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Right to Play and Right to Health: the role of sub-Saharan sport for development programs in the HIV/AIDS pandemic

“Do not train a child to learn by force or harshness; but direct them to it by what amuses their minds, so that you may be better able to discover with accuracy the peculiar bent of the genius of each” – Plato

“Sport has the power to change the world. It has the power to unite in a way that little else does. It speaks to youth in a language they can understand. Sport can create hope where once there was only despair” – Nelson Mandela

Introduction

Throughout a person’s life, sport and play can be valuable tools to promote health and prevent or mitigate disease. Sports are internationally loved and popular—bringing smiles to children’s faces, hope into their lives and opportunities for their future even in the direst of circumstances. Sports have the power of connecting with youth, enhancing standards of living and enacting social change. Additionally, physical activity can positively impact the health and well-being of youth. Sport for health international development programs are a unique and powerful avenue to combat global poverty and further a person’s right to bodily health as well as his or her right to play, two capabilities to which all humans are entitled. In this paper, I will use Martha Nussbaum and Amartya Sen’s Capabilities’ Approach to argue that sport for health development programs realize youth’s rights for health and play.

Considering health and play as human rights requires specific attention to those living in vulnerable situations because those in poverty and marginalized groups bear an undue proportion of unfreedoms, human rights violations and overall health problems. For example, the incidence and spread of HIV/AIDS are disproportionately high among certain populations, including

women, children, those living in poverty, refugees and in certain regions such as sub-Saharan Africa (WHO, n.d.c). HIV/AIDS is an illustration of a larger issue of health disparities and global development; systematic poverty exacerbates the risk of infectious diseases in the developing world, as it limits an individual's and a community's access to healthcare and health-related information (Right to Play, n.d.b, p. 1). Therefore, health and play promotion in places that are lacking in these two areas is not only anti-poverty work but also promotes every individual's basic rights as humans. In this way, health and play promotion are ways to alleviate poverty and also further other goals of international development.

Using the foundation of a child's right of health and right to play, programs in sub-Saharan Africa are making unique and powerful contributions to combatting HIV/AIDS through education. Through critical analysis of the programs' successes and failures, I will draw conclusions on the reach of sport programs in mitigating the disease and thus combatting global poverty and draw inferences regarding the direction sport for health development programs should be taking to lessen HIV/AIDS infection rates. Subsequently, I will identify two areas for growth for sport for development programs: 1) greater outreach to young women and 2) working in partnerships with other key constituents, specifically in the education, healthcare and political sectors. Motivated by an extensive review of the evidence, I make conclusions regarding future research and possible expansion of programs, ultimately judging the value of sport for development programs in regards to both furthering children's unalienable rights of bodily health and play as well as combatting the spread of HIV/AIDS.

HIV Prevalence

Every minute of every day, a child is infected with HIV (Griffiths, 2005, p. 3). Shockingly, 35 million people worldwide are currently infected and living with HIV/AIDS

(AIDS.gov, 2014). In fact, in 2013 the World Health Organization (WHO) reported that 24.7 million people were living with HIV in sub-Saharan Africa alone (WHO, n.d.a). This disease is spreading rapidly, as an estimated 2.1 million individuals worldwide became newly infected with HIV in 2013 (WHO, n.d.a). Clearly, Millennium Development Goal number seven, to “halt and begin to reverse the spread of HIV/AIDS” by 2015, has not been fully realized (Ross, Dick, & Ferguson, 2006, p. 3). In fact, “nearly 90% of all HIV-positive people worldwide don’t know they have the virus, though they can transmit it to others” (IOC & UNAIDS, 2005, p. 21).

Human immunodeficiency virus (HIV) is passed from one person to another through blood-to-blood contact, sexual contact or breast milk and causes an infection called acquired immune deficiency syndrome (AIDS). HIV weakens the body’s immune system until it can no longer fight other diseases and infections (IOC & UNAIDS, 2005, p. 29). By preventing the body from fighting normally non-threatening infections, HIV leads to illnesses and a lower life expectancy; in 2012, people living in the developing countries in sub-Saharan Africa had a life expectancy of only 56 years (World Bank, 2015).

The WHO reports that many factors increase people’s vulnerability to contracting HIV including “a lack of knowledge about HIV/AIDS, lack of education and life skills, poor access to health services and commodities, early sexual debut, early marriage, sexual coercion and violence, trafficking and growing up without parents or other forms of protection from exploitation and abuse” (Ross, Dick, & Ferguson, 2006, p. 2). Many if not all of these factors are inextricably bound up in the sociological problem of poverty, which is widespread in sub-Saharan Africa. In fact, poverty, at both the individual and societal level, has been correlated to HIV prevalence. Sub-Saharan Africa is home to roughly 70% of the world’s HIV cases and also home to 70% of the poorest people in the world (Mbirimetengerenji, 2007, p. 605).

Poverty is associated with deprivation, constrained choices and unfulfilled capabilities that impact a person's standard of living. At the individual level, poverty can limit a person's access to health information, education, counseling, HIV testing and medication. Moreover, poor neighborhoods often lack the necessary social infrastructure to facilitate prevention programs. National health surveys report that only about 30% of young people in low- and middle-income countries have comprehensive HIV prevention knowledge (measured as the percentage of women and men between 15 and 24 who correctly identify the two major ways of preventing the sexual transmission of HIV i.e. using condoms and limiting sex to one faithful, uninfected partner) (Kaufman, Spencer, & Ross, 2013, p. 989). Lack of knowledge is especially rampant in Africa—in a survey in 2006 carried out in 21 African countries, more than 60% of young women had either never heard of HIV or had at least one major misunderstanding about how it spread, such as the conception that it can be spread through sweat or tears (UK Gov., 2006, p. 9). Therefore, combatting HIV/AIDS continues to be a global challenge and priority; work for its prevention and reduction is paramount in current anti-poverty work.

A focus on adolescents. Adolescents, or those between the ages of 10 and 24 years, are at the center of the HIV/AIDS pandemic in developing countries and therefore should be at the center of prevention efforts. This age group has the highest incidence of HIV and is disproportionately represented among population subgroups as being at the highest risk for becoming infected. In fact, WHO reports that half of all new infections in sub-Saharan Africa occur among individuals between the ages of 10 to 24 (Ross, Dick, & Ferguson, 2013, p. 15). Therefore, this group may also have the greatest potential for reversing the pandemic and likewise alleviating its economic and social costs on societies around the world.

