Legal, Constitutional and Ethical Principles for Mandatory Vaccination Requirements for Covid-19
Executive summary

According to the best scientific evidence available, vaccination of the entire population is currently the most efficient measure available for a country to mitigate the consequences of infection and transmission of the Covid-19 virus. With vaccination numbers stagnating, the question of whether to impose mandatory vaccination requirements is under contemplation in many countries. The following principles relate to the legal, constitutional, and ethical dimensions of mandatory vaccination requirements for Covid-19. They concern such policies that would be imposed by both public and private actors. The principles are considered best or ideal practice, but pay specific attention to compliance with widely recognised human rights and constitutional law principles in democratic systems across a broad range of countries.

For the purpose of this document, we consider that a mandatory Covid-19 vaccination requirement is (a) any public law that makes vaccination legally compulsory (with or without imposing a penalty), or (b) any state or non-state policy which requires proof of vaccination in order to access a venue or enjoy a benefit. A vaccination requirement which can be avoided by a person without undue burden is not regarded in this set of principles as a mandatory vaccination requirement. Parts I-IV of the principles address general matters. Parts V-VII address particular sectors.

Part I stresses the general superiority of primary legislation enacted by the legislature over executive rule-making, and that fast-tracked legislation should be replaced at the earliest opportunity. The most proportionate schemes will exhibit consultation with the general population and with particular stakeholders within it. In federal or quasi-federal systems, the crucial importance of sub-national governments in developing and adapting vaccination schemes is emphasised. For non-state actors, the best solution for constraining excess privat discretion is considered public regulation, but in the absence of such regulation a conscientious private scheme can be adopted consistently with international human rights norms when it adapts principles that inform public regulation.

Part II focuses on mandatory vaccination and the enjoyment of human rights. There is no necessary conflict between human rights and mandatory vaccination requirements. Indeed, mandatory vaccination requirements may be regarded as a means for the protection of internationally recognised rights to life, health, education, and work. Interferences with human rights should nevertheless be strictly justified in accordance with the principles of proportionality and equality (the conventional legal tests being set out in Part II below). In connection with the principle of equality, although medical exemptions are widely and rightly recognised, legal systems do vary in their approach to accommodating religious beliefs and freedom of conscience. There is no general duty to recognise religious exemptions. There is a duty to engage constructively with reasonable forms of vaccine hesitancy.

Part III focuses extensively on the risks and benefits associated with the technical design of proof of vaccination. It emphasises the need to balance public health intervention through technical infrastructure with the right to privacy, taking into account the risks
induced and the intended purpose. It suggests best practices, including minimal data collection, availability of the system, and the retaining of public authority over these infrastructures. Part IV draws attention to the impact of national mandatory vaccination requirements on non-residents.

Part V reiterates the need for occupational vaccine requirements to be publicly coordinated through a framework of laws and to respect the law-making principles enumerated in Part I, as well as the principles of necessity and proportionality developed in Part II. It includes specific considerations such as the role of social partners, costs, safety of the workplace, and alternatives to mandatory vaccination.

Part VI on educational vaccine requirements sets out the need to consider exemption from and alternatives to vaccine mandates in the context of schools and universities.

Part VII – on access to public venues and spaces – briefly distinguishes between those venues the access to which is necessary for the enjoyment of human rights and essential services on the one hand, and those that are not on the other. It nevertheless emphasises that such determinations are a matter of degree and definition, and that states should consider providing guidance on these aspects to prevent any discrimination or abuse.


The Lex-Atlas: Covid-19 (LAC19) project provides a scholarly report and analysis of national legal responses to Covid-19 around the world. There are nearly 200 jurists participating in the LAC19 network and who have contributed to writing national country reports. The Oxford Compendium of National Legal Responses to Covid-19 launched on 21 April 2021, with 27 Country and Territory Reports now published and a further 25-30 will be added in the coming months. It is made open-access on a permanent basis through the generous support of the Faculty of Laws, University College London, the Dickson Poon School of Law, King's College London, and the Max Planck Institute of Comparative Public Law and International Law in Heidelberg, Germany. The LAC19 project is supported more widely by the UK's Arts and Humanities Research Council and the Leverhulme Trust. All reports can be accessed here.

Participating members have signed on at the end of this document.
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A. General

1. The rule of law requires that both public and private mandatory vaccination requirements should be based on or closely regulated by public laws.

2. The principle of democratic accountability should guide the mode of law-making chosen. The law-making should be consultative, transparent, facilitate participation by the public and by members of the political opposition, and provide a meaningful opportunity to influence the principles and the details of the legislative scheme. In jurisdictions with existing partnerships between indigenous peoples and state government, indigenous peoples should be actively involved in the design of the principles and details.

3. Primary legislation enacted by legislatures (e.g. statute, loi, legge, ley/estatuto, Gesetz, 法律) is ordinarily superior to secondary legislation enacted by the executive (e.g. regulations, decrees, ordinances, 法规). It is superior on account of its capacity to enable a broader range of political participation,¹ and particularly where it enables non-governmental members of the legislature to move amendments to the scheme.

