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National Immunization Laws –
Australia as
a Case Study**

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Abstract

The paper uses a child centred approach to analyse Australia's child immunization laws. These laws conditions enrolment to early education centres on the child being fully immunized, and provide financial incentives to parents, encouraging them to comply with the national immunization protocol. The paper seeks to contribute to the debates in public health about the utility of human rights and the definition of the 'public' by problematizing the marginalization of children from this space. Navigating between the positionalities of individuals and collectives in two terrains, namely human rights and public health, the paper examines how children and their rights are conceptualized in the development of immunization policies, and asks what these laws tell us about children's positionality, lives and bodies in society. It argues that the current child immunization laws commodify children's bodies, physically and figuratively, as a mean to protect the entire population from infectious diseases. This reproduces children and childhood as a mean to an end, seeing childhood as a vehicle to adulthood. Utilising a child centred approach can advance a different approach to public health matters concerning children, safeguarding their rights in this domain and in turn change their public visibility.

Keywords: children's rights; childhood studies; public health; vaccination; Convention on the Rights of the Child

Introduction

In the last 15 years, Australia has adopted a series of legal and policy reforms in an attempt to increase the number of immunized children. The main federal legislation, the *Social Services Legislation Amendment (No Jab, No Pay) Act 2015* (Cth) (the Act, or No Jab, No Pay) introduced a comprehensive immunization schedule for children and young adults, along with a financial incentive for parents to immunize their children. State and territories introduced new measures too. In 2014, New South Wales, for example adopted a 'No Jab, No Play' scheme through the *Public Health Act 2010* (NSW), which conditions enrolment in childcare centres on the child being fully immunized according to the National Vaccination Plan. Victoria and Queensland have adopted similar laws. This paper takes a child-centred approach and uses the UN Convention on the Rights of the Child (UNCRC, or the Convention) as a normative framework to critically ask what these laws can tell us about children's positionality in society.

As COVID-19 experience has shown, the only way to eradicate infectious diseases is by taking collective steps. On one hand, public health – as the term suggests – focuses on the public and actions affecting the public with the public and the individual composing it being the

beneficiaries. Human rights law, including the Convention, on the other hand, focuses on individuals. As will be discussed later, it has already been suggested that the apparent dichotomy between the two frameworks, namely public health and human rights, should be abandoned in favour of an approach that takes account of and refers to individuals and their human rights (Mann et al. 1994, 8). But this shift seems to overlook the positionality of children and their rights in the context of public health and therefore it requires more attention.

In the context of immunization policy, important and often overlooked questions are whether and how the 'public' is conceptualised, and whether it includes children, and to what extent, and subsequently what sort of protection of their rights – especially, but not only, their rights to health and to life, survival and development (UNCRC, Articles 24 and 6 respectively) is granted. I argue that the nexus of child immunization and public health is a focal point for discussing children's agency and social positionality, and for examining how society sees children. Further, contemporary immunization policies treat children's bodies and lives as a mean to an end: immunization policies take children – mainly babies and toddlers – as a vehicle for creating herd immunity for the entire population thus, subjecting children's lives and bodies for the greater good.

The paper proceeds in four parts. The first part introduces the main debates about the relationship between public health and human rights. In this part, I argue that the question whether human rights can or should inform immunization policies overlook children in at least two ways. First, the rights of children are rarely explicitly discussed. Second, and as a result, immunization policies fail to adequately consider the rights of children. Yet children – as individuals and as a collective – are the immediately and directly affected objects of any immunization policy. The second part looks at the ways in which such questions have featured in the global governance of child immunization, primarily the position of the World Health Organization (WHO). It shows that on the global level, children have moved from being passive subjects to objects, but their rights have nonetheless remained at the margin of the rights analysis of immunization policies. The third part juxtaposes the global debated in the Australian context, focusing on the legal developments in the effort to increase child immunization rates. By looking at the legislative history of public health laws, this part analyses whether, and if so how, children and their rights have been conceptualized. Statistics about the immunization coverage are further used to problematize the potential and actual discriminatory effects *that No Jab, No Pay* and *No Jab, No Play* have on some children, particularly indigenous children. The part critically analyses the paternalistic approach to children's and parents' rights that these laws represent – primarily, the conditionality of children's ability to enjoy their rights to early education and to play and leisure to their parents' views on 'modern' medicine and/or their socio-economic status. The paper concludes, in the fourth part, that these laws commodify children's bodies and lives. On a more fundamental level, I argue that immunization policies use children's bodies – physically and figuratively – as a means to protect the entire population from infectious diseases. This

reproduces the concept of childhood as a means to an end, serving the current populations of adults and children.

Public health, human rights and children

Traditionally, public health focuses on fostering public good and promoting a collective progression towards better living. As such, individual choices and positionalities – let alone individual human rights – are often ignored (Toubia 1995, 137). Overlooking human rights is not necessarily the result of rejecting their moral or normative grounds, or the weight in advocacy, but rather is due to the perspective that public health, as a discipline, takes: it centres the collective, assuming that improvement in the health of individuals can only be achieved by collective actions, while human rights law tends to focus on individuals. Further, and to a large extent, the development of the two fields, international human rights law and public health, is a parallel process.

