Planning and Implementing a Statewide Soccer HIV Awareness and Health Promotion Intervention for African-born Men Living in the United States

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HIV remains a health crisis not only for Africans in Africa, but also for African-born individuals living in the United States (Kerani et al., 2008). In Massachusetts, African-born populations represented 33% of people born outside of the United States diagnosed with HIV from 2007 to 2009, the largest proportion of non-U.S.-born persons diagnosed in that period (Massachusetts Department of Public Health [MDPH], 2011). African-born females accounted for 46% of the HIV cases among foreign-born females diagnosed with HIV, while their male counterparts accounted for 24% of foreign-born males (MDPH, 2011). Heterosexual contact is the main mode of exposure for African-born individuals diagnosed with HIV (MDPH, 2011). Furthermore, 36% of recently diagnosed foreign-born residents, not specifically African-born individuals, were diagnosed with AIDS within 2 months of their initial diagnosis of HIV infection (MDPH, 2007). Another report established that African-born individuals with HIV were diagnosed at later stages of the disease than U.S.-born persons (Blanas et al., 2012).

African-born individuals' reluctance to use HIV services can be attributed to several factors: HIV stigma, lack of knowledge about available services, lack of culturally and linguistically appropriate services, xenophobia, immigration issues, education, gender, economic stressors, and special employment concerns (Feresu & Smith, 2013; Foley, 2005; Venters & Ganny, 2009). African-born individuals living with HIV are isolated by the African-born community for fear of contracting the disease through casual contact. A common belief is that the disease is a curse or divine punishment for immoral behaviors (Blanas et al., 2012). Consequently, HIV services, including testing, are used discreetly or not at all for fear of judgment and discrimination. Structural barriers for African-born individuals include the impact of immigration status on service eligibility criteria, proof of residence requirements at health centers, discrimination in medical settings, and language barriers (Blanas et al., 2012). Cultural beliefs and practices also influence the transmission of HIV by buttressing negative attitudes toward condom use and discouraging communication between partners about sexual practices (Feresu & Smith, 2013; Foley, 2005). Tackling these unique challenges will require programs and

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services to engage community members in a culturally and linguistically appropriate manner and include approaches that decrease structural barriers within community and clinical settings.

Birth of the African Health Cup

You change your steps according to the change in the rhythm of the drum.

Ewe (Ghanaian) proverb

The increasing number of African-born individuals newly diagnosed with HIV in Massachusetts led to a grassroots effort to advocate for needed resources, policies, and programs. The Africans For Improved Access (AFIA) program was formed in 2000 (Nnaji & Oyaniyi, in press) as a community coalition, quickly evolving into an HIV direct care service provider operating under the Multicultural AIDS Coalition, a nonprofit organization launched in 1989 to mobilize communities of color to end the HIV epidemic. The AFIA program was built on the principle that community-led approaches are central to identifying and implementing sustainable HIV prevention strategies. The African Health Cup (AHC) is one of the major innovative programs developed by AFIA in collaboration with community members.

The AHC was established in 2009 by launching a male-specific soccer outreach effort to recruit African-born men into AFIA's services, specifically HIV testing. Up until 2009, most of AFIA's clients had been African-born females. Because heterosexual sex is the main mode of transmission in African-born communities, engaging African-born men is critical to reducing HIV infections in the community. However, there are challenges. African-born males are less likely than their female counterparts to use health services because many of them work more than one job at low wages and lack job security, making it difficult to take time off from work to seek health services (unpublished qualitative data gathered by AFIA). Furthermore, they are reluctant to use health services because of experiences in their native countries where preventive health was not a priority (Foth, 2012). Thus, they are accustomed to seeking health care services only when seriously ill (Foth, 2012), leading to underdiagnosis of HIV (Venters & Ganny, 2009).

However, many African-born men allot time to meet weekly at soccer fields, either to play or to support a team. Soccer is a familiar source of socialization and entertainment that reminds them of their African homelands. Based on this, AFIA staff aggressively mapped the various soccer fields in Massachusetts cities with large African-born communities. More than 50% of the immigrant population in Massachusetts resides in 14 areas, including Boston, Waltham/Arlington, Lynn/Saugus, and Worcester (Immigrant Learning Center, Inc., 2009). In addition, Brockton, Lowell, Waltham, Lynn, and Malden had the highest proportion of people born outside the United States and diagnosed with HIV from 2007 to 2009 (MDPH, 2011). AFIA staff approached various soccer team leaders (coaches and captains) from the above-mentioned cities.