4. Primary legislation—including legislation that pre-dates the development of a particular vaccine—may authorize the executive to enact mandatory vaccination requirements so long as criteria set forth in the primary legislation are met. Consistently with paragraph 12 below, such criteria should approximate the range of considerations applicable to the context of Covid-19 vaccination. Any imposition of mandatory vaccination requirements under such powers should be accompanied by a consultation procedure approximating the requirements set out in paragraphs 9 and 10 below.

5. On grounds of unavoidable urgency, legislative schemes can be enacted under fast-tracked primary legislation or through secondary legislation, if this option is provided by the Constitution. In such cases, the duration of such schemes should ideally be limited to the period required to enact an appropriate scheme in primary legislation, a period that should not ordinarily exceed six months.

6. Primary legislation that is passed on an accelerated parliamentary procedure (i.e. ‘fast-tracked’, where the bill passes through all legislative stages within a few days), should be temporary and fully replaced by

¹ The ECtHR case of Vavříčka and Others v. the Czech Republic [2021] ECHR No. 47621/13, 3867/14, 73094/14, 19298/15, 19306/15 and 43883/15 (European Court of Human Rights), finds that secondary legislation is sufficient to comply with the requirement that the measure is ‘prescribed by law.’
primary legislation rather than extended by simple parliamentary vote. A system which schedules a meaningful parliamentary revision of the scheme is not fast-tracked legislation within the meaning of this paragraph.

7. An appropriate parliamentary scheme will entail pre-legislative consultation, a period of legislative scrutiny not less favourable than typical for important legislation, and provision for the robust participation of legislative committees and the public in the details of the scheme.

8. A consultation period for a scheme enacted in primary legislation should be not less than four to six weeks in duration. The state should publish the consultation submissions promptly. It should also publish the Government’s response to the submissions in advance of presenting any bill to the legislature.

9. Where the scheme is regulatory in nature, it is important that regulated businesses and social partners such as trade unions, representative civil society organisations, religious bodies, feminist organisations, low-income families’ representatives, organizations representing racial and ethnic minority groups, and other relevant interest groups be given meaningful participation in the consultative process. Special attention should be given to the participation of indigenous peoples. Meaningful participation entails consultation at multiple points and a sincere attempt to address concerns raised.

10. Advice from leading public bodies in a range of disciplines, including, but not limited to, scientists, behavioural scientists, psychologists, sociologists, and economists, should be made available to the legislature on a transparent, public, and where required, an expedited basis.

11. The scheme enacted in primary legislation should not leave major questions of policy, and the balancing of human rights considerations, for sole determination by executive rule-making (secondary legislation) or by the exercise of unstructured discretion by private actors.

12. Any non-temporary legislative scheme should in its initial years of operation include a scheduled annual review on the operation of the scheme, run by the Government or by an independent reviewer. A report

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2 An example of fast-tracked legislation not meeting this criterion is found in the United Kingdom’s Coronavirus Act 2020, whose periodical votes on continuation received little political and public engagement.

3 For example, in Italy a statutory decree (decreto legge) is adopted by the executive but later converted into primary law by the Italian Parliament in a process that frequently leads to revisions of the scheme. See S Civitarese Matteucci et al, ‘Italy: Legal Response to Covid-19’ in J King and O LM Ferraz et al (eds), The Oxford Compendium of National Legal Responses to Covid-19 (OUP 2021), Part II.

4 A best practice guide to designing vaccination programmes pre-dates Covid-19 and proposes tailoring programmes to segmented groups in each society through consultation and involvement of a range of academic disciplines. See R Butler and NE MacDonald, ‘Diagnosing the determinants of vaccine hesitancy in specific subgroups: The Guide to Tailoring Immunization Programmes (TIP)’ (2015) 33 Vaccine 4176, 4179.
should be laid before the legislature and legal provision made for it to be debated.

B. **Federal Systems and Multi-Level Government**

13. The level of government at which a scheme of mandatory vaccination should be elaborated will depend significantly on the distribution of health and social care competences within any given state. However, vaccination policies are seldom the sole competence of only one level of government, and should form part of a broader public health strategy. The general principles formulated elsewhere in this document are applicable with equal force to subnational governments (SNGs) where they are the decision-makers.

14. Given that in federal systems health and social care are most often a subnational function or policy domain, SNGs play a key role in providing vaccinations and implementing vaccination requirements. Furthermore, SNGs are also responsible for the key areas of the scheme’s application: education, commerce and trade, transport, and recreation and leisure. In all federations, the central Government is included in the domains of public health and health care and has a legitimate interest in the overall formulation and implementation of mandatory vaccination requirements.

15. During the pandemic, jurisdiction over public health interventions was frequently possessed by or devolved to SNGs in order to allow the tailoring of measures to local circumstances. However, the devolution of powers has also led on occasion to disproportionate results which were invalidated by reviewing courts. To guard against the inappropriate and disproportionate use of the devolved powers, it is advisable that such powers are exercised within a national framework produced in consultation and in cooperation between SNGs and the central Government, and which is compliant with relevant human rights norms.

16. To reduce confusion and facilitate mobility, mandatory vaccination requirements should be aligned in substance and, where feasible, be recognisable across subnational jurisdictions. To achieve this aim, there should be intergovernmental consultation on the question of coordinating policies, ideally in advance of introducing legislation.

