HELEN EPSTEIN

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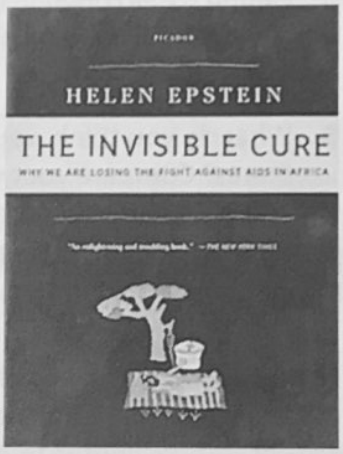

After earning a Ph.D. in molecular biology from Cambridge University, **Helen Epstein** attended the London School of Hygiene and Tropical Medicine, where she earned an M.Sc. in public health in developing countries. In 1993, while working as a scientist for a biotechnology company in search of an AIDS vaccine, Epstein moved to Uganda, where she witnessed the suffering caused by the virus. Epstein still works in public health care in developing countries. She has published articles in magazines such as the *New York Review of Books* and in 2007 published her book, *The Invisible Cure: Africa, the West, and the Fight against AIDS*.

Epstein compiled the information she had gathered in her years as a scientist in Africa, along with her personal observations, to write *The Invisible Cure*. In it she explores the reasons behind the unprecedented AIDS epidemic in Africa and suggests ways to reduce infection rates on that continent. Along the way she corrects the misinformation and misconceptions that Westerners have been using as a guide for aiding Africans who suffer from or are at risk for HIV/AIDS. She points out that programs for prevention might need to be in the hands of Africans themselves in order to account for local cultures. For instance, while campaigns promoting condom usage might be successful in Western countries, this does not mean such campaigns will succeed within other cultures. Instead, listening to and understanding the traditions and customs of individual cultures might lead to more successful approaches to the AIDS epidemic.

In "AIDS, Inc.," a chapter from *The Invisible Cure*, Epstein examines HIV and AIDS prevention programs in Africa. In South Africa, Epstein witnesses a government-run campaign that focuses on creating conversations about sexual activity among the nation's youth in order to help them make informed decisions about sex. However, many of the conversations stop there, leaving out any talk of people who already have AIDS. While the campaign may open up new avenues for youth in terms of sexual responsibility and respect, the lack of conversation surrounding AIDS perpetuates the social stigmas of infected peoples as well as an "out of sight, out of mind" attitude toward the virus. Perhaps, as Epstein points out, campaigns are only as successful as the conversations surrounding them. She points to Uganda — one of the few countries in Africa where the rate of infection has dropped precipitously — as an example of effective conversation. Open conversation among Ugandans about personal experiences with the virus has succeeded in preventing its spread by breaking the cycle of social stigmas surrounding those infected.

What social stigmas concerning HIV and AIDS exist locally and globally? How do these social stigmas interfere with campaigns to successfully prevent the spread of the virus? How might class, race, gender, and religion contribute to the way prevention is approached? While Epstein points out how important conversation is among communities, is it possible to create a global conversation about HIV and AIDS?

▶ TAGS: *adolescence and adulthood, collaboration, community, conversation, culture, education, globalism, health and medicine, judgment and decision-making, media, politics, sexuality, social change*

▶ CONNECTIONS: *Appiah, Duhigg, Southan, Yoshino*

Questions for Critical Reading

1. What is a *lifestyle brand*? Make note of the definition of the term as you read Epstein's text. Then find an example of a lifestyle brand from popular culture. How might such an approach be used in health education? How effective might it be? How effective was it in South Africa?
2. Define *social cohesion* using Epstein's text. What role did it play in HIV infection rates in Uganda? How might that role be extended to other countries, including the United States?
3. What do you think would make an effective HIV prevention program for the United States? Compare your vision to Epstein's and her observations on such programs in Africa. Would the same strategies be effective in those two different cultural contexts? Support your responses with passages from the essay.

AIDS, Inc.

In response to government prevarication over HIV treatment, a vigorous AIDS activist movement emerged in South Africa and a fierce public relations battle ensued. The Treatment Action Campaign, or TAC, along with other activist groups, accused the South African health minister, Manto Tshabalala-Msimang, of "murder" for denying millions of South Africans access to medicine for AIDS. A spokesman from the ANC Youth League then called the activists "paid marketing agents for toxic AIDS drugs from America."[1] An official in the Department of Housing accused journalists who defended the AIDS activists of fanaticism, and quoted Lenin* on how the "press in bourgeois society . . . deceive[s], corrupt[s], and fool[s] the exploited and oppressed mass of the people, the poor."

