COVID-19, the WHO, and the Apparent Collapse of Traditional Medical Research Ethics

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**Abstract**

On January 14, 2021, a WHO Ad Hoc expert group published an article in the highly influential *The New England Journal of Medicine, titled:* “Placebo-Controlled Trials of Covid-19 Vaccines - Why We Still Need Them” justifying the use of placebo in further trials of COVID-19 vaccines, even though purported efficacious vaccines were already available. Medical research involving human beings ought to conform strictly to principles, rules and procedures established since the Nuremberg Code (1947), especially as elaborated in the Declaration of Helsinki (2013) and the WHO/CIOMS Guidelines (2016). The above publication forms part of an observable ethically questionable trend that needs remarking. In this paper, considering traditional medical research ethics under the impact of the COVID-19 pandemic and its ramifications and effects and with a particular focus on the highly vulnerable countries of sub-Saharan Africa, I make some of the remarks that need making. My article is pitched as a worst case scenario on behalf of ethics, relatively blunt in its thrust, so as to avoid speaking with water in the mouth, bearing too many qualifications and equivocations, thereby siding with politeness or decency to trump honesty, although honesty itself, admittedly, is not a criterion of truth.

Keywords: Covid-19, Africa, the WHO, medical research ethics, vulnerability, vaccines, treatments

**Introduction**

The COVID-19 (SARS-CoV- 2) pandemic has had a highly disruptive and disorienting effect on human life and well-being in all parts of the globe. The pandemic seems to mark a turning point in the history of our world, particularly the history of the African continent which has been at the origin of several previous epidemics declared to be pandemics (5).Since the pandemic erupted, the same procedures and attempted solutions–lockdown, social distancing, hand washing, mask wearing, triaging for scarce medical resources– applied in the developed countries have been prescribed even if not completely applied in Africa, with little consideration for contextual differences and specificity.

We must never forget the holocaust. It was the “inflection point” in the development of bioethics and medical research ethics (4; 7). The holocaust marked the active participation of the scientific and medical communities of one of the most advanced countries in the world (Germany) in genocide, culminating after the Nuremberg Trials (1945-1947), in the elaboration of the Nuremberg Code (1947), the Declaration of Helsinki (1948) and later the WHO/CIOMS Guidelines (1992), which specifically focused on the application of these regulations in the developing world. In these regulatory documents some of the elements are purely scientific, others practical or procedural and others ethical (23). Among all the elements that go into the formulation of any of these guidelines, only the ethical element or impulse is timeless and universalizable, whereas all the rest are amenable to changes justifiable by advances in scientific knowledge, techniques and allied procedures. We can isolate the universal and timeless element if, for example, we ask the question “What is it about the holocaust that makes it universally and timelessly horrendous”? The horror we feel about the holocaust is moral horror having nothing to do with the fact that its main perpetrators were Germans and its victims Jews, but rather simply that both the agents and the patients of the sad event were human beings. The level of science and technology in this regard is of no consequence. No particular expertise beyond moral sensibility and sensitivity, which are part and parcel of being human, is required to realize this. In the absence of moral consciousness, even a hall full of experts is not likely to arrive at morally agreeable decisions. I have tried making this argument over the years in various ways and contexts (22; 24; 25) without any palpable results.

The chief subverters of moral sensibility and sensitivity are the will to power and control and personal interest, the desire for personal gain/advantage. It is therefore always important to distinguish the science from the ethics and to keep in mind that, while bad science may rightly be said to be, *ipso facto*, unethical, good science in itself is not necessarily ethical and scientific procedures and techniques, no matter how sophisticated and approbated by the highest expertise, must be subjected to rigorous ethical appraisal.

The COVID-19 pandemic is perhaps one of the worst health events in human history from the point of view of its speed, width and breath of spread, its fatality rate, its disruption of economic and normal everyday activities in all parts of the world (18; 32). Allegedly originating in the Wuhan region of China in December 2019 (11), the epidemic quickly spread to Europe, the Americas and, finally to Africa, all within the space of three months. As extraordinary challenges demand extraordinary responses, medical practices and medical research must act accordingly in efforts to contain the epidemic and especially to save human lives. However, while ethical rules of procedure may be stretched to their elastic limits, they cannot out-rightly be broken or set aside without incurring moral blame. We can talk about a ‘new normal’ for science and technology at various points but there is never a new normal for ethics although that does not imply that our moral consciousness is static.

