MI+

Policy brief

Reaching out to male youth works!

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Policy Brief

Reaching out to male youth works!

Key issues

Reaching male youth through a multi-channel MI+ approach facilitates an open dialogue on SRHR issues among health care workers, peers and teachers.

Continuous, tailored SRHR information and education enable male youth to adopt healthy and positive attitudes to sexuality and to lead meaningful lives.

Why do we need to reach out to male youth?

The situation of male youth in Siaya County presents a strong case for the focused delivery of sexual and reproductive health and rights (SRHR) services, including information on and treatment of sexually transmitted infections (STIs) and HIV. The majority of them become sexually active at an earlier age (15–16 years) than the national average (17.6 years).[1] A recent study, Exploring new ways of improving sexual health and well-being among male youth in Kenya through a motivational intervention (MI+) approach,[2] revealed that 86 per cent of males between 15 and 24 years of age were sexually active, with about half of them having multiple sexual partners.

The most commonly cited reasons for early sexual debut were to satisfy natural feelings, a need to experiment, peer pressure, sexual role modelling, and being approached by older people, including for money and goods.

From the study we know that male youth's knowledge of STI symptoms is relatively low. A number of male youth are not aware of how to avoid STIs. They either do nothing or mistakenly believe that they can avoid them by taking medicines prior to having sex or by washing their genitalia with urine or Dettol after sex. Their perceptions of the risk of contracting HIV vary considerably, as does their condom use.

Few of the health and social care providers interviewed felt comfortable and knew how to discuss sexuality issues and contraceptives with male youth. Some service providers cited a lack of time or a conducive environment as making it challenging to engage with male youth. Others stated that the majority of health problems for male youth revolve around STIs, for which they often only seek care when the problems have escalated to serious levels.

In Siaya County the threat of physical and/or sexual violence against young men is real. The motivational intervention (MI+) study[3] revealed that 25 per cent of the male youth in the study population had been physically abused, with one in ten of those having been a victim of sexual violence.

According to the Kenya AIDS Indicator Survey (KAIS) 2014, Siaya was listed among three counties with the highest prevalence of new HIV infections. This fact is corroborated by the MI+ survey, which showed increased demand for antiretroviral therapy (ART) services in the county. This implies increased susceptibility to HIV of male youth as viewed in the context of their sexual practices vis-à-vis their health-seeking behaviour.

What is motivational intervention?

MI+ (2013–2016) — developed by the Royal Tropical Institute (KIT), GGD Amsterdam and Amref Kenya[4] — aims to better equip male youth in Kenya to make healthier choices about their sexual health. The intervention uses motivational interviewing[5] at individual and peer-led group level. By doing so, it introduces a genuinely new dimension to the interaction between service providers and male youth clients, and between peer educators and male youth, and elicits and strengthens male youth's own motivation for change. With the MI+ approach, nurses, counsellors, teachers, peer educators of youth clubs, and District AIDS Coordinators (DASCOs)[6] were trained to have more collaborative and non-judgemental attitudes and productive approaches to reach out to male youth to facilitate their use of and return to SRH services. To foster sustainability, locally based project members were trained as master trainers in basic MI+ skills.

To measure the outcomes and effectiveness of this approach, a mixed-methods study was conducted before and after the intervention among 1,150 male youth within an intervention (Siaya) and a control group (Bondo), to enable a double difference comparison, as well as a qualitative mid-line study.

Reaching out to male youth through health facilities

One of the pillars of MI+ was to reach out to male youth by training health and social care providers — nurses, counsellors and DASCOs (those involved in and coordinating HIV and STI activities in the counties) — to better understand and address the SRHR needs and entitlements of male youth. By providing these different groups of professionals with the tools and skills to engage differently with male youth, the interaction between service providers and young males improved. Male youth started telling each other which nurse or counsellor to look for in a specific clinic. As a result, the number of male youth accessing the services started to increase.