Meanwhile, across the nation thousands of people were becoming infected daily, from the rural homesteads of the former Bantustans† to the peri-urban townships and squatter camps to the formerly all-white suburbs, now home to a growing black middle class. By 2005, the death rate for young adults had tripled.[2] Surveys showed that nearly everyone in South Africa knew that HIV was sexually transmitted and that it could be prevented with condoms, abstinence, and faithfulness to an uninfected partner. Children were receiving AIDS education in school and condoms were widely available,

*Lenin: Vladimir Lenin (1870–1924), a chief figure in the Russian revolution of 1917 (which led to the communist takeover); Lenin was the first head of the USSR [Ed.].

†Bantustans: Areas in South Africa where the black population was kept separate from whites during the policy of apartheid, or racial segregation, in the twentieth century [Ed.].

but these programs made little difference. In the din of the battle between the activists and the government, the deeper message, that HIV was everyone's problem, was lost.

In 1999, a group of public health experts sponsored by the U.S.-based Kaiser Family Foundation stepped into this fray. They were concerned about the worsening AIDS crisis in South Africa and wanted to launch a bold new HIV prevention program for young people. They also knew they had to take account of the South African government's attitudes toward AIDS and AIDS activists. Their program, called loveLife, would soon become South Africa's largest and most ambitious HIV prevention campaign. It aimed both to overcome the limitations of similar campaigns that had failed in the past and, at the same time, to avoid dealing with the issues of AIDS treatment and care that had become so controversial.

Could this work? I wondered. Was it possible to reduce the spread of HIV without involving HIV-positive people and the activists and community groups that supported them? LoveLife had been endorsed at one time or another by the archbishop of Cape Town; Nelson Mandela; the king of the Zulu tribe; Jacob Zuma, South Africa's former deputy president; and even Zanele Mbeki, the wife of the president. In 2003, loveLife's annual $20 million budget was paid for by the South African government, the Kaiser Family Foundation, UNICEF, the Bill and Melinda Gates Foundation, and the Global Fund to Fight AIDS, Tuberculosis, and Malaria. At least South Africa's leaders were beginning to take AIDS seriously, I thought, but what kind of program was this?

"What we want to do is create a substantive, normative shift in the way young people behave," explained loveLife's director, David Harrison, a white South African doctor, when I met him in his Johannesburg office. The average age at which young South Africans lose their virginity—around seventeen—is not much different from the age at which teenagers in other countries do. What's different, Harrison said, was that many of the young South Africans who were sexually active were very sexually active. They were more likely to start having sex at very young ages, even below the age of fourteen—well below the national average. Those vulnerable young people were more likely to have more than one sexual partner, and they were less likely to use condoms. South African girls were more likely to face sexual coercion or rape, or to exchange sex for money or gifts, all of which placed them at greater risk of HIV infection. For Harrison, the trick was to "get inside the head-space of these young people . . . we have to understand what is driving them into sex—they know what HIV is, but they don't internalize it," he said.

LoveLife's aim was to get young people talking, to each other and to their parents, so they would really understand and act on what they knew. But to reach out to them, you had to use a special language that young people could relate to. According to Harrison, traditional HIV prevention campaigns were too depressing: They tried to scare people into changing their behavior, and this turned kids off. LoveLife's media campaign, on the other hand, was positive and cheerful, and resembled the bright, persuasive modern ad campaigns that many South African kids were very much attracted to.

In the past couple of years, nearly a thousand loveLife billboards had sprouted all along the nation's main roads. They were striking. For example, on one of them, the hands of four women of different races caressed the sculpted back and buttocks of a

young black man as though they were appraising an antique newel post. The caption read, "Everyone he's slept with, is sleeping with you." On another, a gorgeous mixed-race couple—the boy looked like Brad Pitt, the girl like an Indian film star—lay in bed, under the caption "No Pressure." Some people told me they found these ads oversexualized and disturbing, but it is hard to see why. On the same roads, there are torsos advertising sexy underwear and half-naked actresses advertising romantic movies. Sex is a potent theme in marketing all sorts of products; loveLife, according to its creators, tries to turn that message around to get young people thinking and talking about sex in more responsible ways and convince them of the virtues of abstinence, fidelity, and the use of condoms.

Harrison calls loveLife "a brand of positive lifestyle." The sexy billboards and similar ads on TV and radio, as well as newspaper inserts that resemble teen gossip magazines, with articles and advice columns about clothes, relationships, and sexual health, were designed, Harrison says, to persuade young people to avoid sex in the same way a sneaker ad tries to seduce them into buying new sneakers, because the players in the ads look so cool. The idea is "to create a brand so strong that young people who want to be hip and cool and the rest of it want to associate with it," Harrison told an interviewer in 2001.[3]

The concept of a "lifestyle brand" originated with the rise of brand advertising in the 1960s, when ads for such products as Pepsi-Cola and Harley-Davidson began to promote not only soft drinks and motorcycles, but also a certain style or aesthetic. People were urged to "join the Pepsi generation" or ride a Harley-Davidson not just to get around, but to embrace a certain attitude. A Harley wasn't just a bike; it was a macho rebellion, an escape from the workaday world to the open road. In the 1970s, family-planning programs also tried to promote contraceptives in developing countries by tapping into poor people's aspirations for a glamorous Western lifestyle. Campaigns depicted small, well-dressed families surrounded by sleek new commodities, including televisions and cars. Harrison predicted that young South Africans would readily respond to this approach too.

