# Access to Women's Health Information in Monteverde

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## Research Team

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## Introduction

The following report documents the community informed "rapid needs assessment" performed by four students in the Globalization and Field Methods for Community Health Field School. The focus of the project, "Women's Access to Health Information" was developed through observations of and conversations with women in the Monteverde Zone. The issues addressed in our survey and interview instruments (such as domestic violence, HIV/ AIDS, and adolescent development) were informed by local women, and health professionals locally (at the Monteverde Clinic), in Hospital Mexico in San Jose and the regional hospital in Puntarenas. As a result, our definition of reproductive health is a holistic one which includes safety and security as a prerequisite of health (Burns et. al 1997).

We found that women in Monteverde most frequently rated the following as the top four issues that affect them: 1) HIV/AIDS, 2) Adolescent Development, 3) Adolescent Pregnancy, and 4) Domestic Violence. Women most commonly received their health information from their doctor, occasionally from "charlas" (talks) held in the community, and rarely received their health information from their ATAP's (community health outreach workers).

We recommend that the clinic work closely with women's groups in the community to help them receive health information in a comfortable environment. We also suggest that culturally appropriate pamphlets be developed on the issue most interest to women.

## The Costa Rican Health Care System

The Costa Rican health system is considered exceptional among Latin American countries. Formal medical institutions began in the 1900s with the advent of charitable hospitals and company hospital sponsored by the United Fruit Company (Morgan 1993). The major impetus for national health care occurred in the 1950s following the conclusion of the Costa Rican Civil War and the abolishment of the country's standing military. The CCSS was created as the health sector of the social security system. The CCSS functions as the medical provider for the nation's citizens. The Ministry of Health was established to provide health care for uninsured, unemployed and rural populations. During the 1950s-1960s, emphasis was directed to establishing hospitals mostly in the Central Plateau where greater population density existed. In the following decade, policy attention shifted toward decreasing inequalities of care between residents in the Central Plateau and more rural areas of the country. A

primary health care model was adopted in an effort to provide universal basic care to all residents. A system of rural health posts and rural health workers developed to monitor child growth and nutrition, pregnancy, TB, diabetes and parasitic control. Health workers also provided education on sanitary garbage disposal and potable water use. Health workers visited residence at their homes. In conjunction with direct medical services, public health and public infrastructure projects increased residents' access to clean water, sanitation services, and municipal services. The results of the country's public health initiative was a dramatic decrease of infant mortality from 61 in every 1000 live births in the late 1960s to 18 in every 1000 live births in 1978.

During the 1980's political and economic conditions resulted in modifications of the health system. Rural health posts have been phased out and replaced with local clinics. The current health system is a hybrid of state sponsored medical care and public health services and private medical practices and hospitals. State clinics and hospitals are in part funded by employee and employer contributions to the social security fund. The state hierarchical structure includes national hospitals located in San Jose, the capital, and regional hospitals dispersed throughout the country. Local clinics called EBIAS provide services for a population of approximately 4000 residents. A remnant of the village health worker model remains in the form of ATAPs. These health workers make home visits to monitor health concerns and provide referrals and heath information.

Women's health indicators in Costa Rica demonstrate several reproductive and sexual health issues deserving of investigation. The average maternal age at first birth is 19 years old and 21.3% of births resulted from adolescent pregnancies in 2000. The current infant mortality rate is 10.2 in every 1000 live births, placing Costa Rica in statistical proximity to industrial nations including the United States. An eighty percent rate of contraceptive use is reported though a forty percent rate of unintended pregnancies is also reported. Cervical cancer is the third ranking cause of death among women. Abortion is currently illegal in Costa Rica.

**Research Goals**

Considering the complex of women's health indicators, community recommendations and previous research of the Monteverde Institute, students affiliated with the University of South Florida Public Health Field School undertook a research project exploring women's health in the Monteverde region.

