Title

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Journal

AIDS Education and Prevention, 31(3)

ISSN

0899-9546

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Publication Date

2019-06-01

DOI

10.1521/aeap.2019.31.3.224

Peer reviewed

HHS Public Access

Author manuscript

AIDS Educ Prev. Author manuscript; available in PMC 2020 April 30.

Published in final edited form as:

AIDS Educ Prev. 2019 June ; 31(3): 224–236. doi:10.1521/aeap.2019.31.3.224.

The Experiences of Young Men, Their Families and Their Coaches Following a Soccer and Vocational Training Intervention to Prevent HIV and Drug Abuse in South Africa

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Abstract

Young men in South Africa are at high-risk for HIV, substance abuse, and gender-based violence. This paper presents qualitative results from a pilot study testing soccer leagues and vocational training to engage young-adult township men to deliver preventive interventions, including rapid HIV and alcohol/drug testing, shifting attitudes toward gender-based violence, and promoting other prosocial behaviors. Three groups participated in focus groups and in-depth interviews on experiences with the program: 1) a sub-set of 15 participants, 2) 15 family members, and 3) five intervention coaches. Results suggest that participants first reduced substance use on tournament days and then gradually reduced to practice days and beyond. Families suggested that "keeping young men occupied" and encouragement of prosocial behaviors was critical to risk reduction and led to increased community respect for the men. Coaches noted that behavioral and attitudinal changes were incremental and slow. The use of incentives was problematic and more research is needed to understand how incentives can be used in interventions of this nature.

Keywords

HIV prevention; South Africa; Soccer; Substance use; Young men; Engagement

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INTRODUCTION

Young, unemployed men are prone to engage in health compromising behaviors that place them and their partners at risk for HIV infection, hazardous substance use, and violence (UNAIDS, 2010). Evidence based interventions (EBIs), such as those aimed at reducing HIV transmission, have primarily been targeted at young women in the global south and are typically delivered in primary health care settings (Gates & et al., 2016; UNAIDS, 2010). South Africa has 2.4 million HIV-infected men, the highest number of seropositive persons of any nation (UNAIDS, WHO, & UNICEF, 2011), yet young adult men have largely been neglected from intervention efforts (Beyrer, 2010; Bowleg, 2011; Henny & et al., 2012). Men, as much as women, need public health interventions to reduce the risk of HIV infection, substance use and violence, and require pathways into long-term employment in order to adopt healthy roles in their families and communities. Focusing solely on the development and empowerment of women only serves to further marginalize young men (M. J. Rotheram-Borus et al., 2016). It is within this context that we piloted an intervention which made use of soccer as a context for encouraging pro-social and health promoting behaviors that would reduce young men's risk of HIV and substance abuse, while reinforcing behaviors required to secure employment. In this paper we report on qualitative data collected at the end of the intervention from the coaches who delivered the intervention, the young men who participated in the intervention, and members of the participants' family. We describe the lived-experiences of those involved in the intervention and reflect on the implications of these experiences for future interventions of this type.

In South Africa, most men (68%) report unprotected sex, typically with three partners in the last three months (Bhana & Pattman, 2009; Reddy & et al., 2003). More than half report that they do not use condoms with casual partners (Coovadia, Jewkes, Barron, Sanders, & McIntyre, 2009). Furthermore, alcohol, tik (methamphetamine) and marijuana are commonly used by young men (Kalichman, Simbayi, Vermaak, Jooste, & Cain, 2008; Morojele & et al., 2006; Parry et al., 2004). Data suggests that South African men who use alcohol are typically poly-substance users (Parry & Bennetts, 1998) and have multiple sexual partners (Malow, Devieux, Jennings, Lucenko, & Kalichman, 2001). Concurrently, there are few competing prosocial activities for young men. At least half drop out of high school, two-thirds of young people are unemployed, and 25% face lifetime unemployment (Bennell & Segerstrom, 1998; Statistics South Africa., 2013; Wegner, Flisher, Chikobvu, Lombard, & King, 2008). Reducing the risk of HIV infection and transmission among young men in South Africa, requires an integrated approach that simultaneously targets risk behaviors, substance use, gender attitudes and employment opportunities. Furthermore, novel approaches, such as the use of sport, are needed to engage young men.

