VVCR FINAL REPORT
for Healthy America's Foundation

Project Name: Women's Health Awareness and Needs in Costa Rica Project.

Awardee Name: Fundación Voces Vitales Costa Rica

Reporting Period: Apr/14/2022 to Jul/30/2022

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A. Scope of work

Project Description

Voces Vitales Costa Rica will conduct six focus groups to explore how much information and understanding women of different backgrounds and ages have concerning their physical, sexual and mental health. Participant profiles in the focus groups will include: three life stages: (18-25, 26-44, 45 years up) a combination of income levels and rural and urban backgrounds.

Goals and Objectives

Overall Goal:
To explore health knowledge and needs of women in different life stages in order to provide information to the Healthy Americas Foundation regarding what they have been told about in their life stages as well as the expectations they have.

Specific objectives:
1. Explore the awareness of women's health in different life stages. 2. Identify women's understanding in relation to their physical health including gynecological, health and pregnancy, diseases and disorders.
3. Identify women's understanding in relation to their mental health including prevention and willingness to seek help.
4. Identify women's awareness of sociocultural issues and habits that impact their health.
5. List women's major needs in relation to physical, sexual and mental health issues.

Methodology

Research method: 6 focus group, 2.5-hour sessions.

To conduct the focus groups a facilitation guide will be developed considering the criteria from physical, gynecological and mental health specialists. There will be a facilitator and an assistant per group, as well as findings recorded per session. The session will be facilitated by a psychologist experienced in focus groups conduction.
The recruitment will be supported by social organizations in each region or target group.
The main deliverable will be a summarized report of all focus groups' findings.

B. Accomplishments

A total of six in-person 2.5-hour focus groups were carried out, with the following

characteristics: **Rural Guanacaste geographical area in the North Pacific**

These women were recruited through a collaboration with Reserva Conchal, who coordinated with local NGOs (Futuro Brillante and Abriendo Mentes).

Focus Group 1
Ages 26-44, 9 participants, lower-middle and low income
Average Age: 32
Monthly household income: Less than 300,000 to 600,000
Average persons per household: 3.6
Locations: Santa Cruz and Carrillo, Guanacaste

Focus Group 2
Ages: over 45 years, 14 participants, lower-middle and low income
Average Age: 56
Monthly household income: Less than 300,000 to 1,000,000

Average persons per household 4.1
Locations: Santa Cruz and Carrillo, Guanacaste

Rural Atlantic geographical area

Focus group 3

Ages between 18 and 25, 10 participants, low and lower-middle income (IMAS and Guácimo Municipality)
Average Age: 23
Monthly household income: Less than 300,000 and two between 1,000,000 and 1,500,000 Average persons per household: 4.6
Location: Guácimo, Limón

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Focus group 4

Ages between 26 and 44, 9 participants, low and middle income (GRAMEEN-CUNLIMON)
Average Age: 33
Monthly household income: Less than 300,000, one between 300,0001 and 600,000 and one between 2,000,000 to 3,000,000
Average persons per household: 4.2
Location: Guácimo, Limón

GAM Urban Geographical Area

An adjustment was made to the initial profile to facilitate communication and recruitment, segregating the groups by income only, without age discrimination. We recruited through a local NGO Lifting Hands and through our volunteer mentor network.

Focus group 5

Ages 18 and up, 10 participants, middle and lower-middle income (Lifting Hands) Average Age: 41
Monthly household income: Less than 300,000 to maximum 600,000
Average persons per household: 3.8
Location: Escazú and Central, San José

Focus group 6

Ages 18 and up, 14 women, middle and upper-middle income (Vital Voices Mentors)
Average Age: 44
Monthly household income: From 300,000 up
Average persons per household: 2.4
Locations: Heredia, San José and Alajuela

C. Success Stories

The dynamics generated through the focus groups created warm and safe spaces to share experiences among women.

Although at the beginning of each session, most of the participants were unknown, little by little, an atmosphere of listening and relief was created, which many of them appreciated, in addition to considering it necessary and unusual in their daily experience.

Throughout the different activities of the session, the expression of feelings was encouraged, and many were allowed to share personal stories of challenges and resilience.

For example, two of the women (one in Guácimo and one in San José) told their stories of recovery from alcoholism and drug addiction. Both women found themselves in a state of homelessness and with a high level of psychosocial deterioration; however, thanks to rehab and the support received, they managed to develop the skills to get ahead and today they are an example of strength and inspiration for other people.

In the Atlantic area, two cases of domestic violence were identified and referred to the local support network (through the Municipality, with the support of INAMU).