UNAIDS claims that “worldwide, by far the most common means of HIV transmission continues to be unprotected sex with an infected partner” (Visser-Valfrey & Sass, 2009, p. 10). Adolescents, unlike those under ten years old, are mature enough to handle and properly understand education that will inform them about the risks of unprotected sex; this knowledge is crucial for pre-pubescent and immediately post-pubescent individuals to keep them free of sexually transmitted infections and mitigate the spread of the HIV/AIDS epidemic.

Sen and Nussbaum:

The intrinsic and instrumental benefits of health and play

Amartya Sen and Martha Nussbaum’s definitions of capability support the argument that every individual is entitled the right to bodily health and play. Although they utilize different tools, together their Capabilities Approach to poverty combines a quality-of-life assessment with theorizing about basic social justice around the globe (Nussbaum, 2011, p. 18). This approach focuses on choice or freedom, holding that societies should be promoting and furthering a set of opportunities, or substantial freedoms, for their citizens (which they may or may not choose to exercise) to improve the quality of life for all people. In this way, development is about enhancing lives and expanding the freedoms each individual can enjoy.

In *Development as Freedom*, Sen (2000) asserts that freedoms have constitutive as well as instrumental importance—“freedoms are not only the primary ends of development, they are also among the principal means” (p. 10). In other words, capabilities are intrinsically important to human freedom and by themselves enrich human life; at the same time, these freedoms and rights may also be very effective in contributing to other means for development, such as economic progress. Therefore, freedoms of individuals can provide the basic building blocks for the expansion of people’s overall capabilities with the ends of “enhancement of human freedom

in general” (Sen, 2000, p. 10). In acknowledging both the ethical and philosophical importance of freedoms as well as their sociological benefits, Sen’s model can be used to study both the intrinsic and instrumental values of sport for health development programs.

In *Creating Capabilities*, Nussbaum (2011) argues that social justice requires that governments have the job of providing, at bare minimum, ten “Central Capabilities” to all citizens. She emphasizes that a life worthy of human dignity requires an ample threshold level of these ten capabilities and that the process of development as freedom needs to include the removal of related deprivations. Directly pertinent to the discussion at hand, Nussbaum references two interrelated capabilities or substantial freedoms that individuals should have or be able to choose to employ—good bodily health and the right to play. Specifically she asserts that all citizens must be able to secure a threshold level of bodily health or “being able to have good health” and that all citizens must be able to play, which she defines as “being able to laugh, to play [and] to enjoy recreational activities” (Nussbaum, 2011, p. 33-34). In accordance with Sen, Nussbaum highlights the dual benefits of freedoms as both a means and an end to development—“what play and free expansion of the imaginative capabilities contribute to a human life is not merely instrumental but partly constitutive of a worthwhile human life” (2011, p. 36).

The capabilities approach can be linked to the rights language used by the United Nations and other international development programs. Nussbaum (1997) notes that both she and “Sen... stated from the start that the capabilities approach needs to be combined with a focus on rights” (p. 276). This is because rights play an increasingly important role in what constitutes the most important capabilities. Therefore, Nussbaum uses the language of rights, or related languages of liberty and freedom, to flesh out an account of basic capabilities. She asserts that rights should

be thought of as “a list of very urgent items that should be secured to people no matter what else we pursue... in this way we are both conceiving of capabilities as a set of goals—a subset of total social goals—and saying that they have an urgent claim to be promoted” (Nussbaum, 1997, p. 300). Similar to Nussbaum, I use rights vocabulary, in part, as a rhetorical choice to bring together the capabilities approach and language used by international human rights agencies. I also use it theoretically to emphasize the affiliations that the capabilities approach has to liberal rights-based theories and to show how “thinking in terms of capability gives us a benchmark in thinking about what it is really to secure a right to someone” (Nussbaum, 1997, p. 294).

Congruent to Nussbaum’s account, Sen agrees that the capabilities view is supportive of a conception of rights as goals. As noted previously, this makes thinking about rights part of a more general account of social goals that are “reasonable to promote” (Nussbaum, 1997, p. 278). Rights language has value because it emphasizes a person’s choice and autonomy while continuing to be concrete and urgent; Nussbaum (1997) thinks that it lays further emphasis on the important fact that we ought to think of rights as a benchmark for people’s autonomous choices in pursuing or not pursuing certain opportunities. In sum, certain types of positive rights follow from the capabilities approach—rights that must be provided but are still subject to individual choice. For example, sport for development programs are one means through which a society can enable a person’s right to health (which includes health education) and right to play. In this scenario, everyone in sub-Saharan Africa has the right to participate in programs that educate about HIV/AIDS if they so choose.

Furthermore, the capabilities of health and play are what Nussbaum (1997) calls “combined capabilities”—meaning that they are internal capabilities combined with external conditions that are necessary for their full exercise. Applied to the subject at hand, this means

that health and play not only require that these qualities be within individuals but also that suitable external conditions for the exercise of the capability be available to all, such as sport programs that effectively deliver health information. Therefore, the right to health and the right to play can be construed as negative rights (the right to be protected against preventable, communicable diseases and the right to be protected from constant labor) as well as positive rights (the right to health education as a means to pursue the highest possible quality of health and the right to the opportunity of play in terms of resources, social norms and institutional structures). This puts an impetus on public policy to make the production of combined capabilities a paramount goal.

Intrinsic benefits: health and play as basic rights of every child. As highlighted previously, a person's health is intrinsically valuable and paramount to the realization of his or her full human rights. In *Pathologies of Power: Health, Human Rights, and the New War on the Poor*, Paul Farmer (2004) notes that "the right to health is perhaps the least contested social right" (p. 19). From Sen's paradigm, it follows that good health allows a person to live the type of life he or she values, enhancing his or her sense of dignity. Furthermore, Nussbaum believes that bodily health is an extension of the right to not die prematurely from a preventable disease like HIV/AIDS.

Indeed, the right to health has been protected in international and regional treaties as well as national constitutions across the globe. For example, the WHO's Constitution proclaims that the "highest attainable standard of health is a fundamental right of every human being," with health being defined as not merely the absence of disease but a state of "complete physical, mental and social well-being" (WHO, n.d.a). It asserts that regardless of age, gender,

socioeconomic or ethnic background, health is a basic right and an essential need to live a life of dignity.

