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**JOIN
THE CLUB**

**HOW PEER PRESSURE
CAN TRANSFORM THE WORLD**

TINA ROSENBERG

WINNER OF THE PULITZER PRIZE

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Children of Cain: Violence and the Violent in Latin America

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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 a subdivision of brick-and-beige Tudor-style connected houses in Algonquin, Illinois, a far suburb of Chicago, three men in sweatpants jogged up to the house of Ryan Boldt. His family still asleep, Boldt 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 18,000 people at services every weekend, a church repeatedly named the most influential in America. The men—Doug Yonamine, Tim Auch, and Matt Lossau—all live in the neighborhood. The Lossau family 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 a road alongside a field. They run slowly, talking the whole time. “Some of my most intense spiritual conversations have been on the bike paths,” Doug said. He is a kind, earnest, serious, and highly organized man of Japanese ethnicity, then forty-three years old, who works in the legal department at the Willow Creek Association. The men aim to run every Sunday, Tuesday, and Thursday morning at six—the hour dictated by Doug’s promise to Jen to be back in the house before their three children wake up.

Doug, Tim, and Matt do more than jog together. The men and their families, along with two other families, make up a Table group, one of Willow Creek’s neighborhood-based small groups. They do most of the things typical American suburban families do—but they do them together. They eat dinner together once or twice a week. They exercise together. They take one another’s kids to and from Girl Scout meetings, church activities, and school sports. They meet to talk about the Bible and religious issues. When they have problems with their kids, struggles with their jobs or money or 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 form the upper-middle-class, minivan-and-riding-mower version of, well, a commune. Willow Creek was built in the 1970s on the values of anonymity and isolation, constructed so people could meet God without having to bump into other humans along the way. Back then, Bill Hybels, the church’s founder and still its senior pastor, sought to construct a church that would reach out to the person he called “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 nothing. 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 every other large church in America of any denomination, Willow Creek began in the 1980s to place its members in small groups, the idea being that moving nearer to God is best done in close relationship with other people on the same mission.

Willow Creek’s small groups used to be very similar to those in widespread use. Eight or ten people who shared some basic characteristic would get together every two weeks in someone’s living 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 a small group with four other single men who lived all over the Chicago suburbs. The group chose parts 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 group formally ended. When Doug once ran into the group's leader, he was startled; Doug had thought the man had moved to California.

The group had not satisfied him. He did not feel it was helping him grow in his relationship with God. The meetings were too far away, too infrequent, too superficial. As he put it, "How do you get 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 was beginning to realize that conventional small groups were failing many of its members. They could not 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 felt spiritually stalled in their small groups.

So, two years later, Willow Creek redesigned its small groups. Gone were the forty-five-minute 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 Table group—so named because its centerpiece is a communal dinner—are neighbors. They still have formal gatherings twice a month, over dinner at the house of Tim and Michele Auch. But because they are neighbors, a lot of life is going on between the formal meetings. That's what creates the real intimacy. The men now jog together instead of going their separate ways at a health club. Several of the couples were already going to Willow Creek services on Saturday night at 5:30. So they decided to eat dinner afterward in the food court downstairs, as a group. The Auch family shared a back fence with the Moss family and their children treated both houses as their own. In this sprawl of anonymous Chicago suburb, the Table group has created a small town.

Over time, the members of the Algonquin Table found that the intimacy brought results. They started to take risks, to talk about deeper issues, more personal struggles. In the years before the Table group started, Michele Auch had had a strong disagreement with God and decided she didn't want to 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 believe the two communities share a planet. Jawalke is a village about an eight-hour drive east of Mumbai, India. Here are people who by accident of birth dwell at the very bottom of the earth's hierarchy: women from the Untouchable caste, a group so oppressed and reviled that traditionally they have to 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 are transforming their lives and their communities by joining a new peer group, one so strong and closely 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 not attend a single day of school. Instead, she did farm labor for higher-caste families and often was paid 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 he took a second one, and Babai went to live in her mother-in-law's house with her husband and his other wife. There she settled into the traditional role of a daughter-in-law: servant. Her job was to take care of the goats and cows and to carry the milk into the city of Jamkhed to sell it, a five-mile walk. She was given only stale bread and chiles to eat. Her husband and her mother-in-law beat her, sometimes with a stick; she still bears scars on her foot and her lower leg. One day the beating was particularly 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 was sure the rest of her life would be more of the same. "I thought about suicide," she recalled. "I had no support from anyone, no education, no money." The usual consolation for a woman in her situation was that if she has sons, someday she too will become a mother-in-law, able to reduce her daughter-in-law to chattel. But Babai has no children.

