

**Moral Permissibility of Mandatory COVID-19 Vaccinations amongst
Healthcare Workers in
South Africa**

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DECLARATION

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I dedicate this work to my husband Mark Faesen, for supporting and encouraging me through some tough times and to my children, Simone, Ramon and Sean, who have always been a wonderful source of joy and inspiration. I would also like to dedicate this work to my late mother, Mrs D Badal, for being a remarkable role model.

ABSTRACT

Background. The development of COVID-19 vaccines has been expedited resulting in many unanswered questions regarding their long-term safety and efficacy.

Healthcare workers are regarded as high risk for getting infected as well as for transmitting the infection to their patients, colleagues, and families. Based on this high risk, policymakers and healthcare facilities may opt to mandate vaccinations of healthcare workers.

Objective. To normatively analyse the moral permissibility of mandatory COVID-19 vaccinations of healthcare workers in South Africa.

Methods. In this research report arguments to support the stance that vaccine mandates cannot be justified will be explored. Firstly, this report will give an overview of COVID-19 vaccines by addressing uncertainties regarding the longevity of the immune responses and long-term adverse effects. Vaccine hesitancy will also be addressed. Vaccination programmes have been successful as public health measures, however, this concept will be interrogated. Moral theories of Principlism, Kantianism, Utilitarianism and the Philosophy of Ubuntu will be explored to support the argument that vaccine mandates for HCWs is not morally permissible. Finally, the legality of vaccine mandates will be examined.

Conclusion. The lack of long-term data regarding immune responses to COVID-19 vaccines together with the moral and legal arguments presented in this research report, support the argument that mandatory vaccinations of HCWs cannot be justified. However, the Philosophy of Ubuntu is proposed as a possible solution to the dilemma between individual rights and public health measures.

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TABLE OF CONTENTS

Contents

DECLARATION	ii
ABSTRACT	iv
ACKNOWLEDGEMENTS	v
CHAPTER 1: Introduction	1
1.1 Background	1
1.2 Research Question	6
1.3 Rationale for the study	6
1.4 Thesis Statement	7
1.5 Research Aim	7
1.6 Research Objectives	7
1.7 Research Design	8
1.8 Research Methodology	9
1.8.1 Argumentative Strategy.....	9
1.9 Limitations	12
1.10 Ethics	12
2.1 Emergency use Authorization and regulatory requirements for vaccine rollout .14	
2.2 Safety and efficacy of vaccines	16
2.3 What is vaccine hesitancy?	18
2.4 Herd immunity	19
2.5 Hepatitis B vaccination for HCWs as a comparison	20
CHAPTER 3: An evaluation of the Morality of Mandatory Vaccination	22
3.1 Public Health	23
3.2 The Nuffield Intervention Ladder	24
3.3 Paternalism	26
3.4 Mill’s Harm Principle	28
3.5 Utilitarianism	29
3.6 Autonomy and Informed Consent	30
3.7 Principle of Justice	32
3.8 Non-Maleficence and Beneficence	33
3.9 The Philosophy of Ubuntu	34
CHAPTER 4: Guidelines, Laws and Professional Responsibility	37

4.1 United Nations and WHO guidelines.....	37
4.2 Legal considerations in South Africa	39
4.3 Rights and Responsibilities of HCWs.....	44
CHAPTER 5: Conclusion.....	47
REFERENCES	51
APPENDICES.....	57
1. Turnintin Report.....	57
2. Human and Animal Research Ethics Declaration	57

LIST OF ABBREVIATIONS

WHO	: World Health Organization
COVID-19	: Coronavirus Disease 19
EUA	: Emergency Use Access
HCW	: Healthcare Worker
NHA	: National Health Act No 61 of 2003
OHSA	: Occupational Health and Safety Act No 85 of 199
POPIA	: Protection of Personal Information Act No 4 of 2013
US FDA	: United States Food and Drug Administration
SAHPRA	: South African Health Products Regulatory Authority
CDC	: Center for Disease Control and Prevention
PPE	: Personal Protective Equipment
SAMA	: South African Medical Association

CHAPTER 1: Introduction

1.1 Background

Coronaviruses are a family of several hundreds of different viruses majority of which are found in animals such as pigs, bats, camels, and cats. Sometimes these viruses can crossover and cause infection in humans, these are called spillover events. To date only seven of them are known to cause disease in humans, mainly causing respiratory disease. In December 2019, the seventh Coronavirus to cause disease in humans, SARS CoV-2, was identified in Wuhan City, China. (1) On the 30th January 2020, the World Health Organisation (WHO) declared this outbreak a Public Health Emergency of International Importance. This disease was named Coronavirus Disease 19 (COVID-19). Being highly contagious, it spread very rapidly across the globe, and on the 11th March 2020, WHO declared that COVID-19 infections had reached pandemic proportions. (2) Global statistics available from WHO, on the 10th October 2021, shows a total of 236,599,025 confirmed cases of COVID-19 and 4,831,486 deaths. (2) As this pandemic is still ongoing the worldwide morbidity and mortality statistics are changing on a daily basis.

COVID-19 is known to cause more severe infections in older individuals and in individuals that suffer from certain underlying health conditions which are frequently referred to as comorbidities. These include cardiovascular disease, hypertension, obesity, chronic kidney disease, diabetes, chronic respiratory disease, and infectious diseases such as HIV and tuberculosis. (3) The main mode of spread of this disease is via respiratory droplets that are aerosolized during sneezing and coughing. Spread can also occur through direct contact. However, the risk for transmission from surfaces and vertical transmission from mother to child is lower. (4) The presentation of SARS CoV-2 infection can range from asymptomatic disease to very severe disease that could ultimately lead to death. Although, it primarily causes respiratory disease it has been shown to affect other organs as well. (4)

In addition to causing widespread disease and death, this pandemic has had catastrophic effects on the world economy particularly in low-income countries. The initial strict lockdown restrictions, adopted in South Africa at the end of March 2020, resulted in most people being confined to their homes, and any non-essential economic activity grinded to a halt. Education institutions were shut down and travel bans were set up. At that stage, most countries around the world had also implemented some form of lockdown restrictions. Several sectors of the economy were negatively affected by these restrictions, for example, the demand for fuel dropped as a result of the travel ban thus affecting oil production. The travel ban also brought the tourism industry to a standstill. (5) As the lockdown restrictions are slowly being lifted economic activity has started to resume. However, the lifting of restrictions has led to complacency regarding mitigating measures such as mask-wearing and social distancing thereby presenting a real risk of a resurgence in the

infection rates. Complacency together with the arrival of the far more transmissible Delta variant, first detected in India, was responsible for the third wave of infection that ravaged South Africa in May and June of 2021. (6) Laxity in abiding by the rules and regulations and the danger of new variants (mutated virus) of the SARS-CoV-2 virus emerging, continuously pose a threat to reverting back to stricter restrictions which would then result in more economic hardship. There is an urgent necessity to find ways in which to combat this disease and in turn, revive the global economy.