In addition to health, play, in all its kinds and forms, is a basic right of every individual (Ottier, 2005, p. 13). Participation in sport, play, physical education and leisure is a human right that is recognized year after year in numerous United Nations conventions (Higgs, 2012, p. 240). The human right of sport and play was initially protected in Article 31 of the UN Universal Declaration of Human Rights in 1989 (Higgs, 2012, p. 240). Organizations such as UNICEF, UNESCO, USAID and the International Olympic Committee also support the practice of play through sport as a basic right (Higgs, 2012, p. 6). For many people around the world, sport and play are “immediately and inextricably tied to the notion of childhood” (UNICEF, n.d.). In fact, the UN dedicated 2005 as the year of development through physical education and sports in attempts to achieve the Millennium Development Goals. Through sport, children are able to explore, discover, create and enjoy life, playing in a happy and lively way, and every person should be entitled to these opportunities.

Instrumental value: health and organized sport as a vehicle for other positive outcomes. A person’s right to health and right to play are mutually complimentary, as physical activity improves one’s health and one’s health can enable or staunch one’s ability to play. In this way, the right to health is contingent upon, and contributes to, the realization of other human rights. WHO notes that protecting, fulfilling and respecting human rights and promoting and protecting health are inseparably linked; for example, reducing one’s vulnerability to ill health can promote one’s right to information and education and vice versa (WHO, n.d.b). In this way, the right to health includes a host of subsidiary rights such as safe drinking water, adequate sanitation and health-related education. Additionally, health can determine one’s school

attendance, later occupation and duration of working life, which weigh upon the economic growth of countries.

Similarly, play has both intrinsic value and instrumental value, insofar as it contributes to the health of individuals and communities. A child's right to play can be converted into opportunities to build critical life skills through organized physical education and sports programs. Sports contribute to capacity-building, one of the central points of Sen's definition of development as freedom. Sport has the power and potential to transcend political, ethnic, social, cultural, gender and class divisions—it can bridge gaps between diverse peoples, encourage inclusion and cooperation, diffuse information, reach the most marginalized and diverse populations and keep people active, involved and interested in community building. Well-designed sport and play programs can positively influence child health and youth development, speaking to them in a way they understand and see as credible. In fact, there are few areas in development where sport cannot be used as a platform to strengthen communities and improve lives (UNICEF, n.d.).

Well-designed sport programs promote social, physical, emotional and cognitive development and have the ability to transform lives in unique and powerful ways. It contributes to “full body wellness, emotional well-being, strong resilience, lively mind, social competence and creative spark” (One World Play Project, n.d.). Socially, sports can encourage inclusion and cooperation, garnering ties among diverse groups. For example, sport can teach children essential values and life skills such as respect, cooperation, leadership and teamwork. Physically, sports promote healthy lifestyles and encourage the values of fitness and nutrition. Emotionally, sports can teach youth how to express their emotions, gain confidence in their abilities (especially among adolescent girls), develop a positive body image and achieve their

personal goals. Cognitively, there is evidence that sports encourage better academic performance. Studies have shown that high school athletes receive better grades, have higher educational and occupational goals, devote more time to doing homework and have a more positive attitude towards school than non-athletes (Rees & Sabia, 2010, p. 752). Children may learn better when they are having fun, being active and taught from influential figures in their lives. Hence, sport can contribute to individual's well-being, health and education, thereby building capabilities for individuals and communities.

Tackling HIV/AIDS through sport

It is generally recognized that the HIV/AIDS pandemic raises many human rights issues, such as the right to freedom from discrimination, the right to life and the right to the highest attainable standard of health. Thus, safeguarding and fostering human rights is essential for thwarting the transmission of HIV and reducing the impact of AIDS on people's lives. To link the intrinsic and instrumental values of freedoms in the case of health and play, sport programs and activities can be used as a way to realize an individual's rights to health and play through engaging young people and providing a platform for education and information about HIV and AIDS. For all of the aforementioned reasons, sport can and should be used as a method to prevent the spreading of the virus as well as to avoid stigmatization of those infected.

The global appeal of sport makes it an ideal medium to educate and empower entire communities to fight communicable disease and promote "holistic life-long approaches to health," such as the importance of physical activity to health and well-being (Right to Play, n.d.b). Sport is an attractive intervention method because it has the power to entice and engage young people. In sub-Saharan Africa, where 62% of all young people infected with HIV live, sport is the most popular activity among teenagers of both sexes (UK Gov., 2006, p. 13).

Therefore, educating children regarding health issues can and should be coupled with the convincing and far-reaching power of sport to help reduce the spread of communicable diseases.

According to the UN, sport for development initiatives have proven highly successful in reaching populations that are most at risk of infections (Ottier, 2005, p. 12). Since there is no cure, education and prevention programs are the principal and crucial ways of decreasing HIV/AIDS infection and death rates. In the words of the World Bank's Lead Specialist for Education and HIV/AIDS, education is "the social vaccine" against the disease, because, after all, HIV/AIDS is 100% preventable (Griffiths, 2005, p. 3). Coupling education with sport enables what the WHO declares is the most effective way that young people develop new skills—learning by doing and taking part in active, enjoyable learning experiences (Right to Play, 2015, p. 6).

Sport can contribute to effective HIV/AIDS programming through "knowledge, life skills, the provision of safe and supportive environment and access to services" (Banda, Jeanes, Kay, & Lindsey, 2008, p. 5). Research from the U.S. shows that girls who participate in sport "tend to begin sexual activity later, have fewer sexual partners, use contraception more (particularly condoms) and are less likely to get pregnant" (UK Gov., 2006, p. 8). This provides reason for believing in HIV/AIDS initiatives that utilize a sport model, as abstinence and some forms of protection during sexual encounters (especially the use of prophylactics) significantly lowers the likelihood of contracting the virus through sexual activity (Ottier, 2005, p. 31). HIV and AIDS education also reduces the risk of HIV by "delaying the age of first sexual encounter, increasing male and female condom use, reducing the number of sexual partners among those already sexually active, promoting the early treatment of STIs, facilitating access to confidential

and voluntary counseling and testing, and reducing other behaviors that increase risk such as drug use, in particular injecting drug use” (Visser, Valfrey & Sass, 2009, p.16).