"Personally, my attitude on handling the clients has changed, it is now enjoyable. I even now make follow-ups in my referrals — something that in the past I left for the client alone. The number of young men accessing reproductive health services has gone up." — **Nurse**

"Initially, before MI+, the youth we were dealing with were shy coming for services. After, the youth are coming to the facility without fear, and even the quality of services on SRHR offered by the facility has also gone up." — **Nurse**

Before the MI+ intervention male youth were often sent away by health staff. This was confirmed by all health facilities including the district hospital in Siaya. The trained health care providers also started to engage with young men outside the health facilities — for example, in youth groups:

"Youth groups invite me to attend their meetings. I am able to address their issues, and in fact locally I act as a patron of one of the groups." — **Nurse**

The MI+ intervention, which only included a limited number of health professionals, yielded a high response among male youth. During the qualitative mid-line study, the logs of the health facilities showed that around 8–10 new young male clients per month were seeking services approximately nine months after the introduction of the MI+ approach.

Reaching out to male youth through youth groups

A strong pillar of the MI+ intervention was the engagement of 19 youth groups, which consisted of 110 peer educators and counsellors. They were trained three or four times, and after the training most of them also trained the other youth group members. This multiplier effect resulted in a high number of youth reached. As one of the peer educators states:

"There is a sense of responsibility growing among the youth because we are engaging them to come with solutions of their own. They own the challenges." — **Peer educator**

The peer educators and counsellors underlined in the mid-line study that their own attitudes had changed and that when reaching out to their peers and clients they were now less arrogant, but warmer and more understanding:

"MI has brought big change. Before, when I approached clients, I believed and assumed that the client knew nothing and I knew everything. Currently I discuss with clients, get to know what they know, and then we share the knowledge. Our skills have improved in handling our peers, which has led to an increased numbers of clients coming for our group sessions." — **Peer educator**

Through the MI+ intervention male youth realize that they are part of the change process and have a space in the community where they can share information and be heard. The intervention has led to more meetings among the established youth groups but also to the formation of new youth groups, which were meeting more frequently than ever before. In the youth groups that were formed during the MI+ intervention, often so-called champions were identified among the leaders who were able to create trust and an open atmosphere. The youth mentioned that it is easier to go to the leaders of the groups to open up and share their issues with them. These were not only issues related to male sexual health; some of the peer educators and youth group members also recall cases of early pregnancy, use of bang (a local drug), dropping out of school and engaging in crime being discussed as issues raised in the groups.

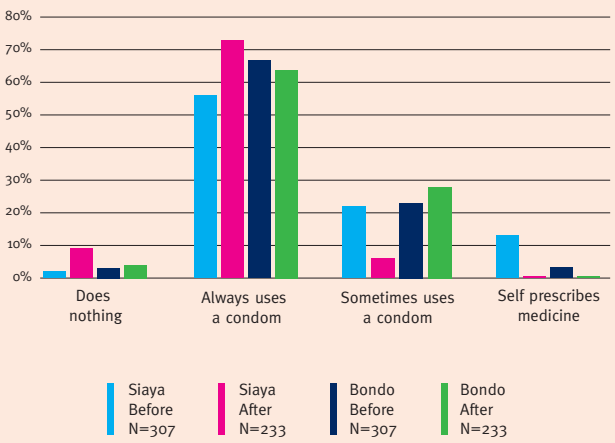
The reality of youth groups suddenly falling apart or disappearing was a challenge for the MI+ intervention, but, overall, youth group members stayed positive. One of the peer educators stated:

"MI+ has helped us in solving conflicts in the group. Conflicts arise every now and then — due to the large number (over 60)." — **Peer educator**

The conversations about HIV, STIs, unsafe sex and dating multiple partners were really liked — especially now that the youth can seek and find their own solutions and are even able to access health care facilities.

All of this contributes to a situation where a higher percentage of male youth always use condoms, and a lower percentage use self-prescribed medicine prior to having sex in an effort to avoid STIs. A minority of male youth still do nothing to avoid STIs.

Action taken by male youth to avoid STIs



Reaching out to male youth through teachers

During the MI+ intervention a number of teachers were trained in Siaya. Overall these teachers indicate that they are now more comfortable about counselling students:

"I have attended all the trainings in MI+. I have acquired several useful skills in handling the youth/students. The greatest skill I got was that in-group counselling, which has enabled me to handle students comfortably when handling SRH issues." — **Teacher**

The training mainly involved counselling teachers. They all said that prior to the training they used to be very rigid during counselling sessions; however now — through the use of reflective listening, open-ended questions and a spirit of confidentiality — they are able to engage youth much more easily. The youth are opening up to share their issues, and they seek solutions together.