Although several pharmaceutical companies are trying to develop a treatment for COVID-19 infection, we currently do not have an effective treatment to cure the disease, hence, the development of vaccines has been accelerated to try to prevent the spread of infection. A vaccine is thought to be the most potent way to try to overcome the pandemic. In recent years, scientists have been under pressure to urgently develop vaccines against new infections caused by H1N1 influenza, Zika, and Ebola, and this, in turn, has been the motivation for biotech companies to invest in mechanisms that will expedite vaccine development. Vaccine development is costly and historically vaccine development took several years. However, the swift speed at which the COVID-19 vaccines are being developed and approved for emergency access use (EUA) brings into question the long-term safety and efficacy of these vaccines. This became evident when the Oxford-AstraZeneca vaccine and later the Johnson and Johnson vaccine rollout were paused for a while because of safety concerns regarding the development of blood clots post-vaccination. (7, 8)

Health Care Workers (HCWs) are categorized as high risk for getting infected with COVID-19 because of occupational exposure. This in turn means that they may not

only pose a risk to their patients but also to their families and other members of the community with whom they interact. With this in mind, mandatory COVID-19 vaccination of HCWs could be considered a plausible option to protect HCWs and in turn the wider public. However, before any mandatory vaccination programme is implemented for HCWs several key points will need to be considered. For instance, doubts about vaccine efficacy, the fear of side effects, misinformation regarding vaccines, cultural and religious beliefs all of which can contribute to vaccine hesitancy. (9) According to Gur-Arie et al there is “prima facie” justification for mandatory vaccinations of HCWs simply on the basis of the medical ethical principles of non-maleficence and beneficence, in other words, there is an expectation for HCWs to act in the best interest of their patients and to protect them from harm. (10) From a Utilitarian point of view, there is also a case for mandatory vaccinations because it has the potential to achieve greater public benefit. (11)

Public health policies are geared towards the prevention of diseases rather than the treatment of diseases. Instead of concentrating on the wellbeing of the individual, these policies target the health of the population. Vaccination programmes are one of the many mechanisms employed in public health policies to improve the health of a population. Vaccinations are believed to not only provide protection to the individual but also to benefit the collective when a large proportion of the population is protected or herd immunity is achieved. The added benefit of vaccination programmes is the protection of the vulnerable. (12) Nevertheless, public health approaches do present ethical challenges because they often impede individual freedom.

On the 1st of April 2021, the Italian government issued a decree making COVID-19 vaccinations mandatory for all HCWs. According to the vice-president of the Italian National Bioethics Committee; “Vaccines are an ethical obligation for health professionals: their professional duty to treat the sick obliges them to avoid transmitting the infection, to operate in safe conditions, and to provide reliable information on the significance of vaccines for the protection of public health.” (13) However, these arguments are aligned with public health practices and are in direct conflict with the HCW’s right to autonomy. Dworkin, as cited by Buchanan described autonomy as “the capacity of a person to critically reflect upon and then attempt to accept or change one’s desires, values and ideals.” (14) HCWs, like all members of society, have the right to act autonomously and should be able to decide what medications they are willing to take. Interestingly, the African philosophy of Ubuntu, according to Sambala et al, has the potential to prevent disagreement between individual rights and the collective good. (15)

In addition to the ethical debate around vaccination mandates, legal arguments must be examined. COVID-19 vaccinations have not been mandated in South Africa. The President of South Africa, on several occasions, reiterated the government’s stance that people would not be compelled to vaccinate. Employers at healthcare facilities should be advised to consider all the applicable laws and regulations before implementing COVID-19 vaccine mandates. Workplace policies must be aligned with the Constitution of South Africa and employment laws.

On the surface, it would appear that mandating COVID-19 vaccinations for HCWs makes logical sense. However, many complex moral and legal issues will need to be taken into consideration.

1.2 Research Question

Is mandatory COVID-19 vaccination of healthcare workers in South Africa morally permissible?

1.3 Rationale for the study

WHO recommends that everyone who will benefit from being vaccinated against COVID-19 should be vaccinated. (16) It is well known that governments around the world are racing to procure large quantities of vaccines in order to achieve herd immunity. People are being bombarded on a daily basis by all types of media platforms about vaccination statistics and efficacy, not to mention misinformation about vaccines. Lockdown fatigue is a reality and there is a longing by most people to return to pre-COVID-19 social and economic activity.

According to WHO, HCWs are at high risk for becoming infected with COVID-19 and in turn pose a risk of infecting their patients, colleagues, family, and friends. For this reason, it is recommended that HCWs should be prioritized to receive vaccines. (16) In South Africa, HCWs were the first to be offered COVID-19 vaccinations. (17) It is very tempting to mandate COVID-19 vaccination particularly in institutions that are reliant on maintaining a good reputation for economic reasons. A healthcare institution can be regarded as a microcosm of a community so public health measures can be applied within that facility. Also important to note is that failure to

vaccinate all HCWs in such institutions may be regarded as a failure to maintain good infection control measures which may negatively influence patient admission numbers. Potential patients may be deterred from attending these facilities as they may view them as unsafe. However, it is still unreasonable to impose vaccinations on HCWs against their will even if it is meant to be for the “greater good”. Also bearing in mind that it has been widely publicized that COVID-19 vaccinations are effective in preventing serious disease but they do not completely prevent infection. (18) It is therefore prudent that the moral permissibility of mandatory vaccination of HCWs be examined particularly when there is such immense pressure to vaccinate.

1.4 Thesis Statement

I will argue that even in a pandemic mandatory COVID-19 vaccination for healthcare workers in South Africa is not morally permissible.

1.5 Research Aim

To argue that mandatory COVID-19 vaccination of HCWs in South Africa is not morally permissible.

1.6 Research Objectives

These are the research objectives:

- To review information on the effectiveness and safety of COVID-19 vaccines.

- To critically evaluate the moral arguments against and for mandatory COVID-19 vaccination of HCWs using ethical theories and principles.
- To describe the professional responsibility of HCWs taking into account the law and professional duties.

1.7 Research Design

This study will be purely normative and will be library and desktop-based research.

The research will not involve any human participants and no new data will be collected. I will employ specific research methods that are applicable to philosophical research and this will involve interpretation and ethical analysis of existing literature. My critical analysis of relevant texts will include definitions, clarification of concepts, identification, and criticism of assumptions, the analysis, and evaluation of theoretical frameworks, the development of arguments and counterarguments, and the articulation of the most plausible interpretation of significant concepts found in the sources. Literature sources will include but will not be limited to research articles, PubMed, books, Google Scholar, online library sources, government legislation, and other academic search engines.

Keywords in the literature search will include the following; COVID-19, WHO, vaccine, herd immunity, vaccine hesitancy, autonomy, informed consent, greater good, justice, beneficence, non-maleficence, paternalism, public health, ethics, Hepatitis B, Nuffield Council on Bioethics, Mill's Harm Principle, public health, duty,

Intervention Ladder, Ubuntu, The Constitution, National Health Act, POPI Act, Occupational Health and Safety Act, United Nations, Siracusa Principle, Health Professions Council Of South Africa, South African Nursing Council, Emergency Use Authorisation.

1.8 Research Methodology

1.8.1 Argumentative Strategy

I will argue that although the COVID-19 pandemic has presented the world with a massive public health problem, where vaccination could provide a plausible solution, it does not make it morally permissible to implement mandatory vaccination of all HCWs. Usually, vaccines have to undergo rigorous safety and efficacy randomised clinical trials prior to registration. There is pressure to expedite the development and rollout of COVID-19 vaccines, Emergency use Access (EUA), has allowed the use of vaccines when 2 months of follow-up data is available, before the completion of clinical trials.(19) Long-term safety data and long-term immunity have not been established. In particular to South Africa, the efficacy of these vaccines against the new COVID-19 variant, Omicron is still to be determined. To address this argument I will present some scientific information about vaccines and discuss vaccine hesitancy in this circumstance.

I will make arguments to support my stance that on moral grounds it is not permissible to mandate COVID-19 vaccinations for HCWs. Before addressing the moral issues pertaining to vaccine mandates, it is important to address some

background information on public health measures, As mentioned earlier, healthcare facilities can be regarded as microcosms of the community. Therefore, it is plausible that public health approaches, such as vaccination and surveillance can be implemented within these facilities. It is common knowledge that HCWs are expected, firstly, not to cause any harm to their patients and secondly to “do their duty”, which encompasses both caring and protecting their patients. The former expectation is aligned to the principle of non-maleficence and the latter is aligned to deontology. However, Immanuel Kant also believed that humans have ‘intrinsic worth’ or ‘dignity’, meaning that humans are rational moral agents and are therefore able to make their own decisions. (20)^{pg137} Beauchamp and Childress also emphasize respect for autonomy and the importance of informed consent. (21)^{pg107} On the other hand, it can be argued that mandatory vaccination places emphasis on the achievement of the “greater good”. Does the individual autonomy and right to self-determination trump attaining the “greater good”? The African philosophy of Ubuntu may provide a solution to bridge the gap between individual rights and public health. This research will evaluate moral arguments against mandatory vaccination of HCWs as well as arguments in favour of such a policy.

