

## **Cruel Poverty: An Examination of Health Disparities in Honduras**

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### **Abstract**

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Only days after health educators and health researchers from Morgan State University and Coppin State University, two Historically Black Colleges/Universities (HBCUs) in Baltimore, Maryland, returned to the United States from a global health disparities fact finding mission to Honduras, the United States experienced one of the largest surges of unaccompanied “alien” children from Honduras and Central America crossing its borders in years.

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Manuel & Garcia (2014) state that an “unaccompanied alien child” as defined by the Homeland Security Act of 2002, is any person under the age of 18 who lacks lawful immigration status and who either doesn’t have a parent or legal guardian in the U.S. or who doesn’t have a parent or legal guardian capable of providing care and physical custody. Negropte (2014) states that approximately 60% of the 2.5 million Central Americans in the U.S. are either undocumented or of temporary protective status. Either way, they can not apply for family reunification privileges and because they cannot legally reunite their families, many of them will pay human traffickers \$6,000 - \$7,000 to get their children to the United States. According to Brick, Challinor, & Rosenblum (2011), Central American immigrants are more likely to be younger married males with children and with less formal education than immigrants from other countries. Brick et al suggest that before the first World War, Central Americans constituted only about 10% of the US immigrant population but by the 1990s they constituted about half of the U.S. immigrant population. According to the U.S. Census Bureau (2009), Mexicans and Central Americans make up 4.7% of the total U.S. population.

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Kandel, Bruno, Meyer, Seelke, Taft-Morales and Wasem (2014) also suggest that a motivating factor for the surge in unaccompanied youth is the opportunity to be reunited with family members already residing in the U.S. and although the prospect of a job and a better education may also be a motivating factor for many of the children crossing the U.S. border, the market for unskilled youth labor is at a low and has been for years. Kandel et al state that the largest influx of unaccompanied children into the U.S. is from Honduras, El Salvador, and Guatemala. This area is often referred to as the "northern triangle." The United Nations High Commissioner for Refugees (UNHCR) interviewed more than 400 unaccompanied children from the "northern triangle" in 2013 concerning their motivations for leaving their home countries and it was found that 21% reported reunification with family members while 51% reported better job opportunities and 19% better educational opportunities (Kandel et al, 2014).

Wong (2014) suggests that violence against children in Central America is the driving force behind this surge. According to Wong, the 2012 murder rate in Honduras, El Salvador, and Guatemala was 54 per 100,000 individuals while the rate in surrounding regions was only 13 per 100,000. However, Kandel, et al. state that the 2012 murder rate in Honduras was 90.4 per 100,000, making Honduras the "murder capital of the world." Wong states that in 2009, fewer than 20,000 unaccompanied children entered the U.S. from Honduras, El Salvador, and Guatemala but already in 2014 more than 51,000 children from that region have entered.

Violence, safety, family reunification, jobs and income, and overcrowded living conditions in addition to nutrition, sanitation, and other such factors all contribute to health. According to Zonta International, Honduras is a country of more than 7 million people. The maternal mortality rate in Honduras is 110 per 100,000 and the infant mortality rate is 25 per 100,000. The United Nation's Human Development Index which measures such factors as life expectancy, educational achievement, and gross national income places Honduras as the world's worst country. According to Honduras.com, most of Honduras' people live in San Pedro Sula, Puerto Cortes, Choluteca, or Tegucigalpa. Villanueva is in Tegucigalpa. San Pedro Sula is Honduras' second largest city and its financial and industrial hub.

The Morgan State University/Coppin State University health and health education delegation (the delegation) was housed in San Pedro Sula and conducted the majority of its health disparities research in Villanueva and the surrounding rural and mountainous areas.

Rennet and Koop (2009) along with Babamoto, Camilleri, Karlan, Catalasan, and Morisky (2009) suggest the utilization of health educators and community health workers, particularly in the very rural and mountainous areas, on such topics as health and health education, safety, nutrition, sanitation, and physical activity is extremely important.

Extreme poverty was observed, not just in the extreme rural and mountainous areas, but also in the towns and villages. According to [proyectormirador.org](http://proyectormirador.org), 65% of all Hondurans live in poverty while more than half (54%) of those living in the rural areas live in extreme poverty. In the extremely rural mountainous areas, the delegation characterized the living conditions as "cruel poverty (Lee, 1960)." Serendipitously, "To Kill a Mockingbird" was observed at one of the rural health clinics. According to Kandel et al, the coffee rust epidemic of 2013 dramatically killed 25% of Honduras' crop leading to a loss of more than 200,000 jobs across the Northern Triangle region.

