INFORMAL SECTOR AND HOUSEHOLD HEALTH IN LATIN AMERICA AND THE CARIBBEAN

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Abstract

Health is linked to global economic and political processes at the societal, community, and household levels. This paper addresses relationships between family health and employment, and is based on the concept that family health is related to the capacity of households to generate income that can cover their basic needs, particularly health. The analysis focuses on the informal sector, which represents half of the economically active population of most countries in Latin America and the Caribbean.

Introduction

The informal sector and development support for microenterprises have received increasing attention, largely because of the prominence of that sector in employment and income generation in the Third World. Until quite recently, though, conceptual and operational links between health and microenterprise development were not well understood, and substantial barriers to defining a common agenda for research and development programming remain. Few commonly-agreed upon tools, methods, or concepts have been available for evaluating the effects of microenterprise programs on both the economic development of households and communities, but on well-being understood in the broader sense. This paper attempts to bridge that gap.

Microenterprises may be regarded as components of complex and dynamic household survival strategies through which, family members contribute to the subsistence of the household in different ways. They are often operated at the household level, frequently by only one person and in most countries, the majority of microentrepreneurs are women (Rodriguez, Macinko, and Waters 2001; Waters 1997). The specific characteristics of the individual enterprise are related to household size and composition, division of labor by gender and age, and the use of remunerative and non-remunerative household labor. Social and economic networks with the extended family, the community, and beyond are also important factors in determining how individual households and their members operate their microenterprises. The microenterprise and the informal sector are not identical, but there is substantial overlap (Waters 1997).

Microenterprise development refers to programs that provide services designed to improve the income-generating capacity of the poor. Most program provide credit and savings services along the model made popular by the Grameen Bank (Todd 1996a; 1996b). Other services include technical training in areas such as accounting, marketing strategies, quality improvement, and organizational development. The constellation of microenterprise development organizations is enormous, particularly in the area of credit. For example, the first Micro Credit Summit in 1996 attracted more than 2,000 practitioners and the 2001 summit is projected to attract more than 3,000. Most organizations that support microenterprises are non-governmental organizations that often work with bilateral or multilateral donors (Rakowski 1994). Among the major international players are USAID through the AIMS (Assessing the Impact of Microenterprise Services) project, the World Bank, and the Inter-American Development Bank. In some countries, public support is provided to microenterprises by specially constituted agencies or development banks, as well as through policies that favor very small businesses.

The provision of credit is the primary focus of most microenterprise development programs because lack of working capital is widely regarded as the most important constraint
to developing building the business in order to more effectively address household poverty. Throughout the world, poor households often lack collateral for securing formal loans from formal banking institutions, and they may face substantial cultural and linguistic barriers to doing business in the formal sector. The poor also generally require smaller loans than commercial and traditional public institutions can provide, so they are often obliged to recur to high-interest informal loans (Rodriguez, Macinko, and Waters 2001).

The microenterprise development sector has focused from the beginning on improving the economic status of its clients and improving efficiency (Otero and Rhyne 1994). Nevertheless, there is general recognition, at least implicitly that lending to the poorest segments of a population can produce effects that go beyond the purely economic. In fact, most organizations that provide services to microentrepreneurs do so with the intention of having a broad impact on poor peoples’ lives even though program planning, implementation, and evaluation may not explicitly take the broader view of enhanced well being. That is, it is understood that that households function as economic as well as social units, and that the microenterprise has a different rationale and needs than larger and more formally constituted business. Nonetheless, programs that address both aspects are still quite rare (Rodriguez, Macinko, and Waters 2001).

Microenterprise development and health are conceptually related in at least four ways, even though they may not be explicitly linked at the programmatic level. First, microenterprise development programs generally aim to increase household income, and both theory and experience demonstrate that particularly in the case of female microentrepreneurs (the majority in most countries), increased income is generally invested in enhanced education and health practices, including health care and the purchase of medicine. Second, while microenterprise support programs may not include educational components, they can enhance the likelihood that children are sent to schools because parents are more likely to be able to meet the costs. Third, participants in microenterprise development programs, particularly women, may acquire new skills and enhanced self-reliance which, in turn, may provide the basis for increased community participation and intra-household decision making, particularly with respect to the use of family income. Fourth, while the link between household income and family health (including nutritional status) is not direct, experience now suggests that increased income (by virtue, for example, of microenterprise development) may be linked to health care and improved household food security (Rodriguez, Macinko, and Waters 2001: 34-39).

In sum, theory and practice suggest that microenterprise development offers opportunities for reducing poverty and empowering the poor to improve their own lives. Just as poverty is a complex tapestry composed of closely intertwined factors, the response to poverty can also be multifactorial and multisectorial. Thus, the need for economic, political, social, and human development as well as improved health outcomes represent an enormous challenge to development organizations in general and microenterprise development organizations in particular.

This paper focuses on the microenterprise sector because in Latin America and the Caribbean, it represents around half of the economically active population of most countries in the region. The report provides a brief conceptual link between microenterprise and household health, describes a multifaceted field-based methodology for observing and analyzing the link, and shows how the methodology can be applied by providing two cases studies corresponding to Peru and Honduras. The paper reflects fieldwork conducted in the
region and in East Africa between 1995 and early 2001. The cases of Cusco, Peru and Tegucigalpa, Honduras are presented here for several reasons. Cusco has the particularity that it is a center for relatively intense international tourism, but it is nevertheless very similar to intermediate cities throughout the Americas as a regional financial, commercial, and administrative center where informal commerce, manufacturing, and services grow side-by-side with the formal economy. Like other intermediate urban centers, poverty, rural-urban migration, and the rapid growth of peri-urban neighborhoods can be seen in conjunction with efforts to provide adequate health care to an increasingly diverse population.

Tegucigalpa, on the other hand, is more typical of larger urban centers that have grown rapidly in a relatively unplanned manner, and where the demand for services can outstrip the capacity to respond. While the aftermath of Hurricane Mitch, which struck the country in August 1998 may appear to place Tegucigalpa in a rather special category, it can be argued that in one way or another, most large cities in the region suffers from a more or less constant state of crisis, whether it be financial, political, environmental, or health-related.

Countries in Latin America and the Caribbean are currently experiencing dramatic changes in the composition of the labor force and high levels of unemployment and underemployment. In the region as a whole, the share of employment in agriculture declined from 34 percent of the total labor force in 1980 to only 19 percent in 1997. The share in industry and manufacturing declined only slightly (from 25 percent to 23 percent and from 16.7 percent to 12.8 percent, respectively between 1980 and 1997). Finally, the service sector occupied 58 percent of the total in 1997, as compared to only 41 percent in 1980. It appears that in less than two decades, a large proportion of the region’s labor force left agriculture and now works in the service sector, which is located for the most part in urban centers (Berry and Mendez, 1999:25).

