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DEVELOPMENT OF ROAD INFRASTRUCTURE AND ITS IMPACT ON THE SPREAD OF HIV/AIDS:
A CASE STUDY OF NJINIKOM IN BOYO DIVISION, CAMEROON

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DEDICATION

To you, Papa and Mami. Your prayers and sacrifices have brought me to where I am today. You are the best parents in the whole wide world. I LOVE YOU.
ACKNOWLEDGEMENT

Sometimes, 'THANK YOU' does not seem to be enough as a sign of gratitude to the people through whose efforts a task of this nature has been achieved. I would like to thank my supervisor, Dr. Han ten Brummelhuis, for his criticisms, comments and suggestions and for ensuring the necessary steps that my endeavours are a success and to the entire staff and students of AMMA for guiding me throughout this academic year.

To my family whose love, faith, prayers, patience, understanding and moral support have seen me through this challenging period of my education and life. PAPA, MAMI, VOLU, GEORGE, PAUL JR and TONY, thanks for being the most important thing in my life, FAMILY. Sincere gratitude also goes to my best friend and husband, TERENCE and our enchanting son, WILLY.

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EXECUTIVE SUMMARY

When HIV/AIDS was first identified in Cameroon in the mid-1980s, it was virtually unknown and non-existent in Njinikom, an area inaccessible and totally isolated by a poor road infrastructure. Njinikom was linked to the Northwest provincial headquarters, Bamenda by a dirt road that often took several hours ply through in the dry season and sometimes a whole day during the rainy season. In 1986 a decision was taken by the Cameroon government to build an-all season road, paved and accessible the whole year round. This was primarily to enhance the production and market of coffee from this rich fertile mountain terrain of the Grassfields. That road was completed about seven years ago opening up the region not only to intensive trade, new ideas, tourisms and but also to disease.

This thesis focuses on the impact of the road on changes that have occurred since its final construction, its possible impact or links to HIV/AIDS spread. The prevalence of HIV/AIDS in Njinikom has risen from 0% in 1985 to almost 12% in 2003. Numerous factors can be used to explain this. This study investigates into the possible connection of the new improved road as one of the factors. The new paved road has brought increased trade, migration and increased contact. Our study shows that HIV/AIDS has infected not only people who have never left Njinikom but also that many young people who migrated to the cities. The sick migrants return home infected to use the Catholic hospital in Njinikom as the place for their final days on earth.

In order to assess the impact of the road I used the following methods: observation (direct and participant), in-depth interviews, informal conversations and literature review. These methods permitted me to gather data from the Kom elite and from the youth. The elite were senior Kom men and women whose knowledge of culture and current dynamics, could assess the changes they have taken place. The youth interviewed were between the ages of 14 and 25; some were still at school; others were unmarried mothers or teenage
mothers and unemployed while others had never left the village. They were in a position to assess and relate HIV/AIDS to their behaviour and changing times. Both groups of informants (elite and youth) agree that HIV/AIDS is a problem but the elite accused the youth for disobeying cultural norms on sexuality that sanctioned sex only within marriage. The youth were quick to point to the economic crisis of the 1980s and 1990s as being the primary cause of sexual promiscuity among youth especially girls who use their bodies as a commodity for cash.

The findings also indicated that external influences have played a part since the opening of the road. But the lives of these youths were greatly influenced by modern technology. Today, there is radio and television, newspapers and other media that are making an impact on the behaviour and think of young people. Two decades ago nightlife was non-existent in Njinikom. Private viewing halls of pornographic films operate without significant control. Therefore the social life has dramatically changed since the road was opened and HIV/AIDS has just come as part of these changes.

Two theoretical perspectives were used to understand and analyse the data. The cognitive symbolic perspective which outlines the importance people give to objects as well as situations permitted me to explore the relationship between what people do and how they perceived situations and relate to them. Understanding an individual’s behaviour was important. I examined the concept of unsafe sex in relation to how they perceive sex and understood HIV/AIDS. Using the same approach I examined the communication that goes on during sexual relations and the meanings given to persons, objects and situations. The emic approach permitted me to understand the internal logic of people’s attitude and behaviour as reflected in my ethnographic data.

Furthermore, the ecological perspective helped me understand human adaptation to nature and culture. The road construction has shown that it modified the landscape and ecology, offering increased in access to health care, urbanization, increase in mobility and change of lifestyle. The two perspectives, therefore, offered me the possibility to analyse the gradual change or adaptation to new situations and providing meaning to
them. As HIV/AIDS spread gains momentum with progressive death toll, it is but possible that this death impact may produce a change of behaviour with regards to sexuality.
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PREFACE

Over the last two decades, Njinikom has witnessed remarkable changes. These include an increase in the number of schools, and the improvement of the main axis road that links the rest of Kom to the provincial capital, Bamenda but it has seen also seen a dramatic rise in the number of HIV/AIDS patients. My research topic set out to study the impact of the newly paved road on the quality of health and the impact of the road on the spread of the disease. This study was made possible by a number of people. First and foremost, my family who provided the resources and sacrifices while in Holland as well as in Cameroon. To all family members, I say Thank you. Secondly, I will also thank the teaching staff of the University of Amsterdam for the knowledge they gave me and more particularly, my supervisor, Dr Han ten Brummelhuis who painstakingly read, made suggestions and bore with me through these difficult weeks of writing this modest thesis. I hope this humble effort does not only contribute to the debate on HIV/AIDS but also offers potential solutions to this pandemic.

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Chapter I

INTRODUCTION

The theme of this thesis is the AIDS epidemic in Cameroon. I want to understand why this disease has entered the Cameroon society so quickly and especially why women are particularly so vulnerable towards this disease. To formulate my research question and to give my analysis some insights, I will attempt in this introduction to describe what I consider as important background information, the manifold openings up of Cameroon rural communities in the last decades.

Road Infrastructure

The quality of a country’s road network is a reliable indicator of its level of development and its domestic trade. Road infrastructure lubricates trade and enables the distribution of regional benefits such as health care, education and wealth. The rural roads in Cameroon are poorly constructed and badly maintained. Most of them suffer from total neglect. Such roads take a toll on different means of transportation (bicycles, motorbikes etc.) and this in turn have an impact on the people. Because the country has become so corrupt the police do not enforce road safety regulations. Vehicles that should be declared unsuitable for the already bad roads are left to be the death trap for many. It is possible to use more wheelbarrows, handcarts, bicycles, motorbikes, trailers and pick up trucks in the rural areas. Cattle-rearing Fulani use horses as a means of transportation to reach areas inaccessible by road. Canoes or speedboats are common in the coastal areas.

The ordinary person in rural Cameroon is safe walking and carries his burden – goods, possessions, produce and crafts. Cameroon will continue to be so in the next decades, if nothing is done to change the situation. Bad roads are generally a plight of rural Cameroon and they are generally constructed making them often impassable during the rainy season (May-August). During the peak of the rainy season certain communities linked by earth roads to urban centres are completely cut off from the rest of the country. Communities in Ekok, Akwaya, Mundemba, Yokadouma, Djoum, Wum and Kom will be out of touch with the rest of the country. About seven years ago, the Kom area used to suffer this same fate until the road was paved with funds from Germany. It was with great
difficulty that a typical rural household in Cameroon could gain access to the basic services such as markets, agricultural extension centres, health clinics and schools. Poor road infrastructure and transport, essential for everyday life of rural dwellers did not permit them to break isolation and explore better ways of dealing with increased poverty. Poor road infrastructure also limited access to information; information critical for the improvement of the quality of life.

The building and efficient maintenance of roads in Cameroon constitute an important, vital and crucial economic, social, political, cultural and environmental, geographical and institutional factor in the development of the country. A good road network does not only bring goods and services such as access to services (health care and education); access to markets for the sale and purchase of goods and services. It also brings new ideas and better ways of doing things such as personal mobility to seek employment and other social and cultural reasons. This road accessibility will also equip the rural areas with some form of local governance and generate a sense of security. Only footpaths, footbridges and narrow earth tracks serve certain rural areas of Cameroon. Therefore, rural dwellers encounter more difficulties during the wet season where an all-weather road seems a far-fetched dream to many.

The provision, maintenance and management of a rural road network constitute socio-economic activities vital for the sustainability of any economy. There are four critical dimensions to this sustainability:

1. The economic dimension depends on adequate funding, maintenance of assets, viable investments and national fiscal resources.
2. The institutional dimension would depend on the ability to adapt and evolve to meet changing needs and to establish procedures to involve local communities in network maintenance.
3. The social dimension looks at political support and understanding of the importance of road accessibility. The willingness and ability of local communities to co-operate with the central or regional authorities to maintain local roads is vital for the community and country.
4. The environmental dimension puts into consideration drainage, pollution of water, adverse impact on water sources, irrigation channels, erosion, gullying, siltation, instability, landslides, flooding, dust, air pollution, accidents and animal impacts. Unless all four dimensions of sustainability are put 'in place' rural access programs or projects are very likely to ultimately fail and rural roads will deteriorate.