Although the objective of the focus groups was to obtain information regarding health, these spaces offered a chance for sharing, which was used to offer psychoeducation about different topics of interest and situations identified by the participating women. There was also space for laughter and sisterhood.

Some of the groups with which we worked were made up of women from community groups, foundations, or the Catholic Church (in the case of older women from Buenos Aires in Guanacaste). Belonging to and participating in these groups is recognized as a protective factor for women's overall wellbeing, not only because it offers them access to spaces for education, support, and community, but in many cases, it also offers them a life purpose, through service to people in the community and support to other women.

Bringing in a few of our mentors to collaborate as participants of the focus group also helps VVCR continue offering spaces for our volunteers to feel appreciated, to share their stories with a sense of belonging and usefulness.

This sense of usefulness was also shared throughout as women knew that the findings from this program can improve future programs for other women beneficiaries.

D. Findings and proposed solutions

The activities implemented in the different groups encouraged discussions about three fundamental thematic axes: (1) Physical health, (2) Gynecological, sexual, and reproductive health, and (3) Mental, emotional and relationship health.

The experience of the body, femininity and mental/emotional stability has been a difficult path for most, in different ways, which the women shared from a place of authenticity – prompted by the various dynamics used – while they commented about their life experiences with the other women.

Women working in groups

In most cases (medium-low and low socioeconomic status), access to reliable sources of information and the health resources offered by the system have been insufficient. Most learn about ailments once they suffer from them, either by consultation with health centers or with relatives, the internet, and acquaintances. We identified common experiences in the different groups among which the following were mentioned:

-Little information related to various aspects of physical, gynecological, and mental/emotional health, as well as psychoeducation from reliable sources (most of them, especially the

youngest). When they feel discomfort, they investigate on the Internet, which often generates confusion and delay in the search for timely and effective help.

-Little knowledge about their own body (myths related to the body and female sexuality, absence of or very few spaces for self-care).

-Late medical diagnoses in critical cases (which have triggered situations of greater severity such as: multiple surgical interventions, permanent pain, partial disabilities, mental/emotional instability, etc.).

-Few efficient support networks for them and their children.

-Little sex education received in a conscious and coherent way.

-Little information and access to resources related to mental, emotional, and relationship health. Many of them express having experienced suffering and not having any support (medical, psychological, social, etc.), with situations such as anxiety disorders, depression, grief, and gender violence. Some of the women also deal with having to take care of the health of other people (mothers, fathers, offspring) and this generates an emotional psychological burden on them.

In Costa Rica, despite the existence of a public social health and safety system (Caja Costarricense del Seguro Social), access to resources is limited, not only because of the current saturation, but because many of the women participants are not insured. Among the consequences of this situation, we can mention:

- Lack of timely and appropriate intervention depending on the person's needs - Lack of consistency in the use of medical treatments, due to little information about their objective and proper way of taking medications or, in some cases, due to fear. - Late diagnoses and long waiting lists for surgical interventions.
- Lack of psychoeducation, psychological and/or psychiatric support in a timely manner.

Here are the main findings on each of the axes:

a) Physical health, comprehension and identified needs

Information was obtained about the attendees' lifestyle (food, exercise, rest, physical self-care, etc.), chronic and critical illnesses.

With regards to lifestyle, most of the women report understanding what it means to maintain a healthy body; however, a significant gap between knowledge and practice is observed. Some of the findings were:

- Many of the women mention a lack of control regarding food, especially when it comes to carbohydrates, sugar, and fat: "*I cannot control myself with sweets, they are my weakness*", says a young participant from the Guanacaste area.

-Several participants (one from each group) report having problems with excess weight and

having dealt with different situations as a result of it, from health issues to problems in the relationship with themselves, as well as at a relational and social level: "*since I was little, I have had weight problems, I have done many diets, but nothing works for me, then I get bored, and I eat everything again*".

-Despite having knowledge about the importance of physical activity, most of them do not perform any physical exercise, or perform below their expectations or needs. Some comment that they have made multiple attempts to exercise; however, for different reasons, the practice does not hold up as a habit.

Sleep Quality- The vast majority report having poor sleep quality, characterized by difficulty staying asleep during the night and feeling tired in the mornings.
To some extent, this difficulty or constant interruption in sleep could be related to the exercise of care roles (children, disabled or sick people, older or sick adults) and / or has a direct relationship with the "overthinking" and stress. Also, in some cases, it could be related to a traumatic event or the presence of Post-Traumatic Stress Disorder.

Some take sleep medication (mostly anxiolytics) as that is the only way they can fall asleep. It is striking that, in the Atlantic region, the vast majority report experiencing insomnia and sleep related problems.

