Gang Violence, Public Health, and Security in Honduras

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The security situation in Central America drew increased attention in 2014 as a result of both the ongoing domestic debate about immigration reform in the U.S. and the influx of unaccompanied minors into the country during the spring and summer. While the children entering the United States come from multiple Central American countries, Honduras alone is estimated to account for over one-third of all unaccompanied minors entering the U.S. since October 1 of last year (Robles and Shear 2014). The prevalence of street crime and gang violence in Honduras is well known: the country was ranked by the UN Office of Drugs and Crime as having the highest per capita murder rate in the world in 2011 and 2013, and both poverty and income inequality have been on the rise since the country's 2009 coup (UNODC 2014; Johnston and Lefebvre 2013).

While gang violence in Honduras has attracted attention for its role in driving emigration to the United States, I argue that this violence also represents a domestic crisis of public health on multiple levels. First, direct violence by gangs against civilians, rival gang members, and those within the gangs creates public harm. Second, the internal displacement of persons, which has contributed to the development of slums and shanty towns, deprives many citizens of basic services and places individuals at risk of developing chronic health conditions. Finally, gang violence inhibits public access to health care by limiting the general mobility of persons and health professionals in a country where access to health services relies upon the free movement of persons. In the following analysis, which draws on both existing research and on my experience in the field in Honduras, I argue that failure to recognize and address the public health issues associated with gang violence may produce a deeper crisis within the country.

Background

The current landscape of organized crime in Honduras has its origins in the United States, among the gang culture of Los Angeles. The largest gangs operating in Honduras today, Mara Salvatrucha and M18, originated in Los Angeles among communities of Central American migrants in the 1980s. At that time, many migrants arrived in the area from El Salvador and Nicaragua, fleeing civil wars in those countries, only to become the victims of street crime in L.A. Mara Salvatrucha was formed as a response to violence against Central American migrants by existing street gangs, and M18 became a later offshoot of this group. Within Central America itself, the gangs only took hold when members were deported from the U.S. or voluntarily repatriated after the end of the wars (Johnson 2014; Bruneau 2014). Even upon their return to the region, the gangs mostly dealt in petty crime until they entered into partnership with Mexican cartels like the Sinaloa cartel and Los Zetas, who offered the gangs more power and funding in exchange for their assistance in the drug trade (Johnson 2014; Longmire 2014; Diario el Heraldo 2013). In Honduras, the political and economic turmoil resulting from the 2009 coup that deposed president Manuel Zelaya may have also helped empower the gangs, as poverty and inequality has worsened in the intervening years (Johnston and Lefebvre 2013).

The United States, among others, has made attempts to support development and alleviate poverty in Honduras. In 2012, the country received about $57 million in bilateral aid from the U.S., with an estimated $33 million in additional aid coming from U.S. government agencies and regional initiatives (Meyer 2013). Health programs have been an area of interest to donors and to the government of Honduras. Approximately $9 million in aid from the U.S. State Department and USAID in 2012 was aimed at improving health in Honduras, and a national program offers cash aid to impoverished families who keep children in school and take them to regular checkups (Meyer 2013). Despite these

efforts, health care remains inaccessible to many within the country, a point I will return to below.

Gang Violence and Public Health

1. *Direct Violence*

The most obvious linkage between public health and gang violence is in the direct acts of violence committed by gangs. In a 2014 report, the UN Office of Drugs and Crime estimated the murder rate per capita in Honduras at 90.4 homicides per 100,000 people, the highest in the world. Honduras also had the highest murder rate per capita in the organization's 2011 report (UNODC 2014). The organization further estimates that about 30% of all murders in the Americas were a result of gang violence (UNODC 2014). Although that figure includes countries throughout North, Central, and South America, it would be reasonable to conclude that in those countries where gangs wield greater power, they commit a higher percentage of murders.

Homicide is only one dimension of gang violence, though. In 2012, the Programa Nacional de Prevención, Rehabilitación, y Reinserción Social (PNPRRS) conducted a study of gang activity in Honduras using surveys, interviews, and focus groups with current and former members of various gangs. They note that the majority of gang members in their study joined between the ages of 11 and 20, and that harassment, threats, and assaults are frequently used to coerce young people into joining gangs (PNPRRS 2012). While assaults represent a hazard to the physical well being of young people, exposure to daily harassment and the threat of violence certainly challenges the emotional and mental well being of Honduran youth as well. Young women face particular challenges. The PNPRRS estimates that women make up at least 20% of gang members [1]. Female gang members tend to hold subordinate positions and perform menial tasks like selling drugs, visiting incarcerated gang members, collecting protection money, and acting as lures for kidnapping victims – tasks which make them visible and place them at risk of arrest or retaliatory violence by those outside the gang. Some women interviewed also reported being victimized or knowing someone who was victimized by men within their own gang, particularly where they rebuffed sexual advances by male gang members (PNPRRS 2012).

