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HOW PEER PRESSURE CAN TRANSFORM THE WORLD

TINA ROSENBERG
WINNER OF THE PULITZER PRIZE

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Join the Club

How Peer Pressure Can Transform the World

Tina Rosenberg

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To Rob

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Join the Club

THE MIST WAS STILL RISING FROM THE FIELDS ON A COLD Sunday morning in early May. In subdivision of brick-and-beige Tudor-style connected houses in Algonquin, Illinois, a far suburb Chicago, three men in sweatpants jogged up to the house of Ryan Boldt. His family still asleep, Bol stepped out the door and into the street. It was just before 6 a.m.

Boldt is an area pastor for Willow Creek Community Church, a megachurch with some 18,00 people at services every weekend, a church repeatedly named the most influential in America. Th men—Doug Yonamine, Tim Auch, and Matt Lossau—all live in the neighborhood. The Lossau famil even moved here in part to be near Doug and his wife, Jen.

For them, this Sunday-morning run is church. The men run through the subdivision and onto road alongside a field. They run slowly, talking the whole time. “Some of my most intense spiritu conversations have been on the bike paths,” Doug said. He is a kind, earnest, serious, and high organized man of Japanese ethnicity, then forty-three years old, who works in the legal department the Willow Creek Association. The men aim to run every Sunday, Tuesday, and Thursday morning a six—the hour dictated by Doug’s promise to Jen to be back in the house before their three childre wake up.

Doug, Tim, and Matt do more than jog together. The men and their families, along with tw other families, make up a Table group, one of Willow Creek’s neighborhood-based small groups. The do most of the things typical American suburban families do—but they do them together. They e dinner together once or twice a week. They exercise together. They take one another’s kids to an from Girl Scout meetings, church activities, and school sports. They meet to talk about the Bible an religious issues. When they have problems with their kids, struggles with their jobs or money personal challenges, they bring them to the group. The meetings, formal and informal, are church to a concept embraced by Willow Creek and the families who make up this small group.

There is some irony in the notion that Willow Creek would be encouraging its members to for the upper-middle-class, minivan-andriding-mower version of, well, a commune. Willow Creek wa built in the 1970s on the values of anonymity and isolation, constructed so people could meet Go without having to bump into other humans along the way. Back then, Bill Hybels, the church’s found and still its senior pastor, sought to construct a church that would reach out to the person he calle “Unchurched Harry.” Harry, the Willow Creek mythology held, was wary of church, so Hybels built Sunday service to make him comfortable, one that didn’t push him and demanded nothin Unchurched Harry, loath to be pressured or even approached, could simply sit and watch.

But Hybels soon realized that more mature believers needed more community. Like nearly eve other large church in America of any denomination, Willow Creek began in the 1980s to place i members in small groups, the idea being that moving nearer to God is best done in close relationsh with other people on the same mission.

Willow Creek’s small groups used to be very similar to those in widespread use. Eight or te people who shared some basic characteristic would get together every two weeks in someone’s livi room to discuss the Bible, talk about a particular reading, or simply discuss how to respond to dai

challenges in a Christ-centered way.

In the early 1990s, when he was still single, Doug Yonamine joined one. He signed up to be in small group with four other single men who lived all over the Chicago suburbs. The group chose par of the Bible to read and discuss or followed a small-group study guide.

Since they had not forged real connections, the members didn't see each other after the grou formally ended. When Doug once ran into the group's leader, he was startled; Doug had thought th man had moved to California.

The group had not satisfied him. He did not feel it was helping him grow in his relationship wi God. The meetings were too far away, too infrequent, too superficial. As he put it, "How do you g someone to become a fully devoted follower of Christ in six hours a month?"

Doug Yonamine's feelings were reflected by many others in the congregation. Willow Creek w beginning to realize that conventional small groups were failing many of its members. They could n provide the intimacy and community that people needed for their spiritual growth. A congregation survey in 2004 confirmed what Doug Yonamine felt: many of the church's most mature believers fe spiritually stalled in their small groups.

So, two years later, Willow Creek redesigned its small groups. Gone were the forty-five-minu drives, the contact limited to twice a month. Now Willow Creek held that the path to God was found "doing life" with next-door neighbors.

This was what was occurring on Sundays at 6 a.m. in Algonquin. The members of this Tab group—so named because its centerpiece is a communal dinner—are neighbors. They still hav formal gatherings twice a month, over dinner at the house of Tim and Michele Auch. But because the are neighbors, a lot of life is going on between the formal meetings. That's what creates the re intimacy. The men now jog together instead of going their separate ways at a health club. Several the couples were already going to Willow Creek services on Saturday night at 5:30. So they decided eat dinner afterward in the food court downstairs, as a group. The Auch family shared a back fen with the Moss family and their children treated both houses as their own. In this sprawl of anonymou Chicago suburb, the Table group has created a small town.

Over time, the members of the Algonquin Table found that the intimacy brought results. The started to take risks, to talk about deeper issues, more personal struggles. In the years before the Tab group started, Michele Auch had had a strong disagreement with God and decided she didn't want talk to Him. "I'd say to Tim, 'OK, I'm ready to try again. I should pray,' " she said.

"But I never did. And I never did. And I never did. I didn't climb out of it until the Table group didn't actually start trying until I was entwined in other people's lives again."

ACROSS THE WORLD LIES JAWALKE, a place so different from Algonquin, Illinois, that it is hard to believ the two communities share a planet. Jawalke is a village about an eight-hour drive east of Mumba India. Here are people who by accident of birth dwell at the very bottom of the earth's hierarch women from the Untouchable caste, a group so oppressed and reviled that traditionally they have walk with a little broom to erase their footprints as they go, lest they contaminate someone of high caste. Yet these women have something in common with Doug Yonamine and Michele Auch: they ar transforming their lives and their communities by joining a new peer group, one so strong and clos knit and persuasive that they have begun to think of themselves in a different way.

Babai Sathe spent her childhood, such as it was, caring for eight younger siblings. She did n attend a single day of school. Instead, she did farm labor for higher-caste families and often was pa in bread and vegetables instead of money. She was married at the age of ten.

Babai's husband was eighteen at their wedding, and had not wanted a ten-year-old wife. So h took a second one, and Babai went to live in her mother-in-law's house with her husband and his oth wife. There she settled into the traditional role of a daughter-in-law: servant. Her job was to take ca of the goats and cows and to carry the milk into the city of Jamkhed to sell it, a five-mile walk. Sh was given only stale bread and chiles to eat. Her husband and her mother-in-law beat her, sometim with a stick; she still bears scars on her foot and her lower leg. One day the beating was particular bad—she couldn't walk the next day. When her mother-in-law was out of the house, Babai ran away.

This was the life that women in rural India expected, especially Untouchable women. Babai w sure the rest of her life would be more of the same. "I thought about suicide," she recalled. "I had n support from anyone, no education, no money." The usual consolation for a woman in her situation that if she has sons, someday she too will become a mother-in-law, able to reduce her daughter-in-la to chattel. But Babai has no children.