Chronic diseases- The presence of chronic diseases (especially diabetes and hypertension) was identified in all the groups, as well as different critical situations at the health level. An important number of women say they have digestive problems, due to conditions such as colitis and gastritis, some of them due to allergies or food intolerances and a few because of other serious conditions and/or surgical interventions.
Some participants reported having significant thyroid problems, due to the presence of both hyperthyroidism and hypothyroidism.
Some of the women diagnosed with chronic conditions report not following the indicated health care and not taking the prescribed medication.
Many participants expressed having good health in general and seldom getting sick.

Serious illnesses- There are reports of very serious ailments (stomach, breast, and cervical cancer, two young women with heart disease in Guanacaste, multiple surgical interventions for different causes, etc.) from several participants in all the groups (except the one carried out in urban areas of medium and medium-high level incomes).

Covid- Participants from all groups report having suffered from Covid (some of them on more than one occasion). In some cases, the side effects of the disease are apparently null or mild, while in others, the presence of more severe side effects is mentioned: respiratory problems, fatigue, loss of sleep, recurrent headaches, and chronic cough, among others. Side effectsrelated to mental health are also noted, which we will mention later.

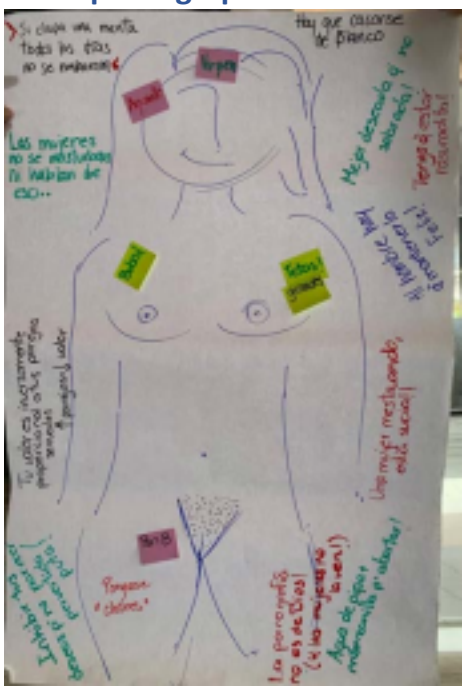
b) Gynecological, sexual, and reproductive health

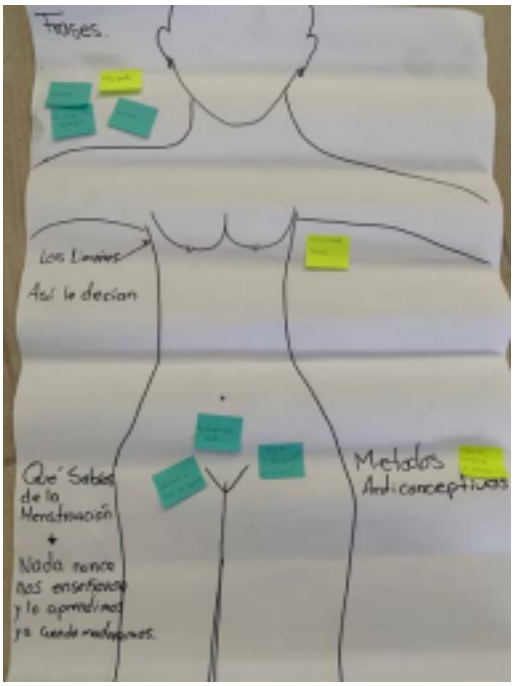
To deepen the scope on this topic, the participants were asked to work in groups on the following questions:

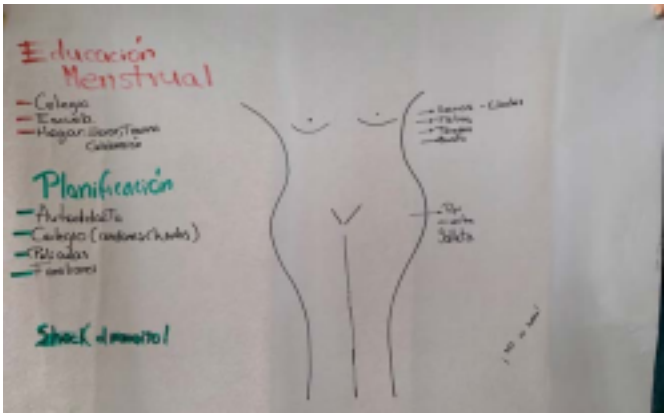
Regarding the body and sexuality: What did we learn? How did we learn it? At what point did we learn it?