I will examine the legality of mandatory vaccination of HCWs. In doing so, I will firstly look at guidelines from international organizations such as the United Nations and WHO. The Constitution of South Africa and the various laws that govern workplace policies, regulations, and practices will be explored. In addition, I will also establish whether any HCW professional bodies have issued any directives regarding mandatory vaccination.

In chapter 2, I will detail some of the latest developments around COVID-19 vaccines, which will include current data on safety and efficacy. Variants of the COVID-19 virus pose potential challenges to vaccine efficacy. I will also outline the regulatory requirements for Emergency Use Authorisation (EUA) and the registration of vaccines. I will describe the concepts of herd immunity and vaccine hesitancy and whether the safety concerns regarding blood clots and the subsequent temporary pausing of the rollout of two of the current vaccines have contributed to the non-acceptance of vaccination. Furthermore, I will discuss the practice of Hepatitis B vaccinations for HCWs as a comparison.

In chapter 3, I will describe moral arguments against mandatory vaccination and explore arguments in favour of vaccination, and present counter-arguments. Firstly, I will look at the concept of public health and comment on the report from the Nuffield Council on Bioethics on public health and vaccinations. I will evaluate Mill's Harm Principle in relation to mandatory vaccinations. I will highlight how mandatory vaccination of HCWs is a public health strategy and is a form of paternalism. I will address the concern of autonomy and informed consent using Kant's Deontology moral theory and Beauchamp and Childress's principle of autonomy and informed consent. The principles of non-maleficence, beneficence, and justice in this context will also be interrogated. The Utilitarian approach to achieving the "greater good" will be described and counterarguments to this moral theory will be put forward. Finally, I will explore the African philosophy of Ubuntu in relation to the mandatory vaccination of HCWs.

In chapter 4, I will illustrate that there are legal key points that need to be considered by institutions that wish to mandate the vaccination of HCWs. Autonomy and informed consent are constitutional rights in South Africa. (22) Section 36 of the Constitution, which allows for restriction on autonomy, will be mentioned. Informed consent is important in the National Health Act No 61 of 2003 (NHA). (23) I will discuss the Occupational Health and Safety Act 85 of 1993 (OHSA) in this context and the new directive. (24) I will also show how compliance with the Protection of Personal Information Act of 2013 (POPIA) will be problematic for mandatory vaccination. Finally, I will look at the pertinent rights and responsibilities of HCWs and establish whether any of the health professional councils have issued any directives regarding mandatory vaccinations.

1.9 Limitations

COVID-19 is a new disease and the current information regarding vaccinations is limited, however, this field is evolving at a tremendous pace, therefore, it is important to note that certain information may have changed since this report was submitted

1.10 Ethics

This is a purely normative research report therefore an ethics certificate is not required.

CHAPTER 2: An Overview of COVID-19 Vaccines

Historically, vaccine development took several years, requiring intensive follow-up to determine safety and efficacy. Under normal circumstances, several candidates are tested but because the potential for failure is high, pharmaceutical companies usually elect to pursue development in a linear fashion, allowing several data analysis pauses to establish safety and efficacy. However, urgent vaccine development requires processes to be conducted in parallel and this can be financially very risky for vaccine developers. (25) Nevertheless, the latter method was adopted for the development of COVID-19 vaccines.

Clinical trials are research projects that evaluate the effectiveness of an intervention in people. These interventions can be medical, surgical or behavioural. Testing a vaccine for safety and effectiveness has to be done through a clinical trial. Testing for safety requires monitoring for any undesirable effects caused by the intervention. Effectiveness or efficacy refers to the ability of the intervention to achieve the intended results. (26) A Data and Safety Monitoring Board, which is an independent group of experts, periodically review the data for safety and efficacy. Based on these reviews this board can make recommendations regarding continuing or terminating a clinical trial.(27) There are four phases to clinical trials, where phase I determines the safety of the intervention as well as the correct dose of the intervention within a small group, in phase II trials, the emphasis is more on the effectiveness of the intervention in a larger group. Phase III trials concentrate on both safety and effectiveness in a much larger group and it is at this stage, if the results are

favourable, the intervention can be registered. Phase IV occurs post approval where safety and effectiveness are monitored in diverse populations. (26) The first candidate, the Moderna vaccine phase 1 trial was started on the 16th March 2020, just 10 weeks after the first genetic sequence of the virus was determined. Several other vaccine candidates followed soon thereafter. (25) On the 24th of September 2020, more than 200 vaccines were in pre-clinical development and 43 in clinical trials. (28)

In this chapter, I will give a description of EUA and some of the regulatory processes required for the registration of vaccines. I will review the current information available on their safety as well as efficacy including the challenge of variant development. The issue of vaccine hesitancy will be explored. I will also elaborate on herd immunity as a public health measure. The chapter will conclude with a discussion using the example of Hepatitis B vaccination of HCWs, to determine whether such a strategy for COVID-19 will be feasible.

2.1 Emergency use Authorization and regulatory requirements for vaccine rollout

The United States Food and Drug Administration (US FDA) is a globally recognised body that reviews the data from clinical trials from both a safety and efficacy perspective before approving the use of any medical product. (29) EUA allows for use of medical interventions, such as vaccines, in emergency situations that are life-threatening. However, the use of this mechanism requires certain specific criteria to be met and that includes not having any approved alternative available. (30) A few

vaccines have received EUA from the US FDA. Usually, the US FDA requires 6 months' worth of safety data for the licensure of a vaccine. However, the US FDA has recommended that data from ongoing phase III clinical trials, which have enrolled more than 3000 participants and have at least 2 months of follow-up data, post-vaccination, can be submitted for EUA. (19) It is also a requirement under EUA for continual active safety data collection that includes tracking of the number of hospitalizations and deaths. (30) The Pfizer Biontech vaccine has received full approval from the US FDA in August 2021. (31) The application of EUA does pose ethical questions about the use of vaccines that are not fully registered as long-term data regarding safety and efficacy are still being established.

In South Africa, the emergency use of vaccines also requires approval from the South African Health Products Regulatory Authority (SAHPRA). This regulatory body will conduct its own review of the data presented to them by the applicant or manufacturer of the vaccine. EUA has made it possible for vaccines to be rolled out prior to the completion of the clinical trials. Long-term safety and efficacy have not been established so continual monitoring post-EUA by regulatory bodies are of paramount importance. This highlights the fact that there are several unanswered questions related to these vaccines and this weakens the argument for mandatory COVID-19 vaccination of HCWs.

2.2 Safety and efficacy of vaccines

Although data regarding safety and efficacy is continually being updated, it will be a while before reliable long-term data becomes available. The first clinical trial, the Moderna phase 1 trial only started in March 2020, so long-term side effects and duration of immunity are still to be determined. Short-term safety concerns regarding the development of blood clots were raised with both the Astra-Zeneca and Johnson and Johnson vaccines. Blood clots can lead to the development of heart attacks and strokes. (32) As a result of this, in the United Kingdom, people below the age of 40 years are being offered an alternative to the Astra-Zeneca vaccine because the safety data revealed a higher incidence of blood clots in younger people. (33) It is evident that there is a need for vaccine administration guidelines to be flexible and this creates uncertainty around the safety of vaccines.

As new variants of the COVID-19 virus develop, the efficacy of the current vaccines will always be questioned. In South Africa, the Astra-Zeneca vaccine showed decreased efficacy against the Beta variant. (34) South African HCWs were offered the Johnson and Johnson vaccine under an open-label phase III trial called Sisonke. An open label trial means both the participants and the healthcare providers know what the participant is receiving. (35) Data released by the company on the 1st July 2021 showed that a single dose of the vaccine was active against the Delta variant. (36) However, since then questions have been raised regarding the maintenance of

vaccine-induced immunity and booster doses are now recommended. (37). If that is the case then previously vaccinated HCWs may have a false sense of safety as breakthrough infections do occur post-vaccination. The emergence of variants may create concern about which vaccine should be administered or whether HCWs should be given a combination of different vaccines. Comparisons of the efficacy of the various vaccines are continually being released creating much confusion about which vaccine is the right vaccine. These concerns cannot be addressed as yet because we simply do not have the data. These uncertainties can contribute to scepticism regarding vaccine mandates.