On the surface, changes in open unemployment are not very dramatic. For all of Latin America (excluding the Caribbean), full unemployment increased from 6 percent in the period 1991-1993 to 7.5 percent in the period 1995-1997 (Berry and Mendez, 1999:26). Four caveats are in order, however, with regard to data on unemployment. First, each country defines the term differently. Second, these data must be interpreted cautiously because in some countries (e.g., Ecuador) people are considered to be employed when they worked for remuneration for as little as one day in the previous month. Third, unemployment has increased sharply in several countries in the region. For example, the rate of unemployment in 1997 reported by Berry and Mendez (1999:26) for Ecuador is 8.8 percent, but by late 1999, fully 16 percent of the population was fully unemployed (El Comercio 1999).

Fourth, and most germane, the rate of underemployment (where people either work less than full time or more than full time but in unproductive labor) equals or exceeds one half of the economically active population in much of the region. In addition, in the formal sector, wages stagnated and even declined in real terms throughout the 1980s, and recovery was modest best in the 1990s. Thus, even families that have members who work in the formal sector may experience shortfalls in income and may therefore be obliged to generate additional income in the informal sector (Waters 1997).

Moreover, high levels of unemployment and low wages are only part of a complex tapestry of poverty in the region. A report released by the International Labor Organization in August 1999 is unequivocal in stating that social progress is at risk of stalling in Latin America
and the Caribbean. While population growth and inflation decreased, rural-urban migration increased and the buying power of workers and their families decreased to only 27 percent of what it had been in 1980. Consequently, many households have had to generate income from different sources, and approximately 85 percent of new jobs are now created in the informal sector (ILO 1999a).

Microenterprises include an extremely broad range of income-generating activities with different characteristics, as shown in Figure 1 (below). Most informal sector enterprises are very small and are part of household subsistence strategies. This category includes ambulatory and semi-ambulatory commerce, which is usually found in or near the streets of the region’s urban centers and peri-urban areas. Microenterprises at this level may also include fixed-location informal markets as well as very small-scale enterprises in the service, productive, and extractive (e.g., mining, forestry, and fishing) sectors (Rodriguez-Garcia, Macinko, and Waters 2001; Waters 1997).

Most of these microenterprises are family owned, and are most often operated by one member of the family, sometimes using unpaid labor provided by family members on a part-time or sporadic basis. The most important characteristics of these microenterprises are:

- ease of entry or startup of the business;
- reliance on local resources, stock, or raw materials;
- small-scale operation and sales of goods or services;
- labor-intensive work, usually for long working hours;
- use of adaptive and often very simple technologies;
- use of skills acquired outside of school;
- an irregular and highly competitive market but which may also be regulated by social networks as well as market forces of supply and demand (ILO 1999b).

Finally, there is a very strong association between subsistence level microenterprises and female participation in the economy. Most of these microenterprises are operated by women, and the income they generate may not only supplement household income from other sources, but may be the only or the principal source of income (Rodriguez, Macinko, and Waters 2001).

The operational objective of microenterprises varies according to scale. Subsistence level microenterprises are so small that their objective is simply to provide sufficient income to assure household survival by covering its expenses. In this case, the family and the business are either identical or overlap. In other words, the microenterprise is not necessarily expected to generate an income that is sufficient to create savings, reinforcement, or growth and given the very low levels of income generation, capital accumulation, and skill levels, they have traditionally been unable to obtain or even seek services such as technical assistance or credit. The actual goods and services they offer may change frequently for reasons related to supply and demand (Waters 1997).

In contrast, as shown at the top of the pyramid, the microenterprise sector also includes small businesses that employ salaried labor. In this case, the business and the family are virtually autonomous. These businesses have a greater endowment of capital and stock, and their objective is to invest and grow. That is, they are in a state of transition to the status of
small formal enterprises. In these cases, household subsistence is not at issue because there are usually other resources and sources of income.

Between these two extremes, a wide range of enterprises may rise or fall according to factors related to general economic conditions, family structure, and health outcomes. At this intermediate level, accumulation may be the objective, but it is not always realized. Some enterprises are able to consolidate and grow, while others fail to consolidate, and they revert to the strategies designed to optimize household subsistence.


The hypothesized relationship between microenterprise and family health is two fold. First and most directly, income derived from the microenterprise allows the family to purchase goods and services related to preventive and curative health. Thus, increased income should permit access to a greater range of health care options. An important corollary is that since most microenterprises in the region are operated by women, and since theory and practice show that women are more likely than men to invest resources in family health, education, and well-being, then microenterprises have the potential for being important vehicles for optimizing family health behaviors and enhancing access to health services.

Second, one of the most important trends in development assistance and cooperation in this decade has been in the area of microenterprise support. Based on successful early experiences like that of the Grameen Bank in Bangladesh, thousands of organizations (international, governmental, and non-governmental) throughout the world presently support microenterprises, particularly with small-scale credit that is often provided to groups of microentrepreneurs through a variety of mechanisms including poverty lending and solidarity groups. The services that are most appropriate depend in part upon the scale of the client base of microenterprises.

Figure 2 further refines the types of microenterprises and shows how they can be supported by microenterprise development agencies. Panel A shows that the microenterprises
at the subsistence level (as portrayed in Figure 1) can be either very small or small, and depend
heavily on unpaid family labor. Family survival is the objective, although a few may be able to
consolidate and grow. They are usually owned and operated by women. They can be
supported with very small loans provided through village banking and other forms of poverty
lending to groups, and they usually can further benefit from health education integrated into the
overall program design. At the other extreme are medium and large enterprises that operate in
order to achieve business objectives related to growth and profit. The family and the business
are distinct at this level, and there may be a high level of technological sophistication. These
enterprises can be supported only with much larger lines of individual credit and technical
assistance. At this level, there is no interest in health education as an integrated part of a
program of cooperation or assistance.

Figure 2. Characteristics of microenterprises and microenterprise support.

<table>
<thead>
<tr>
<th>A. Enterprise Characteristics</th>
<th>Very small</th>
<th>Small</th>
<th>Medium/small</th>
<th>Medium/large</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of workers incl. Operator</td>
<td>Often 1, Never &gt; 5</td>
<td>2 to 5</td>
<td>5 to 10</td>
<td>10 to 20</td>
</tr>
<tr>
<td>Gender of Operator</td>
<td>Often Female</td>
<td>Female or male</td>
<td>Usually male</td>
<td>Usually male</td>
</tr>
<tr>
<td>Character of Enterprise</td>
<td>Sporadic, Temporary, part-time</td>
<td>Usually full-time and/or permanent</td>
<td>Full-time and Permanent</td>
<td>Full-time and Permanent</td>
</tr>
<tr>
<td>Focus</td>
<td>Household</td>
<td>Household</td>
<td>Individual Owner</td>
<td>Individual Owner</td>
</tr>
<tr>
<td>Motive</td>
<td>Survival</td>
<td>Survival</td>
<td>Growth, profit</td>
<td>Growth, profit</td>
</tr>
<tr>
<td>Use of modern Technology</td>
<td>Very low</td>
<td>Low</td>
<td>Intermediate</td>
<td>Intermediate to high</td>
</tr>
<tr>
<td>Level of Investment</td>
<td>Very low</td>
<td>Low</td>
<td>Intermediate</td>
<td>Intermediate to high</td>
</tr>
<tr>
<td>Location</td>
<td>Mobile or at home</td>
<td>Fixed: store, market, or workshop</td>
<td>Fixed</td>
<td>Fixed</td>
</tr>
<tr>
<td>Rural or urban</td>
<td>Rural or Urban</td>
<td>Rural or Urban</td>
<td>Urban</td>
<td>Urban</td>
</tr>
</tbody>
</table>

