When a Pill Is Not Enough

BYLINE: By **Tina Rosenberg.**

In the whole AIDS epidemic, no question is more heartbreaking and confounding than this: Why would a mother choose to condemn her baby to death?

Mothers with H.I.V., the virus that causes AIDS, pass it along to their newborns at birth 25 to 30 percent of the time, and in poor countries, some half a million babies a year are born with H.I.V. But the rate of transmission can be cut to 14 percent with a simple and cheap program: H.I.V.-positive mothers take a single pill of an antiretroviral called nevirapine when they begin labor, and their newborns are given nevirapine drops.

At the Alexandra Health Center and University Clinic in South Africa, pregnant women can get nevirapine free. The antenatal clinic is a complex of low brick buildings on a pretty hospital campus in the middle of the township of Alexandra, a bleak neighborhood on the outskirts of Johannesburg. The clinic has a doctor only on Thursdays, but an advanced midwife and two nurses attend a crowd of patients every day. I had been in South Africa for four days when I visited the clinic, and I had already seen the stigma that AIDS still carries in the country -- those dozens of funerals every Saturday in the townships? Oh, say family members, it was asthma, or tuberculosis, or "a long illness." I thought I understood how powerful denial could be. But I was unprepared for what Pauline Molotsi, a registered nurse at the clinic, told me.

About twice a week, a woman who has tested H.I.V.-positive begins labor at the clinic but refuses to take the nevirapine that might save her baby's life. "She says, 'Oh, no, I'm not positive,'" Molotsi told me. Even though the only person who will know her H.I.V. status is the nurse -- who knows already, since she is holding the patient's chart -- the woman won't take the incriminating pill. "They have not accepted their status," Molotsi said. "They are still in denial."

In most of the world, the biggest reason so many babies are born with the AIDS virus is that their governments do not offer nevirapine; because of shortages of health-care personnel, in many countries this program, like all AIDS programs, is available only in urban hospitals. But in South Africa, there's a different problem. Nevirapine is widely available, yet more than 70,000 babies a year are born there with H.I.V. The government can get nevirapine, condoms and AIDS treatment out to the most remote corners of the country -- by truck or wheelbarrow, to modern hospitals and to clinics with no electricity. But it cannot penetrate what has become the most difficult terrain in AIDS work: the insides of people's heads.

A significant minority of women in South Africa refuse to take an AIDS test. It's not only that they do not want to confront painful facts that could lie buried a while longer. It's also that being tested can be dangerous. At the Alexandra clinic, I listened to a tall young man named Vernon as he gave pretest group counseling to about two dozen pregnant woman. "Think about your baby before you think about yourself," he urged them. He

assured them the results of their H.I.V. tests would be confidential but encouraged the women to tell their families and partners. "Don't hide it. Don't use the phone -- tell him face to face. You use the phone, he will hunt you down. Try to prepare him. Some people are very violent. He will beat you. But when he's alone, he will think about it. If anything happens to you, your family knows you went to tell him your H.I.V. status and never came home." This speech seemed unlikely to encourage many women to be tested. But it obviously reflected reality. Prudence Mabele, who works for a feminist organization, told me about a woman whose husband greeted her disclosure by pouring a kettle of boiling water over her.

Other women end up infecting their babies through breast feeding because they cannot follow the clinic's advice to bottle-feed only -- tantamount in some areas to announcing you have H.I.V. The very present danger posed by disclosure outweighs the future risk that the baby will get sick. And there are those whose denial is so deep it engulfs them. "Labor is already a stressful environment," says Macharia Kamau, a Kenyan who is Unicef's representative in South Africa. "You are pregnant, poor, vulnerable, marginalized, uneducated. At that point, what do you rely on? What your mother told you when you left home? Your cultural beliefs -- or this stranger who's standing there saying, 'Take this pill?'"

As AIDS passes the quarter-century mark, in several countries the epidemic appears to be declining. South Africa is not one of them. In 1990, South Africa and Thailand both had H.I.V. prevalence rates in adults of less than 1 percent. Today, Thailand's rate is 1.4 percent. But in South Africa, AIDS exploded in the 1990's, and now 18.8 percent of adults are infected -- and the number is still rising, though very slowly. Last year 300,000 new South Africans were infected with H.I.V. At the Alexandra Health Center, about 60 percent of women test positive. Choose any two 15-year-olds in South Africa; the odds say one of them will get AIDS.