The participants of the different groups elaborated posters and had discussions to answer those questions.

Some photographs of the work carried out







Synthesizing what was stated in this exercise, the following important data has been extracted:

1. Relationship with one's own body

For most participants, the relationship with their body is lived from a distance and, in many cases, with rejection.

It is a common learning that touching the body is something undesirable or frowned upon. A participant in the urban group from Lifting Hands commented: "*They told me*: *don't touch* your *breasts because they are going to be horrible; they fall off and become wobbly*."

A young participant from the Guanacaste area points out: "*when I grew up, my dad told me that touching my body (especially my private parts) was a sin*", she adds "*it affected me so much that when I bathed, I did not wash well, and I did it quickly so as not to have to touch myself...* "

Some of them point out as something very common, that if a girl (or a boy) touches their own private parts, they are reprimanded with words like "pig".
This restriction to becoming familiar with one's own body has consequences, such as not understanding how the body works and when you must pay attention to something (which can lead to searching for medical attention when it is too late); it also generates lack of self knowledge, fear, and control, regarding experiencing sexuality.

It is contradictory how this experience in relation to the body changes discourse during early adolescence, during which time, through menstruation, women have the risk or the possibility of becoming the property of "another" (partners) who has more control over the woman's body than herself.

Most of the participants in age groups over 25 years of age pointed to the experience of sexuality (especially during youth and young adulthood) at the mercy of their partners' wishes: "*I just had to comply*," says one participant.

Some older women narrate how they have learned to set limits on their own body: "*When I say no, it's no. My husband knows it and respects me*," says a participant from the Guanacaste area.

"*I have a strong character and now I say no, and that is respected. Sometimes my partner gets angry and leaves... but as a child, a relative touched my body without my consent*." Participant from the Atlantic region (Guácimo).

There are few cases (present in all groups) in which sex education was guided in a slightly more informed and conscious way. In these cases, an important figure is pointed out (such as a grandmother, mother, friend, sister, in one case a father) who had the role of directly addressing some of the issues related to development and sexuality during their growth.

2. Little education about menstruation and menopause

Menstruation was received by the majority as something negative, which led to an uncertain transition in which childhood "ended" and they entered another stage, perceived as dangerous for many: "*now you can get pregnant, you have to take care of yourself a lot, because if they give you a kiss they get you pregnant*" points out a young participant from the Guanacaste area, regarding what her grandmother said.

In most cases, menstruation was never discussed, nor what changes in the body caused it, or what these changes in the child's/adolescent's life entailed. The information was provided through shame and fear.

Most report that menstruation caught them off guard, because they had no or very little

previous information: "*I thought I had cut myself"* says a young participant from the Guanacaste area. "*One day your blood is going to go down, that's everything. I don't know why"*, says a participant from the low-income group in San Jose.

Some of them comment that, in menarche, they had support from a relative, who in few cases provided information explicitly and assertively, about the menstrual process and whose help was rather practical (in offering a sanitary towel and explaining how it was used).

The older participants from the Guanacaste area comment that there were no disposable menstrual pads before, so they resorted to using cloths that they inserted as pads in their underwear: "*I remember that my sister gave me a cloth to wear, it seemed that I was walking around with diapers*" says a participant from Guanacaste. "*I hid them, I was embarrassed to be seen wearing or washing them,"* says a woman from the same area.

Regarding menopause, there is a lot of ignorance in younger participants. In the older age groups, there is more information (some of them are already going through this process or are in pre menopause).

In relation to the gyneco-oncological disorders typical of this stage of life, all indicate having heard or having some knowledge about breast cancer and its prevention (they mainly point out self-examination and not mammography); however, the vast majority is unaware of ovarian cancer, which usually has a late detection, a poor prognosis and its highest prevalence occurs at this stage in life. In fact, a woman in Guanacaste said she had periodic pap smears to prevent ovarian cancer as well to check for human papilloma, which denotes ignorance of the disease.

3. Sex education based on silence

Many of the participants had a sex education based on silence, the related topics were not discussed or were treated with censorship or jokes of a sexist nature (in relation to the female body and sexual expectations about women).
The concept of sexuality that was taught was, in many cases, reduced to genitalia and intercourse; that is, there is no concept of overall sexuality, which involves a healthy relationship with one's own body and its needs, and which integrates the experience of affection and enjoyment as a fundamental axis.