She has, however, found other solace. Today Babai Sathe is a respected and influential perso one of Jawalke's village doctors. She provides prenatal care, delivers babies, weighs newborns, tak blood pressure, and treats diabetes and pneumonia and skin infections. She teaches women in Jawal how to cook nutritious food for their children, disinfect water, and avoid disease. She has organize campaigns to plant trees and vegetable gardens and to build toilets, and she has helped women obtain small-business loans. In a swift and dramatic shift that is reversing centuries of oppressio women in Jawalke are now starting their own businesses and participating in village-improveme projects, and Untouchables no longer face the same discrimination. This is in part due to Babai. An in 2005, Babai Sathe—still impoverished, able to read and write only enough to find the right bus an keep her logbooks—was elected mayor of Jawalke.

What happened was this: Babai became a member of a sisterhood of women recruited an trained to become health workers in their village. The Comprehensive Rural Health Project (CRHP founded by a husband-and-wife team of Indian doctors in 1970, is based in the nearby city Jamkhed. The program asks villages to recommend potential health workers from among their mo oppressed citizens, on the theory that it is these women who will care most about the health of th poorest. About half are Untouchables. Some have hands gnarled by leprosy. The model has grown t transform hundreds of villages, and it is being taught to tens of thousands of people who visit Jamkhe from all over the world.

The first step for the women is to go to Jamkhed for two weeks of training. There they lea about the diseases most common in rural India and how to treat and prevent them. They learn deliver babies safely. Most important, they learn how to teach others in their villages about thes practices, as the new ideas usually conflict with cherished beliefs.

Teaching the women these skills is not as difficult, or as important, as teaching them confidenc —encouraging the women, especially the Untouchables, to feel that they can speak up and hav something to teach. Shobha Arole, a doctor who is the daughter of the program's founders and no runs it, said that some women at first would not say their names or lift their gaze from the floor. The are so deeply entrenched in the caste system that some have difficulty accepting that women different castes can cook for each other or sleep in the same room.

But they encourage each other to change. After a few days, they make food for each other. The learn to sleep under one huge blanket. After the initial two weeks, each one spends a week in th village of a more experienced health worker. There the trainee can watch her work and, mo important, gain confidence that she, too, will someday be listened to and respected.

Then the trainees go back to their own villages, reinforced by a team of doctors, nurses, an

social workers who visit each village about once a week. The women go to Jamkhed every Tuesday stay overnight. Each week they study a new health issue—but just as important is the strengthening their bonds with their sister village health workers.

Each of these women began with not a scintilla of hope yet acquired a new identity. "First v change, then we go to work in the village," said Lalenbai Kadam, one of the oldest active heal workers. Each woman is now more prosperous. Although the program does not pay them for the work, they receive training and loans to start their own small businesses. Each is now respected by h fellow villagers. They have the satisfaction of improving the lives of the people with whom they gre up. "We tell each other our troubles," one health worker said. They also tell each other their successe

Babai still lives in a windowless hut, sleeps on a mat on the floor, and cooks outside over a tw fire, but the program has made her rich in other ways. "When I came to Jamkhed, I was like a sto with no soul," said Babai. "They gave me shape and life, courage and boldness. I became a huma being."

THIS BOOK IS THE STORY of a tremendously powerful kind of social change, one that has accomplishe astounding missions. It has drawn oppressed and destitute women in India like Babai Sathe out misery and passivity, women who have in turn transformed the people around them. It has broug worshippers like Doug Yonamine into a closer relationship with God. It has persuaded teenagers t demand safe sex. It has prompted black and Latino students to excel in college-level math and scien classes that minority students, even well-prepared ones, often fail. It has helped cure tuberculosis hundreds of millions of people around the globe. It has enabled generals to have confidence that the troops would emerge from their foxholes to face enemy fire. It has spurred millions to quit drinkin and drugs. It has led teens to rebel against cigarettes, in the process enfeebling a tobacco-compan advertising campaign of $35 million per day. It has organized a passive and fatalistic citizen subjugated by a dictator into the nonviolent army that overthrew him. I call this phenomenon *th social cure*.

I stumbled on the social cure by accident. As a writer, I have specialized in highlightin seemingly intractable problems. I had written a book about political violence in Latin America, an one on the moral and political conundrums of dealing with the past in post-Communist Europe. I ha written magazine articles about human rights, poverty, and public health. Problems were in endle supply. But it was starting to seem more interesting and valuable to write about solutions—to find th places where these problems were being solved.

In 2007, a friend asked me what I was working on. I related to her the story of Ivan Marovic´. few years earlier, Marovic´ had been a student in Belgrade, Yugoslavia, one of the leaders of th student group called *Otpor* ("Resistance" in Serbian), which sparked the popular movement th overthrew Slobodan Miloševic´ in 2000. Marovic´ then began to travel the world, working wi several other Otpor leaders to teach the methods the group had used to bring about nonviolent change

What made Otpor different from every other democracy movement I had ever seen was that focused on stripping away the fear, fatalism, and passivity that keep a dictator's subjects und oppression. Otpor turned passivity into action by making it easy—even cool—to become revolutionary. The movement branded itself with hip slogans and graphics and rock music. Instead long speeches, Otpor relied on humor and street theater that mocked the regime.

Serbia's youth saw life as bleak and hopeless. They thought of themselves only as passiv victims of dictatorship. But now this group everyone was talking about offered them a way to something important. Each of them could be a part of something, a protagonist, someone who cou

actually make history. Otpor turned fear inside out—the movement was appealing *because* of th risks. A teenage boy with no future—and very little present—could be assigned a cell phone an memorize passwords and hide from the police at midnight. He could be James Bond. If he wa arrested, he became a rock star, and the next day all the girls wanted his phone number.

Traditional democracy activists create political parties. Otpor created a party. People joined th movement for the same reasons they go to the hot bar of the moment. "Our product is a lifestyle Marovic´ said. "The movement isn't about the issues—it's about my identity. It's about being coo We're trying to make politics sexy."

While explaining to my friend my fascination with Otpor and its methods, it struck me that I ha already written this story—the year before, in a very different context. South Africa has a teen AIDS prevention program—from the available data, an effective one—called loveLife. It is to the class public-health approach what Otpor is to the typical political party. It doesn't focus on providin information about AIDS—South Africa's teenagers already know about AIDS and how to avoi catching it. Fatalism and denial, however, keep them from applying that information to themselves.

LoveLife doesn't try to scare teenagers. It doesn't lecture. Instead, it aims to create a "aspirational life-style brand for young South Africans," as its literature says. It was initially modele on a Sprite campaign. LoveLife uses celebrity gossip, music, fashion, school sports, relationsh advice, and media comprehensible only to teenagers to create a club that teens want to join. In th club, a girl can hear from another girl—from a similarly bleak and dusty township—why and how sh rejected a boyfriend who demanded sex without a condom. And she will start to think about doing th same.