17. Special attention must be given to the use of ‘vaccination passports’ for the control of persons’ movement between subnational jurisdictions (i.e. internal borders). During “lockdowns,” courts in some countries sanctioned prohibitions on the freedom of movement between provinces / states (Canada), while in others restrictions were invalidated (Argentina). Special care should be taken in consideration of human

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rights and any constitutional law issues potentially arising from restrictions on internal travel.

18. The rights of indigenous peoples to self-determination over their vaccination regimes affecting their internal and local affairs (for example, under the United Nations Declaration on the Rights of Indigenous Peoples) should be recognised so far as practicable. However, where feasible, alignment between measures and programmes adopted by the state government(s) and indigenous peoples should be encouraged through dialogue.

C. **Vaccine Requirements imposed by non-state actors**

19. Mandatory vaccination requirements imposed by non-state actors that control access to essential goods or services or restrict the enjoyment of any human rights should be consistent with a tailored scheme of rules and guidelines that govern the protection of human rights in the private sphere.

a) “Basic human rights” include the right to liberty, non-discrimination, mobility, privacy, health, work, freedom of assembly for the purposes of political protest, freedom of association, including trade union rights, and the exercise of religious liberties;⁶ and

b) “Essential goods or services” include access to basic goods required for the purposes of nutrition, hygiene, health, transport, and essential government services.

20. Regulatory schemes concerning private actors should be narrowly tailored so that private actors are not left with excessive or arbitrary power over the basic human rights or basic needs of other persons. Where a system of public law (e.g. through horizontal direct effect),⁷ or its systems of labour or education law, are developed to the extent of ensuring the full application of relevant human rights, equality, and data protection principles, a new legal scheme may not be needed.

21. The content of regulation will vary between sectors and services. Ideally, the state will consult and enact tailored regulation in each domain,

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⁶ See e.g. the UN International Covenant on Civil and Political Rights; the UN International Covenant on Economic, Social and Cultural Rights; the EU Charter of Fundamental Rights; the UN Declaration of Human Rights; the American Declaration of Human Rights; the African Charter.

⁷ The horizontal effect of human rights norms means that constitutional rights provisions will not only bind state actors but will be applied by national courts to disputes between private parties, ensuring that a private actor does not violate the constitutional rights of others.
following the consultative principles outlined in Part I.A above and the sectoral principles identified in Parts V-VII below.

22. Where the state fails to adopt or delays the adoption of such regulation, non-state actors will often have reasonable grounds for adopting their own requirements in order to protect the health of their staff and clientele. In doing so, they should ideally adopt and where necessary adapt the best practices outlined in this statement of principles and in paragraph 23 in particular.

23. A tailored scheme of rules and guidelines should at a minimum:

   a) be transparent and adopted in consultation with affected persons (Part I.A above);
   b) be framed by reference to public scientific guidance;
   c) address applicable exemptions and reasonable accommodations (Part II below);
   d) meet privacy and data-handling principles (Part III below);
   e) conform with the sectoral principles outlined for occupational mandates, educational mandates, and access to public venues (Parts V-VII below);
   f) be kept under periodic review to remain consistent with current public health guidance and advice; and
   g) be accompanied by a transparent and fair complaints protocol adopted for the internal consideration of grievances.

24. Where an existing system of dispute resolution, grievance handling, collective bargaining or adjudication exists, and can be expected to provide meaningful accountability in disputes about the application of legal standards to individual cases, these may be sufficient and in some cases preferable to new regulation. Where existing dispute resolution mechanisms are not suitably adapted to such requirements, a new scheme of public law regulation will be needed.

25. There should be accessible recourse to an independent dispute resolution mechanism where disputes about the application in individual cases of exemptions or reasonable accommodations, or allegations of unfairness or discrimination, can be heard.

II. Human Rights: Equality, Proportionality and Exemptions

A. Interferences with Human Rights

26. International human rights law recognises the right to health. It recognises an explicit duty to take steps necessary for the ‘prevention,
treatment and control of epidemic [...] diseases. This right and its correlated duties, which are also recognised in two thirds of national constitutions around the world, may provide prima facie justification for the imposition of mandatory vaccination requirements.

27. Protections for human rights are not absolute; interference with a right may be justified based on the risk of harm to others. According to widely accepted principles of democratic constitutional law and international human rights law, any such restrictions must be prescribed by law and necessary in a democratic society in accordance with the legal principle of proportionality.

28. Mandatory vaccination requirements that are imposed as a condition for the enjoyment or exercise of a basic human right, including the right to work, health, education, religious exercise, the freedom of protest or the right to strike are to be presumed to be unavoidable for the subject of such requirements. The consequences of refusing the requirement in such cases are too severe to be presumed to be voluntary.

29. Mandatory vaccination requirements may potentially interfere with several human rights, including the right to liberty, to privacy, to bodily integrity, to freedom of religion, to freedom of assembly, to work, to education, to travel and to adequate housing, and may infringe the right to equal treatment. In this they are mostly analogous to robust public health interventions such as stay-at-home orders.

