



Policy brief

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Policy Brief

Can a motivational intervention create greater respect for the sexual and reproductive rights of groups that are currently denied their rights? The case of men having sex with men in Bangladesh.

"I considered myself inferior to other people. I used to be hesitant to talk to others. People would not want to be seen with me, as I was different. After the MI training, I see a big change in myself. I am confident to talk with others. I can impress them with my words. I use MI everywhere, not only in the office. If I follow the MI approach, I am respected everywhere in the society, and I do not feel humiliated." — [Kothi, Peer Educator](#)

Key issues

The Motivational Intervention (MI+) facilitated quality improvements in interaction between provider/client AND peer educator/client contributing to personalized solutions and genuine interest in use of SRHR services by young MSM.

Motivational Interviewing (MI) training of entire teams resulted in embracement of the approach, full ownership of the newly introduced Motivational Intervention (MI+), and greater self-esteem and empowerment among all those involved.

SRHR content such as sexuality, gender, orientation, safer sex are to be an integrated component of MI+ interventions.

Professionalization combined with compassionate care are the ingredients for a contextualized rights based approach.

What is the current situation of MSM in Bangladesh?

MSM in Bangladesh are not a homogeneous group and the term includes a wide variety of males with a variety of sexuality practices along with multiple gender and masculinity dimensions. Many men involved in same sex activities do not identify themselves as gay or homosexual and may be unfamiliar with such terminology.¹ In Bangladesh MSM can to a certain extent be categorized as Kothi, self-identified males with feminized behaviour; Panthi "real man" who do not see themselves as MSM; Doporata, men who have both penetrative and receptive sexual partners and Hijra the third gender. In the before study close to half of the respondents identified themselves as "real men"; around one third to one fourth labelled themselves as Kothi, and one out of ten said they were Doporata, the rest were mostly Hijra. However, there

is a high fluidity of identities as Kothi can switch over to Hijra and back, "real" men to Doporata and so on.

The sexual activities of these variety of groups of MSM differ enormously. Sexual preferences are not fixed, but shaped by social, moral and economic determinants. They have to obey to the existing gender norms and fulfill their role of masculine men in society, which means getting married and reproducing children. Especially Kothis largely construct such masculine behavior outside the frameworks of personal desire, preferences or eroticism. This translates itself into the situation that most MSM have sex with women, want to get married and have children. So they live up to the expectations of society, how 'real' men should behave.² This could explain that the majority of respondents have no problems with people in their surrounding being MSM, but are not in support of MSM marriages.

Client centered counselling and MI+

The Motivational Intervention (MI+) approach (2013-2016) - developed by The Royal Tropical Institute/KIT, GGD Amsterdam, and Bandhu Social Welfare Society³ - aims to better equip young men having sex with men (MSM) in Bangladesh to make healthier choices about their sexuality. The MI+ intervention builds on and enhances projects implemented by Bandhu Social Welfare Society,⁴ which consist of a combination of health services provided in drop-in centers, outreach work and community activities aiming to create an enabling and supportive environment for sexual minority populations. With the motivational intervention approach, counsellors, medical doctors, managers of drop-in centers, outreach workers and peer educators were trained to have more productive attitudes and approaches with young MSM to ensure that they return for services. In order to measure outcomes and effectiveness of this approach a mixed method before study, and after study and a qualitative midline were conducted.

Transformation through MI+

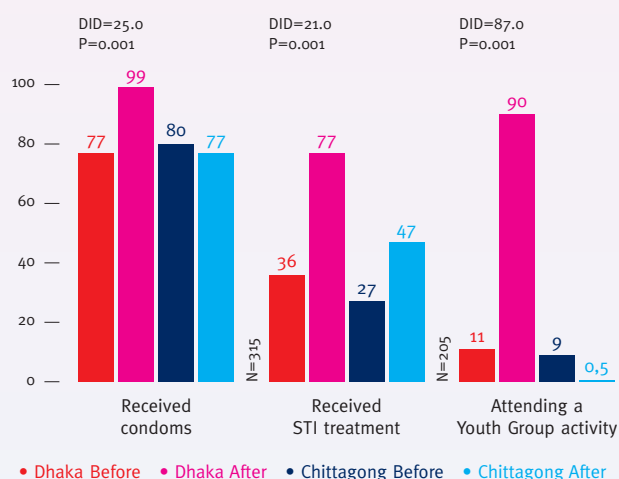
One of the results of the MI+ approach is a creation of genuine interest of MSM to make use of services offered to them. They feel understood and respected and they are able to share their inner emotions and problems they face in life. In collaboration with the counsellors and peer educators they work to find personalized solutions. Being MSM and married to a female partner at the same time, is a problem many respondents face.