A breakthrough infection is defined as a positive COVID-19 test 14 days or more after an individual has been fully vaccinated. (18) According to a report from the Center of Disease Control (CDC), the majority of these infections are asymptomatic or mild, however, a smaller percentage (10%) had more severe disease requiring hospitalization and 2% resulted in death. These breakthrough infections have been attributed to the development of variants. HCWs are at a higher risk of developing breakthrough infections simply because of the high exposure in healthcare facilities. Therefore, if the majority of breakthrough infections are asymptomatic, HCWs will pose a risk to their patients, colleagues and, families because they may unknowingly spread the infection. (18)

With all these uncertainties regarding the long-term safety and sustained immune responses to the COVID-19 vaccines and the risk of breakthrough infections, it is clear that the use of personal protective equipment (PPE) is still a very important

mitigation measure. Whether HCWs are vaccinated or not they would still have to take extra precautions and make use of PPE.

2.3 What is vaccine hesitancy?

Vaccine hesitancy is defined as a “delay in acceptance or refusal of vaccination despite availability of vaccination services.” (38) Reasons for vaccine hesitancy are numerous, the most important being the safety of the vaccine. (39) Other important factors that promote hesitancy are inequalities in health services and socioeconomic status. Racism has also been cited as a reason. In addition, misinformation and conspiracy theories also play a role. HCWs are a source of information for the public and their acceptance of vaccination sends out positive messages regarding vaccination. (39) This places pressure on HCWs because information regarding the safety of COVID-19 vaccines is evolving and they themselves do not have all the answers.

Research has also suggested that when there is insufficient knowledge about the safety of vaccines there is a tendency for individuals to formulate opinions based on their experience with other vaccines. An example of this was the Pandemrix vaccine that was developed to prevent swine flu in 2009. In Finland, there was much debate whether this vaccine caused narcolepsy (a sleeping disorder) and it is believed that this subsequently resulted in vaccine hesitancy not only to the swine flu vaccine but also to standard flu vaccines. (40)

2.4 Herd immunity

WHO uses Acheson's definition to explain the concept of public health, which is, "the art and science of preventing disease, prolonging life and promoting health through the organized efforts of society." (41) Vaccination programmes have been regarded as one of the most successful public health interventions for the prevention of certain infectious diseases. The worldwide eradication of smallpox and more recently polio can be attributed to successful vaccination programmes. Vaccination not only protects the individual but also confers protection to the community provided a large proportion of the community is vaccinated. This concept is called 'herd immunity'. (42) The 'herd immunity threshold' is the percentage of the population that should have immunity in order to confer protection, generally, this is between 70% to 90% of the population. However, an important factor that has to be taken into consideration is the duration of the immunity. (43) At present, we are uncertain about the longevity of immunity post- COVID-19 vaccination. If immunity does not persist, herd immunity will not be achieved. Results from a study conducted in Israel showed waning immunity six months after vaccination with the Pfizer Biontech vaccine. (44) This has sparked debate regarding the administration of booster doses. The question then arises as to whether HCWs and subsequently their patients and families are adequately protected with these vaccines.

2.5 Hepatitis B vaccination for HCWs as a comparison

Hepatitis B infection is highly contagious and HCWs are at very high risk of being infected through blood and bodily fluid exposure. The risk for infection is believed to be 100 times more than the risk of HIV from a needle-stick injury. The Hepatitis B vaccines were initially developed in 1982 and there are several years of data available proving their safety and efficacy. These vaccines are 94.98% effective and provide protection for up to 20 years. (45) In South Africa, HCWs are expected to be vaccinated against Hepatitis B, and these vaccines are made available for HCWs when they are undergoing training. Although immunity post-vaccination is long lasting, the South African National Department of Health recommends that HCWs receive booster doses every 5 years. (46) In a study conducted by Khan et al, it was noted that Hepatitis B vaccination rates were low amongst HCWs. (46) Low rates of Hepatitis B vaccination were also confirmed by another study conducted by Burnett et al, which showed that only 19.9% of HCWs in Gauteng had been fully vaccinated. (47) It is interesting to note that although there is much data available about the long-term safety and efficacy of these Hepatitis B vaccines, together with the recommendation from the South African National Department of Health, that all HCWs get vaccinated, the uptake of these vaccines has not been successful. (47) In light of the fact that we do not have robust information about COVID-19 vaccines when compared to the Hepatitis B vaccine it is very likely that mandating COVID-19 vaccines for HCWs will be bound to be a failure, unless HCWs are threatened with some sort of sanction if they are not compliant. This point will be explored further in the next chapter.

In this chapter, I have illustrated that long-term safety and efficacy data regarding COVID-19 vaccines are lacking. The emergence of variants and breakthrough infections complicate matters. Whether “herd immunity” would be attainable is also questionable. Bearing this in mind, mandatory vaccination may result in HCWs becoming complacent about mitigating measures and thereby posing increased risk to patients and other people that they interact with. Information is evolving at a tremendous pace requiring guidelines to be flexible and this often results in confusion. Fear of the unknown, personal beliefs and misinformation add another dimension to the situation. All of these factors may contribute to vaccine hesitancy amongst HCWs. The poor compliance to Hepatitis B vaccination despite the fact that it is highly recommended and very effective, is proof that new vaccines with limited data will not necessarily result in good compliance. It would be very naïve to assume that all HCWs would automatically accept COVID-19 vaccinations. They too are grappling with unanswered questions. As it stands, our current body of knowledge regarding COVID-19 vaccination is by no means complete and therefore, mandatory vaccination of HCWs cannot be justified.

CHAPTER 3: An evaluation of the Morality of Mandatory Vaccination

The source for the moral dilemma regarding mandatory vaccination of HCWs is the discord between public health ethics and the rights of the individual. A healthcare facility can be viewed as a microcosm of a community where measures to prevent or curb the spread of infectious diseases can be regarded as a public health measure. The development of herd immunity as a result of vaccination in the context of a healthcare facility drives the argument for mandatory vaccinations. However, the European Union Asset project showed that mandating vaccines did not automatically increase vaccination rates. (48)

In this chapter, I will elaborate on the concept of public health and touch on the report from the Nuffield Council on Bioethics on public health and vaccinations. The Intervention Ladder will be discussed in this context. There will be a discussion on how public health is a form of paternalism. Mill's Harm Principle will be discussed in the context of healthcare facilities adopting mandatory vaccinations as a public health strategy. In addition, I will also explore how vaccine mandates as a public health policy is supported by the Utilitarian stance of "for the greater good", for which I will present counterarguments. I will argue that mandating vaccination of HCWs is morally unacceptable as it is a violation of autonomy and the principle of informed consent. There will be a discussion on the principles of non-maleficence,

beneficence, and justice and how these principles can be used to argue against mandating vaccinations. Ubuntu philosophy in this context will also be examined.

3.1 Public Health

The main focus of public health is the health of the population. Winslow as cited by Grant defined public health as the “science and art of preventing disease, prolonging life and promoting physical and mental health and well-being.” (49) Public health involves several disciplines such as engineering, environmental sciences, and biological sciences. The main aim of public health is the prevention of disease and the promotion of good health. Several different mechanisms ranging from vaccinations to urban design are employed in order to protect the public from disease. (50) It is well known that globally, immunization programmes have led to the eradication of diseases such as smallpox as well as the decrease in the number and seriousness of infections such as measles and chickenpox.