She has, however, found other solace. Today Babai Sathe is a respected and influential person, one of Jawalke's village doctors. She provides prenatal care, delivers babies, weighs newborns, takes blood pressure, and treats diabetes and pneumonia and skin infections. She teaches women in Jawalke how to cook nutritious food for their children, disinfect water, and avoid disease. She has organized 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 oppression, women in Jawalke are now starting their own businesses and participating in village-improvement projects, and Untouchables no longer face the same discrimination. This is in part due to Babai. And in 2005, Babai Sathe—still impoverished, able to read and write only enough to find the right bus and keep her logbooks—was elected mayor of Jawalke.

What happened was this: Babai became a member of a sisterhood of women recruited and 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 of Jamkhed. The program asks villages to recommend potential health workers from among their most oppressed citizens, on the theory that it is these women who will care most about the health of the poorest. About half are Untouchables. Some have hands gnarled by leprosy. The model has grown to transform hundreds of villages, and it is being taught to tens of thousands of people who visit Jamkhed from all over the world.

The first step for the women is to go to Jamkhed for two weeks of training. There they learn about the diseases most common in rural India and how to treat and prevent them. They learn to deliver babies safely. Most important, they learn how to teach others in their villages about these 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 confidence—encouraging the women, especially the Untouchables, to feel that they can speak up and have something to teach. Shobha Arole, a doctor who is the daughter of the program's founders and now runs it, said that some women at first would not say their names or lift their gaze from the floor. They are so deeply entrenched in the caste system that some have difficulty accepting that women of 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. They learn to sleep under one huge blanket. After the initial two weeks, each one spends a week in the village of a more experienced health worker. There the trainee can watch her work and, more 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, and

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 we change, then we go to work in the village,” said Lalenbai Kadam, one of the oldest active health workers. Each woman is now more prosperous. Although the program does not pay them for their work, they receive training and loans to start their own small businesses. Each is now respected by her fellow villagers. They have the satisfaction of improving the lives of the people with whom they grew up. “We tell each other our troubles,” one health worker said. They also tell each other their successes.

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

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

I stumbled on the social cure by accident. As a writer, I have specialized in highlighting seemingly intractable problems. I had written a book about political violence in Latin America, and one on the moral and political conundrums of dealing with the past in post-Communist Europe. I had written magazine articles about human rights, poverty, and public health. Problems were in endless supply. But it was starting to seem more interesting and valuable to write about solutions—to find the 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 Marović. A few years earlier, Marović had been a student in Belgrade, Yugoslavia, one of the leaders of the student group called *Otpor* (“Resistance” in Serbian), which sparked the popular movement that overthrew Slobodan Milošević in 2000. Marović then began to travel the world, working with 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 it focused on stripping away the fear, fatalism, and passivity that keep a dictator’s subjects under 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 of 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 passive victims of dictatorship. But now this group everyone was talking about offered them a way to do something important. Each of them could be a part of something, a protagonist, someone who could

actually make history. Otpor turned fear inside out—the movement was appealing *because* of the risks. A teenage boy with no future—and very little present—could be assigned a cell phone and memorize passwords and hide from the police at midnight. He could be James Bond. If he was 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 the 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 cool. We’re trying to make politics sexy.”

While explaining to my friend my fascination with Otpor and its methods, it struck me that I had 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 providing information about AIDS—South Africa’s teenagers already know about AIDS and how to avoid 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 an “aspirational life-style brand for young South Africans,” as its literature says. It was initially modeled on a Sprite campaign. LoveLife uses celebrity gossip, music, fashion, school sports, relationships advice, and media comprehensible only to teenagers to create a club that teens want to join. In the club, a girl can hear from another girl—from a similarly bleak and dusty township—why and how she rejected a boyfriend who demanded sex without a condom. And she will start to think about doing the same.