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"Kids have changed," Harrison explained. Today's young South Africans weren't like the activists who risked their lives in the anti-apartheid demonstrations at Sharpeville and Soweto. "Seventy-five percent of South African teenagers watch TV every day," Harrison informed me. "Their favorite program is *The Bold and the Beautiful*"—an American soap opera in which glamorous characters struggle with personal crises while wearing and driving some very expensive gear. "They are exposed to the global youth culture of music, fashion, pop icons, and commercial brands. They talk about brands among themselves, even if they can't afford everything they see."

The Kaiser Foundation's Michael Sinclair told me that loveLife drew much of its inspiration from the marketing campaign for the soft drink Sprite.[4] In the mid-1990s, sales of Sprite were flagging until the company began an aggressive campaign to embed Sprite in youth culture by sponsoring hip-hop concerts and planting attractive, popular kids in Internet chat rooms or college dormitories and paying them to praise or distribute Sprite in an unobtrusive way. Sprite is now one of the most profitable drinks in the world because it managed to exploit what marketing experts call "the

cool effect"—meaning the influence that a small number of opinion leaders can have on the norms and behavior of large numbers of their peers. So far, corporate marketers had made the greatest use of the cool effect, but there was speculation that small numbers of trendsetters could change more complex behavior than shopping, such as criminality, suicide, and sexual behavior.[5]

For this reason, loveLife had established a small network of recreation centers for young people, known as Y-Centers, throughout the country. At Y-Centers, young people could learn to play basketball, volleyball, and other sports, as well as learn break dancing, radio broadcasting, and word processing. All Y-Center activities were led by "loveLife GroundBreakers"—older youths, usually in their early twenties, who, like the kids who made Sprite cool, were stylish and cheerful and enthusiastic about their product, in this case, loveLife and its program to encourage safer sexual behavior. If abstinence, monogamy, and condoms all happened to fail, each Y-Center was affiliated with a family-planning clinic that offered contraceptives and treatment for sexually transmitted diseases such as syphilis and gonorrhea. The centers offered no treatment for AIDS symptoms, however, and when I visited, none of them offered HIV testing either.

Any young person could become a Y-Center member, but in order to fully participate in its activities, he or she had to complete a program of seminars about HIV, family planning, and other subjects related to sexuality and growing up. The seminars emphasized the biological aspects of HIV and its prevention, but not the experience of the disease and its effects on people's lives. Members also received training to raise their self-esteem, because, as Harrison told an interviewer in 2001,

> there is a direct correlation between young people's sexual behavior and their sense of confidence in the future. Those young people who feel motivated, who feel that they have something to look forward to—they are the ones who protect themselves, who ensure that they do not get HIV/AIDS. . . . It's all about the social discount rates that young people apply to future benefits.[6]

Dr. Harrison arranged for me to visit a loveLife Y-Center in the archipelago of townships in the flat scrubland south of Johannesburg known as the Vaal Triangle. Millions of people live in these townships, many of them recent migrants from rural South Africa or from neighboring countries. The Vaal, once a patchwork of white-owned farms, is now a residential area for poor blacks. At first, only a few families moved here, because the apartheid government used the notorious pass laws to restrict the tide of impoverished blacks seeking a better life in Johannesburg. But when the apartheid laws were scrapped, people poured in. Today, the roads and other services in the area are insufficient for its huge and growing population, and many people have no electricity and lack easy access to clean water and sanitation. Unemployment exceeds 70 percent and the crime rate is one of the highest in South Africa.[7]

The loveLife Y-Center was a compound of two small lavender buildings surrounded 15
by an iron fence and curling razor wire. Inside the compound, a group of young men in shorts and T-shirts were doing warm-up exercises on the outdoor basketball court, while girls and barefoot children looked on. Inside the main building, another group of boys in fashionably droopy jeans and dreadlocks practiced a hip-hop routine, and two girls in the computer room experimented with Microsoft Word.

Valentine's Day was coming up, and the Y-Center had organized a group discussion for some of its members. About thirty teenagers, most of them in school uniforms, sat around on the floor of a large seminar room and argued about who should pay for what on a Valentine's Day date. A GroundBreaker in a loveLife T-shirt and with a loveLife kerchief tied pirate-style on her head officiated. "I go with my chick and I spend money on her and always we have sex," said a husky boy in a gray school uniform. "And I want to know, what's the difference between my chick and a prostitute?" As we have seen, long-term transactional relationships—in which money or gifts are frequently exchanged—may not be the same as prostitution, but they nevertheless put many township youths at risk of HIV.[8]

"Boys, they are expecting too much from us. They say we are parasites if we don't sleep with them," said a plump girl in the uniform of a local Catholic school.

