the interests of the child herself. First I consider the well-established right of the child to access healthcare services, before examining the best interests of the child standard, which is the benchmark by which decisions involving a child are judged in South African law. Then, briefly, I consider the question whether vaccination can be said to be in the child's best interests.

3.4.1 Child's right to healthcare

The child's right to healthcare is afforded recognition in many international human rights treaties, notably the CRC[107] – a key authoritative international instrument on the rights of children. The first international instrument to be ratified by the post-apartheid government,[108] the CRC's comprehensive list of rights includes the child's right 'to the highest attainable standard of health' which incorporates 'access to preventative healthcare'.[109] The right is also given expression in article 14 of the African Charter on the Rights and Welfare of the Child (ACRWC)[110] which obligates states to pursue the realization of the child's right to the best attainable state of physical, mental and spiritual health, and enjoins states to take measures to develop preventative health care. Further international support may be found in the International Covenant on Economic, Social and Cultural Rights, article 12(2)(c) of which provides that in seeking to realize the right to health, states shall take those steps 'necessary for the prevention, treatment and control of

[107] CRC op cit note 82.
[108] Hassim et al (eds) *Health and Democracy: A guide to human rights, health law and policy in post-apartheid South Africa* (2007) at 302.
[109] Article 24.
[110] ACRWC op cit note 83 above, article 14(2).

epidemic, endemic, occupational and other diseases.'[111] This means that the state is obliged to make available the means to avoid vaccine-preventable infectious diseases.

The right to healthcare is given expression also in section 27 of the South African Bill of Rights, which stipulates that everyone has the right of access to health care services, which must be provided reasonably within available resources.[112]

Section 28 outlines children's rights, including the right to basic nutrition, shelter, basic health care services and social services.[113] 'Basic' health care services are not defined, but, given that the CRC and the ACRWC both mention the right to health as including preventative healthcare, and given also that the ICESCR specifically lists the prevention of epidemic diseases as an obligation of states, it is arguable that basic health care services include the right to vaccination against potentially fatal diseases.[114]

Whether the child's right to basic health care services imposes a responsibility on parents to take up opportunities to prevent infectious diseases by means of vaccination is seldom discussed. Arguably, it ought to be the responsibility of the parent to ensure that her child is vaccinated. However, this topic is not pursued further here due to space constraints. The Constitutional Court's stance in respect of the child's right to basic health care services is that the duty to bring the child to health care rests primarily on parents and family members.[115] Accordingly, the duty to ensure that the child accesses basic health care services, such as the state schedule of vaccinations, rests principally on parents. However, the tension between the autonomy of the person who is the parent and the responsibility of the parent leads to confusion about whether the parent is actually free to decide not to vaccinate her child.

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[111] UN Committee on Economic, Social and Cultural Rights (CESCR), *UN Committee on Economic, Social and Cultural Rights: Report on the Twenty-fifth, Twenty-sixth and Twenty-seventh Sessions (23 April-11 May 2001, 13-31 August 2001, 12-30 November 2001)*, 6 June 2002, E/2002/22; E/C.12/2001/17, available at: http://www.unhcr.org/refworld/docid/45c30b330.html [Accessed 16 December 2012].
[112] Section 27(1)(a).
[113] Section 28(1)(c).
[114] M Fine-Goulden 'Should childhood vaccination be compulsory in the UK?' (2010) 8 *Opticon1826* 1 at 2.
[115] *Government of the Republic of South Africa v Grootboom* 2000 11 BCLR 1169 (CC); *Minister of Health v Treatment Action Campaign (1)* 2002 12 BCLR 1033 (CC).

As indicated above, the state is obligated to 'create the necessary environment' for parents and family members to provide access to health care.[116] This means the state must ensure that the requisite vaccinations are available so that parents may access them for their children. Additionally, the National Health Act requires the state to provide free health services to children under the age of six who are not members or beneficiaries of medical aid schemes.[117] These health services include 'basic nutrition and basic health care services contemplated in section 28(1)(c) of the Constitution.'[118] If one accepts the argument sketched above, that vaccination against potentially fatal diseases constitutes 'basic health care services' then this would oblige the State to ensure that children under six years of age who are not covered by medical aid receive the requisite vaccinations.

3.4.2 Best interests of the child

Where parents refuse to vaccinate their children, the rights of parents and children, as sketched in the previous section, are brought into conflict, with the child's right to healthcare being infringed by the parents' exercise of discretion in refusing to allow the child's vaccination. In such circumstances, the best interests standard serves as a useful method for resolving the conflict.

The 'best-interests of the child' standard is widely used as an ethical, legal and social basis for decision-making involving children. Despite its status as a foundational principle in children's rights law,[119] the best-interests standard has been criticised as being 'self-defeating, individualistic, unknowable, vague, dangerous, and open to abuse.'[120] As Mnookin and Szwed have commented: 'the flaw is that what is best for any child or even children in general is often indeterminate and speculative and requires a highly

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[116] *Bannatyne v Bannatyne (Commission for Gender Equality as Amicus Curiae)* 2003 2 BCLR 111 (CC) at 24.
[117] National Health Act 61 of 2003 at section 4.
[118] Ibid at section 1.
[119] Recognised first in South Africa in *McCall v McCall* 1994 (3) SA 201 (C).
[120] See L Kopelman 'The best interests standard as threshold, ideal, and standard of reasonableness' in M Freeman *Children, Medicine and the Law* (2005) 436 for a response to these criticisms.

individualized choice between alternatives.'[121] Despite such criticisms,[122] the standard remains the legal benchmark according to which decisions involving children are reviewed, and is recognised as such in international, regional and domestic law. Indeed, its acceptance is such that commentators have called it '[a]rguably ... the universal principle guiding the adjudication of all matters concerning the welfare of the child.'[123]