Before developing any public health program, policymakers should conduct assessments of the health of the population through data collection and analysis and thereafter provide assurance that the services to protect the health of the public are available for all. (51) Healthcare facilities or governments may choose to mandate the vaccination of HCWs as a public health policy. However, this plan is problematic because although these COVID-19 vaccines have been shown to reduce infections they do not prevent infection. It is, therefore, still a requirement for healthcare facilities to have proper infection control measures in place such as the use of PPE,

sanitizing, and social distancing. Mandating vaccination may prove to be counterproductive for HCWs by adding to the burden of stress that they are already experiencing while working during the pandemic. (52)

It is also important to note that the aim of vaccination is to obtain herd immunity. It will be extremely difficult to attain herd immunity because globally people are very mobile and there is a huge disparity in the rates of vaccinations administered in different parts of the globe, particularly in developing countries. The situation may be exacerbated now that several of the travel bans have been lifted. There was much publicity regarding South Africa being removed from the “red list” for travel to the United Kingdom. It is a well-known fact that richer countries have greater access to vaccines compared to poorer countries. So although strict travel restrictions were initially instituted throughout the world there was still some movement of people. The spread of the Delta variant of the COVID-19 virus, which was originally identified in India, is a case in point. The stricter travel restrictions that were in place at that time did not prevent this variant from spreading relatively quickly to South Africa. I have also detailed earlier how the development of variants and the uncertain longevity of immunity post- vaccination will also influence herd immunity.

3.2 The Nuffield Intervention Ladder

The Nuffield Intervention Ladder, broadly speaking is based on Mill’s understanding of liberty as outlined in his essay, “On Liberty”, and provides guidance on the balance of public health measures versus the impact these measures have on

individual freedom. According to the Nuffield Council of Bioethics, the ‘least intrusive’ public health programmes are ideal. The idea is to start at the lowest rung of the ladder and work up the ladder with the intention of finding the least restrictive measure. The rationale for more stringent measures higher up on the ladder will need justification. The table below illustrates the different levels of the Nuffield Intervention Ladder.

Eliminate Choice	Compulsory isolation of persons with infectious diseases
Restrict Choice	Restrict options with the aim of protecting people
Guide Choice- Disincentive	Fiscal or other disincentives to discourage people from certain activities
Guide Choice- Incentive	Fiscal or other incentives to encourage certain activities
Guide Choice- Change in default policy	Provision of healthier options as a standard
Enable Choice	Enable people to change their behaviour
Provide Information	Provide education and information about vaccines
Do nothing, just monitor	

Adapted from the Intervention Ladder of the Nuffield Council of Bioethics (12)

Firstly, if the Intervention Ladder is followed, widespread dissemination of information and education is the first step. If HCWs are provided with educational material there may be no need to implement mandatory vaccination policies for HCWs. (53) Secondly, according to the Nuffield Council of Bioethics, a disease has to be very contagious and very serious to warrant very strict measures. (12) COVID-19 is contagious but it is not classed as a serious disease because the case fatality rate is low, at around 1.6%, this is because the vast majority of people infected do recover from the infection. (54) According to the Intervention Ladder, it is evident that mandating vaccinations of HCWs in healthcare facilities as a form of public health strategy will be tricky as it cannot be fully justified.

Public Health is often associated with the Utilitarian philosophy, which I will discuss later in this chapter.

3.3 Paternalism

Paternalism as defined by Buchanan, “is the usurpation of decision-making power, by preventing people from doing what they have decided, interfering in how they arrive at their decisions or attempting to substitute one’s judgment for theirs, expressly for the purpose of promoting their welfare.” (14) Mandating vaccinations of HCWs as a “public health” strategy is a form of paternalism as it places the policymakers in a position to make decisions on behalf of HCWs. The morality of such an action is questionable as it gives the impression that policymakers know

better and therefore have the right to make decisions on behalf of the HCWs. In addition, paternalism also infringes the “autonomy” of the individual. (21)^{pg214} It will undermine the ability of HCWs to make their own decisions regarding what they are willing to expose themselves to. Bearing in mind that vaccines are not inert substances. These HCWs are fully capable of making their own decisions regarding what they view is in their own best interests. This type of scenario has the potential to create discord between policymakers or employers and HCWs.

Beauchamp and Childress affirm that paternalism may employ forms of “deception” and “coercion” in forcing individuals into making decisions. (21)^{pg 215} Using deceptive or coercive methods once again will lead to a breakdown in trust between HCWs and their employers. Not to mention such a strategy will only compound the stress levels of an already overwhelmed workforce.

Another ethical concern of a paternalistic approach is the creation of stigmatization. Whose responsibility will it be to keep track of which staff members have been vaccinated? HCWs who choose not to be vaccinated run the risk of being confronted or discriminated against if other staff members learn about their decision not to vaccinate. HCWs may fear that other medical conditions that they may suffer from may become exposed during such an exercise and this could lead to further stigmatization.

The paternalistic approach makes the assumption that because HCWs are working in the healthcare sector they are all comfortable with being vaccinated against

COVID-19. It is not unreasonable that they too may have questions about the long-term safety and efficacy of these vaccines. Engagement and understanding may be more useful than a one-sided paternalistic approach.

3.4 Mill's Harm Principle

In his essay, "On Liberty", John Stuart Mill explores the conflict between the power of authority and individual liberty or freedom. According to Mill, individuals have a right to make their own decisions. However, he endorses the Harm Principle, which states that the only time it is justifiable to infringe on an individual's liberty, without their consent, is when such an action will prevent harm to others. (55) This stance supports a public health strategy. However, this does not justify causing harm to an individual, in this case, the HCW. Forcing individuals to accept vaccination may have deleterious physical and mental health consequences. In a review article by Biwas et al, 22.51% of more than seventy-six thousand HCWs were hesitant to be vaccinated because of concerns related to the safety, side effects, and efficacy of these vaccines. These concerns are very similar to the concerns expressed by the general population. (56)

The Harm Principle stipulates, the rights of the individual can be restricted to avert harm to others, however, HCWs can prevent "harm" to patients, family, and other people that they may be in contact with by using PPE and adhering to infection control practices. HCWs are not the only source of COVID-19 infections, patients can also acquire infection from other sources such as other patients. Mitigating

measures are still required as none of the vaccines are a hundred percent protective. Application of Mill's Harm Principle in this context will be problematic.

3.5 Utilitarianism

The Utilitarian perspective can be summed up as “the greatest happiness of the greatest numbers”. An action is therefore deemed to be the “right action” if it produces the “most good”. For the Utilitarian the consequences of an action are more important, meaning “the end justifies the means”. (20)^{pg112} This approach supports the notion of mandatory vaccination of HCWS, in that the greater the number of HCWs vaccinated the greater the protection from infecting their patients, family members, and acquaintances. This ties in with the concept of herd immunity. However, as mentioned earlier HCWs are not the only source of infection. The vast majority of COVID-19 infections are acquired within communities rather than at healthcare facilities.

According to Giubilini, “a utilitarian approach supports a moral obligation to be vaccinated unless the individual cost of being vaccinated would be so great as to outweigh the expected negative contribution of non-vaccination to the aggregate wellbeing of others.” (11) It can be argued that when compared to vaccines such as the measles vaccine, which has been in use for several decades, and much data is available regarding its safety, the side effects and safety issues of COVID-19 vaccines are still being established. It has come to light that vaccines such as the Moderna and Pfizer vaccines have been associated with the development of

myocarditis and pericarditis post-vaccination. (57) These are serious and potentially life-threatening side effects and will be a tremendous “cost” for any individual to bear. Therefore, although these side effects may occur infrequently, they still pose a potential risk to the individual HCW. It is not possible to predict who will experience such serious side effects. This would imply that according to Giubilini’s description of a utilitarian approach, which takes individual cost into consideration, the Utilitarian argument for mandatory vaccination might be flawed.

Mandatory vaccination may create a false sense of protection for HCWs resulting in them being expected to work in more hazardous situations because of their presumed protection. This may be very likely to occur in institutions where protective measures such as PPE may be in short supply.

In addition, using the Utilitarian argument to implement mandatory vaccination of HCWs also undermines the principles of autonomy and informed consent. Both of which are important pillars of medical ethics. These principles will be discussed next in this chapter.