"The girls, they ask for a lot of things," another boy chimed in.

"Me, I think it is wrong. If most of the boys think Valentine's Day is about buying sex, the boys must stop," a girl said. "We girls must hold our ground."

These young people were certainly talking openly about sexual relationships all right, just as Harrison prescribed. Nevertheless, I felt something was missing. "Do you ever talk about AIDS in those discussion groups?" I asked the GroundBreaker afterward. "We do it indirectly," she replied. "We know that if we just came out and started lecturing them about AIDS, they wouldn't listen. They would just turn off. So we talk about positive things, like making informed choices, sharing responsibility, and positive sexuality."

Was this true? Do young people in South Africa, like their politicians, really want to avoid the subject of AIDS? I wanted to meet young people outside the Y-Center and ask them what they thought about that. A few hundred yards away from the Y-Center stood the headquarters of St. Charles Lwanga, a Catholic organization that carries out a number of activities in the township. Their AIDS program, called Inkanyezi, meaning "star" in Zulu, provides counseling to young people about AIDS and also brings food and other necessities to some four hundred orphans and people living with AIDS in the Vaal.

St. Charles Lwanga was independent of loveLife, and its budget was modest, less than a tenth of what loveLife spent on its billboards alone. The Inkanyezi program was staffed almost entirely by volunteers, whose only compensation was that they were allowed to eat some of the food—usually rice and vegetables—that they prepared for the patients. Lack of funding greatly limited the help that Inkanyezi was able to provide. Although Inkanyezi nurses were able to dispense tuberculosis medicine, antiretroviral drugs were as yet unavailable. Indeed, many of the patients they visited lacked some of the most basic necessities for life and human dignity. Sometimes destitute patients had their water and electricity cut off. But the worst thing was that many of the patients were socially isolated and lived alone in flimsy shacks. The doors were easily broken down and at night neighborhood thugs sometimes came in and stole what little they had. Sometimes the patients were raped.

Justice Showalala, who ran Inkanyezi, organized a meeting for me with a group of about twenty-five young people from Orange Farm. The HIV rate in the area was not known, but several people explained to me how their lives had been changed by the virus. They said they had witnessed extreme prejudice and discrimination against

people with AIDS, and they did not know where to turn when they learned that a relative or friend was HIV positive. "People say you shouldn't touch someone with HIV," said one girl. "I have a friend at school who disclosed she has HIV, and the others won't even walk with her." Justice explained how he had offered to introduce some teachers from a local school to some of his HIV-positive clients. "They said, 'If you want me to meet people with AIDS, you better give me a rubber suit.'"

The loveLife Y-Center did little to help young people deal with such confusion, stigma, and shame. "I learned basketball at the Y-Center," one girl told me, "and at meetings we talked about resisting peer pressure, [like when] your friends advise you to break your virginity, to prove you are girl enough. But I was afraid the people there would find out my sister had HIV. We talked about it as though it was someone else's problem."

In general, although sex was openly discussed at the Y-Center, the experience of AIDS was not. The Y-Center offered individual counseling for a small number of young people with HIV, but those who were hungry, homeless, or destitute, or were suffering from the symptoms of AIDS, were told to consult other organizations, including Inkanyezi. 25

It turns out that talking about the pain, both physical and emotional, that the disease creates is far more difficult than getting over the embarrassment of talking about sex. "I had heard about HIV before," said an Inkanyezi girl, wearing a bright blue T-shirt and matching headband. "But then I found out my mother was HIV positive. I was so shocked, so shocked. I even talked to my teacher about it. She said it can happen to anyone; it must have been from mistakes my mother made, and that I shouldn't make those mistakes in my own life."

"Sometimes, women have no choice," said the older woman sitting next to the girl in blue. She was thin, with intense dark eyes and a deep, wry smile. She was dressed entirely in black, except for a baseball cap with a red ribbon on it—the universal symbol of solidarity with HIV-positive people. "They get infected because of their husbands, and there's nothing they can do.

"It happened like this," the older woman went on. "It was back when we were living in Soweto, before we moved here. One day my daughter and I were washing clothes together," she said, nodding at the girl in blue. "She said she'd had a dream that I was so sick, that I had cancer and I was going to die. I waited until we were done with the washing, and then I told her that I was HIV positive. She said, 'I knew it, you were always sick and always going to support groups.' She was so down, she just cried all day and all night after that. I told her, 'Only God knows why people have this disease. Don't worry, I won't die right away.'

"Once I visited the loveLife Y-Center," the woman continued, "but I just saw children playing. I sat and talked with them, and they were shocked when I said I was HIV positive. I told them about what it was like, and one of them said she would ask the managers whether I could come and talk to a bigger group. But that was about six months ago and they haven't called me. I haven't moved and my number hasn't changed. I don't know why they haven't called."