Soccer is a highly attractive activity for many South African men (Sewpaul, 2009). Participation in sports is associated with physical, psychosocial, and social benefits, increasing involvement with friends and family (Sparling, Owen, Lambert, & Haskell, 2000). Yet, the literature suggests that when men collect in groups, they prompt each other to engage in risk behaviors and to take more risks than they would when acting individually (Dishion, McCord, & Poulin, 1999; Kaminer, 2005). Soccer and vocational training are

largely structural, community-level programs that address social determinants of young men's risk behaviors (Dean & Fenton, 2010; Gupta, Parkhurst, Ogden, Aggleton, & Mahal, 2008). Given the positive associations with soccer for many young men, it seems possible that soccer could be used as a novel way to engage young men in public health interventions and as a context to promote behavioral change.

Together with Grassroots Soccer, an international community-based organization that implements soccer across Africa, we conducted a pilot study of a soccer and vocational training intervention. The intervention is fully described elsewhere (M. J. Rotheram-Borus et al., 2018), however, a brief description of the intervention offered here to help contextualize the qualitative data presented in this paper. Young unemployed men (18–25 years of age) were recruited from two neighborhoods in low resource peri-urban communities in Cape Town, South Africa, and randomly assigned by neighborhood to an intervention group (n= 72) and a control group (n=70). Men in the intervention group were organized into soccer teams and invited to attend two weekly soccer practices and compete in a soccer league (dubbed the Champions League) with the matches taking place on a Saturday. The intervention lasted 6 months. The soccer practices and matches were used as opportunities to engage young men in health promoting activities, and encourage prosocial behaviors and habits of daily living that are required to secure and retain employment (such as punctuality, sobriety, commitment, sustained goal directed activity, and team work). A code of conduct was used to make explicit the behaviors we wanted to reinforce, such as arriving on time and remaining drug and alcohol free. We used point of contact rapid drug and alcohol tests to randomly screen participants at practices and matches as a way of monitoring substance use and enforcing the code of conduct. Incentives were used to reward desirable behaviors such as punctuality, screening negative on drug and alcohol tests, and not engaging in violence during practices and matches. Incentives included a point system and random rewards such as receiving tickets to attend soccer matches and airtime vouchers. The 35 participants with the highest number of points at the end of the intervention earned access to a vocational training program.

The soccer coaches were trained in the fundamentals of behavior change and were taught how to use informal conversations at soccer practices to deliver health messages about HIV and substance use. Coaches were not asked to deliver a manualized intervention with prescribed activities. Instead they used their positions as soccer coaches to build healthy relationships with the young men in the intervention and to provide mentoring. Coaches were instructed to reinforce behaviors consistent with valuing responsible and respectful relationships and health promotion. In addition, coaches actively encouraged health promoting behaviors (such as healthy routines for eating, sleeping and exercising), reinforced HIV risk reduction norms (such as knowing your HIV status and practicing safer sex), and discouraged substance use and violence. Coaches were also extensively trained in 11 fundamental skills common to 80 % of mental health EBI (Chorpita & Daleiden, 2009) (namely, goal setting, problem solving, praise, social rewards, role playing, positive self-talk, relaxation, emotional self-regulation, awareness of feelings, attention, and assertive social behaviors) (Chorpita & Regan, 2009; M. Rotheram-Borus, Swendeman, & Becker, 2014). Coaches were also provided with information about all local resources for care (health, ID cards, employment training, and community agencies) and taught how to make appropriate

referrals. Coaches were recruited on the basis of their good reputations, previous employment, and experience playing soccer. Coaches were selected for intervention participation by Grassroots Soccer based on their social skills and knowledge of soccer. The mean age of the soccer coaches was 24.8 years, and they had on average nine years of experience playing soccer. The results on the feasibility of this intervention are reported elsewhere (M. J. Rotheram-Borus et al., 2016).

To gain more insight into participants' experience of the intervention and identify possible mechanisms of behavioral change, we conducted interviews and focus groups with intervention participants, their family members, and their coaches. This paper examines how the young men, their coaches and family members experienced the intervention and their perceptions of the potential negative consequences of the soccer and vocational training offered in the intervention.

METHODS

Participants and procedures

Participants in the intervention were recruited from a neighborhood in Khayelitsha, an urban township located 30km from Cape Town. The participants in the control group were recruited from a matched neighborhood in the same township. The township is characterized by widespread poverty, and high levels of unemployment and crime. Neighborhoods consisted of a combination of 450–600 formal and informal houses with most households having no access to water in their homes and using a communal tap to access water. All households had access to electricity and were located within 5km of a public healthcare clinic (Rotheram-Borus et al., 2016).

