

# MI+

Exploring new ways of improving sexual health and wellbeing of young MSM in Bangladesh through a **Motivational Intervention (MI+) approach**

# Purpose

The Motivational Intervention (MI+) approach aimed to build the capacity of health providers and peer educators to elicit and strengthen young MSM's motivation for change through four consecutive rounds of training, and a continuous process of mentoring and coaching. This document shares findings from the operational research in Bangladesh which looked at the effectiveness of the approach as well as experiences from the field



KIT | Health



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## **Abbreviation block for MI+ brochure:**

DiC: Drop in Center

MI: Motivational Interviewing

MI+: Motivational Intervention

MSM: Male having Sex with Male

SRHR: Sexual Reproductive Health and Rights

STI: Sexual Transmitted Infection

# Motivational Intervention?

Our consortium, consisting of The Royal Tropical Institute/KIT (Lead), GGD Amsterdam, Bandhu Social Welfare Society and AMREF Kenya, witnessed that young males and men were often absent in SRHR services and related studies. This, while the limited evidence that existed, showed large unmet needs and reduced access to SRHR services among this group. In addition, we also knew that health staff faced challenges with addressing young's people sexuality and that many sessions traditionally ended up providing information and advice, often in a moralizing way. For this reason, our consortium decided to develop a proposal towards the end of 2012 with an innovative approach that focused on young male sexual and reproductive health roles and responsibilities. For this proposal we developed a Motivational Intervention (MI+) approach. Our client-centred MI+ programme aimed to substantially change the way in which health professionals and peer educators engage with young MSM in Bangladesh and young male in Kenya; and introduce a genuinely new dimension to the provider-client and peer educator/peer interaction, eliciting and strengthening clients' motivation for change. While Motivational Interviewing had been used to address a variety of health-related issues also in Kenya and Bangladesh, application in the SRHR including HIV domain, especially among young men, had been limited. Also, Motivational Interviewing was designed to be used on an one-to-one basis, thus foregoing the obvious potential benefits of peer-led interventions at group level. Our programme aimed to bring Motivational Interviewing (MI) to the next level, that of Motivational Intervention (MI+) by applying the approach to young male and MSM clients (by counsellors and other staff) and experimentally adapting the strategy to peer-led group community activities.

Motivational interviewing (MI) refers to a counseling approach in part developed by clinical psychologists Professor William R Miller, Ph.D. and Professor Stephen Rollnick, Ph.D. The concept of motivational interviewing was first described by Miller (1983) in an article published in Behavioural Psychotherapy. The concepts and approaches were later elaborated in more detail by Miller and Rollnick combined (1991). Motivational interviewing is a semi-directive, client-centered counseling style for eliciting behavior

change by helping clients to explore and resolve ambivalence. Compared with non-directive counseling, it's more focused and goal-directed. Motivational Interviewing is a method that works on facilitating and engaging intrinsic motivation within the client in order to change behavior. The examination and resolution of ambivalence is a central purpose, and the counselor is intentionally directive in pursuing this goal<sup>1</sup>.

<sup>1</sup> [www.motivationalinterview.net](http://www.motivationalinterview.net)

# “Motivating safer sex”

Datuni, a male sex worker aged around 30, is one of our irregular clients. I have known him since a year of three. While I always encouraged him to come to our Drop In Center, he never did. I assumed that he practiced safer sex but found out six month ago that this was not the case. At that time, we went to a dance programme together. A client approached him for sex first. After that the client came to me. With me, he refused to use a condom. I said “but you just had sex with my friend Datuni using a condom”. The client said that they had not used protection... So this is how I found out. When I met Datuni next time, he said that he found it difficult to use condoms.