But, in the last 20 years, there has been a paradigm shift and a greater incorporation of human rights language, and logics, in public health. Mann and his colleagues, public health professionals and scholars, contended that human rights and public health are fundamentally linked, and that the violation of the right to health inherently and directly leads to undermining the key objectives of public health policies – namely, increasing the health of the public (Mann et al. 1994, 12–20). They further argued that public health can not be promoted unless the underlying conditions that establish the foundations for realizing physical, mental and social well-being are recognized and addressed, and these foundations should be conceptualized and subsequently protected as a matter of human rights. Further, it is not only the right to health that matters here, but also a broader outlook that accounts to systemic and structural barriers, such as discrimination and limited educational opportunities and outcomes (Mann et al. 1994, 12–20).

In the early 2000s, an editorial in the *American Journal of Public Health* reiterates this intervention and called on public health professionals to adopt the language and logic of human rights as ‘the foundation of public health practices, research and policy’ and, in a similar fashion, to consider human rights as ‘the compass of public health practice’ (Rodriguez-Garcia and Akhter 2000, 694). This call has contributed to mainstreaming human rights into public health, and John Harrington and Maria Stuttaford argue that the right to health has been central in shaping health policies since the turn of the century (Harrington and Stuttaford 2010, 5). John Tobin, however, is somewhat sceptical about this description, arguing that that ‘the status and relevance of the right to health is much less secure and far more marginalized’ (Tobin 2011, 3) as there has been no real effort to unpack the meaning of the right to health, or how it can be utilized in policymaking and in practice. On the conceptual level, John Tasioulas and Effy Vayena share Tobin’s doubts but for a different reason. They

argue that while human rights are important for global health policy, there is little merit in employing human rights terminology as the sole or exclusive basis of global health policy, or in focusing on the right to health in its implementation (Tasioulas and Vayena 2015, e43). But it is not suggested that human rights law is, or should be, the only foundation for designing or implementing public health policy. Rather, human rights law should be one of the foundations and its theoretical and practical utilities can advance public health objectives. In a similar vein, Stephanie Nixon and Lisa Forman assert that the use of human rights discourse by public health actors can further substantiate the ethical consideration in this field, such as debates about access to adequate treatment and broader equity considerations (Nixon and Forman 2008).

The right to health is central to international human rights law. It has been recognized in Article 25 of the Universal Declaration of Human Rights and in other treaties, such as Article 12 of the International Covenant on Economic, Social and Cultural Rights or Article 24 of the UNCRC, to name a few examples. While previously overlooked, since the 1990s the right to health has been receiving increased attention from human rights bodies, such as the UN Committee on Economic, Social and Cultural Rights,ⁱ the UN Committee on the Rights of the Child,ⁱⁱ and the European Committee of Social Rights (Lougarre 2015), which have developed methods of interpretation and measures of implementation. Children, however, and especially their immunization, have rarely been addressed in these debates.

When it comes to children, the question whether they have an explicit right to health has been settled by Article 24(1) of the Convention, which reads: 'States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health....'. Thus, any law or policy that does not account to this right (or other rights of children), is inherently contradictory to the obligations and duties of States Parties to respect and protect the rights enshrined in the Convention. Therefore, this paper will not dwell on justifying why children's rights matter, but rather focuses on a set of subsequent questions: in particular, the positionality of children in public health debates about immunization, and the recognition of – and the protection afforded to – their human dignity.

The right to health of children, as other human rights, is not absolute. Under the Convention, children are promised to right to 'enjoyment of the highest attainable standard of health' and state parties are asked to 'ensure that no child is deprived of his or her right of access to such health care services' (Art 24(1)). This right has many aspects, including access to prevention services (UNCRC: 2013) and a duty for states parties to ensure that all children can use their right to health and that no child is deprived of this right (Vandenhoe et al 2019: 255). According to the UN Committee on the Rights of the Child, health policies should take into account children's rights, including their best interests, and that children should not be subjects of their parents discretion, but rather, and in line with Article 12, a legitimate partners in their own treatment (Ibid: 257).

The right to health of children is not the only right that is relevant in the context of immunization, nor the right to life, which, as Dorit Reiss argues, is often the right that gets most of the attention (Reiss 2017, 80). A closer look at the effect of immunization, in terms of reducing illness and their consequences and death rates from vaccine-preventable diseases, shows that there are other rights of children ought to be addressed. These include the rights to survival and development, the rights to non-discrimination, an adequate standard of living, play and leisure, education, and participation (UNCRC, Articles 6(2), 2, 27, 31, 28, and 12 respectively). The example of measles can illustrate how and why these rights are relevant to the discussion. UNICEF and the WHO estimate that between one and three people in every 1,000 who catch measles will die, while others might suffer from serious complications such as blindness, encephalitis (an infection that causes brain swelling) and pneumonia. Therefore, denying vaccination against measles not only puts the child's life at risk but can also lead to long term health implications, periods of hospitalization or home confinement. This, in turn, can curtail, to different degrees, the child's education, standard of living, play and leisure time, and can negatively affect her development.