All the participantsreport having learned to call their sexual or reproductive organs in many ways, most of them derogatory or burlesque:

Breasts: *Tits, lemons, boobies, tetes, chichis, bolinchas.*
Vagina: *Panocho, thingy, little flower, cookie, pancho, chocha, scissors, empanada, monkey, cockroach, cat face.*
Penis: *piquillo, screw, horn, picha, pinga.*
The use of inappropriate terms and the shame of "calling things by their name" translates into a risk factor with respect to sexual abuse, as it facilitates (from the dynamics of the offender) that the victim (especially if it is a little girl) experiences confusion and does not know how to express what is happening to them.

There are several young mothers (present in all groups) who indicate that they want to offer a better sex education to their daughters and sons than the one they received; however, they have few resources to be able to exercise this task in the desired and appropriate way according to their existing needs.

Women do not report receiving information about sexuality-related pleasure.

4. Onset of active sex life, contraception, and pregnancy

An early onset of sexual intercourse is observed in most groups, in many cases, from the sexual abuse produced by relationships with older men: "*I was 13 years old my first time, it was with the father of my eldest son ... he was 27 years old. He never forced me to anything, we slept together after one year*." A 19-year-old participant from the Guácimo area recounts.

For many of the participants, the experience of female and male sexuality was learned in a distorted way and plagued by biases, related to established gender roles.

A 25-year-old woman from the Atlantic area says: *"My first boyfriend told me: if you don't sleep with me, I'm going to sleep with anybody, because the man has a need – and I'm stupid ... he told me that he was sterile, because he was old, he had already been with many women who had not become pregnant, I got pregnant on my first time."*

Some of the phrases learned and mentioned in the different groups were:

- *When the one below stands up, the one above does not think* (referring to the penis erection and the use of reason).
- *If a man gets into a puddle, he comes out clean; if a woman gets into a puddle, she comes out dirty.*
- *Men work and women take care of others.*
- *You must comply in bed, so that they don't go with another woman.*
- *The man goes as far as the woman lets him.*
- *Better to be desired and not too available.*
- *With a kiss you can get pregnant.*

Just as the beginning of sexual activity is precocious, so is motherhood. Except for urban women with higher income, a large majority of the women have had their children at a very young age, some while being minors.

In the group of women aged 18 to 25 in the Atlantic region, they are all mothers (some of them became mothers while they were minors), most have two children and all of them express no desire to have more.

Regarding the number of children, there is a difference in the group of urban middle or upper middle-class women, both in terms of the number of children (one or two at most) and the time of life when they had them (older ages).

Although most women currently have information about the existence of different contraceptive

methods and sexually transmitted diseases, knowledge and access to these resources are very limited. Some young women report using an intradermal device (placed by the CCSS-Social Security) to prevent pregnancy. The other most used method is the rhythm (ineffective in preventing pregnancies and avoiding STDs).

Some point to frustration with the public health system regarding the decision not to have more children. They say they have been denied sterilization because "they are still very young." In other cases (a few years ago this was the usual practice), they indicate that they have requested authorization from their partner to proceed with sterilization.

This lack of control over pregnancy and motherhood means that many of them are in situations of psychosocial risk, where there is not only an effect in the experience of the body, mental, emotional, and relational health, but also on their possibilities of satisfying their children's and their own basic needs, because of their situation of poverty.

5. Lack of knowledge and access to resources for the treatment of gynecological conditions

Most of them know about the existence of sexually transmitted diseases.

There are some gynecological disorders that are better known than others to the participants. For example, they all report hearing or having some knowledge about breast cancer and about the human papillomavirus (HPV) as a risk factor for the development of cervical cancer.

Few know about postpartum depression even though, in the face of the explanation, many say they feel identified.

There are other gynecological disorders which very few claim to have any knowledge or have "heard of", for example: uterine fibrosis, pelvic floor collapse, endometriosis, polycystic ovary syndrome (despite being common, especially in young women).

Some of them comment that they have suffered from conditions of this type and that they have had interventions such as: partial or total hysterectomy, operations for uterine fibroids, mild and moderate cervical dysplasia, difficulties during pregnancy.

6. Sexual abuse

Unfortunately,sexual abuse was an issue that emerged with different levels of depth in all groups (mainly in the two groups from the Atlantic region). Some participants opened up and commented directly on traumatic experiences lived in childhood and adolescence, as well as experiences of women close to them. Some situations mentioned, related to this type of violence were:

-Abuse inflicted by male relatives (fathers, uncles, grandparents)
-Repeated abuses provoked by these relatives to different women in the family -Abuses "allowed" by the family system, where in some way a code of silence that protects the offender is established and grants them the right over their victims' bodies -Sexual abuse by partners or ex-partners
-Multiple abuses towards the same person, either by the same aggressor or by different

aggressors (re-victimization)

In the group of women aged 25 to 44 from the Atlantic region, a participant says that she currently has problems with her father who is ill and comments: "*my mother died and when I became a girl my dad wanted to make me his wife and abused me (as he had done to all my older sisters) ... the next day I gave my brothers breakfast and left the house never to return... I was 11 years old...* "

In the same area, a 19-year-old participant commentsthat her current partner (whom she started dating at the age of 14) confessed that he intentionally broke the condom the first time they had
intercourse with the aim of getting her pregnant (she has had two children with this same partner who is 10 years her elder).