"I think there should be more counseling and support groups for people who find out their parents are HIV positive," the girl in blue said. "It puts you down, it really gets to you, it haunts you. When you are standing in class and you have to recite a poem 30

or something, I find I can't get anything out of my mouth. I can't concentrate. [The problem] here is ignorance. I didn't care about HIV until I found out about my mother. Then I started to care about these people. I wish many people in our country would also think like that."

In 2003, the only African country that had seen a nationwide decline in HIV prevalence was Uganda. Since 1992 the HIV rate had fallen by some two-thirds, a success that saved perhaps a million lives. The programs and policies that led to this success [are discussed elsewhere], but the epidemiologists Rand Stoneburner and Daniel Low-Beer have argued that a powerful role was played by the ordinary, but frank, conversations people had with family, friends, and neighbors—not about sex, but about the frightening, calamitous effects of AIDS itself.[9] Stoneburner and Low-Beer maintain that these painful personal conversations did more than anything else to persuade Ugandans to come to terms with the reality of AIDS, care for the afflicted, and change their behavior. This in turn led to declines in HIV transmission. The researchers found that people in other sub-Saharan African countries were far less likely to have such discussions.

In South Africa, people told Stoneburner and Low-Beer that they had heard about the epidemic from posters, radio, newspapers, and clinics, as well as from occasional mass rallies, schools, and village meetings; but they seldom spoke about it with the people they knew. They were also far less likely to admit knowing someone with AIDS or to be willing to care for an AIDS patient. It may be no coincidence that the HIV rate in South Africa rose higher than it ever did in Uganda, and has taken far longer to fall.

When I was in Uganda during the early 1990s, the HIV rate was already falling, and I vividly recall how the reality of AIDS was alive in people's minds. Kampala taxi drivers talked as passionately about AIDS as taxi drivers elsewhere discuss politics or football. And they talked about it in a way that would seem foreign to many in South Africa because it was so personal: "my sister," "my father," "my neighbor," "my friend."[10]

Ugandans are not unusually compassionate people, and discrimination against people with AIDS persists in some families and institutions. But Ugandans do seem more willing to openly address painful issues in their lives. This courage owes much to the AIDS information campaigns launched by the government of Uganda early on in the epidemic. But it may have other sources as well. Maybe the difference between the ways South Africa and Uganda have dealt with AIDS has historical roots. Both South Africa and Uganda have bitter histories of conflict. But while Uganda was terrorized for decades by a series of brutal leaders, they could not destroy the traditional rhythms of rural family life. Uganda is one of the most fertile countries in Africa; there is enough land for everyone, and most people live as their ancestors did, as peasant farmers and herders. No large settler population displaced huge numbers of people or set up a system to exploit and humiliate them, as happened in South Africa and in many other African countries. This means Ugandans are more likely to know their neighbors and to live near members of their extended families. This in turn may have contributed to what sociologists call "social cohesion"—the tendency of people to talk openly with one another and form trusted relationships. Perhaps this may have facilitated more realistic and open discussion of AIDS, more compassionate attitudes toward infected people, and pragmatic behavior change.

Perhaps many attempts to prevent the spread of HIV fail because those in charge of them don't recognize that the decisions people make about sex are usually a matter of feeling, not calculation. In other words, sexual behavior is determined less by what Dr. Harrison called "discount rates" that young people "apply to future benefits" than by emotional attachments. I thought of the South African girls who said they had lost a sister or a friend to AIDS. If one of them was faced with a persistent, wealthy seducer, what would be more likely to persuade her to decline? The memory of a loveLife billboard, with its flashy, beautiful models? Or the memory of a person she had known who had died? 35

On the morning before I left South Africa, I attended a loveLife motivational seminar at a school not far from Orange Farm. "These seminars help young people see the future, identify choices, and identify the values that underpin those choices," Harrison had told me. "We help them ask themselves, 'What can you do to chart life's journey and control it as much as possible?' " The seminars were based on Success by Choice, a series devised by Marlon Smith, a California-based African-American motivational speaker. How was Mr. Smith's message of personal empowerment translated to South Africa, I wondered, where children have to contend with poverty, the risk of being robbed or raped, and a grim future of likely unemployment?

About twenty-five children aged ten to fourteen were in the class, and the GroundBreaker asked them to hold their hands out in front of them, pretend they were looking in a mirror, and repeat the following words:

"You are intelligent!"

"You are gifted!"

"There is no one in the world like you!" 40

"I love you!"

The children spoke quietly at first, then louder, as though they were being hypnotized. The GroundBreaker urged them to talk more openly with their parents, to keep themselves clean, and to make positive choices in their lives, especially when it came to sexuality. There was little mention of helping other people, nor was there much advice about how to avoid being raped or harassed by other students as well as teachers, relatives, or strangers, or how to plan a future in a country where unemployment for township blacks was so high.