There is no need, at this stage, to discuss the delicate balancing act required when rights of children might be in conflict with each other, be in a conflict with the rights of others, or how a proportionally analysis for the limitation of any of these rights be applied. Not least because this article asks to establish that the rights of children are by in large ignored in this space, and to argue that it is endemic to their social positionality. A balancing act between competing rights becomes relevant only after the rights are recognized, and in our case, when the rights holders are seen as such.

'The Public' and Children

Contemporary vaccines are very effective and safe, and unvaccinated children are at greater risk of contracting vaccine-preventable diseases in the first place (Reiss 2017, 74). The risks to life, health and other rights resulting from a lack of immunization exceed the individual child, impacting other children as well. Thus, in cases where unvaccinated children meet other children, we have multiple potentially affected individuals, primarily children, and at least one public: children, that policy often overlooks. This in addition to adults who can either get infected and the 'general' public that are front and centre of health policies. In other words, in the context of vaccination policies, children can figure as individual rights holders and as a distinct collective, or as a 'public' in this context.

Children are not the only 'public' concerned with the question of vaccination and a child's centre approach will look at the various domains of children's lives, other collectives of children, besides those who attend an early education centre (the focus of No Jab, No Play laws), are children who go to the local playground, the grocery shop or other public places like the library, as well as those hanging out on the street. The point is that referring to children in the abstract is not enough, and their lives, and the domains in which their lives

happen, should be considered in their own context and when analysing policies and laws that directly affect them. This requires looking at what Barbara Bennett Woodhouse frames as children's webs of interactions, the microsystems and mesosystems that compose the ecological model of childhood (Woodhouse 2020, 3–6). The ecological model of childhood examines child development and well-being in the context of the systems in which children are embedded. These can be divided into microsystems (such as family, school and community), where children spend their time, and mesosystems, which are the interactions and overlaps of the microsystems. Woodhouse argues that social policies affect childhoods in various ways, but that a commitment to children's rights – among other 'progressive' agendas, such as family support – can have positive effects on children's development and well-being (Woodhouse 2020, 225–59). Other relevant publics (or collectives) therefore include carers, teachers and parents (and, subsequently, their children too).

Therefore, a parental decision whether to vaccinate a child or not directly affects other children and their rights, all children who share the same microsystems and mesosystems. Thinking about collectives of children in this way is different from more common discussions about the definitions and compositions of social groups, which often tend to conclude that children cannot be seen as members of such groups – not least because their membership is temporary, lasts 18 years at the most, and has a built-in expiry date, in comparison to other defined social groups, such as women and minorities. Therefore, when thinking about the collective dimension of public health measures, positioning children at the centre of immunization policies will not only increase their social visibility but will also affect policy formation and its account of children's webs of interactions.

Children's Positionality in Global Immunization Governance

This part analyses the WHO's contemporary policies on child immunization, focusing on children's positionality, especially the ways they figure in the conceptualisation of the 'collective', their visibility and questions of establishing accountability for their rights.

In recent years, the WHO have adopted a compound approach to human rights, moving away from the dogmatic rejection of the normative grounds and the utility of human rights in favour of a position that links public health questions about immunization to broader national development and economic concerns and human rights commitments. For example, *Global Vaccine Action Plan for 2011–20* notes that immunization is a 'core component of the human right to health', not least because that 'immunized children have the opportunity to thrive and a better chance of realizing their full potential' (WHO 2013, 12). Strategic Objective 1 of the *Action Plan* reaffirms the determination that immunization is a public health (WHO 2013, 34) and Strategic Objective 2 stipulates that one of the key roles of states is to educate the public so '[i]ndividuals and communities [will. NP] understand the value of vaccines and demand immunization as *both their right and responsibility*' (WHO 2013, 38, emphasis added).

The definition of the 'collective', however, is rarely discussed or explicitly defined. A close reading of key WHO documents from the last twenty years shows that they are based upon an inexplicit assumption that only one collective is relevant to public health policies, which is the general population. Childhood studies have long established that this alleged inclusive and broad definition is often blind to marginalised groups, including children (Welles 2021). It is therefore not surprising that children, as a defined social group, are not explicitly recognized as a separate collective thus despite the recognition of sub-categories of adults, such as parents, who get explicit attention and are labelled as a collective. This definition subsequently leads to the omission of children's rights and interests in any meaningful way.

The difficulty here is not with the lack of naming, but rather the institutional marginality of children that this approach reflects and constitutes, and its implication on children's positionality and (lack of) respect for their agency. If one of the rationales for collective actions in the space of public health is to protect the population, then, from the perspective of children who attend day-care centres, nurseries or playgrounds and libraries, it is their own safety and health that are at stake. Therefore, these children – as the community of learners or players who occupy these spaces more broadly – should be recognized as a relevant collective. Realizing that it is children who are at the minimum one of the relevant collectives, along side adults, and the entire population, not only will move their positionality from the margin to the centre, which is an important change in and of itself, but also should lead to a change in the ways in which public health is conceptualized and promoted in practice when it comes to children. This is not only a symbolic change, but rather a call for a change in practice too. This change requires addressing children's unique needs and rights in the context of the spaces and health, and subsequently designing intervention and educational programs that address those needs and rights.