3.6 Autonomy and Informed Consent

The word “autonomy” is Greek in origin, “auto” meaning “self” and “nomous” meaning “rule”. (21)^{pg101} Beauchamp and Childress go on further to describe three conditions that have to be met for an action to be autonomous, namely, “intentionality”, “understanding” and “noncontrol”. The third condition, “noncontrol”,

means an act should be voluntary and not subjected to other influences or coercion. (21)^{pg101} Forcing HCWs to vaccinate breaches this condition and therefore infringes on their ability to act autonomously. The principle of respect for autonomy recognizes that individuals have rights regarding their opinions and decision-making. This means autonomous individuals, such as HCWs, should be able to give informed consent for any procedure or intervention. Mandating vaccination takes away the HCWs' ability to provide informed consent. It also exposes them to the risk of potential adverse reactions and side effects.

Immanuel Kant said humans have "intrinsic worth" and have the ability to make their own decisions. People should be treated "as an end and never as a means only". Thus, we should "respect their rights", avoid "harming them" and "never use people to achieve our goals no matter how good those goals are."(20) ^{Pg139} Firstly, according to Kant, HCWs have a right to act autonomously, so if a HCW declines a COVID-19 vaccination, this right should be respected. Secondly, COVID-19 vaccinations are not inert and can cause adverse reactions, in other words, they can cause harm. Thirdly, in terms of using people for our own benefit, the motivation of healthcare institutions for mandating vaccination of their employees should be interrogated. Is it solely to protect patients or is it to protect their own interests in terms of marketing themselves as "safe" facilities?

On the other hand, Deontologists may argue that HCWs have a "duty" to protect their patients. However, this argument cannot be justified, as vaccinations are not completely protective in preventing infections so protection of the patient is not

guaranteed. In addition, the risk of adverse reactions related to the vaccine has to be considered. It makes no sense that HCWs are expected to be morally obligated to “do the right” thing at the expense of exposing themselves to potential harm when there are other safe ways of protecting patients such as the proper use of PPE.

The expectation for HCWs to their “duty” may result in them being expected to work in more hazardous situations because of their presumed immunity following vaccination. This immunity as we know is not totally protective. As stated earlier, this type of risky action may very well occur in institutions where protective measures such as PPE may be in short supply. (10) HCWs have demonstrated their dedication to their patients and their work, in other words, they have been “doing their duty”. Globally, during this pandemic, there has been much publicity regarding HCW fatigue as a result of them having to fulfil their duty towards their patients. However, their duty to care for their patients should not be assumed to be limitless. A vaccination mandate assumes their duty is unlimited.

3.7 Principle of Justice

This principle deals with the concept of “fairness”. Distributive justice as defined by Beauchamp and Childress is the “fair, equitable and appropriate distribution of benefits and burdens determined by norms that structure the terms of social cooperation”. (21)^{pg250} This principle would therefore support mandatory vaccinations of HCWs because it would benefit those that are disadvantaged and therefore at risk of being infected such as immunocompromised patients. (58) This simply means that

it would be unfair for non-vaccinated HCWs to treat patients that are at high risk of being infected. This is not entirely correct as it has been established that the vaccines do not confer a hundred percent protection. Furthermore, it was widely publicised that France suspended 3000 unvaccinated HCWs without pay. (59) It can be argued that this action is a violation of the principle of justice because it places the very patients that are dependent on the services of these HCWs at a huge disadvantage.

The principle of justice also encompasses the concept of “rights-based justice” which refers to the respect for an individual’s rights and that includes the right of a HCW to refuse vaccination. (58) It is apparent that applying the justice principle in the case of a mandate will be problematic.

3.8 Non-Maleficence and Beneficence

The principle of non-maleficence compels HCWs to “first do no harm”, that is, refraining from any action that can cause harm. Beneficence on the other hand is the “moral obligation to act for the benefit of others”. These actions should “prevent harm”, “remove harm” and “promote good”. (21)^{Pg204} HCWs are expected to provide care that benefits patients and at the same time ensure harm is either prevented or minimised. It is thought that unvaccinated HCWs may pose a threat as a source of infection to their patients, in other words, they may harm their patients. This notion is flawed as mandating vaccination of HCWs will not remove the potential for harm because vaccinated individuals can also be a source of infection. Once again the

arguments that patients can be exposed to infection from other sources and the lack of complete protection provided by the currently available COVID-19 vaccines can be used in support of not making vaccines mandatory for HCWs. Potential harm is not removed with vaccine mandates.

Beneficence requires protecting the wellbeing of patients. However, this cannot be justified if it places the HCW at risk. Beneficence does not mean protecting patients from harm at the expense of the safety of HCWs. Mandatory vaccinations may expose HCWs to unnecessary adverse effects; it may also give them a false sense of full protection which could result in them taking unnecessary risks. In addition, the emotional harm that mandatory vaccinations may cause such as unnecessary stress of being forced to do something against one's will, the fear of stigma, the fear of losing one's job. All of which can lead to a breakdown in trust between the HCWs and the employers. It will be very difficult for disgruntled HCWs to look out for the wellbeing of patients if they feel victimized.

3.9 The Philosophy of Ubuntu

This African philosophy was described in a review article by Ewuoso et al as “as an essentially relational ethics that prizes relationships of interdependence, fellowship, reconciliation, relationality, community friendliness, harmonious relationships and other-regarding actions, in which actions are morally right to the extent that they honour the capacity to relate communally, reduce discord or promote friendly relationships with others and in which the material world (horizontal line) and the

spiritual world (the vertical line) are fundamentally united.” (60) It would appear that the Ubuntu philosophy places prominence on the wellbeing of the community which contrasts with the Western view that places importance on autonomy. (61) As Sambala et al states, “reasoning using Ubuntu builds on the idea that individuals should act to protect others.” (15) This would indicate that the Ubuntu philosophy should be in agreement with mandating vaccinations because it values the wellbeing of the community. However, Behrens goes on to propose that in the context of African philosophy, the principle of autonomy should be replaced with “respect for persons”. (61) This means fully informed individuals have the right to make their own decisions provided they do not impact on the wellbeing of others. (62)^{pg46}

According to Sambala (15), individuals will be less accepting of an intervention if it appears unfair. Concerns regarding confidentiality and paternalism are also raised for consideration. If the moral capabilities of policymakers are questionable, particularly where the emphasis is placed on outcomes and human rights are ignored this may result in resistance. He goes on to say Ubuntu values autonomy and respect. The essence of Ubuntu is the connection between a person and the community. “A person can be a person only through others.” An individual views himself or herself as part of a whole and decisions are made within that context. Therefore, within the Ubuntu framework individuals will agree to vaccinate not only for their own benefit but because they feel it will benefit others. Importantly, Ubuntu encourages dialogue and engagement, so there is a flow of information. The aim is to create a sense of solidarity where both the needs of the individual, in this case, the HCW, and the needs of “community”, within the healthcare facility, are realised. (15) This way of thinking would therefore avert the need for vaccine mandates.

In this chapter, I have presented moral arguments that support the stance against mandatory COVID-19 vaccination of HCWs. Although it appears that public health policies and Utilitarianism may support the need to mandate HCW vaccinations, I have demonstrated that these arguments are weak in this context. The principles of justice, non-maleficence, and beneficence can be used to justify the argument against compelling HCWs to vaccinate. It is unreasonable to assume that being bound to do their duty and doing what is in the best interest of their patients should come at the expense of the HCW's own physical and mental wellbeing. I have argued that HCWs also have a right to bodily integrity and which entitles them to make autonomous and informed decisions regarding what is injected into their bodies.

A common thread through most of the moral arguments presented against mandatory vaccination is the unwanted consequences such as unpleasant short and long-term side effects, lack of total protection, uncertain sustained immunity, all of which can result in unnecessary stress, stigma, discrimination, a breach in trust and possible risk of job loss. Aside from the impact on the HCWs, the negative repercussions the patients would have to endure from such action should also be considered. HCW shortages cannot be afforded during pandemic conditions. Applying the philosophy of Ubuntu may be a more successful tool in avoiding mandating vaccination of HCWs.

