MUCU ADOLESCENT HEALTH NEWSLETTER

Motivational Interviewing

Photo Courtesy of Humanitarian Photographer Bryan Watt

Makerere University and Columbia University (**MUCU**) are pleased to publish the seventh semi-annual issue of our newsletter!

OUR MISSION:
To provide a forum for adolescent providers in Uganda and East Africa to share news, interesting program updates, clinical cases, and to discuss the latest in "hot" adolescent topics.

OUR GOAL:
To learn from each other and help each and every adolescent grow into a healthy productive adult.

We look forward to hearing about the work **YOU** are doing related to adolescent health so we can publish it in our November 2016 newsletter. See page 2 for submission details.

THIS ISSUE is dedicated to **MOTIVATIONAL INTERVIEWING**.

Issue 7, May, 2016

FUTURE TOPICS will include: Dental Health; Bullying; Sexual Coercion/Violence; Taking a Psychosocial History; Managing the Confidential Visit: Parents and Teens; and Substance Abuse.

Meet the Newsletter Editorial Board

Co-Editors in Chief

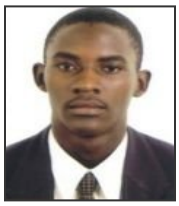
Sabrina Kitaka M.D., *Senior Lecturer & Paediatric & Adolescent Health Specialist, Department of Paediatrics and Child Health, Makerere University College of Health and Sciences Kampala, Uganda. Dr. Kitaka is passionate about promoting adolescent health and medicine in East Africa. For the past 11 years, she has taught Adolescent Medicine at Makerere University College of Health Sciences. Since 2006, she has collaborated with Dr. Betsy Pfeffer and her colleagues at Columbia University, and since 2010, they have conducted three annual in-service adolescent health workshops for East African health providers and one scientific meeting. She is the director of the Adolescent Program at the Paediatrics Infectious Diseases Clinic at the Mulago National Referral Hospital.*

Betsy Pfeffer, M.D., *Assistant Professor of Pediatrics at Columbia University Medical Center and New York Presbyterian Hospital, New York, U.S.A. Dr. Pfeffer is an adolescent medicine clinician who sees teens in an outpatient and inpatient setting, teaches medical students and residents and lectures internationally on multiple topics related to adolescent health care. She has been working together with Dr. Kitaka for over six years and is committed to their efforts to help improve health care delivery to teens in Uganda*

Editorial Team

Denis Lewis Bukenya *BSWSA, MPA is a social worker and an Adolescent Health Training Specialist and the Training Manager at the Naguru Teenage Information and Health Centre, a pioneer Adolescent Sexual Reproductive Health and Rights program in Kampala, Uganda, that provides advocacy and youth-friendly reproductive health and related services. Denis has nine years of progressive involvement in Adolescent Sexual Reproductive health services' delivery and trainings, psychosocial and behavioural support for children and youth, specifically on Adolescent Sexual Reproductive Health and Rights and HIV/AIDS. He has been highly involved in developing innovative and replicable models of youth and children empowerment, leadership and professional collaboration programs based on research and client voice. Denis has also been involved in building the Makarere-Columbia University Collaboration and presented at all four adolescent health conferences.*

Godfrey Zari Rukundo M.D., *Senior Lecturer, Mbarara University of Science and Technology; Child & Adolescent Psychiatrist, Mbarara Regional Referral Hospital Mbarara- Uganda.*



Charles Emma Ofwono, *SAHU Web Administrator and Network and Systems Administrator, He received the B.Sc. degree in Software engineering from Makerere University, Uganda, in 2012, and currently pursuing his M.Sc in Information Technology (online) from Walden University, Minneapolis, affiliated to Makerere University, Kampalan 1997, he joined Naguru Teenage Information and Health Centre, as a peer leader in the Post Test Club, and in 2010 became the club coordinator. Since March 2013, he has been with the Department of Monitoring and Evaluation, where he was ICT/Data Officer.*

NEWSLETTER SUBMISSIONS: The next newsletter will focus on DENTAL HEALTH and will be published in NOVEMBER 2016. SAHU members are encouraged to submit member news, program updates and interesting cases related to this newsletter topic with all patient identifiers removed. The editorial board will conduct a peer review process for all submissions. Submissions will be accepted from June 1st–September 15th, 2016. Please e-mail all submissions to: sabrinakitaka@yahoo.co.uk Thank you beforehand for your participation.

Overview SAHU'S Third Clinical and Scientic Meeting

April 20-21, 2016 Hotel Africana Kampla, Uganda

Submitted by Dr. Sabrina Bakeera- Kitaka

Meeting Theme:

Above and beyond: Caring for the Adolescent Patient

Meeting sub themes were:

Prevention of risk among adolescents
Adolescent-specific programs
Comprehensive adolescent health care
Motivational Interviewing

The theme for this year's conference was carefully selected to include and engage all key stakeholders who are much needed to envelope the resurgence in interest of the adolescent individual. The meeting was fully sponsored by the Global Health Grant through the Department of Pediatrics at Columbia University in New York for all the financial, and technical support and the Department of Paediatrics and Child health Makerere University. There were a total of 112 participants including providers from Tanzania, Kenya, rural areas of Uganda, and Kampala. There were oral abstracts, poster presentations as well as keynote addresses and plenaries from faculty from Makerere, Columbia and the Naguru Teenage Center. The resolutions from this conference included strengthening of sexual and reproductive health rights, as well as meaningful engagement of adolescents irrespective of their adolescent with hearing impairment who was accompanied by her translator. This young lady demonstrated the importance of reaching out to the hard to reach adolescents who often times fall through the cracks of care.

STAY TUNED!

All presentations, detailed conference proceedings and pictures will be posted to www.sahu.ug.