South Africa is not even the worst of it. In Botswana, 24.1 percent of adults have H.I.V., and in tiny Swaziland, a third of all adults do. AIDS rates in southern Africa are far higher than they are anywhere else in the world. No one really knows why. South Africa has astronomical rates of sexual violence -- more than a quarter of the time, a young woman's first sexual experience is coerced -- and a strong culture of male entitlement to sex, but so do many other countries. Much of the blame may go to apartheid, which kept male workers in hostels and their families in villages far away. Similar geographical dislocations come from mining, southern Africa's main industry. Separating families encourages people to maintain ongoing relationships in two places. This is more dangerous than serial monogamous relationships, as H.I.V. is far more contagious when freshly caught.

South Africa's post-apartheid government, besieged with problems, largely ignored AIDS. As president, Nelson Mandela did not publicly speak in South Africa on AIDS until 1998, more than three years into his term. Then came spectacular irrationality -- the government of Thabo Mbeki spent years insisting AIDS was a Western plot, that the drugs were poison, that it was better to use African "cures," that all those people were

dying of something else. Now the public troublemaking of government officials has died down. What has replaced it is not the crusade so badly needed but just an official silence.

In the last few years, however, South Africans have forced their government to begin saving lives despite itself. The country is now spending millions to provide free antiretroviral drugs to AIDS patients, equip maternity clinics with nevirapine and run prevention campaigns. South Africa is successfully pushing services out to its people. But that doesn't mean people always use them. Mothers sometimes reject nevirapine. People decline AIDS tests. Some sick people refuse to take free antiretrovirals. Some orphans will starve -- even though help is available -- rather than make the shameful admission that their parents died of AIDS. And of course, millions of people who know better continue to risk their lives every time they have sex.

All over the world, human psychology, local custom and the pressures of poverty are AIDS's best friends. None of this should be foreign to Americans. We know we should quit smoking. We know we should go have that lump checked out. We know we should give up the French fries. But we don't. In America, as around the world, a good amount of sickness and death is at least in part self-inflicted. In all aspects of health care, the challenge of providing not just solutions but ones patients will embrace is only now beginning to get attention. We are accustomed to thinking of noncompliance as the patient's fault. But when a pregnant woman chooses to keep the nevirapine tablet in her pocket, the real failing belongs to the health system, which did not consider what would help her to follow medical advice. Such thinking is always crucial for health professionals but never more so than with AIDS, a disease that is shrouded in the dark and forbidden -- sex, drug use, betrayal, rejection, death, rape, the struggles of intimate relationships -- and that primarily hits the notoriously irrational young.

But the AIDS establishment has not yet assumed this challenge. "The technology is doing O.K., it's moving," says Peter Piot, executive director of the United Nations' AIDS agency, Unaids. "But we have grossly, grossly neglected the social, cultural and personal stuff that makes it work."

In a bland corporate research office in a strip mall in the Johannesburg suburbs one day late last spring, American and South African investigators were intently trying to prove Piot wrong. They were sitting behind a two-way mirror, watching five young women from Soweto talk about vaginal gel. The research office, normally employed to assess South Africans' views on laundry detergent or breakfast cereal, was now the site of a series of focus groups designed to solve one of the biggest problems in AIDS prevention: the failure of the condom.

It is a social failure, not a mechanical one. Condoms prevent AIDS transmission quite well when people use them consistently. But men would rather not, and in Africa men usually call the shots. One of the most chilling findings of AIDS researchers is that marriage can be a risk factor. Studies in Kenya and Zambia found that young, married, monogamous women had higher rates of AIDS infection than sexually active single women of the same age; if condom use is hard for single women to negotiate, it is nearly

impossible for married women. Even women who know their husbands are unfaithful cannot demand condoms, for to do so indicates a lack of trust. Husbands can get violent, or accuse the woman of infidelity. Condoms are also not an option for couples who wish to conceive. Women need a method of H.I.V. protection that they can control, that does not impede fertility and that men do not object to. +

It does not exist -- yet. But one form of it, a vaginal microbicide, may be available within five years. The Johannesburg focus groups were designed to test three different gels, for use once a day, that may someday contain an ingredient that kills H.I.V. before it can infect the woman. The sessions were run by the International Partnership for Microbicides (I.P.M.), which is based near Washington. I.P.M. scientists realize that creating an effective medicine is just half the battle, and so they are taking a proactive approach to marketing the gel; before the microbicide's active ingredient has even been invented, researchers have spent years figuring out how to get women in a variety of cultures to use it.