In all groups, except the urban middle and upper-middle income women, situations of sexual abuse by touching and intimidation by unknown men on the street are narrated; a girl points out: *"one cannot walk on the street, they have already passed me on a bicycle, and they have touched me twice. I'm scared for my daughter."*

The issue of sexual abuse has multiple emotional, relational, and even physical repercussions.

7. Mental, emotional, and relationship health

All the groups manifest the importance of opening spaces to talk about mental and emotional health. Resilience and the need to share in sisterhood are highlighted through the stories told by these women.

There are groups that were characterized by sharing between several of the participants about situations of discomfort, due to problems related to mental and emotional health.

In the group of young women in Guanacaste, most experience unrest due to anxiety, while, in the same age group in Guácimo, the issues of anxiety and gender violence stand out. In older age groups, issues related to grief and codependency prevailed in their relationships with close people.

The present emotional unrest has different causes that we could identify: intrapersonal and interpersonal factors, domestic violence and other types of abuse, as well as a critical socioeconomic situation of limited opportunities that leads to poverty or extreme poverty, where one of the most important challenges is taking care of their basic needs and those of their family. Some of the problems identified are detailed below:

a) Anxiety, the biggest challenge identified in Mental Health

The most reported conditions are anxiety disorders and, particularly, panic disorder. Many report constantly experiencing related symptoms such as startle, feeling of fear, fear of "going crazy" or dying, crying, feeling of suffocation, palpitations, tingling, etc.

This issue is highly prevalent, especially in the groups of younger rural women (in Guanacaste and Guácimo).
A young participant from the Guanacaste area says: "*I often feel that I cannot breathe. I get scared all the time. I try to tell my mind to control itself.*"

It is also possible to identify some cases with symptoms suggestive of Post-Traumatic Stress Syndrome. A participant from the urban area, from the group organized through Lifting Hands, says: *"I am 58 years old, I had very heavy vaginal hemorrhages due to menopause or something, it looked like a tube spewing out blood. So much bleeding gave me anemia and I was sent to the hospital, they took my womb ... But I don't know what happened to me during the operation... I woke up and I was hooked up to all the devices and a respirator. I thought I was dying. After that, I started having nervous breakdowns and went into a horrible depression. It had never happened to me before. I couldn't be alone. I felt a fear that closed and terrified me, and I couldn't stop crying, and I didn't know what it was. I can't find an explanation. I did not take pills because I had not been sent to a psychologist*" (In Costa Rica, the specialist authorized to prescribe this type of medication is the psychiatrist).
She also says that she has managed to overcome it to a large extent, thanks to the support she has received from the Lifting Hands Foundation.

b) Grief and loss

In the groups, the older participants show a high level of emotion in the face of loss (as well as a greater number of loss situations). Many of the participants are moved and cry as they share their experiences with the other women.

They share experiences of loss related to:
- Illness, death, or separation from a loved one
- Critical health situations
- Abusive relationships
- Sexual abuse in childhood

Some of them have recently had very sensitive losses, such as two participants in Guácimo from the 25-44 age group, who share having lost a son and a brother in the last year; both were murdered.

c) Depression

Some of the women report becoming depressed or struggling with depression right now. A woman from the oldest group in Guanacaste says: "*my husband has a depression because of a serious illness he suffers. I also feel depressed; I do not feel like doing things. Helping in the Church (of the community) helps me take my mind off things.*"

One of the participants of the younger age group in Guanacaste, pointed out that, during her adolescence, she suffered from a strong depression and a high level of anxiety. She talked about how her mother had to sell *empanadas* and ice cream for three months to be able to raise enough money to have a consultation with a psychology professional in San José. Finally, with that accompaniment, she was able to overcome it.

d) Covid and Mental/Emotional Health

In all the groups (except in the younger population in Guanacaste) the issue of the pandemic is present, either because some of the participants suffered from Covid and had a difficult experience (they have side effects), or because someone close to them became ill and/or died because of the disease.

What we experienced with Covid is also a trigger for discomfort and mental/emotional pathology.