We collected qualitative data via in-depth semi-structured interviews and focus groups, at the end of the intervention, from three groups of people:

(1) Intervention participants.—In-depth individual interviews were conducted with a sub-set of soccer players who participated in the intervention (n=15). Two sub-groups of men were purposively selected and invited to be interviewed. The first group (n=8), categorized as the "good responders," regularly attended soccer practice, frequently chose to take the rapid alcohol and drug tests, and earned sufficient points to be included in the vocational training. The second group (n=7), categorized as "poor responders", consisted of men who did not consistently attend soccer practices and failed to earn sufficient points to be included in the vocational training. Attendance records kept by coaches and overall points earned during the intervention were used to distinguish the two groups of responders. Following individual interviews, three separate focus groups with a broader group of players were held to gather data on what participants learned about substance use, HIV, gender relations, gender-based violence, and any changes experienced resulting from the intervention. Each focus group was comprised of between 8 and 11 young men who took part in the soccer intervention.

(2) Family members.—In-depth interviews were conducted with a group (n=15) of family members residing with the men who participated in the intervention. We asked the 15

participants who participated in individual interviews if they were willing for us to contact a family member to take part in an interview. All the participants gave permission for us to speak to family members who had insight into their involvement in the intervention. Family members were expected to be competent reporters of any positive or negative changes that they associated with the 6-month period of vocational training or soccer. The group of family members we interviewed consisted of nine mothers, two fathers, two sisters, one cousin and one niece.

(3) Coaches who delivered the intervention.—We invited all coaches (n=5) to share their experience of the intervention with us. Data were collected via individual interviews with each coach and then in a focus group with all coaches.

Our sampling strategy enabled us to gather a variation of responses to the intervention. Semi-structured interviews and focus group guides were used to elicit experiences of taking part in the intervention and perspectives from family members and coaches about the value of the intervention and perceptions of the mechanisms of behavioral change. While the interviews offered rich, individual narratives on the phenomenon being investigated, the focus groups intended to generate data with higher ecological validity (Rotheram-Borus et al., 2016). Interviews were conducted before the focus groups to ensure that individual perspectives were not contaminated by views expressed in focus group discussions.

Data collection and analysis

Interviews and focus groups were conducted by trained research assistants fluent in both English and isiXhosa (an indigenous language spoken by many of the participants). All interviews and focus groups lasted 40 to 60 minutes, and were audio recorded, transcribed verbatim and translated into English for analysis. Transcripts were uploaded to ATLAS.ti v 7 (www.atlasti.com) and coded using an inductive data-driven approach to generate themes. We used thematic analysis and the procedure outlined by Braun and Clarke (2006) to code the data and identify superordinate and subordinate themes (Braun & Clarke, 2006). Once the coding framework had been developed it was discussed with the research team and appropriate changes were made to accurately reflect the themes that had emerged from the data.

Ethical considerations

This study received IRB approval from both the University of California at Los Angeles and Stellenbosch University. All participants provided written informed consent. Consent procedures, interviews and focus groups took place in a research office located near one of the study sites.

RESULTS

The mean age of the participants was 21.9 years and most had completed 10 years of schooling. Almost all of the young men who took part in the study were living at home with their parents (69.7%); 17% had fathered children, 5% had more than one child. Their households had, on average, 5 members, and only 3.5% lived with a partner. Most lived in

informal housing, with 30% having water on the premises. Only two young men supported children or other people. Almost 80% of the young men reported having been tested for HIV in their lifetime, while 18% had been tested for TB. Approximately a third had more than one sexual partner in the last three months. Almost all (87.8%) had previously used drugs, all had used alcohol, and 40% had used drugs. About one in four (27%) stated that they had forced a woman to have sex. Almost half (46%) had been arrested and 22.7% had received a prison sentence.

We identified three superordinate themes: (1) observed changes in the behaviour and attitudes of players; (2) reported changes in household roles and family relationships; (3) perceptions of the process and mechanisms of change. These themes and the associated subthemes are presented below.

(1) Observed changes in behaviour and attitudes of players

Family members, coaches and players themselves all affirmed that that they had noticed positive behavioral changes since the start of the soccer intervention. As discussed below, the observed changes included a reduction in HIV-risk behaviors, changes in patterns of hazardous substance use, and more positive social engagement. The young men also noted some changes in their attitudes towards gender-based violence and sexual assault.