"A microbicide could be marketed as a sexual aid, or as something to make a woman feel more attractive inside and out," Dr. Zeda Rosenberg, I.P.M.'s C.E.O., told me when I first met her in 2004. She was still puzzling it out when I spoke to her this year in South Africa. "Maybe H.I.V. prevention would be a secondary selling point," she said. "This could be a lubricant that stops H.I.V. If the product made sex great, they would use it even if there were a trust issue."

The focus groups were a chance for I.P.M.'s researchers to hear from their target market. Five young women from Soweto, all paid to participate in the study, sat around a table laden with platters of food and chatted in Zulu, Sotho and English about the gels, which they had been using for the last three weeks. The moderator asked whether they would want to use the gels to avoid getting H.I.V. All responded with enthusiasm. "I would recommend it to women who are married but do not trust their husbands," said a participant. Just as important, they talked about how they handled the issue with their boyfriends. "I didn't tell my boyfriend, but he noticed something different," said Dimakatso, a young-looking girl with a ponytail. She explained to him what she was using, and it was no problem.

But most women preferred stealth -- and it worked. Some didn't tell because South Africans don't normally discuss sex. Others said their boyfriends were superstitious. "He will think I am using something for witchcraft," said one woman. Overall, the women preferred the gel whose texture was easiest to hide from their sexual partners.

Women's groups have been talking about a microbicide for more than a decade, since it became obvious that AIDS was developing into a woman's disease. But the rest of the world wasn't listening. In the late 1990's, Rosenberg was senior scientist for H.I.V.-prevention research at the National Institutes of Health. She, along with some others, tried to focus money and research on developing an AIDS-prevention product that women could control. "It was difficult to get people's attention," she says. "It was not considered interesting scientifically. It was seen as a product-development issue, not a

scientific problem. Scientists in drug and cosmetic companies don't get papers published." Research was slow to get moving. Rosenberg left N.I.H. and eventually became C.E.O. of I.P.M. It is one of several organizations working to develop a microbicide.

For a microbicide, the traditional public-health approach -- invent it, put it out there and tell people to use it -- won't cut it. Nearly as important as whether it kills H.I.V. is whether a microbicide feels acceptable, whether it can be used discreetly if necessary and how it is packaged and promoted. Dr. Mark Mitchnick, the group's senior scientific consultant, worked on sunscreens and other products before switching to AIDS prevention. "One thing I learned with sunscreen is that people will often need a second reason to buy," he says. "You want people to use sunscreen because it protects against melanoma. But people buy it because it prevents wrinkles."

"The cosmetics industry can get women to use all sorts of topical products they don't need," Rosenberg said. Maybe the same tools could be used to make a microbicide popular. "Is there a way to think about it that isn't H.I.V.? Public health can't tell us that."

Every weapon in the fight against AIDS needs to pass these same two tests -- it has to work and people have to use it. But particularly in poor countries, where most of these services are by necessity free, AIDS treatments and prevention strategies are usually offered as if marketing were unnecessary. That is especially true for antiretroviral therapy. After all, the logic goes, it's a lifeline. Surely no one would throw it back.

And when they have access to it, most people don't. Antiretrovirals are now saving lives all over South Africa. The public-health system has gone from 0 to 175,000 people on antiretrovirals in two years. Add in programs run by businesses and nongovernmental groups like Medicins Sans Frontieres, and more than a third of South Africans who need antiretrovirals are now taking them, and the figure continues to rise. Patients who have agreed to start antiretrovirals are very good about taking their medicine, and when they do, few are dying.

But the surprise is that South Africa has indeed had to sell AIDS treatment -- and it's often a hard sell. "People think the health department wants them to be dead," said Sylvia Maguma, a traditional healer, or sangoma, I met in the township of Bekkersdal. I heard many people say this. It may be a hangover from the apartheid years, when it was literally true, and more recently, the government has spent years criticizing as poisonous the same drugs it is giving out now. Some antiretrovirals do have awful side effects, especially at first. But denial and stigma make things worse. People with AIDS tend not to admit, even to themselves, that they are sick; they seek help only when death is imminent. They start the antiretrovirals too late, and then the rumor spreads: the medicines killed her.

But there is something else at work here: the weight of traditional culture. In the township of Tembisa I met Vusi Ziqubu, a 33-year-old who was dying of AIDS. He could get free antiretroviral treatment at his local clinic. But he preferred the herbal remedies of Grace Mhaula, his sangoma. "He was gone," said Mhaula of the moment she first saw Ziqubu.