30. As noted in the introduction, a vaccination requirement which can be avoided by a person without undue burden is not regarded in this set of principles as a mandatory vaccination requirement. What constitutes an undue burden must be assessed in context. Requirements such as accessible and quick testing, the use of personal protective equipment, and proportionate social distancing should not in general be regarded as an undue burden.

31. Formal derogations from human rights instruments are not required to enact rights-compliant schemes of mandatory vaccination requirements. Derogations have the tendency to reduce the scope of rights-based judicial review of particular schemes available to claimants. They are therefore not justifiable on public health grounds.

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8 UN International Covenant on Economic, Social and Cultural Rights, art 12(2)(c).

9 See e.g. Vavříčka and Others v. the Czech Republic [2021] ECtHR No. 47621/13, 3867/14, 73094/14, 19298/15, 19306/15 and 43883/15 (European Court of Human Rights), paras 129 ff and, as part of the proportionality analysis, para 282; see also the Italian Constitutional Court judgment No. 5/2018; and the Brazilian Supreme Federal Tribunal in two cases regarding the constitutionality of compulsory Covid-19 vaccinations: ADIs 6.586 and 6.587 [STF 2020] (finding that the rights invoked by those against compulsory vaccination are not absolute and can therefore be limited for the protection of the equally constitutionally recognised rights to life (art 5, caput), health (arts 6 and 196) and for the protection of children and adolescents (art 227)).
B. Proportionality

32. Any interferences with basic human rights by state and non-state actors must at a minimum be in accordance with the legal principle of proportionality. Though the legal tests diverge in small ways in comparative public law, in general a proportionality test will require that a measure infringing protected rights must:

a) be prescribed by law;

b) pursue a legitimate aim (i.e. a ‘compelling state interest’ or a suitable aim);\(^{10}\)

c) be necessary in a democratic society (i.e. that there is a ‘pressing social need’\(^{11}\) that the measures be rationally connected to that aim;\(^{12}\) and that they are the least restrictive alternative for achieving the policy); and

d) proportionate in the narrow sense that it strikes a fair balance between the importance of the goal and the burden it places on the individual.\(^{13}\)

Prescribed by Law

33. A public mandatory vaccination requirement will be prescribed by law if it is based on clear legal authority under primary or secondary legislation, and the guidance given under the law is reasonably clear, foreseeable, and accessible to the subjects of that law.

34. A private mandatory vaccination requirement will be prescribed by law if it is governed or regulated by a public or civil law scheme affording adequate protection to the rights.\(^{14}\)

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\(^{11}\) See e.g. Vavříčka and Others v. the Czech Republic [2021] ECHR No. 47621/13, 3867/14, 73094/14, 19298/15, 19306/15 and 43883/15 (European Court of Human Rights), paras 273 ff.

\(^{12}\) The standard invoked in *R v. Oakes* [1986] 1 SCR 103 (Supreme Court of Canada). In the ECHR, the court applies the requirement that the policy be supported by ‘relevant and sufficient reasons.’ See e.g. Vavříčka and Others v. the Czech Republic [2021] ECHR No. 47621/13, 3867/14, 73094/14, 19298/15, 19306/15 and 43883/15 (European Court of Human Rights), paras 285 ff.

\(^{13}\) Legal systems vary as to how much emphasis is put on this final category. It is marginal in Canadian jurisprudence and crucial in Germany: see D Grimm, *Proportionality in Canadian and German Constitutional Jurisprudence* (2007) 57 University of Toronto Law Journal 383.

\(^{14}\) See e.g. Söderman v. Sweden (Application No. 5786/08) (ECHR, Grand Chamber) (12 November 2013) (on the positive duty to provide an ‘adequate legal framework affording protection’ of the article 8 right to private and family life that can consist of civil-law remedies).
**Legitimate Aim**

35. The purpose of any mandatory vaccination programme or requirement should be clearly defined so that accurate and objective assessments of proportionality can be made.

36. The primary justification of mandatory vaccination requirements should be the protection of public health. Generally concerned with protecting against harm to others, this category includes the reduction of transmission (whether or not this leads to community immunity), the protection and conservation of health services for the treatment of others, and the securing of essential services from disruption due to the consequences of infection. An ancillary reason may be that such requirements help secure greater freedom for others by enabling the relaxation of social distancing requirements.

37. The application of paternalistic justifications for mandatory vaccination programmes (i.e. the protection of one's own health), beyond the aims of protecting essential services and providing freedom to others, are a matter for determination by individual states. There is no prevailing view on whether such a policy is or is not a legitimate aim within the meaning of international human rights law principles.

**Necessary**

38. A measure that is not rationally connected to a legitimate aim is not necessary. For vaccination requirements, the connection between the measure and its aim should be underpinned by the available public health and scientific evidence. Such a basis should be reviewed periodically by the Government to ensure the connection remains consistent over time.

39. When assessing the evidence underlying the proportionality of mandatory vaccination requirements, national courts should show judicial restraint when asked to judge the probative value of complex scientific or social science evidence and the disposition of the case can have extensive social impact. This is broadly the approach followed in a range of national jurisdictions. Exceptions to this rule could include where a Government refuses to follow its own scientific advisory bodies, or where there is a

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15 The protection of health is recognised as a specific legitimate aim in Articles 8(2), 9(2), 10(2) and 11(2) of the European Convention on Human Rights.

