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Dialectical Tensions of Sustainability and Health during the COVID-19 Pandemic: A Tale from Latin America

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Abstract: The purpose of this article is to discuss the relationship between sustainability and health in the context of the coronavirus pandemic in Latin America, the region with the second highest number of deaths due to COVID-19. After performing a dialectical analysis on mass media discourses about the pandemic, we argue that sustainability must be understood in relation to tensions such as (a) health and economy, (b) isolation and interconnectedness of health management, and (c) access to and excess of information about the pandemic. Based on this analysis, we suggest that if health is to be considered a fourth pillar of sustainability, it needs to be approached in close connection with these inseparable and irreducible tensions in order to broaden the way in which it has been approached in global sustainable development agendas and to recognize the role of individuals and communities in health issues.



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1. Introduction

Images of clear skies in the big cities showing a significant reduction in air pollution contrast with the huge waiting lines to buy food through government subsidies and the shortage of intensive care units to treat COVID-19 patients in developing countries hospitals. In a year, the coronavirus pandemic has evolved from a public health emergency to an economic crisis that poses serious political and social challenges that threaten life as we know it. Since the virus outbreak in December 2019 in Wuhan, China, the pandemic has led politicians, scholars, and practitioners from various fields to ask questions about the effects that COVID-19 will have in globalization [1,2], immigration [3], different economic sectors [4,5] and democracy [6]. Other studies focused on trading and consumer activity during the pandemic. For example, Laato et al. [7] examined unusual consumers' behavior, such as the purchase of certain products (e.g., toilet paper) in large quantities. In a similar way, the coronavirus also led to the study of how financial attitudes during the pandemic have impacted the retail activity of trading services [5].

On one hand, this crisis has shown how interconnected our lives are and how knowledge and practices from different fields are needed to better face the risks and dangers brought about by the pandemic. On the other hand, it has also shown the frailty of our social systems.

The pandemic has made social systems' weaknesses more evident. The latter ushers us to follow Hakovirta and Denuwara's [8] suggestion to redefine the very notion of sustainability in such a way that it includes and highlights human health as a constitutive dimension. The idea of considering health as a broad social objective is not new. The United Nations has taken health into account in documents such as Rio Declaration (1992), Agenda 21 (1989) and, more recently, in the Sustainable Development Goals (2016). However, the

current pandemic has accentuated the importance of considering specific ways in which societies should be able to meet health needs that compromise people's lives in the present and the foreseeable future.

Thus, the purpose of this article is to show how the relationship between sustainability and health can be strengthened and to discuss the characteristics that this approach to health should consider. The current coronavirus pandemic gives us an interesting context to ground our contribution, as the strategies devised by each country to handle the crisis have shown important differences not only in terms of resources but in terms of how people make sense of the situation. We focus on Latin America (Latin America, has a population over 520 million people (World Bank, 2018). The eighteen countries encompassed in the region vary in extension (Brazil and México compared to small Belize or Uruguay), population, and economic, and social indicators. However, they do share a similar historical and cultural background. Most Latin American countries have assumed the institutions of their colonizers [9,10], their language (especially Spanish and Portuguese), and the Catholic religion. As of 2020 all of them are self-proclaimed electoral democracies and most of them (except Nicaragua and Venezuela) de facto live under a capitalist model of economic development. Additionally, these countries are trying to achieve the 2030 sustainable development goals), the region that at this point of the pandemic is the second one in the world with more deaths: the number exceeded 600,000 deaths at the end of January 2021. As the Agence France-Presse [11] reported on 3 February,

"Brazil is the country with the world's second-highest national death toll with more than 226,300 fatalities, and Mexico is number three with at least 159,100 deaths. As a percentage of the population, Peru is hardest hit with 125 deaths per 100,000 people, followed by Mexico and Panama with 123 each per 100,000."

The case of Latin America is particularly interesting because response times, contagion, and death rates and access to vaccines have been influenced by the economic and social conditions of each country (see Table 1). Paradoxically, Latin America has been one of the most affected regions by the pandemic, but not the most studied. This manuscript strives to contribute to the scholarship on COVID-19 in South and Central America. Its novelty lies in the fact that it addresses the subject of health—in the context of the pandemic—from a standpoint of sustainability. While sustainability has been often approached in terms of environmental, economic, and social practices, our focus directly defines sustainability in terms of health in order to understand the implications of such a perspective in the context of the pandemic.

Specifically, we examine this Latin American context by analyzing mass media discourses about the coronavirus pandemic to understand the relationship between health and sustainability. A preliminary analysis showed that those discourses present tensions and contradictions in terms of how health and sustainability interact. Based on this analysis, we argue that sustainability must be understood in relation to tensions such as (a) health and economy, (b) isolation and interconnectedness of health management, and (c) access to and excess of information about the pandemic. Even though organizations such as the United Nations have included health as part of global sustainable development agendas (Millennium Goals 2000–2015; Sustainable Development Goals 2016–2030), the articulation of health as a fourth pillar of sustainability acknowledges the centrality of this dimension for achieving any short- or long-term goal and will prepare us for future pandemics as the prescriptive nature of sustainability tends to define agendas and objectives for nations and organizations.

Next, we present the theoretical perspective that we embrace to understand sustainability as well as the dialectical analysis that we performed to explore the relationship between health and sustainability in the context of the coronavirus pandemic. Later, we discuss the three pairs of dialectics from which the incorporation of health as a fourth pillar of sustainability should be approached. Finally, we conclude by explaining the scope and consequences of this articulation between sustainability and health.

Table 1. Economic, health and human development indicators for Latin American countries.