Road transport in Cameroon is the dominant form of transport. Generally, the economic costs of poor road maintenance are primarily borne by road users through taxes. The rural areas, which produce most of the agricultural output, need an efficient network. In spite of their importance, roads in Cameroon are not considered a priority. In the 1970s and 1980s, the Kom area was the highest producer of quality rabbica coffee in the North West Province of Cameroon. The exportation of coffee to external markets was a major problem due to the bad roads. Trucks carrying coffee from the Njinikom Cooperative Union to Bamenda, (and then to Douala), would spend three to four days on a 54 kilometre road. With political pressure, the Cameroon government accepted to build a paved road from We through the Kom country to the Bamenda urban centre. Seven years ago, the entire road was completed. Today, it is one of the best roads in the North West Province.

The Chiefdom of Kom

The Kom dynasty was established in its present site in the mid-18th century after migrating from the Upper Mbam regions of Cameroon with other Tikar ethnic groups. Its present surface area was determined by its seventh ruler Foyin (1865-1912). Kom covers a surface area of approximately 750 square kilometres (280 square miles) and the territory is part of the newly created Division of Boyo. Kom is one of the four major chiefdoms of Tikar ancestry with a population of more than 170,000 (cf Nkwi, 1976, 1982).

The main occupation in Kom is agriculture and livestock keeping. Its fertile mountain terrain produces both food and cash crops. The main cash crop is coffee, produced mainly for external markets. The farmers have formed themselves into three cooperative unions that assist farmers with agricultural inputs, market their produce in the international
markets and protect their interests against unscrupulous traders and politicians. Having a road outlet was very important for these farmers.

Every Kom man has parcels of land on which he grows food crops such as maize, guinea corn, groundnuts, vegetables, coco yams, kola nuts, millet, tomatoes, plantains, coffee, beans and potatoes. Most of these crops are for domestic consumption but the surplus is sold in the local and regional markets. The local markets operate on an eight-day week permitting farmers and traders from outside to congregate once a week in a given area or village to sell goods and food crops. The newly paved road from Bamenda to Kom has permitted traders to travel about 54 kilometres away to access Kom markets. Besides the local markets, households operate roadside vending stalls for the sale of food crops, and other scarce commodities like snuff and mushrooms.

According to the traditional land tenure system, all land belongs to the ruler of the Kom people, village and lineage heads. They hold in trust pockets or large portions of land for their lineage members. One lineage member needs land for cultivation or house construction; portions of that land are given to him. During the farming season men clear and prepare the farms for ploughing while the women and children plough, plant, weed and harvest (Goheen, 1996).

The keeping of livestock is socially, ritually and economically important. Every household has goats, sheep and chicken, even cattle. These are mostly used in gift exchange (for example marriage) and for ritual purposes during funerals. Like cash and food crops, livestock is used in the regional trade amongst Western Grassfields chiefdoms. Some of these products were traded far beyond limits of the Bamenda highlands.

The Kom people have a dual kinship system. Certain rights were inherited through the mother while some rights are derived from the father. Political office (village headship, succession to a compound and lineage property) is acquired through the mother. The reckoning descent, which confers duties and rights over inheritance of property and
succession, follows the uterine line. Matrilineal succession is important to political and ritual offices, while other kinds of inheritance, such as the right to land is determined through the father. The father must provide land to his own children on which to build and cultivate food and cash crops. The father is usually expected to provide price wealth for his son’s marriage and the son is expected in turn to provide him with goods and services. But the son cannot inherit his compound or transferable goods of lineage (compounds, kola nut trees and palm bushes). The son can inherit these from his mother’s brother (cf Nkwi, 1974).

The Bambui-Kom-We Road

When the Germans expressed interest in the late 1970s in the building of a paved road from Bambui to We, this was intended to go through the fertile Kom country. By the beginning of the 1980s political struggles and sterile debates forced the Germans to pull out. When the Germans decided in 1986 to build the road with the specification of the Cameroon state, the 100-kilometre road was reduced to 62-kilometre road, running through Njinikom to Fundong, the administrative capital of Boyo Division.

Since the completion of the paved road seven years ago, there has been increased traffic of persons, goods and services. Before the construction of the road, less than ten public service vehicles plied the road (Bamenda-Njinikom-Fundong) in a single day. Today, that number has tripled and some public service vehicles make several trips to the Kom country daily. The increase in movement and contact between rural dwellers and visitors is evident. The construction of the road has eased long-distance trade. Traders in Kom can easily reach the Bamenda urban centres within 45 - 60 minutes; a journey that used to take a whole day.

The road has also enhanced building construction. People have improved their houses because it is now easy to purchase cement and building material from the urban centre. The road that runs through one of the most picturesque scenery in the North West is also attracting tourists. With the inflow of many people, the number of hotels or motels has increased and entertainment facilities such as bars and ‘chicken parlours’ have increased.
Secondary schools in the Kom area, which were once not so attractive, are now over crowded with students from outside Kom. The road accessibility has improved in the quality and quantity of services. The handicraft industry that produced ordinary pottery, wooden mortars, baskets, calabashes, stools and masks have found an outlet in the increasing number of tourists. The large quantities of food crops are finding markets outside the Kom country.

The field of research was the village of Njinikom and those under surveillance were young girls between the ages of 15 – 24 who are based in the village. Njinikom is a village with approximately over a population of 30,000 inhabitants, located about 54 kilometres northwest of the North West Provincial Capital, Bamenda. Njinikom is a transitional region that comfortably accommodates inhabitants within and outside the village.
Chapter II

MIGRATION, SEXUAL BEHAVIOUR AND HIV/AIDS

Cameroon is located on the west coast of Africa and covers an area of 475,442 square kilometres with a total population of 16,184,748 inhabitants (June 2000 estimate). With a HIV-prevalence rate of about 11% in Cameroon, this is a dramatic rise from a few cases in 1986 to a thousand cases in 1996 till today. It is estimated that there are about one million adults and children who are HIV-infected and living with AIDS in Cameroon. The HIV epidemic in Cameroon is related to specific forms of behaviours, such as having multiple sexual partners and low use of condoms (5.2% for men and 2.7% for women), that expose individuals to the risk of infection. The predominant mode of transmission of HIV and STDs is through heterosexual intercourse.

Literature Review

Literature on HIV/AIDS in Cameroon focuses on the extent to which the disease has spread among women and children. Other authors discuss what the government and health services have done to prevent its spread. Very little literature was found on rural-urban migration as a factor in the spread of HIV/AIDS. This was a central piece of my research. This piece of discursive prose will be organized into sections that present the themes and relevant theories. My research topic sets out to find out how migration, sexual behaviour, vulnerability, infection, STDs and HIV/AIDS are all interconnected.

Over the years, migration has been studied separately from the spread of AIDS. Migration is an important determinant of global health and social development and it has important implications for those who migrate, those left behind, and those communities that host migrants are important (Williams et al., 2002). Migration has always facilitated the spread of any infectious disease, including HIV/AIDS. The growth of urban areas has been a pull-factor for people in the rural areas. Migration brings people in close contact in densely populated urban areas (Orubuloye et al., 1993). Generally the HIV prevalence rate between urban and rural areas is usually not significant. The fact that many Cameroonians shuttle between the rural areas and the urban areas maintains a social
communion that constitutes channels for the spread of the virus (Anderson, 1992; SWAA, 2002). There is a strong correlation between HIV infection and migration status. People migrate for different reasons. Migration takes individuals away from their homes and places of work where their actions and behaviour are often monitored and controlled, to distant parts where there is no control and a sense of responsibility for exerting much influence on the other thus helping to increase the extent of sexual networking (Adebayo et al, 2002; Anarfi, 1993; Orubuloye, 1991). Long periods away from home, migrants are faced with loneliness and isolation leading to chances of having more than one sexual partner. A majority of those who migrate are adult men who leave their partners in the village and go in search for jobs. Long stay leads to the establishment of relations with women who may be infected. Through sexual contacts the men become infected and later in turn infect their partners or wives once they get back home (Boerma et al, 1998; Pison et al, 1991).

The increase in HIV infection is closely related to migration and other socio-economic, cultural and behavioural factors. Whatever direction migration takes place; the region is bound to have traffic densities, intense trading activities, sexual temptations, bright lights and a vibrant nightlife. AIDS has a much closer relationship to migration as it increases the possibilities for the spread of HIV/AIDS and other STDs. In general, increase in human movement especially to rural areas leads to the emergence of sexual cultures and subcultures which give rise to a change in sexual activity and sexual behaviour (Colvin & Sharp, 2000; Herdt, 1997). Nanda and Warms (1999) argue that different cultures vary in their definitions of appropriate sexual behaviour thus the difficulty of understanding sexual behaviours. Travelling and sexual mixing will subsequently create a milieu conducive for infection and the spread of the disease.

Truck routes are associated with the transmission of sexually transmitted disease on account of sexual activity between truckers, drivers, traders, and women especially commercial sex workers. These women are known for providing part-time or full-time sexual services for a charge (Orubuloye et al, 1993; Romero & Himmelgreen, 2000). Due to strategic locations of meeting points that constitute a beehive of activities, drivers,
mechanics, vendors, hawkers and women usually spend long periods of relaxation. Drivers and traders especially are known for having sexual partners at other stops on their routes thereby providing a common terrain for many and diverse players who inevitably exchange body fluids along the way (Isuiogo-Abanihe & Odiagbe, 1998; Painter, 1990).

