Article

Vaccine Justice and Bioethical Reflections of COVID-19 Immunization in Malaysia

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Abstract: Malaysia has the highest infection rate in Southeast Asia, with over 1 million positive COVID-19 cases and over 8500 deaths. The National Immunization Programme, which began in late February 2021, had a particularly slow vaccination rate, with only 4% of the targeted group receiving vaccination in three months. The delay has sparked a lot of public debate and concern, especially in light of allegations of vaccine injustice, unclear prioritization, queue jumping by people in positions of power, and other aspects of the vaccination process. Using an interpretative social science approach, this paper examines the ethical issues that arise in Malaysia’s COVID-19 vaccination discourse, focusing on vaccine justice and the bioethical principle of ‘respect for autonomy’. The paper finds that despite several shortfalls in the immunization process, most Malaysians remain optimistic and support the government’s immunization initiatives. The paper contributes to the understanding that building public trust is critical to the success of the immunization programme. Health agencies should make more efforts to inform the public about the benefits and risks of vaccines, as well as the transparency of immunization processes, which will increase public trust in health systems.

Keywords: COVID-19; immunization; Malaysia; bioethics; justice; autonomy; public-debate

1. Introduction

The coronavirus disease 2019 (COVID-19) pandemic has presented us with an unprecedented global challenge, affecting every society in every country. The pandemic affects virtually every aspect of people’s lives, including work, education, banking and domestic life. Aside from the health and safety implications, the pandemic has wreaked havoc on people’s lives, resulting in lockdowns, movement restrictions, school closures, high levels of emotional distress, increased crime threats, and food insecurity. According to projections, the pandemic’s negative impact on people’s lives will be doubled. The COVID-19 pandemic is the world’s worst public health epidemic in more than a century. In December 2019, the origin of the COVID-19 outbreak caused by severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) was discovered in Wuhan, China. Within a month of its emergence, the new coronavirus spread rapidly around the world. The World Health Organization (WHO) declared COVID-19 a worldwide pandemic on 11 March 2020. By the end of May, the COVID-19 virus had infected over 5 million people in 215 countries or territories and killed over 300,000 people worldwide [1]. The majority of COVID-19 cases were initially limited to Wuhan province and Chinese borders, but over the next few months, the virus spread quickly to other neighboring regions and eventually the entire world [2]. The genetic sequence of SARS-CoV-2, the coronavirus that causes COVID-19, was released on 11 January 2020, sparking a surge in global research and development efforts to develop a vaccine. Mass vaccination throughout the world is seen as...
the only way out of this pandemic. The goal is to reach herd immunity among the populace. The first COVID-19 vaccine candidate had completed human clinical trials at an unprecedented rate by 16 March 2020 [3]. By December 2020, the COVID-19 vaccine began the roll-out, and countries started to plan for the largest-ever immunization programme.

On 30 May 2022, the World Health Organization issued a policy brief outlining the ethical considerations for COVID-19 and mandatory vaccination. A requirement for implementing a mandate is that the authorized vaccine supply be sufficient and reliable, and that the populations affected by the mandate be able to easily access the vaccine at no cost to them. Those enforcing a mandate should make vaccination as simple as possible. Vaccination programmes, for example, should be delivered in community settings, with a particular emphasis on targeting communities that face disadvantages due to systemic factors. In the absence of a sufficient supply, free access, and meaningful, barrier-free opportunities to be vaccinated, a mandate would not only be rendered ineffective, but would impose an unduly burdensome, unfair demand on those who are required to be vaccinated but cannot access the vaccine. A mandate like this has the potential to exacerbate social inequity.

In Malaysia, the COVID-19 National Immunization Programme began on 24 February 2021, with Prime Minister Muhyiddin Yassin receiving the first shot. By 30 May 2021, a total of 1,906,388 people received their vaccine in 382 vaccine administration centres throughout the world [4]. Front-line workers, such as medical staff, security personnel and personnel from other front-line agencies, were among the first to receive their vaccination. This is a comprehensive COVID-19 immunization campaign aimed to prevent the spread of the COVID-19 virus, and end the pandemic in Malaysia by achieving herd immunity among Malaysians and non-citizens living in the country. Nevertheless, several issues emerged in the implementation of the immunization programme. The immunization campaign, which began in late February 2021, had a particularly slow rate of vaccination, with only 4% of the targeted group vaccinated in three months. The slow rate, combined with negative publicity over claims of queue jumping and other problems associated with the vaccination process, has sparked heated debate. Therefore, this paper examines the critical ethical issues that manifest in the vaccination discourse in Malaysia. Using an interpretative social science approach, this paper examines the ethical issues that arise in Malaysia’s COVID-19 vaccination discourse, focusing on vaccine justice and the bioethical principle of “respect for autonomy” [2, 5].