THE TYPICAL ATTEMPT TO SOLVE a social ill focuses on giving people information, or it tries to motivate people through fear. But these strategies tend to fail exactly when the issue becomes most salient and emotionally fraught. The more important and deeply rooted the behavior, the less impact information 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 on changing behavior by helping people obtain what they most care about: the respect of their peers. Otpor was a student-led, antigovernment democracy movement in Serbia; loveLife is a government-financed public-health program in South Africa. Willow Creek’s Table groups are designed to motivate some of the world’s most comfortable people to take psychological risks in order to deepen their religious commitment; Jamkhed’s village-health-worker program encourages some of the world’s least fortunate people to take social risks to bring better health to their villages and break down caste and sex discrimination.

Although these campaigns differ in almost every conceivable way, they are in essence all the same campaign. They accomplish what countless efforts throughout the centuries have failed to do: persuade people to take action that is crucial to their long-term well-being but appears unpleasant, dangerous, or psychologically difficult today. They get people to join the demonstration or confront their inner demons or avoid risky sex or trespass on long-held concepts of proper behavior not by lecturing them about that long-term interest or, indeed, talking about anything rational at all. Instead, they aim at what people want now: to belong, to be part of the in crowd, to be loved and admired and respected. These programs change personal behavior through social pressure. They offer people a new and desirable club to join—a peer group so strong and persuasive that the individual adopts a new 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 a 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, peer pressure is probably the most important influence on who we are. The conventional wisdom used to be that the way parents raise their children is what is key. Certainly parents like to think so. But that notion was effectively destroyed by Judith Rich Harris in her book *The Nurture Assumption*. She argued that once parents have passed along the genes, they have very little influence over their 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 to convince most readers of the importance of peers. It seems intuitively correct. One does not have to accept Harris’s idea that parental nurture matters practically not at all to comprehend the overwhelming influence of peers. Our parents may be our first language teachers, but after we acquire our peers, we learn how to talk from them—not only what language to speak but also how to pronounce words, which ones to choose, how loudly to say them. Peers control what we wear, what culture we consume, what we buy. The social norms set by our peers dominate our choices about what we value 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 this extremely significant fact. When I would tell someone I was working on a book about peer pressure, invariably my questioner would assume I was talking about bad behavior. The term *peer pressure* 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 argue 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 on information or fear have failed. The social cure does this in a wide variety of situations. It works stunningly well with teenagers—the group most likely to be taking the kind of behavioral risks that cry out for help and, not coincidentally, the group most responsive to peer pressure. But it also works with adults. It is applicable in many different spheres of life, at all different levels of class and economic development. The social cure is a natural solution to help people take care of their own health—to encourage them to accomplish the difficult tasks of avoiding risky sex; abstaining from cigarettes, alcohol, and drugs; losing weight; getting exercise and following doctors’ orders. But it also has been successfully applied to problems in fields as diverse as political change, university education, organized religion, criminal justice, poor-country economic development, and the art of war.

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

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

Every good military commander exploits this phenomenon. Shakespeare’s King Henry V uses it 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 thousand 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 of 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 disciples and the Jewish law that at least ten men are needed for public worship. Randy Frazee, a pastor who is 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 to solve an obstinate problem. South Africa's loveLife and Florida's revolutionary antismoking campaign for teens were government-financed programs created by committee, spearheaded by people who simply believed in getting inside teenagers' heads and reaching them with the messages to which they will respond. Although these are both examples from the field of public health, the people who came up with these strategies were—tellingly—not public-health specialists but marketers and advertisers by instinct.

Willow Creek, also a large bureaucracy, adopted an idea from Frazee, an outsider who was considered rather eccentric. But eccentric is sometimes just another word for pioneering. Many examples of the social cure come from one innovator or a small team of them. Ivan Marovic was one of eleven students at Belgrade University who met in the city's cafés. They smoked, drank coffee, and hatched the unlikely idea that, armed with the sensibilities of Monty Python's Flying Circus and some really great black T-shirts, they could topple Slobodan Milošević, who by the time of his fall had 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 Raj and Mabelle Arole. The Aroles had graduated top in their class at Vellore Medical School—"a medical education that would make you a good doctor in France or Germany," Raj Arole said. But it was not what was needed in rural India. They set out on their own to create a new way to promote health 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 was trying to solve a problem widely seen in college math departments: black and Latino students often did poorly in calculus. This was true even when they reached college well prepared and with high test scores. It was true even when they had taken calculus successfully in high school. Treisman was not willing to accept the usual conjecture about the reasons for this. What he came up with instead he revolutionized the teaching of math—to minorities, but not just to minorities—and upended the

conventional wisdom about why people succeed or fail in college.