In South Africa, section 28(2) of the Constitution states that a child's best interests are of paramount importance in every matter concerning the child. This has been affirmed by the Constitutional Court in *Christian Education South Africa v Minister of Education*[124] where it was stated: 'It is now widely accepted that in every matter concerning the child, the child's best interests must be of paramount importance.'[125] Thus, although previously the application of the standard was limited to family-law proceedings, it is now applicable to all matters concerning a child.[126]

The Children's Act lists factors to consider when applyingthe test, assessed on a case-by-case basis. These include the nature of the parent/child relationship,[127] the parents' capacity to fulfil the child's needs,[128] the need for the child to be raised in a stable family environment,[129] and the need to protect the child from physical or psychological harm which may be caused by maltreatment, abuse, neglect, exploitation.[130] Courts have recognised that the best interests standard 'should be flexible as individual circumstances will determine which factors secure the best interests of a particular child.'[131]

The paramountcy of the child's best interests does not entail ignoring other constitutional rights which are at variance with the child's rights. Whether a child's interest can be limited is weighed against the 'cost' of the interference

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[121] RH Mnookin and E Szwed 'The Best Interest Syndrome as the Allocation of Power in Child Care' in H Geach and E Szwed (eds) *Providing Civil Justice for the Child* (1983) at 8.
[122] Discussion of which is beyond the scope of this dissertation.
[123] C Breen *The Standard of the Best Interests of the Child: A Western Tradition in International and Comparative Law* (2002) at 1.
[124] 2000 10 BCLR 1051 (CC) at [41]. Hereafter referred to as *Christian Education*.
[125] At [41].
[126] Cronje & Heaton op cit note 95 at 261.
[127] Section 7(1)(a).
[128] Section 7(1)(c).
[129] Section 7(1)(i).
[130] Section 7(1)(j).
[131] *Minister of Welfare and Development v Fitzpatrick* 2000 (3) SA 422 (CC).

with the other party's conflicting right. In *Hay v B*,[132] the court authorised a blood transfusion for an infant against the parents' religious views, stating that the child's best interests are 'the single most important factor to be considered when balancing or weighing competing rights and interests concerning children.' Although the parents' reasons for refusing consent were duly considered, they were outweighed by the potentially fatal harm to the child if the transfusion were not given. Limitations on the child's best interests are therefore permissible in appropriate circumstances.[133]

3.4.3 Is vaccination in the best interests of the child?

As noted in the preceding discussion, the best interests standard is well-established in South African law: it is enshrined in the Constitution, and is recognised in statutes and the common law. In the context of vaccination refusals, the standard serves as a useful means to resolve the conflict between the rights of parents and those of children. It must be determined, however, whether, in general, vaccination is in the best interests of a child.

Vaccination against infectious diseases is an effective prophylactic measure. It is estimated that three million children's lives are saved annually thanks to the administration of paediatric vaccines.[134] However, although vaccines are both safe and effective, they are neither perfectly safe, nor perfectly effective.[135] A small minority of those who receive vaccines suffer side-effects and are harmed, whilst others do not produce the typical immune response and, consequently, are not protected from the disease. Most of the adverse side effects associated with vaccines are minor, but, in rare cases, more serious effects such as paralysis and encephalopathy have been noted.[136] Moreover, vaccination involves subjecting a healthy child to vaccine-related side-effects, which would seem, on the face of it, to be against the child's best interests. This is justifiable, however, given the risks posed if the child remains unvaccinated.[137] To illustrate: a child immunized

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[132] 2003 3 SA 492 at 4941J.
[133] See *Petersen v Maintenance Officer* 2004 1 All SA 117 (C) at [20] and *LS v AT* 2001 2 BCLR 152 (CC).
[134] Bonanni op cit note 1.
[135] Malone and Hinman op cit note 19 at 263.
[136] Chatterjee and O'Keefe op cit note 26 at 498.
[137] Fine-Goulden op cit note 116 at 3.

with the MMR vaccine has a 1 in a million chance of developing encephalitis or a severe allergic reaction. In contrast, for a child contracting measles the risk of developing pneumonia is 1 in 20, encephalitis is 1 in 2000, and death is 1 in 3000.[138] Should the child develop mumps the risk of encephalitis rises to 1 in 300, whilst the foetus of a woman infected with rubella has a 1 in 4 chance of developing congenital rubella syndrome.[139]

As with healthcare decisions generally, decisions regarding immunization are based partially on an assessment of the relative balance of risks and benefits (at least in situations where vaccination is not mandatory).[140] In cases where the risk of harm to unvaccinated persons is high, this balance would favour vaccination. Where, for instance, the child faces the risk of significant harm if denied effective preventive treatment in the form of immunization, it is in the child's best interests to be vaccinated. Therefore, to compel parents to immunize the child would seem to be justifiable on the basis that the child's best interests favour vaccination. Failure to vaccinate in such circumstances may be unreasonable conduct.

On balance, therefore, it seems to be in the best interests of children to be vaccinated. However, the risk of harm posed by an infectious disease depends both on the rates of morbidity and mortality associated with the disease, *and* on the chance of contracting the disease.[141] If the chance of being infected is negligible, then the risk of harm in general terms is small, despite the potentially devastating effects of the disease. In such a case, an argument might be made that it is contrary to the best interests of the child to be vaccinated. However, such an argument is premised on the existence of a certain level of herd immunity which would protect the individual from contracting the disease. This forces one to consider the tension between the individual's right to personal autonomy and the interests of the community in public health. I turn now to address this in the following chapter.

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[138] Diekema op cit note 18 at 1430.
[139] Ibid.
[140] Though as chapter 4 will note, current government regulations entail that certain vaccinations are required for admission to public schools in South Africa.
[141] Fine-Goulden op cit note 116 at 3.