B. Type of Support

| Credit needs | < $100 | < $250 | $500-$1,000 | > $1,000 |
| Dynamic | Solidarity Groups | Borrower Groups | Individual | Individual, Corporate |


Between the two extremes are the medium/small and some of the small enterprises with
5-10 and 2-5 employees, respectively. This is the most heterogeneous group and while most
will follow the path of the very small microenterprises and require an integrated approach to credit
and health education, a few will conform to the model of the medium/large enterprises, and
seek to achieve objectives of growth and profit.
Imbedded in this framework is the observation that the operational relationship between microenterprise support and family health may either be direct and explicit (when technical assistance or credit is accompanied by health education or other health services) or indirect and implicit (when health components are absent, but where it is assumed that microenterprise support will positively impact health outcomes at the household level for the reasons discussed above (Rodriguez, Macinko, and Waters 2001).

RESEARCH METHODOLOGY

Qualitative research was conducted in Peru and Honduras following earlier qualitative and quantitative research in Bolivia, Peru, Ecuador, Honduras, the Dominican Republic, Uganda, and Tanzania. The methodology was designed to meet two criteria. First, it had to account for micro- and macro-level components of the functional relationship between microenterprise and family health. That is, observations should be possible at the household level, but also at the level of the larger society and economy. Second, it had to be capable of measuring the relationship between health and microenterprise as understood and experienced by the households. Four tools were used to meet those criteria.

First, published data were collected on employment, unemployment, poverty, social and economic stratification, and health. Second, structured observation was employed to record information on microenterprises and the health system according to pre-determined criteria. The following elements constituted the focus of the observations.

- Who are the microentrepreneurs (including gender and age)?
- What is the structure of the household (including children and extended family members)?
- What goods or services does the microenterprise provide?
- Who are their customers?
- What are the settings within which goods and services are provided (central market, streets, or small shops; ambulatory or fixed location)?
- What is the size of the enterprises and what is the technical level at which they operate?

Third, structured individual interviews were conducted using a question guide prepared to collect information from microentrepreneurs about household structure, the household economy, the microenterprise, and health behavior. The questions were framed to allow respondents to answer in their own words in order to obtain an in-depth, contextual understanding of their perception of those topics and the relationships between them.

Selection of respondents for interviews was based on the principle of saturation. Potential interviewees are not selected randomly, but rather to cover perceptions from an expected range of respondents with characteristics that might be viewed as the independent variables. In this case, the objective was to interview microentrepreneurs that differed by gender; age; and the size, type, and stability of their businesses because those characteristics reflect the intersection between the household and the microenterprise and were expected to influence perceptions about family health and the microenterprise/household link (Weiss 1994).

In addition to interviewing microentrepreneurs, key informant interviews were conducted with people who fell into one of two categories: (a) professionals who work in organizations
that provide credit and/or technical assistance to microentrepreneurs and (b) professionals in local health care facilities or programs that provide services to members of poor households, most of whom would be working in the microenterprise sector.

Interviews were usually taped and detailed notes were taken in order to record respondents ideas and words. Interview were then transcribed, entered into the computer, and carefully reviewed. Work conducted to this point was entirely in Spanish. The transcriptions were then coded. The first round of open coding produced a list of topics and categories, which were then refined in the second round of axial coding, in which relationships between categories were established. Through this process verifiable categories emerge to reflect the object of the investigation as experienced by the interviewees (Strauss and Corbin 1998).

FINDINGS: PERU AND HONDURAS

Published data for Peru and Honduras paint a somber picture. Table 1 provides key data on health and well being at the national level, and suggests that there have been several important overall improvements in public health. These trends are similar to those encountered in other countries in the region. Nevertheless, infant and child mortality rates are still high, and access to safe water and sanitation is limited. Moreover, subnational analyses reveal substantial heterogeneity, so that subpopulations are characterized by data far inferior to those at the national level. One of the principal lines of cleavage is the rural-urban variable.

### Table 1. Health, sanitation, and well-being, Peru and Honduras

<table>
<thead>
<tr>
<th></th>
<th>Peru</th>
<th>Honduras</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life expectancy, years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>1998</td>
<td>66</td>
</tr>
<tr>
<td>Female</td>
<td>1998</td>
<td>71</td>
</tr>
<tr>
<td>&lt; 5 mortality (per 1000 live births)</td>
<td>1980</td>
<td>126</td>
</tr>
<tr>
<td></td>
<td>1998</td>
<td>47</td>
</tr>
<tr>
<td>Infant mortality (per 1000 live births)</td>
<td>1980</td>
<td>81</td>
</tr>
<tr>
<td></td>
<td>1998</td>
<td>40</td>
</tr>
<tr>
<td>Maternal mortality (per 100,000 live births)</td>
<td>1990-98</td>
<td>270</td>
</tr>
<tr>
<td>Access to safe water, % households</td>
<td>1982-85</td>
<td>53</td>
</tr>
<tr>
<td></td>
<td>1990-96</td>
<td>80</td>
</tr>
<tr>
<td>Access to sanitation, % households</td>
<td>1982-85</td>
<td>48</td>
</tr>
<tr>
<td></td>
<td>1990-96</td>
<td>44</td>
</tr>
<tr>
<td>Poverty: % population living on &lt; $2 per day</td>
<td>1996</td>
<td>41.4</td>
</tr>
</tbody>
</table>

Table 2 shows that the population of Peru and Honduras has grown rapidly but that the rate of growth is slowing, particularly in Peru. Likewise, fertility rates remain high, particularly in Honduras, but have declined in the past two decades. Also, the population is increasingly urban, although Honduras continues to be one of the most rural countries in the region. Moreover, it can be seen that the growth of the labor force exceeds population growth in both countries. The importance of this finding is that not all of the growing labor force has been absorbed into the formal economy. Consequently, increasing numbers of people in the economically active population must find employment and generate earnings outside of the formal economy in order to be able to provide for their basic needs, including health. This process has a clear gender component, and will continue to do so. It is likely that there will be a continued disparity between employment of males and females; as Table 2 shows, a breach continues to characterize male and female literacy despite advances in public education. Nevertheless, women occupy a greater proportion of workplaces than before, even if the increase in both countries in the past two decades is only on the order of five percent.