Additionally, it is generally accepted that participation in sports positively benefits people living with HIV (IOC & UNAIDS, 2005, p. 48). Moderate exercise boosts the immune system and has cardiovascular benefits for those currently living with HIV. Additionally, psychological tests show that sports cause a reduction in depression, stress, and fatigue as well as increase the quality of life for those infected (IOC & UNAIDS, 2005, p. 48). Their participation in sport helps break taboos surrounding the virus and promotes social inclusion and support, which is extremely important for HIV-positive people (Kruse, 2006, p. 6). Including HIV-positive individuals in sport requires proper precautions against blood-borne infections, but once staff members are appropriately educated on First Aid procedures and precautionary measures are taken (such as using medical gloves to treat wounds), sport activities benefit infected and non-infected individuals alike (Kruse, 2006).

Organizations in sub-Saharan Africa

Most sport-for-HIV prevention programs in Africa use soccer to share information and raise awareness about HIV/AIDS in hopes of minimizing youth’s risk of contracting the virus (Sport and Development, n.d.). UNICEF reports that young people, aged 15-24, comprise “45% of all new HIV infections, and that many young people still lack accurate, complete information on how to avoid exposure to the virus” (Right to Play, n.d.c). Some African countries cannot financially or logistically provide drug therapies for the multitude of individuals infected, and in the absence of a cure, prevention is the next best option. Since it is usually considered a taboo subject, the establishment of safe and informal spaces to discuss HIV/AIDS through sport and games allows youth to learn about ways they can protect themselves and avoid risky behavior.

UNICEF released a global report on Sport, Recreation and Play that asserted the importance of sport-based organizations in mitigating HIV/AIDS: “through sport, young people have the opportunity to talk about HIV/AIDS openly and with sensitivity and learn ways to protect themselves from the disease, including how to resist unwanted pressure and intimidation... An open discussion about HIV/AIDS can also counteract stigma and discrimination and promote care and support for those affected by the disease” (Right to Play, n.d.c, p. 1).

Sport programs maintain many strengths that make them worthwhile money and time investments. Firstly, they can be low-cost and utilize locally available space and resources. Moreover, sports NGOs that operate at the local level have comparative strengths to alternative approaches in many ways. Due to their more adaptable administrative systems and less cumbersome bureaucracies than governmental organizations, sport NGOs are able to formulate and implement programs faster than governments, which is of particular importance at a time when HIV/AIDS is infecting and killing young children by the minute. Furthermore, NGOs that are created and/or staffed by local community members give their programs credibility; their staff have an understanding of the community they serve and are more likely than foreigners to attract community involvement in HIV/AIDS prevention programs (Griffiths, 2005, p. 12). In the realm of sport for development programs, adapting the programming to each community requires local knowledge such as translating to the local language and changing the names or situations in role-playing games. By employing members of the community, these programs can realize appropriate and effective approaches for the specific area and bring a sense of community ownership to the projects. Lastly, locally sensitive sport programs can act as facilitators between local communities and other sectors such as schools and the country’s government.

Sport for development programs can address the HIV/AIDS pandemic through four pathways: education about the disease and preventative strategies, skill building to enhance youth's capabilities to make informed decisions, knowledge about resources in various realms and an avenue for youth to gain role models. Sport programs can and have utilized a range of approaches to provide youth with education regarding HIV/AIDS, skills for disease prevention and safe and supportive environments for them to feel comfortable asking questions.

Additionally, life skills such as those related to critical thinking, decision making, problem solving and communication help youth navigate risky sexual situations.

Some examples of current programs in sub-Saharan Africa include Mathare Youth Sports Association, Right to Play, Alive and Kicking and UNICEF partnerships. Mathare Youth Sports Association encompasses adolescents ages 9-18 years old and is located in the Mathare slum of Nairobi, Kenya; it aims to impart HIV/AIDS information as well as motivate its participants to stay safe (Ross, Dick, & Ferguson, 2013, p. 279). This program fosters informal conversations among youth through facilitating peer discussion groups at half time and before or after matches (UK Gov., 2006, p. 10). Right to Play uses a similar model, motivated by the idea that taboo topics like how HIV is spread and the importance of condom use are best breeched when coaches lead conversations regarding sexual and reproductive health in the safe environment that sports create for youth. Right to Play's "Live Safe, Play Safe" skills-based health education curriculum expands young people's awareness about HIV/AIDS and builds their skills in "negotiation, assertiveness, coping with peer pressure and feeling compassion for those with HIV/AIDS" (Right to Play, 2015, p. 6). Alive and Kicking uses the soccer ball itself to spread messages by printing HIV prevention slogans on the balls to be used by Kenyan schools (Alive and Kicking, n.d.). Through partnerships with celebrity sports teams, like the partnership between Manchester

United Football Club (a professional soccer club from England that competes in the Premier League) and UNICEF, some programs utilize the media and famous sport role models to advocate for change in attitudes and behavior.

Since girls and women are most affected by AIDS, poverty, poor health and other social problems, some programs are specifically designed to target females. Sport has been traditionally viewed as a male domain, especially in sub-Saharan Africa; however, findings from preliminary studies in developing countries demonstrate that young women who participate in sports learn crucial life skills, develop greater self-esteem and build self-confidence, making them less likely to engage in risky behaviors (UK Gov., 2006, p. 12). Playing sports also helps girls build social status and a healthy self-image that challenges stereotypical and traditional gender roles (UK Gov., 2006, p. 11-13). HIV/AIDS is passed from mother to child through birth and breastfeeding; hence, by reducing the number of women infected with HIV, education through sports can prevent future generations from being infected as well.

One program that empowers girls through soccer and education is Go Sisters in Zambia. Go Sisters acknowledges that sport can be used to address the wide range of social problems affecting girls. Go Sisters strives to help girls develop a sense of belonging, find social support within their communities and boost their self-confidence. One of the program's aims is to increase girls' participation in physical recreation and use sport as a tool to empower girls with skills and resources such as HIV/AIDS education. Chola, Clara and Lister, three Go Sisters participants, comment "since Go Sisters came to our school, we participate in sport twice a week and are feeling very active and happy" (UK Gov., 2006, p. 12).