A process of reflection, building upon the ambiguity many MSMs have in relation to fertility desires, and acceptance in society, family and friends, combined with a fluid sexual identity orientation or behavior, empowers them to lead a more balanced life.

“Earlier the clients were not attentive in the field. But now it is a different issue. The problems they are sharing come from them. Clients feel happy, and they discuss with us. Earlier, the clients used to tease: “Look, look, the condom people are here”. Now they say “let’s sit together and discuss”. The respect has increased. The relation with the clients is stronger.” — [Outreach worker](#)

“I really feel proud that by using MI, I can help people to take the right decision to make their live better.” — [Counsellor](#)

Significant increase in SRHR service uptake last 12 months



Training all staff involved in the drop-in centers, and creating buy-in from the management and important stakeholders like ICDDR,B were crucial for the success of the program. The most significant change was created by the fact that the MI+ approach was embraced by all.

“MI makes our lives easier, because we get to know the real needs of clients by only talking with them. No other material is needed.....MI takes a little bit of time, more than the traditional approach but not always. Sometimes in a short time you get good information from a client.” — [DIC manager](#)

Contextualization matters

We distinguish two types of contextualization here namely “Contextualized basic skills instruction” and “Integrated basic skills instruction”.⁵ What is needed is that within a MI+ approach the participants are trained in the basic skills of MI+ but adjusted to their skills level and the context in which they work and operate; Secondly, the contents meaning sexuality, MSM, orientation, safer sex, pleasure should be an integrated component of the MI+ interventions. Materials should be developed that adhere to the specific topical and cultural environment and target both clients and providers with their specific needs. Results of this will be that participants like MSM are better informed and know what decisions to make and where to go with their questions. They feel better equipped to negotiate safer sex and are actually able to access Sexual Health services.⁶ Health care providers and peers are thus equipped to stimulate young MSM’s own motivation for change.

A call for action: an agenda for respecting rights

Part of programme such as MI+ is advocacy and lobby. This is mainly aimed at making the environment aware and enabled of issues with MSM. Secondly it should be an ongoing process of advocating for respect and lobby for acceptance of young MSM.

From the start of a programme like MI+, an agenda for sharing and engaging with stakeholders should be formulated and integrated in a work and or action plan. There is a need for findings allies who hold power position and who are willing to implement this agenda. Co-production of an awareness and acceptance process by these allies, the MSM, peer educators and significant others is key in creating space for respecting the rights of young MSM.



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¹ Khan SI, et al. (2005) Men who have sex with men’s sexual relations with women in Bangladesh

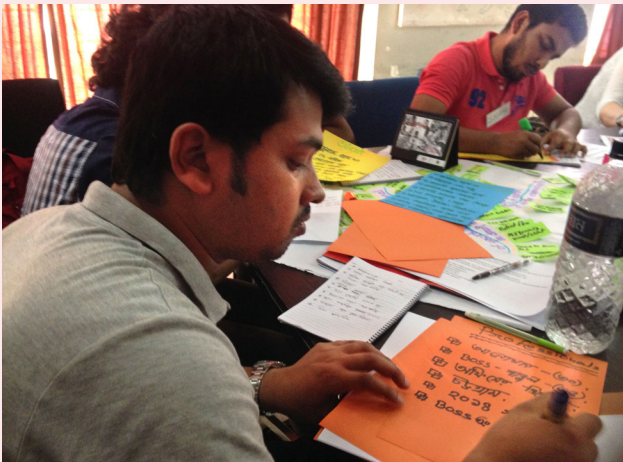
² Khan SI, Hudson-Rodd N, Saggars S, Bhuiya A. Men Who Have Sex with Men’s Sexual Relations with Women in Bangladesh. Culture, Health & Sexuality. 2005; 7(2): 159-169.

³ MI+ is also implemented in Kenya in collaboration with AMREF Kenya

⁴ Bandhu was formed in 1996 to address concerns of human rights abuse and denial of sexual health rights. Bandhu applies a rights-based approach to health and social services for one of the most stigmatized and vulnerable population groups in Bangladesh, sexual minority populations.

⁵ This is inline with <http://ccrc.tc.columbia.edu/media/k2/attachments/facilitating-learning-contextualization-working-paper.pdf>

⁶ Rollnick et al. (2008) Motivational Interviewing in Health Care; Helping patients change behavior. The Guilford Press. New York. London



MI+ intervention