Some counselling teachers mentioned that they had rebranded the health and counselling clubs in schools to form so-called MI+ clubs and had trained some of the students in MI+. This has opened up dialogues on SRH topics and increased levels of accountability among the youth themselves. The teachers also mentioned that too few of them had been trained and that there were colleagues they try to empower who have retained their conservative attitudes. That sometimes caused confusion and a lack of trust on the side of the students. It would be good, as some of the teachers mentioned, to train or at least provide orientation to the school management and other teachers.

Another issue mentioned was the lack of social support for the youth who intend to change their behaviour. As one teacher said:

"Most of the youth regress to old behaviours due to the constant exposure to the vices from which they are trying to change. The best way to handle them would be to extend MI+ to cover even the families of the youth we handle. This would provide a support structure for positive behaviour change … As a solution, the MI+ intervention should strive to target the home environment by also training parents on MI+ or helping youth to establish supporting structures for their behaviour change." — **Teacher**

The male youth themselves actually discussed this same issue in the focus group discussions. Some of them said that they never discussed their issues at home because they felt their parents do not care:

"They would say 'you have got yourself into these problems, thus get yourself out.'"

This call for action to train more teachers and those in the environment of male youth, especially parents, has also been recommended by other recent studies. Venkatraman Chandra-Mouli of the World Health Organization (WHO) shows the outcomes of a systematic review on what works for adolescent health.[7] The systematic review stresses that coordinated and complementary approaches — such as has been employed in MI+ — are a requirement for adolescent and youth SRH programmes to be effective. This can be done by increasing referral between different services, as can be seen in the section below.

Reaching out to male youth through referral between health facilities, youth groups and schools

One of the major challenges in the lives of the young males in Siaya County is the lack of access to sufficient SRHR information. Young males want information but do not know where to get it and thus often seem to turn to their peers for help. The peers in most cases possess wrong information. For example, one youth may have had an STI, and by chance has been cured after self-treatment with drugs from a pharmacy. Another youth with an STI may — based on this experience — be advised by his peers to obtain the same drugs but will have a negative outcome.

One of the strong findings of the MI+ study is that there is a higher uptake of services by male youth: they have had more counselling sessions, among others as result of the strengthened referral between different institutions and actors. This increase in counselling shows that enhanced referral empowers male youth to engage in more open dialogues, which helps them to be better informed about their own health.

The linkage between the different actors and institutions within the MI+ intervention sites was achieved by training the nurses, teachers, peer educators, counsellors and other health care workers together, by making them aware of each other's existence and also by the youth talking about the improved attitudes of service providers.

The DASCOs played a crucial role in supervising the health care workers and in linking their staff to schools and youth groups. Without them, the MI+ intervention would have been less successful.

"Yes! We always share. As a facility, seven people, including the DASCO, were trained in MI+. We came up with a task force that meets every month, and we share our experiences and challenges. It helps build and develop other solutions for common issues." — **Siaya district hospital manager**

Other stakeholders were also informed by hospitals and schools, and this has fostered working in harmony. Peer educators of youth groups as well as teachers also confirmed this:

"We have an easy time tracking the clients from the source of information to the service centre and then from the service centre back to us. Currently we walk with the client through the entire process." — **Peer educator**

"A boy was suffering from STIs. He had no idea of what to do. I did counselling, conducted a referral and did some follow-up. The issue about STIs is a personal issue, and I took it seriously now that he chose to open up. What worked well was that we structured a way forward, which eventually helped the young man to get a solution to his challenge. What didn't work well initially was the referral. The boy refused to visit a local hospital due to fear of lack of confidentiality. I eventually referred him to a facility where I knew a specific clinical officer who attended to him. The young man is now fine, and he believes that I saved his life." — **Teacher**

The creation of communication platforms between different institutions and actors was not intended at the beginning of the MI+ intervention but is one of its unexpected outcomes:

"After the training, all the persons trained (nurses, teachers, counsellors and the peer educators) had a meeting at the sub-county level and created a communication platform with a database of each other's contact details. This enabled communication and easier referrals by the teams trained. For instance, in the schools, whenever the teachers came across a case with their students, they would make phone calls to the nurse at the health facility and book appointments for the students to go and see the nurse. The nurse in turn makes sure the student is attended to once they come to the facility." — **Health care provider**

At the moment, DASCOs take the lead in this, but other actors could also be leading this process. Spaces for dialogue, where male youth meet and feel safe, need to be created continuously. Youth groups but also others can do this. A continuous exchange of tailored SRHR information is needed to enable male youth to keep control over their lives.

