Session 3:
Understanding the Client's Perspective

Objectives

- To identify the different demographic and social characteristics of postabortion clients that are common in the participants' service-delivery settings and the different situations or conditions that lead clients to need postabortion care
- To develop "case studies" for three or four clients who reflect these demographic and social characteristics, situations, and emotional and physical conditions *(These case studies will be used for role plays throughout the remainder of the workshop.)*
- To explain the importance of showing respect for a client's rights of confidentiality, privacy, and dignity
- To identify simple ways in which this respect can be shown during PAC
- To describe the very strong feelings a postabortion client may have about her situation
- To identify ways in which the provider can address the emotional needs and concerns of the postabortion client
- To assist the participants in reflecting upon how their personal experiences and their own sexual development might affect their current views and feelings about sexuality issues, and to explain how these experiences might affect their approach to counseling postabortion clients
- To examine sexuality in the context of PAC, and explain how providers can respond to clients' concerns related to sexuality
- To explain how cultural attitudes about gender can affect the treatment that postabortion clients receive in a service-delivery setting and the client's perception of providers

Training Methods

- Brainstorm
- Large-group work
- Demonstration
- Small-group work
- Discussion
- Demonstration role play
- Presentation

Materials

- Flipchart paper, easel, markers, and tape
- Any materials (such as a sofa, blanket, curtain, or drape) that could be used to depict a clinic setting
- Handout 3-A: Ensuring Clients' Confidentiality, Privacy, and Dignity (page 51)

- Handout 3-B: Gender (page 52)
- Handout 3-C: How Do We Learn about Sex? (page 53)
- Handout 3-D: Sexuality (page 54)

Advance Preparation

1. Prepare a flipchart listing the objectives of this session.
2. When using Option 2 of Part A, select three or four case studies from Appendix D: Sample Case Studies, to reflect a wide range of postabortion client characteristics and situations, and prepare handouts of the selected case studies for all participants.
3. Review all handouts and make one copy for each participant.
4. Gather materials to depict a service-delivery setting.
5. Prepare two flipcharts, one entitled "Demographic and Social Characteristics" and one entitled "Situations and Emotional and Physical Conditions."
6. Prepare one flipchart table for each case-study client (to be developed by the participants during Part A or selected from Appendix D). Each table should be entitled "Addressing the Postabortion Client's Feelings" and should have three columns: "Client's feelings," "Why?" and "Provider's response." (See sample below.)

Addressing the Postabortion Client's Feelings

Client's name: _____

Client's feelings	Why?	Provider's response

Session Time (total): 5 hours, 35 minutes (Option 1), or 4 hours, 30 minutes (Option 2)

SESSION 3 TRAINING STEPS

Part A Developing Case Studies of Postabortion Clients

Option 1: Original Case Studies

Time: 1 hour, 30 minutes

This option should be used if time permits, as it is a key component to helping the participants develop empathy toward and an understanding of the varied needs and feelings of clients. If time for conducting the full counseling training is limited, Option 2 (page 39) may be used to shorten the session.

Activity 1: Brainstorm (20 minutes)

1. Display the flipchart entitled "Demographic and Social Characteristics." Ask the participants to think about the clients they see in PAC and to list their demographic and social characteristics. Write the participants' responses on the flipchart. (Guide the brainstorming by referring to the sample categories listed in the Training Tip below.)
2. Ask the participants to think about the individual situations that cause clients to seek PAC and their emotional or physical condition upon arrival at the facility. Write their ideas on the flipchart entitled "Situations and Emotional and Physical Conditions."

TRAINING TIP ○○○

Explain the difference between demographic and social characteristics, situations, and emotional and physical conditions, using the following examples:

- **Demographic and social characteristics:** age, marital status, parity, income, educational level, and social background
- **Situations:** desired vs. unwanted pregnancy, spontaneous vs. induced abortion, method of induced abortion and whether the partner knows about it, contraceptive failure vs. no use of contraceptives, and referral from a provider vs. self-referral
- **Emotional and physical conditions:** calm vs. hysterical, hemorrhaging vs. in stable physical condition, emergency vs. able to wait for treatment, conscious vs. unconscious, afraid vs. not nervous, and in severe pain vs. in moderate pain

Activity 2: Large-group work (20 minutes)

1. Tell the participants that they will develop client profiles as a large group (based on the list of demographic and social characteristics), and then work in small groups to develop a case study for each profile (based on the lists of situations and emotional and physical conditions).