Ethics and values have emerged as important contemplations in dealing with the many facets of the pandemic, especially when situations become extremely serious, challenging the very existence of life and human dignity. Human perspectives and moral choices regarding the pandemic and immunization can be examined through the lens of the integral assumption of right and wrong actions, and bioethics could provide a suitable moral framework in addressing these issues. According to Macer, bioethics can be employed to deal with issues in a human-created and designed domain [6]. Bioethics can be primarily viewed from three perspectives; firstly, descriptive bioethics is how people perceive their own lives, moral interactions, and responsibilities to other species; secondly, prescriptive bioethics informs people about what is ethically right or wrong, or identifies principles are utmost key in making such decisions; and thirdly, interactive bioethics refer to value systems that will be developed through deliberation among individuals and groups in society [5,7,8,9,10]. Irrespective of the perspectives, bioethics principles may influence the thinking, moral choices and actions of individuals.

In this paper, the authors attempt to show that public trust in vaccines and the health system is an essential component of public health programmes aimed at providing life-saving vaccines. Trust is built on two levels. The first is to make more significant efforts to communicate with the public about the ‘risks and benefits’ of vaccines using evidence-based information, which can improve public confidence in the advantages of being vaccinated. The second is to build public trust that the immunization process is free from abuse by people in authority, and that it is carried out in a fair, just and ethical manner.
To narrow vaccine trust gaps, health agencies should constantly measure and monitor trust levels, and carefully plan efforts to build trust in vaccines and the immunization programme [11].

COVID-19 National Immunization Programme

The World Health Organisation (WHO) played a pivotal role in providing countries with the necessary framework, support and expertise to roll out effective immunization programmes in their respective countries. On 16 November 2020, WHO issued “Guidance on developing a national deployment and vaccination plan for COVID-19 vaccines” to assist countries in planning their national vaccination programme [12]. This guidance came a little over nine months after WHO declared the COVID-19 as an outbreak with an urgency of the highest level, or more specifically as a public health emergency of international concern on 30 January 2020. Subsequently, in March 2020, WHO made the call that COVID-19 was a pandemic opening the way for a pivotal global collaboration of governments, scientists, businesses, civil society, and philanthropists, as well as global health organizations under the umbrella of ‘Access to COVID-19 Tools (ACT) Accelerator’. WHO launched the ACT Accelerator in April 2020 to ensure equitable access for countries to COVID-19 tests, treatments and vaccines. One of the key pillars of ACT Accelerator is COVAX, a pillar founded on the principle of equitable access responsible for ensuring that no one is deprived of COVID-19 vaccines once they are available. Therefore, COVAX, which is co-led by WHO, the Coalition for Epidemic Preparedness Innovations (CEPI) and Global Vaccine Alliance (GAVI), has also been facilitating the pooling of the buying power of high-income nations to enable critical investments in manufacturing facilities so that the scale of vaccine production is sufficient globally. The aim of COVAX is to end the acute phase of the pandemic by the end of 2021. Through COVAX, WHO has circumvented an important issue of high-income nations competing for vaccine doses at the expense of the rest [13].

Malaysia signed on to the COVAX facility in November 2020 to gain access to the supply of vaccines for 10% of those living in Malaysia. Even so, being a country in the upper-middle-income bracket, Malaysia did not qualify for any free vaccines [14]. Like most countries around the world, beginning April 2020, as vaccine development progressed, Malaysia commenced negotiations with countries such as China, the United States (US), Russia and the United Kingdom (UK), as well as 12 major vaccine manufacturing companies for procurement. Negotiations were also conducted at the multilateral level with WHO’s COVAX and CEPI. By February 2021, the collaborative diplomatic efforts of the Ministry of Health (MOH), Ministry of Foreign Affairs (MFA) and the Ministry of Science, Technology and Innovation ( MOSTI) had secured 66.7 million doses of COVID-19 vaccines. The vaccines were obtained from COVAX and were also advance purchases from five vaccine manufacturers, Pfizer, AstraZeneca-Oxford University, Sinovac, CanSinoBIO and Sputnik V. Malaysia’s National Pharmaceutical Regulatory Agency has approved the vaccines of Pfizer-BioNTech and Sinovac, as well as AstraZeneca-Oxford University. Apart from procuring sufficient vaccines for the population, Malaysia also wanted to ensure that there was no overdependence on one source, and continuous dependence on other countries for its vaccine supply. The approach taken was thus to address short-term issues with strategic foresight. Discussion with relevant parties included cooperation towards developing Malaysia’s vaccination manufacturing capabilities in the future. The agreement with the Beijing-based Sinovac pharmaceutical company had already, by late March 2021, enabled knowledge transfer for partial production of the vaccine in Malaysia [15].

Malaysia’s immunization programme was rolled out on 24 February 2021, being voluntary for those aged 18 years and above, involving both citizens and non-citizens alike. The government targets vaccination of at least 80% of the population by February 2022. The first of the three phases of vaccination kick-started in February 2021 for 500,000 frontliners. Phase 2 from April to August 2021 was for 9.4 million front-line workers and high-
risk groups, including senior citizens, and Phase 3 from May 2021 to February 2022 for the rest of the 13.7 million target group [16]. In early June, 100 days into the immunization programme, more than 3.2 million doses of vaccines had been administered to over 2 million individuals in 382 vaccine administration centres nationwide [4]. As cases of COVID-19 started to rapidly increase at the height of the third wave of COVID-19 infections in May 2021, Malaysia ramped up its vaccination programme. By the start of the second half of the year, an increase in vaccine supply and vaccination centres nationwide was planned. At least 1000 more vaccination centres, which included General Practitioner clinics, private hospitals, five mega-vaccination centres, and drive-throughs and mobile vaccination units, were part of this initiative. The health minister had expressed confidence that with all these preparations, the country was on course to achieving herd immunity by December 2021 [17].