The relevance of conducting a conference dedicated to adolescence lies in the fact that although adolescence appears to be a relatively healthy period of life, this population (24% of the national population) has a relatively high burden of disease (more than 33% of the disease burden). According to the World Health Organization, one in every five people in the world is an adolescent, and 85% of them live in developing countries. Nearly two thirds of premature deaths and one third of the total disease burden in adults are associated with conditions or behaviours that began in youth, including tobacco use, a lack of physical activity, unprotected sex or exposure to violence. Almost 28% of maternal deaths in Uganda are attributed to young girls aged 15–24 years and 60% of premature deaths among adults are associated with behaviors or conditions that began or occurred during adolescence. Although declining, Uganda still has one of the highest rates of adolescent pregnancy and HIV incidence among young people in

Sub-Saharan Africa. Overall teenage birth rate or proportion of births per

1000 women aged 15-19 years decreased from 204 to 135 between 1995 and 2011 with 24% giving birth to their first child before turning 19 years. This is a manifestation of early sex debut and unprotected sex and associated with a range of complications such as unsafe abortions, obstructed labor and obstetric fistulae.

Adolescent health needs to be prioritized to enable the adolescents to transition into healthy and responsible adults.

This can best be accomplished if all adults caring for our adolescent population (health care providers, parents, teachers, and the community leaders for example) come together and serve as compassionate understanding non-judgmental mentors who help guide this vibrant population as they navigate their path towards adulthood.

The Society of Adolescent Health in Uganda (SAHU)

SAHU is a multidisciplinary society devoted to advancing the health and well being of adolescents. It was founded in December 2012 following a regional training in Kampala that was led by experts from Columbia and Makerere Universities and the Naguru Teenage Information and Heath Centre. We strive to bring together a community of providers interested in promoting comprehensive adolescent health, growth and development in Uganda and Africa through knowledge dissemination, research, advocacy and affiliation with other societies and bodies involved in adolescent health. The goal is that through these efforts the SAHU community will help provide the opportunity for each and every adolescent to achieve his/her potential and grow into a healthy, responsible and independent adult.

YOU CAN BECOME A SAHU TEAM MEMBER NOW IT'S EASY

The membership form can be found on our website, **www.sahu.ug**, under the membership tab.

SAHU MEMBERSHIP:

30,000 UGX or $10 per person
Lifetime and institution membership is $150

#CelebratingWaitresses in Kabalaga; a Women's Day 2016 Commemoration

Submitted by Mr. Segawa Patrick Program Manager Public Health Ambassadors Uganda (PAHU)

Worldwide, women have been key in the contribution to social, economic, cultural and political achievement. The United Nations recently rolled out the sustainable development goal 5 that aims to achieve gender equality and empower all women and girls. The sustainable development goals seek to change the course of the 21st century by addressing key challenges such as poverty, inequality, and violence against women.

International Women's Day is annually held on March 8 to **celebrate women's** achievements throughout history and across nations. It is now also known as the United Nations (UN) **Day** for **Women's** Rights and this year's theme was dubbed "Equality for Girls and Women."

Public Health Ambassadors Uganda (PHAU) in partnership with AIDS Healthcare Foundation Uganda Cares hosted the Post International Women's Day Celebration 2016 on a bright sunny 12th day of March 2016 in Kikuba Mutwe –Kabalagala where they reached out to waitresses, barmaids and bartenders.

Kikubba –Mutwe – Kabalagala is one of the most densely populated suburbs of Kampala with many lodges, bars and restaurants. It is a place where men frequently go to "have fun". The majority of the work force is comprised of women and girls. Many bars stay active until the late morning hours with women working in long shifts to earn enough money to support their families. The female workers often also resort to commercial sex as a fast and cheap means of earning extra income. The male patrons frequently use alcohol, shisha and other drugs, which ends up placing the women and girls at risk of sexual harassment, gender and domestic based violence that also results in an increased risk of contracting HIV/AIDS, STIs and unplanned pregnancy. In fact it is well know that there is high prevalence of sexual assault reported in kabalangala. Empowering these women and girls with improved knowledge on women's rights and entitlements could potentially help decrease this high rate of sexual assault.

This year's **International Women's Day** celebration focused on reaching out to this unprivileged community. The goal was to increase awareness on women and girl's rights and entitlements in relation to social, political and economic development in their communities with a theme ***'Celebrating waitresses.'***

The day started out with mobilization of the community by a number of youth barked by the Village Health Team (VHTs) who moved through Kikuba-Mutwe distributing and demonstrating the correct and consistent use of condoms and sensitizing women about

their health. The team gladly invited the locals to the official event that was hosted at St. John Baptist Primary School where there was free HIV Testing and Counseling (HCT) services, free Family Planning Services and free Cervical Cancer Screening services.

At the venue, the women were empowered through the use of themed creative and performance arts namely; spoken word poetry, themed dance pieces and inspirational talks by a team from AHF Uganda Cares and some outstanding women and girls who included Miss Y plus- Babirye Robinah.

Robinah gladly shared her story and encouraged many girls to carry the right mindset. She was born with HIV/AIDs but has become a champion in the fight against the scourge.

Robina Babirye – Miss YPlus 2015 giving an inspirational talk during the Post IWD 2016

Celebration in Kabalagala, Kikubba-Mutwe

"There are waitresses who are living with HIV/AIDS and these have a double disadvantage because they have to go through the challenges of living with the HIV/IADS as well as challenges of working as a waitress" added **Robina Babirye** – Miss Y Plus 2015.

A total of 380 people received free HCT services, 33 women were able to get cervical cancer screening and over 28,800 condoms had been distributed and women sensitized on the correct and consistent use of condoms. This cermony was a spendid display of health education with live music performed by Nassanga Ann aka Afrie where they sang the ***'tuli wamu nawe'*** song; an anti-stigma song aimed at raising awareness on the negative effects of HIV related stigma among others.

Dr. Lubanga of AHF Uganda Cares stated, "young people and women should stay busy, productive and not indulge in risky sexual behaviors that could lead to the spread of HIV/AIDS and also informed the audience that cervical cancer can be transmitted through unprotected sex"

PHAU Peer educators conducting a condom distribution drive during the Post IWD 2016 celebration in Kabalagala, Kikubba Mutwe

As we seek to promote gender equality and empower all women and girls worldwide, we should aim to reach out to all communities where women are seen as second class citizens and vulnerable to abuse. As noted above, bar maids and waitresses in kabalagala are women who struggle to support their families and work in arenas that place them at risk of sexual assault. It was against this background that we celebrated this group of women hoping to help empower them to assert their rights

Live performance by Afrie during the Post IWD 2016 celebrattion in Kabalagala – Kikubba Mutwe.

Public Health Ambassadors Uganda
Prevent. Promote. Protect.