2. Explain that the profiles should be varied to reflect the range of different demographic and social characteristics seen in postabortion clients. Each case-study client will be given a name, because the clients will be used in role-play exercises throughout the rest of the workshop. In the role plays, the sample case-study clients will be treated as if they are real postabortion clients.
3. Start developing a client profile by asking the participants to suggest and agree on a woman's first name.
4. Write the woman's name at the top of a flipchart, then ask the participants to agree on the following (see sample profiles in the Training Tip below):
   - Her age
   - Her number of children
   - Her marital and socioeconomic status
   - Her educational level
   - Any other demographic and social characteristics that seem relevant
5. When the group is satisfied with this client profile, repeat the process until you have completed three or four profiles.

TRAINING TIP ○○○

Develop three or four client profiles, depending on the number of participants. (Develop at least three, to reflect a range of different demographic and social characteristics and situations of typical postabortion clients. More than four profiles will take too much time to process during the role-play sessions.) Do not divide the participants into small groups until *after* all of the client profiles are complete; otherwise, they risk developing duplicate sets of demographic and social characteristics.

Throughout the workshop, have the participants work in small groups, performing counseling role plays with each "client." Three or four participants per group would be best. Thus, the following numbers can be used as a guide:

- Six to 12 participants: three client profiles, with two to four participants per role-play group
- 12 to 20 participants: four client profiles, with three to five participants per role-play group

As is noted in the introduction, this training will be more difficult to conduct if there are fewer than six or more than 15 participants.

When developing the profiles, focus only on the client's demographic and social characteristics. Do *not* discuss her postabortion situation or condition, because that is what the small groups will do in developing their case studies.

Sample "profiles":

- Lisa: age 35, two children, married, middle class, has her own business
- Nora: age 18, no children, unmarried, did not finish secondary school, living in poverty
- Ella: age 20, one child, married, finished secondary school

Activity 3: Demonstration (15 minutes)

1. Tell the participants that they will work in small groups to develop case studies for each client profile.
2. First, demonstrate how to do this with one of the client profiles. Refer to the lists of situations and emotional and physical conditions and ask the participants which of these would most likely apply to this particular client.
3. Write their responses on the same flipchart with the client's name and her demographic and social characteristics. Then ask the participants to tell a story about this client, including the nature of her pregnancy (wanted or unwanted), her relationship with her partner(s), and specific details about how she came to need postabortion care.
4. Note the participants' suggestions on the same flipchart. Finally, arrange all of the information listed on this flipchart in a logical order, and write the client's "case study" on a new flipchart. (See below for a sample case study.)

TRAINING TIP ○○○

Developing a case study is like writing a little story. First, you think about what you know about the main character (the client profile), then you try to imagine what happened to this woman that resulted in her being in these situations and having these emotional and physical conditions. This information can be taken directly from the brainstorm lists of demographic and social characteristics and situations and emotional and physical conditions. The following is an example, but your demonstration sample should come from the participants' brainstorm lists.

Sample Case Study for "Nora"

Nora is 18 years old, is unmarried, has no children, does not attend school, lives at the poverty level, and plans to marry her long-term boyfriend, John. Nora believes she became pregnant due to contraceptive failure (John was supposed to pull out). Despite the unplanned nature of the pregnancy, Nora and John were happy with the pregnancy. But today, when John was at work, Nora started bleeding heavily. She has come to the hospital alone, with no referral. She is extremely frightened by what is happening to her body and scared about what they will do to her in the hospital. She is also afraid that people will think her abortion was induced, when in fact it was spontaneous.

Activity 4: Small-group work (25 minutes)

1. Divide the participants into small groups (one group for each of the remaining client profiles), and assign one profile to each group.
2. Remind the participants to refer to the list of situations and emotional and physical conditions and to identify those that apply to their client.
3. Allow the groups 20 minutes to write their cases, putting the "final draft" on a flipchart.

TRAINING TIP ○○○

Circulate frequently among the different groups. First, check with each group to see if they understand the assignment. Then keep checking on the groups to make sure that they are making the situations and emotional and physical conditions realistic, and that they are not telling the same "story" about two different clients. You may have to negotiate between groups to convince them to adjust their stories slightly, so the variety of situations and emotional and physical conditions listed by the participants is reflected in these case studies.