16 The European Court of Human Rights in Vavříčka and Others v. the Czech Republic [2021] ECHR No. 47621/13, 3867/14, 73094/14, 19298/15, 19306/15 and 43883/15 (European Court of Human Rights), para 272, appears to recognise a paternalistic aim as a legitimate aim of protecting ‘health.’

17 These include Canada, the ECtHR, Germany, Ireland, Italy, South Africa, and, more variably, the United States. In the ECtHR case of Vavříčka and Others v. the Czech Republic [2021] ECHR No. 47621/13, 3867/14, 73094/14, 19298/15, 19306/15 and 43883/15 (European Court of Human Rights), paras 276-280, the margin of appreciation in assessing the need for a compulsory vaccination programme ‘is a wide one.’ For an analysis of judicial restraint on the basis of expertise in social rights adjudication, see J King, Judging Social Rights (CUP 2012), ch 8, and O Ferraz, Health as a Human Right. The politics and judicialization of health in Brazil (CUP 2021), ch 9.
substantial uniformity of scientific advice on the subject that is disregarded by the Government adopting the measure.

40. A scheme should be minimally impairing in the sense of doing no more than is necessary to achieve a legitimate aim. Whether exceptions can be permitted to a scheme is a complex question. The adoption of a scheme should evince a careful consideration and clear rationale on the question of exemptions and reasonable accommodation (see Part II.D below). The difficulty of making exceptions to a general rule, without at the same time undermining the effectiveness of the rule, has been recognised by the European Court of Human Rights as a valid reason for the refusal to find a blanket rule disproportionate.18

**Fair balance**

41. The penalty imposed on persons for non-compliance with the mandate are relevant to the proportionality of the scheme. The more coercive and intrusive the regime of penalties, the higher will be the justificatory burden under the legal test of proportionality.19 Forced vaccinations are the most extreme response and are prohibited by some bills of rights.20 The imposition of criminal penalties are also considered harsh and potentially unnecessary absent special circumstances. The imposition of administrative fines or the conditioning of access to some services is among the accepted modes of implementing mandatory vaccination requirements.

42. Governments should make best efforts to ensure the continued access of every individual to essential services, whether provided by public or private actors.

43. Policymakers should consider providing compensation for health impacts of vaccine side-effects for those who submitted to a mandatory vaccination requirement. Some jurisdictions have recognised a

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20 Section 11 of New Zealand’s *Bill of Rights Act 1990* protects the ‘right to refuse to undergo any medical treatment’; Brazil’s Supreme Federal Tribunal ruled that there is a crucial distinction between forced and compulsory vaccinations: ADIs 6.586 and 6.587 [STF 2020]. Several states also provide statutory protection: section 20(6) of Germany’s *Infection Protection Act* includes a statutory protection of the right to refuse otherwise mandatory vaccination on recognised medical grounds; section 45E of the United Kingdom’s *Public Health (Control of Diseases) Act 1984* provides that public health regulations ‘may not include provision requiring a person to undergo medical treatment,’ which includes vaccination. Belgium and Russia both have statutory protections for patients’ right to refuse medical interventions. See also the (legally non-binding) *Universal Declaration on Bioethics and Human Rights*. 
constitutional or statutory obligation to provide such compensation\textsuperscript{21} and the WHO recommends the adoption of no-fault compensation schemes for this purpose.\textsuperscript{22}

C. Equality

44. A policy that imposes a mandatory vaccination requirement where the subjects of the requirement have unequal access to vaccination will be an unfair imposition unless the rationing criterion is fair and transparent (e.g. based on objective need) and not on ability to pay, geographical location, or other irrelevant reason.

45. There is a legal risk that mandatory vaccination requirements may be regarded as discriminatory or contrary to constitutional or statutory equality guarantees if they block the enjoyment of human rights and essential services under conditions where the vaccine is not affordable and accessible.\textsuperscript{23}

46. The administration of any mandatory vaccination requirement must not discriminate on the basis of protected characteristics. What constitute protected characteristics will depend on national equality law frameworks. At a minimum, they tend to include race, religion, political or religious belief, sex, age, and disability.

47. Equality law recognises the right of disabled persons to reasonable accommodations in the workplace and educational settings. An analogous principle finds application in the context of mandatory Covid-19 vaccination requirements.

\textsuperscript{21} Italian Constitutional Court judgment \textit{No. 5/2018}; section 12 of Germany’s \textit{Infection Protection Act} obliges public authorities to compensate for any side effects caused by vaccines recommended by public policy. See also Y Fujiwara et al, ‘\textit{No-fault compensation schemes for COVID-19 medical products}’ (2021) 397 The Lancet 10286, which discusses no-fault compensation schemes, including some financed through contributions from pharmaceutical companies.

\textsuperscript{22} Y Fujiwara et al, ‘\textit{No-fault compensation schemes for COVID-19 medical products}’ (2021) 397 The Lancet 10286; WHO, ‘\textit{No-fault compensation programme for COVID-19 vaccines is a world first}’ (22 February 2021).