Country	Economic				Human Development				
	Population (2018) ¹	GDP 2018 (Millions US) ²	% Informality ³	MPI (0–1) ⁴	Health Investment as % GDP (2014) ⁸	# Hospital Beds × 1000 Inhabitants ⁵	Position (2018) ⁶	Gender Gap Index (2020) ⁷	
Argentina	4,449,450,000	51,987,152	9.2% (2018)	N/A 0.017 (2015–2016)	Public 2.7 3.9	Private 2.1 1.9	0.5 (2014)	48	0.746
Belize	383,071	187,120	6.6% (2017)				1.5 (2014)	103	0.671
Bolivia	1,135,314,000	4,028,765	3.5% (2018)	0.094 (2008)	4.6	1.8	1.3 (2014)	114	0.734
Brazil	20,946,932,000	188,548,253	11.9% (2019)	0.016 (2015)	3.8	4.5	2.2 (2014)	79	0.691
Chile	1,872,916,600	29,823,113	7.3% (2019)	N/A 0.021	3.9	3.9	2.2 (2013)	42	0.723
Colombia	4,966,105,600	33,104,704	10% (2019)	(2015–2016)	5.4	1.8	1.5 (2014)	79	0.758
Costa Rica	499,944,000	6,013,011	11.5% (2019)	N/A 0.018 (2013–2014)	6.8	2.6	1.2 (2015)	68	0.782
Ecuador	1,708,436,000	10,839,806	3.8% (2018)		4.5	4.7	1.5 (2013)	85	0.729
El Salvador	642,074,000	2,605,700	4.0% (2018)	0.033 (2014)	4.5	2.3	1.3 (2014)	124	0.706
Guatemala	1,724,781,000	7,846,045	2.5% (2017)	0.134 (2014–2015) 0.090	2.3	3.9	0.6 (2014)	126	0.666
Honduras	958,752,200	2,402,419	5.6% (2018)	(2011–2012)	4.4	4.3	0.7 (2014)	132	0.722
México	12,619,079,000	122,069,948	3.5% (2019)	0.025 (2016)	3.3	3.0	1.5 (2015)	76	0.754
Nicaragua	646,551,000	1,306,387	4.5% (2014)	0.074 (2011–2012)	5.1	3.9	0.9 (2014)	126	0.804
Panamá	417,687,000	6,505,510	3.9% (2018)	N/A	5.9	2.2	2.3 (2013)	67	0.730
Paraguay	695,607,000	4,049,695	6.6% (2019)	0.019 (2016)	4.5	5.3	1.3 (2011)	98	0.683
Perú	3,198,926,000	22,204,497	6.4% (2019)	0.052 (2012)	3.3	2.2	1.6 (2014)	82	0.714
Uruguay	344,930,000	5,959,689	9.4% (2019)	N/A	6.1	2.5	2.8 (2014)	57	0.737
Venezuela	2,887,019,000	48,235,932	6.6% (2012)	N/A	1.5	3.7	0.8 (2014)	96	0.713

¹ World Bank, <https://datos.bancomundial.org/indicador/SP.POP.TOTL> (accessed on 15 July 2020); ² World Bank, https://datos.bancomundial.org/indicador/NY.GDP.MKTP.CD?most_recent_value_desc=false (accessed on 15 July 2020); ³ International Labor Organization, <https://ilo.org/topics/unemployment-and-labour-underutilization/> (accessed on 16 July 2020); ⁴ OPHI, Oxford Poverty and Human development Initiative, <https://ophi.org.uk/multidimensional-poverty-index/global-mpi-2018/#t2> (accessed on 15 July 2020); ⁵ World Bank, <https://datos.bancomundial.org/indicador/SH.MED.BEDS.ZS?view=chart> (accessed on 16 July 2020); ⁶ United Nations Development Programme, Human Development Reports, http://hdr.undp.org/sites/default/files/hdr_2019_overview_-spanish.pdf (accessed on 15 July 2020); ⁷ World Economic Forum, Global Gender Gap Index, <http://reports.weforum.org/global-gender-gap-report-2020/the-global-gender-gap-index-2020/results-and-analysis/> (accessed on 16 July 2020); ⁸ Pan American Health Organization, Institutional Repository for Information Sharing, https://iris.paho.org/bitstream/handle/10665.2/34330/IndBrasicos2017_spa.pdf?sequence=1&isAllowed=y (accessed on 26 July 2020).

2. Materials and Methods: Conceptual and Analytical Frame

Most discussions about what sustainability is and what it encompasses take on a normative approach. According to Cardonna [12], they revolve around three main ideas. First, sustainability proposes the interconnectedness of human society, economy, and natural environment. Because actions in one dimension have an impact in other dimensions, societies need to consider the dynamic interactions between social, economic, and environmental issues. It is worth noting that health is considered within the factors that make up the social dimension. Second, natural resources are finite, so growth, consumption, and production must have limits to ensure that meeting present needs does not compromise the satisfaction of future needs. This is directly in line with the intergenerational aspect of sustainability as societies must consider next generations in planning for the future. Third, sustainability implies to operate on a smaller scale in order to decentralize and reappreciate local culture and resources as a strategy for societal resilience.

We embrace a social constructionist perspective of sustainability [13] that highlights the continuity between discourses and practices since the latter do not exist outside the realm of language and social interactions. We do not claim that there are not actual sustainability problems, but rather that their approach is necessarily mediated by the discourses through which those problems are understood, communicated, and handled. From this standpoint, economic, social, and environmental accounts compete with other discourses for discursive hegemony. Unlike a functionalist approach to sustainability [14] that claims the positivist, descriptive, objective, and noncritical nature of sustainability, we argue the need to consider the role of competing discourses that show different dimensions of the same phenomenon.

Additionally, this constructionist approach to sustainability makes us acknowledge its prescriptive nature [15], that is, its normative condition according to which sustainability is not a concept that exclusively describes a set of practices, but it also suggests a program of action about those practices. Because of its pragmatic scope, the notion of sustainability also invites individuals, governments, and organizations to act in a certain way by assuming moral, evaluative, and future-oriented actions limiting and preserving the resources of the present [16].