The UN Committee on the Rights of the Child asserts that considering children as a distinct social group when looking into their best interests is particularly important (UN Committee on the Rights of the Child 2013, para 12). Not least because seeing children not only as a group of individuals can help distinguishing between the interests and rights of adults, especially parents, the state's distinct – albeit with some overlaps – duties and responsibilities vis-à-vis parents, and children (as individuals and as a collective). This is highly relevant when talking about immunization and the web of relevant social and legal relationships that can be identified in children's ecological system: these are the rights of children, autonomy and responsibilities of parents, and the duties of the state.

Overlooking children in this space also means that the shift in the WHO's approach towards human rights have resulted, so far, in insufficient recognition of children as individual and collective rights holders.

Australia Immunization Policies as a Case Study

In the 1980s, only about 53% of Australian children were fully immunized (Australian Government, Department of Health 2013, 13). This was far below the WHO's target of 95% immunization, which provides coverage (herd immunity) for the unimmunized population too. To increase this low rate, governments adopted a series of law and policy reforms in the span of 20 years, including improved data collection, incentivising GPs to increase their patients immunization rates and sticks and carrots policies targeting parents, either providing financial benefits or denying some, based on their vaccination intake. This section will focus on some of key changes that happened in this space over the years but will not mention each and every one.ⁱⁱⁱ

In 1994, the government established the Australian Childhood Immunisation Register (ACIR) in order to gather more information about who is immunized, when etc. In 1997, the National Immunisation Program (NIP) was introduced, and a key element of it was providing childcare payments for parents who immunize their children. The NIP also increased Maternity Allowance (MA) payments for parents who ensured that their child's immunization coverage was complete by the age of 18 months (Department of Parliamentary Services 2015). In 2004, the MA was replaced by the Maternity Payment, which was later renamed as Baby Bonus in 2007. Baby Bonus was converted into two equal payments in 2009, which were paid when children met the immunization requirements for 18-month-olds and 4-year-olds.

In 2012 saw another set of changes with the introduction of the Family Tax Benefit Part A (FTB-A). The FTB-A established new criteria, conditioning the eligibility to receive the tax benefit on children meeting the immunization schedules when they turn one, two and five years old (rather than the two benchmarks under the MA), unless one of four exceptions applies (a parent who conscientiously objects to vaccination; a medical contraindication; a child who has natural immunity; or a child who is in a class of persons exempted from the requirements). The following year saw the rolling out of the 2013–2018 National Immunisation Strategy (Australian Government, Department of Health 2013, 20), and its flagship legislation the *Social Services Legislation Amendment (No Jab, No Pay) Act 2015* (Cth). Under this law, which came into force on 1 January 2016, eligibility for tax exemptions and childcare rebates for parents of children under 18 years old who refuse immunization was eliminated, allowing only medical exemptions. The Act also included financial incentives for GPs to vaccinate children whose immunization did not meet the national schedule and mandated the development of education materials to increase community understanding of vaccination and reduce vaccine hesitancy (Allen, Georgousakis and Macartney 2015, 17).

A parallel process happened at the state and territory level. In 2014, for instance, the law known as *No Jab, No Play* came into force in New South Wales, requiring parents to provide documentation about their child's immunization when they enrol in childcare.^{iv} Similar laws were soon adopted in Victoria^v and Queensland.^{vi} Failure to meet the immunization schedule

results in children being denied the ability to attend early education centres. It is assumed that this will, on the one hand, incentivize parents to immunize their children and also, on the other hand, reduce the risk of contracting infectious diseases by children who do attend educational centres.

Immunization Rates

Childhood immunization coverage increased to reach 90% of eligible one-year-olds in 2002, two-year-olds in 2003, and five-year-olds in 2010. In September 2019, the national immunisation rate for five-year-olds was 94.62% (Australian Immunisation Register, 2020). This high national coverage rate masks geographical and societal disparities, where some communities and marginalised populations achieving a much lower immunization rate. In 2017, for example, the immunization rate for one- and two-year-old indigenous children was lower than that for the general population of the same ages (92% compared with 94% for one-year-olds, and 88% compared with 90% for two-year-olds). This trend was reversed for five-year-old children, with a higher immunization rate for indigenous children than for the general population of children (96% compared with 94%) (Australian Institute of Health and Welfare 2018, ch 7). In terms of geographic spread, some areas of Australia do not reach the 95% coverage required for herd immunity (Pearce et al. 2015, 3377).