THE TYPICAL ATTEMPT TO SOLVE a social ill focuses on giving people information, or it tries to motiva people through fear. But these strategies tend to fail exactly when the issue becomes most salient an emotionally fraught. The more important and deeply rooted the behavior, the less impact informatio has and the more people close their minds to messages that scare them.

This book tells the story of people who have successfully used a different way, one based o changing behavior by helping people obtain what they most care about: the respect of their peer Otpor was a student-led, antigovernment democracy movement in Serbia; loveLife is a governmen financed public-health program in South Africa. Willow Creek's Table groups are designed t motivate some of the world's most comfortable people to take psychological risks in order to deepe their religious commitment; Jamkhed's village-health-worker program encourages some of th world's least fortunate people to take social risks to bring better health to their villages and brea down caste and sex discrimination.

Although these campaigns differ in almost every conceivable way, they are in essence all th same campaign. They accomplish what countless efforts throughout the centuries have failed to d persuade people to take action that is crucial to their long-term well-being but appears unpleasan dangerous, or psychologically difficult today. They get people to join the demonstration or confro their inner demons or avoid risky sex or trespass on long-held concepts of proper behavior not b lecturing them about that long-term interest or, indeed, talking about anything rational at all. Instea they aim at what people want now: to belong, to be part of the in crowd, to be loved and admired an respected. These programs change personal behavior through social pressure. They offer people a ne and desirable club to join—a peer group so strong and persuasive that the individual adopts a ne identity.

"When I ask young people what made them change, they never say, 'You gave us information,'

said David Harrison, the former executive director of loveLife. “They say, ‘I feel an identity with new way of life. I can be like my friend whose life has changed.’ ”

No one would dispute the power of peer pressure to modify behavior. Along with genetics, pe pressure is probably the most important influence on who we are. The conventional wisdom used to that the way parents raise their children is what is key. Certainly parents like to think so. But th notion was effectively destroyed by Judith Rich Harris in her book *The Nurture Assumption*. Sh argued that once parents have passed along the genes, they have very little influence over the children—except to choose their child’s peer group. That peer group is what shapes us.

Harris marshaled the scientific arguments, but it is likely that she did not have to go far convince most readers of the importance of peers. It seems intuitively correct. One does not have accept Harris’s idea that parental nurture matters practically not at all to comprehend th overwhelming influence of peers. Our parents may be our first language teachers, but after we acqui peers, we learn how to talk from them—not only what language to speak but also how to pronoun words, which ones to choose, how loudly to say them. Peers control what we wear, what culture v consume, what we buy. The social norms set by our peers dominate our choices about what we valu and what we expect in life.

What is surprising is not the importance of peers but how little use most of us have made of th extremely significant fact. When I would tell someone I was working on a book about peer pressur invariably my questioner would assume I was talking about bad behavior. The term *peer pressu* usually carries negative connotations. People associate it with teens trying drugs and seeming grown-up families falling into debt to keep up with the Joneses. The purpose of this book is to argu that peer pressure can be equally powerful when employed for good, and to show how it is done.

Identification with a new peer group can change people’s behavior where strategies based o information or fear have failed. The social cure does this in a wide variety of situations. It work stunningly well with teenagers—the group most likely to be taking the kind of behavioral risks th cry out for help and, not coincidentally, the group most responsive to peer pressure. But it also work with adults. It is applicable in many different spheres of life, at all different levels of class an economic development. The social cure is a natural solution to help people take care of their ov health—to encourage them to accomplish the difficult tasks of avoiding risky sex; abstaining fro cigarettes, alcohol, and drugs; losing weight; getting exercise and following doctors’ orders. But also has been successfully applied to problems in fields as diverse as political change, universi education, organized religion, criminal justice, poor-country economic development, and the art war.

While many of the stories in this book are relatively recent, emerging even in the past decad the phenomenon is hardly new. The best-known example of the social cure is Alcoholics Anonymou (AA), which works by regularly gathering a small number of people with the common goal sobriety. They reinforce in each other a new pattern of behavior and a new identity, while holding eac other accountable for failure.

AA was born in the 1930s, but the social cure as an idea is much, much older. It has surel existed as long as war has. Armies run on unit cohesion. For a young man with his life before hi leaving the relative safety of the foxhole to charge into enemy fire—often in the service of a cause h does not consider his own—is unnatural behavior. He does it for his buddies, and because his buddie esteem reinforces his own identity as a brave soldier.

Every good military commander exploits this phenomenon. Shakespeare’s King Henry V uses to rally his troops to the Battle of Agincourt on Saint Crispin’s Day in 1415. In the play, Henry’s me

are outnumbered five-to-one by the French. When his cousin Westmoreland wishes for ten thousan more men, Henry stills him with a speech ending in these words:

> We few, we happy few, we band of brothers;
> For he to-day that sheds his blood with me
> Shall be my brother; be he ne'er so vile
> This day shall gentle his condition:
> And gentlemen in England now a-bed
> Shall think themselves accurs'd they were not here,
> And hold their manhoods cheap whiles any speaks
> That fought with us upon Saint Crispin's day.

This is probably the most famous passage in all of Shakespeare's history plays, and it is an example the social cure.

For centuries, organized religions have relied on the idea that your relationship with God deepened when you are also in relationship with others. Hence Jesus's fellowship with his disciple and the Jewish law that at least ten men are needed for public worship. Randy Frazee, a pastor who the guru of neighborhood-based small groups and presided over the formation of Willow Creek Table groups, likes to say that the Table-group concept is simply a return to what Jesus did.

The social cure has been employed by big organizations purposefully searching for a new way solve an obstinate problem. South Africa's loveLife and Florida's revolutionary antismokin campaign for teens were government-financed programs created by committee, spearheaded by peop who simply believed in getting inside teenagers' heads and reaching them with the messages to whic they will respond. Although these are both examples from the field of public health, the people wh came up with these strategies were—tellingly—not public-health specialists but marketers an advertisers by instinct.

Willow Creek, also a large bureaucracy, adopted an idea from Frazee, an outsider who wa considered rather eccentric. But eccentric is sometimes just another word for pioneering. Man examples of the social cure come from one innovator or a small team of them. Ivan Marovic´ was on of eleven students at Belgrade University who met in the city's cafés. They smoked, drank coffee, an hatched the unlikely idea that, armed with the sensibilities of Monty Python's Flying Circus and som really great black T-shirts, they could topple Slobodan Miloševic´, who by the time of his fall ha more blood on his hands than anyone in Europe since Stalin.

Babai Sathe was brought into the sorority of village health workers by a program founded by R and Mabelle Arole. The Aroles had graduated top in their class at Vellore Medical School—"a education that would make you a good doctor in France or Germany," Raj Arole said. But it was no what was needed in rural India. They set out on their own to create a new way to promote heal among India's poor.

Uri Treisman, in the 1970s a mathematics graduate student at the University of California Berkeley, adapted the social cure to the teaching of calculus in American universities. Treisman wa trying to solve a problem widely seen in college math departments: black and Latino students ofte did poorly in calculus. This was true even when they reached college well prepared and with high te scores. It was true even when they had taken calculus successfully in high school. Treisman was n willing to accept the usual conjecture about the reasons for this. What he came up with instead h revolutionized the teaching of math—to minorities, but not just to minorities—and upended th

conventional wisdom about why people succeed or fail in college.