These constructionist and prescriptive approaches allow us to analyze the interplay of health and sustainability. The link between them can be traced back to 1989 when the World Health Organization created the Commission on Health and Environment as well as several specialized panels and groups whose work “laid the foundation for emphasizing health at the Rio Earth Summit” [17] (p. 6). Principle 1 of the Rio Declaration states that human beings “are entitled to a healthy and productive life in harmony with nature” (UN, 1992). At this point, health was linked to sustainability because of its relevance in terms of environmental, agriculture, and food issues. In the 2000s the UN has put forward two global sustainable development agendas: The Millennium Development Goals (MDGs) and the Sustainable Development Goals (SDGs). Both agendas have devoted specific goals to advance health issues. Three out of the eight MDGs were linked to health issues (Goal 4, Child Mortality; Goal 5, Improve maternal health; Goal 6, Combat HIV/AIDS, malaria, and other diseases). The SDGs broaden the agenda to 17 goals and all health issues were grouped in Goal 3, related to “ensure healthy lives and promote well-being for all at all ages”. Both agendas have also targeted premature mortality, disability, and specific illnesses. Even though Goal 3 of the SDGs is broader in scope, it approaches health as the lack of disease, reduction of mortality, and access to health services, vaccines, and medicines.

It is interesting to conceive of health in those terms considering that with “the exception of immunization efforts, overall population health is marginally affected by medical care decisions; health is determined more by decisions made about agriculture, transportation, housing, economic, and education policies than it is by medical decisions” [18] (p. 107). This explains why some scholars as well as policymakers have called for a broader view of health, one that goes beyond the biomedical view to take into account social and environmental factors. From this perspective, health depends as much on having access to medical services, as on daily routines and habits, and the quality of our surroundings. Furthermore, this view calls for a “health in all policies” approach [18] (p. 107). The coronavirus pandemic has put health in the forefront of the global agenda for over a year. However, it has underlined the biomedical view as most discourses focus on the virus, the disease, mortality rates, and health care systems.

Considering that health discourse has different emphasis and that health practices are inseparable from the discourses that underlie to and support them, we examine the relationship between sustainability and health by focusing on the discourses of the coronavirus in the pandemic. We understand discourse here in its broadest sense, that is, as a set of ideologies, logics, forces, and elements that give meaning to social practices. Some scholars within the field of sustainability studies have referred to this perspective as Discourse, with capital “D” [13,19,20] in order to distinguish verbal and nonverbal exchanges (which could be defined as *discourse*) from *Discourse*, understood as the ideologies and meaning systems that underlie different social practices.

Specifically, we examined the discourses about the coronavirus pandemic published in the front pages and Facebook pages of Latin American newspapers considering the constant increase in news consumption in social media [21,22]. We selected a national-non-tabloid newspaper with the highest circulation for each of the countries included in the study based on the Newspaper Web Ranking (constructed from four independent web metrics extracted from different search engines) [23]. Then we collected the front covers and the posts for each of the selected newspapers for two periods: (a) from March to May 2020 in order to examine the beginning of the pandemic, and (b) from December 2020 to February 2021 to explore the beginning of the vaccination processes. We created

a sample that would allow us to identify tensions in these discourses. So, we collected front pages and Facebook posts from the selected newspapers for one week for each of the months considered in the period. We worked with 516 titles collected from front pages and 7762 Facebook posts. We used Nvivo 13 to explore data by using word frequency and to code titles and posts to identify the main trends in how these newspapers were framing the pandemic.

We examined the pandemic discourses through a dialectical analysis that consists of identifying the opposite and dynamic forces and discourses that emerge, in the form of contradiction or conflict, in a given social practice [24]. This dialectical approach belongs to the broad umbrella of paradox studies, which are based on constructs such as tension, dualism, duality, contradiction, and dialectic [25]. Paradox studies have been mainly used in traditions such as organizational communication [24] and interpersonal communication [26]. The fields of sociology, psychology, and education are also starting to recognize the epistemological advantages of this approach [27].

Within paradox studies, we focused on dialectic as a lens of analysis that allowed us to explore the “interdependent opposites aligned with forces that push-pull on each other like a rubber band and exist in an ongoing dynamic interplay as the poles implicate each other” [27] (p. 71). Approaching reality in dialectic terms implies acknowledging the contradictory forces that are at play in social practices. Unlike a dichotomous perspective that tends to favor one pole of a tension over the other, the dialectical perspective focuses on the interplay of potentially contradictory elements of social practices.

This article draws upon dialectical analysis to discuss some of the tensions and contradictions present in mediated discourses about the coronavirus pandemic. We use these tensions to illustrate some traits of the relationship between health and sustainability. Since sustainability consists of a balance between three competing dimensions (economic, social, and environmental), we explore how tensions between these dimensions and health were presented in mediated discourses about the pandemic. The latter showed that at different times of the pandemic certain dimensions were favored over others, creating imbalances and unintended consequences. Seo et al. [28] explain that tensions and contradictions can be approached or managed in four ways that include selection, separation, integration, and transcendence. A tension managed through selection “entails denial in which parties ignore the opposite pole and, thereby, inadvertently select one side of the dichotomy over the other” (p. 76). Managing a tension by separation recognizes both poles of the dichotomy but separates them in different levels of analysis. Integration “refers to a balance in that both ends of the continuum are legitimate at once but remain unfulfilled in their totality” (p. 76). Finally, transcendence entails a synthesis in which dichotomies are reframed as a whole.

Since we argue that, after the pandemic, health should be closely and more strongly connected to the concept of sustainability, we discuss the inherent dialectics of a broad understanding of health. In order to accomplish this purpose we followed some steps for our dialectical analysis, we (a) identified the competing discourses—understood in its broadest sense—of health in the pandemic by exploring their tensions and apparent contradictions; (b) examined those discourses at two specific moments of the pandemic: at the beginning where countries implemented lockdowns and later with the invention of the vaccines; and (c) discussed the way in which those dialectical elements influence practices of health and sustainability. As a result of this process, in the next section we discuss the following tensions: health and economy, isolation and interconnectedness of health management, and access to information and excess of information in a pandemic.