Table 2. Population indicators, Peru and Honduras.

<table>
<thead>
<tr>
<th></th>
<th>Peru</th>
<th>Honduras</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average annual population growth rate, %</td>
<td>1980-90</td>
<td>2.2</td>
</tr>
<tr>
<td></td>
<td>1990-99</td>
<td>1.7</td>
</tr>
<tr>
<td>Average annual labor force growth rate, %</td>
<td>1980</td>
<td>3.1</td>
</tr>
<tr>
<td></td>
<td>1990-99</td>
<td>2.7</td>
</tr>
<tr>
<td>Fertility rate (births per woman)</td>
<td>1980</td>
<td>4.5</td>
</tr>
<tr>
<td></td>
<td>1996</td>
<td>3.1</td>
</tr>
<tr>
<td>Females as % of labor force</td>
<td>1980</td>
<td>24</td>
</tr>
<tr>
<td></td>
<td>1999</td>
<td>31</td>
</tr>
<tr>
<td>Urban population as % of total</td>
<td>1980</td>
<td>65</td>
</tr>
<tr>
<td></td>
<td>1999</td>
<td>72</td>
</tr>
<tr>
<td>Adult illiteracy, % &gt; 15 years</td>
<td>Male</td>
<td>1998</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1999</td>
</tr>
</tbody>
</table>


The health and development situation portrayed in Tables 1 and 2 can be better understood in the context of indicators that link the national and international components of the economy with the performance of the economy at the subnational level. The economies both countries have expanded in recent years; in Peru, growth of 6 percent annually replaced negative growth rates characteristic of the 1980s. In Honduras, the devastating effects of Hurricane Mitch demonstrated the fragility of socioeconomic development in the region. The total cost was estimated at three billion dollars, the country’s GNP shrank by two percent in the year following the hurricane, and most interpretations are that development was set back by at least several decades.
Table 3 demonstrates two interrelated facts that are fairly typical of the region. First, there are substantial differences between Peru and Honduras, but while per capita GNP in Peru is more than three times that of Honduras, both are clearly very poor countries. Moreover, not only are they both highly indebted, but external debts have grown substantially following a mushrooming of debt in the 1980s. Consequently, large proportions of the budgets (earned largely from export earnings) must be dedicated to servicing the debts rather than providing services. Second, the economies and societies of Latin America are among the most unequal in the world, as demonstrated by the Gini coefficients and the distribution of income by quintile. Even a cursory analysis reveals that a fraction of the countries’ population controls most income. Poverty and inequality are not synonymous, but in these countries, as elsewhere in Latin America, they tend to go hand in hand.

<table>
<thead>
<tr>
<th></th>
<th>Peru</th>
<th>Honduras</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross national product per capita ($US)</td>
<td>1999</td>
<td>2,390</td>
</tr>
<tr>
<td>Total external debt (million $US)</td>
<td>1990</td>
<td>20.1</td>
</tr>
<tr>
<td></td>
<td>1998</td>
<td>30.1</td>
</tr>
<tr>
<td>Debt as percent of GNP</td>
<td>1998</td>
<td>55</td>
</tr>
<tr>
<td>Percent of population below poverty line: 1992, 1994*</td>
<td>Rural</td>
<td>67.0</td>
</tr>
<tr>
<td></td>
<td>Urban</td>
<td>46.1</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>53.5</td>
</tr>
<tr>
<td>Distribution of income: % earned by</td>
<td>1996</td>
<td>1.6</td>
</tr>
<tr>
<td>Lowest 10%</td>
<td></td>
<td>4.4</td>
</tr>
<tr>
<td>Lowest 20%</td>
<td></td>
<td>9.1</td>
</tr>
<tr>
<td>Second 20%</td>
<td></td>
<td>14.1</td>
</tr>
<tr>
<td>Third 20%</td>
<td></td>
<td>21.3</td>
</tr>
<tr>
<td>Fourth 20%</td>
<td></td>
<td>51.2</td>
</tr>
<tr>
<td>Highest 20%</td>
<td></td>
<td>35.4</td>
</tr>
<tr>
<td>Highest 10%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gini coefficient of inequality</td>
<td>1996</td>
<td>46.2</td>
</tr>
</tbody>
</table>

* 1992 for Honduras; 1994 for Peru.


It might be noted that regional and local data serve two functions. First, prior to fieldwork, they can be used to select study sites based on a system of prioritization. Second, they can be used to validate field observations. An analysis of data from Peru are illustrative. The Department of Cusco includes 37 districts and the rate of chronic malnutrition ranges from...
37.7 percent in the center of the city of Cusco to 83.7 percent in Quinota District, Chumbivilcas Province. The percentage of housing units considered to be “precarious” is as high as 97.6 percent, and in more than twenty districts, 95 percent or more of houses lack access to safe water and sanitation (Peru 1996).

These sobering data are consistent with economic and population indicators. First, population growth in the Department of Cusco slowed from 2.5 percent in the period 1972-1981 to less than 1.5 percent in the period 1981-1993. This trend reflects net out-migration from the area as a consequence of poverty and unemployment. The structure of employment further suggests that the microenterprise sector and the informal economy in general represent increasingly important responses to the inability of the formal economy to absorb workers in proportion to the growth of the working-age population. Thus, between 1961 and 1993, the proportion of working age people in agriculture decreased from 61 to 35 percent, while service sector workers more than doubled from almost 8 percent to more than 19 percent. The importance of self-employment and family labor is further demonstrated by the preponderance of independent workers in Cusco (45 percent of the total in 1993) and non-remunerated family labor (18 percent of the total) (Bautista 1996; see also World Bank 1999). The principal conclusion to be drawn from these data is that high levels of poverty, informal sector employment (mostly in microenterprises), and ill health are mutually reinforcing characteristics in Cusco.

**Structured Observation**

**Cusco, Peru.** Cusco is an historic city with one of the proudest historic traditions in Latin America. It is now a place of extraordinary contrasts, though. A relatively small urban is either fully employed or has been able to generate income through formal businesses or microenterprises in the transition stage (see Figure 1). One of the niches that elite microentrepreneurs have occupied is the production of high quality handicrafts oriented toward wealthy Peruvians and, especially, tourists. This small group parleys personal and business connections into technical and financial assistance from commercial banks, the chamber of commerce, and international organizations.

A tiny proportion of workers has access to formal sector employment. There is only one large company in Cusco (the brewery of Cusqueña beer), and other companies hire only small numbers of workers on a full-time, permanent basis. In addition, the public sector is shrinking, and many former civil servants have been obliged to seek employment in a constricted labor market.