Recent studies reveal the link between mobility, sexual relations and infection across different cultures. Migration to the urban areas and back has been a point of focus and results in change of sexual activity and behaviour. Enculturation and change in subcultures is bound to entertain a change in sexual behaviour (UNDP, 2001; Quigley, 1997). This change in sexual behaviour is therefore linked to specific occupations of migrants and high-risk behaviour. Poverty is one of those factors, which can limit mobility for young women thus placing them in situations of risk and also limiting their choices (Guest, 2000). Studies have shown that high-risk behaviour is related to commercial sex workers, truckers, drivers and traders. This high-risk behaviour is as a result of or is part of their way of life.

Most migrants are usually married or have regular sexual partners and we would be surprised at how illiterate they are. They are known to make extra money for unofficial operations, mainly from picking up passengers, and selling goods along the way. This extra money gives them a vantage position to their profile lifestyle and responsibility back home. Sexual relations between migrants and women who congregate at centres of booming commercial activities is very common. The migrant usually needs a break from the journey for rest, lodging, meals and refreshments (Ntozi, J. & Lubega, M., 1992; Orubuloye, et al, 1990). Condoms are rarely used during this interaction. Most of them view the condom as a hindrance to an enjoyable sexual affair even though they are aware of the dangers of contacting diseases from their infected sexual partners. This precludes casual sexual relations that take place at the spur of the moment (Isuiogo-Abanihe & Odiagbe, 1998; Muizarubi et al, 1991; Morris, M. et al, 1999).

Demographic, behavioural and social factors place sexually active people at risk of being infected with sexually transmitted infections. The different risk factors for infection are
partnership status in certain cultures, new sexual partners, multiple partners and opportunistic diseases make people vulnerable to infection especially women. Women and young girls are more vulnerable to STDs and can contract HIV/AIDS much easier than men (Hardon, 1995; UNAIDS, 2002; USAID, 1999). This interplay of factors, including the subordination of the rights of women, heightens their vulnerability to disease. For some women, sexual intercourse is not a matter of choice but of survival.

Anatomical differences, powerlessness, dependency, illiteracy and poverty serve to diminish the woman’s ability to negotiate sexual relations and fend off the risks of infection. Ignorance and passivity only accelerate the risks of HIV transmission to women and children. In addition to all these risks, gender inequalities, unemployment and lack of sufficient health education may contribute to risk taking behaviour. Guest (2000) asserts that evidence from research all over the world shows that men are more able than women to influence how sex takes place thereby seriously disempowering them when it comes to prevention (Foreman, 1999). If migration can render women vulnerable to this degree, then all must change if women and men are to achieve greater sex equality in their sexual relationships and contribute to HIV prevention.

HIV/AIDS is one of those health conditions that have led to deaths in Cameroon. The epidemic remains a serious health problem among young people between 14 – 25 years of age. Even among young people, adolescent girls are the most affected (Konde-Lule et al, 1998). Evidence from research in some parts of the world and in Cameroon, shows that the age of first sexual relations is almost equal to that age (15 – 24 years) at which infection is high (Garcia-Calleja, 1992; Macauley, 1997). This is not always the case. It is likely that instead of youths being infected, housewives or polygamous couples are the most infected.

Today Africa finds itself in the heart of the epidemic with over 30 million people infected (UNAIDS 2000). Unless more efforts are made to understand cultural barriers, advocate for gender equality and equity, encourage a more participatory approach with vulnerable groups especially women and migrants, educate people even in the hinterlands, provide
accessible and affordable health care services and most especially deal with the problem of stigma, the disease will continue to spread. Africa has been stalked by many plagues yet the AIDS epidemic has affected all spheres of human life and killed millions of people. Some of the available literature laid emphasis on the effects of AIDS on urban areas. Some studies focus on rural areas yet very little has been published on HIV/AIDS in rural communities. This is where majority of the people have been greatly affected and this may have an impact on agricultural production.

**Theoretical Perspectives**

Two theoretical perspectives were used to better understand the topic of this research and the purpose for these approaches. The main framework of this research would be the cognitive symbolic perspective which outlines the importance people give to objects as well as situations. This approach also explores the relationship between what people do, how they perceive situations and how they relate to them. Understanding an individual’s behaviour is important but understanding the crux of their actions is fundamental. For example what is unsafe sex, how they perceive the road infrastructure, what do they understand by AIDS, what kind of communication goes on during sexual relations and the meanings given to persons, objects and situations. With the use of the emic approach, ethnographic interviews are likely to give us the required results.

The ecological perspective on the other hand seeks to understand human adaptation to nature and culture. The kind of development that Kom has witnessed over the decades is as a result of the road constructed about seven years ago. This perspective has shown to us that with the coming of the road (modification of the landscape and ecology), health care services have improved, there is an increase in access to health care, urbanization, increase in mobility and change of lifestyle. The ‘functionalist’ approach was also used in the study and analysis of the data. This seeks to understand how within a social structure each element performs a function in order to maintain the structure as a whole.

Cognitive symbolism provides a good way of investigating human and social behaviour that has led to high risky behaviour and high rates of infection. Ecologists say that human
adaptation to nature and culture results from development and infrastructure (Barfield, 1997). The combination of these two perspectives may bring out an overall of how adaptation leads to a particular kind of behaviour. Adaptations come with change in behaviour that can be of vital importance to the community and the individual. Not all change is positive; sometimes it is negative. This goes to acknowledge that ‘bad habits die hard’. This is the case with the Bambui-Fundong road, which passes through Njinikom. This newly paved road has brought many positive changes in the life of the people and people have come to adapt to the changes but the road has facilitated the spread of diseases such as sexually transmitted diseases and HIV/AIDS. The paved road opened up a once reserved and conservative community to the swifter winds of change, and indirectly, affected the health status of the community.

The cognitive symbolic and ecological perspectives therefore offer the possibility to analyse the gradual change or adaptation to new situations and always provide meaning to them. This adaptation is not limited to the people using the road, but the adaptation will affect everyone or development will lead to some form of adjustment.
Chapter III

HOW THE RESEARCH WAS DONE

This chapter outlines the plan used to accomplish research objectives by the collection and description of both qualitative and quantitative measures. This methodology will enable the understanding of the relationship between risk behaviour, HIV vulnerability and the actual HIV infection. The motivation to use this method is a necessity to understand people and the reasons for their actions. This chapter will look into the following: kinds of interviews, how the entire research was carried out, problems / difficulties encountered and limitations of the research.

Purpose

There are three reasons why I chose Njinikom to do my fieldwork. First of all, I am a native of Kom and communication in ‘pidgin’ or the dialect was very convenient for the respondents and myself. Personally there is a strong need to help vulnerable groups especially young girls who are involved in a high degree of movement and contact and thus exposed to infection in this era of AIDS. Secondly, the village is linked to a good road network to the town of Bamenda, serving as a reason to believe the increase in movement and contact can lead to an increase in HIV infection. Lastly, the biggest health institution in the area is the St Martin De Porres hospital. It is the best catholic hospital of the archdiocese of Bamenda, which serves as a reference institution in the region. Good record keeping of statistics by this hospital would permit me to collect reliable quantitative data.

The collection of health data from the hospital did not start almost immediately because I had to wait for a letter from the University of Amsterdam, Holland which had specifications for my fieldwork. The letter was meant to explain what my research was all about, how long it will take for the research to be carried out. While waiting for the letter, I carried out informal conversations with young adolescent girls. The interviews focused on sexual relationships, sex, increase in movement, increase in contact and the
disease AIDS. When I started the interviews at the Njinikom hospital the matron, Rev. Sr. Xaviera Nteinmusi introduced me to her professional staff: the nurses and the pharmacist, Dr Muko Kenneth. Dr Kenneth gave me access to the hospital files and records and discussed the situation of AIDS in Kom. During the first weeks, I looked at statistics in the hospital, talked to staff and patients. I observed the behaviour of youths in the village, patients in the hospital and the degree and kinds of movement that takes place on a market day. Since once a week people come from different villages, this gave me an opportunity to observe mobility by assessing the different places traders came from.

**Participant Observation**

On arrival in Yaoundé from Holland, I spent time looking at additional literature on HIV in Cameroon and rural areas and preparing to travel to Bamenda for the fieldwork. When I arrived Bamenda, I decided to observe the behaviour of people at different motor parks. Motor parks, as they are called locally, are places where vehicles, mostly motor vehicles, assemble to pick up passengers travelling to different places in and outside the North West Province. It is usually busy with passengers arriving or departing as well as people waiting for relatives arriving from different places. The observation, I believed, would help me understand what kind of risky behaviour is likely to take place at motor parks which are the departing points of drivers and travellers as well as a joint for vendors, passers-by and even pickpockets. These motor parks provide transportation to people travelling to the Kom country, 54 kilometres away from Bamenda. Observing what went on in these motor parks would provide me with information on how mobility is a critical variable in my study.