3. Results: Dialectical Tensions of Sustainability and Health

3.1. Health-Economy Tension

In several Latin American countries, politicians, media, and citizens have made sense of the coronavirus pandemic as a situation that involves choosing between two broad discourses: preserving human life or saving the economy. For example, at the beginning of the pandemic, president Fernandez of Argentina ordered a strict and early lockdown

for the whole country arguing his concern for Argentinians' health [29]; while president Bolsonaro of Brazil referred to a possible coronavirus lockdown in his country as a major "crime" because of its consequences for the economic life of the people [30]. Presented in these dichotomous terms, the relationship between life and economy implies that actions on one dimension affect negatively the other. After several weeks into lockdown, Chile and Peru faced high numbers of COVID-19 cases and the difference between the health care services that upper and lower classes could afford were more than evident [31]. In this sense, a report of Oxfam International [32] suggested that measures as basic as washing hands or avoiding physical contact were difficult to follow for 21% of the Latin American countries' urban population living in slums, informal settlements or inadequate housing where basic services are not affordable.

The coronavirus pandemic has brought significant challenges for the satisfaction of needs due to the increase of unemployment and the reduction of mobility that we saw in most countries. However, this challenge was more worrisome in regions like Latin America where such unemployment and reduced mobility affected the satisfaction of the most basic needs including food and housing. This is the effect of informality that according to David, et al., [33] characterizes labor markets in Latin America. Although informality has decreased in the region over the last decades, in average, half of overall employment remains in the informal sector. Reduced mobility also affected the popular practice of selling goods or offering services to commuters to and from work at the stop lights in heavily populated and extended cities such as Mexico City, Bogotá, Buenos Aires, Sao Paulo, Río de Janeiro, Lima, or Santiago de Chile. With fewer commuters on the streets, the street vendors had no opportunities for business and their incomes were drastically reduced or almost non-existent. They, of course, lacked health protection and benefits. The Economic Commission for Latin America and the Caribbean (ECLAC) and the Food and Agriculture Organization (FAO) officials for Latin America warned that the current health pandemic could be followed by a hunger crisis that would impact at least 80 million people living in extreme poverty and experiencing severe food insecurity after COVID-19 [34].

When the satisfaction of these most basic needs is at risk, it is useful to reflect on the perspectives that Latin American scholars have suggested to understand the scope and nature of sustainability in their own region. For example, Maxwell Max-Neef's human-scale development paradigm could help us understand the way in which Latin American governments and citizens have reacted to the pandemic. This Chilean author invites us to understand development in terms of meeting human needs and to focus on the development of people rather than those of objects [35]. Max-Neef explains that while all cultures and regions share the same types of needs, the satisfaction of those needs depends on the structural characteristics of each culture.

The management of contagion rates of coronavirus in Latin-America illustrates the articulation of the social and economic dimensions of sustainability and the salience of culture predicated in Max-Neef ideas. For example, because Peru was one of the Latin American countries that implemented some of the strongest containment measures at the beginning of the pandemic, specialists expected lower rates of contagion in this country. However, by May 2020, Peru had the third highest official number of COVID-19 cases in Latin America and seventh in the world. This can be explained by considering that most Peruvians (71%) satisfy their needs through informality [36], that is, by obtaining their income on a daily basis in cash, there is no place for saving or expense planning. In addition, the fact that in Peru one out of five poor households has a refrigerator explains the need for Peruvians to go out every day to buy food [36]. The active life of food markets in many regions of Latin America has created a routine in which millions of people go out on a daily basis to buy fresh food for immediate consumption.

Likewise, these behavior patterns in the region illustrate the relative character that Max-Neef attributed to needs as it is difficult to establish an agreed upon hierarchy in terms of their urgent or essential nature. In countries where people earn their income each day in an informal street job, it is difficult if not impossible to stay home to protect their

health. Once again, health and economy are in tension. Favoring one pole of the tension over the other compromises life itself. Thus, it is important to get artificial ventilators and vaccines, but it is also essential to guarantee a way in which poor people—who constitute the majority of the population in Latin America—have access to a minimum vital income that allows them to attain food and housing amid the culture and economy of informality that has been ingrained for decades in the region.

In addition to problematizing the types of satisfiers and the hierarchy of needs in Latin America, Max-Neef's perspective—based on a main concern of sustainability—leads us to consider the satisfaction of needs in terms of time. On the one hand, an important part of the Latin American population tends to meet their basic needs on a day-to-day basis, and on the other hand, it is really challenging to consider the needs of the future in an economy and culture of informality. The coronavirus pandemic has suggested that, in the same way that military apparatuses prepare with weapons and military forces for probable future threats to territories and national sovereignties, health systems should prepare for probable pandemics in the future.

The pandemic has thus exposed the fragility of health systems in Latin America. The average hospital bed capacity (including ventilators and emergency bed units) for the region is low. On average, there are only 1.4 hospital beds per thousand inhabitants (see Table 1, column 7). Although this number varies according to countries, it remains below the average for countries of the Organization for Economic Cooperation and Development (OECD), which constitutes five hospital beds per thousand inhabitants. When looking at the number of intensive care beds the scenario becomes even darker: Uruguay has the highest number of intensive care beds in the region, that is, 5 per 100,000 inhabitants. We saw how Italy and Spain had a higher number of intensive care beds, (thirteen and ten, respectively) and their health systems collapsed.