3.5 Conclusion

As in every other state, the family forms the basic unit of South African society. South Africa's children's rights discourse reflects international recognition and protection of family life and, accordingly, the law affords parents a considerable measure of discretion in their decision-making regarding their child. To prevent parental decision-making powers from being arbitrarily countermanded by the state, parents may rely on the right to dignity, which includes the right to family life.

Recognition of the importance of the family unit and parental authority is balanced by emphasis on the rights of the child, both as an individual and as a member of a family unit. These rights include the constitutional right of children to basic health care services, which arguably includes the right to vaccination against potentially fatal diseases.[142] Though this right can be limited in terms of the Bill of Rights limitation clause, the best interests of the child must be considered when determining whether to vaccinate the child. Though courts are reluctant to interfere with parental responsibilities, they will protect children from injurious consequences of their parents' decisions. Where a parent unreasonably fails to give effect to the child's right to healthcare, the courts will exercise their common law or statutory powers to protect the child. In the context of vaccination refusal, this may involve the court ordering treatment where it is unreasonably refused by the parent, to ensure that the child's best interests are served. The determination of whether vaccination is indeed in the child's best interests is contingent on the vaccination coverage that prevails in the community, and on whether the individual child is able to be a free rider who benefits from herd immunity. The next chapter explores this tension between the individual and the community.

[142] Ibid at 2.

CHAPTER 4

THE CONFLICT BETWEEN INDIVIDUAL AND COMMUNITY

4.1 Introduction

A multiplicity of interests – some overlapping and some contradictory – impinges on child vaccination. The previous chapter examined the tension arising between the child's interest in having access to healthcare in the form of vaccinations, and the parents' discretion in raising their children in accordance with the right to family life. Overlaying this is the potential conflict between the community's public health interest and the individual's interest in exercising personal autonomy. This conflict between community and individual interests has been decided usually in favour of the individual, if only because relatively few parents refuse to vaccinate their children. Given the general tendency of rights-based discourses to favour individual autonomy, it is unsurprising that the community's interest has been somewhat overlooked in favour of the individual's. This state of affairs (in which the individual's interest is favoured) occurs usually in clinical settings where the individual wants treatment e.g. that is not generally available or is extraordinarily expensive. The individual's interest in appropriate treatment is obvious, while the community interest is in fair resource allocation rather than treatment per se. Consequently, the language of rights fits the context of the individual's interest, but is less helpful when considering community interests.

This chapter begins by explaining the concept of herd immunity (also known as community immunity), which describes the situation where the number of vaccinated individuals indirectly protects the unvaccinated. In other words, because the majority of persons are vaccinated, the infectious disease is unable to gain a foothold in the community easily, thereby resulting in the unvaccinated also being protected. This explanation leads naturally into a discussion of a result of herd immunity: free-riders, i.e. those individuals who benefit from others being vaccinated without risking potential side effects of vaccination themselves. Thereafter, I consider the South African law

governing communicable diseases, which permits mandatory vaccination in certain circumstances.

4.2 Herd immunity

Most vaccine-preventable infectious diseases are transmitted from person to person. A sufficiently large vaccinated proportion[143] of a community provides a protective barrier against the likelihood of transmission of the virus or bacterium in the community, thus decreasing the incidence of the infectious disease.[144] As a result, the risk of contracting the disease diminishes. Immunization thus indirectly protects those persons who are not immunized, or in whom the vaccine has failed, by ensuring that there are fewer opportunities to be in contact with an infected person.

Where herd immunity is prevalent, it is argued that compulsory vaccination is not necessary as the risk of infection posed by an unimmunized child to an immunized child is small.[145] Rather than agitating for mandatory immunization for all persons, the solution proposed is for people to ensure that they and their children are themselves immunized.[146] This argument overlooks the fact that several groups in society are unable to be vaccinated, not by choice but for medical reasons. As noted in the introductory chapter, these groups include immunocompromised persons (such as AIDS sufferers, the elderly, or those undergoing chemotherapy), persons with contraindications to vaccination, persons whose vaccine-induced immunity has waned over time or in whom the vaccine failed to have effect, and persons who are unvaccinated, either by choice or because they lack access to vaccines.[147] These vulnerable groups have no option but to rely on community immunity to protect themselves from infectious diseases, for where the vaccination coverage dips below the required percentage, they are unable to use the direct protection of vaccination.

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[143] The proportion of the population which must be immune in order for this 'herd immunity' to arise varies according to the infectiousness of the disease: for poliomyelitis 80% of the population is said to be sufficient, whereas for measles, 90-95% is required. Malone and Hinman op cit note 19 at 264.

[144] Malone and Hinman op cit note 19 at 264.

[145] P Bradley 'Should childhood immunisation be compulsory?' (1999) 25 *Journal of Medical Ethics* 330.

[146] Ibid.

[147] Fine and Mulholland op cit note 20 at 1395.

Herd immunity is therefore important for the protection provided to those who cannot be immunized. These groups of people are unable to protect themselves through vaccination, and must perforce rely on the indirect immunity provided by the vaccinated population. In this regard, some commentators have suggested that a social contract operates between parents inter se, obligating them to vaccinate their children not simply to provide the child with immunity, but also to contribute to the protection of other children who cannot be vaccinated, or for whom the vaccine is not effective.[148] This has been identified as an example of the 'commonweal' justifications which are used frequently to justify public health interventions.[149] Individuals, so the argument goes, congregated to secure material advantages they could not obtain on their own.[150] In exchange for these benefits, society is entitled to demand certain sacrifices of the individual, such as submission to vaccination and other public health interventions. This rationale was clearly endorsed in *Jacobson v Massachusetts,*[151] the seminal vaccination refusal judgment of the US Supreme Court. The court stated that since the individual who wished to refuse vaccination had 'enjoy[ed] the general protection afforded by an organized local government,' he could not hope to 'remain a part of that population' without paying the proper price, which required him to be vaccinated.[152]

