PUBLIC HEALTH 128 (2014) 671–673

Available online at www.sciencedirect.com

Public Health

journal homepage: www.elsevier.com/puhe

Short Communication

Assessing youth well-being in rural Honduras: a qualitative study

M.Y. Kubik [a,*], B.R. Jennings [b], N.M. Olivier [a]

[a] University of Minnesota, School of Nursing, Minneapolis, MN, USA
[b] Shoulder to Shoulder, Inc., Cincinnati, OH, USA

ARTICLE INFO

Article history:
Received 18 August 2013
Received in revised form
2 April 2014
Accepted 2 May 2014
Available online 2 July 2014

Introduction

Little is known about the impact of globalization on the health and well-being of rural youth residing in low-income countries. The current study reports results from a youth-focused needs assessment conducted in seven rural villages in the Honduran department of Intibucá. Honduras, among the poorest countries in the Western Hemisphere, is a largely rural country where young people comprise about 40% of the total population.[1] The current study engaged a convenience sample of adults and youth and explored perspectives about community assets that support healthy youth development, concerns about risk behaviours among local youth and resources needed to support youth development. The research was done in collaboration with Honduras-based partner Asociacion Hombro a Hombro, a non-profit, non-governmental organization operating under the sister US organization Shoulder to Shoulder.[2]

Methods

A qualitative design was used that included key informant (KI) interviews and focus groups (FG). Community leaders in local villages were invited to participate in a 60–90 minute interview, conducted in November 2010 by trained, bilingual research staff and audio-taped. FG participants were adults with a child between 10 and 24 years old. Youth participants were 18–24 years old. Parents and youth were recommended by teachers who participated in KI interviews or were youth recipients of a Shoulder to Shoulder academic scholarship or parents whose child was a scholarship recipient. See Table 1 for a description of the participants. Focus groups were conducted in June 2011, facilitated by a trained bilingual moderator, audiotaped and lasted 60–90 minute. Audiotapes were transcribed verbatim into Spanish and translated into English. Data were analysed using a three-step process for thematic analysis.[3] Transcripts were reviewed independently by two research staff, with a high level of concordance noted.

Results

Community assets

The traditional roles assigned to girls were in the home and included household chores and childcare. A boy's primary role was in agriculture, working in the field with his father. Young people were expected to be obedient and help the family. Youth able to attend secondary school were expected to study and finish school.

* *Corresponding author*. University of Minnesota, School of Nursing, 5-140 Weaver Densford Hall, 308 Harvard St SE, Minneapolis, MN 55455, USA. Tel.: +1 612 625 0606; fax: +1 612 626 2359.
E-mail address: kubik002@umn.edu (M.Y. Kubik).
http://dx.doi.org/10.1016/j.puhe.2014.05.003

Table 1 – Key informant interview and focus group participants, Honduras, 2010–2011.

Participants	*n* 109	Gender	
		Male	Female
Key Informant Interviews	19	12	7
Teachers	11	6	5
Health Professionals	4	2	2
Religious Leaders	2	1	1
Organization Leaders	2	2	0
Focus Groups = 9	90	39	51
Parent Groups = 4	26	11	15
Youth Groups = 7	64	28	36

The responsibilities of the youth are to be responsible to the directions of their parents. They need to be responsible for their education as well and to their teachers and the laws of society. An example is to respect their elders, respect their community and to respect authority. (KI)

Education, sports and access to role models were identified as factors contributing to youth well-being. Parent support was regarded as essential and included 'as much spiritual as material support' and a balance of 'love and rigor'. Spiritual teachings and beliefs were important, as was support from governmental and nongovernmental organizations. Health care access was regarded as important, but mostly targeting young children and pregnant women.