\textsuperscript{23} In some systems, the constitution may protect a general right to equal protection of the law: e.g. the fourteenth Amendment of the \textit{US Constitution} guarantees ‘equal protection of the law’; article 3 of the \textit{German Basic Law} provides that ‘All people are equal before the law’; section 6 of the \textit{Constitution of Finland} provides that ‘Everyone is equal before the law’; the \textit{Constitution of Ireland} that ‘All citizens shall...be held equal before the law’; section 13(3) of the \textit{Constitution of Jamaica} provides the ‘right to equality before the law.’ In some other systems, constitutional and other guarantees enumerate grounds of discrimination, but also provide for a category such as ‘analogous grounds’ (e.g. section 1, \textit{Canadian Charter}) or ‘other status’ (e.g. article 14, \textit{ECHR}), where vaccination status may arguably be covered.
D. Religious Exemptions and Freedom of Conscience

48. Exemptions legally excuse a category of persons from compliance with an otherwise generally applicable mandatory vaccination requirement. Exempt individuals may be required to comply with alternative requirements, such as testing or face covering.

49. The provision of exemptions for some categories of people may be consistent with the aims of mandatory vaccination requirements as detailed in Part II.B above. Exemptions for medical reasons are widely recognised in the imposition of vaccination requirements.

50. States have a duty to consider and consult with leading public bodies, as detailed in Part I.A above, on categories of exemptions and whether to expand or reduce such categories over time.

51. Legal systems vary in their approach to accommodating religious beliefs and freedom of conscience, and often these rights are subject to proportionality testing. Exemptions from mandatory vaccination requirements on account of these grounds are not, in principle, required by human rights law. Although some states have chosen to provide the possibility for an exemption based on a sincerely held religious belief, other states do not recognise religious exemptions for mandatory vaccination requirements.24

E. Constructive engagement with vaccine hesitancy

52. For reasons of efficacy, voluntary uptake, and out of respect for persons, public and non-state actors should seek constructive engagement with reasonable forms of vaccine hesitancy when imposing mandatory vaccination requirements. Constructive engagement should not impose

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24 In Jacobson v. Massachusetts 197 US 11 (1905) (US Supreme Court), the Supreme Court upheld ‘a law imposing a criminal fine on any adult who refused to comply with a local smallpox vaccination order on the grounds that laws may limit the bodily autonomy of individuals to secure the public’s health’ (see L Wiley, ‘United States: litigation challenging vaccine requirements’ Lex:Atlas: Covid-19 (7 September 2021) – although the author emphasises that this precedent has been called into question in November 2020). In Italy and in the United Kingdom, the vaccination regimes offer no religious exemption. In Vavlička and Others v. the Czech Republic [2021] ECHR No. 47621/13, 3867/14, 73094/14, 19298/15, 19306/15 and 43883/15 (European Court of Human Rights), the European Court of Human Rights considered the issue of whether vaccine hesitancy could be protected under the freedom of conscience and religious exercise under article 9 of the ECHR. Leaving the issue open, it found that the applicants’ claims did not amount to any assertion of religious freedom, and that the opposition to the vaccine on grounds of conscience failed to amount to ‘conviction or belief of sufficient cogency, seriousness, cohesion and importance to attract the guarantees of Article 9’ (para 335). The Governments of France and Germany intervened in the case to argue that neutrally applied compulsory vaccination requirements did not even engage article 9, let alone fail to be justifiable as a proportionate restriction under article 9(2) (paras 325-326).
an undue burden on service providers or obstruct public health objectives in a substantial way.

53. Reasonable vaccine hesitancy has frequently been found in communities which have experienced a history of state-complicit persecution, discrimination, marginalisation, or neglect. Such experiences will find reasonable grounds for distrust in dealings between the state and that community and generate a corresponding duty to take such hesitancy seriously.

54. Constructive engagement does not constitute a disapplication of the existing policy. It could include giving adequate time to understand and take advice on safety and other concerns; to make available advice from sources more likely to be trusted by subjects of the mandate; to consider adjustments to the service or employment, such as redeployment or flexible work arrangements; and a reasonable transition period for those who are unwilling to be vaccinated and cannot be accommodated by any other means.

III. Privacy and Technical Design of Proof of Vaccination

55. Verifying vaccination status requires a two-step process of connecting a natural person to an identity (e.g. through an identity document, or a biometric database), and linking an identity to a vaccination status (e.g. through medical records, or a cryptographically signed certificate of status connected to an established identifier such as a name or number). Both of these steps can be implemented in many different ways, and bring different risks and benefits which must be considered.

56. Interventions and infrastructures designed to reduce the risk of fraud and forgery must be proportionate to the risks they introduce and the intended purpose of the healthcare intervention. Achieving a fraud-proof system is likely unrealistic where the pressure for rapid and universal vaccination means the vaccine database itself may be unreliable, and where agents examining any vaccination proof are unreliable gatekeepers. Consequently, efforts to reduce specific types of fraud which have impacts on rights and freedoms, such as the introduction of biometric infrastructures, must be justified in light of an evidenced public health need.