There are many travel agencies that provide transportation to the rural areas on a daily basis. Competition is high and the motor parks are always crowded. No agency has been able to monopolize the traffic on all the rural roads but one agency, ‘Guarantee Express’, which seems to provide a better and more efficient transportation. It also controls a large chunk of the transport market. Just as there are peak seasons when many people travel, there are also periods when people do less travelling. It was May 26th when I started my observations. It was the season when most boarding schools were going on holidays.
while many people were going on vacation. The motor park was jammed full and the main road was almost impossible to pass through. The travel agencies usually have road agents that wait for taxis to help travellers with their luggage to their agency. I observed that these road agents had good public relations or communication skills. They know how to approach and convince a passenger to board their buses instead of another. At the same time street vendors and traders are also trying to sell their goods to travellers. The motor park is usually in a state of pandemonium. The urban motor parks are themselves in areas that open 24 hours a day and seven days a week. The nightlife, the bars, discos and the ‘border’ scenario operate on fringes of these motor parks. The park boys, night travellers, bar seller and street vendors are in close contact with prostitutes who loiter around looking for potential customers. Some travellers usually fall prey to these “ladies of the night”.

I conducted two types of observations – direct and participant observations. In direct observation, I observed people and their behaviour non-obtrusively, without asking questions or making them aware of my observation. In participant observation, I engaged and took part in some activities, such as drinking in a bar or eating with the people at their homes, or at meetings.

Having made direct observations in Bamenda, I continued this when I arrived at my research site, Njinikom, 54 kilometres away. So much seemed to be happening at the same time and taking note of situations was a difficulty. I was not able to take notes during those situations of distraction so I took down notes of what I had observed later. Having been a child of that village, some people were able to recognize me and greet me. I suffered from divided attention yet I had to act properly by not rushing away giving the impression my mission was more important than showing allegiance to the people of the village. Everyone wished to know when I arrived and what must have brought me to the village. The most I could say was that I had to meet someone and on my way back I would stop and explain the purpose of my visit. I went to the hospital and it took me over an hour to see the matron of the hospital. When I finally met her, she was pleased with

1 A kind of free and promiscuous lifestyle. Very often the word is used to refer to a prostitute.
my intentions and told me what was required of me before I could start any work in the hospital. I needed to show proof of my student status in Holland and a letter from the University of Amsterdam stating the purpose, duration and objective of my study as mentioned above. When the requirements were ready, the matron introduced me to Dr. Kenneth Muko who is a Pharmacist and Project Administrator for InterCare Project Hope\(^2\) in Njinikom. He was most helpful in assisting me obtain the necessary health statistics on HIV in Njinikom.

During the time I was in the field, I pursued two types of observations and made notes of what I observed in motor parks, bars (pubs), markets and the general behaviour in the village as a whole. It was important that I know what the villagers thought of me. On the whole, the people were receptive because they were used to students from the universities of Yaoundé, Dschang and Buea coming to do their fieldwork but none had focused on the issues I was addressing – HIV/AIDS. Because sexuality and HIV/AIDS were virtually taboo subjects in the village, I hoped this would not constitute a barrier to my work. Sexuality and the modern disease HIV/AIDS are words which people are prohibited to talk about. Everyone in Kom called AIDS ‘famassi’\(^3\). Because these words are mentioned of and discussed in low tones or in hiding, I was not very sure to what extent people will want to provide me with the kind of information I would need.

Very little participation could be done because of the hours when participant observation was necessary. Apart from the fact that it was late, cold and dark, for a woman, the risk was very high. Very interesting information could only be obtained after midnight. Any woman who was seen loitering without a man is considered a free woman or a woman who wants men to call on her. During the nights in Kom, temperatures can drop to about 10 degrees. Objection to a date could be followed by insults or slangs despite the efforts I made to explain the purpose of my research. Some men said I would obtain better information if I accepted to have a drink or spend the night with them. Ethically, that kind

\(^2\) A special unit of a British NGO INTERCARE. The project seeks to identify and address behavioural / cultural habits that predispose inhabitants involved in the increase of HIV/AIDS infection. They also provide voluntary counselling and testing services.

\(^3\) Local term for AIDS in Kom.
of participant observation was not acceptable. The little observations I made enabled me obtain some additional data on people's behaviour; data, which I doubt, I would have gathered from an interview. Observations made up one of the primary sources of data and filled the gaps on the information collected.

At the Njinikom hospital, what I immediately took note of was the peaceful and quiet nature of the hospital premises. By the time anyone gets in through the gates, there is this air of tranquillity at every hour of the day. Not far from the hospital is the convent and somewhere in the middle of the hospital is a chapel. Another aspect of the hospital and its immediate surroundings is the cleanliness. No dirt is littered around the compound, there are a number of litterbins to serve everyone and the wards are cleaned everyday. The hospital has a welcoming atmosphere and a place that gives you the hope of recovery, as compared to government health facilities or hospitals. Unlike mission or private hospitals, government hospitals are not organised. They are untidy, smelling and very often the staffs are rude. In government hospitals, they give one the impression that the more money one has the better the health care and patients are attended to on a 'man-know-man' basis.

**In-depth Interviews**

One of my main data collection techniques was the use of in-depth interviews, conducted with ease and some degree of flexibility. Having identified key respondents and created some rapport with them, the in-depth interviews were conducted in tandem with observations. After making an appointment, at a place and time convenient to the respondent, I brought along with me material or equipment useful for the interview. All in-depth interviews took between 30 minutes to about 90 minutes? Another interview with the same respondent was not always possible because most young girls preferred to have other girls interviewed. Most of the female respondents refused a second interview giving excuses like water carrying, going to the farm, or they just refused without any specific reason. This gave me the impression the topic was more sensitive and they would not give further in-depth information.
When a respondent and I were able to make it to the appointed day, I would begin by thanking the person for honouring my invitation for an interview then I would introduce myself and explain the purpose of my research briefly yet easily for the respondent to understand me. In most cases, the language of communication was Pidgin English⁴ and where there was any difficulty on the part of the respondent, I would speak in the local dialect, ‘itangikom’. Nearly all Kom residents are multilingual in ‘itangikom’, Pidgin and English. A consent form was always presented to each of them assuring them of confidentiality, security and appreciation of their participation in the research. In order to obtain accurate information, I used a tape recorder, a note pad and a pen. But the respondent’s permission was sought. All respondents accepted the use of the tape recorder except one informant. Some of the answers to the questions were written down because some respondents wanted me to have more complete and explicit answers or responses. Notes were taken on body language and other circumstances under which the research took place.

The body language I observed comprised of facial expressions and distractions. I would have been able to tell whether the respondents were comfortable or tense. Sitting postures and facial expressions were the most common kind of body language. I made notes on these different expressions. Some informants often remained in a reflexive mood or position before responding. Most of the respondents would either hesitate to answer a question, by being silent for about 10 seconds. Sometimes they would refuse to answer a particular question. This gave me the impression they were either trying to give me the right answer or they were not sure of what to tell me. The posture they would take would be to look up in the sky or at the roof in a reflective way. They gave the impression they were comfortable, but it was easy to detect if the informant was uneasy. Sometimes, if a direct question they least expected was asked, they will feel embarrassed but would attempt to respond. For example, if I asked the question. Do you use condoms?’ the informant would laugh. The laughter very often was followed by exclamations like ‘wo meh’ or ‘wih’. In some cases there was a refusal to answer certain questions that sought

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⁴ Pidgin English is corrupt English popular in West and Central Africa. It is a language of commerce.
⁵ Both exclamations are used to show surprise and/or disgust. Or why such a personal question was asked.
personal in-depth information. So, I asked the question in a different way. For example, ‘Do you practice unsafe sex?’ Or ‘Have you ever had more than one sexual partner at a time?’ When it was possible to answer a more impersonal question, they would readily answer and even narrate stories or other experiences. That these kinds of responses came up more often may be because of the very sensitive nature of my research topic. Sexuality was not discussed in families and girls spoke of their sexuality when they were among people they were close to or familiar with. Talking about sexuality with a total stranger was much easier than discussing such issues with family members.

The place or venue of the interview was most of the time to the convenience of the respondent. This was because I felt that if the informant was in an environment that was convenient or they were familiar with they would talk freely. For example, I carried out two interviews in my research house with Patience and Michelle, one at the prenatal hall of the hospital with Beatrice, one in the car with Colette, one at a bar with Reneta and one at the respondent’s apartment, Sidonie. Two interviews took place in my field station house because the respondents felt comfortable in that environment. They came at night and left unnoticed. The interview in my research car was the only option for Colette because the car was parked near a video club where the respondent was watching a Nigerian film before the interview. If she had to choose another place, it would not be possible, because she was looking forward to watching another Nigerian film. Besides, she explained, her mother did not like her loitering aimlessly around ‘3 Corners’. If I had conducted the interview at the bar it would have provided better information combined with conversations, but the music was too loud, the respondent, a bartender, was often called or distracted. Reneta shared some of her experiences and her interview was characterised by a lot of laughter. Because Sidonie is a nursing mother, her house was the most convenient for her even though neighbours and music in a nearby ‘off-license’ often disturbed us.