Full and open unemployment is not as prevalent as might be imagined, though, because people do not have the luxury of not working at all. The search for employment, even on a temporary basis, consumes many people, especially young men with few marketable skills other than those required for general labor. They seek to hire themselves out on a daily, weekly, or (in the best of cases) monthly basis. One of the mechanisms for linking the plentiful supply of unskilled labor with the limited demand is the job market, which can be seen in several places in the city. Usually located in a private courtyard, the job market provides a venue where potential employers can post advertisements for available positions on the walls, and they pay a small fee for this service. Job seekers can then note down the information (free of charge) and apply for the position. These sites are invariably crowded, not only early in the morning and early in the week (where there would be the chance of securing employment for the entire week.
at a higher rate of pay for the *semana integral*), but throughout the week, even Friday afternoons. While this system would suggest the availability of employment, it actually demonstrates the incapacity of the formal sector to absorb new entrants into the economically active population. It also reveals a structural breach between supply and demand in that most of the posts that were advertised are for skilled, experienced labor, whereas most of the job seekers were unskilled individuals looking for jobs in construction and similar areas that require unskilled labor, which is in plentiful supply.

One of the most notable phenomena in the city is the informal sector microenterprise, which corresponds, in most cases, to the subsistence level shown in Figure 1. The Central Market of Cusco, like markets throughout the Americas, is the venue for apparently innumerable vendors of goods and services. It is located in a specific part of the city and includes both sets of market stalls and vendors located on the sidewalks. As in many parts of Latin America, Cusco’s market is organized by types of goods and services; fresh fruits and vegetables are in one part, shoes in another, and so forth. An adjacent section of the market offers imported finished goods, especially clothing and small appliances. Interestingly, even though these goods are considered to be “black market” (i.e., produced or imported illegally), the marketplace itself belongs to and is administered by the municipal government.

Cusco’s microenterprise sector has the particularity that because of the large number of foreign tourists, the production and sale of souvenirs is very extensive. But goods and services for tourists are offered in and near the city’s main plaza. In contrast, the Central Market is on the other side of the city, where few tourists are observed, and the sellers of foodstuffs and household goods serve the local population.

The level of the microenterprise in the Central Market varies; in the same vicinity are found: (1) small shops, (2) fairly elaborate and well-stocked permanent locales, (3) simpler, semi-permanent enterprises where business is conducted from a table or stand on the street, (4) very small microenterprises, where the goods (usually foodstuffs) are spread out on a blanket or directly on the sidewalk, and (5) ambulatory vendors, whose stock is limited to the amount of goods they can carry.

In sum, observation in Cusco confirmed the heterogeneous nature of the microenterprise sector. On one hand, for many microentrepreneurs—mostly women—the household subsistence strategy can not be very successful in providing sufficient income to cover basic needs, in part because the level of competition is extremely high. Many people sell the same items, and there are relatively few buyers in relation to the number of sellers. To a great extent, working families in this sector constitute the backbone of the population denominated poor by the government and international organizations.

With respect to health outcomes and access to health care, observation and informal interviews revealed that a fee for service structure recently implemented by the Ministry of Health may constitute a barrier to care for the poorest of the poor. An initial checkup costs a little less than the equivalent of one US dollar, but prescriptions and additional services have additional costs. Since the formal sector is so small, the number of people who qualify for treatment in social security facilities is very small, and the number of people with private or corporate insurance is smaller still. Thus, all costs must be paid out of pocket by most people on very restricted budgets. For example, most people in the Central Market regularly eat a lunch consisting of a small amount of rice topped by cooked greens (*nabo*). While this meal
has a certain level of nutritional value, it could be improved by the addition of a protein source. For example, eggs cost the equivalent of US 8 cents in the same market, but they are rarely eaten because that would effectively double the cost of a lunch. Another health implication that is readily visible is that babies and small children necessarily are brought to the place of work and since the work day is extended in most cases to 12 hours, the risk of exposure to infectious disease and environmental hazards is quite high.

**Tegucigalpa, Honduras.** The capital of Honduras is in many ways typical of cities in the region that are experiencing severe growing pains. With a population of 850,000 within city limits and at least a million in the metropolitan area, the city has grown rapidly and without much control or planning. Patterns of rural-urban migration and other precursors of distorted urban development, like nearly everything in Honduras, was altered by Hurricane Mitch. Repair from the hurricane still continues, and the microenterprise sector has reestablished itself in a low-lying sector in one of the city’s *colonias* adjacent to one of the several rivers that bisect Tegucigalpa, and which were under six feet of water after the hurricane.

Interviews revealed that many small businesses and microenterprises were completely destroyed by the hurricane, and that many of the people who work in that sector had lost their homes. The poorest segments of the populations of Latin American countries and others in the developing world are often obliged to live in places that are vulnerable to natural disasters, especially steeply sloped areas and riversides (Waters, 1989). In Honduras, homes in both of those environments were the most affected by the hurricane.

Perhaps the most striking observation was the proliferation of subsistence microenterprises. In the central market area and in many places elsewhere in the city, large numbers of ambulatory vendors offer extremely small amounts of goods for sale, mostly at very low cost. Most are men, and examples of the goods they sell include disposable razors, batteries, and one or two items of clothing. In contrast, tables set up in market area feature the same goods offered in analogous markets in Cusco and nearly every city in the region: inexpensive clothing, shoes, school supplies, items for personal hygiene, and other consumer goods. Most vendors in this setting (still in the subsistence category) are women. The sites are still temporary; the goods are packed up and stored at the end of each day. Finally, like Cusco and virtually every city in the Americas, there is an established and permanent market, where sellers in individual stalls offers specific types of foodstuffs (fruits and vegetables, bread, meat, canned goods, and so forth) and other consumer items.

**Structured Individual Interviews**

**Family Strategies and The Microenterprise**

**Microenterprise characteristics.** One of principal areas in which microenterprises are particularly active is the food sector. On one hand, small-scale commercial activities center on food, with a focus on selling either raw foodstuffs or in the preparation of foods, usually cooked. In Honduras, it is common to see small huts equipped with gas stoves on street corners, where simple foods are prepared. At a lower level are ambulatory vendors or sellers of small quantities of staple foods, vegetables, or a combination of goods that may change from day to day. As one respondent stated, microentrepreneurs at this level sell *de todo un poquito* (a little of everything). The microenterprise in some cases was so small that a multivalent
strategy was adopted, by which additional tasks were undertaken, such as doing laundry or cleaning houses.

At a slightly higher level of development are the sellers of clothing. In Honduras, as described above, many microenterprises in this category work from tables placed on the sidewalks of the Central Market area and in neighborhood (colonia) markets. In Cusco, the shops are located in a covered market place owned by the municipal government. In both places, a higher level of enterprise was also observed. In Cusco, several small businesses produce and sell high-quality ceramic goods to tourists and restaurants that serve the tourist market. Another business had practically made the transition to a formal small business by producing marmalade, coffee and other goods. The business began in the kitchen of the owner, but is production is now located in a small factory and sales in a centrally-located shop.