Public Health Ambassadors Uganda (PHAU) is registered not for profit youth led organization comprised of young people from different academic backgrounds that are passionate and interested in addressing key sexual and reproductive health issues in their own communities using health promotion, youth empowerment, advocacy and social entrepreneurship.

This event was supported by African Women's Development Fund (AWDF), AHF Uganda Cares, VHTs and local Leaders from Kabalagala – Kikubba Mutwe. To follow the project activities, check out our Facebook, Twitter, YouTube and Vimeo.

#Empowering Young People in Rural Western Uganda

The Profile of Innovation Program for Community Transformation (InPact)

Submitted by Alvin Muhwezi

InPact
INNOVATION PROGRAM FOR COMMUNITY TRANSFORMATION

InPact
MEDICAL CENTRE

Innovation Program for Community Transformation (InPact) is a non-profit Ugandan organization established in 2010. InPact works to improve the health and wellbeing of young people aged 10-30 years in Kanungu district (South Western Uganda). Our community transformation programs are designed to mobilize and apply energies, creativity and innovation of young people in implementation of high impact interventions that provide solutions to challenges and needs of Young people.

Our core intervention areas span through four major sectors of: **health,**

education, livelihoods, and the environment. InPact empowers young people through equipping them with productive skills, creating spaces for advocacy around issues that concern youth, increasing access to youth friendly services and youth sensitive information and gender equity in all we do.

Vision: A healthy and vibrant community.

Mission: To empower young people to access the full range of comprehensive services critical to living healthy and productive lives.

Strategic Objectives:

SO 1: Expand access to a broad range of reproductive health services at facility and community level.

SO 2: Enhance access to and use of life saving maternal, newborn & child health (MNCH) information and services among young adults of reproductive age.

SO 3: Advocate for girls' education and retention in schools.

SO 4: Improve household incomes, food security and nutrition.

SO 5: Promote community based environmental conservation.

OUR WORK

Health: We focus on expanding access to a broad range of health services at facility and community level. InPact specifically works to increase access to affordable, high quality health care for all communities across Kanungu district. Our health care services include, Maternal, Newborn and Child Health (MNCH), Reproductive Health, management of a range of Non Communicable Diseases, Mental Health and broader primary health care services.

Education: InPact advocates for girls' education and retention in schools. In this area, we provide full scholarships to selected girls in secondary school, promote school based health and sanitation, and advocate for better policies and learning conditions for the girl child in schools.

Livelihoods: Improved household incomes, food security and nutrition are a prerequisite for improved livelihoods. We prioritize promotion of agriculture among young people as a socio-economic alternative both for improving household income through 'farming as a business' centered approach and also to boost household food security and nutrition.

Environment Conservation: We promote community based environmental conservation through education, community awareness and advocacy targeting households and communities. InPact works with communities to improve their ability to use natural resources more productively, and to diversify their income sources away from dependence upon natural resources alone.

INPACT MEDICAL CENTER.

Established in 2014, InPact Medical Center aims to provide high-quality, accessible youth friendly healthcare services to adolescents and other community members in Kanungu District, with an emphasis on Adolescent Sexual and Reproductive Health (ASRH), and Maternal, Newborn and Child health (MNCH).

InPact Medical Center was set up originally to support young people and particularly adolescent girls access contraceptives and other reproductive health services at an affordable rate, and in a convenient and safe environment. However, we soon found that these adolescents preferred to receive additional services at the same premises during their reproductive health visits, including bringing along their peers, children and partners for additional health services. As a result, InPact Medical Center has expanded the scope of its services to include the full range of primary health care.

Key Services Delivered:

InPact Medical Center is open 24 hours a day on a walk-in basis. We mostly run an outpatient program, with limited in-patient services mostly for our MNCH program.

As part of our community wellness initative, the center provides a number of free health services including free HIV Counseling and Testing, free Hypertension and Diabetes screening, free contraceptives for sexually active adolescent girls, free condoms, and community health talks on a weekly basis at the center.

We also conduct community health outreach programs, where medical teams from the facility go to the hard-to-reach communities across Kanungu district and take the health care services to those families.

CLIENTS SERVED SO FAR

Family Planning Services (inc. contraceptives)

2014:

Implants	Injectable	Emergency Contraception	Oral Contraceptives – Pill Plan	Condoms	Total
____	169	65	131	414	779

2015:

Implants	Injectable	Emergency Contraception	Oral Contraceptives – Pill Plan	Condoms	Total
60	126	48	144	715	1093

2016 (As of April):

Implants	Injectable	Emergency Contraception	Oral Contraceptives – Pill Plan	Condoms	Total
24	**179**	**18**	**100**	**512**	**833**

Maternal, Newborn and Child Health (MNCH)

Antenatal Visits	ANC1	ANC2	ANC3	ANC4	Deliveries	Referrals
2014	56	41	35	22	49	5
2015	71	64	48	27	63	8
2016 (As of April).	33	29	18	11	17	1

Other Services Provided.

Services	Malaria		HCT		RPR		Urinalysis		BAT		Typhoid (TST)	
Gender	F	M	F	M	F	M	F	M	F	M	F	M
2014	119	109	101	96	36	30	30	27	38	27	41	28
2015	102	89	111	109	54	31	27	33	30	31	37	40
2016 (As of April).	40	20	69	20	56	20	56	19	20	11	30	22

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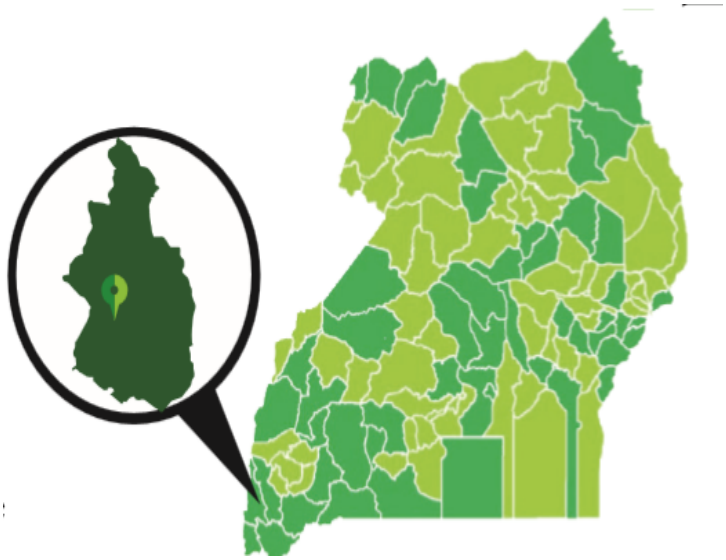
Alvin Bio:

A Professional Social Worker, Alvin has more than 10 years' experience in community development, empowering vulnerable communities to meet their basic needs and transform into healthy and productive members of society.