One omission, however, during the MI+ intervention was the exclusion of community health workers. Only one of two of them were trained, and they need to be included in future interventions. There is also a need for refresher training and to keep the MI+ spirit alive. Leadership among all actors is a must to realize this.

Recommendations

To support the outcomes of the MI+ intervention and sustain change, regular forums need to be organized by all sectors. A multi-channel approach endorsed by different sectors and/or ministries is needed. The MI+ intervention can only be scaled up by combining individual- and group-level activities when this has been achieved. Empowering young males with SRH information is not a role of the health sector alone; parents and teachers need to be included and contribute to an open and supportive environment. Only if there is a joint effort will male youth be able to lead meaningful lives.

Abbreviation block for MI+ brochure:

ART:	Antiretroviral therapy
DASCO:	District AIDS Coordinator
MI:	Motivational interviewing
MI+:	Motivational intervention
SRHR:	Sexual and reproductive health and rights
STI:	Sexually transmitted infection

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1 National Bureau of Statistics, Ministry of Health, National AIDS Control Council, Medical Research Institute, National Council for Population and Development, The DHS Program and ICF International, 2015. Kenya Demographic and Health Survey 2014. Nairobi: National Bureau of Statistics, Ministry of Health, National AIDS Control Council, Medical Research Institute, National Council for Population and Development and The DHS Program, and Rockville, MD, USA: ICF International. See https://dhsprogram.com/pubs/pdf/FR308/FR308.pdf.

2 Kiage, Paul et al., 2016. Exploring new ways of improving sexual health and well-being among young males in Kenya through a motivational Intervention (MI+) approach. Comparative analysis of the after and before study of young males (15–24 years) in Siaya County, Kenya. Amsterdam: Royal Tropical Institute.

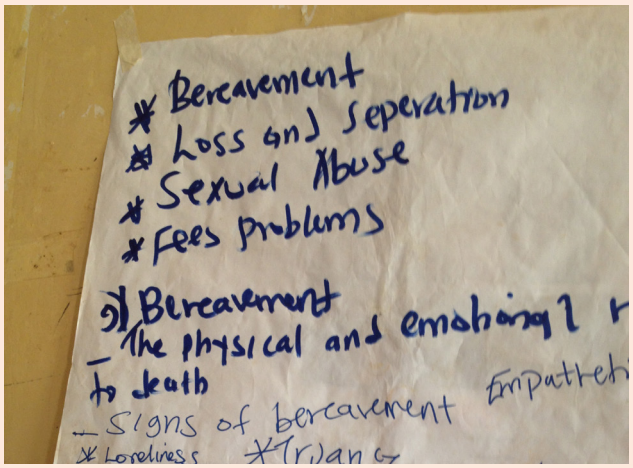
3 Kiage, Paul et al., 2016. Exploring new ways of improving sexual health and well-being among young males in Kenya through a motivational intervention (MI+) approach. Comparative analysis of the after and before study of young males (15–24 years) in Siaya Country, Kenya. Amsterdam: Royal Tropical Institute.

4 MI+ is also being implemented in Bangladesh with Bandhu Social Welfare Society.

5 Motivational interviewing is a client-centred, semi-directive counselling method focused on facilitating and engaging intrinsic motivation within the client for behaviour change. The examination and resolution of ambivalence is a central purpose, and the counsellor is intentionally directive in pursuing this goal. See http://www.motivationalinterview.net/.

6 District AIDS Coordinators (DASCOs) were involved in MI+ from 2013 to 2016. Since 2016 they have been called Sub-Country AIDS Coordinators (STASCOs).

7 Chandra-Mouli, Venkatraman, Catherine Lane, and Sylvia Wong, 2015. What Does Not Work in Adolescent Sexual and Reproductive Health: A Review of Evidence on Interventions Commonly Accepted as Best Practices, Global Health: Science and Practice, Vol. 3, No. 3, pp. 333–340.



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