Sex in cruising areas is a quick thing. He finds it a hassle. He also said “If I use condoms I do not get clients because they do not get the ultimate satisfaction”. Then we talked about unsafe sex and its consequences. I asked him what risks he might face in his life, and what he thought he should do. Then I took him to our DIC office and encouraged him to get an STI and HIV test done. Before the MI intervention, I did not have a clue what steps I should follow to motivate someone. But now I do. It helps me to do things in a calm, poised way. — **Nasir**, Darusalam DIC, Dhaka

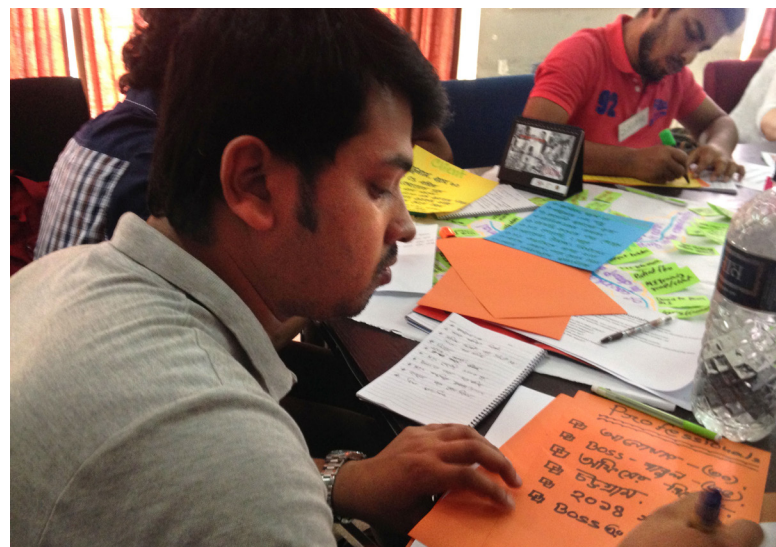
# Programme Strategies

The MI+ project aims to 1) better equip young MSM in Bangladesh to make healthier choices about their sexuality; this through 2) enhancing the skills of medical service providers, counsellors and peer educators to assist clients/peers with how they could change their behaviour instead of telling them what to do. Health care providers have been trained to have more productive attitudes and approaches with young MSM to ensure that they come again for the next service; that young MSM are better informed and know what decisions to make and where to go with their questions; feel better equipped to negotiate safer sex; know where to go for condoms, HIV testing and counselling, Antiretroviral Treatment, etc. and are actually able to access and utilise these services. Health care providers and peers have also been trained in activating the young MSM's own motivation for change. With changing behaviour, we mean a mix of knowledge, skills and behaviours related to sexual health and rights, HIV, pregnancy (female partners of MSM), negotiation skills for safer sex and adopt safer sexual practices.

## Main programme activities

The programme builds on and enhances interventions that are already in place and consist of a combination of health service, outreach work and community level activities aiming to create an enabling environment. A number of these services and outreach work were enhanced with the MI+ approach focused on the individual, group, and community level (intervention sites); while other sites continued their work as usual (control group).

The health care providers, including counselors, and peer educators in the intervention sites received formal induction training and three refresher trainings on motivational interviewing over the course of the first 1,5 year. The trainings consisted of a combination of interactive class-room activities, on-the-job training, and coaching and mentoring to ensure they are well equipped to apply the motivation interviewing approach in their work with young MSM in Bangladesh. The training of the peer educators was enhanced with an motivational intervention approach that is suitable for group level/ community level activities focusing on risk-reduction and addressing issues of intimacy, relationships, coping skills, interpersonal skills, relapse prevention, sexual negotiation and communication skills.



## Training

The GGD Municipal Health Services in Amsterdam trained three master trainers from Bandhu, and conducted the training for the other groups in close consultation with these master trainers. The GGD also provided continuous mentoring and coaching support in between each training. The role of the master trainers expanded over time, with the master trainers being able to train the controle sites independently.