Despite the positive developments, there are ongoing apprehensions towards the immunization programme from the populace. Primarily, the rate of registration for vaccinations still reflect hesitancy among people. In the first month of the vaccination programme roll-out, only 7.9 million of the 26.7 million people targeted registered through MySejahtera, an application created specifically for the management of the pandemic in the country. The Malaysian Medical Association had expressed concerns over the low rate of registration, indicating that the government engages social influencers and corporate and religious leaders to encourage registration [18]. The government had also started to consider implementing policies that could boost the vaccination rates, such as clearance to travel across state borders [19]. Nevertheless, initiatives to assist registration for the senior citizens and groups with no access to internet facilities were undertaken, along with campaigns in the media highlighting the importance of vaccination [20]. Three months later, by the end of early June, registration had risen to slightly more than 12 million, but still only 45 percent of the target number. The increase was probably due to the anxiety associated with the spike in COVID-19 cases. Malaysia’s third wave of COVID-19 infections recorded a surge in May, hitting a high of nearly 10,000 cases in the last few days of the month [21]. This led to another round of total lockdown being implemented in the country.

Another prevailing apprehension regarding the vaccination programme was about the alleged grave side-effects of the AstraZeneca vaccine. Although Malaysia had issued approval for the vaccine based on WHO’s guidelines, the deliberations on the safety of AstraZeneca continued in light of emerging scientific evidence [22, 23]. This caused the Malaysian government to initially give assurance that AstraZeneca will only be given to people above the age of 60, but later decided to introduce a parallel track for the vaccination of recipients in Selangor and Kuala Lumpur with the AstraZeneca vaccine on a voluntary basis in early May. Initially, this earned the government praise, as all slots offered on the dedicated website for vaccination registration were taken up within hours [24]. This was also due to the general increasing concerns, as cases rose steadily since late April. There was also the issue of the slow roll-out of vaccination in the country. This was attributed by the Minister-in-Charge of vaccination, to low vaccine supplies in Malaysia arising from the hoarding of the vaccine market by richer countries [25].

Hence, the opt-in for AstraZeneca was very popular. However, when the coverage was broadened two weeks later to those living in Kuala Lumpur, Selangor, Penang, Johor and Sarawak, it proved to be full of glitches due to computer system issues owing to overwhelming interest. Following this, the opt-in track for AstraZeneca was removed, and all vaccinations were again offered through the same channel, with no opt-in for any particular vaccine [26]. This flip-flop in policy created an impression that the government still was incapable of managing the vaccination process for the people. This was made worse by incidences that imply that celebrities, political aides and senior government officials were given preference for vaccination over the more vulnerable groups such as the medical front-liners and the elderly [27, 28].
Although the increase in vaccination registration and the improvement in the perception of AstraZeneca indicate important progress in the country’s vaccination programme, they were probably more due to fears related to increasing infection rates in the country. This was something that the government was well aware of, as the public will very likely not be given the right to choose their vaccines. As such, the lack of transparency that led to trust deficiency in administering the vaccine by the government remains an issue that needs to be addressed. Compared to when the programme started, more information is available on vaccines and their side effects, as well as the rate of infections and the clusters that are emerging. However, meaningful information, including the side effects among those vaccinated; the basis for vaccine approval for selection of candidates for vaccination; and the choice of vaccine to be administered must be made available. In the short term, the vaccination drive and the target of achieving herd immunity may be achieved even if the issues are not addressed satisfactorily; people’s compliance is driven by the fear of contracting the disease, which continues to claim many lives. However, how many lives would have been saved, or how low the infection rate would have been had the vaccination programme been conducted in a more ethical manner from its commencement are some questions that will remain.

2. Materials and Methods

The article adopts an interpretative social science approach to examine the vaccine-justice issues in Malaysia from bioethical perspectives. The author examines extensive literature on the subject matter and presents the analysis based on the principles of Justice and Respect for Autonomy. The interpretive social science method is concerned with describing and comprehending “the actual human interactions, meanings, and processes that constitute real-life organizational settings” [29]. Interpretive methodologies place the meaning-making practices of human actors at the center of scientific explanation. They are conducted from an experience-near perspective, in that the researcher does not start with concepts determined a priori, but instead seeks to allow these to emerge from encounters in ‘the field’ [30]. The goal of interpretive research is to reveal such meaning-making behaviors analytically while also demonstrating how those practices interact to produce observable consequences. This uniqueness is reflected in its research design, conceptualization, analysis of data and assessment [31, 32, 33, 34].