Activity 5: Discussion (10 minutes)

1. Ask a volunteer from each group to present the group's case study on a flipchart.
2. Allow a few questions to clarify or suggest changes, but do not encourage major revision.

TRAINING TIP ○○○

When each group presents its case study, the participants in the other groups are likely to have different opinions about how each one should or should not be written. There are endless possibilities for case studies, so it is not necessary to have all of the participants agree on every aspect of each. That is why discussion should be limited. However, if one group has clearly presented a case study that is not realistic for the local situation, work with that group separately to revise it, instead of trying to revise it in front of the rest of the participants.

After the case studies have been presented, post the flipcharts on the wall in a place where they will remain visible and uncovered. The case studies will be referred to repeatedly throughout the training, wherever the following symbol appears in this training curriculum:

Option 2: Adapted Case Studies

Time: 25 minutes

If time is extremely limited, select three or four of the prepared case studies found in Appendix D. (This should be done prior to the session.) The case studies selected should reflect a wide range of client characteristics and situations, including age, parity, marital status, spontaneous or induced abortion, etc.

Activity 1: Presentation and small-group work (15 minutes)

1. Present the three to four case studies preselected from Appendix D. Distribute the handout with the selected case studies (created by the trainer prior to the session) to all participants.
2. Divide the participants into small groups (one for each of the case studies) and assign one case study to each group. Explain that the stories are varied to reflect the range of different demographic and social characteristics, situations, and emotional and physical conditions seen in postabortion clients.
3. Give each group 10 minutes to adapt its respective case study to fit their local situation. Tell each group to write a final draft of the case study on a flipchart.
4. Remind the participants that each case-study client has a name because the clients will be used in role-play exercises throughout the rest of the workshop. In the role plays, the sample case-study clients will be treated as if they are real postabortion clients.

Activity 2: Discussion (10 minutes)

1. Ask a volunteer from each group to present the group's case study on a flipchart.
2. Allow a few questions to clarify or suggest changes, but do not encourage major revision. (See Training Tip in Activity 5 of Option 1, page 38.)

Part B Confidentiality, Privacy, and Dignity

Time: 45 minutes

Activity 1: Brainstorm (10 minutes)

1. Ask the participants what the words *confidentiality*, *privacy*, and *dignity* mean.
2. Briefly note their responses on a flipchart.

Activity 2: Demonstration role play (15 minutes)

1. Tell the participants that you and the other trainer will now perform a role play demonstrating some of the things that can go *wrong* in ensuring a client's confidentiality, privacy, and dignity.
2. Ask the participants to watch carefully for both verbal and nonverbal cues.

3. Perform the role play, using one of the case-study clients developed in Part A (preferably one in an anxious condition) as the client being treated.

TRAINING TIP ○○○

For this demonstration, the trainers (rather than the participants) should perform the role play, to ensure that it achieves the intended objectives and gives appropriate examples for discussion.

Negative cues for possible use in the role play include:

- The client is lying in a busy, open area.
- Her feet are facing the door, with her genitals exposed.
- There are no screens or curtains around her.
- She is not adequately draped.
- The provider openly discusses her case with anyone who walks by.
- People frequently walk in and out of the area, sometimes stopping to talk casually with the provider or nurse.
- The provider attempts to discuss discharge information or to provide counseling in this busy, nonprivate environment.

If items such as a sofa or blanket are not available, the client should lie on the floor in a space visible to all observers.

Activity 3: Discussion (20 minutes)

1. Facilitate a discussion about how the client must have felt in this situation by asking the following questions:
   - How do you think the client felt in this situation?
   - How would you feel if you were this client?
   - Why do these conditions exist in the delivery of PAC services?
2. Distribute Handout 3-A: Ensuring Clients' Confidentiality, Privacy, and Dignity, and review the information with the participants.
3. Ask the participants how they can apply what was discussed in their own service sites. Focus the discussion on ensuring confidentiality, privacy, and dignity, within the realities of the participants' service-delivery settings, rather than imagining an ideal situation.

Part C Addressing the Postabortion Client's Feelings

Time: 1 hour, 35 minutes

Activity 1: Brainstorm (20 minutes)

1. Explain that clients have other needs and concerns besides confidentiality, privacy, and dignity; these may include emotional, informational, or economic needs. Explain that the group will focus on informational needs later in the workshop, and that economic needs can be addressed by referring clients to local resources that may lie outside of the health care system (also to be discussed later in the workshop). Therefore, this exercise will help the participants focus on the emotional needs and concerns of clients during all phases of PAC.