A participant from the group of older women in Guanacaste says: "*since I got Covid I do not feel well. It has been more than a year now and I am not the same ... I get scared all the time, I can't sleep well, I get a headache and a body ache and crying, all the time*."

e) Situations of domestic and gender-based violence

The issue of relationships is a fundamental aspect that impacts the quality of life of all women attendees, in some cases because there are abusive links (as well as related conditions: alcoholism, violence, sexual abuse, etc.) and in others because they are women who serve as caregivers to sick or disabled persons.

Unfortunately, one of the issues that comes up with more recurrence is the emotional and/or physical abuse from their partners or ex-partners.

In the group held in Guácimo, there are four active cases of gender violence. Three of these cases were found in the younger group of women and one in the 25–45-year-old group. In these cases, there has been physical, sexual, and emotional violence, in addition to death threats and threats of kidnapping of children, among other situations with a very high level of risk.

One of them points out: *"I have such a relationship with two ex-partners, both mistreat me. They are my children's fathers. One of them is in jail convicted of theft, neither gives me a pension".*

Another young woman in the group, 19 years old with two children says: "*he threatens me all the time. He has beaten me. He has raped me... last time he took my one-year-old son for five days, kidnapped him or... threatens to kill me and my relatives*."

In these critical situations, there is little access to information about existing resources and how to proceed in this case.

In conclusion, in relation to mental and emotional health there is a lot of work to be done and broad needs identified in the populations with which we worked. Fortunately, we were able to offer some psychoeducation during the focus groups, although there was limited time and space.

8. Other important aspects

a. Relationship with the Health System

Many of the women have little faith in the health system: "*I don't believe doctors at all. Those serve to kill*," says a participant in San Jose.

In general, the health system is perceived as distant and with little awareness/action to positively impact women's overall health.

A worrying situation, in which several participants from both groups from the Atlantic region agree, is one related to a doctor from the Costa Rican health system (CCSS), who has verbally and psychologically assaulted users and relatives through ruthless and unempathetic comments. Among the situations they mention:

- This doctor told a relative with rectal cancer: "You *are going to die, your butt is rotten";* • One of the participants in the group was told at the time of delivery that her baby was deceased, which was not true;
- Situations of neglect and verbal and emotional abuse.

Another participant in the urban group carried out with Lifting Hands, talks about malpractice in a central hospital, where, after performing a cesarean section, the doctors left a gauze inside her body. This caused her many problems that left her on the verge of death and subjected her to a long hospitalization for the infection, in addition to leaving side effects like permanent pain, as well as psychological sequelae.

There are also women with diagnosed conditions who do not receive any type of treatment, because they do not have access to medical care, as well as others who, for various reasons, have gone to the social security and have been prescribed medicines, which they do not take or do not take properly, because they do not understand what they are for, or how they work and they are "afraid" to take them.
The drugs that cause the most fear are the ones related to mental health, due to ignorance and fear of developing addiction: "*I was taking it, but then I felt good, and I left it... then I had a bad depression,"* says a participant from the Guanacaste area.

b. Socioeconomic problems and gender roles as an element of risk In the situations exposed during the focus groups, it was possible to identify socio-cultural and economic factors of inequality in relationships and little access to opportunities for women. This is especially relevant for women in the Atlantic area: several of them expressed frustration for not getting a job and others for not being able to access study opportunities or childcare.
Also, in violence dynamics there are codependency links, which have strong roots in the gender roles imposed on women, which put them in a place of caregivers, who "sacrifice" and "restore" men who have "potential" and who can "change".
This issue is especially relevant, because for these women who are immersed in highly destructive relationships which can represent a risk to their lives, there is a lack of support networks or the possibility of strengthening themselves to effectively cut these relationships.

c. A note for the urban upper economic group:

-The group that explores women in the middle and upper-middle income population in the urban area, because it is the one that is concentrated in that area of the country, is a group that did not manifest incidences of violence and in which there is less anxiety compared to the others. It is a different group from the others and problems with the health system were not

mentioned. It is assumed that they have access to a private health service solution if the public system does not respond in time. Most of these women have jobs and much higher incomes and currently much more access to information through the internet and private services. Although they have these characteristics regarding their health, it is a group that had little access to information about their sexuality and reproductive health when young.

Findings and proposed solutions

By way of synthesis, we found the following needs:

-Little equal and equitable access to health resources: although on many occasions participants have gone and accessed the health system to receive interventions and treatments, the level of need found exceeds the possibility of response by the public health system. Apparently, when it comes to an urgent or critical condition, in most cases it has been possible to access the services required. This is not so when it comes to information, psychoeducation, and prevention needs, especially in relation to sexual health and mental health issues.