Another characteristic of the Latin American health system is that its quality depends on its location: the closer hospitals are to main cities, the better care they offer. The rural population suffers even more hardships than urban population and among the former, indigenous communities face almost impossible odds. The COVID-19 pandemic has been no different. In Brazil, after initial efforts to protect around 800,000 members of Amazonian indigenous groups, president Bolsonaro vetoed 16 sections of a law “that mandated the government provide drinking water, disinfectants, and hospital bed quotas for indigenous peoples during the pandemic, while leaving the proposed testing supplies, ambulance services, and medical equipment” [36]. Similarly, on 20 April 2020, an association of Peruvian indigenous peoples filed a formal complaint to the government for lack of a plan to address the pandemic within the country’s 1800 communities. On May 2020, Iquitos (Peru), became a hotspot of the pandemic. Local health officials estimated that up to 90% COVID-19 fatalities in the city—the largest one in the world not accessible by car—were due to lack of medical equipment and low staffing numbers because many doctors and nurses had fallen ill [37]. The indigenous community of Pucacuro, also in Peru, reported that 600 of their 800 members were infected. Their chief added that for the last 40 years, millions of oil barrels have been going out from their territory and now they do not even have one doctor to attend to their health needs [38].

If the availability and quality of medical care could prevent the loss of lives due to coronavirus pandemic, a new challenge arises when planning for massive vaccination once each country secures and brings the vaccines to the population that needs them. Here again the competing interests reveal themselves and offer different outcomes depending on the country. As Table 2 shows the rolling out of the vaccination plans vary in scope and reach between the countries.

Plans have been designed according to the number of vaccines each government has been able to secure. The latter depends on the availability of vaccines but also on the economic resources as well as each government’s ability to negotiate with pharmaceutical companies and their Chinese and Indian counterparts. Chile, for example, started signing deals with Pfizer, AstraZeneca, Johnson & Johnson and China’s Sinovac early on in 2020 [39].

This multifront strategy to secure vaccines was successful and Pfizer delivered the first badge of vaccines at the end of December 2020 [40]. By the middle of March 2021, Chile had already vaccinated 25% of its population, a vaccination rate among the highest in the world and the highest in Latin America. Contrary to the successful story of Chile, countries such as Nicaragua, Ecuador, and Venezuela are falling behind and by the beginning of March 2021 had barely started rolling out their plans. México with 2% of its population vaccinated is below the world average of 3.5% and Brazil's 4% seems also very low considering that Brazilian's governors declared on the first week of March that the country was living "the worst of the pandemic" [41].

Table 2. Latin America's vaccination plans.

Country	ECLAC Vaccination Plan	ECLAC Vaccines Already Being Distributed (III-2021)	OWID Vaccination Doses Administered per 100 People 8 March 2021
Argentina	x	x	3.42
Belize	x	x	0.25
Bolivia	x	x	0.96
Brazil	x	x	5.15
Chile	x	x	25.89
Colombia	x	x	0.62
Costa Rica	x	x	3.79
Ecuador	No reports	x	0.42
El Salvador	x	x	(25 February) 0.25
Guatemala	x	x	(1 March) 0.01
Honduras	x	x	(28 February) 0.03
México	x	x	2.21
Nicaragua	x	x	No info
Panamá	x	x	4.91
Paraguay	x	x	(7 March) 0.02
Perú	x	x	(7 March) 1.15
Uruguay	No reports	x	2.90
Venezuela	No reports	x	(4 March) 0.04

Sources: ECLAC = Economic Commission for Latin America and the Caribbean; OWID = Our World in Data.

Although acquiring vaccines and strengthening hospitals became a priority among Latin American countries facing the coronavirus pandemic, most governments centered their actions in alleviating the economic situation of their populations. Different fiscal and economic strategies were implemented all over the region. As of August 2020, most countries had negotiated their debts—already at historic highs—and looked for new sources of funding that might help them cope with the situation [37]. The United Nations Conference on Trade and Development has estimated that developing countries will need at least EUR 2.5 trillion over the next two years to meet their external financing needs [42]. Thus, the Latin American case shows that it is not only a matter of preparing for the health needs of the future, but also of thinking about the satisfaction of needs in the medium and long term beyond the day-to-day subsistence. Instead of privileging some models, elements, or characteristics (economy over life) in dichotomous frameworks, we argue that dialectical tensions help us to approach health and economy as two sides of the same coin.

3.2. Isolation and Interconnectedness of Health Management Tension

The coronavirus pandemic suggests another contradiction, this time between the discourses that invite people to isolate themselves and those that encourage interconnectedness to manage the pandemic. While the pandemic has called for a global response and a collective effort in the production of vaccines against the virus, the management of the pandemic takes place at the level of the nation-states. Not only did the virus spread rapidly

throughout the planet because of the dynamics of interconnectedness among regions, but also because the strategies adopted to cope against it are mostly national and autonomous.

In fact, at the beginning of the pandemic, the tension between isolation and interconnectedness manifested in the discourses that invited countries to close borders in order to avoid the spread of the virus and, at the same time, discourses that aimed for the interdependent work of scientists and physicians to find treatments and vaccines against the virus. As Table 3 shows, initial measures of lockdowns or curfews were put in place between middle and late March 2020, the exception being Nicaragua where the only measure enforced was to tighten control over its borders with Costa Rica and Honduras. Interestingly, the closing of the borders to certain nationalities was a disposition that eventually most countries adopted.

Table 3. Date and actions taken by Latin American Countries.