Alvin is the founding director on Innovation Program for Community Transformation (InPact), a Not-for-Profit organization that strives to improve the health and wellbeing of communities in South Western Uganda. Running an organization that is directly involved in grassroots development work has propelled Alvin into strategic programming, planning and innovation driven community engagement. Alvin brings breadth of experience managing public and private sector projects and interventions focused on achieving sustainable development

KANUNGU DISTRICT LOCATION



Alvin Muhwezi - InPact's Founder and Executive Director

Figure 1: InPact Medical Center Staff in the field providing free health services

Figure 3: An expectant mother being examined by our staff.

Figure 2: InPact's Laboratory Technician carrying out some tests in our Lab.

Figure 4: A health talk organized for young people at the InPact premises.

Figure 5: InPact also uses sports as an avenue to reach adolescents particularly young men with health messages and services.

Figure 7: Alvin Meeting with the Rt.Hon. Prime Minister of Uganda in 2015 to make a case for better youth service delivery in Kanungu district.

Figure 6: Alvin Muhwezi (Center) the InPact Founding Director with UNFPA Uganda Country Representative - Ms. Esperance Fundira (Left) and Kanungu District Local Council V Chairperson Ms. Josephine Kasya - Right.

Mbarara Epilepsy Project: Training to Improve Assessment and Treatment of Epilepsy in Children and Adolescents in South Western Uganda

Submitted by Godfrey Zari Rukundo
MBChB, MMed Psych, PCAP, PhD

There is evidence that epilepsy accounts for more than 60% of patients seen in outpatient and outreach mental health services in South Western Uganda (Byaruhanga et al, 2008). Yet, there is only one neurologist in the region. Similar to many African countries, most epilepsy patients receive medical care within mental health services. These are limited to those provided within regional or national referral hospitals.

In 2013, East London NHS Trust, Mbarara University of Science and Technology, Mbarara Regional Referral Hospital (MRRH) were given a start-up grant from THET to do a needs assessment relating to accessibility of epilepsy services in South Western Uganda. A stakeholders conference was held in Mbarara, titled 'Improving Access to Services for People With Epilepsy with 48 stakeholders in attendance, including representatives from the Ministry of Health, service providers, Epilepsy Support Association Uganda (ESAU), traditional healers, service users and community leaders. The conference was successful in raising awareness of the scale of the problem of epilepsy in Uganda and it generated both ideas and momentum for how the problem could be best addressed. Through the process of the conference and meetings we learned that there are many challenges in this area:

- There is limited knowledge about epilepsy in the community and there are many common myths about its causes, meaning and transmission.
- Epilepsy is heavily stigmatised so that children are hidden away or treatment is sought from traditional healers rather than seeking a service from medical professionals.
- Children with epilepsy in schools are discriminated against and often not educated.
- An estimated 80% of people with epilepsy in the country are still not getting treated, and an estimated 80% of the information about epilepsy available to communities is inaccurate.
- Often help from medical services is only sought after uncontrolled seizures have led to irreversible brain damage.
- Village Health Teams and primary health care workers who are best placed to deliver community education about the illness, and to assess the need for treatment, have little knowledge about epilepsy and its management.
- Apart from some local outreach clinics, most patients have to travel long distances to access services at MRRH and their attendance for follow-up appointments is unreliable,

resulting in medication treatment being interrupted.
- The skills and knowledge even of specialist mental health staff in the diagnosis and treatment of the different sorts of epilepsy are limited.

This project aims to build local capacity for the early assessment, recognition and treatment of epilepsy. We plan to do this by first training mental health workers at MRRH in better recognition, understanding and management of epilepsy and in training skills. This training will then be cascaded by members of this cohort into two sub-counties of Mbarara to train health workers at the primary care level so that they will be able to recognise and treat epilepsy more effectively. Village Health Teams in the two sub-counties will also be trained so that they will be able to recognise and refer children and young people with epilepsy. The introduction of such knowledge into local communities would result in:

- Opportunities for those trained to share what they have learnt more widely throughout populations in these communities.
- More children and young people with epilepsy will be identified earlier, and their parents directed towards appropriate medical care.
- More straightforward treatment provision will be delivered locally by primary health care workers, reducing the need for patients to undertake journeys to MRRH, and therefore patients will receive more accessible, uninterrupted and effective care.

The project will thus increase the skills of specialist mental health workers to assess and treat children and adolescents with epilepsy presenting to tertiary care, and also improve management of epilepsy in the community.

This project is being implemented by Mbarara University of Science and Technology, Mbarara Regional Referral hospital and East London NHS Trust through a funding from the Tropical Health Educational Trust (THET).

Motivational Interviewing

Submitted by Dr. Melanie Gold, Professor Pediatrics Columbia University and Population & Family Health, Mailman School of Public Health, Medical Director, School Based Health Centers, New York Presbyterian Hospital & Melissa Dunn Columbia University, Mailman School of Public Health, Expected Graduation May 2017, Masters Candidate Department of Population & Family Health, Certificate: Child, Youth and Family Health

Introduction to Motivational Interviewing (MI)

What is the definition and spirit of MI?
MI is a collaborative, goal-oriented style of talking with patients about their behavior with particular attention paid to the language of change. The conversation is designed to strengthen patients' personal motivation for and

commitment to a specific goal by eliciting and exploring patients' own reasons for change within an atmosphere of acceptance and compassion.

In general, people are more likely to make changes when *they* come up with the ways that would best work for them rather than being told what they need to do by others!

In MI, patients are viewed as experts about themselves and their experiences, goals, values, beliefs, and resources. The patient and physician both share information allowing the patient to both come up with the motivations for starting and maintaining health behavior changes and then determine the pace for these changes.