Herd immunity thus minimizes the social costs of infectious diseases and also serves a second important purpose by significantly reducing the financial costs of infectious disease to society. The global savings due to the eradication of smallpox have been estimated to be between US$ 1.35 billion[153] and US$ 2 billion[154] annually. Closer to home the mass measles immunization campaign of 1996 and 1997 has been shown to have had a

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[148] G L Freed et al 'Safety of vaccinations: Miss America, the media, and public health' (1996) 276 *JAMA* 1869.
[149] P Cole 'The Moral Bases for Public Health Interventions' (1995) 6(1) *Epidemiology* 78 at 81.
[150] DJ Merritt *The Constitutional Balance between Health and Liberty: Hastings Center Report* (1986) at 4
[151] 197 U.S. 11 (1905).
[152] At [37].
[153] J Ehreth 'The value of vaccination: a global perspective' (2003) 21 *Vaccine* 4105.
[154] Bloom op cit note 30 at 29

marked economic benefit in Mpumalanga.[155] The financial benefits of vaccination mean that, increasingly, countries employ vaccination laws to combat diseases even in the absence of epidemics.[156] Both financial and public health reasons therefore play a role in motivating states to adopt compulsory vaccination policies, otherwise known as vaccination mandates. In the case of vaccination mandates adopted primarily for financial purposes, where the disease vaccinated against is not infectious (e.g. tetanus) and therefore does not expose the community to the risk of infection, it is arguable that there is less scope for the state to compel immunization. This line of argument will be considered further in the following chapter.

4.3 Free riders

Free riders assume none of the possible medical risks of vaccination, but receive the collective benefit of herd immunity. This weakens herd immunity protection for the whole community: if enough individuals choose to pursue their 'best' individual interest (to remain unvaccinated), protection levels in the community would decrease and the herd immunity effect would be lost as the disease begins to circulate more freely.[157] This could even lead to a return of epidemics. This happened in the 1970s in the United States, when a widespread belief that pertussis vaccination could cause a severe encephalopathy led vaccination coverage rates to plummet from 79% to 31%.[158] This decrease in vaccination rates resulted in outbreaks of pertussis with some 5000 hospital admissions, many more cases of pneumonia and convulsions, and at least 28 deaths of children.[159] More recently, the spurious link between the measles vaccine and autism has diminished vaccination rates and led to measles outbreaks across Europe, the US, Canada, and South Africa.[160]

A community with a high vaccination rate and which is free of an infectious disease can be viewed as 'a common', to use Garrett Hardin's classic

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[155] A Uzicanin et al 'Economic analysis of the 1996–1997 mass measles immunization campaigns in South Africa' 22(25-26) *Vaccine* 3419.
[156] Malone and Hinman op cit note 19 at 279.
[157] Ibid at 263.
[158] Fine-Goulden op cit note 116 at 3.
[159] Ibid.
[160] Chatterjee and O'Keefe op cit note 26 at 498.

analogy.[161] The existence of this common places the unimmunized individual's interests in tension with those of the community. As discussed above, high immunization rates diminish the risk for disease, so although no unimmunized individual is completely free of risk of infection by the vaccinated disease, protection from the vaccinated community significantly decreases the risk of infection. The unvaccinated individual gains an additional benefit as avoidance of the vaccine reduces the risk of any vaccine-related adverse effects. Electing not to be immunized, therefore, only minimally increases the risk of illness for the unimmunized individual, whilst it confers the benefit of avoiding adverse side-effects.[162]

Paradoxically, if the individual pursues her own interests without regard to those of society generally, the common will fail eventually, thereby detrimentally affecting also the individual's interests. The community interest in herd immunity can be sustained only by limiting individuals' choice to refuse vaccination in situations where vaccination coverage is low. It would be reasonable, thus, for the state to limit the freedom of individual parents to refuse to vaccinate their child for the sake of the common good.[163] This was recognised in *Jacobson v Massachusetts*, where the court stated:

> *[T]he liberty secured by the Constitution of the United States... does not import an absolute right in each person to be, at all times and in all circumstances, wholly freed from restraint. There are manifold restraints to which every person is necessarily subject for the common good. On any other basis organized society could not exist with safety to its members.*[164]

Having established that high levels of immunization are in the community's interest, the question that remains is when immunization may be required by the state. I turn now to consider the South African law in this regard.

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[161] Ibid at 263.
[162] J E Frader and E Flanagan-Klygis 'Ethics and Immunization' in G Miller (ed) *Pediatric Bioethics* (2010) 226
[163] Ibid at 4.
[164] *Jacobson* supra note 153 at 37-39.

4.4 South Africa and compulsory vaccination

Prior to 1987 South Africa enforced a vaccination policy which identified certain vaccinations as compulsory; for instance, all children were required to have BCG and polio vaccinations.[165] After this, vaccinations have not been mandatory and, at present, the only compulsory vaccination is for travelers who enter South Africa from high risk areas, who must have been vaccinated against yellow fever before entry.[166] Various regulations deal with immunization, including the education policy for school admissions, which creates what some see as de facto mandatory vaccination requirements.