Country	Date First Case Confirmed—2020	Action Taken (1)-Date	Days after the First Case Was Confirmed (1)
Argentina	3 March	Compulsory Lockdown started 20 March	17
Belize	23 March	National State of emergency/Curfew (20h00 to 04h59) declared 1 May	38
Bolivia	11 March	Compulsory Lockdown started 22 March	11
Brazil	25 February	Voluntary lockdown started 17 March	21
Chile	3 March	Partial compulsory lockdown started 19 March	16
Colombia	6 March	Compulsory national lockdown started 25 March	19
Costa Rica	5 March	Voluntary national lockdown started 15 March	10
Ecuador	29 February	Compulsory National Lockdown plus curfew started 17 March	17
El Salvador	19 March	Compulsory National Lockdown plus curfew started 21 March	2
Guatemala	13 March	Partial lockdown started 22 March	9
Honduras	11 March	Compulsory National Lockdown plus curfew started 20 March	9
México	28 February	Voluntary lockdown started 30 March	31
Nicaragua	19 March	No lockdown was declared	-
Panamá	10 March	Compulsory National Lockdown plus curfew started 25 March	15
Paraguay	7 March	Voluntary lockdown with curfew started 30 March	23
Perú	6 March	Compulsory National Lockdown plus curfew started 16 March	10
Uruguay	13 March	Voluntary lockdown started 13 March	0
Venezuela	13 March	Compulsory National Lockdown plus curfew started 17 March	4

Source: ECLAC, 2020. COVID-19 Observatory for Latin America and the Caribbean Economic and Social Impact updated 15 July 2020.

Beyond closing of borders, dispositions taken by Latin American countries mostly included closing of all non-essential businesses, establishing curfews, imposing social isolation and social distancing, and suspending travel and movements within and between countries (see Table 4). Although these measurements were very similar in nature, they were enforced differently. In Brazil, for example, the state governors were the agents in charge of introducing and upholding the dispositions to protect the health of their people, while the president openly disagreed with such actions [30]. Conversely in neighborly Argentina, the national government extended and enforced, upon request of governors, the specific measures necessary to protect the population [43].

As pharmaceutical laboratories started to produce vaccines, this dialectic between interconnectedness and isolation manifested, on one hand, in the joint work required to produce vaccines and, on the other, in the autonomous national measurements related to the management, purchase, and application of those vaccines. One of the main consequences of this isolation can be seen in the different access to vaccination by industrialized and third world countries. For example, Latin American countries—as opposed to the African Union—negotiated the acquisition of vaccines separately fighting against each other and facing problematic procurement deals [42]. Most countries in Latin America are accessing vaccines through the Covax initiative that intends to obtain and deliver doses of a safe, effective, and approved vaccine for fair distribution around the world. The initiative is coordinated by the World Health Organization (WHO) in partnership with GAVI, the Vaccine Alliance,

and CEPI, the Centre for Epidemics Preparedness Innovations, and plans to have enough doses to protect high risk and vulnerable individuals as well as frontline healthcare workers around the world [44]. High-, middle- and low-income countries have signed into the scheme. The first ones will receive sufficient doses to protect a certain proportion of their population paying a premium to help middle- and low-income countries. However, the initiative will only cover 20% of the population of the funded countries; each country will have to acquire the doses needed to inoculate the rest of their population [45].

Table 4. Actions implemented by the different Latin American countries.

Country	Restrictions or Prohibition on the Entry of Foreign Travelers	Border Closures and Controls	Border Controls	Restriction or Closure of Public Places and Mass Gatherings	Other	Total Movements across and within Countries
Argentina	2	1	1	1		5
Belize	3	3	4	5	2	17
Bolivia	1	1	2	5		9
Brazil	6	2	1	6	4	19
Chile	2	9	5	19	1	36
Colombia	2	3		2	1	8
Costa Rica	2	3	5	10	5	25
Ecuador	1	2		3	1	7
Guatemala	2	1	1	2	9	15
Honduras	2	1	1	1		5
Mexico	1			1		2
Nicaragua		1	1			2
Panamá	3	2		1		6
Perú	1	1	1	1		4
Paraguay	1	2		6		9
San Salvador	2	3	2	8	1	16
Uruguay	1	5	1	1		8
Venezuela	1	1	1	3	2	8

Source: ECLAC, 2020. COVID-19 Observatory for Latin America and the Caribbean Economic and social Impact updated 15 July 2020.

Some low-income countries such as Bolivia, El Salvador, Honduras, and Nicaragua are counting on the free vaccines coming from Covax [46]. Other countries with enough resources and provision such as Chile, dealt directly with pharmaceutical firms and governments to secure the vaccines needed for their people. So did Colombia, Argentina, Brazil, and Mexico although somewhat later than Chile. Because most of the developed world had already bought up nearly all of the Western-made vaccines, Latin American countries turned to China and Russia: by March 2021, Argentina and Bolivia were vaccinating with the Russia's Sputnik V, Chile started distributing the four million doses of China Sinovac's, and Peru celebrated on February 2021 the arrival of China's Sinopharm [47].

This lack of coordination and joint work among Latin American countries along with the shortage of vaccines has affected the implementation of vaccination plans, especially for the smaller countries. Argentina, Brazil, and Mexico—the giants of the region—plan to make their own vaccines, but they face shortages of the basic components already captured by pharmaceutical firms in the developed world. China has offered assistance in this endeavor since their vaccine is less complicated to produce and requires fewer specifications for distribution. Argentina and Brazil are also ready to start producing the Sputnik V [47]. Conversely, Cuba started developing their own vaccines and, by the end of 2020, already had two vaccines in clinical trials. Finally, it is important to remember that one way that Latin American countries had to secure vaccines was to serve as volunteers to pharmaceutical firms for late-stage trials [47].

As with the first dialectic, we argue that if health is to be considered as a fourth pillar of sustainability, it needs to be approached both as a global yet locally handled issue.

The pharmaceutical production and distribution of vaccines supports the need to overcome this tension between interconnectedness and isolation in the management of health issues. As the pandemic is global, it requires global actions that can be adapted and applied to every country striving to overcome the commercial interests of private pharmaceutical companies and the hoarding of medicines and vaccines by powerful countries.