Initially we were uncertain of the direction of our research. During the first phase of research, our exploratory phase, we focused on reproductive health issues as well as general women's health issues in the Monteverde region. For this reason, our first research question (and the fundamental goal of our research) was to determine what health issues are important to women in the Monteverde region. It should be noted that research in reproductive health should include men, as they are participants in the reproductive process. However, the research group consisted of four young, American women. Upon reflection, we felt that Costa Rican men either could not or would not talk honestly and frankly with us. This unfortunately limits the scope of our research.

Our second research goal was to determine the modes and medias of health information utilized by the women in the Monteverde region. More simply stated, how do women in the Monteverde region access health information? Having determined the most important issues and the ways in which women access health information, we aimed to improve health communication between the regional clinic and the women in the Monteverde region. Upon completion of this research we are sharing our findings with our colleagues at the Monteverde Institute, with the community at large and with the clinic in particular.

**Methods of Research**

Our team set methodology priorities based upon the two week timeframe to complete the project, while continuing to involve women at all phases of the research. Given these considerations, a rapid needs assessment was determined to be an ideal tool for the project. According to Finan and Van Willigen in *The Pursuit of Social Knowledge: Methodology and the Practice of Anthropology* (2002) time and money are highlighted as the primary constraints placed upon anthropological fieldwork. For these reasons, quantitative methodologies (such as survey instruments) have been heavily relied upon by policy makers in search of solutions. There are limitations to this approach, however; though quantitative data collection techniques may illuminate a pattern in a society, it may fail to explain *why* such a pattern exists (Finan and Van Willigen 2002). It also may fail to provide depth and context to the data. Especially in rural areas, Finan and Van Willigen argue, surveys may be both expensive and inefficient. They offer solutions, such as focus groups as an extension on the key informant but seem to endorse the Rapid Appraisal (RA) which can include a series of sub-methods. The purposes of the RA are the following: 1) identify relevant categories for a survey; 2) perceived problems and 3) general patterns of variation.

Further sub-methods may include participant observation and key informant interviewing, focus groups, and other qualitative methods such as social indicators and questionnaire. The triangulation of three different methods creates a richer research product. For these reasons, we agreed to do an exploratory questionnaire (later to be refined into a survey), key informant interviews, and focus groups.

**Community Informed Research**

Community informed research is a process that allows individuals to inform researchers which health issues are most important to them, thereby giving them more control over their own health decisions (Green 2007; Werner and Bower 1995). Ideally, this approach allows the research to yield results that are more useful for the community. In order for this to be actualized, researchers must do exploratory research and ask individuals about what is important to them.

Our topic of reproductive health was informed by the community as a concern. Furthermore, we conducted informal interviews with our host families and other local women to gain insight into what issues they might find important regarding reproductive health. Additionally, we asked and noted what the health professionals believed were the prominent issues facing women both in Costa Rican and the Monteverde Zone.

**Project Methods**

Phase one of our exploratory research revealed two aspects crucial to our research. The first was the determination of several recurring themes in women's health in the Monteverde region. The second was the low attendance of a charla about adolescent development. These aspects, in combination with our research questions, were used to create our survey instrument.

Our survey consisted of 21 questions and contained a variety of question types: one Guttman scale question, one Likert scale question, seven structured response questions and twelve unstructured written response questions. Two questions acted as filter questions to separate women into two groups, those who had attended charlas and one who had not. Both of these questions were dichotomous structured filter questions. Those who had not attended a charla were asked roughly half the questions that were asked of women

Item two of the survey was an ordinal question that stated 'please order the following issues in women's health from first to last in order of importance to you.' This survey item listed ten different women's health issues. To facilitate involvement of survey participants and to make simultaneous comprehension of several health issues easier, we created a visual aid consisting of several cards.

Each card had a women's health issue listed on the left, with a pictorial representation on the right. The pictures were dual purposed. Firstly they made the issue(s) listed more tangible and accessed the right side of the brain. Secondly, they were a visual alternative to words for women with low literacy levels.