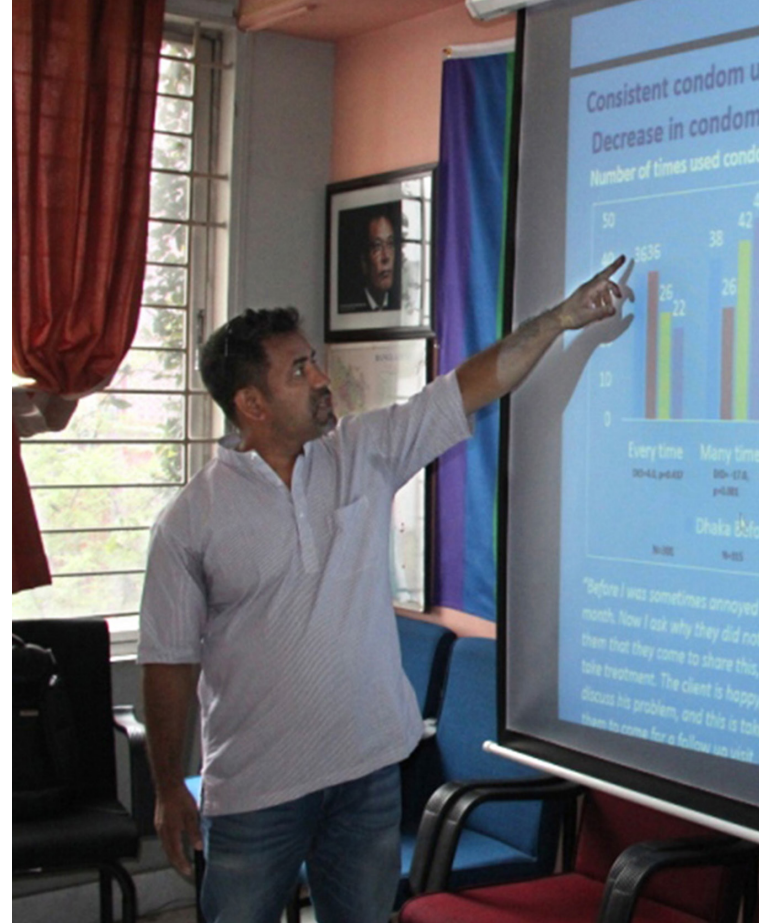




# Operational research

In order to know whether the innovative MI+ approach works operational research was undertaken. Our main operational research questions:

- Is MI+ is an effective approach to improve the SRHR of young MSM in Bangladesh in terms of improved access to and uptake of services and SRHR practices?
- Are those who have never used services now taking them up and are those using them getting better quality services that respond to their needs and rights?



## Operational research methodology

### Mixed methods

We used a mixed methods approach with a quasi-experimental design to document the effect of the motivational intervention in relation to the competencies of service providers and peer educators as well as young MSM. This allowed a double difference analysis between the “intervention – MI+” and “control – non-MI+” sites. The core of the operational research consists of a “Before” and “After” study. The “Before” and “After” studies have been conducted in Dhaka (intervention) and Chittagong (control) in Bangladesh. Immediately following the “before” study, the intervention sites started with integrating the MI+ approach in their routine, while the control sites continued their business as usual. In addition, a number of individuals were followed through an in-depth “trajectory” in the intervention sites to better describe the effect and value of the motivational intervention.



## “Testimonial”

When I started working as a peer educator I used to give condoms and lubricants away to my clients because I was concerned for their safety. I never talked about why they needed condoms and lubricant, or who to use it with. I was in a rush to reach my targets. After receiving the MI training, I learned that you need to listen to the views and problems of your clients. Because of this, I have been able to solve Murali's problem. Around six month after my first MI+ training, Murali shared that he was being abused by his family and that he wanted to improve his relationship with them. I tried to figure out how I could apply MI. First, I listened to what Murali had to say, to every minor detail. I sympathized with him and told him “You love your family members and want to make things better.” Then I asked “How can we work together to improve your relationship with your family”. Murali asked me to talk to his parents. Because I knew his family, Murali thought it would be better if I went alone. I went to Murali 's house and asked why the problem had occurred. His parents said not to have any problems with

Murali except for his feminine behaviour as he was wearing lipstick and other make-up, which brought shame to the family. We then discussed what other things they liked or disliked about Murali. They could only identify good things about him, such as Murali being good at school, polite, honest, helping with household chores. His parents also realized that while neighbours had complained about their other children, they never had about Murali. We then had a discussion of why Murali wanted to wear make-up, and I explained that this is something a person is born with. We also discussed whether Murali was responsible for how he was born, and how they could accept him in their family. His parents said, “If he reduces the amount of make-up, things will get better”. I went the talk with his parents around 10 to 15 times, they live close by, and eventually they came to an understanding. Before MI, we would just talk, but after MI I came to know the steps in counselling and became more confident. — **Mamun**, 25 year, Jatrabari DIC, Dhaka

**“From negligence  
to acceptance,  
MI all the way”**

# Findings

## MI+ approach embraced

Health providers and peer educators in Bangladesh embrace the MI+ approach. MI is not only used with young MSM but also with colleagues in the office; with family members and friends.