A central part of MI is supporting autonomy, which is accomplished by the medical provider recognizing that the patient has the freedom of choice to make health behavior change or not. In practice, this is demonstrated by statements such as: "You are the best judge of if and when you want to make a change, and how you will be most successful in this change when you are ready."

Another important part of MI is affirmation, where the medical provider acknowledges a patient's strengths or efforts related to making health behavior change. This is accomplished by making statements which give voice to the individual patient's strengths and/or efforts, such as: "You are a very strong and resourceful person with clear reasons for why you want to make some changes. It must feel good to know you can apply what you have learned from past successes to being successful with this too."

What are the Core Communication Skills of MI?

There are four essential MI communication skills that allow medical providers to most effectively engage patients in conversations about their readiness to make health behavior changes.

Open-ended questions are questions that encourage patients to do most of the talking and to share their experience and perspectives on making health behavior change. These are different from closed questions, which can be answered with "yes" or "no" or other short answers.

> ***Open:*** Can you tell me about your family? What is your diet like? How do you feel about your current method of birth control?
> ***Closed:*** How many siblings do you have? Do you think you have a healthy diet? Did you use condoms with your last partner?

Affirmations are statements that recognize and comment on a patient's strengths, abilities, good intentions, and efforts related to health behavior change.

Example: I appreciate how hard it must have been for you to come in and talk with me about this. Thank you for being so honest.

Reflective listening is the use of statements that paraphrase what the patient has said or what you think the patient feels or means. These types of statements show the patient that you have been listening and that you understand what they are communicating to you.

Example: So you are not sure that you are ready to make a change, and at the same time you know that your drug use has affected your work, relationships and health, and this makes you anxious.

Summaries are strings of reflections that recount previous statements a patient has said throughout the encounter and put them together to motivate behavior change.

Example: You said earlier that you're not using condoms with your boyfriend because he doesn't like them. At the same time, you want to go to university next year to get a teaching degree, and you don't think that this would be a good time in your life to have a baby. You also think it's possible that your boyfriend has been with other girls since you have been together.

What are the three Communication Styles and how do they fit in with MI?
There are 3 communication styles:

- **Directing** by informing a lot, asking a little and listening very little: "I know what you should do, and here is how to do it."
- **Following** by listening a lot, asking a bit and informing a little: "I trust your own wisdom, and I will stay with you and let you work this out in your own way."
- **Guiding** by providing equal proportions of informing, asking open-ended questions and being a good, compassionate listener, and offering expertise when needed. This style falls in between directing and following, and is used in MI.

All three of these communication styles are necessary in different circumstances, and skillful medical providers shift flexibly among these styles as appropriate to the patient and situation.

How can you give Medical Information and Advice using MI?
Ask-Tell-Ask is an example for how to incorporate the spirit of MI. There are four steps:

Step 1. Ask the patient what she knows about the topic and/or what options she knows of for behavior change. You might stop here if the patient has all the accurate information or suggestions needed to move onto the next step of planning

for change. If the patient knows all she needs to make behavior change, affirm how smart and resourceful she is and move on to planning first steps and asking how you can assist.

Step 2. Ask permission to give information or advice that might help. Patients nearly always say "Yes," but be prepared for what to say if the patient refuses! When a patient says, "No," it can be helpful to support their autonomy by saying, "I appreciate your being honest about what information you want or need. You know best what is most useful or helpful to you right now. In the future, if you want any information or suggestions, just let me know. So what would be most useful to you now?"

Step 3. If the patient says, "Yes" (e.g. gives permission), provide information or advice in short chunks, not a long diatribe, and then go to the next step before offering more information or advice.

Step 4. Ask for the patient's reaction to the information or advice you've provided by asking, "What do you make of this information / these options? How does this help you or change things?

If the patient is ready to make a change related to a particular behavior, help the patient start small. Decide on a few concrete changes (never more than 3) that are realistic and achievable. Suggest early follow-up to assess progress and make revisions to the plan as needed.

Motivational Interviewing with Adolescents Around the World: Literature Review

Over the past three decades, MI has been employed around the world in studies focusing on a range of topics, from medication adherence to weight loss to alcohol abuse treatment[1,2,3]. The use of MI in studies with adolescents is more recent, but multiple studies have shown the impact that using MI with adolescents can have in a variety of health care topics[4].

Aims: To date, evidence supports the use of MI for a variety of health behaviors, with a growing compendium of research showing the benefits of MI use with adolescents. The aim of this review was to examine successful uses of MI with patients in Africa, and with health behaviors that Ugandan health workers see frequently with their adolescent patients.

Methods

Study Design: We took three steps to identify articles for this review. First, we searched electronic databases for pertinent articles published since 2000. Next, we narrowed down the list based on location, use of strict MI practices, and conditions treated regularly by healthcare providers who work with adolescents. Finally, we submitted the list of articles to a Ugandan pediatrician/adolescent medicine

physician and the director of training at a local teenage health and information center for review. They highlighted the articles that they felt were most important to include in this review, based on the cases being both instructive and typical of cases they see in their daily practice.

Inclusion and exclusion criteria: To address the aims of this review, articles were considered using several inclusion criteria. Inclusion criteria were: (1) article was in English, (2) article was written between 2000 and 2016, (3) article was published in a peer-reviewed journal, and (4) patients in the article were under the age of 19 years. Exclusion criteria were: (1) article did not use Motivational Interviewing, (2) article combined Motivational Interviewing with another health behavior strategy, (3) article discussed health behaviors that were outside of the scope of what an adolescent medicine provider would typically encounter, such as glaucoma treatment, and (4) article was a meta-analysis or review article of studies.

Search strategies: Using these review steps, we examined the literature for articles that used Motivational Interviewing with adolescents on health behaviors that healthcare providers regularly see. First, we conducted searches on PubMed, the Columbia University Libraries/ Information Services System, and Google Scholar to locate peer reviewed articles published between 2000 and 2016. Keywords were "motivational interview AND adolescents," "motivational interview AND adolescents AND sub-Saharan Africa," "motivational interview AND adolescents AND Africa," "motivational interview AND adolescents AND Uganda," "motivational interview AND adolescents AND East Africa," ""motivational interview AND Africa," "motivational interview AND Uganda." Second, any meta-analyses found were reviewed for relevant reference studies.