We conducted two semi-structured interviews with medical workers in the Santa Elena clinic. Our interest in health information access and charlas informed the majority of our questions for the health professionals.

We pilot tested our survey at the Health Fair in Cañitas. There we discovered that some of our Spanish translations of both questions and phrases were not translating well to respondents. Subsequently, we made appropriate adjustments to both the cards and our survey instrument to better facilitate communication between people who don't really speak each other's languages.

**Sampling**

We used a convenience and snowball sampling of women for the study. Women were identified through social contacts with Monteverde Institute personnel, women's groups, a local business and a Monteverde Institute sponsored health fair. A total of 44 women participated in the study. The research team administered surveys and interviews to 40 women from Canitas, Cerro Plano, Santa Elena and surrounding communities. Four women participated in a focus group also. The convenience sample reflects women of child bearing age. The age range of participants is 15 to 83 years with the average age being 39.8 years. Sixty-six percent of women sampled are between the ages of 26-45 years. The age distribution leans toward women who are of child bearing age and may be differently concerned with reproductive issues and adolescent sexual development. The majority of our sample (72.5%, 19 of 37 women) have attended some years of primary school or completed the sixth grade, while 12.5% (5 of 37 women) of the sample have obtained at least some university education. The rate of university educated women may be elevated due to the inclusion of two professionally trained health workers.

**Discussion of Key Findings**

From the qualitative and quantitative data collection, several key issues emerged including: important women's health topics, domestic violence, men's role in reproductive health, charlas, ATAPs, and adolescent sexual development and pregnancy.

**Ranking of Reproductive Health Issues**

To determine the issues that were most important to women in the Monteverde zone, we created a series of ten cards of health issues and attached pictures to serve as visual cues for the issues. During our surveys and interviews, we set these cards out on tables and had women rearrange the cards in order of their perceived importance. This was an important aspect of our methodology for several reasons. First, it allowed for greater participant engagement. Several women commented that rearranging the cards was like a game, and said that it was the most interesting and enjoyable part of the questions. Second, by having women physically rearrange the cards, we could ask them to explain their thought processes with us on why they had decided on a particular order, and we received many rich quotes on women's ideas about these issues. Third, creating cards with pictures relating to the health issue made the cards more user friendly for individuals with low levels of literacy. We selected the ten issues by listening to concerns about topics from the community. It is important to note, however, that some women we spoke with questioned our inclusion of some of the issues, such as domestic violence, because they were unsure whether they would consider these issues as aspects of women's health. Other women told us that domestic violence was a very important women's health issue, because family security facilitates health. This understanding of women's health was better

matched with our own holistic view of women's health. For one woman in our study, domestic violence was the most important issue. She told us that..

> "Para mi (violencia domestica) es como la base de todo esto (otros temas). Si en un hogar, hay paz, hay armonía, los jóvenes vienen desarrollando todo esto...como un orden. Ellos reciben información sexual, pueden disfrutar de la sexualidad y placer sanamente con buena información. Ellos van a aprender a usar anticonceptivos, van a aprender de prevenir enfermedades como SIDA, embarazos en adolescentes, van a saber si hay un embarazo, se necesita atención prenatal que es muy importante, como prevenir estas enfermedades (venéreas) que es igual el SIDA, y saber como cuidar su cuerpo y saber, como le digo estar atenta a las síntomas, pero todo si tiene buena información."