In all these examples, the people who employed the social cure bushwhacked their own rout They possessed no map. They had to grope in the dark to formulate their ideas and make them wor They had to fight off the armies of conventional wisdom to defend them. Their stories, which form th basis of this book, show how the social cure's various creators invented it and fought for it, how the applied it and defended it against challenges, and how the social cure might work on other problems.

Because of these entrepreneurs, those who are wrestling with large and important soci challenges that have proven resistant to conventional attacks can now take a fresh look at the problems. We can draw on an accumulating store of join-the-club models for guidance an encouragement. Perhaps most important, these stories compel us to look at people anew. They reve novel answers to the questions of what moves us, what we want and need, and why we do the thing we do. The innovators described in this book have reimagined fields as diverse as public healt poverty alleviation, education, spiritual development, and political change. But they are also part of a even broader struggle—to reimagine social change, to introduce into common parlance a new strateg based on the most powerful of human motivations: our longing for connection with one another.

Turning Positive

IF AIDS EVER FINALLY VANISHES FROM THE EARTH , humankind will likely look back on one aspect of th epidemic as the most damaging and also the most puzzling: our near-complete failure to stop sexu transmission of the disease. There are very few people who do *not* know how AIDS is transmitted. good number of the people most at risk for AIDS have watched friends or family members waste awa and die from the disease. Yet they continue to have sex unprotected by monogamy or even condoms.

At the turn of the twenty-first century, AIDS was a crisis of biblical proportions in South Afric In 1990, only 1 percent of South African adults had been infected; by the end of the decade, th number was closer to 15 percent. In 1998, a fifteen-year-old in South Africa had a better than eve chance of dying of AIDS.

The government's response was minimal. Until 1994, when the apartheid regime fell and Nelso Mandela became the country's first black president, AIDS had been ignored. It was largely a blac disease, which meant the white government wasn't interested—indeed, a plague that selectively kill black people was welcomed by some hard-core apartheid supporters.

After 1994, AIDS was still not a priority in a country where the needs were endless and th government's to-do list infinite. South Africa's AIDS-prevention campaign was perfunctory consisting mainly of billboards featuring the iconic AIDS red ribbon. Then the health minister spent fifth of her AIDS budget to produce a play about AIDS called *Sarafina II*. The resulting scand paralyzed the government's efforts to fight the disease.

Nonetheless, even if South Africa had done what other countries were doing in the 1990s, it unlikely that would have helped to reduce the scope of AIDS. Then, as now, transmission of HIV, th virus that causes AIDS, happened largely among young people. Other countries were trying to reac teenagers through talks in schools, churches, and community groups and through advertisements in th mass media. They were telling teenagers what AIDS is and how it is spread, advising them to us condoms and limit their partners, and warning them about the threat of early death.

None of it was working. Rates of new infections among young people were going up, in som places soaring. Public-health experts believed that if teenagers understood what was at stake and we taught how to protect themselves, they would surely do it. But in country after country, teenage proved them wrong.

South Africa ended up trying something very different, a strategy designed not only by publi health experts—those usual suspects—but also by psychologists, advertising executives, marketin gurus, and teens themselves. They designed what eventually became South Africa's largest AIDS prevention campaign. It used no appeals to fear, and its information about AIDS arrived wrapped in coating of the frothy stuff teenagers love—pop stars, fashion, love advice, teen slang, and gossip. Th AIDS-prevention campaign concentrated on teens' need for belonging and connection. It tried to mak an HIV-free lifestyle fun and cool. Rather than resort to finger-wagging, it helped young peopl change their lives by putting them in the company of peers who had changed theirs.

THIS STRATEGY WAS BORN because in 1997, people concerned about AIDS in South Africa recognize

that something new was needed. “The challenge was how to get through to younger people, who we articulating feelings of AIDS fatigue, and no sense of relationship to the red ribbon and tradition symbols,” said Michael Sinclair, a South African who is now senior vice president of the Kais Family Foundation, a health charity based in California. Kaiser decided that if South Africans cou decide what was needed to prevent the spread of AIDS in young people, the foundation would pay f the campaign.

Kaiser staffers met with AIDS groups and government officials. Together, they decided that th campaign needed to target teenagers from twelve to seventeen. Research showed that most were sti HIV-negative at fourteen, and by eighteen it was already too late. The group also decided to hire Ju Nwokedi to conceptualize the program. Nwokedi was forty-one at the time, a charismatic whirlwi who had recently returned from exile in Thailand and Australia, where she had worked as psychologist with sexually abused children.

South Africa at the time was a particularly difficult environment for beginning a serious AIDS prevention campaign. So many people had the virus that any sexual partner had a one-in-six chance carrying infection. This was Russian roulette, odds that permitted no slip-ups.

No one is sure why the AIDS rate was and is higher in South Africa and its nearest neighbo than in the rest of the world. South Africans do not have more sexual partners than people in oth countries. Nor is poverty the answer. Even though South Africa and its neighbors—Botswan Lesotho, and Swaziland—have had the world’s highest AIDS rates, some of them are the riche countries in Africa.

There are several theories about what makes South Africa different. South African men a unlikely to be circumcised, and circumcision, as we have learned in the last few years, helps to prote men from catching HIV. Another factor may have been apartheid—a political system that segregate living areas by race and thus forced many male workers to live in hostels near their jobs, away fro their families. Separating families leads to a pattern of simultaneous relationships— one woman town, one in the countryside. Concurrent relationships help to explode the AIDS epidemic, as th amount of virus in a person’s body spikes right after infection; HIV is most contagious when fresh caught. Apartheid is gone, but southern African countries still depend heavily on mining, an industr that continues to separate men from their wives, and the tradition of conducting several simultaneo relationships continues.

South Africans, moreover, did not talk much about AIDS, and largely did not talk about sex. I contrast to America, where gay members of organizations such as ACT UP were so vocal that the forced AIDS into the news, AIDS in South Africa was smothered by a curtain of silence. In 200 when 600 South Africans were dying of the disease every day, President Thabo Mbeki told th *Washington Post* he didn’t know anyone who had died of AIDS.

People with AIDS were stigmatized to the point where the social reaction could be as dangerou as the disease. A small, soft-spoken woman named Gugu Dlamini was stoned to death by he neighbors in December 1998, three weeks after she announced at an AIDS-awareness gathering th she had the virus. Her attackers then threatened to kill her family. Nelson Mandela often said th when he told traditional chiefs that he planned to speak out about AIDS and sex, they told him h would lose their support. He did not give a speech on AIDS in South Africa until late 1998, four yea into his presidency. Parents usually limited their conversations about sex with their daughters “don’t run around with boys,” and with their sons to nothing at all.