At the same time, the number of children whose parent or guardian has denied their vaccination on non-medical grounds, as recorded on the ACIR, grew from 0.23% in December 1999 to 1.44% in May 2012. While these numbers might look small, they reflect a steady increase and a worrying trend. Further, considering the high concentration of some of these children in certain geographic locations or close-knit groups, this potentially presents a risk to disease-control efforts due to the failure to achieve herd immunity in these locations (Australian Government, Department of Health 2013, 19). For instance, in some neighbourhoods or communities, as many as one in 10 children were unvaccinated or had missed at least one vaccine on the NIP. In 2018, six areas in New South Wales had vaccination rates below 90% for five-year-olds. Five of those six areas were in Sydney. The northern contingent of the eastern suburbs had Sydney's lowest rate of fully immunized five-year-olds (88.39%), followed by the North Sydney and Mosman area (88.98%), Manly (89.15%) and inner-city Sydney (89.18%). The southern part of the eastern suburbs recorded 89.34%. The sixth area under 90% – and the lowest rate in the state – was the Richmond Valley (86.09%) in the northern coastal area of New South Wales, including the Northern Rivers region and Byron Bay. A word of caution is necessary here, as the accuracy of the ACIR data might not be sufficiently accurate due to underreporting, incorrect reporting, data entry errors and technical issues with the way medical practice software sends data to the ACIR system.

Demographic breakdown of child immunization

Two main groups of unimmunized children can be identified: the first group comprises children of non-immunizing parents (Pearce et al. 2015, 3377). These parents have concerns about immunization and therefore may decline or delay having their children vaccinated, or be selective about which vaccines they allow. The numbers of 'conscientious objectors' or hesitant parents has increased over recent years, with tens of thousands recorded annually on the ACIR, but they account for less than 2% of unvaccinated children (ibid, 3381). In other words, as vocal as these parents might be – especially on social media – they represent a small minority. The second group consists of children whose parents are experiencing barriers to access, which may relate to social disadvantage and logistical difficulties, but who otherwise have no objections to vaccinations.

A study published in 2015 examined the barriers to immunization experienced by families from the second group. It divided the barriers into five categories: (1) minimal barriers; (2) lone parent, mobile families with good support; (3) low social contact and service information, psychological distress; (4) larger families, not using formal childcare; and (5) child health issues/concerns (ibid, 3381). It is possible to overcome and remove some of these barriers, or, at the very least, minimize their influence through educational and logistical support that in turn will make access easier and more affordable, and subsequently will increase the number of children receiving their immunization according to the national schedule. One example of a successful educational support was the positive impact of Aboriginal Immunisation Officers in New South Wales. This project saw families of Aboriginal children contacted before the due immunization date and reminded of the deadline. In cases of need, it facilitated contact with culturally safe local immunization services (Cashman et al. 2016).

Aboriginal and Torres Strait Islander peoples, culturally and linguistically diverse communities, recent migrants, and refugees and asylum seekers are social groups who systemically experience lower than average immunization rates (Allen, Georgousakis and Macartney 2015, 17). Coverage rates vary significantly across different parts of Australia. For example, in 2012–13, the rate of full immunization for two-year-olds was 97.5% in Katherine in the Northern Territory but only 81.6% in the Richmond Valley area of northern New South Wales (Department of Parliamentary Services 2015). A study assessed the catch-up vaccination rates for measles–mumps–rubella vaccine second dose (MMR2) by age group, Indigenous status, and socio-economic status before and after introduction of No Jab, No Pay. Brynley Hull and colleagues found that the proportion of incomplete vaccinated children aged 5-7 years have gone up under this law, especially for children in the lower socio-economic status areas, and for indigenous children (Brynley Hull et al 2020).

To illustrate this data, the table below shows the number of reported cases of vaccine-preventable diseases in Australia (WHO 2016). The table is clear evidence of the number of children who have contracted diseases that could otherwise have been prevented had they been vaccinated against those diseases.

Disease	2015	2014	2013	2012	2011	2010
Diphtheria	2	2	1	0	4	0
Japanese encephalitis	3	1	4	1	0	0
Measles	74	340	158	199	190	70
Mumps	633	187	216	195	145	89
Pertussis	22 508	11 842	12 319	23 855	38 040	34 285
Polio ^{vii}	0	0	0	0	0	0
Rubella	18	17	26	35	60	42
Rubella (CRS)	1	0	2	1	0	0
Tetanus (neonatal)	0	0	0	0	0	0
Tetanus (total) ^{viii}	3	3	4	7	3	2
Yellow fever	0	0	0	0	0	0

Predominantly, it is children from marginalized, racialized and poor communities who still struggle with access to immunization. Thus, despite what seems to be a success, a deep dive into the numbers shows that not all children have benefited from these developments equally. At the next sections I argue that these figures should be understood in light of the problematic conceptual and normative assumptions about children and their rights that underpin these policies.

Policy Objectives: Protecting the Health of Whom?

The intended purposes of the federal law *No Jab, No Pay*, as the explanatory memorandum stipulates, was ‘to encourage parents to immunise their children’.^{ix} The memorandum briefly refers to the human rights dimensions of the Bill, mentioning that ‘this Bill is compatible with human rights because it advances the protection of the right to physical health, and, to the extent that it may also limit human rights, those limitations are reasonable, necessary and proportionate’. Thus, human rights are explicitly mentioned as an object of protection, albeit in vague terms, but children are not mentioned as the rights holders, and the document fall short of recognizing the full set of rights that are relevant to the question of immunization. Moreover, in the section that discusses the proportionate limitation on rights by this law, the memorandum inexplicitly conceptualizes parents as the only rights holders. This is particularly evident when the document justifies limitation on the rights to choose, which refers to parental powers to choose whether to vaccinate a child or not.