~~In all these examples, the people who employed the social cure bushwhacked their own route.~~ They possessed no map. They had to grope in the dark to formulate their ideas and make them work. They had to fight off the armies of conventional wisdom to defend them. Their stories, which form the basis of this book, show how the social cure's various creators invented it and fought for it, how they 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 social 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 and encouragement. Perhaps most important, these stories compel us to look at people anew. They reveal novel answers to the questions of what moves us, what we want and need, and why we do the things we do. The innovators described in this book have reimagined fields as diverse as public health, poverty alleviation, education, spiritual development, and political change. But they are also part of an even broader struggle—to reimagine social change, to introduce into common parlance a new strategy 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 the epidemic as the most damaging and also the most puzzling: our near-complete failure to stop sexual transmission of the disease. There are very few people who do *not* know how AIDS is transmitted. A good number of the people most at risk for AIDS have watched friends or family members waste away 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 Africa. In 1990, only 1 percent of South African adults had been infected; by the end of the decade, the number was closer to 15 percent. In 1998, a fifteen-year-old in South Africa had a better than even chance of dying of AIDS.

The government's response was minimal. Until 1994, when the apartheid regime fell and Nelson Mandela became the country's first black president, AIDS had been ignored. It was largely a black disease, which meant the white government wasn't interested—indeed, a plague that selectively killed 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 the 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 a fifth of her AIDS budget to produce a play about AIDS called *Sarafina II*. The resulting scandal 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 is unlikely that would have helped to reduce the scope of AIDS. Then, as now, transmission of HIV, the virus that causes AIDS, happened largely among young people. Other countries were trying to reach teenagers through talks in schools, churches, and community groups and through advertisements in the mass media. They were telling teenagers what AIDS is and how it is spread, advising them to use 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 some places soaring. Public-health experts believed that if teenagers understood what was at stake and were taught how to protect themselves, they would surely do it. But in country after country, teenagers proved them wrong.

South Africa ended up trying something very different, a strategy designed not only by public health experts—those usual suspects—but also by psychologists, advertising executives, marketing 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 a coating of the frothy stuff teenagers love—pop stars, fashion, love advice, teen slang, and gossip. The AIDS-prevention campaign concentrated on teens' need for belonging and connection. It tried to make an HIV-free lifestyle fun and cool. Rather than resort to finger-wagging, it helped young people 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 recognized

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

Kaiser staffers met with AIDS groups and government officials. Together, they decided that the campaign needed to target teenagers from twelve to seventeen. Research showed that most were still HIV-negative at fourteen, and by eighteen it was already too late. The group also decided to hire Judith Nwokedi to conceptualize the program. Nwokedi was forty-one at the time, a charismatic whirlwind who had recently returned from exile in Thailand and Australia, where she had worked as a 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 of 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 neighbors than in the rest of the world. South Africans do not have more sexual partners than people in other countries. Nor is poverty the answer. Even though South Africa and its neighbors—Botswana, Lesotho, and Swaziland—have had the world’s highest AIDS rates, some of them are the richest countries in Africa.

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

South Africans, moreover, did not talk much about AIDS, and largely did not talk about sex. In contrast to America, where gay members of organizations such as ACT UP were so vocal that they forced AIDS into the news, AIDS in South Africa was smothered by a curtain of silence. In 2000, when 600 South Africans were dying of the disease every day, President Thabo Mbeki told the *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 dangerous as the disease. A small, soft-spoken woman named Gugu Dlamini was stoned to death by her neighbors in December 1998, three weeks after she announced at an AIDS-awareness gathering that she had the virus. Her attackers then threatened to kill her family. Nelson Mandela often said that when he told traditional chiefs that he planned to speak out about AIDS and sex, they told him he would lose their support. He did not give a speech on AIDS in South Africa until late 1998, four years into his presidency. Parents usually limited their conversations about sex with their daughters to “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. It turned out that teenagers were completely turned off by the traditional prevention campaigns—“the

message was coming from Mars,” she said—and were most receptive to an AIDS campaign that was about more than just AIDS. “They were saying, ‘Don’t isolate HIV and make it everything that I’m about as a young person. Engage with me on the level of my excitement and confusion as a young person—sex, parents, friends, drugs, school, rural vs. city,’ ” she said. “They were completely turned 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. “The normal way of AIDS or any peer education with young people was to pack them into the church hall or the school hall,” Nwokedi said. “They would have to sit there while someone would stand up there and talk at them, unconscious of whether people were listening. And whatever they told you, you went out and did the exact opposite because you were so angry that they kept you there for five hours. We wanted HIV education to have another dimension—it had to be interactive, engaging, question-and-answer, vibrant debate.”