Many of the observed homes are crudely crafted. Cloth and rags cover the openings that serve as windows and doors. The better homes are constructed of cinder block while the lesser homes can be constructed of any combination of tin, wood, or cardboard. Just about all of the homes are fenced with even the most modest of them surrounded by barbed wire or razor wire. Armed guards with automatic rifles and shotguns were observed throughout the cities even guarding and protecting the small street and roadside vendors. According to Kandel et al, "Honduras has long struggled to address high levels of crime and violence, but the deterioration in security conditions has accelerated over the past decade."

In the extremely mountainous areas, many people sleep outdoors on hammocks. Families that cannot afford to purchase bottled water (not just in the extremely rural and mountainous areas) are left to drink, bathe, and cook with polluted water from cisterns while others must rely on polluted water from nearby streams, or rainwater. The rainy season is only from about July through September.

Many of the observed homes lacked toilets or other basic sanitation. Those homes that do have toilets were crude and basic. Even in the observed health clinics restroom sanitation was extremely poor. Prado & Pena (2010) agree that in the health clinics, the maintenance and cleanliness of the restrooms is a major concern.

Extremely lethargic dogs were observed roaming the streets, living in close proximity to most observed homes, and even roaming around the “open air” health clinics. One such animal with an extremely large growth on its side was reported to be suffering from Chagas Disease. According to Yun, Lima, Ellman, Chambi, et al. (2009) and the Centers for Disease Control, Chagas Disease is endemic to Central America and is caused by a particular insect that infects animals and then humans. It is often called the “kissing disease” because the insects usually infect humans in the face around the mouth, nose (mucous membranes) or eyes.

According to Prado and Pena, healthcare in Honduras is financed through the Ministry of Health (MOH) through public-private contracts that usually combine the services of non-governmental organizations (NGOs), private non-profit organizations, the various municipalities, and the municipalities’ elected officials. These health services are usually managed by the municipalities and guided by elected residents who form committees to represent the people. In many cases nurses supervise the health centers.

All of the observed health clinics were supervised by nurses with occasional visits from a physician. According to the World Health Organization (2010), there are only about six physicians for every 10,000 people in Honduras. According to ruralpovertyportal.org, only 6% of Honduras’ 2009 gross domestic product (GDP) was spent on healthcare and according the World Health Organization, only 8.6% of Honduras’ 2012 GDP was spent on healthcare.

The delegation donated a large quantity of healthcare supplies to one of the neediest rural mountainous health centers but according to the nurse who supervises that health center, the center serves more than 1,500 patients per week so the donation was not nearly enough. Pedro and Pena state that the vast majority of clients at these health clinics are women and 32% of the services provided are to children under the age of five. Sixty percent of the clients have no source of income and come from families with an average of as many as nine children.

Eighty-three percent of Hondurans lacked health insurance in 2007 while another 30% lacked healthcare (Pearson, Stevens, Sanogo and Bearman, 2012). Several systemic factors converge concerning health and healthcare in Honduras. Systems can be defined as connecting things that don’t always seem to be connected or connectable.

In addition to the aforementioned violence, poverty, and sanitation factors, Pearson et al. cite "cost, distance, transportation, facility overcrowding, ability to take time off from work, and obtaining alternate child care" as factors also affecting health in Honduras. Shiffman (2007) offers several other systemic factors such as "insufficient donor resources, lack of consensus on intervention strategies, weak health systems, and (poor) national political support for particular health goals."

Cost is a major health factor in Honduras. Aside from the major health costs, it was both observed and reported that individuals visiting the health clinics and public hospital emergency rooms have to bring with them their own examination gloves and, in some cases, first aid supplies before they can be examined and treated. Cost, distance, and transportation factored into the health equation from a number of different perspectives. It was both observed and reported that in addition to having to pay for transportation and then travel long distances, the buses wait until they are completely filled with passengers before they move, resulting in excessively long waits. Additionally, many times at the roadside check points, passengers would have to disembark, be searched, and then re-board before they can again be on their way. Those individuals choosing not to pay for bus transportation will pay to ride on the back of trucks, in overcrowded vans, or in small golf cart type vehicles. It was reported that many of these vehicles and their drivers are unlicensed and unsafe and, as such, it was reported that pedestrian/vehicle collisions occur at a very high daily rate.

Overcrowding was observed at the visited health clinics and the public hospitals, particularly the emergency rooms. Clinic personnel reported that so many individuals are waiting to be seen when the clinic opens that a ticketing system is employed. Once a certain number of tickets have been dispensed, usually one or two hundred, no other clients can be seen that day. At one public hospital emergency room, hundreds of individuals were observed waiting outside in the parking lot as late as 10 PM. Hospital personnel reported that many of these individuals must stay all night for as many as several nights and days.

Hondurans are a most hospitable people with much pride even in spite of their living conditions. No kindness, gift, or donation given to them goes unreciprocated, no matter how great or small the gift or donation.

The delegation consisted of Dr. Raymond Terry, Dr. Irving Smith, Professor Robin Butler, and Mr. Dylan Allen who all contributed to this article.

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