The microenterprise spectrum can be appreciated by comparing four shoemakers interviewed in Cusco. One works in an open-air market place under a plastic awning, and uses rudimentary hand tools to repair the shoes of passersby. He is one of more than a dozen such individuals, yet he seemed to have quite a bit of work. Nevertheless, repair jobs at this level are invariably minor cost on average only around one US dollar. A second shoemaker has a very small workshop and several apprentices, but very little stock; shoes are made or repaired on order. A third produces shoes and boots in larger quantities under contract with public institutions such as schools and the army. A fourth has five full-time employees, a small store with dozens of pairs of shoes as stock, and a workshop that occupies an entire house with much more elaborate equipment.

Subsistence level microentrepreneurs report that they start small with little or no capital investment. The level of technical skill is very limited, and most learned their limited skills very rapidly on the job rather than in formal settings. The principal source of knowledge and information is family members, especially parents. In some cases, businesses are inherited or taken over from relatives who no longer want them. Alternatively, subsistence level microenterprises are started up with loans from local moneylenders (prestamistas, chulqueros), while others are started or enlarged using loans provided by microenterprise development organizations. In contrast, microenterprises at the transition level are generally started up as a means of establishing sources of income independent of parents and spouses. In many cases created by relatively well-to-do young women, these businesses operate with at least some wage labor and always with a larger stock of goods and services.

There is a direct relationship between the scale of the enterprise and the amount of time dedicated to the business. The smallest enterprises work every day of the week for up to 12 hours per day, whereas the larger ones work regular hours during normal working days. Nearly all respondents reported that they had begun to work in the microenterprise sector out of economic necessity because it was necessary to complement household incomes from other sources in the formal and informal sectors.

**Family labor in the microenterprise.** One of the key components of microenterprise operation is the use of unpaid family labor as well as paid labor and the participation of adolescents. Most of the smaller microentrepreneurs reported that they work alone. Where other workers are present, they are usually non-remunerated family members, often daughters, daughters-in-law, and nieces who range in age from 13 to 20. In most cases, family labor is more or less permanent, but is rarely full time. A second pattern is to have occasional help
from husbands. Respondents at the accumulation and transition levels reported having more help from members of the family, sometimes on a full-time basis. Finally, the more capitalized microenterprises employ one or two full-time workers; the largest one examined has around five workers at any one time.

**Work site.** Informal sector microenterprises operate in a wide range of sites, including the home, in ambulatory sales, fixed but informal commercial sites (especially tables) and more formally-constituted small shops. In Cusco, work sites included the street itself (ambulatory sales), usually concentrated in a particular part of the city, and aimed at a particular type of customer. One young woman, for example, sells inexpensive paintings to tourists in the central plaza of the city. Others sell clothing or foodstuffs in the Central Market area to residents of the city because tourists are rarely seen in the Central Market. On the other end of the scale, established businesses usually work out of private residences converted into workshops for the production or display of ceramics or other goods. This arrangement allows them to have access to electricity, telephones, and other services.

Tegucigalpa also displayed the range of work sites typical for Latin America. Clothing is sold in fixed sites in the streets of the marketplace, while prepared foods are cooked in small huts or shacks in fixed locations. A substantial proportion of microentrepreneurs provides goods and services from their own home. This segment includes laundry services, the sale of small amounts of dry goods, and even the sale of contraband merchandise, such as liquor or uninspected meat.

Except for those that operate in the central market area, most microenterprises function in or near the place of residence and nearly always in the same neighborhood, again reflecting the blending of the economic and family aspects of the subsistence-level microenterprise. In most cases, the microentrepreneur has worked in the same site, usually because it was selected due to its location conducive to the sale of the respective goods and services.

**Customers.** Microentrepreneurs are invariably able to identify their client base. For those that operate in a specific neighborhood (particularly in the provision of prepared foods), customers are the residents of the neighborhoods, and are usually individuals who have come to expect to encounter the same goods and services. For those that work in the commercial or central market areas, the sites are selected to optimize contact with passersby, who may be bus passengers, people going to or from work, or people who are in the market specifically to make purchases.

**Use of microenterprise income.** One of the key assumptions of microenterprise development is that women are more likely to parlay independent income into health care and other basic necessities. The use of income generated from microenterprises was reported for a variety of purposes, and the relative importance given varies more according to the individual priorities of microentrepreneurs than levels of income.

Three categories of reported expenditures stand out. First, for many clients of microenterprise loan programs, portions of their earnings are automatically destined to loan repayments and obligatory savings accounts. Second, expenditures were reported for maintaining the business (especially the purchase of materials and stock) and for expanding the business (for example, the purchase of a new sewing machine). Third, household expenditures were reported for the purchase of clothing, paying bills (especially water and electricity), and
family well being. The cost of education, which is nominally free but which requires out-of-pocket expenditures for registration, uniforms, and school supplies, was frequently mentioned. Few respondents reported having enough income to improve their homes, and in Tegucigalpa, many reported that they are now paying rent because their homes were destroyed by Hurricane Mitch.

In Honduras in particular, most respondents reported that they spent little on health, and that they spent nothing if it were not absolutely necessary. Several respondents in Cusco provided similar answers; when free health services were available, especially for school children through the Seguro Estudiantil Gratuito (Free Student Insurance), health care is availed of, but adults regularly postpone or forego medical attention. While the literature reflects a greater propensity among women to spend on health care as compared to men, other analyses report that households will cut back on a variety of necessities, including health care, when resources are stretched to the limit (Hentschel and Waters, forthcoming). There was considerable variation on this point, however, and some respondents reported that their incomes were sufficient for health care and health maintenance, particularly in inexpensive public facilities. In contrast, among the urban elite, health care is usually sought in private clinics that operate on a fee-for-service basis.

**Decision making in the microenterprise.** Another key assumption was that the microenterprise was mainly—but not exclusively—the purvey of women, and that as business operators, they make key decisions alone. Most of the microenterprises studied are at the subsistence level, meaning that they were owned and operated by a single family member (usually female, and very often the female head of household), with occasional input from other family members. In all of these cases, whether the microentrepreneur was a client of a microenterprise development organization or not, she (or he) made business-related decisions alone. This includes all decisions on what to buy and sell, price structure, work schedule, and other working conditions. This characteristic reflects two points. First, most microenterprises function at a low level of complexity, so business decisions at the subsistence level are usually straightforward, based on prior experience, and often repetitious or cyclical. Second, family members usually dedicate their time to a variety of remunerative and non-remunerative activities, and therefore can not always be involved in all household activities.

In cases where the microenterprise is regularly operated by more than one person, several family members (occasionally a couple) share decision-making. Finally, in the cases where the microenterprise had reached the level of transition, decision making was likely to be more formal, being affected, for example, by agreements with banks and other institutions.