During the mapping stage, it was crucial to identify teams from each region of Africa–north, south, central, east, and west – because soccer teams developed by African-born communities were associated with specific African countries. AFIA staff began outreach activities with condom distribution and one-on-one HIV discussions. Outreach sessions progressed to a 10- to 15-minute group session, focused on HIV transmission and prevention, and typically included a request from a player to demonstrate the proper use of a male or female condom. Given the stigma surrounding HIV, some coaches were initially skeptical about whether the players would embrace HIV education on the soccer field, but after consistent and persistent messages about the impact of HIV on the community and the need to work together to address the epidemic, the coaches agreed. The key to encouraging African-born men to participate in HIV prevention and education was building and maintaining a trusting relationship with the coaches because they were respected within their teams, and they could influence players.

In the infancy of the soccer outreach activities, AFIA was actively involved with community teams representing Cameroon, Zambia, Liberia, Ghana, Somalia, Kenya, Uganda, and Togo. The leaders of these teams, spearheaded by Cameroon and Zambia team leaders, proposed the formation of an annual all-African soccer

tournament that embedded HIV prevention and education. The leaders contended that the proposed tournament would foster social cohesion and increase HIV awareness while decreasing HIV stigma among African-born males. As a result, in January 2010, AFIA convened a meeting with leaders of the aforementioned teams and other stakeholders, and the AHC was formed.

In developing the first AHC, team leaders identified related assets in the community, which included existing annual soccer tournaments targeting ethnic communities in Massachusetts: Worcester World Cup and One Lowell World Cup. The African teams participating in these tournaments introduced AFIA staff to the key organizers of Worcester World Cup and One Lowell World Cup, who in turn helped AFIA staff contract Massachusetts-certified referees and develop the rules and regulations of the AHC. In the first year of the AHC, six African community teams participated, growing rapidly to 12 teams in 2013 (Table 1). The six original teams, representing Cameroon, Ghana, Kenya, Liberia, Uganda, and Zambia, have participated in the AHC for 4 years.

Table 1. AHC Growth and Countries Represented

Year	Teams, *n*	Participants, *n*[a]	Countries Represented
2010	6	250	Cameroon, Ghana, Kenya, Liberia, Uganda, Zambia
2011	12	375	Cameroon, Ghana, Guinea, Ivory Coast, Kenya, Liberia, Somalia, South Africa, Tanzania, Togo, Uganda, Zambia
2012	12	415	Cameroon, Cape Verde, Ghana, Guinea, Ivory Coast, Kenya, Liberia, Nigeria, Sierra Leone, Togo, Uganda, Zambia
2013	12	500	Cameroon, Cape Verde, Ghana, Ivory Coast, Kenya, Liberia, Nigeria, Sierra Leone, Sudan, Tanzania, Uganda, Zambia

Note. AHC = African Health Cup.
a. Number of participants is an estimate of the total number of spectators, coaches, and registered players.

Planning the African Health Cup

If birds travel without coordination, they beat each other's wings.

Swahili proverb

The AHC is an annual 1-day event held in early July that has three main activities: (a) a soccer competition among teams, (b) HIV discussion sessions with participating players and team leaders, and (c) on-site health screenings that include HIV testing and screening for blood pressure, glucose, cholesterol, and body mass index. A planning committee, consisting of AFIA staff, team leaders (coaches and captains), students, health service providers, representatives of African civil and business organizations, and community members, meet from January to June. Subcommittees are charged with various responsibilities: assessing assets in the community; arranging with health providers to offer health screenings; advertising the event; recruiting and registering participating teams; reviewing the rules and regulations of the tournament; fundraising; contracting Massachusetts-certified referees to officiate matches; and recruiting-volunteers and vendors. Each subcommittee gives progress reports to the larger body at biweekly meetings, held in person or via teleconferences. A vital aspect of planning the AHC is preparing the participating teams to adhere to the rules and regulations of the tournament (Table 2).

Consistent with soccer tradition, trophies and medals are awarded to the first- and second-place winners and the most valuable player. Besides these traditional incentives, a special trophy is given to the most disciplined team to cultivate sportsmanship and compliance with the tournament's rules. For the purpose of the AHC, the most disciplined team is defined as a team that complies with rules, including the ground rules for the 30-minute HIV group session, and exhibits sportsmanship on the field of play.

Planning also entails partnering with local health centers and volunteer groups to perform health screenings and first-aid services, and to arrange for vans where on-site screenings are conducted. In previous tournaments, AFIA's partners have been Lowell Community Health Center and Whittier Street Health Center (Roxbury, Massachusetts).