57. Systems should be designed in line with the principles of data minimisation and purpose limitation, the latter being preferably regulated by law. Proof of vaccination must be designed to reveal only the minimum data an agent needs to make a legitimate decision. Underlying data must only be used for public health purposes, with providers of any technical infrastructures forbidden from retaining or repurposing any records beyond legitimate healthcare delivery and public health purposes.
58. Systems to prove vaccination status must be easily available to all, including those with limited documentation or unclear legal residency status, those without digital and related technologies, connectivity or literacy, and those with disabilities or impairments.

59. Where digital systems are used to authenticate certificates, such systems should leave no implicit or explicit logs of when and where any proof of vaccination was verified which may be used to reconstruct individuals’ activities, for example, by using ‘offline’ verification.

60. Technology should be standardised and fully interoperable within, and where possible across, states. Such standardisation processes must be open and inclusive, considering states’ different technological and health infrastructures and ensure such states can realistically work to these standards within existing public sector capacities.

61. Technical standards should be openly licensed and developed, free to use, study, share and improve, and not reliant on proprietary systems or infrastructures.

62. States must remain in a position of control over the technical infrastructures underpinning proof of vaccination, responsible for design and policy decisions and retaining authority to retire or disable these infrastructures. The need for such infrastructures should be reassessed regularly in light of the aim pursued by the state.

IV. International impact of national mandatory vaccination requirements

63. Mandatory vaccination schemes can have a profound and disproportionate impact on non-residents such as asylum seekers, migrant-workers, and tourists, as well as foreign businesses. It is essential that mandatory vaccination schemes are not used to restrict cross-border circulation of non-nationals for reasons that are in reality not related to public health.

64. Due to unequal accessibility and affordability, vaccination rates in low- and middle-income countries fall far below those in high-income countries.\(^\text{25}\) Mandatory vaccination programmes should be designed having regard to the need to avoid deepening existing global inequalities.\(^\text{26}\)

65. There is a risk that high-income countries design complex and costly vaccination certification systems from which residents of low- and middle-income countries are excluded on the grounds of cost and lack of infrastructure or are placed at risk due to poor regulatory practices. As stated in Part III above, interoperable certification systems that are both

\(^{25}\) See [Global Dashboard on Vaccine Equity](https://www.globaldashonvaccineequity.org), featuring data from Covid-19 tracker.

\(^{26}\) For example, COVID-19 Data Futures Platform, “How can vaccines be financed?” United Nations Development Programme (2021).
affordable and practical should be designed in order to address these concerns and not create pernicious externalities.

66. It is essential that mandatory vaccinations are not used as a de facto barrier to persons seeking an asylum determination.

67. In cases of other important cross-border migration (e.g. seasonal migrant workers, family reunification), it is crucial that vaccination requirements are focused on public health concerns and not conflated with other immigration policies and priorities, and that special measures are taken to address the vulnerability of such groups.

68. Vaccine approval has occurred at the national or regional level, with some countries stating that they will refuse to allow free entry to citizens inoculated with vaccines not on their approved list. Furthermore, approval and recognition between states risk being bound up in broader geopolitical orientations. A system of mutual recognition, to be decided upon by states, should be put in place alongside interoperable certification systems to lessen this problem.

V. Occupational Vaccine Requirements

69. According to the International Covenant on Economic, Social and Cultural Rights, which has been ratified by 171 countries, everyone has a human right to work. This right includes not only the opportunity to freely choose an occupation (article 6), but also a right to safe and healthy conditions of work (article 7(b)). The protection of employees at work, and of vulnerable groups cared for within particular workplaces, is a human rights obligation of states.

70. Mandatory vaccination schemes often impose some restrictions on the right to work and, as with any other right, must therefore be proportionate (see Part II.B above).

71. A publicly coordinated framework of laws must be enacted consistently with the principles set out in Part I above. Within that framework, sectoral social dialogue with representative social partners is the best means to

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28 As L E E Tsung-Ling, ‘COVID-19 Vaccination Certificates and Their Geopolitical Discontents’ (2021) 12 European Journal of Risk Regulation 321, 331 notes, the contentious political status of Taiwan excludes the nation from membership of the WHO and renders it caught in geopolitical rivalry between China and the USA.


30 UN International Covenant on Economic, Social and Cultural Rights, art 7(b).
establish if vaccination might indeed be required for certain industries and jobs on the basis of objective criteria.

72. The regulatory scheme for vaccine requirements in the workplace should respect the following principles. 31

73. Mandatory vaccination policies in the workplace should be a last resort and where used, be based upon principles of necessity and proportionality (see Part II.B above), and should be based in a public statutory framework. Where the state has not provided a public law framework, employers may be justified in adopting mandatory vaccination requirements (see paragraphs 22 and 23 above).

74. Necessity and proportionality should be determined by the basic human needs of workers, service users, and customers. In particular, it should be based upon an objective risk assessment ensuring safe and healthy workplaces. This risk assessment should be undertaken by health and safety committees supported by representative trade unions. Where workers and/or service users have particular vulnerabilities to Covid-19 exposure or to developing severe disease, as in frontline health care, and residential social care, mandatory vaccination is more likely to be justified. As part of the proportionality determination, such policies should be subject to an ‘individualised assessment’ to determine whether an unvaccinated employee would pose a direct threat to the health or safety of others in the workplace.