"He was frail, smelling of death." Mhaula gave him a solution of herbs to drink four times a day. When I visited him in his house, he was thin, but looked strong and was up and around.

It is commonly said in South Africa that 80 percent of blacks go to a traditional healer first when they are sick. To South Africa's poor, the bones of the sangoma are the reassuring and trustworthy medicine their families have used forever. It is the clinic's fabulous tales of invisible bugs that sound to them like hoodoo. The science of the rich is the magic of the poor, and vice versa. And the sangoma, unlike the nurses at the clinic, can spend time with the patient.

But traditional healers can be a dangerous first stop for people with H.I.V., and not just because they often mean a delay in starting antiretrovirals. Sometimes the consequences are more dire. "I discourage older men from going to young girls to cure AIDS," said Mhaula, but horrifyingly, some healers do not, spreading the message that sex with a virgin is curative. Many sangomas, Mhaula said, induce diarrhea or vomiting to clean out the illness, which can be debilitating for someone sick with AIDS.

So South African officials have begun to train traditional healers about H.I.V. Training often lasts only a few days, and it varies greatly in quality, but it is nonetheless useful and has reached thousands of sangomas. Mhaula took the training and trained others herself. I met her in April, and I later found out that she died suddenly three weeks after I visited her, of an infection unrelated to AIDS. She was an enormous woman of 53 who greeted me in a muumuu and fuzzy pink slippers. The daughter of two traditional healers, she had been one herself since the late 1970's. But she also worked in the labs of a multinational drug company for 27 years, and the company paid her college tuition. Arthritis forced her into early retirement, but she was bored at home. At Tembisa's health clinic, she received training in H.I.V. counseling and caring for the terminally ill. Her own daughter died of AIDS six years ago, and Mhaula was raising her daughter's child.

Off her patio was a small room -- her indumba, or consulting room. The walls were lined with hundreds of glass jars and plastic tubs containing mixtures of herbs. Animal skins and straw mats covered the concrete floor. Hanging from the ceiling were candles, the clothes of her ancestors and beaded necklaces. There was a plate of bones. When her clients (she does not call them patients) visited her, she read the bones. When she was alone, she put on the clothes of her ancestors and called their spirits. There were seven different ancestors that she talked to.

Mhaula walked me through what she did when she recognized symptoms of H.I.V. "I say: 'Think about it. We live in the 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 want me to go get their test results. They say, 'Don't tell me the results, just give me imbiza'" -- the herbal mixture she makes that she says boosts the immune system. "I say, 'How are you going to change your behavior?' They say, 'I'm not yet ready.' I tell them: 'It's good to have one partner. You must use condoms.'"

Working with traditional healers is hugely important for fighting AIDS in South Africa. But it has a dangerous side. The problem lies in the stack of white tubs that were behind the door of the indumba -- Mhaula's imbiza. She was careful not to call it a cure. It might indeed strengthen the immune system -- it has never been tested in clinical trials, so we don't know. But it cannot be taken with antiretroviral drugs. That meant Vusi Ziqubu had to choose.

"Traditional healing is being manipulated to put forth a political agenda," says Jonathan Berger, head of policy and research at the AIDS Law Project in Johannesburg. "It's a way to push the anti-Western-medicine line by appealing to culture and tradition." When I was in South Africa, a "cure" called the mopane worm was on the front pages of the tabloid papers. Health officials' embrace of a long line of charlatans has encouraged a thriving industry in such cures. Hundreds of sangomas sell them.

They are very tempting to people fearful of the impersonal clinic. "With us, you don't have to take it the rest of your life," Mhaula told me. "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."

Imbiza seemed to be helping Ziqubu -- for now. 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 came back to meet the woman. But she had already died.

AIDS is a disease of taboos. For its sufferers, psychological comfort, like that provided by traditional healers, is paramount -- sometimes more important than even staying alive. But over the next few years, word will spread about the Lazarus effect of antiretroviral drugs. Although logistical and personnel problems will no doubt remain, few people will be able to argue that the drugs are poison, and few will shun them for herbal remedies.