2. Ask the participants to think about the case-study clients they developed or discussed earlier and what feelings those clients might have from the time they arrive at the site until the time they leave.
3. Using the prepared flipchart tables "Addressing the Postabortion Client's Feelings," list the feelings for each case-study client. Leave plenty of space between each feeling listed in the "Client's feelings" column to match up with the longer writing expected in the "Why?" and "Provider's response" columns.
4. When the participants have completed the feelings list for each case-study client, ask them why, for each feeling identified, each client might feel that way. Briefly record their responses on the flipchart. Leave the third column blank until the small-group work.

TRAINING TIP ○○○

Remind the participants to focus on feelings specific to postabortion clients, and clarify the reasons why clients have these feelings (particularly if it seems that the participants have not fully understood the exercise).

In settings where abortion is legal, clients' emotional concerns are often centered on the procedure itself. For example, clients may fear pain during the procedure or may fear potential complications. Another client concern is the implicit or explicit pressure to accept a family planning method immediately postabortion.

In settings where abortion is illegal or highly restricted, clients may commonly feel guilt, shame, anxiety, and fear of an induced abortion being discovered (by family members, local authorities, or others).

Across all settings, women who have had spontaneous abortions may experience a great sense of loss, disappointment, frustration, and guilt over not having been able to carry the pregnancy to term. (For a more detailed exploration of this issue, see Session 6, Part C, page 101, on responding to threatened abortion.)

Activity 2: Small-group work (30 minutes)

1. Divide the participants into the same small groups that developed or discussed the case-study clients. Give the flipchart for each case-study client used above to the respective group.
2. Ask each group to fill in the third column for their respective case-study clients. They should ask themselves: What can the provider do when a client is feeling this way?
3. Ask each group to choose a spokesperson who will report to the rest of the participants during the large-group discussion.

Activity 3: Discussion (45 minutes)

1. Post the "Addressing the Postabortion Client's Feelings" flipcharts on the wall, alongside the respective case-study flipcharts. (Save the flipcharts after this session for use in Session 6.)
2. Ask the spokesperson from each group to share the group's ideas. Ask for comments or questions from the rest of the participants.

Sample completed flipchart—DO NOT COPY CONTENT

Addressing the Postabortion Client's Feelings

Client's name: Nora

Client's feelings	Why?	Provider's response
FEAR ***Where abortion is legal***	***Fear of:*** ■ Feeling pain during the procedure ■ Experiencing complications resulting from the procedure ■ Feeling pressure to accept a permanent or long-term family planning method	***Examples:*** ■ Explain what to expect during the procedure, and tell the client what pain control medication will be used (if any) ■ Tell the client about the risk of abortion complications, relative to the risk of complications during delivery ■ Tell the client that she may choose whether to receive a family planning method immediately postabortion
FEAR ***Where abortion is illegal or highly restricted***	***Fear of:*** ■ Dying ■ Becoming infertile ■ Becoming disabled ■ Being prosecuted (if abortion was illegally induced) or criticized ■ "The unknown" (what will happen at the hospital) ■ Not receiving treatment because of inability to pay for services	***Examples:*** ■ Listen ■ Reassure the client ■ Find out why or what the client fears ■ Provide information ■ Arrange for family planning counseling or referral for other services, if needed ■ Be aware of one's own possible negative bias toward the client, and try not to be judgmental

Adapted from: Ipas. 1996. Module 2: Patient-provider interaction and communication. In *MVA trainer's handbook*. Carrboro, NC.

Part D Gender Issues

Time: 50 minutes

Activity 1: Brainstorm/large-group discussion (5 minutes)

1. Ask the participants to brainstorm a definition of *gender* and write it on a flipchart.
2. Explain the difference between *gender* and *sex characteristics,* and clarify any misconceptions.

TRAINING TIP ○○○

Gender refers to a set of qualities and behaviors expected from a female or male by society. *Sex characteristics* are what make us "male" or "female" and are based on anatomy, physiology, and genetics.

Gender roles are learned and can be affected by factors such as education or economics. They vary widely within and among cultures. While an individual's sex generally does not change, gender roles are socially determined and can evolve over time.