The subcommittee responsible for promotion collaborates with African media organizations to market

Table 2. African Health Cup Tournament Rules

Rule Category	Brief Description
Application	Team registration begins in March and ends in May of each year. The nonrefundable registration fee for each team is $200.
Composition of Team	Each team may register up to 25 players and two technical staff. Players must be 18 years of age or older. Each team may register 5 non-African-born individuals.
Ceremony/Education	Each team is required to participate in a 30-minute discussion session on HIV prevention education before playing the first game.
Waivers/Release/Rules	All players must sign a liability release form prior to playing.
Game Start and Forfeits	Teams must appear on the field 10 minutes before the start of each scheduled match. Teams failing to show up on the field at their scheduled game time will forfeit, and the score will be 3-0 in favor of the opposing team.
Game Duration	Elimination Stage: 25 minutes per half plus a 5-minute half time break. Semi Finals Stage: 30 minutes per half plus a 10-minute half time break. Final Stage: 45 minutes per half plus a 10-minute half time break.
Substitutions	Unlimited substitutions will be allowed throughout the tournament with the referees' permission.
Rules for Advancement	Game points: A win earns 3 points, a tie earns 1 point, and a loss earns 0 points. If teams in the same group are tied in position in the elimination round, the team moving to the next stage will be determined by one of the following methods: goal differential or FIFA penalty kicks. If teams are tied in the semifinal and final, the winner will be determined by the FIFA penalty kick method.
Awards	The first place winner will receive a trophy, a gold medal for each registered member, and a cash prize. The second place winner will receive a cash prize and a silver medal for each registered member. The most disciplined team and Most Valuable Player will receive a trophy.
Officiating	Certified semiprofessional referees will officiate at all matches. Teams will not sit on the same side of the field, as determined by the tournament officials and referees. Only coaches and trainers may stay on the players' sideline. Any harassment of referees by coaches or spectators will not be tolerated and is grounds for removing the offender from the premises.
Protests	No protests will be allowed. The referees' decisions are final.
Disciplinary Action	If a player, coach, or official receives a red card or two yellow cards during a match, that person must leave the field and sit out their next match. Any player who receives a yellow card in three matches must sit out the following match. No violent behavior will be tolerated. Anyone who initiates a fight will be required to leave the premises and will be suspended from the tournament.
Field Marshals	Marshalls will remove an unruly or uncivil spectator from the facility.
Alcohol and Illicit Drugs	Alcohol beverages and illicit drugs are prohibited on the premises or any areas near the field.
Players' Equipment	All players, except the goalkeeper, on a team must wear matching shirts with unique numbers.
Unforeseen Circumstances	The technical committee of the tournament reserves the right to cancel, delay, or reschedule a match in unforeseen circumstances. Each team should identify one individual to be on the Technical Committee of the Tournament.

Note: AFIA = Africans For Improved Access; FIFA = Fédération Internationale de Football Association (International Federation of Soccer Associations).

the tournament through news articles and advertisements, schedules subcommittee members for live television and radio shows, and uses social media, specifically Facebook pages and Web sites. The subcommittee also produces flyers that are distributed at African organizations, events, and places where African-born individuals congregate.

Although the primary funder of the AFIA program is MDPH, Bureau of Infectious Diseases, Office of HIV/AIDS, the AHC is designed to self-generate funding for operational costs to ensure community ownership and sustainability. The majority of funding comes from participating teams' registration fees, ads from African community businesses and civic organizations for the event booklet, vendors' fees, sponsorships, and contributions from community members.

Implementing the African Health Cup

The AHC mainly features soccer games in accordance with tournament rules and regulations, free confidential health screenings, health education

tables, vendors of African food, arts and crafts, and children's activities. The principal focus of the AHC is engaging soccer players and spectators in discussions about HIV, distributing education and prevention materials (HIV brochures, condoms, and lubricants), and navigating participants to on-site health screening services. These tasks are executed by AFIA staff and trained volunteers who are positioned strategically at the tournament venue. A first-aid team is on the field to respond rapidly to medical emergencies. A registration table is set up to check in players of each team, verify that they meet the participation criteria, and give information about games and discussion group sessions.

HIV Prevention, Education, and Testing

Lack of knowledge is darker than night.
African proverb

To participate in the AHC, each team is required to take part in a 30-minute group discussion. Opposing teams meet in a private space, before their first game, to participate in the discussion session. The focus of the education sessions change each year, with topics including HIV testing, HIV stigma, and biomedical HIV prevention research. The goal of the discussions is to reduce stigma by dispelling myths and misconceptions about HIV and emphasizing the importance of knowing one's HIV status. The discussions also encourage early care post diagnosis. At the conclusion, participants are offered HIV prevention and education materials (e.g., condoms, lubricants, brochures) and are encouraged to take advantage of the on-site health screenings. The tournament also engages spectators in two ways: (a) an HIV resource table is set up at the main entrance of the sport stadium, and (b) AFIA staff and volunteers at different locations around the stadium speak with spectators about HIV and the on-site health screenings, and offer them prevention materials.

Debriefing After the African Health Cup

The planning committee convenes at least 3 weeks after the conclusion of every AHC to gain feedback from coaches, captains, players, volunteers, and others about what worked well and what needed to be improved. Each person is asked to articulate his/her opinions regarding the integration of lessons learned from the tournament. All feedback is documented and considered when planning the next tournament.