There is also reason for optimism that other weapons in the fight against AIDS will win more public acceptance. Improvements in service will encourage more women to protect their babies. In the Alexandra clinic, the resourceful nurse Pauline Molotsi has hit on a strategy that sometimes helps. If an H.I.V.-positive woman does not want to take the nevirapine, Molotsi thrusts a piece of paper and a pen toward the woman, essentially making her take responsibility for her decision. "Would you really like your baby to have the virus?" she asks. "If you don't take the pill, you will have to sign." At Chris Hani Baragwanath Hospital in Soweto, which has an unusually well-financed and -run antenatal clinic, 98 percent of pregnant women agree to be tested for H.I.V. There will always be psychological barriers, but good service can overcome them.

That may not be true with South Africa's most basic challenge: to bring down AIDS's astronomical prevalence in the general population. Help could come from the brand-new technology of microbicides, but it could also come from the very old one of circumcision, which may offer some protection from H.I.V. infection. (Clinical studies due to conclude next year may tell how much protection.) That's the future, though. For the moment,

AIDS prevention is entirely a conundrum of psychology and culture -- one we know very little about how to solve. The small list of countries that have had some success with prevention includes such dysfunctional places as Haiti, Zimbabwe and Cambodia. Experts can point to some good programs in these countries, but plenty of nations with rising AIDS rates have the same programs. The country that had an early drop in AIDS prevalence, Uganda, probably achieved this because its particular culture of openness brought the disease into the public eye, and the country treated it like World War III.

In South Africa, where AIDS has already exploded through the general population, prevention is an even more overwhelming challenge. One disturbing fact: Surveys show that South Africa's teenagers know about AIDS and how it is transmitted. They know the behaviors that put people at risk. But they don't apply this information to themselves. There is no correlation between information and behavior change. Two-thirds of young people who test H.I.V.-positive -- in anonymous surveys, so they don't know it -- do not consider themselves at risk for AIDS. Especially for teenagers, the psychology of sexual behavior resides in some deep and mysterious place, apparently shielded from the reach of traditional public-health messages as if by a lead curtain. The question is whether anything can get through.

South Africa is trying to answer that question with a controversial H.I.V./AIDS-prevention program called loveLife, which generally serves youths from 12 to 17. It is as far from the traditional campaigns as it could be. I went to the community hall in Emzinoni, a black township in Mpumalanga province in the country's east, to hear a dialogue staged by loveLife. Outside, geese ran in the dirt yard next to purple loveLife banners. Inside the auditorium, vibrant music blared and balloons filled the stage. A pop star named Elle sang a song about believing in yourself. A woman in jeans and a pink hat and a man in khaki shorts strode back and forth in front of the crowd, each with a microphone in hand, bantering in Zulu and English with about 500 Emzinoni parents and children, leading them in games and discussions about AIDS. Sithembile Sefako, the woman, and Mnqobi Nyembe, the man, are trainers from loveLife's national office. They are local versions of a motivational speaker like Tony Robbins, traveling the country holding these events -- but the problems they are discussing are not the ones Tony Robbins usually has to confront.

Sefako asked for volunteers for a little play: a university student named Beauty comes back from college to tell her parents she is pregnant and has H.I.V. Afterward, the actors compared their skit to reality. "Our parents scream at you and call you names," said the young man who played the father. "They say: 'I've seen you walking in the street! I knew you were going to fall pregnant!' They beat you."

"We use culture as an excuse," Sefako said. "They say, 'I can't talk to my children, it's not right.' We hide behind culture."

Next Sefako opened a discussion about responsibility for teen sex. A girl in a flowered cap said: "Most guys force us. Then they say if you are going to open a case with the police, we'll beat you. We'll come with a group and we'll kill you."

"Guys compete," one boy said. "You say, 'I'm going to sleep with six girls before Sunday.'"

"Is it true most women are falling pregnant to prove they can bear children?" Sefako asked.

One girl said: "We mustn't lie. Most fall pregnant because they want the money" -- the South African government's grant of $30 per month per child. "They think, I'll buy myself sneakers and jeans."

A man differed: "The reason women fall pregnant is that we see females in the street in a miniskirt."

"Are you saying young girls are getting raped because of what they wear?" Sefako asked.

"Yes, because of the way they are dressing, they end up in trouble."

A girl responded: "Then what about someone who rapes a 3-year-old child?"

"A child from 10 upward knows how to sleep with a guy, and she knows the way she is dressing," the man responded. The crowd hooted.

These unnerving comments contrasted bizarrely with the festive tone of the event. What was most remarkable to participants, however, was not what people were saying but that they were saying anything at all. 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. What passes for communication between parents and children about sex is often just a cryptic warning to girls to "stay away from boys" and to boys, nothing. Yet children whose parents do talk to them about sex abstain longer and are more likely to use condoms. In general, openness is the anti-AIDS -- if the sick came out of hiding, it would be easier for their friends and neighbors to accept that they, too, are at risk. That's one reason loveLife's principal slogan is "Talk About It."