Gender roles and expectations are often identified as factors hindering the rights and status of women, with adverse consequences that may affect family life, education, socioeconomic status, and health. For this reason, awareness of gender, like sexuality, is an important element of reproductive health services.

Activity 2: Large-group exercise (45 minutes)

1. Ask the participants if they were ever told to "act like a man" or "act like a woman" (based on their sex). Tell them to give examples of some experiences in which someone has said this or something similar to them. Ask:
   - Why did the individual say this?
   - How did it make you feel?
2. Tell the participants that the group will now look more closely at these two phrases to see how society can make it very difficult to be either male or female.
3. Print the phrase "Act like a man" on a flipchart.
4. Ask the participants to share their ideas about what this means. (These are society's expectations of who men should be, how men should act, and what men should feel and say.) Write the participants' ideas about "acting like a man" on the flipchart. Some responses might include the following:
   - Be tough
   - Do not cry
   - Show no emotions
   - Take care of other people
   - Do not back down

5. Once the participants have finished their list, ask the following questions and discuss:
   - Is it limiting for a man to be expected to behave in this manner?
   - What emotions are men not allowed to express?
   - How can "acting like a man" affect a man's relationship with his partner(s) and children?
   - How can social norms and expectations to "act like a man" have a negative impact on a man's sexual and reproductive health?
   - How can pressure to "act like a man" influence how a man behaves sexually and how he feels about his sexuality?
   - Do men need to conform to these social norms? Is it possible for men to challenge and change existing gender roles?
6. Next, print the phrase "Act like a woman" on a flipchart.
7. Ask the participants to share their ideas about what this means. (These are society's expectations of who women should be, how women should act, and what women should feel and say.) Write the participants' ideas about "acting like a woman" on the flipchart. Some responses might include the following:
   - Be passive
   - Be the caretaker
   - Put others first
   - Act sexy, but not too sexy
   - Be quiet
   - Listen to others
   - Be the homemaker
8. Once the participants have finished their list, ask the following questions and discuss:
   - Is it limiting for a woman to be expected to behave in this manner?
   - What emotions are women not allowed to express?
   - How can "acting like a woman" affect a woman's relationship with her partner(s) and children?
   - How can social norms and expectations to "act like a woman" have a negative impact on a woman's sexual and reproductive health?
   - How can pressure to "act like a woman" influence how a woman behaves sexually and how she feels about her sexuality?
   - Do women need to conform to these social norms? Is it possible for women to challenge and change existing gender roles?
9. Summarize the activity by asking the following questions and discussing the responses:
   - How can gender roles facilitate and limit what men and women can and cannot do in sexual relationships?
   - How might gender stereotypes have a negative impact on the ways in which providers relate to men and women as clients?
   - Based on gender stereotypes, what messages does society give about men's and women's roles in determining aspects of a sexual relationship (i.e., who makes decisions about when to have sex and whether to use contraception)?
   - As providers, how can we help clients when pressure (internal or external) to conform to gender-role expectations potentially threatens their sexual or reproductive health? (An example of this could be a young woman who places herself at risk of unintended pregnancy because having a contraceptive would indicate that she "planned" to have sex.)

- How do you think an awareness of gender roles and stereotypes can help us in our work as providers?

(This exercise was adapted from: EngenderHealth. 2002. *Integration of HIV/STI prevention, sexuality, and dual protection in family planning counseling: A training manual*. Working draft. New York.)

TRAINING TIP ○○○

When discussing responses to the questions above, include the following points:

- Gender-role expectations or cultural norms may result in unwanted pregnancy. This may occur because women do not have full control over when they have sex, or because women cannot easily access contraceptives, or for other reasons. Providers should be aware of this possibility when dealing with clients.
- Providers may have different expectations for female clients than for male clients. This may mean that they inhibit women's choices without even realizing it. (For example, providers may believe that unmarried women do not have a right to use family planning methods, because women should not engage in sexual activity before marriage.)
- This exercise cannot solve the gender-based problems that face our clients, but it can help us become more aware of how gender roles affect our clients' lives.
- Use the case-study clients as examples throughout the discussion, so the participants can apply this information to hypothetical postabortion clients.