One of the first things Nwokedi did was to commission surveys of South Africa’s teenagers. turned out that teenagers were completely turned off by the traditional prevention campaigns—“th

message was coming from Mars," she said—and were most receptive to an AIDS campaign that wa
about more than just AIDS. "They were saying, 'Don't isolate HIV and make it everything that I'
about as a young person. Engage with me on the level of my excitement and confusion as a youn
person—sex, parents, friends, drugs, school, rural vs. city,' " she said. "They were completely turne
off by the red ribbon. And they didn't want to be threatened."

So the message to teenagers had to change. The next question was how to reach them. "Th
normal way of AIDS or any peer education with young people was to pack them into the church hal
or the school hall," Nwokedi said. "They would have to sit there while someone would stand up the
and talk at them, unconscious of whether people were listening. And whatever they told you, you we
out and did the exact opposite because you were so angry that they kept you there for five hours.
wanted HIV education to have another dimension—it had to be interactive, engaging, question-an
answer, vibrant debate."

Under apartheid, young people had identified with collective political action. Now they we
tired of politics, tired of "we." An expansion of electrical service was bringing television to man
neighborhoods that had never had it before. Young people were tuning into the global popular cultu
they saw on TV, with a very high level of brand awareness.

Nwokedi convened a panel of advisers—including teenagers as well as advertising executiv
who designed messages. The working title for the campaign had been the National Adolescent Sexu
Health Initiative. Nwokedi and her advisers nixed that. "You're dead before you can even go out t
young people," she said. "They'd call it NASHI as an acronym—that was *soooo* public health!" Th
AIDS-prevention program had to be a brand.

The relevant model, they decided, was not any previous public-health campaign, but rather
recent relaunch of the soft drink Sprite. "Sprite took the brand off the shelf and into the communities
Nwokedi said. "They did basketball, fun activities. They sponsored concerts, sent cool kids on
campus, talked up Sprite in Internet chat rooms. It was very driven by celebrities in the communi
creating the hype. I was looking at what is tactile about your brand, what experiences you create."

Instead of a fear-driven, preachy, stodgy NASHI, the AIDS-prevention campaign becam
loveLife—positive, hip, and fun.

WHEN I VISITED LOVELIFE in 2006, the "aspirational lifestyle brand" was ubiquitous, one of the ten bes
known brands in the country. South Africa was dotted with loveLife's 1,200 billboards. Radio call-i
shows reached three million young listeners a week. LoveLife had TV spots and TV reality shows th
sent attractive young people into the wilderness to compete in AIDS-related games, such as using th
other sex's tools of seduction. A hotline dispensing advice or just a friendly voice received more tha
a million calls a year. A Web site and magazines featured not only graphic information about AID
but also fashion, gossip, and relationship advice. (The fashion tips were not those found in *Vogue*-
one issue of the magazine was promoting a contest for clothing constructed of found objects, costi
no money at all.)

The most controversial part of loveLife's media campaign—because it was the most visible
adults—was the billboards. Adults overwhelmingly hated them. "What does this have to do wi
AIDS?" they asked. Indeed, the connection of slogans like "Get Attitude!" to AIDS is distant. But th
grown-ups missed the point: the billboards were not designed to impart information. The billboar
were there to get people talking and get young people in the door of loveLife's programs. Enigmat
coolness can help. It reinforces the message that this is a *teen* thing—it told teenagers, "It's for yo
not them."

LoveLife's research shows that the media campaign by itself is not associated with behavi change in young people, but it brings them in to the face-to-face programs that are. "The logic of t brand is to create something larger than life, a sense of belonging," said David Harrison, the tall, lan physician who was the director of loveLife from 2000 to 2009. "That creates participation in clini schools—people go because they like to be a part of loveLife."

That is crucial, because young people already have information. The problem was to get them internalize it. South Africa's health surveys showed that young people knew that when *other peop* had unprotected sex, they could catch the AIDS virus. But they didn't see themselves in the sam position. There was no correlation between information and the internalization of risk. The mo chilling statistic was that two-thirds of young people who tested HIV-positive—in anonymou surveys, so they didn't know it—did not consider themselves at risk for AIDS.

Later researchers found that this had changed, had morphed into a phenomenon in its own wa equally terrifying. The study of HIV-positive people has not been repeated, but other studies aske young people about their behaviors and their perception of their own risk. The kids who were in fa having unprotected sex with lots of partners did accurately report that they were at high risk f catching HIV. But they had no problem living with that high risk. It had become normal, part of th background noise of life. AIDS information was ubiquitous, and teenagers internalized the message risk. They didn't care.

Especially for teenagers, the psychology of sexual behavior seems to reside in some deep ar mysterious place, apparently shielded, as if by a lead curtain, from the reach of traditional publi health messages.

So loveLife used new strategies to help the message penetrate the teenage mind. As Sprite di loveLife employed kids to recruit their peers. Almost all its programs are run by people th organization calls groundBREAKERS. They are between the ages of eighteen and twenty-five, traine in counseling and sexual health. Along with thousands of younger teens called *mpintshis,* or friend they run radio stations and computer workshops and school sports competitions (South Africa's onl public-school sports in most of the country). They teach debate and talk about sex, AIDS, ar relationships. When I visited in 2006, loveLife was recruiting 1,300 new groundBREAKERS eac year.

In Orange Farm, a bleak and often violent township southwest of Johannesburg, the loveLi center was a complex of buildings that drew kids in with a basketball court, radio production facilit and computer workshop, but anyone who wanted to take computer classes first had to complete AID training. LoveLife seemed to be Orange Farm's only after-school entertainment, aside from drinkin gangs, and sex. After school, it was always filled with kids.

The quality of the groundBREAKERS' programs varied with the local environment and the skil of the young people who ran them. Some groundBREAKERS, especially in remote rural areas, seeme unlikely to motivate anyone. They ran groups of kids through the usual repeat-after-me ro memorization of facts that was the hallmark of education in South Africa.

Some of the groundBREAKERS, however, were admirable. At Serokolo High School, in mining town in the northern province of Limpopo, twenty-three-year-old Tebatso Klass Leswi conducted a quiz on HIV, with plenty of discussion that ranged from whether girls get pregna because of the government's $30-a-month child grant to why you would want to know your HI status. It was raucous. Leswifi also worked at the local health clinic, helping teenagers fe comfortable going in to get information and treatment. He also ran a league with ten basketball team The high school's aerobics team— also coached in part by Leswifi—put on a show to the music

Laura Branigan's "Gloria." A seventeen-year-old named Princess said she called Leswifi every day f
some words of wisdom to motivate her to stay in school.

Leswifi seemed to be trying to save Serokolo High School's students from AIDS singlehandedl
He said loveLife saved him, crediting the organization with getting him off drugs: "They gave me
motivation manual that was like a mirror of myself."

In many ways, loveLife resembles a cult. This is a good thing. Many young people said th
loveLife had saved them in big or little ways, and they were on a mission to pass that along to others.