**Household Strategies**

**Family structure.** As expected, family structure varied greatly in the population under study. The variable that best predicts size and complexity of the family unit is the age of the microentrepreneur, especially when that person is a woman. Several patterns were detected in Peru and Honduras.

a. *Young women with young husbands or living with parents.* These women were between 19 and 25 years old and were either childless or had one or two young children. This group includes some of the poorest microentrepreneurs, but it also includes several of the well-to-do women who operated fairly sophisticated enterprises.
that produce, for example, ceramics in the city of Cusco. In most cases, their income was either supplemental to total household income or in the case of the wealthy women or was independent income, but not ultimately essential to their well-being.

b. Women over the age of 25, living with a husband or common-law-husband (compañero). In these cases, the size of the nuclear family, including children, ranged from four to seven or eight, and in a few cases, members of the extended family were also part of the household.

c. Single female heads of households. Particularly in Honduras, a substantial proportion of female microentrepreneurs are heads of households, and live alone with their children. In some cases, there is a husband who is rarely present, usually because of work in other parts of the country or employment-related travel.

**Household decision-making.** Responsibility for income generation enhances the capacity of women to negotiate household distribution of power and to participate in decision making. At the same time, this characteristic varies in different cultural and economic settings. Nearly all women who were not single parents reported that they share decision-making with their spouses, but they all clarified that this had always been so. In other words, it is not clear that participation in the microenterprise enhanced decision-making power, as often hypothesized. In fact, it might be that factors related to gender explain the ability of women to generate independent income and participate in decision-making. In the entire study, only one woman reported that she deferred all decision-making to her spouse. In Honduras, in particular, many female entrepreneurs are single parents and make all household decisions, sometimes with input from their mothers.

**Health Behaviors**

**Definition of health.** It is a maxim in the international public health profession that health is more than the absence of disease, being related to a state of complete well-being. We can distinguish between two concepts of health. One reflects a curative approach, characterized by the belief that health is simply the absence of disease; here, health behaviors basically address illness after it is detected. The second concept is reflects an understanding of prevention and is related to behaviors designed around nutrition, sanitation, healthy lifestyles at the family and community level, rather than simply treating illness.

A bifurcated pattern of response emerged in Cusco. Microentrepreneurs in the accumulation and transition stages reported that they thought of and practiced health in terms of prevention. An analysis of the health system had revealed that a small fee for service is required in public hospitals and clinics that serve the majority of the population. Nevertheless, many people reported that either they could not afford those fees (the equivalent of approximately 1 US dollar), or that they postpone hospital and clinic visits as long as possible when free services are not available through, for instance, the student insurance program. Thus, for most respondents in Cusco, health is in fact considered to be the absence of disease; that is, one is well basically if one is not ill.
Responses in Honduras reveal an almost equal split between the curative and preventive understandings of health. For some respondents, good health simply means not feeling or getting sick and not having to take medications. For others, in contrast, health means being well, seeing a physician for checkups (rather than seeking treatment only for illness), good nutrition, cleanliness, and having access to an income that allows for maintaining health. As one person reported, good health is “prevención de cualquier cosa” through personal hygiene, health education, and a good diet.

**Treatment for health problems.** An interesting dichotomy arose between the belief that minor health problems can be treated at home and that it is necessary (or at least preferable) to be treated at a public health hospital or clinic. The former reflects the idea that individuals and families can sometimes take care of minor problems using traditional knowledge or, more commonly, by obtaining medication from a pharmacy without visiting a physician. The latter was the most common response, particularly in Honduras, where a basic checkup costs the equivalent of seven cents. Other responses included: doing nothing, getting advice from a project health officer, obtaining the services of a private physician or clinic (the answer more commonly given by wealthier microentrepreneurs), and an explicit reference to the use of traditional home remedies such as herbs and teas.

With regard to the treatment for more serious health problems, most respondents simply referred to a higher level of treatment. Those who responded to the previous question that they would either treat the health problem at home or obtain medications from the pharmacy reported that they would seek services at a public clinic or hospital. Those who reported that they resolved minor health problems at a public clinic also reported that serious health problems were addressed in hospitals. A pattern that was clearly distinguishable in both Peru and Honduras was that wealthier microentrepreneurs expressed a strong preference for private physicians or clinics to resolve serious health problems. Almost without exception, the reason given for this preference was not better service, but faster service. For this group, time is indeed money, and they find that the long waits that are involved in obtaining services are unacceptable because they represent lost income.

**Decision making in health.** In nearly all cases, respondents reported that health decisions (principally related to when and where health services should be obtained) were shared with spouses. Nevertheless, several women, particularly in Honduras, reported that they made these decisions alone, usually because they were more regularly available to respond to a health problem, while men were more regularly absent. Several women, however, responded in a manner that reflects the view of “women as healers;” they said that they made health decisions because they know more about it than their spouses. In both countries, only one female respondent deferred health decisions to her husband.

**Payment for health expenses.** Nearly all respondents reported that the costs of health services are paid out of pocket. In Honduras, public health services were not seen to be prohibitively expensive, and the cost of a basic checkup was not considered a barrier to care. But some respondents reported that beyond the basic cost of services must be added other associated costs such as transportation and, in particular, their opportunity cost, which was seen to be quite high because obtaining public services is so time-consuming.

The relatively low cost of public services was invariably compared to private services, which in the case of Honduras, could be up to 75 times more expensive. An illustration from
Cusco is illustrative. There, the public hospital nearest the Central Market (dubbed by its clients as *El Hospital de los Pobres*) has instituted a program by which in the same locale, there is a clinic operated like a private institution, where more personalized services are offered to those who are willing to pay more than the public fee required of all patients. Nevertheless, a recent visit confirmed that the “private” part of the hospital was nearly deserted, and an occupancy rate of less that 25 percent was reported, while the “public” portion was nearly full.

One respondent, whose microenterprise was in the transition stage (and who was therefore relatively well off) reported that she had taken her sister for treatment in a private clinic, was told that the cost would be over $US 1,000. She declined that treatment and went instead to a public hospital because as she said “if you are poor, you must look for free services.”

**Health insurance.** One of the emerging trends in health care financing in Latin America is private insurance. There are a number of very complex issues related to the need for this kind of financing, and in addition, there are many questions related to the relationship between the desire for them and the ability or willingness to pay for them.

Response to this question was surprisingly uniform in that all respondents reported that they would be interested in participating in a private insurance program, and that they would be willing to pay for it if the cost were reasonable. Different respondents emphasized the caveat regarding the cost of such a program to different degrees. Nonetheless, it is clear that there is a desire for prepaid health plans that might supplement or replace nominally free or very inexpensive coverage of public health services.

**Ability of microenterprise-generated income to cover household health needs.** This area of inquiry generated the greatest discrepancy between the two countries. The pattern of responses in Peru revealed a generalized perception that family income generated by microenterprise and other sources was not sufficient to provide for family health. In contrast, nearly all respondents in Honduras felt that their incomes that were sufficient for maintaining family health.