3. Results and Discussion: Ethical Issues on COVID-19 Immunization

The approach taken in this paper is to examine the bioethical principles of justice, autonomy, beneficence and non-maleficence, which was initially described by Beauchamp and Childress in 1979. Bioethics is the investigation of ethical issues that arise as a result of new advancements in science, medicine, and future technologies. It recommends a discourse in society about moral discernment, which is frequently related to medical policy and practice, but also to broader issues such as the environment and well-being [7, 8, 9, 10]. The findings, discussed in the following subtitles, suggest that the principles of justice and autonomy play a primary role in vaccine discourse, while beneficence and non-maleficence play a secondary and embedded role within the primary aspects.

3.1. Principle of Justice

Scholars believe that the death and suffering of COVID-19 will continue until we address vaccine equity and justice [35, 36]. In the fight against COVID-19, vaccines will be crucial. All societies face difficult decisions about how to allocate limited life-saving resources in the form of COVID-19 vaccines [37]. Vaccines have been shown to effectively control and eradicate life-threatening infectious diseases, making them one of the most cost-effective and efficient healthcare investments ever made for public health services. Vaccination has not only protected people’s health, but has also aided in the development and maintenance of education, the economy, and poverty prevention [38]. Public health
experts have stressed that the need for universal vaccination coverage to control the pandemic is a moral and ethical issue, which questions the notions of justice and just actions. However, there were some objections to the implementation of a mandatory COVID-19 vaccine, in that adherents of certain religions or philosophical beliefs may refuse vaccination on religious or philosophical grounds, and thus may be considered as discriminated [39].

Many countries provide free vaccines to their citizens. Some countries with a vaccine manufacturing capacity or vaccine surplus offer vaccines to their neighbors as part of their economic recovery and regional solidarity strategy [40]. However, it appears that high-income countries have better access to vaccines than low-income countries. According to Oxfam, the world’s high-income countries, which account for 13% of the global population, have placed 51% of the orders for COVID-19 vaccines, and 61 percent of the world’s population will not have access to the vaccine until 2022 [41]. This is to be expected, given the world’s uneven economic structures. There seems to be a lack of practical justice on many levels in the vaccine discourse, especially the criteria for distribution, given the intense clamor to secure vaccine supply by individual countries [42]. As such, the social and structural determinants of the healthcare system require improvement so that the disadvantaged and the vulnerable are not left out in vaccine rationing [43].

The issue of vaccination manifests as a global justice issue. Furthermore, some countries, particularly those that manufacture vaccines, prioritize vaccine access for their populations over others. This scenario promotes vaccine nationalism, as shown by the European Union’s imposing export licenses for COVID-19 vaccines manufactured in Europe. In March 2021, India, the world’s leading manufacturer of COVID-19 vaccines, imposed some restrictions on vaccine exports due to higher COVID-19 rates at home [40]. Low-income countries received approximately 0.8 percent of all COVID vaccines distributed worldwide, while developed countries took up most of the 1.65 billion vaccine doses. The vaccine injustice and inequity have posed a significant challenge to low-income countries, lacking adequate public healthcare facilities to manage the pandemic effectively. Global vaccination coverage is critical to preventing the spread of this disease and assisting in the prevention of new variants. COVID-19 will remain a threat until the global vaccine imbalance is addressed. In order to rectify this problem, charitable models of richer countries giving handouts of leftover vaccines must be changed. Sharing leftover vaccines is unsustainable, and solely dependent on the interests of donor countries. Instead, manufacturing and distribution capacity must be developed globally to enable faster and more efficient delivery of vaccines to all, particularly the vulnerable population [44, 45]. Therefore, in healthcare settings, it is vital that actions and decisions are made ethically to assist in gaining and maintaining trust among all the key stakeholders involved [46]. Healthcare providers should recognize that the correctness of an action or policy decision is determined by considering all relevant factors and making decisions, not solely based on justice but also goals that logically support being right under the circumstances [36]. Furthermore, regarding vaccine allocation, Williams and Dawson found that a ‘major omission’ was attention to global distributive justice, with only a limited number of countries possessing capacity to manufacture vaccines on their own against the virus [47]. As such, without a reliable framework of vaccine distribution, the place of domicile may become the most important factor of vaccination [48].

In Malaysia, several issues of vaccine justice have emerged out of the national vaccination programme, which include vaccine access, vaccine prioritization, queue jumping and care for the vulnerable population. The public took to the social media platforms to discuss these issues. They started to question the justifications on who gets the vaccine first; whose life is more important; why are some groups prioritized for a specific type of vaccine; and why are people of political and government positions prioritized over other vulnerable groups? Despite the Malaysian authorities’ effort to identify target groups for vaccination in their national vaccination programme, public disgruntlement was on the rise. Just a week into its national immunization plan, doctors complained that political
aides and workers cut ahead of medical front liners to get inoculated [28]. Front-line agencies, such as the uniformed services, have been prioritized in the national immunization policy to receive vaccines first. On the other hand, the public was dissatisfied, as not all members of the uniformed services are front liners; a majority never really come into contact with any COVID-19 high-risk groups. As a result, many question why they have prioritized this group over other high-risk and vulnerable groups. The government has yet to provide a credible explanation for this issue. In fact, there were issues of social hierarchy within some of these designated groups, with higher-ranking officers being given priority over their lower-ranking colleagues. The teaching fraternity in Malaysia was also excluded from the COVID-19 front-line groups. Teachers, particularly those with comorbidities and who have direct contact with students, were not prioritized for faster vaccination. As a result, several COVID-19 clusters were discovered since the schools reopened in mid-April 2021, prompting another school closure nationwide [49]. With regard to vaccine hoarding by industrialized nations, Malaysia has expressed grave concerns on the ill-effects of such immoral actions to low-income countries. Malaysia’s coordinating minister for immunization has asked the World Bank to raise the matter on behalf of developing countries. He further claimed that the setting up the COVAX as a global mechanism to ensure vaccine equity among countries has been a terrible failure [50].