There is an urgent need during a deadly infectious pandemic to provide firm plastic as opposed to cast-iron 'garde fous' (safeguards) within which science/technology may ethically be carried out as well as to ensure respect of those limits. In all human activities, ethics must be the permanent referee, showing red (stop!), yellow (pause and think!) or green (go ahead!) cards as appropriate. Ethics is often assisted in this role by the law and by customs, traditions, and practices, depending on the context, paradigm, and system in operation.

If all forms of opportunism and exploitation are ethically problematic at all times, this is particularly the case during a deadly pandemic. It is therefore ethically questionable to opportunistically use a deadly pandemic as the occasion to advance profit-driven science and medicine, permitting a fraction of the global population to enrich itself and to enhance its power and control over the rest of humanity. It is hard to assert with confidence that this has not been the case with COVID-19. The comfortable marriage between global medicine and open market commerce and processes (3) remains a problematic we must never tire of addressing and re-addressing.

**Global Response to COVID-19**

The global response to COVID-19 has been heavily tilted towards vaccines to the neglect of treatments and this is an ethical issue. The first intuitive reaction of anyone (including any vaccinologist) who catches an illness, even a highly infectious one, is to seek a cure or treatment, not a prophylactic against future infection, even if such can be described as “immunotherapeutic”. It is difficult for many ordinary people to comprehend why the global response to COVID-19 has been so disproportionately accented on vaccines as against treatments, especially where experimented treatments seemed to be quite effective against the virus. This is one putative reason that conspiracy theories and even misinformation against vaccines have gained believers (2). And the speed with which candidate vaccines, even granted the advantages of advanced scientific methods and techniques, seem to be ready for mass application, remains rather question-begging.

Compared to the traditional steps and stages of medicine and vaccine development, one gets the impression that, with COVID-19, vaccine developers have opted for wide open experimentation on human beings of candidate products whose medium and long term effects have not yet thoroughly been investigated. This is a major ethical issue. However, we have not witnessed any debates reminiscent of those in the late 1990s and early 2000s over such issues as use of placebos in clinical trials or post-trial access to treatments. The situation seems to be back to the pre-Nuremberg world where medical investigators did whatever they fancied on human beings in the name of medical research. The world medical association (WMA) always so defensive of the Hippocratic tradition in medicine seems in the face of COVID-19 to have abandoned their traditional role and struggle to keep harm at bay and ethics at the centre of medicine and medical research. I for one have not heard the voice of the WMA since the outbreak of COVID-19.

**The African Situation**

Africa’s well known pre-COVID-19 multiple vulnerabilities have remained intact within the pandemic although, in terms of COVID-related deaths, Africa (excepting the Republic of South Africa) has fared better, against all expectations and predictions (28). This situation is likely due to a number of factors including environmental and climatic factors and reliance on herbal treatments. The Republic of South Africa (RSA) is a special case within the African continent. COVID-19 in the RSA, including a high death toll, for unknown reasons in need of elucidation, has been very similar to cases in the Western world. The RSA enthusiastically participated in the testing of some Western candidate vaccines (15) but does not seem to have derived any post-trial benefits from such participation owing to failure to negotiate post trial access and benefit sharing mechanisms (16). That also is an ethical issue.

Regarding herbal treatments against COVID-19, Cameroon, on the heels of Madagascar, has come up with several plant-based remedies that seem to cure the infection (9; 20). In April 2020, Madagascar had officially launched a herbal medicine, COVID Organics (CVO), developed by the Malagasy Institute of Applied Research, from the Artemisia plant, well known for its anti-Malaria properties, that it claimed both prevents and cures COVID-19 (1; 6). Although the WHO was prompt in dismissing the claim that CVO cures COVID-19, and insisting that there is as yet no cure for the disease (29), other African countries have been enthusiastic in placing orders for the medicine from Madagascar (14; 19) and South Africa did offer to carry out a confirmatory scientific analysis of the herbal mixture (6).

Whenever the WHO declares that there is no treatment for a disease, what it clearly seems to mean is that there is as yet no drug approved by the US Food and Drug Administration (FDA) or duly licensed in any part of the industrialized developed world. For an organization with a global mandate, this is not good enough except on the assumption that globalization is no more and no less than Westernization (22). Furthermore, the WHO seems to be under the subtle influence and control of for-profit medical research with a clear preference for research on vaccines, putatively on account of their high profitability. That is a major ethical issue.