Teens are interested in achieving, being someone, and so they go to school. Parents also see the problems with the economy, society, the country, the world and they are making their kids go to school so that they can be somebody in life. (KI)

Risk behaviours

Substance use, primarily marijuana and alcohol, was identified as the most prevalent risk behaviour among youth, particularly young males. Increasing use was attributed to cell phone access, media exposure, limited recreational activities and travel by youth to urban areas for work. Many felt migration, a common occurrence among men in this area and 'not having a father as the highest authority figure [in the home]' contributed to poor decision-making by young males. Substance use was linked to increases in youth violence, sexual activity, mental health problems and unintentional injury.

Well many years ago this was a very healthy area. There weren't any drugs. But now, this is happening a lot, right. Kids are using drugs, like cocaine, and the most common, which is marijuana. These are the highest risk drugs, but the supposedly legal drugs, are bad too like cigarettes and alcohol. (KI)

Sexual activity starting at a young age and pregnancy that 'can cut short your aspirations' are considered 'especially damaging' for girls were also primary concerns. Sexually transmitted diseases were identified as a risk affecting girls and boys, particularly youth travelling to urban areas for work. Sex education was identified as a need.

The majority of teens are thirteen, fourteen years old when they start their sexual life. They experiment. So it's very precocious, you could say. Because really there aren't any teachings that insist that they don't do this. (KI)

Malnutrition was identified as an ongoing concern. However, increasing availability of sugar-sweetened soda and processed foods, such as high-fat, salty snacks (called churros) were a growing concern. Nutrition education was identified as a need.

The majority of people have a poor diet. More or less we eat things that are fattening. We don't have this kind of education. Some don't have anything to eat. (KI)

The risk is that they eat churros and soda because the churros have a lot of fat and the sodas have a lot of sugar. And they don't eat fruit, but that helps your body, helps you stay healthy. (FG: Girl)

Some expressed concern about violence, abuse and mental health problems. More females than males were concerned about violence and abuse, reporting 'it stays within the family.' Concern about low self-esteem among youth was common, as was stress related to 'broken families,' often attributed to migration. Many identified a need for mental health services.

Maybe parents leave each other, they move away. So that has a big effect because it brings bad things to the child's life. So this will affect him when he is an adult. (FG: Boy)

With mental health, you have to work a lot. There isn't a program. … Many people are getting addicted to drugs, others to cigarettes and some to alcohol, because there is no education. (KI)

Physical inactivity was not a concern. Sport, primarily soccer, was considered a community strength. Access to television was increasingly common, as was time spent by youth and adults watching television.

We don't have these kinds of problems because people do physical activities everyday, logging firewood, herding cattle, anything like this. So they always walk, they run, they do everything. (KI)

We have come to live in a monotonous way. We eat on the sofa watching TV. We don't exercise. We don't go for a walk. We are becoming sedentary. (KI)

Resources needed

Among study participants, interest was highest for educational programming, including scholarship and tutoring programs for youth and trainings to develop decision-making and job skills. Providing adolescent health services was an interest, but privacy and cost were concerns. Sport programs and after-school activities were identified as a need 'because there is nothing to do, nothing to keep their minds busy.' Volunteering was recognized as a way for youth 'to get involved in important work.'

If he's a good student who gets good grades he could get a scholarship and with this scholarship he could stay in school to achieve the goals he has. (FG: Girl)

The health treatment that a teen needs is different than an adult or a child. Yes, we would like to have this health service for teens. (FG: Father)

Discussion

Results of this formative assessment conducted in rural Honduras indicate a community challenged by a rapidly changing environment and shifts in behaviour that pose a risk to the health and well-being of local youth. The risk profile of young people worldwide is more similar than different.[4–6] However, data is rarely disaggregated by rurality.[5] The current study adds to the literature by addressing this gap.

Substance use was the primary concern. Worldwide, alcohol and illicit drug use are main risk factors for incident disability-adjusted life-years among 10–24 year old youth; tobacco use contributes to the global disease burden in mid-to-late adulthood.[6] Global surveillance data indicate increasing numbers of youth in low- and middle-income countries are using licit and illicit drugs.[7,8] The current study suggests adolescent substance use is an emerging problem in rural areas, where communities are ill-equipped to handle the associated social and physical consequences.