Programming. "People who are physically fit and eat a balanced diet cannot get HIV." Lindiwe contemplates for a second, places a "false" card down and taps her classmate on the

shoulder so he can dribble down the field to another card. This true or false relay is one example from the Kicking AIDS Out (KAO) movement, an African initiative started in 2001 by Edusport Foundation in Zambia (Kruse, 2006, p. 1). The program also uses traditional games like “Agode” where groups of children sit in a circle, sing rhythmic songs and pass rocks around; when the leader yells “Stop!” and one of the children has three stones, the leader asks them to imagine the stones are facts about HIV/AIDS. The discussion then ranges from the responsibilities they have towards sharing information with friends and families and why it is important to share this information. Additionally, role play games provide youth with an interactive learning process to address issues such as stigma, where coaches can facilitate discussions about in-group bias.

KAO has now developed into an international network of organizations that enables the sharing of experiences and information and the promotion of policy development. KAO also works to improve teaching and learning strategies of schools and sport programs and provides regional training and support to members in the network. The Norwegian Olympic Committee and Confederation of Sport (NIF) report that representatives from the government, donors and other NGOs strongly believe that the KAO Alliance has helped young people learn more HIV/AIDS facts and prevention strategies (Kruse, 2006, p. 1). Surveys sponsored by the NIF report that there is evidence of an increase in youth discussing HIV/AIDS with their parents, which is interpreted by the organization as a sign that young people are more open to talk about the issue and are making more informed and mature decisions (Kruse, 2006, p. 33).

**Evaluations of organizations: Exploring the instrumental value of sport in improving
HIV/AIDS education and outcomes**

Personal experience. My analysis of sport for development programs in sub-Saharan Africa is informed by my personal experience. I did my Shepherd internship with Soccer Without Borders (SWB) in Kampala, Uganda, which in my estimation has significant, positive impacts on the community and population it serves. The dirt pitch in the Nsambya neighborhood of Kampala was typically crowded with local players and fans. The pitch was a hub of action in the neighborhood, where people of all ages gathered to eat, chat, spectate and play. Every day I witnessed children play with remarkable joy and abandon and heard about how SWB is the highlight of their day. The relationships among the program's participants and the skills they acquired through the program have yet to be quantified by a formal study. However, my general impression, based on many expressions of gratitude and affection, was that youth and parents were deeply grateful for the program. My experience with SWB led me to believe that sport has great potential to bridge networks across social, ethnic and economic divides.

My internship also exposed me to the widespread lack of education about HIV/AIDS in sub-Saharan Africa. The locals I encountered, including the local coaches employed by SWB, had little to no health education. For example, they did not wash their hands before or after treating blood wounds (a common occurrence on the hard, dirt soccer pitch) and they also did not use medical gloves around open lacerations. Due to this and other related occurrences, I concluded that there appeared to be a significant need for health education among the population.

In the case of SWB and similar cases in sub-Saharan Africa, schools were not the optimal answer to spreading needed health education to today's youth. None of our 300 refugee participants were enrolled in Ugandan schools due to financial constraints, as school fees are far too expensive for families living in poverty to afford. In fact, UNESCO reported that in 2011, 21.5% of children in sub-Saharan Africa did not attend primary schools (UNESCO, 2012).

Therefore, needed virus education that may be taught in schools does not reach these children. My own experiences with SWB are further confirmed by a UNESCO proclamation in 2008—“in many countries, the majority of children and young people who are most at risk, and therefore most need to learn about HIV prevention, have never been to school or are no longer in school” (Visser-Valfrey & Sass, 2009, p. 21)

Additionally, Uganda and other sub-Saharan African countries have widely reported problems with teacher training, attrition and absenteeism rates in schools (Griffiths, 2005, p. 8-10). Many educators report that they do not believe that health education is within the proper scope of their duties as teachers. More broadly, throughout many sub-Saharan African countries, a culture of silence surrounds HIV/AIDS that impedes teachers from giving students needed sex and health education (Griffiths, 2005, p. 6-7). Another obstacle to using schools as vehicles for HIV/AIDS education are the pervasive financial constraints of the African education system (Griffiths, 2005, p. 8-10). Schools' curricula are already overloaded and because of widespread stigma, they do not tend to make room for health education. Since the most vulnerable youth often do not attend African schools, and many other obstacles face the schools themselves, youth must receive HIV/AIDS education using non-formal systems of education.

Survey results. Evidence has become increasingly clear that young people who participate in sport for health development programs display higher levels of knowledge about HIV/AIDS and higher levels of self-efficacy than those who do not—both important steps in reducing an individual's risk of exposure to the disease. Although some studies utilize small sample sizes and weak study designs, as sample sizes get bigger and studies gain more validity, there is increasingly strong evidence of the positive effects of programs on a range of factors that affect HIV/AIDS rates.

Using a small sample size of two groups of 40 adolescents ages 14-18 (20 girls and 20 boys in each group), KAO attempted to assess its impact in comparison to those not exposed to the program. Results of the study showed that there were notable differences between the treatment and control groups in three questions: “the ability to make independent decisions, the ability to say no in matters of sex” and also on self-reported “level of self-confidence” (Kruse, 2006, p. 35). The primary investigator subsequently argues that decision making and self-confidence may be fundamental in preventing contraction of the virus, and that it is likely that KAO activities contribute to the strengthening of such life skills (Kruse, 2006, p. 39). On other items, the study found that there were insignificant differences between the groups in the level of knowledge about HIV/AIDS, namely, attitudes to stigma and discrimination (Kruse, 2006, p. 35). Although not true for all areas of Zambia, the young people of the Kabwata and Chilenje Compounds seemed, for the most part, to be gathering HIV/AIDS knowledge from other channels. Although one of the survey’s hypotheses was that KAO participants and non-participants would display statistically different levels of knowledge about HIV/AIDS, KAO is still important in these areas even if its main benefits are different than those originally conceived.

Using survey data from four intervention schools and a control group (n=314), the Children’s Health Council, an affiliate of Stanford University, administered a survey to evaluate Grassroot Soccer (GRS) in August of 2004. GRS, located in South Africa, Zambia and Zimbabwe, integrates soccer with “evidence-based HIV prevention and life skills programs that arm young Africans with the knowledge, skills and support to live HIV-free” (Grassroot Soccer, .). Using a small grant from the Bill and Melinda Gates Foundation, as well as overwhelming support from targeted communities, GRS is an international nongovernmental health

organization that targets seventh graders to provide them with HIV knowledge and understanding using professional soccer players and other role models. GRS uses a framework based on social learning theory by Dr. Albert Bandura (a behavioral change psychologist and board member of GRS) that theorizes that people learn to change their behaviors through observing role models and imitating them. Taking strides towards gender equality, GRS participants are comprised of 50% males and 50% females.