10. Distribute Handout 3-B: Gender to all participants.

Part E Sexuality Issues

Time: 55 minutes

Activity 1: Brainstorm/large-group discussion (10 minutes)

1. Ask the participants to brainstorm a definition of *sexuality* and write it on a flipchart. Discuss this definition and clarify any misconceptions.
2. Present the following definition of sexuality and briefly explain why it is important to discuss its role in reproductive health:

   "Human sexuality encompasses the sexual knowledge, beliefs, attitudes, values, and behaviors of individuals. It deals with the anatomy, physiology, and biochemistry of the sexual response system; roles, identity, and personality; and individual thoughts, feelings, behaviors, and relationships."

   —Definition developed by the Sexuality Information and Education Council of the United States (SIECUS)

TRAINING TIP ○○○

Sexuality, when defined in this way, is an important part of family planning and reproductive health service delivery. Client-centered counseling and the facilitation of informed choice in reproductive health care depend on providers being aware of issues related to sexuality. A client's sexual history, relationships, and circumstances can play an important part in her contraceptive choice, her decision to be screened for sexually transmitted infections (STIs), and her long-term satisfaction with health care services. In addition, the ability of women to improve their reproductive health and achieve their reproductive intentions is deeply affected by the degree to which they are knowledgeable about and in control of their sexuality and sexual relationships. Health care providers can help to empower women by supporting them in the process of developing knowledge and control.

Activity 2: Small-group work (30 minutes)

1. Distribute Handout 3-C: How Do We Learn about Sex? and a pen or pencil to each participant.
2. Ask the participants to write answers to the questions on the handout, working by themselves. Encourage them to keep their answers short, listing a few main points for each question.
3. After 15 minutes, divide the participants into pairs, and ask each pair to discuss their answers with each other and whether they now agree or disagree with the ideas they were taught from each source.

Activity 3: Large-group discussion (15 minutes)

1. Reconvene the larger group and facilitate a discussion about what we learned about sex and gender as children and how these ideas influence our work as service providers.
2. Address some or all of the following questions during the discussion:
   - Based on your discussions in pairs, what do you think are the most common negative ideas that we are taught about sex?
   - How does our society give us messages about sex?
   - How do the ideas conveyed or the messages received about sex differ for boys and for girls?
   - What messages does society give about when women are supposed to have sex for the first time and with whom (e.g., after marriage, with her husband)?
   - What messages does society give about when men are supposed to have sex for the first time and with whom (e.g., before marriage, with a prostitute)?
   - Do you think your clients learned about sex in the same ways you did? What are the similarities? What are the differences?
   - Why is it important for us to consider how our clients learned about sex and sexuality? How does it apply to our work as providers?
   - How do our own sexual experiences and learning about sexuality affect our ability to counsel clients about issues related to sexuality and gender?
   - How can you be sensitive to gender-based issues that may be facing your clients?

- How can you help your clients to be more comfortable discussing sexuality issues with you?

(This exercise was adapted from: EngenderHealth. 2002. *Integration of HIV/STI prevention, sexuality, and dual protection in family planning counseling: A training manual*. Working draft. New York.)

TRAINING TIP ○○○

When discussing responses to the questions above, include the following points:

- Our own inhibitions and attitudes about sexuality might affect the way we talk to our clients about sex, as well as our comfort in doing so. Understanding where our own feelings and beliefs stem from can help us empathize with the experiences of clients and with the difficulties we all have in talking about our sexuality.
- Sexual practices and relationships are affected by the way we feel about sex, what we think is proper and improper, and what it means to relate to another person in a sexual way. These types of thoughts and feelings are often filled with emotions—including, for example, pleasure, but also some times fear, guilt, shame, or embarrassment. These feelings come from our personal experiences, as well as from the meanings that our society and culture attach to sex.
- This exercise alone might not help us to feel more comfortable discussing sexuality with our clients, but it can be a helpful step in the process.
- Use the case-study clients as examples throughout the discussion, so the participants can apply this information to hypothetical postabortion clients.

3. Distribute Handout 3-D: Sexuality to all participants.

Session 3

Handouts

Handout 3-A
Ensuring Clients' Confidentiality, Privacy, and Dignity

Confidentiality means not discussing the client's personal information with her partner, with the family member(s) accompanying her, or with staff members not directly involved in her treatment (except where required in a life-threatening emergency). Personal information includes her medical history and the conditions bringing her to seek care, the services provided to her, and the family planning decisions she makes. (If she wants to involve a spouse or partner in decision making, however, her wishes should be followed.)