-Lack of deep and integral support: one of the needs found in the different groups, refers to finding spaces in which the women can find information and knowledge and that contributes, in turn, elements of self-care and communication with other women.

-Regarding the subject of sexual and reproductive health, there is a great need to learn, not only about preventive aspects of women's health, but about the experience of sexuality in an integral way, from establishing a healthy relationship with one's own body, to the psycho affective experience of relationships and shared sexuality.

-With regard to mental and emotional health, there is a clear need to offer spaces for conversation and coexistence, as well as for psychoeducation in different aspects related to life experiences and the challenges faced in different areas. Also, in the case of undiagnosed or untreated mental/emotional disorders, timely treatment mechanisms and resources are needed; as well as information/training regarding these treatments.

-An important need was identified to offer their children an education different from the one they received, especially in relation to issues of sexual and reproductive health and mental and emotional health; however, the knowledge and resources available limit this task to the existing possibilities (many times they do not have the educational, emotional, communication or economic resources) to be able to address these situations in a healthy manner. Therefore, it is important that, as mothers, the women are trained so they can share relevant information with their children in an appropriate and timely manner.

-It is also possible to identify levels of socio-economic problems that limit health and well-being for most of these women: poverty, unemployment and lack of opportunities seem to be the most prevalent.

-Finally, and by way of conclusion, there is a need for a more holistic and more humane medical service, which takes the women's true needs into consideration, both at the individual and community level, both at the preventive and palliative level.

As we have pointed out throughout the report, the limitations faced by women participants in the groups are largely the product of social and economic situations that expose them to greater risk factors (poverty, lack of access to health, late care, etc.), as well as situations that can enhance psychosocial risks. Due to this, joint and well-articulated work (public-private partnerships) constitutes a fundamental axis of the possible solutions that could be implemented
in the medium and long term.

In relation to the needs identified in these groups, we can mention the enormous informational, therapeutic, and collaborative potential of designing and implementing a medical support and training program for women's groups, over a series of sessions, in closed groups.

Some of the benefits of working in this modality are:

-Having a greater reach when carrying out the activity in a group
-Possibility of addressing different topics of interest in a participatory way
-Possibility of identifying critical cases to refer for the necessary attention
-Creation of a space for self-care and health promotion
-Promotion of support networks among the participants, as well as with other women's groups.

This is an isolated, small, qualitative investigation that brings out important insights on women´s health knowledge and needs. Further quantitative and qualitative investigation would be needed to really understand women´s current situation and which actors in Costa Rica as a whole and in local communities could articulate appropriately to work on a general and local plans to address these issues.

E. ANEXXES

a. Annex of demographic data by groups in Excel

b. Budget status and financial results

ANNEX B

Healthy Americas Foundation
Project Name: Women's Health Awareness and Needs in Costa Rica Project.
Awardee Name: Fundación Voces Vitales Costa Rica

1. REPORTING PERIOD Actual
Apr/14/2022 to Jul/30 /2022

2. BUDGET AND EXPENDITURES

Item	Budget	Expenditures YTD)
Focus group guide development	**$ 400**	**$ 400**
Focus group consultation (facilitator and assistant) and individual reports	**$ 4.500**	**$ 4.500**
Final results report	**$ 400**	**$ 550**
Translation spanish to english (not included in original report)		**$ 452**
Recruitment	**$ 900**	**$ 900**
Venue for face to face groups	**$ 900**	**$ 900**
Food and Beverage	**$ 1.620**	**$ 745**
Materials	**$ 100**	**$ 92**
In kind royalty for participants	**$ 900**	**$ 849**
Staff per diem	**$ 600**	**$ 479**
Transportation participants	**$ 270**	**$ 120**
Outbound inbound fees for previous and last payment (not included in original report - but mentioned)		**$ 80**
SUBTOTAL	**$ 10.590**	**$ 10.067**
*Venue donation for 4 groups Venue donation received for 5 groups	**$ (600)**	**$ (750)**
TOTAL	**$ 9.990**	**$ 9.317**
Less all amounts previously received		**$ (5.000)**
TOTAL due to contractor		**$ 4.317**

Notes: We report using the same budget structure that was approved. We report no previous balance as there were no payments made during first reporting period. In blue concepts added to the original budget. We had not included the translation service as well as inbound and outbound fees. Nevertheless, there were services that we were able to negotiate at lower places allowing the project to be executed with an even lower budget.

3. Certification

Official Signature:  Date: July/30/2022 Name of Certifying Official: Antonieta Chaverri

Title of Certifying Official: Executive Director