(a) Reduction in HIV-risk behaviour—Of the 15 players interviewed individually, nine reported testing for HIV for the first time as a result of their participation in the intervention. Players reported an increase in the awareness of and knowledge about HIV risk. They also said that they had adopted a number of behaviours to reduce the risk of HIV infection and transmission, including regular HIV testing, condom use and a reduction in the number of sexual partners. During his individual interview one player stated:

> “Yes, because I was always reluctant to go for HIV tests but I got motivated when we were tested as a group and was looking forward to get my results.”

Similarly, another player said:

> “I learned a lot about HIV that it is real […] and also one has to use protection during sexual intercourse to avoid being infected. One has to stick to one partner instead of multiple partners.”

Nonetheless, a number of young men reported that they were still fearful about HIV testing. For example, in a focus group, one player said:

> “No it has not changed because I am still very scared to go for HIV test because I don’t know how I will accept the fact that I am HIV positive should I test positive.”

(b) Change in patterns of hazardous substance use—The coaches, the young men, and their family members reported noticing a change in the pattern of substance use. They reported less frequent substance use and a reduction in the quantity consumed. These changes were attributed to the fact that attending soccer practices twice a week and competing in the matches Saturdays, diverted them from consuming substances. During a focus group one player said:

> "This program really helped in limiting the amount of alcohol that we consumed because we had a busy schedule at Champions League."

Some participants, however, acknowledged that they had on several occasions only refrained from substance use prior to practices and matches, suggesting that the behavior did not generalize to other areas of their lives.

(c) Positive social engagement and adopting pro-social behaviours—Several players stated that participation in the intervention meant that their time was used more constructively and provided more opportunity for social engagement, relationship building and activities that did not involve substance use or fighting. Family members observed that many of the young man had refrained from stealing money for drugs, and some had returned to school. In an interview, one young man's father said:

> "I was very worried because he was doing matric, but he left school because of these gangs and drugs. [….] It (Champions League) was a great idea, because he completely stopped his wrong doing ways, robbing people, and I was afraid that he was getting involved in drugs […]."

A similar sentiment was shared by another player's mother:

> "Yes there is change because ever since he started joining [Champions League] he now has his own money. For example, he used to sleep with us here in the house but now he managed to buy himself a shack and put it at the back. He even buys us some food. And he knows what to do with his money. He does not waste it on alcohol and smoking, he doesn't even smoke."

(d) Attitudes on gender-based violence and sexual assault—During the interviews and focus groups a number of players reported that they knew it was unacceptable to physically abuse women and were aware that this was a punishable crime. Furthermore, most players associated rape and abuse with drug and alcohol use. Although a number of players said that the intervention had affirmed their belief that the use of physical force and violence was wrong, other players explicitly said that these behaviors were sometimes justified. During his interview, one player said:

> "Yes, it [violence] is necessary sometimes because they [women] can also be abusive and you also end up losing temper and physically abuse her. Because sometimes these girls are the first ones to klap [hit] you on your face and you will also fight back."

Another player stated that violence was necessary to retain respect and maintain a strong and dominant presence:

> A little bit sometimes because women can be disrespectful and if you don't [use violence], they think you are too soft or you are a gay.

It was remarkable that some of the participants, while appearing to condemn gender-based violence, still spoke about women in ways which suggested patriarchal and stereotypical views about women. For example, during a focus group one player said:

> "We must protect women because they are very sensitive and vulnerable in everything and we must motivate them in whatever they do, and to be open to them, to be always friendly, and confide in her with your problems."

(2) Changes in household roles and family relationships

All family members reported positive changes in the young men's engagement at home and with family, which they attributed directly to the soccer intervention. For example, family members reported that many of the young men were spending more time at home, since the start of the intervention, and were behaving more responsibly and positively to the family. Examples were given of how some young men had started helping with cleaning, cooking, and other household chores. Family members reported that the young men were taking more financial responsibility and demonstrated better interpersonal and communication skills. It was reported that the young men were using their study incentive vouchers to purchase food and other household items for the family. This is evident in the following extract from an interview with one young man's mother:

> "…his mood changed, the reason I say that is that before he didn't know that dishes need to be washed, and the house need to be cleaned, but now he knows that he needs to clean the dining room and [he] cleans the kitchen, they take turns to wash the dishes, as a result day before yesterday I washed the dishes for him because he started at school…. he knows when to come to home and he is even able to say sorry, which is something he never did before, he used to just leave while I am talking to him which I didn't like, I used to tell him that I'm his mother I will talk until the day I die, now he stands there and listens to me and apologizes and ask me not to stress because I will get sick. He was not worried about those things before."