**The Particular Case of Cameroon**

In Cameroon, there is a veritable plethora of plant-based cures for COVID-19 (9; 10). Notable among these are the following:

1. A well-known traditional healer, claims to have a cocktail, composed of a tea, a sirop and a powder made from plants, which eliminates all the symptoms of COVID-19.
2. Another traditional healer claims to have a plant-based remedy “Covid Cure” which is both curative and preventive, and of which he has distributed about 1,000 doses and cured approximately 400 COVID-19 cases.
3. A third herbalist has developed “Corovitaz”, composed of vitamins, anti-bacteria, anti-parasites and anti-inflammatories. He does not give an exact number but claims to have cured hundreds of COVID-19 patients.
4. In the case of a Cameroonian trained in Allopathic Western medicine and based in the USA where he runs a research laboratory, he claims to have discovered a “magic cure”,called “Stop Corona” against COVID-19.
5. The last case here is that of a Catholic Archbishop in Cameroon, who announced the successful treatment of COVID-19 positive patients with an herbal mixture, “Elixir COVID” and “Adsak COVID”. It is alleged that over 3,000 patients, among them some patients who were already on ventilators in state hospitals, have been successfully treated, including several healthcare workers.

Each of the above claimants of a cure for COVID-19 has reported about their remedy to the governmental authorities and on the media in the hope that it would be investigated and officially approved. But, not surprisingly, the government as well as the majority of Western-trained medical scientists, is highly reticent if not dismissive of these claims, preferring to wait for instructions or cues from the International Community and the WHO. Most Governments and Western-educated elite of all African countries would seem urgently to need mental decolonization (31). Their life and well-being are parasitical to exploitative colonialism and neo-colonialism in their own countries. If science is evidence-based, then the scientific merits of these herbal medicines cannot lightly be brushed aside but ought to be investigated with rigor in all objectivity. Why do they seem to work and what is it in each of them that make them to produce the observed effects? The scientific and medical merit of efficacious herbal remedies ought to be investigated and in fact ought to form the main focus of the country’s efforts in the face of COVID-19.

Cameroon is remarkable for its biodiversity – plant, animal and human – and the vast majority of its inhabitants still live close to nature; and this plethora of possible cures is a fruit of that biodiversity combined with a relatively natural mode of living. This is a very good thing for Cameroon which, otherwise, presents perhaps the worst global case scenario for tackling COVID-19 as both the government and the populations, steeped in an on-going deadly genocidal civil war, have shown no seriousness with preventive measures.

**The WHO: An Agency for Global Health or an Arm of Global Westernization?**

The WHO is perhaps the most important agency of the United Nations with a global mandate whose importance is evident and acknowledged by all and sundry. All around the world, governments, especially ministries of public health, healthcare providers and medical researchers, listen to the WHO and sometimes obey its recommendations with unthinking automatism. For these reasons, the WHO needs to be not only highly professional in its actions and pronouncements but also transparently fair to all the different global communities and competing interests in global health. Unfortunately, the WHO seems to fail short of these ideals (12; 27).

Seemingly anticipating the evolution of things with COVID-19, the WHO had issued directives shortly after its outbreak outlining “criteria for ethical acceptability” of human challenge studies – deliberate infection of a healthy individual with a virus (8; 30) - for any candidate vaccine against COVID-19. Was this ethics, calculated at protecting human subjects of medical experimentations, or rather calculative expert support of vaccine developers? Deliberately infecting a human being with a pathogen is an action that merits extensive ethical debate.

An expert group connected with the WHO (Vaswani et al 2020) goes even further to make a strong case for including uneducated persons in deliberate pathogen infection studies. Medical research ethics thus seems to have come under the tyranny of experts who know how to, technicalize, rationalize and ethicalize any scientifically convenient procedure in the interest of global for-profit medical research. Their altruistic philanthropic rhetoric, sedating platitudes and ubiquitous use of the word ‘ethical’ are just a dressing accompanying the text.With such trend, medical research ethics clearly stands in need of rebooting.

Maani N, *et al*. (2021) in their recent article on the new WHO Foundation, express this concern more pointedly: “If the current pandemic has taught us anything, it is that prevention is better than the cure, and that the WHO forms a crucial element of coordinating and informing that prevention globally. The WHO cannot be seen to be sacrificing its independence or impartiality to commercial determinants of health in order to access greater resources. The current signs from the WHO Foundation are troubling...” (12). We should all be troubled!

In Africa, the WHO has in the recent past, before the outbreak of COVID-19, conducted or facilitated the conduct of ethically controversial or questionable vaccine research such as in the case of Ebola in Guinea and the Democratic Republic of the Congo (17).

**Vaccination Lobbies and Campaigns in Africa**

There is a strong lobby for COVID-19 vaccination even though the vaccines that are in the market seem to be still under testing against emerging new mutations, strains, variations or varieties of the virus, necessitating, *inter alia,* introduction of boosters; and it is not yet quite clear how much protection, for how long on what category of patients, each vaccine confers on its recipients. In Africa, the vaccination lobby is taking on the contours of a strong campaign, given that it is coming at a time many people, in addition to their natural reticence, are getting to hear for the first time, thanks to the social media and conspiracy theories, not only about the advantages/disadvantages of vaccines but also about the commercial aspects regarding who actually owns which of the vaccines and their comparative costs.