This generalized response was accompanied by four different caveats. First, many of the microentrepreneurs with very modest incomes felt that they had enough resources to take care of their health needs even though they recognized the limitations of their incomes, which, as one person said “*no le da para tanto.*” A second, and related caveat was that the family must make do with the resources it has. There was a distinct feeling that this perception was at least a product of having overcome the disastrous consequences of Hurricane Mitch.

Third, several respondents reported that their incomes were sufficient to cover their health needs as long as there were no extraordinary expenditures. In other words, they recognized that they were vulnerable in terms of both income and health. Fourth, several respondents reported that their incomes permitted them to cover their health needs because they were able to directly and personally care for minor illnesses at home at little or no expense.

**Summary of Structured Individual Interviews**

**Household strategies and the microenterprise.** These interviews confirm that the microenterprise is a crucial component of the family’s ability to generate income. In an
environment of limited employment opportunities and generalized poverty, the household is obliged to develop strategies to make ends meet. This feature of societies in Honduras and Peru—as elsewhere in the region—appears to be intergenerational, as men and women learn the skills required for starting and sustaining a microenterprise from their parents and are clearly passing them onto their children.

It is also apparent that many microenterprises are not designed to enter into a trajectory of accumulation, growth, or expansion. Indeed, there are many structural obstacles to such a trajectory and they are well-recognized by the microentrepreneurs themselves. Most microentrepreneurs lack basic knowledge of business strategies, and their access to the resources needed to grow are limited. Microenterprise development organizations are devoted to addressing these needs. But there are other structural impediments related to supply and demand. On the supply side, there are many (sometimes innumerable) other businesses that offer the same or similar goods and services. On the demand side, high levels of poverty limit the capacity of large segments of the public to consume goods and services in quantities sufficient to sustain a burgeoning informal sector.

Consequently, most microentrepreneurs operate with the basic objective of providing for basic family well being for the immediate future (today and tomorrow), as well as into the more indefinite future. One of the principal resources available to the family is the labor of its own members. Only a small number of enterprises in the transition stage regularly employ workers on a formal basis; for the bulk of microentrepreneurs, the occasional assistance of children and spouses is very important (although it is quite surprising that many women in particular work alone with no help at all, often because their children are very young or are old enough to have left their house).

In this view, the very small microenterprise (in terminology introduced in Figure 2) is a response to prevailing structural conditions, especially poverty and inequality. At the same time, households are not hapless victims of their fate; rather, they are protagonists in a real life drama. Among other things, microentrepreneurs have clearly defined and very realistic priorities with respect to the use of the income generated by their microenterprises. Here, the role of the microenterprise support organizations can be very important in channeling the conceptualization that women have, in particular, of the importance of health and well-being into informed responses. This is one of the levels at which a focus on household health can work together with income generation in the informal sector microenterprise.

**Family strategies.** The pattern of responses to questions about strategies developed within the household reveal a clear orientation toward addressing poverty in an active and realistic way. What stands out in this portion of the study is the relationship of the microenterprise to family structure, particularly for those at the subsistence level. Two models emerge. First, for many families, the microenterprise is a key element of a multivalent strategy that also includes income from other sources, which is earned by other family members in the formal or informal sectors. Second, it is clear that in some parts of the region (particularly, in this case, in Honduras) that there are many single mothers who depend upon the income generated by the microenterprise for all of their needs. In both cases, the dependence upon occasional or sporadic unpaid household labor is notable. In most cases, help is provided by adolescent children (most often, young women) and only occasionally by spouses because they are generally involved in other income generating activities.
Health Behaviors. The concept of health varies greatly. Many respondents stated that they consider health to be absence of disease. Consequently, health is addressed in the context of illness and the need for services, rather than thought of ahead of time. The reason for this is at least partly economic; even free health care connotes costs: direct, in the case of medicines and fees for private health care providers and indirect for time lost for potentially remunerative activities.

To the degree that microenterprises represent the principal or even exclusive source of income for at least half of the families in Cusco, and many in Tegucigalpa, it is clear that the household expenses depend on the income that those enterprises can provide. Respondents to the structured interview clearly view their family and their income-generation functions as part of a continuum of interlinked responsibilities and activities rather than bifurcating work and family. Thus, family expenses are diminished to the degree possible if income that is generated is insufficient to cover all basic needs. Consequently, clothing, housing, and other items, including food, are consumed to the absolute minimum possible. Children receive health care if they qualify for free or subsidized care, and non-insured individuals seek and obtain care only when it is absolutely essential, which often means when it may be too late. The cases of acute malnutrition complicated by tuberculosis observed in the pediatric ward of one of Cusco’s public hospitals attest to the inability of many households to provide adequately for preschool children.

Nevertheless, while microenterprise employment may appear to be a relatively inefficient mechanism for addressing family health issues, because most fail to grow or even do well, they are, for large proportions of the population, the only or the best alternative available, even if it inevitably means limited income for long hours of work. Thus, understanding family health and addressing the needs for health care for most microentrepreneurs requires an understanding of how the family business—the microenterprise—in fact may represent the only and best hope for providing the income necessary for seeking and obtaining care.

CONCLUSIONS

The city of Cusco, Peru is notable for its unique place in history as the center of the Incan culture. Nevertheless, it is also representative of intermediate cities in Latin America with respect to many features, including rapid population growth and high rates of rural-urban migration; a growing ring of pueblos jovenes in the hillsides surrounding the city center; a large and sprawling central market with innumerable informal microenterprises combined with a very large number of ambulatory vendors; a heterogeneous and multiethnic population; high rates of poverty, unemployment, and underemployment. In contrast, Tegucigalpa more closely typifies larger cities of the region that are growing very rapidly and find it increasingly difficult to provide adequate services to a burgeoning urban population. Both places are feeling the winds of health reform that blow over the region, bringing a devolution of responsibility for health care services to the private sector.

Health outcomes are very much circumscribed by the level and form of income generation in Peru and Honduras. In general, microenterprises are operated by women who, as theory predicts, are actively engaged in decision making related to health. Nonetheless, both curative and preventive approaches to health care are limited by available income. It is incorrect to assume that income generated by microenterprises is merely supplemental, but it is not the case that it automatically allows households to greatly increase expenses. Therefore,
reliance upon free or inexpensive health care is still crucial, and will probably continue to be so as long as the kind of macroeconomic and macrosocial conditions discussed earlier characterizes the region.

Household health extends beyond issues that are strictly medical. The well-being of the household depends on appropriate links to the economic, political, and social structures within which it functions. This paper draws particular attention to the link between household health and informal sector microenterprise-based employment. This emphasis does not detract from other components of well-being such as education and political participation. Rather, it acknowledges that the “lost decade” of the 1980s extended into the 1990s, and that crisis has become a persistent feature of many Latin American socioeconomic systems. In that context, families are increasingly called upon to depend less on public programs and to cover more of the costs of health care. The informal sector microenterprise allows them to do so, and microenterprise development organizations can play a key role in optimizing the links.

REFERENCES