4.4.1 Communicable Disease Regulations

Certain communicable diseases in South Africa are notifiable, that is, the medical practitioner diagnosing the disease is obligated to notify the relevant health authorities of the disease. The Communicable Disease Regulations[167] promulgated in terms of section 90 of the National Health Act 61 of 2003 prescribe which diseases require notification and how soon after diagnosis such notification is required for each condition in order to interrupt the cycle of transmission. Outbreaks of measles, for instance, must be reported to the relevant branch of local government or the provincial government within seven days of diagnosis.[168]

The regulations stipulate also that if sufficient scientific grounds exist to support the view that that the health of the population (or any part thereof) may be affected by a vaccine-preventable medical condition, a notice in the Government Gazette may require compulsory immunization at particular health institutions for a stipulated period and also that persons who refuse to be immunized may be placed under quarantine.[169]

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[165] S Kling 'Vaccination and ethical issues' (2009) 22(4) *Current Allergy & Clinical Immunology* 178.
[166] South African Vaccination and Immunisation Centre, presentation by P Rautenbach 'Vaccination: Ethics and Law' Available at http://www.savic.ac.za/backend/docs/Vaccination_ethics%20and%20law.pdf [Accessed 1 November 2012].
[167] Regulations Regarding Communicable Diseases GNR 27 GG 30681 of 25 January 2005.
[168] Section 6(1)(b).
[169] Section 8.

Regulation 12 deals with institutional contexts. Where the head of an institution (e.g. a school) knows or reasonably suspects that a person at the institution either suffers from a communicable disease listed in Annexure 1 or was in contact with a carrier of the disease the head must immediately inform the local government both verbally and in writing.[170] The head must also quarantine, or isolate and treat such person until informed otherwise by the relevant health authority.[171] In school settings, the parent or guardian of a learner falling into this category is required to inform the head of the school and to ensure that the child does not leave their place of residence until informed otherwise by the relevant health authority.[172] Heads of schools are obligated to 'ensure prevention of transmission of communicable diseases, particularly those that are vaccine-preventable.'[173]

Particularly important for the purposes of this dissertation is Regulation 12(3), which states that:

> *'The parent or guardian of a child of school entry age or younger who attends a care or educational institution as a learner may on admission of the child to the institution be required to submit written proof of all vaccinations against communicable diseases that such child has received, or written proof of having suffered from a vaccine-preventable disease.'*

4.4.2 Admission Policy for Ordinary Schools

The stance adopted in Regulation 12(3) is reflected in Section 16 Admission Policy for Ordinary Schools,[174] issued in terms of Section 3(4)(i) of the National Health Policy Act 27 of 1996:

> *'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*

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[170] Section 12(1)(a).
[171] Section 12(1)(b).
[172] Section 12(2).
[173] Section 12(5).
[174] Admission Policy for Ordinary Schools GNR 2432 GG 19377 of 19 October 1998.

> *show proof of immunization, the principal must advise the parent on having the learner immunised as part of the free primary health care programme.'*

This is couched in slightly different terms than Regulation 12(3). Whereas the Regulation provides only that parents *may* be required to submit proof of vaccinations, the Admissions Policy states that parents *must* show proof of immunization. Unlike the Regulation, the Admission Policy stipulates which communicable diseases the learner should be immunised against.

Most importantly, whereas the Regulation is silent as to the consequences of failure to produce proof of immunization, the Admission Policy states that the parents must be advised by the principal to have the child immunized as part of the state immunization programme.[175] Whether the child can be refused admission on the basis of a failure to produce the proof of immunization is not stated. Whilst the right of an unimmunized child to attend a school has not been tested in court, it seems unlikely that admission could be refused on such grounds, particularly given that section 7 of the same notice states that '[t]he admission policy of a public school... must be consistent with the Constitution of the Republic of South Africa, 1996 (No. 108 of 1996), the South African Schools Act, 1996 and applicable provincial law.' Refusing admission on the grounds of failure to produce immunization records would infringe the child's right to education, which is enshrined in section 29(1)(a) of the Constitution. Unless it can be shown that such infringement falls within the permissible bounds of the section 36 limitations clause, it would be unconstitutional and hence impermissible. The following chapter will return to this point, and argue that based on our courts' stance towards the child's right to education, it is highly unlikely that refusing a child admission for failing to produce vaccination records could be a justifiable infringement of the right to education. But it should be remembered that the constitutional argument has to take place against a backdrop of prevailing herd immunity. Absent this condition, the best interests of the child would indicate that prevention of an infectious disease is likely to outweigh the other considerations, especially individual parental discretion,

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[175] Section 16.

4.5 Conclusion

The conflict between the interests of the individual and those of the community in situations of vaccine refusal is particularly interesting given the phenomenon of herd immunity. Vaccination's dual function of protecting the individual as well as the wider community means that the repercussions of refusing to vaccinate a child are not limited to the child's immunity, but extend to the rest of the community. This is especially significant for those sectors of society who cannot be vaccinated, or in whom vaccination fails to produce the intended immune response. Individuals who free ride on the benefit from herd immunity without hazarding the potential side effects of vaccination weaken the community's immunity, and where vaccination levels are sufficiently low, their refusal to be immunized may lead to epidemics of the vaccine-preventable disease in unvaccinated sectors. It is therefore accepted that the state's intervention into vaccination may be permissible in order to protect those vulnerable groups in society from the risk of disease which they are unable to protect themselves against.

Currently South African law only mandates yellow fever vaccination for travellers from high risk areas who enter South Africa. Regulations governing communicable diseases permit mandatory vaccination in certain circumstances, notably within a demarcated area where the Minister of Health has determined that the health of a community will be affected by a vaccine-preventable condition. Several of the regulations speak to school immunization policy, including that children suspected of being infectious should remain at home in order to contain the disease and to prevent its transmission. Additionally, the Admission Policy for Ordinary Schools stipulates that parents of learners must provide proof of vaccination against certain specified diseases on enrolment. It is unlikely, though, that schools may refuse admission to school on the basis of a failure to vaccinate, since this would infringe the child's right to education. The following chapter will draw on these considerations, together with those issues raised in the previous chapter concerning the parent-child relationship, and consider different strategies which South Africa might adopt in respect of refusals to vaccinate.