Vaccine Prioritization and Queue Jumping

Another issue emerging in vaccine-rights discourse is ‘vaccine prioritization’, which refers to embedded structural inequalities in vaccine procurement and roll-out. In a pandemic, vaccines are recognized as a public good, which means no one should be deprived of the right to life-saving interventions, and the State authorities bear the responsibility to ensure this right is met to the fullest, without delay and any forms of favoritism and discrimination. The lack of resources or the use of public or private insurance schemes should never be used as an excuse to discriminate against specific patient groups [51]. The right to good health is a fundamental human right. In Malaysia, several issues emerged regarding vaccine prioritization in vaccine procurement and roll-out. In vaccine procurement, the government has made procurements from several sources to ensure adequate supply for the targeted group. The government appointed Pharmaniaga and Duopharma, companies linked to the government, also known as Government-Link Companies (GLCs), to manage these procurements [52]. Since GLCs have been linked to political patronage in Malaysia, there has been widespread public concern about the lack of transparency regarding appointment terms and vaccine pricing. Since vaccines were recognized as a public good, many (especially netizens) have questioned why the government did not deal directly with vaccine manufacturers instead of going through profit-driven pharmaceutical companies. These concerns arose from widespread knowledge that political patronage, in the form of directorships in GLCs, was a common contributor to corrupt practices in these companies [53].

The second issue is unclear vaccine prioritization, which refers to the possibility of certain groups of society being favored over others and the possibility of queue jumping. Vaccination schemes give priority to those who are most at risk of developing severe health complications. If someone skips the line, a higher-risk person’s vaccine will be delayed, and they may become seriously ill in the meantime. The Malaysian NIP has clearly defined priority vaccination groups based on infection risks. The first phase of vaccination involves approximately 5,000,000 front-line workers, including medical personnel, essential services, and law enforcement agencies, who were prioritized based on their high risk of infection. The second phase involves 9.4 million people, most of whom are elderly citizens, chronic illness patients, and disabled people. The third phase involves the general adult population of 18 and older, totaling approximately 13.7 million people. While government agencies appear to be making every effort to ensure a smooth implementation of the vaccination process and a higher vaccination roll-out, the public has expressed concerns about queue-jumping.
There have been allegations in the media of individuals of a younger age receiving vaccination during Phase 2, which is reserved for senior citizens, the disabled and those suffering from chronic diseases [54]. Some high-ranking government employees who work in the essential services sector, but not front-line workers, were among the first to receive the vaccine. There also have allegations—although not substantiated—that members of the elite class had been prioritized to receive vaccines. Government hospital doctors are given preference over private hospital and clinic doctors, even though private hospitals and clinics remained open to the public throughout the pandemic. On the other hand, the Malaysian vaccination authority was quick to acknowledge the problem, even claiming that it had received more than 200 complaints about queue jumping, though not all of them provided evidence to back up their claims. A whistleblower system was immediately established to report COVID-19 vaccination queue jumpers and fine-tune vaccine distribution to more deserving groups [55]. However, queue jumping is not always an immoral act, especially when individuals or groups are displaced and at a higher risk of virus infection and spread. Prioritizing vulnerable groups such as refugees and displaced people is morally correct. In a nutshell, the principle of respect for autonomy paves the way for a better understanding that people are fundamentally human, regardless of their benign proclivities or traits. This fundamental understanding can go a long way in fostering and strengthening societal cohesion.

3.2. Principle of Respect for Autonomy

What is respect for autonomy? It is a concept that stems from the need to respect an individual and his/her choices. In fact, any concept of moral decision-making assumes rational agents making informed and voluntary choices. In health, autonomy refers to a patient’s ability to act intentionally, with understanding, and without controlling influences that would mitigate against a free and voluntary act. This principle serves as the foundation for the practice of “informed consent” in physician-patient interactions [56]. This is not the only consideration, however, as the patient’s competence in providing consent would have to be scrutinized, and the legalities surrounding the consent would have to be verified. As a result, respect for autonomy must be viewed in this context. Perhaps a more recent perspective would be the measures imposed in response to the recent COVID-19 global pandemic. Although some people may not have given their informed consent for their quarantine, given public health concerns, it would be a necessary measure to contain the spread of the disease. Public health concerns may take precedence over an individual’s autonomy, particularly in severe crisis situations where the State has a moral obligation to act for the benefit of others or the community. Thus, respect for autonomy is not a license for selfish individualism or a free pass for authoritarianism. This principle should be used in society as a foundation for enabling others to be themselves, but it should not be the ultimate one [7, 8, 9].