Training entire Drop in Center teams facilitated this, as counsellors, physicians, paramedics, managers, outreach supervisors and peer educators in these Drop in Centers, inspire and encourage each other to continuously apply the MI+ approach.

## Needs of clients central

The research shows that as result of the new approach, Health staff and Peer Educators give more respect and positive feedback to their clients. They are more appreciative of clients coming for the services and being open about their problems. This is a huge turn-around in terms of attitude.

“Before I was sometimes annoyed when clients came back with the same problem as last month. Now I ask why they did not use a condom, or why the condom broke. I now thank them that they come to share this, and tell them that it is good that they come back to take treatment. The client is happy, and now I am not annoyed... The client shares, and when I ask them to come for a follow up visit, they come again” — [Counsellor MI+ site](#)

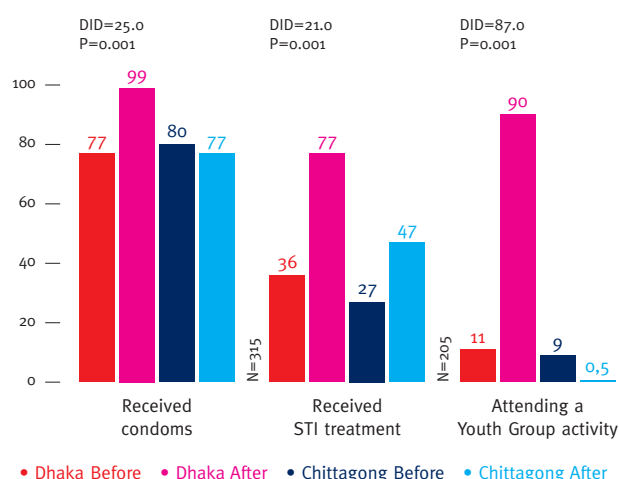
“The relationship has changed. Before, we asked closed questions, with yes and no answers. Now clients tell us lots of things, and can get a solution. We inspire clients to talk more... The clients disclose so many things... now issues as anal bleeding and anal STIs are being discussed. Before, clients would not discuss this, they were not sharing...” — [Peer Educator MI+ site](#)

As result of their new role, self-esteem of Peer Educators in MI+ sites has increased, and they feel more confident to address sensitive issues such as wet dreams, and relationships.



## Increase in service uptake

### Significant increase in SRHR service uptake last 12 months



Young MSM show more genuine interest in coming to and making use of the STI services, receiving condoms, and attending youth group activities. The survey data also show a significant increase in preference to go directly to DiC health workers for STI treatment in MI+ sites, matched with a significant reduction in use of the pharmacy and private health services.

“Before, Peer Educators and outreach workers would escort clients to the DiC, now the clients come themselves to the STI clinic” — [Peer Educator MI+ site](#)

“MI helps us to work. Earlier we used a kind of pressure. Now we say, “if you have time, you can come”. The training has helped us to work in a better way” — [Peer Educator MI+ site](#)

This improvement in Client-Peer Educator interaction is also confirmed by the young MSM themselves. They report a significant increase in – individual but especially group level - counselling by Peer Educators in MI+ sites. Young MSM in both MI+ and non MI+ sites mentioned to have received behavioural change counselling. However, in MI+ sites these discussions focus more on a specific change in behaviour, which young MSM find very helpful for actual realizing behavioural change.