CHAPTER 5

CONCLUSIONS

5.1 Introduction

Despite the numerous demands on its limited resources, South Africa has demonstrated remarkable commitment to vaccination. Most recently, in April 2009 EPI-SA added two new vaccines to the national schedule: pneumococcal conjugate vaccine (PCV) and rotavirus vaccine (RV). South Africa was the first country on the continent to do so, and remains the only country in the WHO Africa region which self finances these vaccines.[176] This is consistent with the leadership role South Africa has played in taking up new vaccines, dating from the introduction of hepatitis B (Hep B) in 1995 and haemophilus influenzae type b (Hib) in 1999.[177] Political commitment notwithstanding, the WHO statistics[178] regarding South Africa's vaccination coverage give cause for concern – if accurate, they show that for some diseases (such as diphtheria, tetanus and pertussis) vaccination coverage levels are below the threshold required for herd immunity. This is largely due to logistical issues surrounding health care delivery, rather than vaccination refusals. However, the fact remains that low levels of vaccination coverage mean the effect of refusing vaccination is not cushioned by the vaccinated community, as it would be in situations where herd immunity supports a small unimmunised group.

The UN Millennium Development Goal 4 is to reduce mortality in children under-five by two thirds between 1990 and 2015.[179] Much remains to be done in the area of immunization if this is to be achieved, as the global toll from infectious diseases – many of these vaccine-preventable – remains high. According to one estimate, in 2008 roughly 68% of the 8.795 million deaths worldwide in children under-five was attributed to infectious diseases.[180] Sub-Saharan Africa provides a major portion of this figure,[181]

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[176] N J Ngcobo and N A Cameron 'The decision making process on new vaccines introduction in South Africa' (2012) 30 *Vaccine* 9.
[177] Ibid.
[178] WHO op cit note 40.
[179] United Nations *Millennium Development Goals Report 2011* (2011) Available at: http://www.unhcr.org/refworld/docid/4e42118b2.html [Accessed 6 January 2013]
[180] R E Black et al 'Global, regional, and national causes of child mortality in 2008: a systematic analysis' (2010) 375(9730) *Lancet* 1969.

and as such, debates about vaccination are of particular relevance to South Africa.

This final chapter synthesises the preceding discussions concerning vaccination refusal, and suggests how South Africa could learn from other jurisdictions when dealing with vaccination refusals in the school setting. The chapter summarises the key arguments developed in preceding chapters, drawing together the issues raised, and suggests when it may be justifiable for the state to overrule a parent's decision to refuse to vaccinate her child.

5.2 The conflicts between parent and child, and individual and community

Vaccination refusal by a parent gives rise to two central conflicts, between the interests of the parent and of the child, and between the interests of the individual and of the community.

Chapter three examined the conflict between the child's right to healthcare and the parent's right (and responsibility) to make choices for her child, in accordance with the right to dignity and the obligation to make decisions in the child's best interest. Though South African law reflects the international emphasis of children's rights over parental authority, the parents' right to dignity has been recognised as protecting the right to family life.[182] Consequently, the law affords parents a considerable measure of discretion in their decision-making regarding their child and prevents the state from arbitrarily countermanding parental decisions. In exercising this parental discretion, however, parents must ensure they are acting in the child's best interests.[183]

The law recognises the importance of the family unit and parents' role as guardians and caregivers of their children.[184] It also recognises that children are bearers of certain rights, including the constitutional right to basic health

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[181] The World Bank 'Disease and mortality in Sub-Saharan Africa' (2006) Available at http://www.dcp2.org/file/66/Disease%20and%20Mortality%20in%20SSA.pdf [Accessed 12 December 2012].
[182] *Dawood* supra note 101.
[183] Bekink op cit note 60.
[184] Fine-Goulden op cit note 116.

care services, which arguably incorporates the right to vaccination against potentially fatal diseases.[185] Though this right may be limited in accordance with the Bill of Rights limitation clause, the best interests of the child are paramount in deciding whether to vaccinate the child. Courts are ordinarily reluctant to intervene with the manner in which parents raise their children, though they will do so to ensure the child's best interests are served, even where this entails limiting the rights of the parents.[186] Where a parent unreasonably fails to give effect to the child's right to healthcare, therefore, the courts will exercise their common law or statutory powers to protect the child and may justifiably order vaccination.

Chapter four considered the conflict between the interests of the individual and those of the community in situations of vaccine refusal. The dual function of vaccination of protecting the individual and the community means that the individual's healthcare decisions have social consequences. This is of particular significance to those groups for whom vaccination is contraindicated, and who must rely on herd immunity. If sufficient numbers of people elect to make a self-interested decision to refuse vaccination and free-ride on the benefit from herd immunity without hazarding potential side effects of vaccination, this will weaken the community's immunity. Should vaccination levels drop sufficiently low, this may cause epidemics of the vaccine-preventable disease in unvaccinated sectors. Compulsory vaccination may therefore be permissible in order to protect vulnerable groups in society from the risk of disease where they are unable to protect themselves.[187]

South Africa does not have a policy of compulsory vaccination at present, save for travellers who enter South Africa from high risk yellow fever areas. Compulsory vaccination is permitted in certain circumstances, in terms of the regulations governing communicable diseases. Several of these regulations concern school immunization policy, and provide that children suspected of being infectious should not attend school in order to prevent transmission of the disease. Additionally, the Admission Policy for Ordinary Schools stipulates that parents of learners must provide proof of vaccination against

[185] Hassim op cit note 110.
[186] Bekink op cit note 60.
[187] Frader and Flanagan-Klygis op cit note 164.

certain specified diseases on enrolment. The consequence of failure to produce such proof is unstated. Consideration of some different stances towards school vaccination requirements helps to suggest how best South Africa might approach vaccination refusals in the school setting.