Results

Substance Abuse: MI has been used many times to treat substance abuse and help adolescents achieve substance cessation. MI allows health care providers to engage an adolescent who abuses substances in a conversation about their own health. Asking questions, listening, and responding to the patient's ideas can be tremendously effective in facilitating health behavior change.

One core question is how many sessions of MI are necessary for an adolescent to make a health behavior change. A 2005 quasi-experimental pilot study was conducted in England to determine if a single session of MI with a teen struggling with drinking alcohol, or smoking cigarettes or cannabis, could lead to reductions in use. The study took place at three colleges in London, and youth workers trained in MI recruited participants during their regular meetings and interactions with students. A total of 162 adolescents (mean age 17 years) participated, and 59

adolescents received MI. Follow-up was conducted at three months to determine the extent of behavior change. At the three month follow-up, those who had received a single session of MI were more likely than their control counterparts to have attempted to quit smoking since their MI session, and had cut down drinking alcohol by an average of two days per month compared to the control group[5].

A 2007 randomized control trial conducted in the Western Cape, South Africa, used five sessions of MI to reduce Alcohol Exposed Pregnancy among women of reproductive age. The 165 participants ranged in age from 18-44 years old. The five sessions of MI were conducted as follows:

- Session 1 aimed to build rapport and set the agenda for participants' five-session program
- Session 2 focused on assessing participants' readiness to change and perceived confidence in enacting behavior change
- Session 3 involved developing a behavior change (BC) plan and assisting with action plans
- Session 4 focused on implementing the BC plan, assessing challenges and problem solving
- Session 5 reviewed the counseling experience and progress, reinforced an after-care plan and referred the client, when necessary[6].

Of the participants, 82 women were randomized to receive the MI intervention, 31 were put in a life skills group, and 83 women were randomized to a control group. Structured questionnaires about the participants' drinking were administered at baseline, and then 3 and 12 months after the intervention using questionnaires and in-person interviews. The study found that the women who received MI were more than twice as likely as those in the control group to take actions hat reduced their risk of an Alcohol Exposed Pregnancy.

HIV Treatment Adherence: Treatment adherence is a proven way to prevent many of the negative long-term health effects of HIV infection. Getting adolescents to commit to and follow through with an HIV treatment regimen is critical for their own health and the health of their partners. A randomized control trial of HIV-infected young adults (16-29 years old), conducted in Detroit, MI between 2003 and 2005, assessed the impact of MI on adherence to an HIV treatment program[7]. Either a peer outreach worker or a health professional delivered the MI. The intervention consisted of a 30-45 minute MI session focusing on treatment and current behaviors, and both the peer outreach workers and professionals used standard MI practices during the session. At the end of the session, adolescents completed a change plan with their intended health behavior changes written down. The treatment consisted of a baseline session of MI,

and another six months later. Both groups saw high retention in primary care and treatment, suggesting that MI is a useful tool to employ for treatment retention of HIV-infected adolescents.

A 2014 quasi-experimental study in Mexico explored the use of MI with the parents of HIV-infected children[8]. The study was conducted in San Luis Potosi, Mexico, and the average age of children enrolled in the study was six years old. At such an age, a child is completely dependent on their caregiver to ensure their adherence to HIV treatment. During the study, parents were engaged in MI between three and five times over the course of the year. The conversations focused on ensuring the child consistently received their required care. Compared to baseline data, treatment adherence increased markedly among the HIV-infected children by the end of the one-year study.

In 2005-2007, a multi-site study in the US used MI to increase treatment adherence and reduce risk behaviors in HIV positive youth, ages 16-24 years[9]. The study involved 92 HIV-infected youth from five locations in the United States participating in four MI sessions over the course of ten weeks. During the first two sessions youth set their behavior change plan; during the second two sessions they reviewed their plans and problem-solved around barriers they faced. Six and nine months after the intervention, viral load was measured for both those who had undergone MI and the control group. At six months, there was a statistically significant difference in viral load between the two groups, with those who had participated in MI having significantly lower viral loads than the control groups.

MI has also been used with HIV-infected adults around the world with positive outcomes. HIV infected adults in the United States who participated in MI interventions reported increased levels of self-efficacy when it came to practicing safe sex[10]. A Thai study of 16-25 year old HIV infected men who has sex with men found that MI was effective in decreasing the amount and frequency of risky sex the men engaged in[11]. A 2012 study of HIV infected women in Uganda engaged participants in weekly group MI sessions[12]. The study found that after 8 weeks, women who participated in the MI sessions had statistically significant higher levels of treatment adherence than women in the control group.

Unintended pregnancy: A 2002 study in rural Colorado used MI to increase contraceptive use among at-risk female adolescents[13]. The adolescents were selected for the trial after answering a screening survey in which they indicated that they either wanted to get pregnant or were ambivalent about pregnancy. These adolescents were also not currently on contraception and their partners rarely, if ever, used condoms during sex. In order to delay pregnancy or prevent unwanted pregnancies, the

teens participated in individual MI sessions. During the sessions, providers asked them about their future plans, goals, and intentions, and asked if they would consider trying contraception for a brief period. Participants did not have a set number of follow up appointments, and the female adolescent came back between 1 and 13 times over the next 10 months. Each time they returned, they received MI from a medical provider. By the end of the 10-month period, one third of the participants who originally said they would not start contraception had initiated a course of oral contraceptives. Interestingly, most of the women who started taking contraception began only after a third or fourth visit to the clinic, suggesting that the number of doses of MI may have impacted the women's decision to start contraception.

MI has also been used as a tool to reduce rapid subsequent births in young mothers[14]. According to a 2003 study, almost one-fourth of adolescent mothers gave birth to another child within two years of having a baby. The study aimed to use MI with adolescent mothers in Baltimore, Maryland to reduce the number of women who became pregnant within two years of giving birth. To do this, the health care workers visited the adolescents' homes quarterly, starting six weeks after they gave birth. The adolescent mothers were followed for two years. Two groups received MI treatment, and one control group did not. Adolescent mothers were eligible for a maximum of eight MI session, but the study found that those who participated in just two sessions of MI had a significantly lower rate of becoming pregnant again within two years of giving birth compared to the control group. The study found evidence that "motivational intervention, conducted by paraprofessionals in community-based settings, is effective in reducing a subsequent birth within 24 months to low-income, African-American teenage mothers" when compared to the national average and the control group.