The study by the Children's Health Council was carried out on four of nine schools in Bulawayo, Zimbabwe with the goal of reducing the spread of HIV/AIDS through training adult soccer players to educate at-risk youth. The program trained fourteen locally and nationally known soccer players who were identified as acknowledged role models for the students. The independent evaluation reported that "overall, the Grassroot Soccer Program is a culturally appropriate, internationally suitable, creative, and effective way to educate at-risk youth about HIV/AIDS and its prevention... Significant changes in students' knowledge, attitudes and perceived social support are observed as a result of the program. These changes were sustained after five months" (Botcheya & Huffman, 2004, p. 3). The majority of students also reported that they were very satisfied with the program and wanted to see more ways to sustain the results. Furthermore, teachers in schools reported that they wanted to be involved in future projects.

Using a larger sample size, an independent evaluation was carried out on Right to Play's "Live Safe, Play Safe" program in 2008; it took place over 3 months and spanned 3 different countries, engaging over 1,000 participants using interviews, surveys, questionnaires, site visitations and focus groups. After the program, "95% of participants in Rwanda and 87% of participants in Sierra Leone were able to correctly identify unprotected sex as being the leading

cause of HIV infections. Program participants also expressed more informed attitudes related to risk-reduction behaviour, and demonstrated sophisticated coping mechanisms to confront issues related to HIV and AIDS in their own lives” (Right to Play, n.d.c). When compared to those that did not participate in the program, participants were more likely to correctly diagnose how HIV was transmitted, how to determine HIV status and subsequently what to do. Specifically, Right to Play boasts “92% of kids in [their] programs knew ways of preventing HIV from sexual transmission vs. 50% of kids not in [the] program” (Right to Play, n.d.a). Additionally, participants demonstrated more positive attitudes towards those living with HIV and AIDS and were less likely than members of the control group to discriminate (although Right to Play did not publish exact quantitative results on these items) (Right to Play, n.d.a).

Yet another program, EMIMA, was established in 2001 to reach at-risk youth in sub-Saharan Africa. After finding that campaigns coordinated through hospitals, schools, churches and the mass media in Tanzania did not seem to decrease HIV infection in youth, locals recommended programs try to involve peers and use more valued and familiar activities to reach adolescents. A private organization carried out an eight week experiment to assess the effects of education through sport with peer coaches distributing the educational messages. The sample included 800 participants divided into three groups: the intervention group used sport to learn about HIV and safe sexual practices while the control groups either received traditional school AIDS education or were neither involved in school education nor the EMIMA Programme. After eight weeks, a questionnaire asked basic questions regarding the participant’s demographic information, HIV/AIDS knowledge and their beliefs, attitudes and the risks of sexual behavior. The findings showed the AIDS education through sport and peer coaches was more effective than conventional education or no education at all: “sport participants increased their HIV/AIDS

related knowledge, expressed intention to avoid unsafe sexual practices, had more experience with condoms and perceived to have control in engaging in unprotected sex. The changes were observed [eight weeks] after [the] intervention” (Maro, Roberts, & Sorensen, 2009, p. 129).

Furthermore, Kaufman, Spencer and Ross (2013) carried out a systematic meta-study on the effectiveness of sport-based HIV prevention interventions to assess programs implemented in Zimbabwe and South Africa across 6 categories of HIV-related outcomes. Overall, “strong evidence was observed for positive effects on HIV-related knowledge, self-efficacy, reported communication and reported recent condom use by roughly 20-40%” (Kaufman, Spencer, & Ross, 2013, p. 987). The review found largely encouraging evidence for short-term effects but relied on predominately low quality studies with small sample sizes. Kaufman, Spencer and Ross note that it is not possible, with current information, to draw conclusions about the comparative impact of different sport-based interventions (e.g. KAO vs. GRS) because each of these studies uses different approaches, strategies, indicators and methods. Therefore, more rigorous and comprehensive research needs to be carried out to objectively assess the programs’ comparative effectiveness. Future studies should compare the impacts of various programs to determine the most beneficial and efficient use of scarce resources. Overall, the researchers concluded that sport activities combined with HIV interventions are indeed a new, innovative and promising way to approach the fight against HIV/AIDS (Kaufman, Spencer, & Ross, 2013, 987).

Critical Analysis

Although rigorous longitudinal and comparative research is needed to more conclusively determine whether sport for health development programs impact infections rates in sub-Saharan Africa, studies performed to date provide highly suggestive positive evidence of such an impact.

One limitation of the studies performed thus far is selection bias; people and children who participate in sport may have more interest in their health, more access to resources that give them time to participate in sports, and more interest in learning from what the sport programs have to offer.

One potential model for a research design to provide better data and overcome selection bias comes from Abhijit V. Banerjee and Esther Duflo, who use natural experiments and randomized evaluations of implemented programs to see if significant differences appear and persist between different groups (Banerjee & Duflo, 2012). One type of study that could further research in this field would be to advertise for a sport program that utilizes an HIV/AIDS education model in a number of randomly selected neighborhoods in sub-Saharan African countries. To control for selection effects, the study could look at three different groups at each site: a control group that never applied for the soccer program, a group that applied and was accepted to the program and a group that applied but was not accepted. The study would then collect survey data and health outcomes from the three groups over the course of their lifetimes. This type of study would satisfy the need for long-term, comprehensive data and correctly control for selection bias, or the fact that individuals and families who participate in sport programs may already be health conscious and/or have strong social capital and thus access to information on HIV/AIDS outside of the sport program.

Intrinsic value revisited. No matter the results of previous or future surveys, sports are still intrinsically valuable. Sen, for example, would say that the freedom to engage in organized sport is important regardless of whether it raises HIV/AIDS awareness, future incomes or any other instrumental use. This is because play, as an end rather than merely a means, contributes to human development. Its value in enhancing human health is an added benefit of sport, but does

not take away from the fact that by itself, sport and play is intrinsically valuable and a human right. Likewise, health is intrinsically valuable and also contributes to a person's dignity and well-being.