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

Nwokedi convened a panel of advisers—including teenagers as well as advertising executives—who designed messages. The working title for the campaign had been the National Adolescent Sexual Health Initiative. Nwokedi and her advisers nixed that. “You’re dead before you can even go out with young people,” she said. “They’d call it NASHI as an acronym—that was soooo public health!” The AIDS-prevention program had to be a brand.

The relevant model, they decided, was not any previous public-health campaign, but rather the 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 community 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 became loveLife—positive, hip, and fun.

WHEN I VISITED LOVELIFE in 2006, the “aspirational lifestyle brand” was ubiquitous, one of the ten best known brands in the country. South Africa was dotted with loveLife’s 1,200 billboards. Radio call-in shows reached three million young listeners a week. LoveLife had TV spots and TV reality shows that sent attractive young people into the wilderness to compete in AIDS-related games, such as using the other sex’s tools of seduction. A hotline dispensing advice or just a friendly voice received more than a million calls a year. A Web site and magazines featured not only graphic information about AIDS 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, costing no money at all.)

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

LoveLife's research shows that the media campaign by itself is not associated with behavior change in young people, but it brings them in to the face-to-face programs that are. "The logic of the brand is to create something larger than life, a sense of belonging," said David Harrison, the tall, lanky physician who was the director of loveLife from 2000 to 2009. "That creates participation in clinics and 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 to internalize it. South Africa's health surveys showed that young people knew that when *other people* had unprotected sex, they could catch the AIDS virus. But they didn't see themselves in the same position. There was no correlation between information and the internalization of risk. The most chilling statistic was that two-thirds of young people who tested HIV-positive—in anonymous 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 way, equally terrifying. The study of HIV-positive people has not been repeated, but other studies asked young people about their behaviors and their perception of their own risk. The kids who were in fact having unprotected sex with lots of partners did accurately report that they were at high risk for catching HIV. But they had no problem living with that high risk. It had become normal, part of the background noise of life. AIDS information was ubiquitous, and teenagers internalized the message of risk. They didn't care.

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

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

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

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

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

Laura Branigan's "Gloria." A seventeen-year-old named Princess said she called Leswifi every day for 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 singlehandedly. He said loveLife saved him, crediting the organization with getting him off drugs: "They gave me a 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 that 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 would have used: here's what AIDS is, here's how you catch it, now please abstain from sex, or be faithful or use a condom. This has become known as ABC—Abstain, Be faithful, use a Condom. But the ABC 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 by sharing their own personal history. When a teenage girl hears about ABC from a public-health expert in a church hall, it's in a language she doesn't speak. When it comes from Sibaca, it is urgently and immediately about her life.

Sibaca knows, because that's what happened to her. She is a petite, enthusiastic, energetic woman from Langa, a township outside of Cape Town. In 2006, she was twenty-two, a corporate social investment manager for Richard Branson's Virgin Group in South Africa, mature and confident. She attributed her success to loveLife. When she was twelve, her mother died of AIDS: her father followed four years later. "Before I joined loveLife, I had a serious history of self-destruction," she said. "I saw 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 going to its programs. "I had been engaging in highly risky behavior, but I pulled back," she said. "LoveLife made me realize there were things I wanted to achieve in my life, and I couldn't afford to have sex without a condom. The reality is that every young person has a dream, but a lot of us look at our situation and think, 'Who are we kidding?' But the minute someone triggers in your brain that [the 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 someone 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 way you've lived your life is not good and we're going to help you. These were people the same age as me. It wasn't a celebrity telling me their story living in a million-dollar house. It was another young person from the same township as me."