5.3 School vaccination

Diseases against which children are commonly vaccinated include measles, mumps, pertussis, tetanus, poliomyelitis, streptococcus pneumonia and haemophilus influenzae type b. Save tetanus, which is contracted by wound contamination, each of these is transmitted from one person to another by direct contact or by aerosol droplet transmission.[188] Historically, most of these have had a high occurrence in school-aged children due to the high potential for transmission in large groups of people.[189] A logical nexus exists between mandatory vaccination and school attendance – requiring schoolchildren to be vaccinated minimizes the risk of outbreaks that are most likely to occur in settings where many children are in close proximity.

Requiring proof of vaccination for school registration purposes can be problematic, however, as the proliferation of vaccinations has expanded vaccination programmes considerably in the last decade, and many standard programmes include diseases which are not infectious, or which have low morbidity. It is arguable, therefore, that vaccination against certain diseases should not be compulsory for school purposes.[190] Some parents have argued, for instance, that there is no compelling state interest in requiring schoolchildren to be vaccinated against some diseases children commonly receive vaccination against, such as varicella, a mild disease in children which claims relatively few fatalities annually in South Africa.[191] Though this argument makes a good point, it does not entail that school vaccination policies should be abandoned, only that the diseases for which vaccination is required must pose a demonstrable threat to the health of other children.

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[188] Malone and Hinman op cit note 19 at 265.
[189] Ibid.
[190] Ibid.
[191] Malone and Hinman op cit note 19 at 279. See also M Rothberg et al 'Do the Benefits of Varicella Vaccination Outweigh the Long-Term Risks? A Decision-Analytic Model for Policymakers and Pediatricians' (2002) 34 *CID* 885.

Requiring vaccination of schoolchildren is a measure which is manifestly in the community's interest: not only does it save lives and prevent many serious disabilities, it is also a cost-effective means of promoting public health. However, as was noted in chapter four,[192] a tension exists between the individual's right to make decisions about her health, or in the case of children, the parent's right to make healthcare decisions for their child, and the community's interest in promoting public health by preventing the spread of infectious diseases easily avoided by vaccination. This is particularly significant as vaccination is performed upon asymptomatic individuals, who must bear the risk (however small) of possible harm caused by the vaccination, whilst the benefits of vaccination accrue to the individual as well as to the population.[193] Thus, although the healthy individual carries the risk of vaccine-related harm, both individuals and populations benefit where herd immunity exists.

School vaccination is therefore a contested issue, which has elicited different responses in different countries. The policies of the United States and Canada will be sketched briefly to serve as a counterpoint to South Africa's position.

5.3.1 United States

In the US all states have adopted a 'no shots, no school' policy, where school children are refused entry into state schools without proof of vaccination against certain diseases.[194] Exemptions to the vaccination requirement vary by state, though all make provision for a medical exemption. Personal belief exemptions are also available for those who have no medical reason for remaining unimmunized, but who object to being vaccinated for religious or philosophical reasons.[195]

The ease of obtaining a personal belief exemption has been shown to correlate directly with high rates of exemption.[196] In some states it is simply

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[192] See page 33 above.
[193] A Dawson 'Vaccination and the prevention problem' (2004) 12 *Bioethics* 515.
[194] J G Hodge and L O Gostin 'School Vaccination Requirements: Historical, Social, and Legal Perspectives' (2001) 90 *Kentucky Law Journal* 831.
[195] Ibid.
[196] Omer et al op cit note 14.

easier and less time-consuming to claim an exemption than it is to get a child vaccinated, leading hesitant parents to opt for an exemption for the sake of convenience, rather than out of any deep-seated philosophical objection. This has led some to argue for the elimination of personal belief exemptions altogether.[197] Such a move may undermine the goal of vaccination, as failure to provide any mechanism for non-medical exemptions could galvanise anti-vaccination advocates, estrange parents hesitant to vaccinate their children, and erode parental trust.[198] Such consequences would be highly detrimental in the long term and undermine future adherence to vaccination mandates. Rather than eliminating personal belief exemptions, it has been suggested that the process followed in granting such exemptions should be revised and the requirements made more stringent.[199] Though interrogating the sincerity of the parents' personal beliefs may be impractical, greater administrative oversight is required, if only to ensure that parents refusing to vaccinate their children are informed of the medical risks of allowing their child to remain unvaccinated.[200]

Aside from the administrative burden involved, a disadvantage of compulsory vaccination is that it may leave the state open to claims from those suffering adverse vaccine-related effects. State liability is managed by the Vaccine Injury Compensation Program,[201] which compensates individuals for injuries associated with routinely administered childhood vaccines. The program is funded by an excise tax levied on each dose of covered vaccine. The rationale behind this system is that patients do bear some risk in being vaccinated, and vaccination benefits the public health through the creation of herd immunity, so individuals who are harmed by vaccination should be adequately compensated.[202] Thus, whilst vaccination of school children is compulsory in the US, the system provides for various exemptions, as well as a compensation scheme for any harmful side-effects suffered as a result of vaccination.

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[197] J D Lantos et al 'Why we should eliminate personal belief exemptions to vaccine mandates' (2012) 37(1) *J Health Polit Policy Law* 131.
[198] D J Opel and D S Diekema 'Finding the Proper Balance between Freedom and Justice: Why We Should Not Eliminate Personal Belief Exemptions to Vaccine Mandates' (2012) 37(1) *J Health Polit Policy Law* 141.
[199] Ibid.
[200] Ibid at 143.
[201] Established in terms of the National Childhood Vaccine Injury Act 42 U.S.C §§300aa-1 *et seq*.
[202] Malone and Hinman op cit note 19 at 267.