By 1997 AIDS was a crisis of biblical proportion in South Africa, with 13 percent of adults infected. The red-ribbon billboards that passed for an AIDS-prevention campaign were failing disastrously, especially with young people. For girls -- who tend to have sex with older men -- the riskiest age was between 12 and 17. The Kaiser Family Foundation, a health organization based in California, pledged that if South Africans could decide what was needed to prevent the spread of AIDS in young people, the foundation would pay the bill for the first five years.

Kaiser hired Judi Nwokedi to help plan the program. Nwokedi is a charismatic whirlwind who is head of government relations for Motorola in South Africa. A psychologist by training, she worked with sexually abused children and on AIDS projects while in exile in Thailand and Australia. Nwokedi met with AIDS groups, government officials and

international experts to forge agreement on the basics. She also commissioned surveys of South Africa's teenagers. The surveys found that teenagers tuned out the traditional prevention messages and were most receptive to an AIDS campaign that was about more than just AIDS. The teenagers also said their parents didn't talk to them about sex or relationships -- and they desperately wanted that kind of communication and wanted their parents to set limits. Significantly, the study found that poorer girls realized their first sexual encounter would probably be coerced and violent.

The next question was how to reach the children and young people at risk. "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 says. "They would have to sit there while someone would stand up there and talk at them. 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. I wanted H.I.V. education to have another dimension -- it had to be interactive, engaging, question-and-answer, vibrant debate."

Under apartheid, young people identified with collective action. Now they were tired of politics, tired of "we." An expansion of electrical service in the late 1990's had allowed the number of households with televisions to soar. Young people were tuning into the global popular culture they saw on TV, with a very high level of awareness of brands.

The working title for the campaign had been the National Adolescent Sexual Health Initiative. Nwokedi, consulting with teenagers, public-health leaders and marketing experts, nixed it. "You're dead before you can even go out to young people," she said. "They'd call it Nashi as an acronym -- that was soooo public health!"

The AIDS-prevention program had to be branded. The closest model was a recent relaunch of Sprite. "Sprite took the brand off the shelf into the communities," Nwokedi says. "They did basketball, sponsored concerts, sent cool kids onto 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, "an aspirational lifestyle brand for young South Africans," as the group's literature says. Today loveLife is one of the 15 best-known brands in South Africa. The country is dotted with 1,750 loveLife billboards. Radio call-in shows reach three million young listeners a week. LoveLife has TV spots and TV reality shows, including one that sent attractive young people into the wilderness to compete in AIDS-related games, like using the other sex's tools of seduction. A Web site (www.lovelife.org.za) and magazines feature not only graphic information about H.I.V. but also fashion, gossip and relationship advice.

There are very few South Africans who lack strong opinions about loveLife. South Africa has other AIDS-themed TV series and media campaigns and many other behavior-change programs. But at $25 million a year, loveLife is the giant, and it attracts most of the controversy. Initially, I was a skeptic. LoveLife struck me as empty cheerleading --

telling young people who live in cardboard houses and eat a few handfuls of cornmeal mush each day to look on the bright side, when there is no bright side.

LoveLife started out promising too much, pledging to halve the rate of new H.I.V. infections among young people in five years. More recently, it has suffered management problems. South Africans cluck about the fact that the Global Fund to Fight AIDS, Tuberculosis and Malaria cut off a loveLife grant last year -- one of only three grants stopped worldwide. The money was being used to, among other things, build rooms where teenagers could go, known as "chill rooms," in health clinics. Brad Herbert, who was chief of operations at the Global Fund at the time, told me that the grant was canceled because construction was too slow and expensive, but that there were no charges of impropriety. (The grant arrived six months late, and loveLife officials argue that the delay caused cash-flow and exchange-rate problems.)

But many people also question loveLife's basics. Virtually every South African adult I met thinks that the messages on loveLife's billboards -- the media most visible to adults -- are incomprehensible. Many -- like "Get Attitude!"-- indeed appear to have nothing to do with AIDS. But loveLife's leaders argue that the billboards, like all of loveLife's media, are not there to educate young people but to draw them into the face-to-face programs. They promote loveLife as an exclusive club that you, as a teenager, can join. The celebrity gossip and fashion advice in loveLife magazines is also not a message but a delivery system. "The logic of the brand is to create something larger than life, a sense of belonging," says Dr. David Harrison, a tall, lanky, white physician who became head of loveLife in 2000. "That creates participation in clinics, schools -- people go because they like to be a part of loveLife."