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

She told me about one girl she had in class, a girl from Sibaca's own township. "She was fifteen and came to me and said, 'My boyfriend is pressuring me to have sex without a condom.' Her fear was that her boyfriend would break up with her if she said no, and she had to hold on to him because he gave her money and clothes that her family could not provide her with. I gave her all the different 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. She hugged me 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 pregnant 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 new AIDS infections within three to five years—in other words, by 2004 at the latest. This did not happen. From 2000 to 2004, there was no progress—the HIV prevalence rate among pregnant teenagers (pregnant women are the only people the government tests every year) was 16.1 percent in those years. And while no one in South Africa was happy about this, loveLife had been controversial, arrogant, and 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 dismay and stubbornness of the AIDS numbers did not mean that the program had failed. The national HIV rates are not a fair measure of any program’s success or failure—especially prevalence rates, which do not tally how many people became infected in a specific year, merely how many people *are* infected. Many factors combine to steer an epidemic up or down, from economics (one theory goes that Zimbabwe’s economic collapse has driven down AIDS rates, as men there can no longer afford to maintain girlfriends on the side) to the availability of surgery (widespread adoption of circumcision would dramatically curtail the spread of AIDS) to the fact that epidemics run a natural course. LoveLife is far from the only factor affecting the spread of AIDS. It is also not South Africa’s only AIDS-prevention program, although it is by far the largest and most comprehensive one, and the only national program aimed at teenagers.

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

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

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

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

dropping, by enormous margins. The rate of new infections among teenagers went up between 2000 and 2005 and then plummeted. Among eighteen-year-olds, for example, it fell by 55 percent between 2005 and 2008.

At the time the news of the decline in teenage HIV rates broke, there was little celebration. HIV rates were still terrifyingly high, and some 400,000 people a year were dying of the disease. The government was dragging its feet—not just President Mbeki but also his disastrous health minister, Dr. Manto Tshabalala-Msimang, who put obstacle after obstacle in the way of antiretroviral treatment and was derided as “Dr. Beetroot” for her statement that eating local foods was the way to deal with AIDS. She, at least, was rejoicing at the new AIDS figures. “I think it’s something we must celebrate as South Africans, and say ‘thank you’ to the youth of this country, because we think they are 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 was right. Some of the reduction may have been due to the maturing of the epidemic—HIV rates are beginning to stabilize in many countries. Indeed, the AIDS infection rate is beginning to drop in South Africa in general, but that is only because the decline among young women has been so stunning. For 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, which are difficult to measure, are a far more accurate indicator of the epidemic than prevalence, especially in countries like South Africa where prevalence figures are inflated by the new-widespread use of antiretroviral medicines.) This decline is much greater than that seen among young people in other high-prevalence countries, such as Botswana and Namibia.

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

The bad news is that as teenagers are wont to do, they are still having plenty of sex, and they have it early, and with multiple partners. The good news is that condom use has soared. Nearly 90 percent of males aged fifteen to twenty-four reported using a condom the last time they had sex. The same figure was under 60 percent in 2002. Condom use is much higher among young people than among adults.

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

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

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

personality).

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

“Without a sense that tomorrow can be any different from today, being HIV-free is not that great when you're looking at ten years of hustling to get by,” Harrison said. “The analysis was that two really important factors that contribute to high tolerance of risk are a general sense of lack of choice and opportunity, and lack of social cohesion or solidarity. Aimless, excluded and alienated individuals are at highest risk for HIV infection.” Young people just waiting for something to happen live for now. To a girl out of school, with no job, living in a bad neighborhood, taking on a sugar daddy can 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. The 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 after they leave school and to help them negotiate the choices they will face. One TV spot showed a boy sitting by the side of the road, waiting to wash the windows of passing cars, only to be pushed away by 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 of branded clubs in schools that transcend school-leaving.” The clubs would be places to go after school 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 want them to explain,” said Audrey Pettifor, a professor of epidemiology at the University of North Carolina who has researched South Africa's AIDS programs extensively and was one of the authors of the 2005 Reproductive Health and HIV Research Unit study. “But you do see things like graduating from high school. We should keep giving correct factual information, but it is right to be saying: let's focus on bigger-picture issues that influence whether kids want to use condoms and get into risky 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 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 keep teenagers HIV-free. We struggle to keep teenagers off drugs and cigarettes. In America, as around the world, a good amount of sickness and death is at least in part self-inflicted—the product of behavioral choices we make even when we know we should not. Lack of information isn't the problem—is there anyone who doesn't know that smoking is bad for you? Just like South African teenagers, we 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 ourselves. By the time I'm older, they'll have found a cure for lung cancer. I'm not going to listen to what adults say—they're just trying to tell me what to do. Exercising will be easier after I've lost some weight. One bacon cheeseburger isn't going to kill me. I can keep it to just one drink. I just like to get relaxed. I control my habit—it doesn't control me. My new boyfriend looks so healthy—I'm sure he could

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

—Beyond matters of health, people are also expert at finding justifications for bad behavior—from pilching 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 unpleasant in the short term, even if we know they are in our long-term best interests, such as saving money for retirement.