CHAPTER 4: Guidelines, Laws and Professional Responsibility

As the rollout of COVID-19 vaccines gains momentum in South Africa, there is much debate regarding mandating vaccinations particularly in the workplace. Some private companies have made public their intention to make COVID-19 vaccination mandatory for their employees. Although, as mentioned in earlier chapters, countries such as Italy and France have mandated COVID-19 vaccination of HCWs. Thus far, in South Africa mandatory vaccinations have not been imposed on all HCWs.

In this chapter, I will initially look at recommendations from the United Nations regarding rights and restrictions. The recommendations from WHO regarding mandating vaccinations will be explored. I will then look at the question of mandatory vaccination in South Africa paying specific attention to Section 12 and Section 36 of the Constitution. Provisions made by the NHA will be reviewed. There will be a discussion on the new directive gazetted on the 11th June 2021 by the minister of employment and labour regarding COVID-19 vaccinations in the workplace. The implications of mandatory vaccination with respect to the POPIA will be described. Lastly, the rights and responsibilities of HCWs as well as any guidelines or directives from HCW professional councils about mandatory vaccination will be discussed.

4.1 United Nations and WHO guidelines

The Universal Declaration on Human Rights was proclaimed in 1948 and states that every person has equal dignity and rights that should be respected. It also goes on

to say that, no person should be exposed to discrimination. (63) South Africa is a signatory to the Declaration of Human Rights and it is entrenched in the Constitution.

(64)

The Siracusa Principle was adopted by the United Nations in 1985, it provides that any restrictions placed on human rights must be based on law, absolutely necessary, least restrictive, based on scientific evidence, and should not be discriminatory. (65) Looking at these provisions the criteria to mandate vaccinations of HCWs will not be met. Firstly, there is currently no law in South Africa that explicitly mandates vaccinations. More details regarding the laws of South Africa will be discussed later in this chapter. Secondly, mandated vaccination is not absolutely necessary if other mitigating measures are adhered to. Lastly, compelling HCWs to vaccinate could lead to discrimination from employers and other employees.

The WHO encourages HCWs to get vaccinated but is not in favour of the mandatory vaccination of HCWs. Although their work environment places them at high risk, WHO insists that any institution wishing to mandate vaccination has to take into consideration ethical implications, such as “necessity and proportionality.” (66) This means it should be determined whether it is absolutely required and that the risks and benefits have been considered. Mandates interfere with autonomy and should only be considered if absolutely necessary. The issue of a breakdown in trust between HCWs and their employers is also mentioned in the policy. This in turn could lead to further resistance to vaccination. The WHO policy also goes on to say, vaccine mandate strategies may place unnecessary stress on HCWs, as individuals that are not vaccinated may be asked to stay at home or may be transferred to other

departments. The consequences of such action could result in a shortage of capable staff where they are most needed. This will obviously have a major negative impact on the care of patients. (66)

4.2 Legal considerations in South Africa

According to section 12 (2) of the South African Constitution, every person “has the right to bodily and psychological integrity, which includes the right to make decisions concerning reproduction, to security in and control over their body and not be subjected to medical or scientific experiments without their informed consent.” (19) This means individuals have a right to make decisions regarding treatment options available to them and this includes the right to refuse any treatment including vaccinations. The process of informed consent is vital in the Constitution. The NHA affirms the importance of informed consent in the health setting. (23) Globally, data regarding safety and long-term effectiveness is continuously being collected because this is uncharted territory. It is therefore quite understandable that individuals have doubts and questions about these vaccines. Bearing this in mind, some people may feel that agreement to be vaccinated at this stage when there are still several unanswered questions may amount to them being part of an “experiment”. The whole debate surrounding the use of booster doses of vaccines adds to the confusion. Is a booster dose necessary? Which vaccine should be used to boost? In order to maximise benefit, what should the timing of the booster dose be? Too many questions with no concrete answers.

Posts on social media platforms also contribute to the confusion by fuelling misinformation. The government taking charge of the vaccination procurement and distribution, the initial delays in procuring vaccines, and the confusion surrounding the efficacy of the AstraZeneca vaccine which the government originally procured, has created an environment that has contributed to vaccine hesitancy. It is therefore not unreasonable for people to question the motivation for mandatory vaccinations. Employees/ HCWs on the basis of the Constitution have a right to consider all the information available to them before providing informed consent.

Section 10 of the Constitution goes on to state that every person has “inherent dignity” which has to be respected. So compelling HCWs to be vaccinated can be viewed as a violation of their right to dignity. (22)

Also noteworthy, section 36 (1) of the Constitution allows rights within the Constitution to be limited provided that the “limitation is reasonable, justifiable and least restrictive in a society that values human dignity, equality, and freedom.” The public health principle is known as the “principle of least restrictive alternative” also reiterates the importance of policies being the “least intrusive of personal rights and freedoms.”(67) It allows individuals to maintain their autonomous rights. This principle expects policymakers to make decisions that least impact the autonomy of individuals. Therefore, in the scenario of vaccination programmes, the best method to achieve herd immunity would be the least coercive method. According to Allen as cited by Bester, coercion can result in the development of more organised resistance. Meaning that coercion could quite possibly be counterproductive. Bester

cites two examples from Allen where this has occurred. Firstly, in 1871 Britain introduced harsh penalties for vaccination refusal, however, these penalties had to be abandoned in 1948 due to the development of more organised resistance to vaccination. Secondly, it is thought that the stringent vaccination laws in the United States of America have forced the anti-vaccination movement to change from a passive resistance movement to a more defiant and well-oiled movement. (68)

Vaccination mandates are a form of coercion that cannot be dismissed as the least restrictive measure. It will undermine the autonomy of HCWs and will create an atmosphere of mistrust. HCWs may feel threatened because they may feel their refusal of mandatory vaccination would lead to them being dismissed. Could such a scenario be regarded as constructive dismissal? This would have to be tested in the labour courts. Such an approach clearly undermines the dignity of HCWs and is by no means “reasonable or justifiable.” Furthermore, South Africa is plagued by shortages of HCWs; we cannot afford to lose more HCWs due to unfair labour practices. Section 23(1) of the Constitution, explicitly states that individuals have a right to fair labour practice. (22)

According to Dhali, the NHA requires informed consent to be obtained when a healthcare service is provided to an individual unless a law or court order overrules it or in the event there is a threat to public health. (69) Firstly, from a legal perspective, the need for informed consent stands, the South African Government has not mandated vaccination of HCWs. Secondly, the threat of COVID-19 to public health can be averted by the use of other mitigating mechanisms such as the use of PPE.

This is a non-invasive method to curb the spread of the disease and may be more acceptable to those HCWs that decline vaccination, whatever their reasoning, be it religious, cultural or even opinion. A reason for religious objection is the use of foetal cells derived from previous abortions in the development and manufacture of COVID-19 vaccines. Therefore, it is understandable that any HCW who is opposed to abortion on religious grounds may have an issue with receiving a vaccine. (70) It goes without saying that the religious and cultural beliefs, of individual HCWs must be respected as these are constitutional rights as stated in section 12 (1) of the Constitution. (22)

On the 11th June 2021, the employment and labour minister gazetted a directive regarding vaccination in the workplace. Importantly, this directive does not call for mandatory vaccination, however, it expects employers to be responsible for making analyses and thereby ensuring a safe environment for employees and any other individuals that may be at risk. This is a requirement for being compliant with the OHS Act. (71) It also stipulates that the Constitutional rights of employees, which include the right to “bodily and psychological integrity” and the right to “freedom of religion, belief, and opinion”, should not be violated. (69)

Vaccinations by themselves do not provide a hundred percent protection and can therefore not guarantee a hundred percent safe environment. Certain HCWs may be more vulnerable to infection because of their own medical conditions. Compliance with this directive will require a balancing act from the employers. The directive does not advise employers on the course of action should employees refuse to be

vaccinated. There is also no guidance as to whom will take responsibility should an employee experience a life-threatening side effect. This begs the question as to whether healthcare institutions, particularly private institutions, can afford to take such risks. Essentially the government has placed the ball in the court of employers.