Unfreedoms like socioeconomic status, geographical location and economic poverty should not bar people from the capability of either play or health. Education regarding preventable diseases and the enjoyment of recreational activities should not be available only to those that are more economically privileged. Sen would say that these unfreedoms link closely to the lack of public facilities and social care, such as the lack of arrangements for HIV/AIDS health care and educational programs, for those living in poverty. Without access to programs such as Grassroots Soccer and Soccer Without Borders, individuals in sub-Saharan Africa are being denied the freedom of basic capabilities to which they are entitled. By increasing access to and scaling up successful sport for health development programs, organized sport can be an avenue to provide youth with the basic entitlements of health and play.

Recommendations

Sport for development programs can impact youth self-efficacy and education about safe sex practices and HIV/AIDS. However, to maximize their impact and become a key player in the global fight against HIV/AIDS, sport for development programs should broaden their scope by increasing female participation and fostering partnerships with other non-sport social sectors. Taking additional steps beyond simply providing soccer programming and establishing stronger partnerships with the education, health and government sectors will help programs more effectively encompass the widespread and pervasive nature of the pandemic.

Targeting adolescent women. Fifty nine percent of HIV positive individuals in sub-Saharan Africa are women. For example, Human Rights Watch reports that HIV prevalence is

five times higher among girls than boys in Zambia (Human Rights Watch, n.d.). Unfortunately, women continue to suffer from marginalization and subjugation, not only in sub-Saharan Africa but also throughout the world. Hence, they generally do not have equal opportunities as men to engage in sporting activities. Although it is true that women and girls are less likely to participate in sport than males, it is a mistake to assume that they do not wish to participate. Some possible reasons for why a gender disparity exists in participation in sports include poverty (women are at a greater risk than men of living in poverty, as they earn roughly 50% of what men earn globally (Higgs, 2012, p. 37)), domestic demands, a lack of access or opportunities to participate in sport programs and sociocultural norms that prevent girls and women from being active in a recreational setting.

Some projects, like Go Sisters and Soccer Without Borders Uganda, are attempting to address gender bias by using sport as a didactic tool for women. However, soccer is a male dominated sport and although each gender should have equal opportunities, cultural barriers and preferences make sport for development interventions more difficult for young girls. To overcome this obstacle, and to make programs more holistically effective, members of the local community should primarily comprise the staff of these organizations, as these members understand local cultures and are more likely to recognize what is effective and appropriate for girls in their communities. Models that take advantage of local knowledge increase the potential of transforming community beliefs, attitudes and behaviors of the affected populations. An example of listening to locals and adapting programs to suit the needs of the community is the Girl's Program of Soccer Without Borders in Uganda. According to my own observation, unlike the Boy's Program, the coaches found that the girls enjoyed a combination of soccer, team building games and modeling practice, which is a local favorite in the Nsambya community. To

address the gender gap, all sport for health development programs should make a conscious effort to include at least 50% females and incorporate programming that empowers young girls using a locally sensitive approach.

Partnerships

Sports alone will not stop the spread of HIV/AIDS since social, economic, cultural and political factors affect its spread. International organizations, governments, NGOs, schools and local people need to work together to make real changes in communities at the grassroots level. This means that if sport for development programs are going to play an important role in improving HIV/AIDS education and decrease sub-Saharan infection rates, they will need to work collaboratively with other institutions in their area, region and internationally, thus broadening their scope beyond simply providing sports services. Partnerships should be promoted to coordinate HIV/AIDS responses within civil society and between civil society, the private sector, governments and international organizations and donors. By partnering with key constituencies in other social sectors, sport for development programs can better address the social, cultural, economic and political conditions that contribute to increased vulnerability for youth to contract HIV/AIDS as well as vulnerability to the daily and long-term struggles of living in poverty.

The hypothesized benefits of partnerships fall into two groups. Firstly, partnerships may result in more efficient and effective provision of resources; for example, Lister suggests that synergies derived from partnerships may make better use of scarce funds and proliferate the sustainability of interventions (as cited in Banda et al., 2008). Secondly, partnerships allow for the devolution of power, as large-scale development decisions are transferred closer to local communities. The epidemic differs by location and thus partnerships can help account for differences between neighborhoods and regions, rural and urban areas and population

characteristics (such as vulnerable and displaced groups). While isolated policies or programs cannot in themselves mitigate the impact of the disease, actions to strengthen partnerships across various sectors can help communities and nations respond more effectively to the pandemic.

Sport for development programs should utilize context specific, multi-sectorial and comprehensive vertical and horizontal partnerships to coordinate the HIV/AIDS response in sub-Saharan Africa. Organizations in this region should take lessons from KAO and Right to Play, as they are two prominent programs that have tapped into the potential of fostering partnerships. KAO, as noted previously, has developed into an international network of organizations that provides an avenue for sharing information and coordinating programming. KAO's network (called the KAO Alliance) also promotes policy development and provides regional training and support to members in the network (Kruse, 2006, p. 2-4). Also on a global scale, Right to Play works with international organizations like WHO, UNICEF and the Global Alliance for Vaccines and Immunization which not only help the program with funding but also with resources and information dispersal. Specifically, Right to Play in Uganda joined forces with UNICEF and the Ministry of Health to coordinate and implement an immunization campaign against measles (Right to Play, n.d.b). These organizations also involve the community in sport initiatives such as play days, commemorative days like World AIDS Days, tournaments and more.

Three major areas that sport for development programs should tap into include the education, health and government sectors. By broadening the scope of sport for development programs to reach these other sectors, organizations can enact more wide-scale change. One way that programs can utilize other agencies within civil society is through contacting coordinating agents that specialize in organizing HIV/AIDS prevention and care across different sectors. An

example of a coordinating agency in sub-Saharan Africa is the *Zambian National AIDS Network (ZNAN)* (Banda et al., 2008, p. 26). Since youth service organizations, education, health and national authorities play critical roles in developing and supporting non-formal education on HIV and AIDS, coordination across these sectors is essential in the future fight against the pandemic.

The education sector. As previously detailed, non school-based sport for development programs are important because they can reach the large sector of African children who do not attend school. However, there is abundant evidence that education in itself, even in the absence of HIV-specific interventions, offers an important measure of protection against HIV and AIDS (Visser-Valfrey & Sass, 2009, p. 15). The Global Campaign for Education estimates that “universal primary education would prevent 700,000 new HIV infections each year” (Visser-Valfrey & Sass, 2009, p. 15). Access to good quality, equitable education would require coordination between the education and government sectors for various tasks: removing financial barriers to education through the elimination of school fees and removal of hidden costs (i.e. books and uniforms); improving teacher training; addressing barriers that prevent girls from attending school; strengthening management and supervision of schools; and developing strong relationships between schools and communities so as to develop good quality curricula that are relevant to individual and societal needs and to the local context. Therefore, sport for development programs should partner with local schools in attempts to immediately tackle some of the wide reaching issues that face the education sector in sub-Saharan Africa.