In 2006, loveLife contained a large dollop of the same public-health gospel that NASHI wou
have used: here's what AIDS is, here's how you catch it, now please abstain from sex, or be faithfu
or use a condom. This has become known as ABC—Abstain, Be faithful, use a Condom. But the AB
message is received very differently if it comes during a five-hour lecture in the church hall
wrapped in a powerfully motivating message from Sibu Sibaca. This was the groundBREAK-ER
secret weapon and loveLife's most important strategy: it teaches young people to motivate others b
sharing their own personal history. When a teenage girl hears about ABC from a public-health expe
in a church hall, it's in a language she doesn't speak. When it comes from Sibaca, it is urgently ar
immediately about her life.

Sibaca knows, because that's what happened to her. She is a petite, enthusiastic, energet
woman from Langa, a township outside of Cape Town. In 2006, she was twenty-two, a corporate soci
investment manager for Richard Branson's Virgin Group in South Africa, mature and confident. Sh
attributed her success to loveLife. When she was twelve, her mother died of AIDS: her father followe
four years later. "Before I joined loveLife, I had a serious history of self-destruction," she said. "I sa
my life ending up in the township, pregnant, not knowing who the father of my child is."

She managed to get through high school. When a friend told her about loveLife, she began goin
to its programs. "I had been engaging in highly risky behavior, but I pulled back," she said. "LoveLi
made me realize there were things I wanted to achieve in my life, and I couldn't afford to have se
without a condom. The reality is that every young person has a dream, but a lot of us look at o
situation and think, 'Who are we kidding?' But the minute someone triggers in your brain that [th
dream] is possible, so much changes. You start looking at life in a different way."

"Seeing billboards of a dying person didn't tell me about me," said Sibaca. "But when someon
says, 'You have such amazing potential that HIV shouldn't be a part of it'—then it wasn't about HIV
It was about me. No one is wagging a finger at me, just young people, peers, telling me the wa
you've lived your life is not good and we're going to help you. These were people the same age as m
It wasn't a celebrity telling me their story living in a million-dollar house. It was another youn
person from the same township as me."

She applied to be a groundBREAKER. LoveLife trained her to do motivational speaking an
gave her facts and ways to talk about teen pregnancy, peer pressure, HIV, and other issues. She went
work in a high school, teaching a class of twenty people a half hour to an hour a day for twenty-on
weeks.

She told me about one girl she had in class, a girl from Sibaca's own township. "She was fiftee
and came to me and said, 'My boyfriend is pressuring me to have sex without a condom.' Her fear wa
that her boyfriend would break up with her if she said no, and she had to hold on to him because h
gave her money and clothes that her family could not provide her with. I gave her all the differe
choices and consequences, and said, 'Are you willing to live with those consequences at age sixteen?

"She came to me the next week and said, 'I'm single.' She had broken up with her boyfriend.
hugged her and started crying—she saw her fears and was willing to go through with it anyway

Sibaca saw the young woman again several years later. “She was not HIV-positive and not pregnan
and she was going to study law the next year.”

WHEN LOVELIFE BEGAN IN late 1999, its founders set a goal of cutting in half South Africa’s rate of ne
AIDS infections within three to five years—in other words, by 2004 at the latest. This did not happe
From 2000 to 2004, there was no progress—the HIV prevalence rate among pregnant teenage
(pregnant women are the only people the government tests every year) was 16.1 percent in those year
And while no one in South Africa was happy about this, loveLife had been controversial, arrogant, ar
large enough that some people who worked on AIDS projects enjoyed seeing it taken down.

Clearly, the claim was one that loveLife’s founders never should have made. But the dismayin
stubbornness of the AIDS numbers did not mean that the program had failed. The national HIV rat
are not a fair measure of any program’s success or failure—especially prevalence rates, which do n
tally how many people became infected in a specific year. merely how many people *are* infecte
Many factors combine to steer an epidemic up or down, from economics (one theory goes th
Zimbabwe’s economic collapse has driven down AIDS rates, as men there can no longer afford t
maintain girlfriends on the side) to the availability of surgery (widespread adoption of circumcisio
would dramatically curtail the spread of AIDS) to the fact that epidemics run a natural cours
LoveLife is far from the only factor affecting the spread of AIDS. It is also not South Africa’s onl
AIDS-prevention program, although it is by far the largest and most comprehensive one, and the on
national program aimed at teenagers.

Then there is the issue of size. Although it is a national program, loveLife has always been brok
and has never reached more than 40 percent of South African teenagers with face-to-face programs
any given year. David Harrison, loveLife’s former executive director, estimated that to really crac
the epidemic, the organization needed to reach 60 or 70 percent of teens. So even if it were the on
thing affecting HIV rates, it would have to have a huge effect on the people it did touch in order
have much impact on the overall numbers.

Judged by other, more reasonable standards, however, there is evidence that loveLife is workin

In 2003, the Reproductive Health and HIV Research Unit of the University of the Witwatersran
in Johannesburg did a nationwide survey of fifteen- to twenty-four-year-olds. It found that those wh
had participated in loveLife’s programs were only 60 percent as likely to be infected with HIV a
those who had not, and the association was stronger for those who had participated in more than on
program. In other words, people who participated a little in loveLife had *somewhat* lower infectio
rates; those who participated a lot had *much* lower infection rates. The survey also found a stron
association between loveLife participation and increased condom use, the likelihood of talking abo
AIDS with friends and family, getting an AIDS test, and a greater sense of optimism about the futur
But the survey did not find any statistically significant effect on a reduction in the number of partner

Another study of loveLife’s effects was conducted in 2007 in one area of KwaZulu-Natal, th
province with the country’s highest rates of AIDS infection. LoveLife was the only AIDS-preventio
program operating in the area. The study confirmed most of what was found in 2003 in terms
loveLife’s affect on teen behavior, but it did no AIDS testing and so could not confirm whethe
loveLife’s programs were associated with lower rates of infection.

As for South Africa and AIDS, five years after loveLife began, something remarkable happene
Teen AIDS rates in South Africa began to stabilize, and then to drop. By 2007, 12.9 percent of teenag
women in prenatal clinics were HIV-positive, down from 16.1 percent in 2004—a 20 percent dro
National household surveys conducted in 2002, 2005, and 2008 also showed that teen AIDS rates we

dropping, by enormous margins. The rate of new infections among teenagers went up between 200 and 2005 and then plummeted. Among eighteen-year-olds, for example, it fell by 55 percent betwee 2005 and 2008.

At the time the news of the decline in teenage HIV rates broke, there was little celebration. HI rates were still terrifyingly high, and some 400,000 people a year were dying of the disease. Th government was dragging its feet—not just President Mbeki but also his disastrous health ministe Dr. Manto Tshabalala-Msimang, who put obstacle after obstacle in the way of antiretroviral treatmen and was derided as "Dr. Beetroot" for her statement that eating local foods was the way to deal wi AIDS. She, at least, was rejoicing at the new AIDS figures. "I think it's something we must celebra as South Africans, and say 'thank you' to the youth of this country, because we think they ar beginning to take prevention messages seriously," she told journalists in 2007.