Finally, MI was used as part of a computer-assisted MI intervention aimed at reducing the risk of female adolescents having unprotected sexual intercourse. Investigators in Pittsburgh, PA conducted a 9-month, longitudinal randomized controlled trial comparing MI to didactic educational counseling with 572 female adolescents. The participants had a mean age of 17 years (range 13-21 years) and 59% were African American. Compared to the didactic educational counseling, there was a significant effect of the MI intervention in reducing unprotected sex among those adolescents who completed the intervention[15].

Conclusions

MI is a well-documented skill that engages adolescent patients and medical providers in dialogues about health behavior change. When medical providers ask open-ended questions and use reflective listening, adolescent patients come up with their own action

plans to change their health behaviors and commit themselves to a course of action. MI has been used to help adolescents commit to and maintain weight loss, adhere to medications, and practice safer sex.

Much of the MI research has been conducted with adults. However, there is a growing body of literature about the efficacy of MI with adolescents. This literature review assessed ways in which MI has been used with adolescents around the world to decrease substance abuse, increase HIV treatment adherence, and prevent unintended pregnancies. The studies presented in this review show that different doses of MI have been successful, and MI conducted by peer workers and home visitors as well as doctors can have profound impacts on health behaviors. Overall, there is clear evidence that MI is an effective tool to use when working with adolescents to facilitate health behavior change.

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Let's see how MI can be used with two Challenging Cases in Uganda

Case 1, RT:

RT is a 17-year-old male Ugandan who presented to the Friday Adolescent Clinic. His key complaints are general malaise, fever, and a cough for 3 days. The physician conducts a psychosocial assessment and RT reports that he is living with his 8 year old brother and his mother, who sells alcohol for a living. RT is responsible for paying his brother's school fees and helping to support his family. His father is living away from home in their rural town and does not support the family financially. RT dropped out of school in P.4, at 11 years of age. He is currently doing odd jobs for a living. He smokes occasionally, including cannabis, and drinks alcohol several days a week. He recently broke up with his 20-year-old girlfriend of two years because he could not cope with her financial demands. Some of his friends are street children, and once in a while he participates in pickpocketing; the police chased him a few months prior to his presentation at the clinic. He reports sniffing aero fuel and glue occasionally. Physically he appears well, but is dramatic in his appearance with brightly bleached, multicolored long hair. Significant finding on his systemic examination included: a high temperature of 39 C, tachycardia of 120/min, and inflamed tonsils. He is confirmed to have P. falciparum malaria (blood smear was 3+). He is treated for malaria and acute tonsillitis.

Questions to consider before reading the case reflection:

What do you think the patient should do?

What do you want to tell him to do?

What information do you think would be useful?

How would you find out what information RT has and what he wants to do?

Case Reflection:
MI Counseling Approach:

As medical providers, based on RT's history, we likely feel that RT would benefit from changing a number of behaviors including:

- Reducing or stopping smoking tobacco and cannabis, drinking alcohol, and sniffing aero fuel and glue
- Changing his appearance by cutting his hair and/or changing the color
- Stopping pickpocketing
- Getting a job and staying off the streets

If we simply *tell* RT to stop his unhealthy behaviors, cut his hair and go get a job, the chance of successfully effecting any change is unlikely.

REMEMBER, people are more likely to make changes when they come up with the ways that would best work for them rather than being told by others what they need to do!

The use of MI techniques may help RT come up with ways that he can begin to make healthy choices and thereby improve the chance for successful change.

THE ASK-TELL-ASK APPROACH

ASK:

The medical provider might start by asking RT if it is okay to discuss some of his behavioral choices in order to get a better understanding of RT's perception of the consequences of these behaviors. If RT says yes, the medical provider can ask RT about his understanding of the risks of tobacco, alcohol and drug use, and the potential consequences of pickpocketing. The medical provider can also ask what RT thinks about how his hair might affect his employment opportunities.

TELL:

As long as RT agrees, the medical provider can fill in any gaps of knowledge related to the risks of tobacco, alcohol and drug use, and the potential consequences of pickpocketing. Information should be brief and to the point so as not to overwhelm RT. The medical provider might also explain to RT, if RT has not already mentioned it, how his hair might impact his chances of getting a job.

ASK:

The medical provider can ask RT what he thinks about the information he has been given, and also ask how this information impacts RT's decision about making any changes.

Assuming RT has some information about drugs, alcohol and cannabis, and that he has given the medical provider permission to fill in gaps of knowledge and discuss concerns related to RT's appearance, here is an example of what the conversation might look like next:

Medical Provider: RT, thank you for your honesty and for allowing us to discuss some of the choices you have been making. You have an impressive understanding about the risks of drugs, alcohol and smoking cannabis, and you are committed to supporting your family. I also appreciate your allowing me to share with you information I have about drug and alcohol use and some concerns I have about how your appearance might affect your job opportunities. (*Affirmation*) What do you make of this information? (*Open-ended question*)

RT: It has been very useful. I never really knew that there were so many long-term side effects of drug and alcohol use.

Medical Provider: I am glad that this information was helpful.

How might this information affect your decisions about changing any of your behaviors? (*Open-ended question*) You are the best judge of whether or not you would like to make any changes. (*Autonomy statement*)

RT: I think I want to focus on getting a job and staying off the streets. If I do that, then it will be easier to stop smoking cannabis, drinking alcohol and sniffing glue. Also, if I get a job I won't be tempted to pick pockets to pay for cigarettes, since I am really not interested in stopping smoking right now, and I'll have money from my job for other things. I'm tired of having the police chasing me, and my street friends just hang around all day getting high. I want to have a better life than that. Maybe I will stop smoking cigarettes in the future.

Medical Provider: You are very insightful and have a good understanding about how getting a job can help you change other unhealthy habits. (*Affirmation*) You really know yourself well and have decided that this is not the time to stop smoking cigarettes. (*Affirmation*) Would it be okay if I mentioned something about your appearance again? (*Open-ended question*)

RT: Sure.

Medical Provider: Since you want to get a job, it might be easier to find one if your hairstyle and color were more conservative. The Teen Center can help you get some interviews for a job, and you may want to present yourself as reliable and responsible. The multicolored hair might not be well received by conservative employers. But you know how much you are willing to make changes to find a job. (*Autonomy support*) What do you think? (*Open-ended question*)

RT: I like my hair this way, but I do see your point. I think I will be willing to change it if it will help me get a job.