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6 For my research, I used one of my parent’s car.
7 The local term for a bar.
Creating a good rapport and respecting each respondent was very essential. It is true that first impressions count and so I had to abide by the ethics of the discipline in order to have a good relationship with the respondents. Some of the respondents gradually got to feel relaxed in the course of the interviews making the interview more free and open. Voluntary participation was not anything I looked forward to but, however, two informants volunteered, namely Michelle and Patience. Some informants preferred more informal conversations.

**Informal Conversations**
The first informants who were some friends and cousins helped me identify other young girls who were willing to discuss HIV/AIDS informally. As word got around about my work in Kom, some girls voluntarily opted to take part and provide useful and additional information, during the in-depth interviews. The informal conversations were a critical source of information and were often more interesting despite the limited time available. These would take place in a taxi, while walking with some youths and while sitting in a video club. Most of the informants were young girls of about the same age group (15-25 years) with elementary education. The informal conversations could also be conducted at any hour that was possible. The length of the conversation was not important as long as useful information was obtained.

One of the things that characterised my research was the willingness of some respondents like Dr. Kenneth, Patience, Michelle and other young girls to help me in my research by participating in the interviews. Their initiative was welcome and it served as an eye opener to some of the happenings in the village, which many would not have disclosed to me. Talking about prostitution was difficult. Prostitution is gradually but steadily taking its place within the village. Prostitution is commonly referred to as the ‘ashawo business’ and those who take part in it especially the girls are called names such as ‘ashawo’, ‘wohohwos’ ‘akwara’ or ‘nkane’. In order to obtain some money and have frequent contact with men, some people operate ‘chicken parlours’ and ‘beer houses’ where call girls can always be found. Its prevalence is low because most of the girls considered as
Prostitutes have come back to the village from the cities (Yaoundé and Douala) where it is believed that life is difficult or they have come to spread consciously the disease AIDS.

Problems and Difficulties Encountered
To say that the research was carried out without any obstacles would be an overstatement. Some of these difficulties included explaining the purpose of my research, obtaining statistical data, the failure of informants to keep to an appointment, and limited research funds. For example, it was difficult to obtain sufficiently reliable statistics to prove that high mobility brought about by the newly constructed road had led to an increase in the spread of HIV/AIDS.

Dr. Kenneth Muko, of the Njinikom hospital disclosed that after every 10 years, the health statistics were destroyed and most of the hospital registers or records were not kept orderly or consistently. This was a handicap. However, I obtained health statistics from 1999 to 2002 and examined the maternity register from June 2002 up to May 2003 for HIV positive mothers.

Appointments with respondents were hardly respected. Sometimes they would turn up late or never showed up at all. Rescheduling appointments was crucial in collecting sufficient data yet some were a failure or a disappointment. Conducting a good number of in-depth interviews was difficult because the respondents reacted negatively to them by refusing to answer certain questions. This gave me the impression that some respondents did not want to respond because their responses to certain questions would directly or indirectly imply their involvement of such behaviours under study. A young girl, though engaged in occasional prostitution would not answer questions that implicated or cast a moral doubt on her behaviour. Responses from some informants were sometimes incomplete or unreliable. Creating an atmosphere that was comfortable and flexible for the respondent was another problem. After listening to me on the purpose of my research, some respondents felt obliged to choose their words and talk more frankly. Even after trying to make them feel at ease, they would talk to impress me or give me the
impression they had obtained some level of education. Some informants did not object to
the tape recorder but some were reticent to its use.

In general, like every research, I was faced with problems. Yet I was able to understand
how the hospital functions, how they deal with HIV positive patients, the kinds of drugs
they have available for patients and the kinds of HIV related prevention and intervention
programs that were going on in the village.
Chapter IV

THE ROAD, ELITE AND YOUTH

HIV/AIDS in Njinikom

According to the Cameroon Demographic and Health Survey (DHS, 1998), a majority of the people have heard about HIV/AIDS in Cameroon. The survey shows that 97% of men and 90% of women have heard of AIDS. Due to lack of reliable statistical data, the table below gives an idea of the AIDS situation in a rural area, Njinikom, of men and women above 15 years of age. The population of Njinikom is about 37,000 and hospital records in Njinikom show that most HIV patients come from places, which can be about 60km to over 240km away from Njinikom. Between 1999 and 2002, the rate of HIV infection has been fluctuating. The hospital records disclosed that over 45% of patients came from other places than Njinikom.

The hospital records available disclosed that the rates of infection between men and women (both in-patients and out-patients) were different.

Table 1: HIV/AIDS infection from Hospital records, Njinikom

<table>
<thead>
<tr>
<th></th>
<th>1999</th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men</td>
<td>14 (45.1%)</td>
<td>59 (56.7%)</td>
<td>111 (52.4%)</td>
<td>53 (44.9%)</td>
<td>237</td>
</tr>
<tr>
<td>Women</td>
<td>17 (54.9%)</td>
<td>45 (43.3%)</td>
<td>101 (47.6%)</td>
<td>65 (55.1%)</td>
<td>228</td>
</tr>
<tr>
<td>Total</td>
<td>31 (100%)</td>
<td>104 (100%)</td>
<td>212 (100%)</td>
<td>118 (100%)</td>
<td>465</td>
</tr>
</tbody>
</table>


These figures indicate that slightly more men were provided care than women, although not in all years. Young men who migrated to the towns and cities elsewhere, get infected; become ill and return home to Njinikom to die. The hospital has been the best place for them.

In 1999, there were a total of 31 registered AIDS patients, among whom 14 were men (45.1%) and 17 were women (54.9%). In 2000, 104 patients were registered with AIDS; 45 women (43.3%) and 59 men (56.7%). In 2001, there were 212 AIDS patients.
disclosing that there were 101 women (47.6 %) and 111 men (52.4 %). In 2002, the number dropped to 118 AIDS patients representing 65 women (55.1 %) and 53 men (44.9 %). There were very few cases of children with AIDS yet many children have been orphaned as a result of the disease. The records in the maternity show that 30 pregnant women (9 single mothers and 21 married women) were registered with AIDS between June 2002 and May 2003, all between the ages of 18 and 44. It must be said that the maternity serves most women from Njinikom area because within a 3-kilometre radius there are at least three maternities. The Njinikom Rural Council established one maternity while the Government and the Catholic Mission created two. When there were only to maternities most women went to other places.

Of the women recorded in the register as AIDS patients in the Njinikom hospital, 62.7 % were housewives 31.4 % were traders. That women most infected were housewives is, I believe, a result of the non-empowerment of women in general to control and manage their sexuality. They also do not get any financial assistance to obtain health services and they rely more on local or traditional treatment, which they say is affordable and always available. Traders on the other hand make up another highly infected group as a result of their mobile occupations that permits them to move from one place to another within a short period of time thus making new relationships. Housewives do not move to the cities because of their social and cultural obligation to provide care and food to the family. Men are known to migrate to the cities. When they feel real sick or have been diagnosed in the city to be seropositive, they return home to die. And when the men come home with infection, they spread it to their wives.

We may therefore conclude that AIDS is a disease that has infected and affected many people and their families. The rate of migration of men to the cities is high leaving more women in the rural area. Among the infected persons in a village women are a majority since more men migrated. Young married women are vulnerable given that most of their husbands migrate to the cities in search of jobs. Due to social and cultural norms sexual intercourse must necessarily imply procreation, they find it difficult to use condoms to
protect themselves from the infections of their partners. Men and women marry to have children, and sexual intercourse should not preclude this finality of marriage.

**Local Conceptions of HIV/AIDS**

Since the appearance of AIDS in Cameroon, local people have described it in different ways. At first it was known as ‘7 plus 1’. Others translated AIDS to mean the ‘American Invention to Discourage Sex’; after all, the Americans want Africans to slow down their birth rates. There is wide popular belief that AIDS came from the USA and since birth rates are falling there, they would like to slow the birth rates of African. Empirical evidence shows that African-Americans tend to have more children than other Americans just like their brothers and sisters on the continent. Others believe that AIDS was genetically engineered and tried out on homosexuals who later heterosexually began to spread the disease, first in America and then to Africa, through the tourist route. The French equivalence of AIDS, SIDA was rendered to mean Syndrome Imaginaire pour Decourager I’Amour. This rendering of AIDS is among the Francophone population in Cameroon.

Young people have added such words as ‘njapa’ to the repertoire. The word ‘njapa’ was as a coded word used generally by young people to refer to sex. It was used instead of the word sex, to conceal from their parents discussions on sex. As the HIV/AIDS pandemic began to spread and awareness creation was mounted, the word came to be used by the young people to refer to AIDS.