As Sprite did, loveLife uses kids to recruit their peers. It has programs now in a third of the country's high schools, a seventh of the nation's health clinics, 130 community organizations and 16 loveLife centers. All these programs are run by what loveLife calls, with a typical typographical flourish, groundBREAKERs. They are young people between 18 and 25, trained and hired for one year at minimum wage to talk about sex, AIDS and relationships, help run school sports competitions (South Africa's only public-school sports in most of the country), radio stations and computer workshops. Perhaps most important, they are taught how to motivate young people by sharing their own personal histories. That is crucial, as loveLife's challenge is not to impart information but to cut through fatalism and denial to get young people to apply the information they already know.

I met Harrison in loveLife's headquarters in the Johannesburg suburb of Sandton, a pleasant campus of modern buildings with interiors painted in loveLife's trademark purple and white. He said that loveLife's research found that what particularly put young people at risk was coerced sex. Other factors were low self-esteem, absence of belief that the future offered any reason to make wiser choices today, peer pressure, lack of parental communication and the popular belief that a girl is not a woman until she has a baby. Poverty, low education and marginalization also led to higher rates of AIDS.

LoveLife cannot do much about those last three. Instead it tries to promote family and society communication and help young people acquire the skills and motivation to resist pressure to have sex, especially unprotected sex. "When I ask young people what made them change, they never say, 'You gave us information,' " Harrison says. "They say: 'I feel an identity with a new way of life. I can be like my friend whose life has changed.'"

There have been some good recent analyses about how to tinker effectively with teenagers' heads. A study last year led by Dolores Albarracin of the University of Florida examined evaluations of hundreds of H.I.V.-prevention programs. The group found that threats and fear don't work. This finding argues against "AIDS kills" messages and also against more sophisticated programs that encourage teenagers to confront how AIDS has ravaged their families. For young people, not surprisingly, one of the most effective arguments for making healthier choices is that their peers are doing the same. Programs that produced the most behavior change combined H.I.V. information, attitude change and training in skills like saying no to sex without a condom.

The most serious criticism is that loveLife is aimed in the wrong direction. "LoveLife is too focused on individual choice," says Warren Parker, the executive director of Cadre, an AIDS group. "We need community organizing around the issues of sexual violence, gender imbalance." The question of whether to try to change an individual's behavior or a society's culture is a big debate in AIDS work. Certainly in South Africa, both seem necessary.

"To stop the epidemic in the long term we need to tackle sexual violence," says Piot of Unaids. "But the problem is we still have a crisis. If we're going to wait till men and women have equality and no one has to sell their body -- well, we can't wait for that."

LoveLife's message is the same public-health gospel a Nashi would have used: abstinence, fidelity, condoms. But that message is received very differently if it comes during a five-hour lecture in the church hall than it is if it comes from Sibulele Sibaca, a petite, enthusiastic, energetic 23-year-old from Langa, a township outside of Cape Town. Today she is a corporate social investment manager in Richard Branson's Virgin Group in South Africa. That, she says, is because of loveLife. When she was 12, her mother died of AIDS. When she was 16, her father followed. "Before I joined loveLife, I had a serious history of self-destruction," she said by phone from Cape Town. "I saw my life ending up in the township, pregnant, not knowing who the father of my child is."

She got through high school. A friend told her about loveLife, and she began going to its programs. "I had been engaging in highly risky behavior, but loveLife helped me realize there were things I wanted to achieve in my life, and I couldn't afford to have sex without a condom," she said. "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 it is possible, you start looking at life in a different way.

"Seeing billboards of a dying person didn't tell me about me," Sibaca says. "But when someone says, 'You have such amazing potential that H.I.V. shouldn't be a part of it' --

then it wasn't about H.I.V. It was about me. No one is wagging a finger at me. 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, H.I.V. and other issues. She went to work in a high school, visiting the same class every day for 21 weeks. I asked her whether she felt it helped anyone. She told me about one girl in her class two years ago, also from Langa. "She was 15 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 16?'

"She came to me the next week and said, 'I'm single.' She had broken up with her boyfriend. I hugged her and started crying -- she saw her fears and was willing to go through with it anyway." Sibaca saw the young woman again a few months ago. "She was not H.I.V.-positive and not pregnant, and she was going to study law next year."