This approach informed the later stages of the legislation process. As Scott Morrison, then the Minister for Social Services, noted in his second reading speech (House of Representatives 2015):

Parents who vaccinate their children should have confidence that they can take their children to child care in particular, without the fear that their children will be at risk of contracting a serious or potentially life-threatening illness because of the conscientious objections of others.

Evidently, the government is concerned with the autonomy of parents, while children are passive subjects whose rights and interests to be safe and avoid risk while attending childcare are secondary to the rights of parents. Morrison divides parents and parental autonomy into two groups: parents who are conscientious objectors, and parents who send their children to childcare centres while being reassured that the children are not exposed to preventable harm (that is, parents who immunize their children but are worried about the herd immunity rate). Morrison argues that the law strikes the balance in favour of the latter group, suggesting that their parental autonomy prevails over that of the autonomy of the former group. Accidentally, this balance favours children's health too, but neither children's autonomy nor their rights are front and centre of Morrison's speech. The benefit to children's health seems to be a by-product of settling a tension between the ways in which two groups of parents prefer to exercise their autonomy.

Paraphrasing Morrison's reasoning in child-centred ways will suggest that it is children who should have the confidence that they can go to a childcare centre knowing that they will not risk contracting a serious illness because of the failure of adults to respect their rights, especially the right to health, and the rights of other children. It is children's lives that are at stake here, and that should be at the centre of attention, rather than adults' objection to, or support of, medicine or their autonomy.

The Parliamentary Joint Committee on Human Rights report Bill is even more troubling, as it focuses solely on the rights of parents.^x The report reviews key international human rights law treaties but only in relation to parents, and the Convention on the Rights of the Child is not discussed in any details. The Senate Community Affairs Legislation Committee's report on the bill (Senate Community Affairs Legislation Committee 2015) presents a different approach. It explicitly refers to children as objects of protection, but it does not go beyond that in any greater detail. In comparison, when it comes to parents, the report dedicates much more space to discussing the impact that the law might have on their rights. For instance, considering the conscientious objectors' clause, the report notes that 'the Bill's proposed measures seek to address the growing rate of conscientious objectors ... and the risk this poses to young children and the broader community' (ibid, 2.7). It thus acknowledges the effect that parental decisions have on children as a community, in addition to their impact on individual children, and how the conscience of adults has the potential to put children, and the greater community (children and adults alike), at risk.

But at the same time, the report bundles parents and children's rights together, noting that 'the Bill risks infringing upon the human rights of parents making decisions about their children's health and the rights of children to access child care services and early childhood

education' (ibid, 2.84). While children are acknowledged as rights holders, the report falls short from using an explicit human rights language, and does not name any specific rights of children. Furthermore, parents' duty to care for their children's health is conceptualized as a right of parents, reflecting – from a children's rights point of view – an outdated conceptions of parental autonomy and privacy rights. A child's rights approach refers to parents' duties, not rights vis-à-vis their children (Article 18 UNCRC).

The report concludes that these 'infringements are necessary and fairly outweighed by the rights of all members of the community to health and that vaccination is a critical and important health measure' (ibid). Or, in other words, not only does the public health objective of the Bill prevails in this balancing exercise, but also the right to health of the entire community (presumably but not explicitly children and adults alike) takes precedence. The use of human rights language is welcomed, but this statement centres 'the public' as the right holder, overlooking children, and, at best, considers the protection of their health as a by-product of protecting autonomy rights of parents.

The No Jab, No Pay law has wide implications for children's rights, beyond the rights to education and health, as well as on their social positionality. The law portrays a clear relationship between children, their parents, the community and the state that falls short of the obligations of states under Articles 4 and 18 of the Convention, which define the scope of states' responsibilities and parental duties. From a children's rights perspective, parents have the right to freedom of conscience and religion and to be protected against unwarranted intervention by the state (as much as this right is relevant in this context to begin with, as one can question whether preventing your child from dying of a preventable cause is a matter of conscience or of religion). But, when it comes to parents' relationships with their children, and as mentioned before, parents have duties, responsibilities and obligations – and not rights (UNCRC, Articles 18 and 4). Parental autonomy, in children's rights terms, is the freedom to exercise your responsibilities towards your child in a way that supports the child's upbringing and development and is in the best interests of the child. It is not the freedom to do as they pleased, or just to cause no harm to their child. Under the Convention, parents' upbringing of their children is target specific. As for the state, it has the duty to assist parents in fulfilling their obligations as part of its duties towards all children in its territory. The focus, therefore, of Bills should be children and their rights, instead of being a secondary outcome for protecting parents' rights.

Children's Rights Impact Assessment

This part focuses on the discriminatory effects that these laws and policies have on children, the commodification of their bodies, and the paternalistic approach to their lives. Children's bodies are instrumentalized as a vehicle to promote the greater good while children's rights and agency are overlooked.