Then something really odd occurred. One of the GroundBreakers asked the children to stand up because it was time for an "Icebreaker." "This is a little song-and-dance thing we do, to give the children a chance to stretch. It improves their concentration," another GroundBreaker told me. The words of the song were as follows:

Pizza Hut
Pizza Hut
Kentucky Fried Chicken and a Pizza Hut
McDonald's
McDonald's
Kentucky Fried Chicken and a Pizza Hut.

In the dance, the children spread their arms out as though they were rolling out a pizza, or flapped their elbows like chickens.

What kinds of choices was Dr. Harrison really referring to? I wondered. The techniques of marketing attempt to impose scientific principles on human choices. But it seemed a mad experiment to see whether teenagers living through very difficult times could be persuaded to choose a new sexual lifestyle as they might choose a new brand of shampoo, or whether children could be trained to associate safe sex with pizza and self-esteem.

Afterward, I spoke to some of the children who had participated in the seminar. They all knew how to protect themselves from HIV, and they were eager to show off their knowledge about condoms, abstinence, and fidelity within relationships. But they all said they didn't personally know anyone with AIDS; nor did they know of any children who had lost parents to AIDS. They did mention Nkosi Johnson, the brave HIV-positive twelve-year-old boy who became world-famous in 2000 when he stood up at an International Conference on AIDS and challenged the South African president, Thabo Mbeki, to do more for people living with the virus.

In fact, their principal would tell me later, more than twenty children at the school were AIDS orphans, and many more had been forced to drop out because there was no one to pay their expenses after their parents died. The children I spoke to seemed not to know why some of their classmates wore ragged uniforms or had no shoes or stopped showing up at all.

The week before, I had met some teenage girls in Soweto and I had asked them the same question. They answered in the same way: The only person they knew with AIDS was Nkosi Johnson, the famous boy at the AIDS conference. Just as Harrison had warned me, these girls said they were tired of hearing about AIDS. The girls were orphans, although they said their parents had not died of AIDS. I later discovered that, in another part of that same orphanage, there was a nursery where thirty babies and small children, all of them HIV positive, all abandoned by their parents, lay on cots or sat quietly on the floor, struggling for life. No wonder those girls were tired of hearing about HIV. It was right in their midst, within earshot, but the world around them was telling them to look the other way.

A couple of years later, I would meet a group of primary-school students in Kigali, Rwanda. By then, the HIV infection rate in Rwanda had fallen steeply, just as it had in Uganda years earlier. The school was a typical single-story line of classrooms in one of the poorest sections of Kigali. I spoke to the principal first, and he showed me the government-issued manual used for teaching about AIDS, which contained the usual information about abstinence and condoms. The school day had just ended, and he went outside and asked a few students to stay behind and chat with me.[11]

The Rwandan students had no idea in advance what I wanted to talk to them about. But when I asked them the same question I had asked the South African children, "Do you know anyone with AIDS?" their answers floored me. Every one of them had a story about someone they knew who was HIV positive or suffering from AIDS. "I knew a man who had bad lips [sores] and tears all over his skin," said a fourteen-year-old boy. "People stigmatized him and he died because no one was caring for him." Another boy described a woman who was "so thin, she almost died." But then her relatives took her to the hospital, where she was given AIDS treatment. "She got better because people cared for her," he said.

When I asked the Rwandan children whether they had any questions for me, all they wanted to know was what they could do to help people with AIDS. The responses of the South African children were strikingly different. When I asked them if they had questions for me, they quickly changed the subject from AIDS and asked me what America was like and whether I knew any of the pop stars they admired on TV. 50

The persistent denial of AIDS in South Africa was deeply disturbing. People liked the colorful, frank advertising and the basketball games sponsored by loveLife. But its programs seemed to me to reinforce the denial that posed so many obstacles to preventing HIV in the first place. In 2005, the Global Fund to Fight AIDS, Tuberculosis, and Malaria would come to similar conclusions and terminate its multimillion-dollar grant to loveLife.[12]

The persistent denial of AIDS in South Africa was deeply disturbing.

Epidemiologists are equivocal about whether loveLife had any effect on HIV transmission in South Africa, but during the program's first seven years, HIV infection rates continued to rise steadily.[13]

A more realistic HIV prevention program would have paid less attention to aspirations and dreams unattainable for so many young people, and greater attention to the real circumstances in people's lives that make it hard for them to avoid infection. It would also have been more frank about the real human consequences of the disease. But that would have meant dealing with some very painful matters that South Africa's policy-makers seemed determined to evade.