One example of how sport programs could partner with the formal education sector would be for programs like *Grassroots Soccer* to involve and educate interested schoolteachers while at the same time educating role-model athletes and adolescents. Indeed, the evaluation done by the *Children’s Health Council* noted that the teachers were satisfied with GRS but would

like to “be more actively involved in the educational process” (Botcheva & Huffman, 2004, p. 3). Organizations can also partner with established programs like the Family Health Trust in Zambia that administers school education programs, such as Action AIDS clubs in schools (Banda et al., 2008, p. 23-26). Additionally, education can reach those who do not attend school to offer access to learning opportunities when coupled with sport for development programs. For these reasons, programs in sub-Saharan Africa should work towards developing ties and working with local schools to provide adolescents with comprehensive HIV/AIDS and health education.

The healthcare sector. Sport for development programs are a cost-effective way to impart HIV/AIDS programming through providing participants with knowledge, life skills, access to services and the establishment of a safe and supportive environment. Kicking AIDS Out, Soccer Without Borders and other organizations impart knowledge and skills to prevent youth from becoming infected with HIV as well as establish open environments for uncomfortable conversations; however, these programs have not tapped into or have not fully grasped the potential of the health service sector to provide their participants with access to health services in regards to HIV/AIDS. Sport for development programs should look to foster partnerships with healthcare agencies so that participants can be screened for HIV/AIDS and if found positive, can receive counseling and anti-viral medication. Healthcare agencies can also offer male circumcision services and distribute male and female condoms to families with children and adolescents in sport programs. An example of this partnership is Grassroots Soccer’s “Skillz Tournaments” that couple soccer games with voluntary counseling and testing (Grassroots Soccer, 2010). Furthermore, an agency in Zambia that sport programs could partner with is the Society for Family Health (SFH) that tests for HIV/AIDS, performs male circumcisions and uses social marketing to deliver condoms (Banda et al., 2008, p. 23-26).

Programs could also look to global organizations like the Red Cross for similar free services in their area.

The political sector. It is important for sport for development programs to take into account governmental policies, as a person's ability to avoid HIV infection depends only partly on their own individual knowledge and skills because social and economic factors that are out of a individual's control can put young people at a higher or lower risk of infection (Ross, Dick, & Ferguson, 2013, p. 33). An example of one of these factors that can result in young people having less power to reduce their risk of HIV is a country's social norms, such as the status of women in society. Governments should have a hand in implementing laws and policies to challenge gender inequality and social norms that contribute to HIV/AIDS expansion; however, this is not the case in many countries. Unfortunately for sub-Saharan African countries with weak governments, U.N. Secretary-General Kofi Annan notes that "in most countries where major progress against HIV/AIDS is reported, strong political leadership is a central feature" (Griffiths, 2005, p. 11). This aligns with Paul Farmer's (2004) notion of structural violence, or the notion that rights violations are symptoms of deeper pathologies of power linked to social conditions such as gender, race and class. In other words, structures are put into place (such as governmental, bureaucratic structures) that need to be amended in order to advance education, health policy, access to care and prevalence rates of the pandemic.

Therefore, in the short-term, sport for development programs should continue to facilitate girls programs to combat the lack of gender-neutral policies and set an example for other programs and sub-Saharan African governments. In the long-term, sport for development programs should think critically about their relationship to the governments of countries in which they work. They need to brainstorm and creatively come up with ideas about how to overcome

governmental issues, change governmental policies and/or support related efforts. For example, sport for health development programs can take a stand against government corruption and support pro-democracy efforts. In this way, sport for development programs can affect the root causes of the pandemic and poverty issues and exert a wider influence than they would without changes in policies, laws and governmental practices. Therefore, sport for development programs and their global partners should do their best to lobby and partner with governments to provide equal access to sports, health services and HIV-related information, education and means of prevention.

Conclusion

There is compelling evidence that sport for development programs are making measurable and worthwhile impacts, whether it is for health education, general well-being, or enabling equal access to opportunities. The AIDS epidemic has impacted human development by deepening poverty among vulnerable households and communities, devastating human capital and abating the capacity of institutions and systems. Therefore, any decrease in the epidemic and poverty rates of these countries should be valued. One uniquely effective prevention tool that should be further expanded and tested in the global fight against AIDS is sport for development programs.

Tragically, the children most at risk of acquiring HIV live in the poorest neighborhoods without access to prevention, care and treatment. Something needs to be done immediately to mitigate the far-reaching effects of the HIV/AIDS pandemic as more and more people are infected every day, thus pushing them deeper into poverty and eventual mortality. Fortunately, sport for development programs are currently making valuable contributions to furthering an individual's unalienable rights and facilitating the instrumental benefits of health and play. Sports programs have proven to be an effective instrument for social mobilization and outreach

for children that either don't learn valuable health lessons in school or do not have the opportunity to go to school. Likewise, many governments in sub-Saharan Africa are not fully capable, at this time, of providing quality HIV/AIDS prevention programs. Therefore sport for health development programs are essential and a visible alternative to the slow moving governmental policy and problematic school systems in Africa.

Although future research and expansion of programs is needed, there is compelling, initial evidence that sport for development programs can strengthen youth's HIV-related knowledge, self-efficacy, reported communication about issues relating to the pandemic and reported recent condom use—valuable contributions in combatting the spread of HIV/AIDS. Additionally, sport for development programs have strength and value in their ability to entice youth's interest, attract community involvement, employ locals, implement programs and changes quickly, and be culturally sensitive.

Sport for health development programs are not necessarily a panacea to the epidemic but one component within a broader set of interventions, all of which have a place in enacting change. Broad-reaching programs are especially important since some of the highest infection rates occur in countries with other barriers to well-being including food insecurity and high poverty rates. The HIV epidemic's effects are far-reaching—impacting households, communities, healthcare systems, economic growth and governments. Therefore, in order for sport for development programs to achieve their full potential, they will need support from such entities. Partnerships between sport for development programs, schools, healthcare programs and governments will further the goal of realizing an AIDS-free sub-Saharan Africa.

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