Since the study was undertaken among the Kom people, I was also interested in knowing how people perceive and conceive HIV/AIDS. AIDS in Kom is called ‘famassi’ which is a direct translation of the number eight (again the concept of ‘7 plus 1’ or 9 minus 1’). The number eight ‘fama’ is used in reference to the virus. This has led many informants to believe AIDS (‘famassi’) (the plural of eight) is a punishment from God and man needs to atone for sins. In the Kom culture, odd numbers bring luck and prosperity while even numbers ill luck, death and misfortune. Since HIV/AIDS is incurable, the local
people consider it as a punishment from the ancestors. In the past, the *kwifoyn*, the highest institution in the land was expected to pray and offer sacrifices to the goods and ancestors to protect the people against such diseases. At one point HIV/AIDS was considered by the diviners of the Kom to be a disease brought from outside and not indigenous. Leprosy was considered as a polluting disease and as a sign of divine punishment. The Kom do not consider the name *famassi* given to the disease as a mistake or a coincidence but that it is tied to the philosophical meaning of AIDS in the Kom culture.

The Objectives of the Research

One of the objectives of my research was to find out why unmarried youths between 15 - 24 years of age, are sexually active and vulnerable to disease and if the rates of STDs and HIV/AIDS among them are high. Examining the statistics of the hospital in Njinikom I found that among the population of infected women, housewives (between the ages of 18 - 77) make up 62.7% of infected women. Farmers were the most of HIV men (31.4%) followed by traders and grazers (13.6% and 6.6% respectively). These findings led to the conclusion of other authors (Anderson, 1992, Anarfi, 1993, Boerma, 1998, Orubuloye et al, 1990, 1991) that polygyny, low condom use, poverty, illiteracy and high prevalence of untreated STDs were among the key factors explaining the spread of HIV/AIDS. AIDS stigma, denial and low status of women were also found to be critical factors of HIV prevalence among housewives in Njinikom. Stigma is more strongly experienced by women than men. Actions and reactions towards patients create room for further spread and thus denial on the part of patients. When a person dies of HIV/AIDS or full-blown AIDS, relatives prefer to say he or she died of another disease and not AIDS. Usually family members treat an HIV/AIDS patient as if he or she was suffering from a common disease. Although awareness creation is pretty high in Njinikom area, many families simply do not accept its pervasive effects despite that fact they have had a relative who dies of a disease having symptoms of HIV/AIDS. Furthermore, the low socio-economic and cultural status of women has also helped to contribute to the spread of AIDS among women than men. The poverty situation in Njinikom has led many
women to use their bodies to gain some income through prostitution. Many women do not have regular employment and depend to a large extent on men to provide income.

Having read some literature on the sexual life of youths between the ages of 15–24 years in Africa, and how the pandemic was devastating the youthful population, I thought I would find the same situation in Njinikom. Yet my brief research results have shown a number of things: although there is a high degree of sexual activity among these youths, they are more aware of the dangers of the killer disease than most people. I would conclude that this was due to their inquisitive nature and the amount of awareness programs they have been exposed to. And probably I am allowed to conclude that most educational institutions in the areas were doing a fairly good job at sex education. Instead of youths in Njinikom being the most with AIDS, the results showed that a much older group of women especially housewives were infected. There is reason to be optimistic because of their inquisitive nature and the programs and education that are provided. At the other hand, they engage more in changing sexual contacts than the older generation. The figures suggest that the older generation is more frequently infected, but we should remark that we have only figures of registered patients and that it can take 6-12 years before infection becomes visible in a symptom.

This study focuses on the new road, the elite and the youth because these are three important variables in the social and cultural dynamics of HIV/AIDS in Njinikom. The paved or tarred road gives access to an area once isolated and conservative. The road permits the circulation of people, goods and ideas and enhances communication. The elite represent the transition from tradition to modernity; the modern elite have in one way or another been instrumental in bringing change while at the same time trying to moderate that change. They are eager to preserve the traditions and customs but they are also keen in modernising traditions. The youth represent the future and they are often ready to contradict traditions and the elders, especially those traditions that control their freedom and the desire to innovate. In matters of sexuality, the youth seems to desire greater...
freedom against the background of traditions that seeks to transmit sexual culture through a deliberate and slow process.

The Bambui-Kom Road
There is a common saying in Cameroon, *that where the road goes, development follows.* The construction or the improvement of roads brings the inflow of people, ideas and new forms of behaviour. Road construction brings social, economic, health as well as cultural impact and change. Part of my hypothesis is that the construction of the Bambui-Kom road has produced a significant impact, especially health impact on the life of the people. In order to understand this impact, I conducted a series of interviews with key informants familiar with the region and the whole politics of the road project as well as the general conditions before the construction.

In an interview with the former Municipal Administrator in Kom, Bobe C.K. Barth, he disclosed the genesis of the Kom road. The main criterion for choosing the Kom road for construction and not any other village was simply for the tonnage of coffee produced. The high quality and quantity of coffee produced induced the German and Cameroon governments to consider the Kom road. This decision was also based on the hope of improving the country’s economy. As a one-time produce inspector, Bobe C. K. Barth knew the tonnage that came from Banso, Moghamo, Nkambe, Santa and Kom; he mentioned that after 5 years the average tonnage from Kom superseded those from different regions in the grass fields.

In another interview Prof. Paul Nkwi, a university professor, once a senior government official and a Kom elite, confirmed that the importance of building the road. He said that the poor road network or infrastructure slowed down the high production of coffee in Kom. He added that heavy vehicles carrying coffee to Bamenda for exportation could be stuck on a muddy road for days during the rainy season. The then earth road deteriorated making it impossible for people to travel and for coffee to be transported. For years travelling outside Kom was a journey for a few and had to be well planned and executed. The road infrastructure was poor and bad. Between 1981 and 1986 the roads were inaccessible. The Cameroon government began to prospect for investors for the
construction of the road. A German bank (KFW) carried out the studies and decided to build and pave the Bambui-Kom road. For political and technical reasons, the construction was stalled for a number of years. As a member of an eight-man delegation to Germany to prepare the visit of President Paul Biya in September 1986, Prof. Nkwii participated in the renegotiation and the endorsement of the road project by the German government. When H.E. Paul Biya visited Germany in September 1986, the road construction was put back on programme and the then German Chancellor Helmut Köln visited Cameroon in December 1986. The final documents were signed. The construction of the road began a few years later and by 1996, the road was opened to heavy traffic.

Every Kom man back at home and abroad will certainly never hesitate to appreciate what the German government did by constructing the Bambui-Kom road that passes through Njinikom. On the whole, the road is a dream that came true. This dream can, however, be considered from two perspectives.

On the one hand, it has come with some advantages. Easy movement within and out of Kom is very common. Most interior parts of Kom with health posts are reachable by motorbike. This enables the inhabitants to receive or try to get access to available health services. This has equally resulted in a decrease in transport fare. Before the construction of the road, it would cost approximately 3000 CFA Frs. to 5000 CFA Frs. from Njinikom to Bamenda. But today it costs about 800 CFA Frs. 1000 CFA Frs. This is a remarkable decrease in expenditure for people who wish to go to the city as well as for anyone who would have to come to the village for any reasons. The Kom road has made access and availability to health care services much easier. The Njinikom hospital has always been a referral hospital to the Archdiocese of Bamenda and it was difficult to get to Kom because it took about 3 – 5 hours to get to Njinikom during the dry season and a whole day in the wet season. Now, the hospital can be reached from Bamenda within a maximum of about 50 minutes. Clients can access the hospital in time for consultation and return to Bamenda before nightfall. Again, the road has brought about urbanization and other change. This is clearly seen with an increase in economy and the opening of many business like ‘rest’ houses (hotels, motels, inns etc.), bars, video clubs, call boxes
(personal mobile phones used to generate personal income), stores and an increase in the number of motor bikes and cars that ply the road for economical purposes.

On the other hand, the road has brought some disadvantage. Increased mobility is good but the car accidents have increased. These accidents have resulted from bad driving. Because the road is good, drivers tend to run fast, sometimes to make extra money from the many passengers willing to travel. Careless driving has killed innocent children selling food crops or food by the roadside and innocent people have lost their lives. The poor driving has wounded many badly and crippled many. The increase in the number of cars in the Kom countryside has also contributed to pollution of the environment causing an increase in respiratory tract infections. Theft and armed robbery have become very common leading to loss of property, traumatised status, insecurity and fear. At first, when a stranger came into to Kom it was easy to tell he was a stranger. Everybody knew everybody, if not by face, by name. Today, many strangers come to Kom and leave unnoticed. Just as it is possible for a stranger to come and leave Njinikom unnoticed, it has equally become possible that armed robbers can raid a home or administrative block and leave without the rest of the village being aware of the crime committed. One informant, Mrs. Mukala (a retired midwife and nurse), said ‘it was possible to put a pot of food on the fire, take a car to town, buy some spices and come back to put the spice without the pot getting burnt or anyone knowing a pot was left unattended’. This goes to tell the degree to which the paved road has facilitated mobility and certain atrocities can be committed and may not be known until days or weeks after. Most often than not, they are not known. The road has permitted people to move in and out of Kom with ease.