2. *Displacement*

The forcible displacement of civilians by gangs also creates a less obvious health problem. While specific statistics on the number of evictions are likely inaccurate – owing to a fear of reporting gang violence to the police – alliances between gangs and Mexican drug cartels are thought to be influencing this practice. Evicting people from their homes is strategically advantageous for gangs, since abandoned homes can be converted to safe houses and meeting locations. Poor households are disproportionately affected by this displacement, which fuels the development and growth of favela-type encampments on the margins of cities. One such slum in the area of Comayagüela is estimated to contain as many as 10,000 residents (Diario el Heraldo 2012).

The public health risks faced by slum-dwellers elsewhere in the world are well documented. Such areas lack basic services like water, electricity, and sanitation. Dirt floors in poorly constructed homes have been linked to parasitic infections, which cause diarrhea and malnutrition in children (Cattaneo et al. 2009). Household air pollution from improper ventilation contributes to health problems including pneumonia, bronchitis, heart disease, and lung cancer. In children, exposure to household air pollution almost doubles the risk for childhood pneumonia, contributing to an increase in child mortality (WHO 2014). Women and girls are thought to be especially vulnerable, since they generally spend more time in the home and preparing meals (Wirth 2011). While aid groups and NGOs have made efforts to improve sanitation and housing in Honduras, the continued eviction of poor families from their homes threatens to undermine years of development work in the country.

3. *Access to Health Care*

A third dimension through which crime and public health are linked is through access to health care. As mentioned above, access to health care is uneven throughout the country and many rural areas rely on mobile health clinics as their primary source of care. I accompanied one such clinic of medical practitioners and volunteers in the spring of

2013 [2]. During my time in the country, I saw that the availability of medical services to rural Hondurans is already hindered by poor infrastructure, rough terrain, and a lack of trained medical specialists. The professionals accompanying us included one dentist and five general practitioners, all from Honduras, and several pharmacy students from the United States. The doctors working with us noted that most doctors in Honduras are general practitioners. The small population of medical professionals makes specialization impractical, therefore most doctors must be prepared to handle a variety of tasks ranging from regular checkups to obstetrics and gynecology to emergency medicine [3]. Most of the doctors who traveled with us had permanent offices in Tegucigalpa, but received financial support from the government to make occasional visits to rural areas. The village where we spent most of our time was less than two hours from Tegucigalpa, but it was located mid-way up a mountain along dirt roads, and only received visits from health professionals three to four times annually [4]. Since most of the area's residents did not have cars, the clinic was their only convenient way to visit a doctor or dentist, to get routine testing, to fill prescriptions, or to get professional medical care for their children. The Honduran government also uses data collected at these mobile clinics to track health trends.

Since the mobility of health professionals is key to public health within the country, the impact of gang activity is a concern. Data on gang penetration has, thus far, focused mainly on urban areas of Honduras. Yet these gangs are unquestionably making inroads into rural areas [5]. If the spread of drug trafficking in Mexico is any indication, gangs involved in drug activities are likely to expand into rural areas of Honduras as they look to grow their operations and evade law enforcement. In urban areas, gangs already rule neighborhoods: collecting "war taxes," monitoring daily comings and goings, and routinely interfering with public transportation (Bruneau 2014; Wilkinson 2013; Diario el Heraldo 2013). A nurse speaking to the *Los Angeles Times* in 2013 noted that violence among rival gang members attending her clinic in San Pedro Sula had forced her to cut back on clients (Wilkinson 2013). Should this pattern continue in more rural parts of the country, it would be hugely detrimental to a rural population that is almost entirely reliant on the mobility of medical professionals for access to care.

A Way Forward?

While the current discourse on Honduras in the United States centers on the link between gang violence and migration, the public health crisis linked to gang violence has gone largely unexamined. Left unchecked, gang violence threatens to undo years of development work in the country, and will almost certainly lead to the further deterioration of physical and mental health. The precarious state of public health also leaves Honduras exceptionally vulnerable, and an acute event like a natural disaster or an outbreak of disease could potentially lead to a new refugee crisis. Any discussion of further aid and assistance to Honduras should take these factors into account. Without addressing the human security issues underlying youth migration, any attempt to deal with the issue of migration itself is likely to be a short-term solution. By allocating funds and resources to disrupting gang activity, the United States and the international community can not only prevent Honduras from losing the gains it has made in health and development, they can also insure against the potential future costs of a public health crisis in the country.

Notes

[1] 20% was the figure they noted based on surveys and focus groups, though they suggest the number may actually be higher because many romantic partners of male gang members hold an ambiguous status (PNPRRS 2012).

[2] During my time in Honduras, I accompanied a group that included Honduran medical professionals, staff from the nongovernmental organization Global Brigades, and volunteers from the University of Arizona's College of Pharmacy.

[3] They must also be prepared to handle a high volume of patients. On average, over 130 people visited our clinic per day.

[4] Indeed, even in villages that are fortunate enough to have permanent health clinics, those clinics are still served by doctors who rotate in and out. In our case, the village of Cuesta Grande did have a small, two-room medical center. We used that building for women's health exams, while the majority of patients were seen down the street in

the village school. Classrooms were converted into a pharmacy, a dental room, and a medical room for the occasion. Patient intake and childcare took place outdoors.

[5] While in transit to the medical clinic, our group was accompanied at all times by an armed military escort. This seems to reflect the government's concern that equipment, medication, and/or personnel could make attractive targets for criminal elements.

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