3.3. Access to and Excess of Information in a Pandemic Tension

The coronavirus pandemic suggests another dialectical tension, this time between the governments' need to provide accurate information about the pandemic and, on the other pole, the current dynamics of communication in which large amounts of information generate phenomena such as fake news, health misinformation, infodemic risk, and the rise of popular narratives that help individuals to make sense about the pandemic. Navigating between the poles of this tension from a dialectic perspective is important because sustainability depends precisely on discerning, in the deep flow of information, what resources and practices can in fact sustain individuals over time.

The delay of the Chinese government in reporting the first cases and scope of a new virus—later known as coronavirus—illustrate the first element of the dialectical relationship between the limited access to data about the virus and the excess of information and disinformation that currently circulates about it. The distrust in the Chinese data not only generated an environment of uncertainty, but also delayed transnational actions to contain the pandemic.

In the specific case of Latin America, at the beginning of the pandemic some governments also generated skepticism about the pandemic. This was the case of Nicaragua, on one hand, Ortega's government refused to put in place preventive measures calling "demands for quarantine 'alarmist and extremist'" [48] and encouraging public gatherings. Nevertheless, citizens have implemented self-isolation measures, moving to telework, closing stores, and keeping children home for school" [48]. On the other hand, the government's official information about the pandemic raised doubts because the number of reported cases was the lowest in Latin America. Even though the official message minimized the magnitude of the pandemic, Nicaraguan citizens made sense of these facts and created the Observatorio Ciudadano to keep track of the pandemic and "fill the information void from official data" [49].

Contrary to this limited access to information, at the other extreme of the dialectical tension we find the dynamics of the excess of information that also lead to misinformation and disinformation. Times of exacerbated uncertainty, such as those of the pandemic, generate specific processes of production, circulation, and consumption of health information as individuals strive to make sense and understand the scope of the coronavirus and its treatments. Preliminary studies have shown that most of this information has been shared and consumed online through social media such as Facebook, Twitter, YouTube, and WhatsApp and, even though some of the information that circulate through these networks come from reliable sources such as the WHO or the national health ministries, Singh and Bansal's [50] study contended that "sources that we can confidently label as producers of misinformation . . . are also not shared in great numbers even though they are retweeted more often than credible health sources" (p. 20).

The fact that misinformation is more reproduced than accurate information, leads to the phenomenon known as health misinformation which, in turn, causes infodemic risk [50] as significant amounts of rumors and inaccurate information on coronavirus rapidly circulates and makes difficult for individuals to discern about its veracity, relevance, and usefulness. The case of Brazil is illustrative as misinformation about COVID-19 in this country seems to have helped to establish a media agenda where fake news overlapped with misinformation (false information) and disinformation (information whose purpose consists of deceiving and confusing people) [51]. Health ministries around the world had to fine tune their communication strategies for vaccination because of the messages from various sources against the vaccine.

Most of the information that the public have consumed about pandemic circulates through social media and takes the form of narratives [52], that is, stories with mythical content (i.e., home remedies against the COVID-19) that are intended to be revelatory (i.e., conspiracy theories that explain the origin of the coronavirus) starring by ordinary characters (i.e., neighbors, friends) who are also close to the vital world (i.e., from the same context) and that easily generate identification (i.e., “that person could be me”, or “I could try that home remedy”).

These narratives perfectly fit into the formats and dynamics of social media and, in the case of Latin America, especially circulate on Facebook and WhatsApp [41]. In fact, in a study that compares the circulation of misinformation about coronavirus in five Latin American countries and Spain, Gutiérrez-Coba, Coba-Gutiérrez and Gómez-Díaz [53] found that almost a quarter of the studied population (24%) used WhatsApp to find and share news about COVID-19; about a fifth (18%) joined a support or discussion group with people they did not know on Facebook or WhatsApp; and half (51%) participated in groups with friends or family.

The core of these narratives is constituted by myths such as the similarities between COVID-19 and the flu, the way in which heat can kill the virus, the different home remedies that can be used to fight the disease, the origin of the virus, and the development of a vaccine against it [38]. Pagés and Khan [54] showed how scientific explanations of the coronavirus made by organizations such as the US Center of Disease Control or the WHO generated much less engagement among social media users compared with the conspiracy theories sites that were often shared in an effort to show a supposed political and Machiavellian artificial creation of the virus. Similar myths that work as the content of transnational coronavirus narratives have circulated in Latin America and include false actions of the government, false financial aid, risks and forms of contagion, conspiracy theories, and cures for the disease [53].

In addition to being based on myths such as those exposed above, these coronavirus narratives are also based on telling stories that are close to the vital world of social media users. In a study on misinformation about COVID-19 in Brazil, Biancovilli and Jurberg [51] found that half of the coronavirus stories in this country focus on everyday situations that involve actual people. Those narratives showed, for example stories about individuals who cured themselves by using chloroquine and hydroxychloroquine. Insofar as these stories are structured with myths, characters, and close contexts, they invite users to emotional identification. This emotional identification, in turn, makes those stories more likely to become viral, to boost tribalism, and to increase preconceptions [53].

Although preliminary studies show that social media is an important scenario for coronavirus conversations, the particular characteristics of the narratives described above are also related to what Martín-Barbero [55] calls the Latin American cultural matrix according to which Latin American national identities are strongly influenced by the manifestations of popular culture anchored to the worlds of stories, orality, soccer, television consumption, neighborhoods and, in general, all the practices that synthesize the mestizo and peasant heritage of the Latin American cultures.

This cultural matrix exacerbates the information challenge in a pandemic crisis since scientific knowledge rarely circulates in the narrative genre explained above. Thus, governments and health organizations compete with narratives of fast production that widely circulate on channels such as Facebook, WhatsApp, and Twitter. This immense flow of information makes it difficult for users to discern between information and misinformation. Interestingly, the consumption of accurate information, as we put it, is precisely what can make individuals sustain over time. The confusion may grow within this cultural matrix when authoritative figures such as country leaders feed misinformation. This is the case of Bolsonaro, president of Brazil, who has underplayed the degree of the pandemic and its results in his country. He has expressed his mistrust on the effect of the vaccines and ridiculed them claiming that the Pfizer-BioNTech shot could turn people into alligators, cause women to grow beards and men to speak effeminately [46].