## (MI+ )challenges

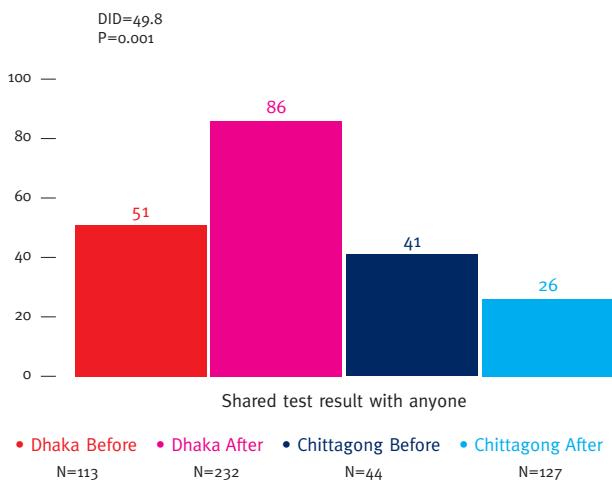
Full application of motivational interviewing is challenging. Most trainees are able to apply basic principles that facilitate greater interest in clients and therewith a positive attitude change towards these clients. However, enhancing capacity so that the full motivational interviewing process can be applied, would require further resources.

“Using MI is a challenge as we have been doing things in the same way for a long time, it takes time to break our habit. We need to practice and practice. We have used the same approach over the last 13, 14 years, and now we have to use a different language, open ended questions and a non-judgmental attitude with respect to the clients.”  
— [Drop in Center manager in MI+ site](#)

## Creating greater openness

While uptake of HIV testing increased both in MI+ and non-MI+ sites due to testing becoming available in the drop in centers itself, a significant higher percentage in the MI+ sites shared their HIV test result with another person. In addition, a significant higher percentage in the MI+ intervention sites were very confident that they could ask sexual health questions to any health worker. All this points to the MI+ approach contributing to a greater sense of openness.

A higher percentage in Dhaka than in Chittagong shared their HIV test result with another person indicating greater openness



If the capacity towards full application of MI could be enhanced within the MI+ approach, this could possibly also have a positive effect on increasing consistent condom use in relation to safer sex. Consistent condom use remained the same in the MI+ sites, and slightly decreased in the non- MI+ site.

Some misconceptions around sexual reproductive health are very strong for instance around masturbation. The majority of young MSM continue to be convinced that masturbation has negative health consequences. More time and effort would be required to change such ingrained ideas, whereby the MI+ approach through creating greater openness to address sensitive issues seems to have great potential.



## “Testimonial”

One of my fellow university students is a MSM. I have known him for two years, but only found out he was a MSM nine months ago. I was doing research in the DIC for the MI+ study when Zakir entered. Zakir felt very uncomfortable when he saw me, because none of his class mates knew about his orientation. He always tried to hide this fact from others. He had a negative self-image and felt guilty that he was a MSM. He wanted to know how to overcome this problem. That is why he came to meet the counsellor. As he was really uncomfortable seeing me there, I greeted him very friendly and tried to make him comfortable. I also told him that I would keep this confidential. After Zakir saw the counsellor, he told me about the session. First the counsellor listened to him very carefully and asked him his opinion. Zakir said “I don’t know, sometimes I think good about myself, sometimes I don’t, I am confused”. They first discussed whether Zakir wanted others to know about his sexual orientation. Zakir did not want to do this, as he was afraid they may avoid him. They then discussed whether Zakir would want to disclose his orientation to the MSM community. Zakir thought that was a good idea as it would provide him with an opportunity to meet like- minded people, and that it would help him to mentally relax somewhat. He really appreciated the session with the counsellor, and felt much better about himself afterwards. — Shah, research assistant MI+ operational research)

Two office colleagues had a conflict about their responsibilities for producing monthly reports. After having received MI training in August 2015, I called these two colleagues, and asked them individually what the problem was about. They both mentioned that they needed more support from each other. I asked them if they could come up with a solution together. They sat together, jointly prepared a plan in which they divided the responsibilities. We discussed this plan the following week. Because they both had developed the plan, they were also motivated to implement the plan together. As result their working relationship much improved. Before the MI training, I would have blamed them for the problems but that would not have had any effect. Through the MI training, I learned that we should not give specific solutions but that the solution has to come from within, and that makes things easier. — Mostofa Kamal, Haliashahar DIC, Chittagong

**“MI for  
increasing  
self-respect”**

**“MI and  
facilitating  
collaboration  
between  
colleagues:  
Let’s work  
together”**