Disregarding children as a collective can explain the de facto discrimination that was described earlier, whereby indigenous children, for example, are, by and large, under-immunized in absolute and relative terms. The financial incentives embedded in the legislation – both federal and state – have further discriminatory effects on children, as they create disparities in access to education for children who are already subject to discriminatory, and at times racial, policies. This is in addition to the conditionality of financial incentives to their immunization, thus commodifying their bodies and instrumentalizing their lives and health.

No Jab, No Pay includes a particular form of performance-based payment that is contingent on a set of behavioural requirements, which makes it a classic example of a conditional cash transfer law. This form of behavioural incentive policy is not unique to public health – although it is usually used in low- or medium-income countries, where it also has relatively higher levels of success (Molyneux, Jones and Samuels 2016, 1087). The overt effects on women (Levasseur, Paterson and Carvalho Moreira 2018), and especially mothers (Molyneux 2006) and subsequently their children, were not, however, front and centre of the policy debates in Australia.

Meghna Ranganathan and Mylene Lagard have reviewed the impact that cash transfer policies have on immunization rates among children in a number of developing countries. Their policies have a mixed effect. In some places – for instance, Mexico and Honduras – evidence suggests an increase in child immunization rates in the immediate range, while in Colombia no such conclusion could be established (Ranganathan and Lagarde 2012, S95–S99). But, in the Australian context, No Jab, No Pay does not have an explicit objective to reduce poverty or to minimize non-financial obstacles to accessing health care – objectives that usually underpin such programs in other places. Rather, as discussed earlier, the main goal of this law is to direct parents towards using preventative health-care services while overlooking systemic access issues, especially those barriers faced by indigenous parents. Furthermore, and as described earlier, the immunization rates have risen, on average, since No Jab, No Pay came into force but not in equal rates among different communities and, by and large, the rates are still lower for members of low socio economic and remote communities. There is insufficient data to conclude causality between the laws and the increase in immunization rates, but the class and racial disparities are evident. Class and race intersect when talking about indigenous and non-indigenous children and their parents – notably, the decision of non-indigenous parents to follow their conviction and deny immunization for their children, despite the effect it can have on their own pockets and on the educational opportunities that would be available for the children.

Another dimension of the financial penalties is the discriminatory effect that they have on parents: parents who experience difficulties in accessing vaccination will be subject to the same financial penalties as those who choose, for whatever reason, to deny their children vaccination. Moreover, it is usually the former group that suffers from financial hardship to

begin with, which can lead to a decision to skip a doctor's appointment due to the cost of travel, or because the parent had to care for other children and could not spend the day travelling to the neighbouring town. The financial penalties thus result in situations where some parents are hit in their pockets (which affects the wealth of the entire household, including the children), despite the fact that financial barriers were the reason that they failed to vaccinate their child in the first place, while well-off parents can afford to decide against vaccination. And, given that parents who face access barriers also suffer from institutional and systemic discrimination in other domains of their lives, including access barriers to their own health and education, No Jab, No Pay adds another layer of hardship for them and their children, while it fails to promote children's health. A child-centred approach would have been mindful of these intersectionality effects on children and of the corresponding duties and obligations of the state that might arise (Hanson and Peleg, 2020).

No Jab, No Play penalizes children by denying them the realization of their own right to education, if their parents fail to vaccinate them (irrespective of the reasons for that decision). In other words, children who belong to marginalized communities who experience systemic barriers from accessing health care, which can result in vaccination denial, will be refused entry to childcare centres. The conditionality of access to education embedded in this law also results in a denial of a crucial developmental stage for children, known as the 'first 1,000 days'. Nonetheless, No Jab, No Play, as well as No Jab, No Pay, instrumentalize and commodify children's bodies and lives. They condition children's bodies, children's education and children's futures upon their parents' ability or willingness to discharge their parental duties or their desire to increase their net income.

No Jab, No Play is applicable only to early education centres. Given that enrolment in primary school is not conditional upon compliance with the immunization schedule, some schools see low immunization rates among their young students. These rates can be as low as 75%, which results in increased risks of transmission for all children who attend that school. This not only shows the adverse effect of this law on children in different age groups and social groups, but it also underscores the need to conceptualize children as the relevant collective point of reference for child-related public health policy and especially to see them as rights holders (of the rights to education, health, life, survival and development) and to modify legislation accordingly. If the law and its potential short- and long-term impacts had been considered from a child-centred perspective, than it would have become clear early on that children from different social classes and age groups would have disparate experiences and that the impact on their rights would be, at best, inconsistent or, at worst, discriminatory and far below any acceptable minimal benchmark.