It was heartening that Western donors were now spending so much money on AIDS programs in Africa. But the problem with some large foreign-aid programs was that distributing the funds often involved negotiating with governments with a poor record of dealing with AIDS. In addition, the huge sums of money involved were often very difficult to manage, so that small community-based groups that need thousands of dollars, rather than millions—like Inkanyezi in Orange Farm—were often overlooked in favor of overly ambitious megaprojects, whose effectiveness had not been demonstrated and whose premises were open to question. It seemed clear to me that more could be learned from Inkanyezi's attempt to help people deal with the reality of AIDS than from loveLife's attempt to create a new consumerist man and woman for South Africa.

NOTES

1. Helen Schneider, "On the fault-line: The politics of AIDS policy in contemporary South Africa," *Afr Stud* 61:1 (July 1, 2002), 145–67; Samantha Power, "The AIDS Rebel," *New Yorker*, May 19, 2003, pp. 54–67.
2. Rob Dorrington et al., "The Impact of HIV/AIDS on Adult Mortality in South Africa" (Cape Town: Burden of Disease Research Unit, Medical Research Council of South Africa, September 2001); "Mortality and causes of death in South Africa, 2003 and 2004," Statistics South Africa, May 2006.
3. Richard Delate, "The Struggle for Meaning: A Semiotic Analysis of Interpretations of the loveLife His&Hers Billboard Campaign," November 2001, http://www.comminit.com/stlovelife/sld-4389.html.

4. Personal communication, February 2003.
5. For more about this, see Malcolm Gladwell, *The Tipping Point* (Boston: Little, Brown, 2000), and Everett Rogers, *Diffusion of Innovations* (New York: Free Press, 1983).
6. Delate, "Struggle for Meaning."
7. See Prishani Naidoo, "Youth Divided: A Review of loveLife's Y-Centre in Orange Farm" (Johannesburg: CADRE Report, 2003).
8. Nancy Luke and Kathleen M. Kurtz, "Cross-Generational and Transactional Sexual Relations in Sub-Saharan Africa: Prevalence of Behavior and Implications for Negotiating Safer Sexual Practices," International Center for Research on Women, 2002, http://www.icrw.org/docs/CrossGenSex_ Report_902.pdf; J. Swart-Kruger and L. M. Richter, "AIDS-related knowledge, attitudes and behaviour among South African street youth: Reflections on power, sexuality and the autonomous self," *Soc Sci Med* 45:6 (1997), 957–66; Editorial, "Reassessing priorities: Identifying the determinants of HIV transmission," *Soc Sci Med* 36:5 (1993), iii–viii.
9. Daniel Low-Beer and Rand Stoneburner, "Uganda and the Challenge of AIDS," in *The Political Economy of AIDS in Africa*, eds. Nana Poku and Alan Whiteside (London: Ashgate, 2004).
10. See Helen Epstein, "Fat," *Granta* 49 (1995). Low-Beer and Stoneburner make this observation, too, as do Janice Hogle et al. in *What Happened in Uganda? Declining HIV Prevalence, Behavior Change and the National Response* (USAID, 2002).
11. In 2006, the *Washington Post* reported that the HIV infection rate in Rwanda, once estimated to be 15 percent, was now estimated to be 3 percent. See Craig Timberg, "How AIDS in Africa Was Overstated: Reliance on Data from Urban Prenatal Clinics Skewed Early Projections," *Washington Post*, April 6, 2006, p. A1. Timberg attributed the downward revision to a new U.S. government survey and suggested that the earlier estimate, issued by the UNAIDS program, had been inflated, perhaps to raise money or appease AIDS activists. Although the old UNAIDS statistics were in need of correction, there clearly had been a decline in the true infection rate. A population-based survey carried out in Rwanda in 1986 found that prevalence was 17.8 percent in urban areas and 1.3 percent in rural areas. (Rwandan HIV Seroprevalence Study Group, "Nationwide community-based serological survey of HIV-1 and other human retrovirus infections in a country," *Lancet* 1 (ii) (1989), 941–43.
12. A. E. Pettifor et al., "Young people's sexual health in South Africa: HIV prevalence and sexual behaviors from a nationally representative household survey," *AIDS* 19:14 (September 23, 2005), 1525–34; but see R. Jewkes, "Response to Pettifor et al.," *AIDS* 20:6 (April 4, 2006), 952–53; author reply, 956–58; and W. M. Parker and M. Colvin, "Response to Pettifor et al.," *AIDS* 20:6 (April 4, 2006), 954–55.
13. In 2005, an article in the prestigious medical journal *AIDS* reported that young people who had attended at least one loveLife program were slightly, but significantly, less likely to be HIV positive than those who had not. The author argued that this was consistent with the possibility that loveLife reduced risky sexual behavior. However, there could well be another explanation. From what I saw, loveLife attracted young people who would have been at lower risk of infection in the first place, either because they were wealthier or better educated or less vulnerable to abuse. (While the loveLife study attempted to control for education and wealth, it did not do so rigorously.) Indeed, the tendency to avoid the subject of AIDS would seem to discourage HIV-positive young people from attending loveLife's programs, and this could make it look as though loveLife protected young people when in fact it merely alienated those most at risk. Most loveLife materials were in English, and thus accessible only to young people with