Better means of transportation and a better road infrastructure has increased the level of mobility in Kom; mobility that has brought in new ideas, different perspectives to development and new health problems. Many people use the Kom road for a variety of reasons. Records in the hospital show that referral patients come from all over the province, and even from Nigeria. Njinikom is located between two other major market

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6 During the time I was in Cameroon for fieldwork, armed gangs from Bamenda raided Mbingo Baptist Hospital, which is on the Bambui-Fundong road axis. They stole a car in Bamenda; drove to Mbingo hospital raided the hospital for money, mobile phones and other valuables.
centres (Belo and Fundong); it is a transitional town, with a growing economy built on the export of coffee. The coffee mill situated at Wombong (1 km away from Njinikom) provides employment to hundreds of people who process coffee for export. The labour used in coffee processing is just local. The construction of more 'rest houses', opening of more bars as well as market stores indicates increased growth. The area has three secondary schools; two private schools and one government school\(^9\). Although the road has brought significant improvement to the quality of life in the region, people have failed to realise the negative impact of this innovation: increase in risk behaviour, vulnerability and an increase in infectious diseases. As a result of the increase in trade, many people come and go out of the village. They socialise in the village, they are likely to drink, stay up and out late with friends or have sex with commercial sex workers. The inflow of people from outside, with more resources, impacts on young girls who exchange sexual favours for money and services. If such relationships are unprotected the young girls are exposed to unwanted pregnancy, sexually transmitted infections (STI) and above all to HIV/AIDS.

**Location for Contacts**

The most popular area in Njinikom is called '3 Corners' and it is a meeting point for many inhabitants and visitors. This area is characterised by provision stores, a motor park, popular drinking spots, rest houses and even a documentation centre. Not far from '3 Corners' is located a secondary school (Jua Memorial College), a market, a football field, the grand stand and some metres away is located the St. Martin Porres Hospital. The 'rest houses' include 'Millennium Summer Hotel', 'St. James Gate', 'Credit Union Hotel' and the 'Cooperative Rest House'. Before the road was opened, these hotel facilities did not exist. At '3 Corners' bars include 'Wisdom Bar' (whose motto is 'The Word of God is Alive'), 'Continental Cool Corner', 'Jerusalem Complex', 'Bridget's Corner', 'New Nation', 'Heritage Hot Spot', DC\(^10\) and 'Soul Redemption'. In these places, life seems to go on 24 hours. People do not seem to go to sleep and there is

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\(^9\) Jua Memorial College, Georgian City Academy (established by Prof. Paul NkwI) and Government Secondary School.

\(^10\) DC or Divorce Centre is a popular spot operated by a woman who divorced and decided to make a living by selling beer and food. In the evening, divorced ladies congregate there.
constant music and excitement at ‘3 Corners’. What makes ‘3 Corners’ a place of potential risk are the numerous bars, major meeting spots, video clubs (where pornographic films are shown with no age restrictions), barbershops with limited information on HIV/AIDS and the motor park. These facilities offer occasions for potential sexual exposure and sexual contact.

In Njinikom sub-division, the traditional eight-day\footnote{Kom eight-day week – 1. tuk-boli (rest day), 2. tuk-tuo, 3. tuk-kijem, 4. tuk-we-njikom, 5. tuk-abum, 6. tuk-ivi, 7. tuk-ivisamni, 8. tuk-Kom.} market system functions in a rotating manner such that every village can have a chance to sell their products. This market day has fixed days and it brings people from distant places, sometimes 60 kilometres away. Many traders and visitors, even tourists, are seen notably the day before, the day itself and the day after the market day. The day before the market day the migrants come in from the city with their goods and look for a place to keep their goods and a place to spend the next few days. With the transitional market system in Kom, migrants are likely to spend three of four days away from homes and loved ones.

The construction of the road is only one important condition that has made increased contacts possible and thus is the cause of an increase in sexual activities. This new road is also related to an increase in multiple partnerships. Seasonal workers, migrants and uniformed personnel who are likely to spend some period of time away from their families and loved ones, create some familiarity with the inhabitants of Njinikom and enter into sexual relations. Some key informants asserted that mobile people have sexual partners in and out of Kom. In the Kom culture, odd numbers bring luck and prosperity while even numbers ill luck, death and misfortune.

The increase in more than one partner has eventually introduced what one would hardly believe takes place in Njinikom, a form of ‘hidden’ sexual contact. ‘Hidden’ because no girl will want the community to be aware of her sexual activities and her way of making a living. It is a way of survival for some yet no Kom girl will be proud of doing what most people in Njinikom consider as prostitution. These ‘hidden’ prostitutes do not own brothels or pimps but they use their homes or rooms to indulge in what the Kom people
especially the youths refer to as ‘ndamba de la nyiete’. These young girls very often leave the village for the city in search of a better life. Due to economic hardship and an expensive lifestyle they are unable to stay in the city. They returned to the village in the hope that a continuation of their life from the city will yield them some money to keep their lives running. Some people think that they have come with diseases to distribute to as many people as possible. Some informant asserted that some infected person do not want to die, deliberately decided to spread the virus further.

Apart from a paved highway, reduction in transport fares, easy mobility has also brought to Kom landscape tourism. Many foreign tourists enjoy driving through this mountainous district with spectacular scenery. The road has led to the improvement of health care services in the three hospitals – Mbingo Baptist Hospital, St. Martin De Porres, Njinikom and the Fundong Government Hospital. Access to these hospitals has brought patients and diseases from cities as far as Bafoussam in the western province and Yaoundé in the Centre Province.

In discussing these advantages and disadvantages, I interviewed five key adult informants who were well above 60 years old. They have lived in the area for over 30 years and have ideas of the road before and after its construction. The youths constitute a bigger sample. It was important to compare the views and perceptions of the adults with those of the youth aged 15 to 25 and to know their contrasting views and opinions in order to measure change as well as understanding the social processes going on in Njinikom.

The Vision of Some Kom Elites

My study also focuses on how culture handles issues of sexuality, sexual relations, contraception, youths, risk behaviour and AIDS. It was important to study the views of the older generation as well as those of the younger generation. This permitted me to assess the degree of divergence between the two groups on cultural norms, values and prescribed required behaviour in the Kom culture. Four key informants were selected.

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12 This is another word for sex and it refers to a football match. In other words it means a struggle between two people as well as there can be a negotiation.
namely, Mrs. Mukala, a midwife and retired nurse, Prof. Paul Nkwi, a university professor, Bobe C.K. Barth, a teacher and former municipal administrator, Mr. Peter Mbeng, a local politician and a onetime president of the Farmers Cooperative Union and Mr. Wallang, a retired teacher. They are among the few educated elites with a wealth of knowledge on Kom culture. They have been living in the village for over 30 years and have witnessed many changes. They have seen and lived different experiences with road transportation before the construction of the paved road seven years ago. In general these key informants provided information on sexuality, contraception, road mobility, and diseases, especially on HIV/AIDS.

With respect to sexuality, they all agreed sexuality was never discussed, displayed, witnessed or talked about openly and publicly unless within the context of marriage. In their days, it was rare to see a boy and girl holding hands, walking together or kissing. If it did occur and they were seen by an elder, they would try hiding in the bush, or walking away in opposite directions. Love and sexuality are considered so sacred that it was not expressed openly.

A proverb in Kom says ‘if a man loves his son, he will give him a cutlass’. Men achieve manhood and strength by doing three things: marrying a wife, building a house and having their own farm. When a man was mature and had proven himself worthy, his father would give him a wife. The father, and not the young man, usually made the choice and there was no objection. Marriage was a permanent, social commitment not only between the individuals but also between the families of the couple. Such marriages were forever.

‘In the good old days when culture was culture’ said Bobe C.K. Barth, ‘sexual relations only existed when a man and a woman had consented to spend their lives together’. He further explained that when a man is of age, he would express his intentions to his parents about the woman he wants to marry. His family would try to find out if the girl in question were a virgin, of decent character (in behaviour and speech), no history of mental illness and could bring forth children. If these qualities were obvious, then the
boy's family will send word to the girl's family and the marriage procedure would begin. In some cases, the man's father would look for a wife for him. If there were no objections, the couple would marry and live happily.

For respect of tradition, love, if it did exist among young people, could not be expressed openly. They could be seen together once they were engaged, but not before. Unless both families had made the first gift exchange ('se yenndo'), they were supposed to be seen in public. Because marriage was based on procreation and bringing up children and living happily together, divorce ('se tang kuo tu ni wulwi') was rare. Marriage was first and foremost an alliance between families and a guarantee of progeny. The two individuals were conferred with the rights and privileges of continuing the lineage through the birth of children.

The primary essence of marriage among the Kom is having children. Regardless of the number, children were and still are considered a blessing. In former days, there were family planning methods such as abstinence, fidelity, breast-feeding, safe period, and child spacing. When a child was born, it was nursed till it was at least 18 months before the parents were culturally and socially allowed to resume sexual relations. Bobe Wallang said 'Today life is different and difficult' and he explained that in earlier times, parents used to have 9 to 12 children because infant mortality was very high and formal education did not exist, or if it did exist, educating them was not a major problem.