In Malaysia, like many other countries, the implementation of movement control measures and other associated COVID-19 containment protocols has impacted the populace’s principle of autonomy. The government, employers, corporate, public, and social organizations have enacted “shelter-in-place” policies, social distancing practices, mask-wearing, entry requirements, work-from-home requirements and other similar orders that limit individuals’ freedom of choice. This situation also manifests significantly in public discourses relating to the immunization programme and its processes. It should be noted that Malaysian society is divided into many layers, each of which contains racial, religious and socioeconomic divides, and these disharmonies tend to manifest themselves during times of crisis. In analyzing this principle in the immunization initiatives in Malaysia, the authors seek to investigate the manifestations of individuals’ autonomy concerning: (i) right to be vaccinated and right of refusal; (ii) the right to receive adequate and truthful information to facilitate informed decision making; and (iii) autonomy to choose vaccines. Respect for autonomy is associated with allowing or enabling citizens under health emergencies to make their own decisions about healthcare interventions through the
vaccination program. Thus, the discourse on individual autonomy on vaccines entails citizen’s reception of vaccines (i.e., whether they want or do not want to receive the vaccine), evaluation of risk-benefit of the vaccine, the choice for types of vaccines, fears of the vaccine and purity status of the vaccine (i.e., halal).

3.2.1. Right to Be Vaccinated and Right of Refusal

In Malaysia, citizens were given the choice of whether they want or do not want to receive a vaccine, with the option to register with the application My Sejahtera to assign dates for vaccination. A non-probability social media study on adults (above 18 years old) in Malaysia by Elnaiem et al. revealed that 99% of respondents had registered for the National COVID-19 Vaccination Program, with a majority (81.5%) registering through the MySejahtera application, suggesting elements of autonomy and exercising individual rights [57]. As such, citizens have the autonomy to decide in wanting to take the vaccine, know the consequences of not taking the vaccine, and oblige the state to respect the decisions (self-determination) of adults who have decision-making capacity. This respect for the decisions concerning their own lives is in line with the principle of human dignity. However, certain segments of the population do not have a say in not wanting to receive the vaccine, and encounter forced vaccination with no choice or no right of refusal, especially for front-line workers such as doctors, nurses and police personnel, as they are viewed as high-risk personnel [58]. Here, the authorities take the position of their duty and obligation to protect the welfare of their personnel and the potential impact of this person when they come into contact with the broader population they serve. One has the autonomy to choose not to be vaccinated, but they do not have the right to harm the vulnerable with a preventable disease [39]. Here, the autonomy principle is balanced against the beneficence principle, in which the authorities take the position that it is their duty and obligation to ensure the benefits by protecting not only the welfare of their personnel, but also the potential impact of this person when they come into contact with the broader population that they serve.

3.2.2. Right for Adequate and Accurate Information for Informed Decision Making

Relevant, reliable and timely information has become even more vital in the face of the COVID-19 pandemic. The proliferation of unsubstantiated and even fake information in social media is unstoppable, and has created confusion and anxiety among people. National agencies should improve access to share and disseminate COVID-19 information and knowledge to their populations in a scientifically sound and systematic manner. This will facilitate better informed decision-making among the people regarding the pandemic’s specific aspects, such as the vaccination process. According to Dorcas et al., health communication must reach all communities, particularly the most vulnerable, to educate them on the safety of vaccines and their effectiveness in preventing future infections and deaths [59]. To educate the general public about vaccine-related information such as accessibility, availability, efficacy, known side effects, benefits, protocols, and triage decisions, community van mobilization, radios, televisions, leaflets, and telephone hotlines can be used. Respected community-based organizations and non-governmental organizations, such as the Red Cross, faith leaders, and religious leaders, who are widely regarded as neutral, play an important role in promoting COVID-19 vaccine acceptance. An Italian study by di Giuseppe et al., found that those who received enough information about the COVID-19 vaccines were less likely to express concerns/mistrust (or vaccine hesitancy), particularly about the vaccines’ safety [60]. In fact, many countries, including Malaysia, have taken stringent measures to curtail the dissemination of fallacious and misleading information. Some may see these actions as inhibiting the right to information. Governments are required by international human rights law to protect the right to freedom of expression, which includes the right to seek, receive and transmit information of all kinds, irrespective of frontiers. However, certain restrictions on freedom of expression for public health reasons are deemed permissible, and may not jeopardize the right itself to curb
misinformation and public chaos. Public health authorities’ responsibility and core obligations are to provide the information needed to protect and promote rights, including the right to health. This includes education and information about the community’s major health issues, as well as methods for preventing and controlling them [61].