In applying mandatory vaccination of HCWs the provisions of the POPIA will have to be taken into consideration. (72) Personal information regarding medical conditions and proof of vaccination fall under the protection of the POPIA. In order to obtain this information, informed consent will need to be obtained from HCWs. It could very well be the case that some HCWs may not be comfortable disclosing any of their personal information, which includes medical conditions that they may be suffering from. For instance, it is quite understandable that HCWs who are HIV positive may find it very distressing that their HIV status may become exposed. This creates unnecessary stress in a workforce that is already under immense pressure.

Once again it will be the responsibility of the employer to ensure that this personal information is kept confidential. Another question to consider, which staff members will be responsible for maintaining these records? These staff members have to be trustworthy. Information regarding HCWs that have declined vaccination on religious or medical grounds, must not become common knowledge since there may be a risk that such individuals find themselves victims of discrimination and stigma in the workplace. Section 9 of the Constitution stipulates individuals have a right not to be unfairly discriminated against. (22)

In an article published, by Abdool Karim, she states that COVID-19 vaccinations can be made mandatory, firstly, because COVID-19 is a notifiable disease in South Africa and secondly, the regulations under the state of disaster that was announced in March 2020 will support such a mandate. However, both circumstances would require a court order. This would make it a very onerous process. The courts do not have the resources to cope should this be implemented on a large scale. She also goes on to confirm that this reasoning has been used in the past but in the current situation, mandating vaccination will not be realistic. (73)

4.3 Rights and Responsibilities of HCWs

Professional councils such as the Health Professions Council of South Africa and the South African Nursing Council are statutory bodies that provide ethical guidelines to their members. According to these ethical codes of conduct, HCWs have a duty to act in the patient's best interest. By providing a safe environment, HCWs are acting in a patient's best interest. However, as discussed earlier several other measures can be employed to create a "safe" environment for patients. These professional councils have encouraged HCWs to be vaccinated but there has been no directive to mandate vaccination. The reason is that the Constitution protects the rights of all South Africans including HCWs. Therefore, HCWs have a choice to do what is best for themselves and at the same do what is best for their patients.

On the 14th October 2021, the South African Medical Association (SAMA), launched a statement affirming their support for the universal vaccination of HCWs. This

statement provides numerous reasons for vaccinations however, it falls short of actually mandating vaccinations of HCWs. (74)

In July 2021, the French President, Emmanuel Macron, made COVID-19 vaccinations mandatory for HCWs or risk not being paid. Almost three thousand HCWs were affected by this policy. (75) In North Carolina, a medical hospital group fired 175 workers for not being vaccinated. (76) Such stringent policies may be counterproductive leading to unpleasant outcomes, which in turn may be more deleterious to patients. Healthcare facilities with no HCWs are of no use to patients that are ill and in need of care. Such an outcome will then be in contravention of section 27 of the Constitution, which states every person is entitled to healthcare services. (22)

In this chapter, the legal considerations and professional codes of conduct have been explored and have confirmed that the concepts of autonomy and informed consent are entrenched in the South African Constitution. Policymakers, whether in healthcare institutions or government, have to take cognizance of these rights. The South African government has not mandated vaccination so any healthcare facility wanting to mandate vaccinations would have to tread carefully. It would be prudent to engage with staff from the onset to avoid potential distrust and perceived discrimination. In compliance with the Constitution employers need to be sensitive to the religious and cultural beliefs of HCWs. In addition, any medical conditions that may be a contraindication to vaccination should also be taken into consideration.

Instead of compelling HCWs to vaccinate, the use of information and education campaigns to dispel fears and myths about COVID-19 will be key in this situation. Giving HCWs all the tools to make an informed decision would certainly go a long way in winning them over to vaccinate as opposed to mandating vaccination.

CHAPTER 5: Conclusion

The aim of this research report is not to discourage HCWs from vaccinating but it questions the moral permissibility of a mandatory COVID-19 vaccination programme for HCWs during the ongoing pandemic. Currently, there is much debate on all media platforms regarding vaccine mandates. In a recent article, Moodley argues that it is legally possible to implement vaccine mandates in certain work and leisure environments. (77) In contrast to this stance, Thaldor and Shozi in another article, caution against mandates using the argument of autonomous rights which is entrenched in the South African Constitution. (78) In this research report, both moral and legal arguments have been put forward to support the stance that a vaccine mandate is not acceptable as it undermines the dignity of HCWs and their right to autonomous and informed decision-making.

All the scientific evidence presented in chapter 2, confirms there are many uncertainties about the COVID-19 vaccines. Scientists are still gathering data so information regarding their safety and efficacy is constantly being updated. This means policymakers have to be flexible. None of the currently available COVID-19 vaccines provide full protection and mitigating measures such as the use of PPE cannot be abandoned. The development of variants will continue to threaten the efficacy of these vaccines. As we navigate through these uncharted waters, it is only natural to expect HCWs to question and resist any mandatory policy. Compelling

HCWs to vaccinate may be counterproductive leading to unnecessary tension between healthcare facilities and HCWs.

As part of their training many HCWs are made aware of the rigorous processes each and every medication, be it for the treatment or prevention of disease, has to undergo before it is made available for use. These validation processes, which include phase I through to phase III clinical trials usually take several years. (25) It is therefore understandable that there is nervousness amongst HCWs regarding the expedited development of COVID-19 vaccines. To illustrate this point, the Moderna vaccine phase 1 clinical trials began on the 16th March 2020 and the vaccine received EUA approval on the 18th December 2020. It took just over nine months for the vaccine to be rolled out to the general public. (79)

In chapter 3, I acknowledge vaccination programmes have been a successful public health measure. Utilitarianism which places emphasis on the consequences of actions, where the “end justifies the means”, will be in agreement with a public health approach that includes vaccine mandates. Nevertheless, the application of the Intervention Ladder confirms that less restrictive measures such as the provision of education are more appropriate as opposed to eliminating choice by introducing vaccine mandates.

The overarching moral argument in support of my stance is the HCWs right to make informed autonomous decisions. Autonomy and informed consent are well-established principles in medical practice. Over and above the moral argument, in

Chapter 4, I demonstrated that the concepts of dignity and autonomy are deep-rooted in our Constitution. Key to autonomous decision-making is the provision of information and education.

The question is how to bridge the gap between the rights of the individual and the rights of the public or community. Buchanan states that “ the field of public health needs to engage the public directly in building consensus on what we owe each other in creating a society in which all citizens feel supported in living decent lives characterized by dignity, integrity, and mutual responsibility.” (14) This in turn speaks to the philosophy of Ubuntu. Sambala believes Ubuntu has the potential to overcome the discord between the rights of the individual and public health.

Vaccine mandates have the potential to cause distrust as HCWs may feel they are being victimized or discriminated against. Harnessing the Ubuntu philosophy will require genuine engagement with HCWs, where they are given an opportunity to express their concerns, which then must be taken to heart. The focus should be on building a relationship based on trust. Thaldor and Shozi, echo this concept in their article. (78) Perhaps involving HCW representatives in the implementation plan could prove to be helpful. Such a strategy was implemented in an Indian district, which resulted in a hundred percent of the eligible population receiving the first dose of the COVID-19 vaccine. This success was achieved through meaningful engagement with local community leaders and spiritual leaders. (80)

Interestingly, Moodley, in her article where she argues for mandatory COVID-19 vaccine, acknowledges that vaccine education even in parallel with vaccination programmes is vital. (77) It is crucial that information and education based on sound scientific evidence should be shared. However, any educational plan will need to be well thought out. Sensational educational material should be avoided as it may have the opposite effect. (68) HCWs are very aware of the effects of COVID-19 infection as they are exposed to it on a daily basis. Allowing for an opt-out option, where HCWs can choose not to be vaccinated, also affirms respect for dignity and autonomy. Resources earmarked for enforcement of vaccine mandates would be better spent if they are diverted to education programmes on vaccines.

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APPENDICES

1. Turnintin Report

2. Human and Animal Research Ethics Declaration