But it turned out that on the issue of whether there was something to celebrate, Dr. Beetroot wa right. Some of the reduction may have been due to the maturing of the epidemic—HIV rates a beginning to stabilize in many countries. Indeed, the AIDS infection rate is beginning to drop in Sou Africa in general, but that is only because the decline among young women has been so stunning. F women aged fifteen to twenty-four, the best estimates show that the new infection rate dropped by 6 percent between the early part of the decade (2000–2010) and the latter part. (New infections, whi difficult to measure, are a far more accurate indicator of the epidemic than prevalence, especially countries like South Africa where prevalence figures are inflated by the new-widespread use antiretroviral medicines.) This decline is much greater than that seen among young people in oth high-prevalence countries, such as Botswana and Namibia.

Something is happening to teenagers in South Africa that is not happening to adults, and is n happening elsewhere.

The bad news is that as teenagers are wont to do, they are still having plenty of sex, and the have it early, and with multiple partners. The good news is that condom use has soared. Nearly 9 percent of males aged fifteen to twenty-four reported using a condom the last time they had sex. Th same figure was under 60 percent in 2002. Condom use is much higher among young people tha among adults.

Is this loveLife's doing? There is no way to tell, but the evidence indicates that it is likely a ke factor in young people's behavior change. The national household survey showed that the loveLi program had by far the highest reach, especially among young people—the 2008 study found that reached 80 percent of people between fifteen and twenty-four. And we know that loveLife's program are associated with increased condom usage. Teenagers in South Africa have begun to think about th future. It is likely that one important reason is that loveLife has offered them a way to, as Dav Harrison said, "be like my friend, whose life has changed."

Even as more teenagers are using condoms, however, there is another challenge for loveLif safe behavior doesn't last. At age eighteen, there is a sharp increase in infection; prevalence rates f women in their early twenties are more than double the rates for women in their teens. It is the time greatest exposure to AIDS—about a third of all infections occur in those between the ages of eightee and twenty-three.

What happens to teenagers around the age of eighteen is that they leave school. "Almost half th lifetime probability of HIV is crammed into just four or five years after leaving school," Dav Harrison and two colleagues wrote in a research paper. School protects. One 2008 study of teenage in the province of Limpopo found that teens out of school had ten times the HIV rates of teens school (although the relationship may not be causal—they may both be symptoms of a risk-takin

personality).

It's not what they are learning that is keeping students HIV-free. It's simply being in schoo When students leave school, two things happen: They lose their community, their social network, an they lose a sense of progression toward the future. They are in limbo, waiting for something better happen.

"Without a sense that tomorrow can be any different from today, being HIV-free is not that grea when you're looking at ten years of hustling to get by," Harrison said. "The analysis was that tw really important factors that contribute to high tolerance of risk are a general sense of lack of choi and opportunity, and lack of social cohesion or solidarity. Aimless, excluded and alienated individual are at highest risk for HIV infection." Young people just waiting for something to happen live fo now. To a girl out of school, with no job, living in a bad neighborhood, taking on a sugar daddy ca make sense. Why not have unprotected sex if it brings clothes, spending money, and a new cell phone There's no hope for a future, therefore no reason to sacrifice.

To respond to this phenomenon, said Harrison in 2008, "our approach has shifted somewhat. Th center of our construct is no longer promoting healthy sexuality, but changing perceptions of day-to day opportunity for young people." LoveLife is trying to create connections for young people aft they leave school and to help them negotiate the choices they will face. One TV spot showed a bo sitting by the side of the road, waiting to wash the windows of passing cars, only to be pushed away b a crowd of other window-washers. The slogan is "Make Your Move."

Harrison said that if he could restart loveLife from scratch, "I would have created a system branded clubs in schools that transcend school-leaving." The clubs would be places to go after scho and after leaving school. "We need to support people at their time of greatest vulnerability," he said.

What does this have to do with AIDS? The same thing as the "Get Attitude" billboards did– nothing and everything. "In Africa you don't see behavioral risk factors explaining what you wa them to explain," said Audrey Pettifor, a professor of epidemiology at the University of Nort Carolina who has researched South Africa's AIDS programs extensively and was one of the authors o the 2005 Reproductive Health and HIV Research Unit study. "But you do see things like graduatin from high school. We should keep giving correct factual information, but it is right to be saying: let focus on bigger-picture issues that influence whether kids want to use condoms and get into risk relationships or not." LoveLife is betting that the way to keep teenagers healthy is to make them feel part of something.

THE SELF-DECEPTION PRACTICED BY by South Africa's teenagers is hardly a South African phenomenon In America, we know we should quit smoking. We know we should have that lump checked out. We know we should give up the french fries. But we don't always do it. South Africa struggles to kee teenagers HIV-free. We struggle to keep teenagers off drugs and cigarettes. In America, as around th world, a good amount of sickness and death is at least in part self-inflicted—the product of behavior choices we make even when we know we should not. Lack of information isn't the problem—is the anyone who doesn't know that smoking is bad for you? Just like South African teenagers, w understand the risk—in the abstract, or for other people.

We can all too easily invent dozens of reasons to avoid applying this information to ourselve By the time I'm older, they'll have found a cure for lung cancer. I'm not going to listen to what adul say—they're just trying to tell me what to do. Exercising will be easier after I've lost some weigh One bacon cheeseburger isn't going to kill me. I can keep it to just one drink. I just like to get relaxe I control my habit—it doesn't control me. My new boyfriend looks so healthy—I'm sure he couldn

have HIV. He loves me—he couldn't have HIV.

Beyond matters of health, people are also expert at finding justifications for bad behavior—fro filching office supplies at work (I'm underpaid!) to selling drugs (if they don't buy it from me, they just buy it from someone else!). We have many reasons not to do things that are difficult or unpleasa in the short term, even if we know they are in our long-term best interests, such as saving money f retirement.

Particularly striking, however, are bad decisions about health, as the consequences can inclu death. Such bad decisions are particularly common, for the same reason—it is very difficult to thi about death. A dramatic example of the lengths people will go to in order to avoid psychologic discomfort can be seen in South Africa's challenges in getting people to do what should not be challenge: take the medications that keep AIDS patients healthy.

In 2006, antiretroviral drugs that have successfully treated AIDS patients around the wor finally were becoming available all over South Africa. President Mbeki, otherwise a sane an reasonable leader, had been inexplicably hostile to antiretrovirals; his government delayed an delayed their rollout, arguing that there were African ways to treat AIDS and that the drugs were pa of a plot by multinational pharmaceutical companies to take advantage of South Africa's miser Eventually, the strength of hundreds of thousands of AIDS activists and the sheer numbers of th dying forced the government to listen. The public-health system went from zero to 175,000 people o antiretroviral drugs between 2004 and 2006. They were available for free, in neighborhood heal clinics. (Mbeki's successor as president, Jacob Zuma, also heeded the call. In 2010, his governme finally began to deal with AIDS as if it were fighting World War III. It began promoting circumcision made HIV tests available in pharmacies, and planned to double the number of people on antiretrovir drugs, which by 2010 was half a million.)