Privacy is critical to protecting the client's confidentiality, sense of security and dignity, and willingness to communicate honestly. Often, simple changes in the physical setting where clients are treated or counseled will offer them more privacy.

Dignity means that a client can feel self-worth and honor, regardless of her physical circumstances. Ensuring privacy and confidentiality can help a client to maintain her dignity.

The following situations may disturb a client's confidentiality, privacy, and dignity:

- Leaving the client lying in a busy, open area
- Facing her feet toward the door, with her genitals exposed
- Not using screens or curtains around her
- Not adequately draping her
- Openly discussing her case with anyone who walks by
- Allowing people to walk in and out of the area frequently
- Having casual conversations with other staff during treatment and/or counseling
- Attempting to discuss discharge information or provide counseling in a busy, nonprivate environment

Handout 3-B
Gender

Gender refers to a set of qualities and behaviors expected by society from a woman or a man. Gender roles are learned and can be affected by factors such as education or economics. They vary widely within and among cultures. While an individual's sex generally does not change, gender roles are socially determined and can evolve over time.

Gender roles and expectations are often identified as factors hindering the rights and status of women, with adverse consequences that may affect family life, education, socioeconomic status, and health. For this reason, awareness of gender, like sexuality, is an important element of reproductive health services.

The following are some examples of gender-role stereotypes:

- Women are supposed to be mothers, and their primary function is to reproduce.
- Men should be sexually experienced.
- Women should remain virgins until marriage.
- Men may demand to have sex with their wives or partners whenever they choose.
- Women do not enjoy sex and do not experience sexual desire.
- Men demonstrate their virility by having sex frequently and with many partners.
- Women who use family planning methods are able to be unfaithful to their husbands without getting "caught."
- Women who were raped were probably asking for it.

Discussion Points

If a provider feels that women who were raped are somehow responsible for this, then he or she may be less sensitive to the client's feelings and needs.

Examine the relationship between gender roles and power, and acknowledge that in some cases women are able to choose neither whether they engage in sexual activity nor whether they use a family planning method.

The experience of becoming pregnant as a result of male coercion, force, or dominance can make a postabortion client distrust a male PAC provider. She may be reluctant to ask questions or to express concerns and may be particularly tense during a procedure under local anesthesia.

Handout 3-C
How Do We Learn about Sex?

Please write short answers to the following questions, identifying two or three main ideas in response to each question.

When you were growing up:

1. What did you learn about sex from your family?

2. What did you learn about sex from your friends?

3. What did you learn about sex from your religion?

4. What did you learn about sex from your schools and teachers?

5. What did you learn about sex from music, movies, newspapers, and other media?

6. What did you learn about sex in your professional training or education?

7. What else did you learn about sex, and where did you learn it?

Handout 3-D
Sexuality

"Human sexuality encompasses the sexual knowledge, beliefs, attitudes, values, and behaviors of individuals. It deals with the anatomy, physiology, and biochemistry of the sexual response system; roles, identity, and personality; and individual thoughts, feelings, behaviors, and relationships."

—Sexuality Information and Education Council of the United States (SIECUS)

As defined in this way, sexuality is an important part of family planning and reproductive health service delivery. Client-centered counseling and the facilitation of informed choice in reproductive health care depend on providers' being aware of issues related to sexuality. A client's sexual history, relationships, and circumstances can play an important part in her contraceptive choice, her decision to be screened for sexually transmitted infections, and her long-term satisfaction with health care services. In addition, the ability of women to improve their reproductive health and achieve their reproductive intentions is deeply affected by the degree to which they are knowledgeable about and in control of their sexuality and sexual relationships. Health care providers can help to empower women by supporting them in the process of developing knowledge and control.

The following are examples of characteristics that relate to sexuality:

- Being newly sexually active
- Being unmarried and pregnant
- Surviving rape, incest, or sexual abuse
- Lacking choice or control over when and how to engage in sexual activity
- Discontinuing use of a contraceptive method because of its negative effects on sexual activity

Responses to the client's concerns might include:

- Assuring the client that all conversations will be kept confidential
- Addressing concerns in a respectful, nonjudgmental manner
- Acknowledging to the client that it may be difficult to talk about the sexual activity or relationship that resulted in an unwanted pregnancy, but letting her know that it may be helpful if she is to prevent unwanted pregnancy in the future
- Referring clients to family planning counselors, psychologists, or other resources within or outside of the institution