Again, as with the other two tensions, we argue that if health will become a central dimension of sustainability, it needs to be approached in terms of health promotion and communication, that is, by considering the information and communication processes that help individuals make sense and act when health problems occur. Access to information but also the quality of this information becomes crucial to handle the pandemic, and, at the same time, educating about the excess, sources, and contents of information also constitutes a fundamental task to avoid misinformation.

4. Discussion: Health as a Fourth Pillar of Sustainability

In this manuscript we argued why health should be considered as a fourth pillar of sustainability. Discussing the scope of the concept of sustainability is not a futile effort. Insofar as sustainability is a normative notion (16,17), it calls for specific ways of action. Because of its pragmatic nature, sustainability suggests approaches, measures, concrete actions, and desired outcomes in social life. If sustainability is explained in terms of a relationship between present and future, its definition is not only normative and pragmatic, but also political [56] and ethical [57] as it allows us to think about the world that we live in today and the one that we want for future generations. This political condition explains why sustainability is a concept that, not only scholars, but also politicians and citizens often resignify.

Making health a protagonist in this normative and pragmatic concept as several scholars have contended [8,58] implies some challenges in the way in which we define and approach health. So far, official sustainable development agendas have considered health, mainly, in biomedical terms, as the absence of illness, and also in its intersection with environmental factors. While these views are effective in putting health problems in the global agenda, they also place actions to address health issues in the realm of governments and local health systems. A broader view of health conceived as personal and social development [58] introduces an individual and a community dimension to health issues that extends the chain of involved agents, and it also sheds light into the multiple factors that intervene and their interconnection. Health is, thus understood “as a daily achievement” [59] (p. 172). While this view acknowledges individuals’ agency and stresses the role of information and communication processes in health issues, it also recognizes that daily choices depend on environmental, cultural, social, and economic conditions of the individual.

5. Implications

From a theoretical standpoint, we can approach making human health a constitutive dimension of sustainability as part of the evolution that the concept has undergone over the last decades. At the beginning, development theories focused on economic aspects. These were followed by a set of theories oriented towards the social aspects of human development. Next, finally, came the sustainable perspectives that highlighted the ecological relationship among nature, on one hand, and social and economic development, on the other. In dialectical terms, despite their contradictory nature, both health and economy can be articulated, precisely as current approaches to sustainable development do, that is, by suggesting a way of development that balances the role of natural and social systems in well-being. Insofar as sustainable development highlights the balance between social development and economic life [5], we can use this notion to overcome the dichotomy between health and economy that the coronavirus pandemic seems to have imposed on governments and citizens and, instead, approaching it as a dialectical tension between two interrelated aspects of development. In the same way that the notion of sustainable development “permitted new forms of alliance and action and opened possibilities for rearticulating the historically oppositional relationship between business and environmentalists” [60] (p. 317), an approach to sustainable development that highlights the notion of human health might help us overcome the false dichotomy between life and economy that the coronavirus has provoked.

In practical terms, this focus implies giving more prominence to health within the framework of sustainability in such a way that it becomes part of the agenda not only of governments and international organizations that design and execute public policies, but also in the agendas of companies and social organizations as part of their sustainability programs. This leads to thinking about health in various levels of action and consciously multiplying the agents involved in health issues. Thus, health issues are negotiated and defined at a public policy level where government and health system officials are involved as it is an issue that is defined through our daily decisions and choices.

6. Conclusions, Limitations and Future Research

In this paper, we used the coronavirus pandemic in Latin America to illustrate the ways in which the concept of health is understood. Then, based on a dialectical analysis we suggested that if health is to be considered a pillar of sustainability, it needs to be approached in close connection with inseparable and irreducible tensions such as health and economy, isolation and interconnectedness, and access to information and excess of information. Our analysis showed that most of these tensions were dealt with by using a selection strategy [28], that is, by favoring one pole of the contradiction over the other. We read the term “new normality” as an attempt to reframe daily practices but also to transcend some of these tensions.

One limitation of our study has to do with the fact that we are studying a phenomenon while it evolves; data about the coronavirus pandemic (e.g., measures, infections, vaccinations) changes around the world every day, and thus it accounts for the state of the pandemic at a particular period of time. Additionally, this study only explored newspapers, other non-hegemonic mass media or communication processes may show new nuances of the dialectical tensions discussed here. Finally, we chose to study how to strengthen the relation between health and sustainability in a context where health is in the forefront. Other scenarios (e.g., climate change, human rights) may show new aspects of the relationship between sustainability and health. From a positivist perspective, one of the main limitations of this manuscript has to do with its interpretative and critical nature, which favors the analysis of three macro dialectics to understand the relationship between sustainability and health, rather than the detailed measurement and description of the empirical data that led us to suggest such dialectics. Considering the proliferation of quantitative studies about various phenomena related to the pandemic, we considered it important to discuss the subject from a qualitative perspective that *zooms in* media discourses that give sense to how we experience the pandemic, but also to how we understand health and its relation to sustainability.

Future studies could explore other non-conjunctural scenarios different to a pandemic to better understand health as a fourth pillar of sustainability; these scenarios could include, for example, regular dynamics of organizational work or community initiatives where the health dimension of sustainability is at play. In a similar way, the relationship between health and sustainability could be analyzed in non-hegemonic mass media, for instance processes of interpersonal, community or organizational communication. Finally, future studies could examine the three dialectical tensions discussed here in different regions, in order to understand whether (a) health and economy, (b) isolation and interconnectedness of health management, and (c) access to and excess of information are standard elements in the relationship between health and sustainability, or whether they are rather a result that corresponds to the culture and context of Latin America.

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