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Learning from COVID-19: A social science perspective on pandemic medicine. Comments on Benatar (S Afr J Sci. 2022;118(11/12))

Significance:

Understanding the public health crisis in the wake of COVID-19 requires the complementary knowledges of the biomedical and the social sciences. It also demands that we examine closely the ways in which health inequalities between the Global North and the Global South are sustained. That said, breakthroughs in African medical science, such as the discovery of the Omicron variant, place South Africa in the contradictory positions of inventor and supplicant (waiting in line for vaccines from rich countries) – something that social science and medicine are only beginning to make sense of.

As a young undergraduate science student, I was once invited to attend a progressive health forum of doctors and dentists against apartheid. It would be a life-changing experience, because up to that point, I had little understanding of the links between medicine and the social world. On the platform were two professorial giants, one Jerry Coovadia and another Solly Benatar. Benatar made a simple, but for me profound, point. Tuberculosis was not simply a disease of the body; it was a consequence of social conditions such as damp housing and poor ventilation. Years later we would think and write together about ethics, medicine and society, while I found myself drawn to fascinating journals such as *Social Science and Medicine*.

In Benatar's two recent papers in this Journal^{1,2}, he offers us the accumulation of a lifetime of research and activism on global public health; his sheer breadth of understanding and grasp of the issues are astounding. The first paper describes the nature of the problem and the second ventures some solutions. None of the key arguments is contestable. Public health by its very nature constitutes a global crisis, something the pandemic made crystal clear. The health crisis lies at the intersection of other problems such as climate change, environmental degradation and pandemics – all of which are expected to become even worse in the years ahead of us.

What sustains these problems? An unequal world in which the profit motive of an unbridled capitalism once again revealed the sharp divides between the Global North and the Global South during the COVID-19 crisis. Suddenly, new words were popularised in the media around the pandemic crisis, including terms like vaccine nationalism and even vaccine apartheid. The health of a poor villager in rural Africa was much more vulnerable than the health of those in the North where therapeutics and then vaccines became available on demand. Not everybody's public health crisis is the same: it depends on where you are on the planet and, dare one say this, who you are as a race.

Benatar's systematic, if sometimes pertinacious, account of the nature of the crisis is at once accurate and compelling, carrying the urgency of an activist for whom public health and politics is the same thing. Politics, in this sense, is about power and the authority of the privileged, whether within a country or among the wealthy nations to decide, in Laswellian terms, who gets what and when, and on what terms. In the logics of capitalism, even something as *broodnodig* (basic, essential) as a vaccine is subject to stockpiling, intellectual property rights, and international purchasing agreements that favour the rich and leave the poor waiting.

This raises the question of speed. Its pretensions notwithstanding, Albert Bourla's *Moonshot: Inside Pfizer's Nine-Month Race to Make the Impossible Possible*³, sheds light on an obvious question. What made the production of a vaccine possible in less than a year? There are some useful hints in the book: the pre-existence of vaccine-making capabilities, the (risky) decision to use mRNA technologies, and the determination to produce a vaccine over the constraints of existing protocols. Most of all, the political will was there to make this life-saving vaccine against the odds. The HIV/AIDS research community, still hunting for a vaccine, must have been stunned by this exceptional behaviour on the part of the scientists and governments in the wealthy nations. But what will never again be argued when the next pandemic comes around is that laborious and lengthy trials of vaccines are inevitable.

What the Benatar papers do not explore, however, are the ways in which African medical science revealed itself as a major player in the heat of the crisis to identify variants and vaccines. It is a narrative that needs a place in the telling of the story of how we got through, or are still getting through, the devastation of COVID-19. When our scientists discovered what became known as the Omicron variant in South Africa and Botswana, it stunned the Western world. The first reaction was disbelief, because in the lingering colonial mindset, Africa is the departure point for misery and disease, not a seat of medical ingenuity and discovery; this is a theme to be explored in a forthcoming book, *Racial Logics and the Politics of Knowledge in the Biomedical Sciences in South Africa*⁴. The second reaction was punitive. For the act of discovery and transparency, South Africa was promptly served with flight bans to several Western nations and, to add insult to injury, one of them even required COVID tests be done in a third country. Needless to say, this act of arrogance and ignorance (variant-spread outspurred travel bans) incensed South Africa's medical science community.

But the discovery and reaction usefully revealed a world in which South Africa finds itself in the contradictory position of being a major contributor in the South to medical science and at the same being a supplicant in the supply chain waiting for much-needed vaccines from a dominant North.⁵ For social scientists, this was intellectually fertile soil for re-examining the changing architecture of North–South relations in knowledge production where African agency in medical science alters our understanding of a changing world.

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Of course, this capacity for breakthrough medical science is not new in South Africa, only seldom acknowledged. Before and since the first heart transplant to world leadership on poverty and cardiovascular disease, and of course global leadership in HIV prevention among women, South Africa is a major player in the competitive world of medical science research. That capacity has been steadily built up over the years in our leading universities but also through international collaborations and networks that brought high-level expertise back and forth to change the ways in which African science contributes to public health. The homegrown capacity for advanced genomic sequencing composed and built up from the AIDS crisis, for example, positioned South Africa well when the novel coronavirus breached our shores.

All of this means that, in describing the global health crisis, we need to reset our parameters, not only for policy and planning but also for research and analysis, in recognition of the entangled worlds in which knowledge is now produced and from which reality public actions can be pursued. I am not sure that any solution lies with altering “a wicked economic system” as Benatar calls the capitalist world order, but there are other options for deeper understanding and informed actions.

I like very much the notion of starting with Benatar’s correct observation of “the multifactorial sociological underpinnings of ongoing global crises” and the corresponding need for transdisciplinary teams to rethink approaches to public health in the light of the pandemic. This is where South African medical science can again provide leadership in the wake of what we learnt from COVID-19.

As already published in the pages of the *South African Journal of Science*, one of the critical mistakes made by the elaborately named National Coronavirus Command Council was that the body was stacked with biomedical experts without vital perspectives from the social sciences and humanities. The result was an authoritarian clampdown in poor communities for not complying with lockdown regulations; there was little grasp of the meaninglessness of the construct of ‘social distancing’ within cramped settlements. Nor was there an early enough understanding of the economic impacts on street vendors facing the more immediate and felt threat of hunger over that of a deadly but invisible virus. And there was little attention to the need for cultural rituals

at funerals or weddings among those removed from the high ideals and sometimes abstruse language of modern medicine. In other words, sociologists, economists, anthropologists and even linguists would have been invaluable in the sensemaking required during the early months of the pandemic.

There is little attention to these complexities in Benatar’s papers, and yet they offer an opportunity for South African science and scholarship to advance in these times – not only a more elaborate technological capacity in preparation for the next round of epidemics, but also a more sophisticated conceptual apparatus that brings together the best minds from the social and medical sciences to develop new languages and approaches to public health crises.

What Benatar offers in this regard in these two highly valuable papers, is a solid platform for next-generation research and scholarship that works from a more integrated and efficacious platform for intervention as well as prevention in public health crises.

Competing interests

There are no competing interests to declare.

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