A shift in diet and activity patterns was also a major concern, mirroring a global shift that is contributing to a 'pandemic of obesity' in low- and middle-income countries and an emerging global pandemic of non-communicable diseases.[9] Considerable evidence supports that risk factor and disease prevention should start in childhood and adolescence and target diet and activity habits.[9,10] For resource-poor, low-income countries like Honduras, prevention should be a primary focus, particularly in rural areas where access to health care is limited.

Study strengths included a focus on rural youth residing in a resource-poor, low-income country; a community-based approach that engaged a range of stakeholders; and standardized data collection and analysis procedures to minimize bias. Study limitations include use of a convenience sample and limited generalizability.

In summary, there is an urgent need to address the health needs of rural youth in low-income countries where youth well-being is closely linked to population health and economic stability. Meaningful action will be informed by community engagement and an up-to-date needs assessment considerate of changing social contexts and a physical environment that appears more like the rest of the world.

Author statements

The authors wish to thank the study participants, as well as the staff of Hombro a Hombro in Honduras and Shoulder to Shoulder in the US.

Ethical approval

The study received approval from the University of Minnesota Institutional Review Board, Shoulder to Shoulder Research Advisory Board and Honduras Ministry of Health, Intibucá, Honduras. Informed consent was obtained from each participant.

Funding

This research was funded by a University of Minnesota Academic Health Center Seed Grant #2010.62. The funder had no role in the study design; in the collection, analysis and interpretation of data; in the writing of the manuscript; and in the decision to submit the manuscript for publication.

Competing interests

None declared.

REFERENCES

1. World Health Organization. *Country cooperation strategy at a glance*. Honduras. Available at:, http://www.who.int/countryfocus/cooperation_strategy/ccsbrief_hnd_en.pdf; 2012 (accessed 15 May 2013).
2. Heck JE, Bazemore A, Diller P. The Shoulder to Shoulder Model – channeling medical volunteerism toward sustainable health change. *Fam Med* 2007;**39**(9):644–50.
3. Miles MB, Huberman AM. *Qualitative data analysis*. 2nd edn. London: Sage; 1994.
4. Sawyer SM, Afifi RA, Bearinger LH, Blakemore SJ, Dick B, Ezeh AC, Patton GC. Adolescence: a foundation for future health. *Lancet* 2012;**379**:1630–40.
5. United Nations Children's Fund (UNICEF). *The state of the world's children 2011. Adolescence – an age of opportunity*. Hatteras Press. Available at: http://www.unicef.org/sowc2011/fullreport.php; February 2011 (accessed 13 June 2013).
6. Gore FM, Bloem PJN, Patton GC, Ferguson J, Veronique J, Coffey C, Sawyer SM, Mothers CD. Global burden of disease in young people aged 10–24 years: a systematic analysis. *Lancet* 2011;**377**:2093–102.
7. Jernigan DH. *Global status report: alcohol and young people*. Geneva: World Health Organization. Available at: http://whqlibdoc.who.int/hq/2001/WHO_MSD_MSB_01.1.pdf; 2001 (accessed 15 June 2013).
8. Warren CW, Jones NR, Peruga A, Chauvin J, Baptiste JP, Costa de Silva V, el Awa F, Tsouros A, Rahman K, Fishburn B, Bettcher W, Asma S. Global youth tobacco surveillance, 2000–2007. *MMWR* 2008;**57**(SS01):1–21.
9. Popkin BM, Adair LS, Ng SW. Global nutrition transition and the pandemic of obesity in developing countries. *Nutr Rev* 2011;**70**:3–21.
10. Expert panel on integrated guidelines for cardiovascular health and risk reduction in children and adolescents: summary report. *Pediatrics* 2011;**128**(5):S213–56.