(3) Perception of the process and mechanisms of change

The individuals we interviewed shared a number of perceptions about the process of change that had been facilitated through this intervention. As discussed below, they also shared a number of ideas about factors that may have contributed to or hindered the process of change.

(a) Change is slow—Coaches noted that the process of change was slow and it took time for men to replace old habits with more constructive behaviors. They also noted that some of the young men seemed to be resistant to change. In this context, coaches noted that even though the intervention had lasted for six months, this may not have been enough time for some of the young men to change their attitudes or behavior. During an interview, one coach said:

> "…it [the Champions League] has changed their behaviours but there are some who are still dragging their feet […]. I so much wanted that Champion's League could last forever even outside this program because even those who were dragging their feet were slowly dragging them in."

(b) The value of constructive activities to fill idle time—Many of the individuals we interviewed noted that, in part, the value of this intervention was that it provided the

young men with a constructive structured activity that was physically demanding and filled idle time. It was noted that these young men were often bored and found themselves with nothing to do but consume substances. The intervention appeared to provide a distraction from these activities and provided an opportunity for the young men to direct their energy into a productive pursuit while engaging positively with peers. During an interview, one young man affirmed this, saying:

> "It would have been the same with me because one did not have anything to do [before the intervention], so drinking and smoking is the only form of socializing."

(c) The use of incentives—Coaches and players acknowledged the role that incentives played in motivating positive behaviour change, especially in reducing alcohol and substance use. One coach stated:

> "That [incentives] really helped a lot to encourage them to stay clean. Had there been no incentives they would not have been tested… it sort of became a competition as to who tested positive or negative as they would brag about being negative … Towards the end of the program, testing was something they were looking forward to and enjoyed doing."

Similarly, one young man said:

> "Yes, whenever I tested positive [for drugs or alcohol] I did not get the incentives and I felt bad and that also made me to seriously consider the consequences that this will have on my health."

Coaches did, however, express some concern about the use of the incentives and suggested that they were not always helpful. They noted that some young men were only focused on the external rewards and that this impeded their positive engagement with the soccer activities. They expressed a perception that while the incentives worked to get the young men to come to the intervention, they did not necessarily promote genuine engagement with the content of the intervention. This sentiment is reflected in the words of a coach who said:

> "There are people who came into this program not for football but for incentives, there was a player who never gave us any support, never showed any commitment but he would just only come for R5 [cell phone] airtime and when he gets it he would hold it up and say, 'this one is for my girlfriend'. But, incentives is just a motivation for them to come to the practice. Even those who have injury would come to the training we would compensate them because they show commitment."

Some coaches also noted that the use of so many incentives may have created the impression that those responsible for the intervention had a lot of money and resources. Coaches reported that they were pressured by players with demands for incentives like money, vouchers, shoes, and track suits. It was noted that players were not always clear about when incentives would be provided and what form these incentives would take. Consequently, incentives sometimes became a point of conflict between the players and the coaches. This perception was articulated during a focus group with the coaches:

> "It seemed that there was a problem as the players were not clear about the incentives part of the program; they had high expectations. I wish next time it can

> be clarified from the beginning and the incentives should not be the main focus in the program. We really had a problem because most players use to ask us about their incentives. And, if they did not get their incentives, they stayed away from the practice."

This sentiment was echoed by another coach who said:

> "Players were only entitled to [cell phone] airtime when they attended practice on regular basis and were punctual for practice, and when they tested negative for drugs and alcohol. But when they got their incentives, they started questioning us about unequal incentives even though they were aware of how [they] were awarded. They were all aware that should you reach 50 points, this is what you are entitled to. Also during tournaments, the way the incentives were awarded differed. For example, in the first tournament when we won, we got 4 balls. In the second, we won R250 and that was a way of motivating players and to keep them interested in the program. So that way the incentives differed according to the particular tournaments and the players complained about that and compared the incentives they received against the other teams. The players were not proactive but reactive. They did not ask before the beginning of the tournament and only complained after the tournament after the awards."

(d) Use of random drug tests—Coaches expressed a perception that the observed reduction in substance use was a direct result of the use of random drug tests and the negative consequences of arriving intoxicated at practices and matches. The results of these drug tests provided immediate and public feedback to players, the rest of their team, and the coaches about substance use. The coaches believe that this was a powerful deterrent and helped the players to curtail their substance use. For example, one coach said:

> "There are some players I can see, even if they're still using drugs, they know the consequences and they are no more abusing the substance the way they used to before the implementation of this program."