This is cheerleading -- but it's not empty cheerleading. LoveLife cannot promise any South African teenager that life will be good. But living on one meal a day is even harder if you have AIDS. It seemed valuable to help young people realize that there were reasons to stay healthy and that the choice is theirs.

In Orange Farm, a forlorn and violent township southwest of Johannesburg, I visited a loveLife center, a complex of buildings that draws kids in with a basketball court, a radio-production facility and a computer workshop -- but first, kids have to do AIDS training. LoveLife seemed to be Orange Farm's only after-school alternative to drinking, gangs and sex. In a mining district in rural Limpopo, I visited several health clinics. Nurses at clinics are famous for simply yelling at kids who come in with gonorrhea or a request for contraception, or threatening to tell their mothers. Now these clinics have loveLife chill rooms manned by groundBREAKERs. They have persuaded nurses not to drive teenagers away and will escort teenagers into their appointments.

I watched groundBREAKERs give talks on H.I.V. in schools and after school. The quality of their programs varied with their skills and the local environment. Some were pretty good. At Serokolo high school in the Limpopo mining town, I watched 23-year-old Tebatso Klass Leswifi run a class through a quiz on H.I.V., with discussion that ranged from whether girls become pregnant because of the country's child grant to why you would want to know your H.I.V. status. He also works at the local health clinic and helps run a league with 10 basketball teams. The high school's aerobics team -- also coached in part by Leswifi -- put on a show to the music of the pop hit "Gloria." I met a 17-year-old named Princess who said she calls Leswifi every day for some words of wisdom to motivate her to stay in school. In another Limpopo health clinic, however, I watched about 20 bored-looking kids sit through a lecture by groundBREAKERs on H.I.V. and

loveLife's programs. It was done in the rote-memorization style still typical in South Africa's rural schools, with practically no discussion. Still, I heard too many young people tell me loveLife had changed their lives to dismiss it. The organization seemed a little like a cult -- and that's good. Many young people I met told me that loveLife had saved them in big or little ways, and they said they were on a mission to pass that along to others.

There are strong indications that loveLife does indeed change young people's behavior. In 2003, the Reproductive Health Research Unit of the University of the Witwatersrand in Johannesburg did a survey of 15- to 24-year-olds. It found that people who had participated in loveLife's programs were only 60 percent as likely to be infected with H.I.V. as those who had not, and the risk diminished further for those who had participated in more than one program. There was also a strong association between loveLife participation and increased condom use -- although there was no statistically significant effect on abstention or partner reduction. Since the study was not a randomized, controlled one, it could not prove that loveLife programs caused the behavior change.

LoveLife has not, of course, produced the promised 50 percent drop in new H.I.V. infections. But loveLife's face-to-face programs have been working nationwide since only 2002. "It is too early to dismiss this," says Purnima Mane, the director of policy, evidence and partnerships at Unaids in Geneva. "It can take five or six years to see results." And last month, the South African government reported that new surveys of pregnant women showed that rates of infection in teenagers are holding steady, while the rates of other age groups are rising. This suggests something is working with teenagers.

LoveLife currently reaches around 40 percent of South Africa's youth with face-to-face programs. That's a lot, but more would be better -- given the scope of the catastrophe, $25 million a year is not that much. There are other programs that take a different but equally sophisticated approach, and it would help if they were broadened as well. Where the likelihood your partner is infected is as high as in South Africa, ordinary success might not be enough.

The thinking behind loveLife -- get into their heads -- needs to become part of every AIDS program, in South Africa and around the world. Governments are still setting goals of providing "access" to medicines or condoms, but access and accessed are very different things. It will be a complicated and expensive change, because what works in one culture may not work in another. It will also require people to take into account what works. It sounds strange to say it, but this is often not a factor. Across Africa, groups are turning to abstinence-only programs not because they work -- they don't -- but because that's what Washington wants to finance. Rigorous evaluation to show which AIDS programs are effective is also necessary, something that is only an occasional afterthought today.

Without attention to the social, psychological and cultural factors surrounding the disease, we are throwing away money and lives. This is the new frontier. Twenty-five years into the epidemic, we now know how to keep people from dying of AIDS. The

challenge for the future is to keep them from dying of stigma, denial and silence.

Tina Rosenberg writes editorials for The New York Times. She has written for the magazine about AIDS, malaria and tuberculosis, among other subjects.

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LOAD-DATE: August 6, 2006