higher social status. This would have sent a clear signal to those—often marginalized and vulnerable young people—who could not speak English well that loveLife was not for them. The main author of the article reporting lower HIV rates among young people exposed to loveLife admitted to me in an interview that an anthropologist hired by loveLife itself had come to these same conclusions, but her results remain unpublished. See Pettifor et al., "A community-based study to examine the effect of a youth HIV prevention intervention on young people aged 15–24 in South Africa: results of the baseline survey," *Trop Med Int Health* 10:10 (October 2005), 971–80; but see also Jewkes, "Response to Pettifor et al.," author reply, and Parker and Colvin, "Response to Pettifor." Information re the loveLife anthropologist from Pettifor, personal communication, April 2006.

Exploring Context

1. The (RED) campaign (red.org) pairs popular products with fundraising in the fight against AIDS in Africa. Explore the (RED) Web site. Given Epstein's argument, how successful might this campaign be? How does your work with lifestyle brands from Question 1 of Questions for Critical Reading inform your answer?
2. Use the Web to locate information on current HIV infection rates in Africa. Has the situation improved since Epstein wrote her essay, or is it continuing to get worse? What might account for this trend, given Epstein's argument?
3. One of Epstein's central arguments is the usefulness of conversation in combating HIV infection in Africa. How might social networking technologies like Facebook or Twitter help in such a campaign?

Questions for Connecting

1. Kwame Anthony Appiah, in "Making Conversation" and "The Primacy of Practice" (p. 44), examines the mechanisms of cultural change. Apply his ideas to the fight against HIV/AIDS in Africa. How does social cohesion leverage the power of conversation? How might we promote new practices around sex in Africa regardless of the values that people hold? Work with your definition of social cohesion from Question 2 of Questions for Critical Reading as well as your thoughts on effective HIV prevention programs from Question 3 of Questions for Critical Reading.
2. How has imagination failed in the fight against HIV/AIDS in Africa? Use Daniel Gilbert's insights from "Reporting Live from Tomorrow" (p. 179) to expand Epstein's argument. What role do super-replicators play in the spread of the disease? How could they be used to help eradicate it? Are surrogates available? Why aren't they being used, and what effect might they have?
3. Kenji Yoshino, in "Preface" and "The New Civil Rights" (p. 539), suggests that conversation has an important role to play in producing change around civil rights. How does Epstein's argument confirm or complicate Yoshino's ideas? What makes conversation useful in producing social change?

Language Matters

1. Periods are important marks of punctuation, denoting the units of meaning we call sentences. Select a key passage from Epstein's text and type it into a word processor without any capital letters or periods. In class, trade these never-ending sentences and work on replacing the missing punctuation marks. How can you tell when a period is needed in Epstein's text? How can you tell when one is needed in your own text?
2. Outlines can be helpful in creating organization before we start writing, but they can also help us see the organization of any existing piece of writing. Create an outline of Epstein's piece, using a one-sentence summary of each major move of her argument. What sections do you see in her essay? How do they relate to each other? How can you use postdraft outlines of your own papers to check your organization as you revise?
3. Because it is sexually transmitted, HIV/AIDS is a delicate issue for many people. What sort of tone and language does Epstein use to discuss the disease and its transmission? How do her choices reflect both her audience and the delicacy of the subject matter? When would you make similar choices in your own writing?

Assignments for Writing

1. Epstein explores the way children and families address the AIDS crisis in Africa. In a short paper, examine the generational response to HIV/AIDS using Epstein's essay. Here are some questions to help your critical thinking: How do adults handle the discussion of AIDS? Is this separate from the discussion of other sexually transmitted diseases? How do children and young adults handle this topic? How do *you* handle it? You might want to draw on your work on social cohesion from Question 2 of Questions for Critical Reading or your analysis of conversation's potential for combating HIV from Question 3 of Exploring Context.
2. Epstein evaluates a number of approaches to HIV prevention, both formal and informal campaigns. Write a paper in which you assess the role of government in the prevention of diseases like HIV. Consider: What should the role of the government be in addressing the HIV/AIDS crisis? Both loveLife and Inkanyezi are private organizations that address sexually transmitted diseases and HIV/AIDS; should there be a similar government outreach program? What role would that program play? Are ordinary people better at preventing disease? How can a government promote the kind of strategies that were effective in Uganda?
3. South Africa's loveLife relies heavily on an advertising campaign. Write an essay in which you evaluate the role of commercial culture in addressing national crises such as HIV/AIDS. What role should companies and advertisers take upon themselves? How does that differ from what they appear to do? Are they really just out for profit, or do companies have a conscience? Should or can they act on issues that affect national health? You might want to reference your work on (RED) from Question 1 in Exploring Context in making your argument.