Vaccine development as we have known it generally takes several years if not decades but COVID-19 vaccine development seems to have been on a super fast track. Proponents and defenders of COVID-19 vaccines testing in Africa are, arguably, mostly eminent scientists and research funders. The gist of the recurring thrust of their several arguments for vaccine testing is that Africa bears 25% of the global burden of disease but conducts only 2% of clinical trials; that Africa’s virtual absence from the “clinical trials map” is a big problem; that it is vital for Africans to take part in vaccine trials or else the aim of finding a vaccine that works worldwide and not just for the richer nations would be jeopardized; that Africa risks being ‘locked out’ from the world to continue in its legacy of exclusion, inequality and poverty; that different circumstances and genetic profiles affect how a vaccine may work and Africa needs to take part in vaccine tests to ensure having a vaccine that works in Africa (13; 21).

These are well-resourced and articulated arguments by those who probably have a vested stake in the vaccine they envisage being tested in Africa and they therefore sound like planned project drives, if not rehearsed product propaganda. A detail in these arguments is worth further consideration. If genetic makeup and circumstances are so important for a vaccine, that would seem to be a very good reason why each country or region that shares the same gene pool, worldview and underpinning culture, with a similar level of material affluence and existential conditions should be engaged in developing their own vaccine.

**Different Healthcare Systems**

There needs to be different healthcare systems around the globe, each harmonized with its particular environment, instead of the current situation where the healthcare system of the industrialized developed world is being globalized as a consequence of colonialism, domination and exploitation. The current dilemmas of rationing in the face of COVID-19 as well as the challenges of vaccine development and distribution are highly accentuated because of a system in which healthcare is inextricably dovetailed with commerce, for profit procedures and attendant morally blind forces (3).There is a need to question whether the institutions and traditions of medicine and healthcare as they have been known in the Western world itself are really morally compatible with its market thinking, theory and practice? But this important consideration evidently seems to have been overtaken by the sheer evolution and momentum of things. In short, it seems that liberal capitalist economic thinking and mindset has overwhelmed everything else in the Western world and is in the process of overwhelming the rest of the world through colonial hegemony and globalization.

It is odd that many African countries, without basic hygiene and sanitation, without any primary healthcare system, without even a glance at their own traditional healthcare systems and the values on which over 80% of their populations depend, focus their attention and public resources on imitative mimicry of high-tech medicine developed elsewhere and not yet domesticated on African soil. High-tech medicine is a patent of the industrialized developed world, harmonized with its general culture and traditional medicine from which it evolved, and those outside of that world cannot fully participate in it except as colonized, dependent, subjugated and exploited people. The imperative alternative is to acquire and use science and technology to modernize African traditional medicine and, if need be, to develop it to high-tech medicine. Otherwise, the best that is achievable is what is observable, namely, that the beneficiaries of high-tech medicine in Africa are the small percentage of Western-educated elite who, since colonization, have assumed the status of privileged happy slaves aiding, abating, and facilitating the subjugation and exploitation of their own lands and peoples in exchange for comfortable careers that permit a developed world lifestyle in the developing world and, above all, power and authority without any responsibility. But then, where are the masses? There is need for drastic change in Africa.

**Conclusion**

COVID-19 is one of the most devastating epidemics in human history. It has affected all continents of the world, all countries and all human communities although in different ways and to varying degrees, thereby truly earning the title of a pandemic. Different peoples in different parts of the world who survive the epidemic must learn what lessons they can learn from the event to move forward with their lives. Africa is the least technologically developed of the continents and has been a colonized and exploited continent for several centuries. Even in the face of COVID-19, Africa seems to have been looked upon by many in the rest of the world mainly as the continent where COVID-19 vaccine tests can speedily and cost-effectively be carried out, for the benefit of the rest of the world. The enthusiasts for testing COVID-19 vaccines in Africa, conceived and developed elsewhere, have all characteristically ignored or downplayed the remarkable simple treatments of the disease in several African countries with plant-based medicines. This situation is teaching a powerful course whose first lesson is that Africa at this moment in its chequered history more urgently needs decolonization than a vaccine. Genuine decolonization should be followed by transforming the continent into a place where all black people and all people of African descent can feel completely at home; where all human beings, no matter from where they are coming, can feel at home because of the pervasive spirit and practice of the BihWir/Ubuntu philosophy (26).

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