DISCUSSION

The qualitative data presented in this paper, suggests that the six-month soccer intervention precipitated a number of positive changes to behavior which have the potential to reduce the risk of HIV infection and transmission, and curb hazardous substance use. These qualitative findings augment the results of the quantitative analysis of outcomes, reported elsewhere (Medich et al., 2018) and suggest that in addition to reductions in substance use, the intervention also results in important changes in family roles and relationships. Our data suggest that participation in this intervention facilitated a positive change in young men's family relationships and roles, causing them to assume more household responsibilities and curb anti-social behavior. Thus the benefits of the intervention were felt by the families of the young men, particularly their parents. These benefits to family were not reflected in the quantitative data collected from the young men at the end of the intervention, and highlight the need for researchers to also consider how their interventions may have indirect benefits to those who live with participants.

However, our data also showed that the intervention did not significantly promote changes in attitudes to gender-based violence or shifts in beliefs about hegemonic masculinity. This finding suggests that much more intervention is going to be needed, perhaps different types of interventions, to change young men's attitudes towards women. Specifically, at the end of our intervention, some young men stated that physical abuse of women was socially acceptable and justified in some circumstances. Similar attitudes have been previously found in other studies (Shefer & et al., 2008). The failure to improve men's ideas about gender-based violence was concurrently found in the self-report ratings of attitudes. The lack of change in this area may reflect the fact that the intervention set out to achieve too much and consequently did not focus enough on this aspect as a target for change. It is also possible that soccer may not be the most effective intervention modality to change these issue of gender relations and how patriarchal power dynamics manifest in the participants' relationships with their intimate female partners. Sports like soccer have been critiqued for reinforcing heteronormative and hegemonic models of masculinity (McKay, Messner, & Sabo, 2000; Scraton, Flintoff, & (Eds.). 2002), which suggests that perhaps soccer-based interventions should be used judiciously to address gender roles and attitudes to women.

Our findings provide important insights into perceptions of the process of change and factors that might have facilitated or impeded behavioral change. Our data point to the importance of sustained interventions over a long period of time, given that behavior change is a slow and incremental process. Crucially, our data suggest that while the use of incentives may be helpful in engaging young men and reinforcing particular behaviors, incentives might also create problems in interventions of this nature. Our data suggest that the use of incentives may have caused problems by creating a perverse motive for attending soccer practices and may have distracted some players from engaging with the content of the intervention. Problems with incentives were also a result of an unclear and insistent schedule of reinforcement and confusion about how incentives were earned. These findings suggest that more research is needed about both the potential positive and negative impacts of using incentives in community-based HIV prevention programs with young men in resource constrained communities. While it seems to be important to use external motivation and material rewards to ensure enrollment in the intervention and attendance, it is not clear how to use incentives in a way that does not impede behavior change or cause conflict between the people responsible for delivering the intervention and those who take part in the intervention.

Our findings also suggest that the use of point of care, rapid drug tests was an important component of this intervention, as was the use of HIV testing. Young men reported that they were embarrassed if they tested positive on drug tests and felt social pressure to undergo drug testing at soccer practices. Peers gave young men courage to participate in HIV testing. These findings highlight the potential role of social pressure as a positive force in group interventions with young men and point to the power of immediate feedback to shape behavior.

Finally, it appears that an important element of the intervention was the regular soccer practices (twice weekly) and weekly matches, which provided young men with a

constructive way to fill their time and replace risky behaviors. It seems that keeping young men occupied and filling their time was critical for reducing substance use.

CONCLUSION

Most HIV EBIs are designed, demonstrated efficacious, and then disseminated through organizations. Currently, interventions are focused on being pushed into medical settings. This pilot intervention project was designed to work on the cultural pull and attractiveness of soccer as an intervention modality in community settings attractive to young men who often do not engage in medical settings. Many young, South African men experience high rates of HIV and substance use but avoid health care settings—the primary site for delivery of HIV intervention activities. Therefore, it is unlikely health care settings alone will be sufficient to reach young men with combination prevention strategies. This study provides evidence for the utility of soccer as a culturally compelling vehicle for behavior change that diverges from standard HIV EBIs in engaging young men. Notable in the interviews and focus groups, the soccer league created a context for men to engage in camaraderie on the field and yielded a reduction in substance use, an increase in income, and an increase in awareness about the benefits of HIV prevention strategies among a sample of young men with long histories of risky behaviors. Further research is warranted to explore how incentives motivate behavior change and how to effectively address gender-based violence.

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