75. Governments should introduce framework legislation that, where appropriate, permits sectoral solutions negotiated by representative social partners. Framework legislation should specify general principles to be observed by collectively agreed sectoral solutions. These principles must be based upon international laws and standards on health and safety at work, fundamental rights of workers, and trade union rights.

76. Where the duty to provide a healthy and safe working environment and the duty to ensure the safety of service users (especially in care settings) justifies a mandatory vaccination policy, the employer ought to take responsibility for everyone undertaking personal work for the organisation. This is regardless of their specific contractual status, such as whether they are engaged on a self-employed or on a ‘casual’ basis. The duty relates to the workplace environment. Leave for vaccination, and time off for any ill effects associated with vaccination, should be paid at the rate of normal remuneration.

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77. As any required occupational health and safety measures, mandatory vaccination shall not involve any expenditure for the workers, and the employer or state should bear the costs of vaccination.

78. Mandatory vaccination policies do not normally obviate the need for other occupational health and safety measures necessary to control and prevent the spread of biological agents and occupational diseases in the workplace.

79. In considering responses to individual refusal of vaccination, the legal framework should address both dismissal and refusals of employment, since both involve the exercise of private power.

80. The regulatory system should specify permissible exemptions and any applicable appeals process.

81. Dismissal, suspension, and workplace exclusion should be a last resort for workers who refuse to be vaccinated. The employer is under a duty to consider alternatives to dismissal, such as, when feasible within reasonable costs, relocation or reassignment of duties or adoption of alternative public health measures, such as the use of testing or personal protective equipment, with equivalent effect.

82. Any mandatory vaccination policy should be subject to ongoing equality monitoring, with a particular focus on disparate impacts on particular racial groups and groups experiencing socio-economic disadvantage. The employer is under a duty to pursue constructive engagement having regard to any adverse equality impacts caused by a compulsory vaccination policy in the workplace.

83. If a worker provides cogent evidence of becoming ill or suffering a significant adverse reaction to the vaccine, requiring medical treatment and/or time off work, compensation for reasonable expenses and loss of income should be borne by the employer, the state and/or the vaccine manufacturer rather than by the worker.

VI. Educational Vaccine Requirements: Schools and Universities

84. International human rights law recognises a right to primary and secondary school education.\footnote{UN International Covenant on Economic, Social and Cultural Rights, art 13.} In many states, access to higher education can be regarded as an essential public service for achieving civic equality and equality of opportunity.

85. Compulsory vaccination programmes for students are an established feature of educational provision in over 100 countries.\footnote{S Vanderslott and T Marks, ‘Charting mandatory childhood vaccination policies worldwide’ (2021) 39 Vaccine 4054, 4062.} The widespread use of such programmes has resulted in fewer mandatory adult
vaccination requirements because many adults have acquired immunity due to childhood immunization.

86. Vaccination mandates in education interfere with the right to education and must therefore be a proportionate means of achieving the aims detailed in Part II.B above. There is a duty to consider exemptions (see Part II.D above) and carry out constructive engagement with reasonable vaccine hesitancy among staff and pupils (see Part II.E above).

87. Where a student or a student’s family refuses to comply with a vaccination requirement, the provider has a duty to consider alternative means of education. A failure to provide alternative means of education that are of equal or comparable quality to the main educational provision is not, in itself, a form of unequal treatment. It will, nevertheless, be important for the educational provider to have regard to the way in which unequal access to online technologies or unequal material resources in the home setting can impact adversely upon the ability of students to carry out home study as an alternative to school attendance.

88. Any educational provider should ensure that internal procedures are in place for handling grievances and complaints by staff and students arising from the application of a mandatory vaccination requirement and exemption requests. These procedures should include investigations to establish whether the policy was administered fairly, reasonably, and in compliance with the principle of proportionality (which entails the duty to consider exemptions and pursue constructive engagement with reasonable vaccine hesitancy).

89. The principles relating to consultation and law-making in Part I apply to the use of mandatory vaccination requirements in the public and private sector. Consultation should take due account of the various stakeholders in the education sector, including staff, students, and where applicable, parents.

VII. Access to Public Venues and Spaces

90. There is a distinction between access to services or venues that are necessary for the enjoyment of human rights and essential services and those venues and services that are not. Venues that can be regarded as entirely non-essential for persons will have a broad discretion under most legal systems when adopting mandatory vaccination requirements. This general principle is qualified by two caveats.

91. Whether a venue is generally non-essential is a matter of degree. Some venues (e.g. gyms) and services (e.g. delivery, cleaning) that may be optional for most may for some persons rise to the level of being necessities. Where that is the case, special care should be taken to
ensure the principles in this document are respected in relation to such persons.

92. Mandatory vaccination requirements imposed in non-essential public venues and for services regarded as optional should nevertheless be provided consistently with the basic principles of non-discrimination law and respect the principles of privacy and data-handling set out in Part III above.

93. States should consider setting out guidance on the framing and adoption of mandatory vaccination requirements for public venues and the service economy. Even where venues are optional, the exercise of arbitrary power to exclude persons can frequently lead to abuse and be sites of discrimination.
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