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

In 2006, antiretroviral drugs that have successfully treated AIDS patients around the world finally were becoming available all over South Africa. President Mbeki, otherwise a sane and reasonable leader, had been inexplicably hostile to antiretrovirals; his government delayed and delayed their rollout, arguing that there were African ways to treat AIDS and that the drugs were part of a plot by multinational pharmaceutical companies to take advantage of South Africa's misery. Eventually, the strength of hundreds of thousands of AIDS activists and the sheer numbers of the dying forced the government to listen. The public-health system went from zero to 175,000 people on antiretroviral drugs between 2004 and 2006. They were available for free, in neighborhood health clinics. (Mbeki's successor as president, Jacob Zuma, also heeded the call. In 2010, his government 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 antiretroviral drugs, which by 2010 was half a million.)

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

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

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

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

What was happening in South Africa was universal. For the sick, psychological comfort was paramount—sometimes even more important than staying alive. They were stricken with a terrifying, stigmatized plague, a disease shrouded in the dark and forbidden—sex, drug use, betrayal, rejection, death, rape, the struggles of intimate relationships. At the Western-medicine clinic, they could have gotten a new, lifesaving AIDS treatment—but at the price of increasing the anxiety and isolation they 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 Mhaura in 2006, she was an enormous woman of fifty-four, wearing fuzzy pink slippers and a muumuu in the brilliant colors of the South African flag. She lived in Tembisa, a township outside Johannesburg, its dusty and treeless streets filled with jobless men. The only businesses I saw were hair-straightening salons, phone stations, chicken restaurants, and funeral parlors. Parts of Tembisa were squatter settlements, shacks with tarps for roofs; Mhaura's neighborhood had paved roads and solid houses. Hers was a stucco building with a nice kitchen and living room. In the back, off her patio, was her *indumba* (consulting room).

Mhaura inherited her calling from her parents, *sangomas* both. She had a collection of the bones 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* was spread with mats and animal skins; the tables were crammed with candles, traditional clothes and beads, and dozens and dozens of jars of herbs. A single bare lightbulb hung from the tin roof.

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

She moved easily back and forth between African and Western medicine, reflecting a fluidity of cultural forces quite common in Africa. Her clients visited her when they believed themselves bewitched, when their car was stolen and they felt their ancestors were angry, when they had sexually transmitted diseases or cancer or persistent cough, but increasingly they came because of AIDS. "When someone comes in with symptoms of AIDS," she told me, "I always say, 'What do you want me to do? Think about it—we live in a modern age. Don't you think we should go to the clinic? You 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 test 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 herbal mixture were stacked. This was her *imbiza*. The clinic offers free antiretroviral treatment, but Mhaura offered comfort, which many of her patients preferred. "We get more respect than the clinic," she

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 and 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 Africa are not as responsible. Mhaula called her *imbiza* an immune-system booster. “With us, you don’t have to take it for the rest of your life.” Mhaula said. “And there are no side effects. Patients come in, and they are so afraid, and then I give them the *imbiza* and I give them some porridge to eat. And it’s all right.”

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

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

Imbiza seemed to be helping Ziqubu—for the moment. But there was another patient taking Mhaula’s *imbiza*, a close family friend, a mother of three children. She was doing well, Mhaula told 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 everything to be respected and reassured right now, that makes it necessary to find strategies that save people from AIDS in a way that also offers emotional consolation today. When you think about it, this is an extremely circuitous route to saving lives. The whole enterprise, in fact, has a touch of the absurd. It should not be necessary to have to employ sophisticated strategies to steer people away from behaviors they are aware may lead to a very early, very unpleasant death. Surely it should be enough just to warn people of the extreme consequences.

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

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