Another important element which is almost entirely missing from the legislation is a sufficient consideration to the best interests of children. Exploring the legislation history led to the conclusion that the laws in Australia were drafted with insufficient attention to the obligations that arise from the Convention, especially Article 3 which requires the best interests of the

child to be a primary consideration in any decision affecting children, including policy formation and legislation. No evidence to suggest that the compatibility of the laws with children's best interests could be found – which is a violation of States Parties' obligations under Article 3 (UN Committee on the Rights of the Child 2013). The discussion in Parliament and the Senate Community Affairs Legislation Committee's report on the No Job, No Pay law show that the rights of children and the potential effect on their best interests were not considered in any sufficient way too. This is in contrast to the ample attention that was given to the rights of parents. In a similar vein, there are also no evidence to suggest that children have been involved in the process of developing these laws, or that children's views were given any or due weight in this process. This is contradictory to Article 12 of the Convention, and to the recommendations of the UN Committee on the Rights of the Child about the need to involve children in legislation process (UNCRC, 2016). The formulation, implementation and assessment of these laws also fail to comply with the duty of Australia under Article 4 of the Convention, let alone comply and follow best practices that have been developed in the literature. One excellent example is Bronagh Byrne and Laura Lundy's 6 p model, which requires policy makers to account to the principles/ provisions of the CRC; the process of children's rights impact assessment; the participation of children and young people; partnership to ensure joined up working; public budgeting to ensure that the resources are in place for implementation; and publicity to make the policies known to children and young people (Byrne and Lundy 2019).

Vaccination presents a unique challenge to children's social positionality in the sense that the health of the entire population depends, to a large extent, on the health of children – often babies and toddlers – and whether they receive timely vaccinations. In that sense, protecting the health of children, as individuals and as a collective, is a precondition to protecting the health of the entire population. This positionality can reinforce paternalistic approaches to children's lives, similar to those that prevailed in the Western world until the late 19th century, whereby children were seen as their father's property and their lives and livelihood were dependent on their contribution to the household. Vaccination re-creates this instrumentalization of children's bodies and lives. As this paper demonstrates, it is adults and their autonomy and rights that are often at the centre of attention when vaccination policies are formed. One of the main incentives for the adoption of vaccinations laws in Australia was to achieve herd immunity rates – in other words, to ensure that adults would be protected and healthy. This reproduces the idea of childhood as a means to an end, serving the current populations of adults and children.

Conclusion

Vaccination is a public health issue and children should be at its centre together with two key other actors, namely the state and parents. It is through children's bodies that the health of the public is inscribed. Therefore, there is a need to shift vaccination debates from children as subjects to children as objects, and to look at vaccination as a children's rights issue and

through a child-centred lens. This change will ensure respect for the child's agency and rights. Couching the conversation and policymaking in a children's rights framework will also ensure better public health results, protecting the public and children and their rights. For these reasons, the article suggests that it is essential to address children and their rights when immunization policies are created and implemented.

The distinctive invisibility of children and their rights in public health policy debates in the Australian context is demonstrated in the parliamentary discussion of No Jab, No Pay. This focus on parents and communities, while making only passing references to children, is not unique. To a large extent, it mimics the WHO's policies on child immunization. This suggests that questions about the marginality of children in the space of public health is inherent to the discipline.

A range of key rights of children – primarily, their right to life – is directly and immediately affected by these policies. Disregarding children as individuals and as a collective in this space contravenes State Parties' obligations under the Convention, while the focus on parental autonomy perpetuates paternalistic approaches to children's lives. When the fundamental rights of children that are affected by vaccination – or the denial of it – are considered in light of parents having 'responsibilities for the upbringing and development of the child' (UNCRC, Article 18), a legislation that facilitate an opt-out mechanism on non medical grounds inherently violates the UN Convention on the Rights of the Child.

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ⁱ See especially General Comment No 14 on the right to health (UN Committee on Economic, Social and Cultural Rights 2000).

ⁱⁱ See General Comments on, for example, the right of the child to the enjoyment of the highest attainable standard of health (UN Committee on the Rights of the Child 2013), on the implementation of the rights of the child during adolescence (UN Committee on the Rights of the Child 2016), the rights of children with disabilities (UN Committee on the Rights of the Child 2006) and implementing child rights in early childhood (UN Committee on the Rights of the Child 2005) health and early childhood.

ⁱⁱⁱ For a comprehensive review of early childhood policies see Amy Conley Wright, 'Social Investment in Early Childhood in Australia' in James Midgley et al (eds) *Social Investment and Social Welfare* (Edward Elgar, 2017), 33-51.

^{iv} *Public Health Amendment (Vaccination of Children Attending Child Care Facilities) Act 2013* (NSW); see further https://www.health.nsw.gov.au/immunisation/pages/vaccination_enrolment.aspx.

^v *Public Health and Wellbeing Amendment (No Jab, No Play) Act 2015* (Vic).

^{vi} *Public Health (Childcare Vaccination) and Other Legislation Amendment Act 2015* (Qld).

^{vii} Polio refers to all polio cases (indigenous or imported), including those caused by vaccine-derived polio viruses (VDPV).

^{viii} Neonatal tetanus and total tetanus cases equality may result from the lack of a non-neonatal tetanus surveillance system.

^{ix} Explanatory Memorandum, Social Services Legislation Amendment (No Jab, No Pay) Bill 2015 (Cth), Statement of Compatibility with Human Rights, 1.

^x Parliamentary Joint Committee on Human Rights, Twenty-ninth report of the 44th Parliament, The Senate, Canberra, 13 October 2015, pp. 31– 33, accessed 15 October 2015.