In the case of Malaysia, even though health authorities have constantly disseminated COVID-19 information since the disease was first discovered in Malaysia, there has been an increase in incorrect and misleading information, leading to some confusion among the public. Most Malaysians, like other countries, rely on social media for all sorts of information regarding the pandemic. The spread of varying and unauthenticated information did create misperception regarding all aspects of the pandemic. However, the government makes every effort to provide accurate and timely information on the status of infections, the number of recoveries, the number of deaths, and other relevant data on a daily basis. These details are broadcast on television every day, and can be found on the relevant government website and online applications. These platforms also carry scientifically verified information regarding types of vaccines, sources of vaccines, their efficacy, and risk factors and side effects. People have ample opportunity to weigh the risk-benefit factors of vaccination, and make informed decisions whether or not to be vaccinated. A recent study on knowledge, attitudes and practices of Malaysians toward COVID-19 shows that 90% of respondents were optimistic that Malaysia would defeat the virus, and that the government was handling the health crisis admirably. The authorities’ prompt actions in enforcing the movement control order (MCO) may also have contributed to these positive attitudes. The findings also indicate that Malaysians have an adequate level of knowledge about COVID-19, and are generally optimistic about resolving the pandemic. Furthermore, consistent messaging by public health authorities has been critical in increasing public knowledge and understanding of COVID-19 [62]. Additionally, another study on vaccine usage by adults in Malaysia found that more than 80% of respondents felt very confident in the COVID-19 vaccinations’ efficacy, and thought they had received adequate and reliable information about the COVID-19 vaccines (80.1%). Notably, almost all respondents (97.2%) were aware that COVID-19 infection could occur even after receiving the advised immunization dose. They were also aware that vaccinated patients’ COVID-19 complications were less severe (94.4%) than those of unvaccinated COVID-19 patients [57]); this shows that most Malaysians are well informed of the risk-benefit before vaccination.

3.2.3. Autonomy to Choose Vaccines

Undoubtedly, one of the critical public health achievements of the twentieth century is the prevention of serious diseases in vaccinated populations. However, for religious, political or health reasons, some people have always been opposed to or refused vaccination. Despite vaccination’s significant success in protecting the community against diseases such as measles, rubella and polio, the anti-vaccination drive has evolved into a populist movement, increasing people’s vaccine hesitancy. Vaccines are not guaranteed to be 100 percent effective. However, they can become more effective when a large proportion of the population is vaccinated and spread in the population contained, a phenomenon known as “herd immunity.” People who are unable to be vaccinated, or for whom the vaccine is not sufficiently protective, are put at risk if vaccination levels fall below those required to achieve and maintain herd immunity [63]. In discussing the autonomy to choose vaccines, two aspects can be observed: the lack of choice for the majority and the second vaccine hesitancy. When people do not have the option to choose, they are denied the right to informed consent and the ability to choose whether or not to receive a vaccine. The key reason for denying the free choice of the vaccine is due to its accessibility, usually attributed to global supply. As a result, the government must be pragmatic in carrying out the vaccination process without giving citizens the option of choosing their vaccine, as this could create a logistical nightmare and impede administrative efficiency [64].
A study by Lin, Y. et al. in China examined vaccine demand and hesitancy by assessing willingness-to-pay and intention to vaccinate against COVID-19 [65]. According to the study, a significant proportion of the Chinese public perceived vaccine acceptance of the COVID-19 vaccine. The health belief model constructs perceived benefits and hesitance to vaccination (namely vaccine efficacy and adverse event concerns). Although many people were concerned about fake or faulty COVID-19 vaccines, this did not hamper the vaccination process. This study also discovered increased trust in domestically manufactured COVID-19 vaccines. The preference for domestically produced COVID-19 vaccines over foreign-produced COVID-19 vaccines suggests that a future COVID-19 vaccine developed by domestic companies will be well received by the local populace. Besides trust, another study by OECD found that transparency and an understanding of the benefits of vaccines are critical in vaccine acceptance [66]. Meaningful community engagement, particularly with marginalized and vulnerable groups, those with low trust in government services and/or those disproportionately impacted by the pandemic, is critical to successful and equitable vaccine acceptance [66]. To increase vaccine acceptance, promotional messages framing the benefit of vaccination and concerns about new vaccine safety are warranted [65].

In Malaysia, despite the initial promises to allow people to choose their type of vaccine, the government has decided against giving this option. They claimed that their primary concern is to increase the vaccination figures in the race to reach herd immunity. The medical fraternity in Malaysia had previously supported the idea of having people choose their vaccine to mitigate vaccine hesitancy among people against getting vaccinated. Malaysia currently uses three types of vaccines—Pfizer-BioNTech, Sinovac and AstraZeneca—though the AstraZeneca vaccine was removed from the national immunization programme, and administered separately on voluntary sign-ups. Due to high demands for the vaccine, however, it was once again placed back into the programme. There are several factors that contribute to vaccine acceptance among the public. According to Ng et al., these factors include those who perceive risk of infection (prevalent among the senior generation), social pressure to get vaccinated, those who have a positive attitude and high levels of trust in the vaccine [67]. Meanwhile, another study found patients or family members who had previous COVID-19 experiences are more likely to accept the vaccine [57].