Evaluation of the African Health Cup

Work on your reputation until it is established; when it is established it will work for you.
Tunisian proverb

From January 2012 through July 2012, a pilot study was conducted to develop the AHC into a sustainable, replicable, and evaluable intervention. It was funded through a grant from the National Institutes of Health administered by the University of Massachusetts Medical School. Data were collected in focus groups, interviews, and self-administered surveys, as well as by tracking the number of participants who received health screenings. We present only data from the focus groups, which evaluated the process of planning, organizing, and running the AHC. Each focus group lasted 60 minutes and was tape-recorded. Transcripts were analyzed by a note-based analysis procedure (Krueger, 1998). Each focus group member received a $25 gift card as thanks for participation. The University of Massachusetts Medical School Institutional Review Board approved all study-related procedures. Three focus groups were held. A semi-structured interview guide was used to ask participants about the AHC planning and implementation processes before the 2012 AHC, after the 2012 AHC, and before the 2013 AHC. Participants (N = 19) were 28–59 years old, natives of Cameroon, Nigeria, Sierra Leone, Guinea, United States (one coach), Trinidad, Cape Verde, Kenya, Liberia, Zambia, Ivory Coast, and Uganda.

Data from the focus group conducted before the 2012 AHC suggested that the majority of participants joined the AHC primarily to play soccer. However, they saw the tournament as an effective strategy for mobilizing the community to raise HIV awareness and promote solidarity among African-born men. The participants made several suggestions to improve

the AHC. The majority stressed safety concerns (e.g., the need for an on-site medical emergency first responder and a law enforcement officer). They also emphasized the need for the AHC to provide players with drinking water and to hold all HIV discussion sessions before the teams played their first matches. To enhance communication among the planning committee members and avoid one AFIA staff member handling multiple responsibilities in planning and implementing the AHC, the majority of participants recommended having more AFIA staff or volunteers help with coordinating the process. Finally, participants proposed that coaches be given the opportunity to immediately provide feedback at the conclusion of the tournament. Based on these suggestions, the 2012 AHC was improved by providing water and a first-aid team and by giving coaches a one-page evaluation immediately following the final game of the tournament.

After the 2012 AHC, focus group participants expressed overall satisfaction with the inclusion of some of the items they had proposed and the referees' performances. The majority of participants were also pleased with the HIV discussion group sessions, increased attendance from the community, and the health screenings being conducted in a private space. However, they observed some gaps and recommended the following: (a) inviting a person living with HIV (PLWH) to speak at the group discussion session to positively influence players to test for HIV, (b) having a greater variety of food choices, (c) enforcing the timing rules of the tournament to deter teams from arriving or checking in late, (d) increasing advertisement to draw more spectators, and (e) including children's activities to attract families.

The final focus group was held before the 2013 AHC. Participant observations were similar to those at the focus group held after the 2012 AHC. In addition, the majority of participants stressed the challenge of distinguishing AHC staff from spectators when seeking help, and suggested that staff and volunteers wear branded clothing. During the 2013 AHC, children's activities were included, an African-born PLWH was the speaker for the discussion sessions, and the number of food vendors was increased.

Conclusion

When spider webs unite, they can tie up a lion.
Ethiopian proverb

The AFIA program works with community members to undertake responsibility for defining problems and finding solutions. The success of this strategy was evident in the level of community engagement in planning and implementing the AHC. This engagement also created opportunities to improve and sustain the tournament. Several members from the community have embraced the concept of combining soccer and HIV prevention, and have contributed financially. Consequently, the AHC has grown bigger in terms of the number of activities, attendees, and those participating in HIV prevention services. Overall, the AHC has introduced avenues to talk openly about HIV in a manner that dispels myths and misconceptions about the disease and potentially reduces stigma, especially toward PLWH in African-born communities. Further, community participation has increased AFIA's visibility as the tournament reaches African-born individuals diversified by age, country of birth, religion, gender, profession, and marital status.

The partnership between the community and AFIA has been built on mutual trust and respect for each person's role in ensuring a healthier community. This has helped sustain the AHC in the midst of challenges, including budget cuts, reduced staffing, difficulty in engaging clinical partners for a weekend activity, and soccer team tardiness. The AHC has the advantage of addressing these problems by capitalizing on the community's human and material resources. To alleviate staff shortage problems, the AHC has begun to nurture volunteerism with African student associations at several colleges and universities. The planning community is also enhancing fundraiser strategies to provide stipends or incentives for important services, such as clinical services, when volunteers are not available. The strengths of the AHC are its backing from African-born communities in Massachusetts and its demonstrated sustainability over the last 4 years.

Disclosures

The authors report no real or perceived vested interests that relate to this article that could be construed as a conflict of interest.

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