Availability of antiretrovirals did not guarantee that people would take them. They do now South Africa, because the lifesaving effects of these drugs have become visible to all. But in th beginning, South Africa indeed had to sell AIDS treatment—and it was a hard sell. "People think th health department wants them to be dead," said Sylvia Maguma, a *sangoma* (traditional healer) in th township of Bekkersdal. Many others said this. It might have been a hangover from the aparthe years, when it was literally true. More recently, the government had spent years criticizing a poisonous the same drugs it was giving out now. Some antiretrovirals do have awful side effect especially at first. Another problem was the widespread stigma attached to AIDS. Everyone who wa doing well on antiretrovirals hid the illness; only the dying were visible. Most didn't want acknowledge that they could have HIV. Many sought help only when death was imminent, when it wa way too late.

Instead of taking the drugs, people often turned to magic. In 2006, reports of an AIDS "cur called the mopane worm appeared on the front pages of the tabloid newspapers. Government heal officials' embrace of a long line of charlatans has encouraged a thriving industry in such cure hundreds of *sangomas* sell them. It seemed that practically every traditional healer had his or her ov special treatment. Many *sangomas* also pushed the popular concept that sex with a virgin could cu AIDS.

People embrace such magic because they need to—it brings hope. AIDS sufferers in Sou Africa are mostly desperate, overwhelmed, and alone. Middle-class Americans have far mo resources and education, yet we can be depended upon to pay money for diet books and drinks th promise we will lose twenty pounds in a month without deprivation or exercise. Are these so-calle panaceas really that different? One must willfully ignore reality to think they will work, but people d

—over and over. People in Johannesburg, South Africa, have herbal potions from witch doctor people in Harrisburg, Pennsylvania, have Laetrile and pyramids and angels.

What was happening in South Africa was universal. For the sick, psychological comfort wa paramount—sometimes even more important than staying alive. They were stricken with a terrifyin stigmatized plague, a disease shrouded in the dark and forbidden—sex, drug use, betrayal, rejectio death, rape, the struggles of intimate relationships. At the Western-medicine clinic, they could hav gotten a new, lifesaving AIDS treatment—but at the price of increasing the anxiety and isolation the already felt. Instead, they went to the familiar healer they had known all their lives—the *sangoma*.

Wanting to understand this behavior, I went to one, too. When I met Grace Mhaula in 2006, sh was an enormous woman of fifty-four, wearing fuzzy pink slippers and a muumuu in the brillia colors of the South African flag. She lived in Tembisa, a township outside Johannesburg, its dusty an treeless streets filled with jobless men. The only businesses I saw were hair-straightening salon phone stations, chicken restaurants, and funeral parlors. Parts of Tembisa were squatter settlement shacks with tarps for roofs; Mhaula's neighborhood had paved roads and solid houses. Hers was stucco building with a nice kitchen and living room. In the back, off her patio, was her *indumb* (consulting room).

Mhaula inherited her calling from her parents, *sangomas* both. She had a collection of the bon of seven ancestors, and she would read the bones to provide advice, medical and otherwise, for 5 rand, or about $8.50. She also prescribed herbal medicines. The cement floor of her *indumba* wa spread with mats and animal skins; the tables were crammed with candles, traditional clothes an beads, and dozens and dozens of jars of herbs. A single bare lightbulb hung from the tin roof.

Mhaula was an unusual *sangoma*: for twenty-seven years, she had worked as a lab technician f Glaxo Wellcome (now GlaxoSmithKline), and the company had sent her to college. Arthritis ha forced her to retire from Glaxo, but she was bored at home. At Tembisa's health clinic, she receive training in HIV counseling and caring for the terminally ill. For a sick person—she was vast overweight and walked with difficulty, and she died of sepsis just three weeks after I met her—sh seemed more active than three people half her age. Her own daughter had died of AIDS six yea earlier, and Mhaula was raising her daughter's child. She also received government money to run home-based care business with a staff of fifteen local women who visited, nursed, and fed AID patients in the neighborhood. In addition, she conducted workshops for *sangomas* to teach them abo AIDS. At the workshop I attended, Mhaula and her family had also cooked lunch for about thir people.

She moved easily back and forth between African and Western medicine, reflecting a fluidity o cultural forces quite common in Africa. Her clients visited her when they believed themselv bewitched, when their car was stolen and they felt their ancestors were angry, when they had sexuall transmitted diseases or cancer or persistent cough, but increasingly they came because of AID "When someone comes in with symptoms of AIDS," she told me, "I always say, 'What do you wa me to do? Think about it—we live in a modern age. Don't you think we should go to the clinic? Yo will be in a safe environment.'

"They say, 'will you go with me?' I say, 'Yes.' Sometimes they just want me to go get their tes results and they say, 'Don't tell me the results, just give me *imbiza* [the herbal mixture she prepares]"

She gestured to the door of the consulting room, where white plastic tubs filled with an herb mixture were stacked. This was her *imbiza*. The clinic offers free antiretroviral treatment, but Mhau offered comfort, which many of her patients preferred. "We get more respect than the clinic," sh

said. “When we talk to them, we have time for them.

We sit down and listen.” What Mhaula was particularly good at was combining Western an traditional medicines—her presence took the mystery and coldness out of the clinic.

She was careful not to call her *imbiza* a cure for AIDS—many other sangomas in South Afric are not as responsible. Mhaula called her imbiza an immune-system booster. “With us, you don’t hav to take it for the rest of your life.” Mhaula said. “And there are no side effects. Patients come in, ar they are so afraid, and then I give them the *imbiza* and I give them some porridge to eat. And it’s a right.”

Her mixture might indeed boost the immune system—it has never been tested, so no one knov —but it seemed unlikely to me that it could compete with the antiretroviral drugs that were savi lives worldwide. Mhaula maintained that her *imbiza* could not be taken with antiretrovirals, so h patients had to choose.

I met one of them, thirty-three-year-old Vusi Ziqubu. “He was gone,” said Mhaula of th moment she first saw Ziqubu. “He was frail, smelling of death.” Mhaula gave him her *imbiza* to dri four times a day. When I visited him in his house, he was thin but looked strong and was up ar around.

Imbiza seemed to be helping Ziqubu—for the moment. But there was another patient takin Mhaula’s *imbiza*, a close family friend, a mother of three children. She was doing well, Mhaula to me—please come talk to her. Two days later, I returned to meet the woman. But she had already died

It is the universal hunger for psychological comfort, people’s willingness to sacrifice everythi to be respected and reassured right now, that makes it necessary to find strategies that save peop from AIDS in a way that also offers emotional consolation today. When you think about it, this is a extremely circuitous route to saving lives. The whole enterprise, in fact, has a touch of the absurd. should not be necessary to have to employ sophisticated strategies to steer people away from behavi they are aware may lead to a very early, very unpleasant death. Surely it should be enough just to wa people of the extreme consequences.

Yet we know that warnings do not work—not in South Africa, not in America, not anywhere. T understand the value of the social cure, it is first essential to look at why this should be: what v harbor in our psyches, our genes, our economics, and our culture that makes us act so illogically.