On the other hand, people also exhibit some level of vaccine hesitancy in their choice of vaccine-type during the initial period. Vaccines produced by Pfizer-BioNTech displayed higher acceptance than those from other vaccine manufacturers, while vaccines produced by Chinese manufacturers suffered massive hesitancy from the public. Secondly, patients or family members who were not infected by COVID-19 are more likely to resist the vaccine [57] Thirdly, the lack of evidence of vaccine effectiveness and its purported side effects had further dampened public confidence [58]. Incidents of blood clots after receiving the AstraZeneca vaccines in Denmark raised serious health risk concerns the world over. The Malaysian authorities, on the other hand, relied on the European Medicines Agency’s (EMA) assessment and its own National Pharmaceutical Regulatory Agency (NPRA), the Drug Control Authority (DCA), to grant access to this vaccine [68]. The benefits of the vaccine continue to outweigh the risks, allaying concerns.

Fourthly, a study by Ng et al., [67] found that individuals who perceive that their religious beliefs are against vaccination are more likely to exhibit uncertainty toward it. In Malaysia, Islamic discourse on religious purity strongly dominates public opinion and policy realms. The majority-Muslim population was concerned with the halal status of the vaccines, which refers to the consumption of products permissible for Muslims under Islamic law. Concern arose when Indonesia’s religious authority revealed that the AstraZeneca vaccine is made with pork-derived trypsin, which is required to break down proteins [69]. For Muslims, pork is regarded as non-halal or haram (forbidden) for consumption. This concern had an immediate ripple effect in Malaysia. However, the religious authorities in both of these countries declared that the use of the vaccine is permissible by
Islamic laws, due to the critical need to get people vaccinated immediately to contain the pandemic. A credible halal vaccine is not yet available to the population. In Malaysia, the health ministry clarified that it would prefer vaccines that are halal-compliant, but they need not be halal to be registered and administered in the country. Furthermore, more clerics argued that the non-halal components in the vaccine might have undergone chemical alteration in the production process, and such vaccines are permissible to be used, especially in disaster or crisis situations [70]. The National Fatwa Council (national-level Islamic authority) has affirmed that all types of vaccines currently being used in Malaysia are halal. This declaration has managed to appease the Muslim public’s concerns.

Vaccine perception and other related issues may also be viewed among different demographics in Malaysia. According to a study on attitudes, perceptions, and side effects related to the COVID-19 vaccine by Elnaem et al. [56], out of a total of 428 respondents, more than 80% of all respondents felt highly confident in the COVID-19 vaccines’ efficacy, and thought they (80.1%) had received accurate and sufficient information about the COVID-19 vaccines. The findings demonstrated a high level of post-vaccination adherence to SOP, and generally positive attitudes toward the ongoing vaccination programme. This could also be attributed to increased digital literacy among older adults and the inundation of COVID-19 information on the internet [71]. Individuals who felt they had received adequate information about the COVID-19 vaccines were less likely to be concerned about the vaccine’s safety [60]. The acceptance rate of vaccines varies from country to country. Malaysia records among the highest (94.3%). Other high-ranking countries include Ecuador (97.0%), Indonesia (93.3%) and China (91.3%), while the lowest acceptance rates were discovered in Kuwait (23.6%), Jordan (28.4%), Italy (53.7), Russia (54.9%), Poland (56.3%), the US (56.9%) and France (58.9%) [72]. The level of vaccine trust is critical in dealing with this pandemic. Transparency in vaccine distribution and COVID-19 updates are critical for preventing vaccine distrust.

4. Conclusions

Vaccine justice and respect for autonomy are moral obligations, as well as functional requirements in dealing with the pandemic. Just action warrants moral judgement of individuals, based on the values of fairness, equality and prioritizing the needy in a given situation [73]. However, vaccination authorities are often faced with a host of challenges and considerations that drive them to make certain decisions that may be seen as unjust. Some even use the reasoning that the ‘means justifies the end’ as justification to push through certain initiatives. The authors argue that this justification may have some utility in addressing grave situations such as the pandemic. However, society deserves precise clarification of public health policy and initiatives. Public health policies’ success hinges on providing a rationale that the general public can understand and support. As a result, policy communication is critical to ensure that the public is adequately informed, and aware of the larger benefits resulting in greater responsibility and increased public trust and support. In the case of Malaysia, despite varying views about vaccine justice, vaccine efficacy, vaccine prioritization, religious anxieties and other issues related to the vaccination process, most Malaysians are willing to be vaccinated. They have considerable trust in the government’s ability to succeed in reaching the national immunization targets eventually. The vaccination authorities have been exceptionally proactive in addressing many of the public’s concerns, including encouraging people to report misconduct or irregularities in the vaccination process. Building public trust in the vaccination programme is crucial in ensuring the mitigation of this pandemic. Furthermore, vaccines must be regarded as an essential public good accessible to all people, regardless of their status and positions in society. In times of crisis, the manifestation of human values and ethics becomes all the more important.

Future research in the area of vaccine justice may focus on three areas. Firstly, on how to ensure sustained vaccine justice discourse in the light of new variants and the need for repeated vaccinations. Secondly, the right for equitable access to vaccines for all of
humanity, especially vulnerable groups who have limited or no access to public health amenities. Global production and distribution of vaccines should also focus on low- and middle-income countries. The third is global intellectual property regulations that may hinder global production and vaccine access worldwide. These regulations should not impede the manufacturing of vaccines or transfer of research technologies to other facilities worldwide, nor hinder fair access to vital medical tools for the masses.

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