> "For me (domestic violence) is like the base of all this (other issues). If in a house there is peace, there is harmony, the children will develop all this… as an order. They receive sexual information; they can enjoy sexuality and pleasure healthfully and with good information. They are going to learn to use contraceptives, they are going to learn to prevent illnesses like AIDS, teen pregnancies, they are going to know that if there is a pregnancy, prenatal attention is necessary, they are going to know how to prevent STDs, and to know how to take care of their bodies and to know how to be attentive to symptoms, but all of this only if they have good information. "

For many women, the health issues were all very important, and also very connected. It was interesting, however, that the importance that women assigned to these issues did not necessarily seem to reflect the levels of interest in these issues. For example, women ranked AIDS as the most important issue of all ten, but when we asked women what they wanted to learn more about, they very rarely mentioned AIDS. It is also necessary to mention that the average ranking was most likely influenced by the ages of our sample. As 66% of our sample was of childbearing age (26-45 years), it is not surprising that sexual development of adolescents was ranked highly, since many of our sample are likely to currently be raising adolescents. Also, menopause was ranked as the last issue in order of importance on average, but this could perhaps be accounted for by the fact that very few of our sample had reached menopause yet.

**Charlas**

Our focus on women's health information prompted survey and interview questions that ask about how they receive health information, the best sources of information and the about charlas in particular. Respondents most frequently stated that a doctor or clinic personnel is the most used source of information followed by TV and radio and then family and friends. Charlas are the fourth most often stated source of information though from survey and interview data it was discovered that 67% of women sampled report having attended a charla and 75% stated that they believe charlas are useful for communicating health information and 45% of those women described the charlas as "very useful." Women who have attended a charla were also asked to report on perceived strengths and weakness of charlas. The most common primary strength of charlas is the topic of the presentation. Charlas seem to be perceived primarily as a source of information and learning. The weaknesses described by women varied. Thirty-three percent of respondents stated that there are no weaknesses of charlas. Women stated that low attendance, difficulty obtaining transportation to the location of charlas, and the time charlas are scheduled are weaknesses of charlas. When asked to state the 'best source of health information for women in their community', women most frequently mentioned charlas. In contrast 43% of survey respondents stated that doctors and clinic personnel are the best source of health information for themselves. All except one respondent stated that she would recommend charlas to others. Despite the positive assessment women offered of charlas, attendance at charlas is reported to be low. Clinic

personnel and local women both report that attendance is a considered at problem. Women described barriers to attending charlas as a lack of transportation, time and child care.

The challenges of recruiting and successfully completing focus groups may reflect the barriers Monteverde women describe with attending charlas. Traveling to a location, which is often the clinic, requires transportation. Women may also need child care while she is attending a charla. Child care is not provided at clinic charlas. Our attempts to conduct focus groups with women in Monteverde may illustrate this point; Women were identified through a key informant and through social networks of people affiliated with the Monteverde Institute. Women were either telephoned and verbally invited to attend a focus group or given a flyer and verbally invited in person. Two focus groups were scheduled and women were offered to attend in the morning or afternoon of one day. Transportation from Santa Elena to the Monteverde Institute was offered. In spite of both verbal and written confirmation of attendance of five women, only two women attended the morning focus group. Four women attended the afternoon group, however the women arrived at different times making a focus group impossible to conduct. Interviews and surveys were administered to these women instead of focus groups. A third attempt to conduct a focus group was successful. For this group, women were recruited from a local business and *the focus group was held at the business location* in the late afternoon (with the permission of the management). This experience helps inform our recommendation for the clinic to do more outreach in places of employment.

**ATAPs**

Another theme that emerged concerns the role and effectiveness of ATAPs in dissemination of health information. The responsibility of ATAPs is to visit households in order to provide health evaluations. In the Monteverde area, two men are employed as ATAPs. The system is designed for ATAPs to be a possible first point of access to the health care system. However, 75% of women surveyed did not consider ATAPs as a means of health communication and many women did not recognize the term "ATAP". It is reported that ATAPs make home visits in weekday mornings and work in the clinic in the afternoons. However, completion of home visits may be hampered by transportation and scheduling considerations. In Monteverde, the two ATAPs ride motorcycles to visit residents and are therefore unable to travel during inclement weather. ATAPs also work during typical business hours of 8:00 a.m. to 5:00 p.m. If parents and children are at work or school during these times visits are unsuccessful. The situation is intensified with the growing numbers of women who are working outside of the home. Beyond logistical concerns affecting the completion of home visits, women's comfort in discussing potentially sensitive reproductive and sexual health concerns with males in their home was questioned by some participants.