5.3.2 Canada

An alternative policy option is that adopted by Canada, where provinces such as Ontario have legislation that permits unvaccinated children to be excluded from schools during an outbreak of a vaccine-preventable disease.[203] Vaccination status of children must be reported to local health authorities; parents who fail to do so may incur heavy penalties.[204] This policy minimizes harm to others and ensures that the outbreak is contained as quickly as possible, and also entails minimum interference in the child's education.

5.3.3 South Africa

School vaccination requirements have been instrumental in preventing and controlling vaccine-preventable diseases both in foreign jurisdictions such as the United States and Canada, and in South Africa. However, failure to produce proof of vaccination should not be accepted as a reason for refusing to admit children to schools in South Africa. Refusing children entrance to schools would be particularly problematic where high levels of vaccination mean a small minority of unvaccinated children should not pose a substantial risk. However, even where the vaccination coverage is below herd immunity level, it is unlikely that unimmunized children could justifiably be excluded from schools.

Though an unimmunized child's right to register at a public school has not been tested in the courts, given the stance our courts have adopted towards the right to education,[205] it seems unlikely that schools would be permitted to exclude pupils on the basis of their immunization status. Doing so would be an infringement of the child's constitutional right to receive a basic education, enshrined in section 29(1)(a) of the Constitution. The infringement would likely be found to be unjustifiable, as demonstrated by a brief limitations analysis. Whilst the exclusion of unimmunized children serves a valuable purpose (curbing the spread of infectious disease), the right to education is

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[203] E Walkinshaw 'Mandatory vaccinations: The Canadian picture' (2011) 183(16) *CMAJ* 1165.
[204] Ibid.
[205] L Arendse 'The Obligation to Provide Free Basic Education in South Africa' (2011) 14(6) *Potchefstroom Electronic Law Journal* 97.

an important right, which would be severely limited by refusing to register a child for school. Moreover, since there are other less restrictive means of achieving the purpose of controlling and preventing the spread of infectious diseases, such as exclusion for the period of the epidemic only, the exclusion of unvaccinated children from public schools would be an unjustifiable limitation of the right to a basic education.

It seems, therefore, that though parents must show proof of vaccination for the illnesses specified in the Admission Policy, schools should not be permitted to refuse to register unvaccinated children whose parents fail to produce such proof. In line with the Admission Policy, the school principal should encourage the parents to have the child immunized as part of the national immunization programme. If the child develops an infectious disease, the school must ensure that the child stays at home and does not attend school, preventing the spread of the disease.

5.4 Implications for a potential HIV vaccine

An issue not discussed in this dissertation, but which is nonetheless worthy of mention, is the relevance of state-mandated vaccination to the development of an HIV vaccine. Considerable effort and investment is currently directed towards developing a preventive HIV vaccine. Whilst realisation of this goal remains tantalisingly out of reach at present, the scientific community has expressed guarded optimism that a vaccine may be available in the next decade.[206] As host to the largest HIV-positive population globally,[207] South Africa would benefit greatly from an early roll-out of an HIV vaccine. Policymakers would do well to pre-emptively consider the potential ethical challenges faced in distribution of such a vaccine, particularly given that South Africa has the highest rate of HIV infection in the world (previously

[206] See J Maurice 'Quest for effective AIDS vaccine takes a new tack' (2011) 378(9787) *Lancet* 213 for an overview of promising avenues of research in HIV/AIDS research and development.

[207] South Africa is home to 5.6 million people living with HIV, and is second only to Swaziland in terms of HIV prevalence, with 17.3% of the population HIV-positive, per the UNAIDS 'South Africa country situation' Available at: http://www.unaids.org/en/regionscountries/countries/southafrica [Accessed 1 February 2013].

estimated at an alarming 1000 new infections daily).[208] Many of the conclusions reached in this dissertation would be pertinent to the distribution of an HIV vaccine; so although the search for this is still in progress, the desirability and constitutionality of state-imposed vaccination will become topical when an HIV vaccine is developed.

5.5 Conclusion

As this dissertation has sought to emphasise, vaccination coverage worldwide is by no means at a point where it no longer requires attention. Though vaccination campaigns secured tremendous gains in the twentieth century, communities risk losing valuable ground if guided by misinformation or complacent thinking. Proponents of vaccination are in an unenviable position. They confront the Sisyphean task of encouraging parents to vaccinate their children at a time when vaccinations' success has rendered their need less obvious.[209] The task is complicated by the debate concerning vaccine safety, which persists, fuelled by a vocal cohort of activists who reject the significant growing body of scientific evidence demonstrating the safety and efficacy of vaccines.

In South Africa at present, vaccination coverage levels are lower than in countries with less developed healthcare systems and lower gross national income. There is a need for continued communication between healthcare practitioners and the public to dispel vaccine suspicions and promote effective immunization policies. In addition to this, it is necessary to consider in which circumstances the state could legitimately intervene in a vaccination refusal, and mandate vaccination. This dissertation has examined two conflicts in this regard, and determined that state intervention would be justifiable in two general situations:

Firstly, state intervention in vaccination is justifiable where this is to protect the best interests of the child. Whilst balancing parental discretion with

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[208] United Nations Economic Commission for Africa 'HIV and AIDS: the issues for Africa' in *Securing our Future* (2008) at 3. Available at: http://www.uneca.org/chga/report/chap1.pdf [Accessed 1 February 2013]

[209] R M Jacobsen 'Vaccination refusal and parental education: lessons learnt and future challenges' (2010) 4(3) *Pediatric Health* 239.

recognition of the child's rights is a daunting task, South African courts have demonstrated a willingness to fetter parental rights where their exercise undermines the best interests of the child. Secondly, vaccination can be compelled in order to protect vulnerable groups in society from the risk of disease against which they are unable to protect themselves. In cases where herd immunity drops sufficiently low and epidemics of vaccine-preventable diseases threaten unvaccinated communities, then the protection of these groups' rights may require the abrogation of the rights of those would refuse vaccination.

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