Refugees and the Scope for Mandatory COVID-19 Vaccination

Kristin Bergtora Sandvik†

Introduction

Vaccination programs are regularly celebrated as one of the most successful and cost-effective public health interventions ever developed. Yet, in a global context characterized by an acute lack of vaccines coupled with unfair distribution, COVID-19 vaccination schemes are controversial. Inaccurate and misleading stories about the vaccines risk becoming a "second pandemic." However, long before COVID-19, growing vaccine hesitancy and skepticism were affecting the uptake for vaccination schemes in humanitarian contexts and considered a serious threat to global health.

How should international refugee law grapple with COVID-19 vaccine hesitancy, mistrust, and refusal? According to the Principles of Protection for Migrants, Refugees, and Displaced People During COVID-19 (the "*14 Principles"*), States must respect the right to health of migrants, refugees, and other displaced persons by ensuring that the provision of essential medicines, prevention, and treatment are provided in a non-discriminatory manner (Principle 2). Refugees have the right to access COVID-19 vaccination schemes on a non-discriminatory basis under international law. But do they have a right to refuse?

Given the devastating global impact of the pandemic, old debates about compulsory vaccination schemes resurface with new disease outbreaks—as do familiar issues of fear and stigmatization. For COVID-19 vaccinations, we need to engage in critical work to flesh out pertinent legal dilemmas and emergent protection scenarios. To that end, this intervention considers the legality of mandatory vaccination schemes and asks whether vaccination can be a prerequisite for access to legal protection (at entry points or at in-country facilities), given the prohibition on *refoulement* (as reiterated in Principle 6). Considerations applying to third-country resettlement (as a durable solution) and the *refoulement* prohibition under international human rights law applicable to migrants should be considered separately.

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† Kristin Bergtora Sandvik is a professor of legal sociology at the Faculty of Law, University of Oslo and a Research Professor in Humanitarian Studies at Peace Research Institute Oslo (PRIO). Her research focuses on the development of a political and legal sociology of humanitarianism. She teaches sociology of law, legal anthropology, legal technology and artificial intelligence and robot regulations. In 2011, Sandvik cofounded the Norwegian Center for Humanitarian Studies (NCHS), where she was the director from 2012 to 2016. Sandvik graduated from the University of Oslo with a Masters in Women's Law in 2002. She obtained an LL.M (waived) from Harvard Law School in 2003, and a doctorate in Juridical Sciences (S.J.D) from Harvard Law School in 2008. Sandvik has also studied social anthropology at the University of Oslo, and she has been a guest researcher at the Oxford Refugee Studies Centre and the Refugee Law Project (Uganda).

I. Vaccine Hesitancy in Highly Fragile Systems of Trust

In the forced displacement context, vaccination refusals are not necessarily caused by irrationality and deviance, but may be due to a broader mistrust of humanitarian government. Can vulnerable people trust humanitarians to give aid fairly and to behave respectfully? Refusals may also be based on experiences with authoritarian enrollment of communities in vaccine programs. Prior to COVID-19, the challenges limiting migrants' access to vaccination in Europe included mobility, lack of access to information on immunization status, non-access to vaccines in the host community, refusal of medical registration due to fear of legal (and penal) consequences, as well as organizational and political failures of cross-border coordination among health authorities to cover vaccination gaps. The poor treatment of refugees and asylum seekers during the pandemic has included virus scapegoating, stigmatization, and the use of public health exception clauses to block their entry, suspend asylum processing, or trigger deportations (see here and here). New research indicates significant skepticism vis-à-vis COVID-19 immunization in migrant communities. In sum, grasping the historical and contemporary reasons for hesitancy and refusal is key to identifying, analyzing, and solving evolving legal dilemmas concerning vaccination.

II. Individual Choice and Mandatory Vaccinations

From the perspective of the State, the issue is whether the risk of COVID-19 spread by unvaccinated asylum seekers and refugees constitute a harm to public health which is concrete and serious enough to mandate vaccination in return for access to legal protection mechanisms. The scenario is not moot: We do not know if existing vaccines will cover new mutations. We do know that vaccines lose efficacy over time. Turning back international travelers is different from turning back individuals requesting protection. Citizens and residents and others on whom States confer rights to enter can be referred to quarantine hotels. This leaves States facing a dilemma with respect to those seeking protection and who arrive without the ability to enter.

The key issue with respect to vaccines is how States strike a fair balance between protecting the community and interfering in individuals' private lives. What is the scope of individual choice? Vaccinations require free and informed consent, with strict criteria for derogation in exceptional circumstances. While international human rights law is silent on the right to refuse medical treatment, under the torture-prohibition in ICCPR article 7, there is a right not to be subjected to medical experimentation without appropriate consent (see also the Helsinki Declaration of 1964). According to the 1997 Council of Europe Convention on Human Rights and Biomedicine (Oviedo), vaccine measures must not violate the right and liberty of an individual to bodily autonomy and informed consent. According to Article 2, the interests and the welfare of the individual prevail over the interest of "society or science", and Article 5 emphasizes that interventions in the health field require free and informed consent. It should be noted that coercion in health care settings may cross the threshold of mistreatment tantamount to

torture or cruel, inhuman or degrading treatment or punishment. However, mandatory schemes entail a combination of administrative, legal, and penal sanctions. Research indicates that sanctions usually involve fines, parental rights penalties, conditionality for benefits and services and, in rare instances, jail time. Sanctions can also involve termination of professional duties and dismissal from work.