**Domestic Violence**

Domestic Violence is a concern repeated by participants in all phases of the research. Many women we spoke with described frustration and concern over men's attitudes toward women. Interfamilial violence is considered a major problem and associated with the concept of Machismo. The idea of male pride and honor in familial, work and community responsibility can also include male domination of women and promiscuous behavior. In discussions of domestic violence with women, the definition of what qualifies as abuse was described. Physical abuse is commonly accepted as domestic violence. Other forms of abuse, verbal, sexual and emotional, seem to be less recognized as forms domestic violence can assume. Men were described as the central piece in a discussion about domestic violence, however due to the composition of the research team being four North American women, this investigation focuses on women. Gender relations should be a priority for long-term community discussion, education and intervention that is beyond the scope of this project.

**The Importance of Men in Reproductive Health**

Though this study did not include the participation of men, we recognize that men play a pivotal role in reproductive health. It is of great importance that men, as well as women, are given access to health information. As a group of four foreign women, we felt that we would have a difficult time engaging men in a meaningful discussion of reproductive health and therefore made the collective decision to work only with women. In spite of this, many of our recommendations suggest the inclusion of men in further research and outreach.

**Adolescent Sexual Development and Adolescent Pregnancy**

Adolescent sexual development is voiced as a major issue by our sample of the women in Monteverde. Through interviews, a focus group and surveys, women emphasized their concern over communicating with their family's children and adolescents. Sex education is reported by local women and health providers to be offered in the school, however the content and extensiveness is unclear. Women suggested training on how to speak with their adolescents about sex. This is significant given the conservative reputation Costa Rica holds as an officially Catholic country. It is also important given the concern women voice about adolescent pregnancy. The statistic that the average of age of first birth is 19 years supports the belief of women that women are beginning child bearing early.

**Study Limitations**

This exploratory study has several limitations affecting the outcomes of the research. Due to time constraints of the field school schedule, we were unable to reach saturation with our semi-structured interviews and focus groups; however, they allowed us to explore issues to a greater depth than our survey instrument. Time limitations necessitated the use of a convenience and snowball sampling methods. The limitations of such sampling mean that age groups and residential areas are not equally distributed, nor are educational attainment or length of residence in the Monte Verde zone. Recruiting women through social contacts also limits the potential life experiences of the women included in the sample. Another major limitation of the project is our limited Spanish language ability. Optimally, native Spanish speakers should conduct the research.

**Recommendations**

From the themes and issues raised in the study, the research team suggests several recommendations for enhancing access to reproductive and sexual health information.

- Provide ATAP personnel with health pamphlets for distribution in homes
- Create/obtain culturally appropriate pamphlets with appropriate reading levels
- Reassess the format and location of charlas considering time and transportation barriers
- Reinstate coordination between clinic personnel and women's groups
- Create and maintain a directory of women's groups to be housed at the clinic
- Expand community outreach in local workplaces and women's meeting to provide charlas
- Increase visual information sources at clinic: Visually appealing posters and bulletin boards on relevant issues and assign clinic personnel to regularly update displays
- Increase and expand advertisements of charlas to make announcements more open to public

- Make the charlas more inviting: offer snacks, vary formats, include discussion activities

**Conclusions**

Reproductive health was widely defined for the purpose of our study in order to capture the full range of issues that were important to women in the Monteverde region. HIV/ AIDS, adolescent development, teen pregnancy and domestic violence were the primary health concerns for women in the area. In order for these topics to be fully addressed, men must also be included in the conversation. Despite these limitations, this exploratory research highlights key issues affecting women's health in Monteverde.

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