Medical Provider: You want to keep your individuality and at the same time are willing to make some changes so that you can have the life you want in the future. (*Reflection*)

RT: That's right. It's a small price to pay for a better life.

Medical Provider: You know what you want for your future and don't want your hair to get in your way. (*Reflection*) What type of job might you consider? (*Open-ended question*)

RT: I don't know. I don't know where to begin to find a job.

Medical Provider: You know you don't want to keep living on the streets and you are also unsure where to begin to make changes. (*Reflection*) If it is okay, I can refer you to one of our counselors today who can help you, and then you and I can make an appointment for one month from now so we can check in and see how you are doing. How does that sound? (*Open-ended question*)

RT: That would be great!

Case 2, SZ:

SZ is a 16-year-old girl who lost her parents to HIV/AIDS. She currently lives with her auntie and uncle and is supported by a religious group for her education. SZ is on school holiday. SZ`s auntie works in the city center and returns home by 7:00pm. SZ is scared of her uncle because he repeatedly harasses her, insults her and often randomly hits her. After several months, SZ decides to tell her auntie about what is going on; her auntie does not believe her and says that this is not possible. SZ feels alone and isolated, and is unsure about what to do next. She is thankful that she will be returning to school in a few weeks and will therefore not be at home as much. A few days after SZ speaks to her auntie, SZ's uncle comes home mid-day and takes advantage of SZ and, against SZ's will, forcefully has sex with her. SZ is devastated and informs a neighbor, who tells her to visit the health center immediately to seek counseling and any other assistance. As SZ arrives at Naguru Teen Information and Health Center, she is welcomed and registered. She tells the medical provider that she wants to see a counselor.

Questions to consider before reading the case reflection:

What do you think the patient should do?

What do you want to tell her to do?

What information do you think would be useful?

How would you find out what information SZ has and what she wants to do?

Case Reflection:

As compared to Case 1, this case has the clear priority of assuring SZ's safety.

The typical standard approach directs care by telling SZ how unsafe her environment is, insisting that she leave, and telling her where she should go. Unfortunately, this approach often results in a teen defending the unhealthy living environment and refusing to hear and accept help, and ultimately remaining in an unsafe environment.

MI Counseling Approach:

COLLABORATIVE DISCUSSION USING THE ASK-TELL-ASK APPROACH

ASK:

Ask SZ about the good and not-so-good things about her living situation. Assess what SZ knows about the safety of her living situation, her legal rights, and her options for alternate living situations.

TELL: Ask permission to give information about where SZ might go for legal and social support and advice. The medical provider can share ways that she might prepare to leave and move to a safer environment. Additionally, the medical provider could offer support and explain that it is not uncommon to be upset and confused when bad things happen in a previously good situation.

ASK:

Ask SZ what she thinks of think of the advice given. Assess how she might like to proceed based on this advice.

Here is an example of what the conversation could look like using MI with specific MI skills in italics to illustrate open ended questions, reflections, affirmations, summaries, asking permission, and autonomy statements:

Provider: Hi SZ. Thank you for meeting with me today. I appreciate you sharing with us what has been going on at home. It took a lot of courage for you to come in today and tell us what is happening at home. (*Affirmation*) Your home situation should be one where you feel supported and cared for and safe. It seems like a number of unpleasant things have happened while living with your auntie and uncle. In the past, what were the good things about living with them? (*Open-ended question*)

SZ: Well, my auntie is one of my only remaining relatives. I know she loves me and has looked out for me for a long time, ever since my parents died, but she does not trust me now and that is upsetting.

Medical Provider: She has really been there for you in the past, and you are upset because she is not there for you now. (*Reflection*)

SZ: I don't want to sound ungrateful. She gives me a place to live and food to eat and supports me getting an education.

Medical Provider: There have been some good things about living with your auntie. (*Reflection*) What are other good things about your current situation? (*Open-ended question*)

SZ: My uncle helps out financially, and they live in a safe neighborhood.

Medical Provider: Your uncle has provided for you and your auntie financially, and you used to feel safe where you lived until recently. (*Reflection*)

SZ: It used to be better than it is right now.

Medical Provider: So how is it now? What is not so good about living with them? (*Open-ended question*)

SZ: It isn't a safe place to be anymore. I am so frightened of my uncle and that he will try to hurt me again.

Medical Provider: Although it used to be a safe place to be, now it feels very unsafe. (*Reflection*)

SZ: I am just so upset that my auntie doesn't believe me. Why won't she believe that he is hurting me?

Medical Provider: You hoped she would protect you. (*Reflection*)

SZ: I guess I have to take steps to protect myself.

Medical Provider: You are a strong person and you know you need to

protect yourself and not rely on your auntie to be your sole protector. (*Reflection*)

SZ: Yes, that is true.

Medical Provider: Let's review what you have said so far. On the one hand, your auntie has been taking care of you since your parents died, she has been providing you with a place to live as well as food and support, and the neighbourhood where they live is safe. At the same time, living with your auntie is no longer a safe and supportive place to be. Your uncle hurt you, your auntie doesn't believe you and is not protecting you, and you are very afraid your uncle will hurt you again. (*Summary)* What do you think would be the best option for you right now? (*Open-ended question*)

SZ: I think I need to find a new place to live. I can't risk staying there anymore. What are my options? Where will I go? What will I do?

Medical Provider: You are not sure what your options are and would like some help figuring out where to go where you will be safe. (*Reflection*)

SZ: Yes.

Medical Provider: I'll refer you to the counselor who can tell you what your options are. Perhaps together you can come up with other family members like grandparents or cousins with whom you could live during holidays when you are not away at school. How does that sound? (*Open- ended question*)

SZ: Great.

Provider: The counselor could also advise you about how to get legal advice.

SZ: I would never want to see a lawyer. These are my relatives and I would never want to hurt them.

Medical Provider: You are very protective of your family and you are sure about how you want to proceed. (*Reflection*)

SZ: Yes.

Medical Provider: You are a resilient person and know yourself well. (*Affirmation*) How would you feel about coming back to see me in two weeks so we can review what is going on? (*Open-ended question*)

SZ: I would really like that. Thank you.

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