At the same time, according to CESCR general comment No. 14, governments must also safeguard citizens' lives by preventing and controlling disease and protecting citizens, thus allowing for certain legally demarcated restrictions on individual vaccine choice. The recent decision in *Vavřička and others v. The Czech Republic* by the European Court of Human Rights (ECHR) seems to pull in the direction of giving States a broad margin of discretion with respect to mandatory vaccinations, albeit on a subject matter (education) quite different from *non-refoulement*.

Declaring something to be an "emergency" requiring urgent interventions shapes notions of what needs to be done and by whom. In many jurisdictions, COVID-19 has been recognized as an emergency requiring highly intrusive measures. Thus, a possible basis for formulating such restrictions is Oviedo Article 8, which reiterates that, in emergency contexts when appropriate consent cannot be obtained, a medically necessary intervention may be carried out *immediately* for the benefit of the health of the individual concerned. Yet, while COVID-19 constitutes an emergency, it is not clear that it constitutes an emergency for individuals where consent "cannot be obtained" (where an individual is incapacitated or cannot give timely consent, for example, to a blood transfusion after a terror attack). Furthermore, a refusal is not the *absence* of consent; it is a *negation* of consent. In sum, Article 8 does not work here.

Instead, focus must be given to Oviedo Article 26, which provides for a possible exception for the protection of collective interests, including public health, and the 1984 Siracusa principles, which further demarcate the scope for derogations. These instruments limit the restrictions on the exercise of the rights and protective provisions to those prescribed by law and necessary in a democratic society in the interest of public safety, for the prevention of crime, for the protection of public health or for the protection of the rights and freedoms of others. Any curtailment of rights must consider the disproportionate impact on specific populations or marginalized groups. Specifically, vaccination should be voluntary unless it becomes critical to "prevent a concrete and serious harm." COVID-19 and its ensuing (and future) mutations seem to pass these tests.

Individual rights must be balanced against the type and severity of emergency the State is faced with and the resources the State has at hand. The rights of individuals must also be calibrated vis-à-vis the existence of the State's other rights and duties. This includes a country's rights to protect its sovereign borders and to jurisdictional sovereignty over its territory. States must protect their domestic populations vis-à-vis the threat of infectious diseases. This obligation includes the protection of medical and bureaucratic frontline workers against infectious disease (but, conversely, also the rights of health personnel not to be required to engage in unethical medical

interventions, for example, to provide forced or unsafe vaccinations, or vaccinations lacking informed and free consent).

To be legally sustainable, a mandate for compulsory vaccination cannot amount to medical experimentation and would require extensive scientific documentation of the safety of a vaccination scheme (a challenge illustrated by the AstraZeneca controversy related to mortality rates following rare blood clots) and passing the proportionality and necessity tests. This has implications not only for the legality of mandatory vaccination schemes but also concretely for how States organize their vaccination efforts.

III. Requirements for Mandatory COVID-19 Vaccination Schemes

If a State were to decide that, to protect a domestic population, refugees must be vaccinated before accessing legal processes, attention would then need to be given to what it takes (in terms of capacity, institutional arrangements, financial resources, and procedures) to make such schemes legal. The complexity of this endeavor suggests that mandatory schemes should not take a top-down, command-and-control approach.

Instead, States must give adequate financial, logistical, and medical attention to non-coercive, acceptance-driving aspects of vaccination programs. States must ensure appropriate organization of their vaccination programs; that programs for refugees and asylum seekers are not of lesser quality; and that there are safeguards against abusive applications of vaccination programs. Central here (also noted in Principle 9 on the right to information about COVID-19) is the importance of health information and making clear its relationship to refugee law, *i.e.*, the rights and obligations of States. Adequate, appropriate, and accessible information about vaccination *and* the rationale for requiring vaccination before processing of legal claims must be provided to those seeking legal protection. This necessitates providing accurate and credible information in a language and culturally appropriate format recipients will understand—as well as adapting information for people with special needs or no literacy or internet access.

Conclusion

States may mandate COVID-19 vaccination for refugees under certain narrowly tailored circumstances. Correspondingly, the right to health for refugees does not appear to include *a right to refuse* COVID-19 vaccination with no administrative consequences if certain requirements are fulfilled by the State. Admittedly, this is only the beginning of the discussion: How a mandatory vaccination scheme may be meaningfully coupled with the *non-refoulement* obligation needs more elaboration. Neither States nor UNHCR are left with many options faced with refusal: As noted, physical coercion has no place in a mandatory vaccination program, and *refoulment* remains prohibited. Detaining or quarantining those refusing is costly and may engender broader problems with communal vaccine acceptability, including among populations that do not have a track record of refusing immunization. The same will probably be the case with fines and deferment of access to status determination procedures. Doing nothing, *i.e.*, letting people disappear

in the crowd, undermines emergency health objectives. Thus, even with a mandatory vaccine scheme, authorities and humanitarian staff will be left to persuade, nudge, and cajole to get people vaccinated. It would be welcome if a revised version of the *14 Principles* addressed this dilemma.