Unlike the past, Bobe C.K. Barth believes that most sexual relations occur because one of the partners is economically viable. Youths think financial comfort is what matters and it is followed by the belief that love will erupt. The aspect of being 'disease-free' is absent. Today a girl meets a man, dates him and they get married the following week without considering some of the basic qualities of character, health and morals in the relationship. Financial viability and security seem to determine the marriages of today among youths. A partner's fidelity and commitment in marriage is questioned thus revealing a high level of suspicion that was never heard of in the past. Sexually transmitted diseases especially HIV is more prevalent because young girls and boys are eager to get into marriage for
social and financial security. Bobe C.K. Barth also added with disgust that young people, if not all, need money for survival and they believe that with money you can have anything as well as partnership. The cultural values that were built into a marriage relationship are being disregarded and disrespected by the youth. The old generations are astonished at the sexual behaviour and sexual practice of young people and the prevalence of HIV/AIDS and other STDs. The former municipal administrator thinks that the consumption of alcohol, marijuana and other forms of drugs by youths is jeopardising their future. He asserted that the circulation of marijuana among the youth as well as the consumption of alcohol is doing much damage on the youth. This has exposed them to risk behaviour and increased chances of becoming infected with HIV/AIDS and other STDs.

Among the Kom people an unexpected guest or visitor is always considered something special. When a strange face was seen in Kom, it was evident that the person had some business in Kom or had been posted for a period of time. With the construction of the Kom road, movement in and out of Kom has increased dramatically. Before the road, just few cars per day would come carrying mostly Kom men who had travelled out. There were fewer cars and the road was extremely poor during the rains. However, men would push or walk a considerable distance before continuing the journey by car. Today, over 40 cars ply the Kom road daily, permitting an inflow of people and a possible outflow of people including some local inhabitants of Kom. Mrs. Mukala said 'place wey road pass, all thing dey'. She meant that wherever a road passes, there is everything. She also added that the road has brought an increase in spontaneous marriages, an increase in inter-ethnic marriages, an increase in STDs, a high consumption of alcohol as well as an increase in sexual promiscuity and the spread of AIDS.

According to Bobe C.K. Barth, venereal diseases were not heard of in Kom until 1945 and 1946 when the Kom soldiers who fought the Second World War, returned home. During the post World War II, more young men from Kom travelled all the way to the coastal region of Cameroon to work on plantations and returned home at Christmas and New Year. In those days, few foreigners visited Kom. It must also be said that Njinikom
was for a very long time; beginning from 1936 to 1946, one of the few places young people from all over the North West province could have both primary and post primary education. St. Anthony’s Catholic School attracted many ethnic groups to Njinikom and by 1944, a Teacher’s Training College was opened in Njinikom. However, only a few Kom people were able to travel out of the village and they served as migrant labour in the cities. There was very little movement and thus very few venereal diseases. Some informants believed that the return of these migrants also contributed to the introduction of certain sexually transmitted diseases. With the completion of the road in 1996, Kom witnessed another wave of migration as tourists visit the area. According to hospital records in Njinikom, the most common venereal diseases are gonorrhoea and syphilis. Genital wart, herpes, vaginitis and candidiasis are prevalent but to a lesser degree.

According to some health informants in Njinikom including Mrs. Mukala, the known signs and symptoms of HIV/AIDS appeared in 1986. In 1991 the prevalence rate in Njinikom was estimated at 5% and by 1998 the prevalence rate rose to 10%. Mrs Mukala has worked as a nurse in Njinikom for many years until she retired some years ago. She tells of how the rates created an impact among health provider.

Bobo Peter Mbeng said everyone in the past had been employed or was self-employed. The men took care of livestock and palm bushes while children and women worked in the farms. Rising unemployment is blamed on the economic crisis the country is presently going through. Mr. Mbeng believes that young people can create employment if they want to but they are too lazy and lax. They want to have money by doing nothing or making no effort. The youth today enjoy a certain degree of freedom, but their laxity and laziness are not making things easy for their parents.

I asked also about the role of social networks between families, friends, neighbours and the rest of the community in the prevention of the spread of HIV/AIDS. The elites emphasized the role played by family members when someone was sick or if he died. During such periods, the family was said to be cooperative; it provided assistance in the farm, in taking care of the children at home and the sick person. Money was also contributed to pay for medical bills, food and to make life easy. In a case of death, despite
the mourning, the family gets sufficient assistance in food, emotional support and labour
from neighbours and the community. This solidarity and fellowship among the Kom
people still continues.

For this older generation, HIV/AIDS is a modern disease that spreads as a result of
increased mobility, promiscuity and socialisation. They assert that the disease is killing
more youths than older people and they believe that unless the youths change their
lifestyle and behaviour, the disease will continue to spread. There is a saying that goes
thus; 'You can take a horse to the river but you cannot force it to drink water'. The elites
have admitted to the difficulty of helping the youths change and they believe that the
youths are to be blamed. Change is a process and not just a definition of a new state of
affairs, which requires a lot of time, different steps and strategies. Due to the inability of
the elites to help the youths find a solution to the problem of increase in sexual behaviour
which is risky and can lead to the vulnerability and infection, it is important to know
what the youths have to say.

The Position of the Youths
Having talked to the older generation, I spent a considerable amount of time talking to
young people. The youths seem to have a completely different view from the elites and I
decided to talk to them because I thought I would understand the reason for an increase in
sexual behaviour, sexual contact and the spread of AIDS. For them, the situation is
different. The youths perceive their sexuality: distinctly from the elites. Most youths in
Njinikom think establishing a relationship leads to sexual intercourse. Colette and
Patience feel that partnership; intimacy, sexual satisfaction, procreation, happiness,
financial stability, excitement and companionship are constitutive elements of a
relationship between a man and a woman. Reneta and Sidonie do not reject this point of
view but think that money can buy everything; money is the ultimate solution to all
problems.

Today most young people choose their partners and when things do not work out, they
easily go their separate ways. Today, most youths do not aspire to achieve these
fundamental values. They want money because with money they can achieve a different lifestyle: drink beer, smoke and date. The youths do not think they have lost their sense of purpose, as the older generation seem to assert. Even though Bobe C.K. Barth says with regret that he does not 'see any culture in the youths', the youths do not feel that way. The youths have their own culture, which is a contrast to that of the older generation. Most of the youths feel that their parents have lived the life of the past and should let them live their own. Most female respondents would like to marry but do not think they have to rush. They talk of having fun while they are young, being independent before marriage and a few talk of single parenthood thus raising their children without necessarily the assistance of a man. In order to enjoy a better life, young people prefer to have fewer children, say 2 or 3, who can correspond to their income and resources so as to live conveniently, decently and comfortably.

In the past sexuality was a taboo topic. Young people today talk about sexuality regardless of their surroundings. Both boys and girls discuss sex and love more openly than their peers several generations ago. They do not only talk of sexuality, they practice sex. From the study, unsafe sex occurs very often in Njinikom for several reasons. Youngsters think that sex with condoms is degrading. Using condoms portrays infidelity, sexual irresponsibility, one's degree of sexual activity and inability to prove manhood. Some youths expressed the disgust of sex with a condom and defined it as unpleasant and not enjoyable. 'Full contact', 'flesh-to-flesh' and 'direct current' are some of the terms used by youths to refer to pleasant sex — sex without a condom.

After talking with some young people, they said they know of the use and sale of condoms. Most of them say they use them yet they consider condoms a hindrance in their sexual life even though they are aware that the end product of sexual activity can be a pregnancy or an infection. But a majority is aware of the consequences of unsafe sex yet they continue to engage in risky sexual behaviour. Dr. Kenneth, one of my informants, explained that the rate of unsafe sex in Njinikom is linked to the low use of condoms. Condoms are common and available at affordable prices yet the belief and perceptions attached to condoms discourages many people from using them (Gregson et al, 1997). Young people use them yet they think that they are meant for people with venereal
diseases, sex workers and military personnel. Most respondents fear what their partners would think or say about them if they proposed the use of condoms. The use of condoms has often led to disgrace, shame and stigma in relationships.

A. GIRLS AND CONDOMS
Stigma is more experienced by women than men. This is attributed to the belief that AIDS is associated with promiscuity (women) and in some regions of Kom and Cameroon, it is called a ‘woman’s disease’ (Sam-Abbenyi et al, 1994). While sitting in a bar observing the kind of activity that was going on, I heard a military man say that ‘to cheat was a disease of men’. This is further exacerbated by the fact that infidelity is socially and culturally tolerable for men. Having another regular is acceptable for men but treated with disgust for women who will be classified as ‘prostitutes’ (Mnyika et al, 1997; UNAIDS, 2002). Below are some excerpts of conversations in which young girls give reasons why they should not buy condoms.

CASE ONE: - HEDWIG, 22 YEARS
‘I think some girls do not want people to know that they are interested in sex. Some of us think it is the place of the men to buy condoms since they are the ones who wear them.’
Hedwig gives the impression she does not want to be identified as one interested in sex and she kind of thinks the men should buy condoms since they wear them. What she forgets is that not all men who buy condoms wear them.

CASE TWO: - CLAUDIA, 17 YEARS
‘Some of us are discouraged by the belief that a girl is not supposed to ask for sex from a boy. So when a girl goes to buy condoms, it gives the impression she is too hungry to have sex.’
Claudia like Hedwig does not want to be labelled as interested in sex. It does not matter who asks for sex. What matters here is the belief they have grown up with and how they look at ‘asking a boy for sex’.
CASE THREE: - Pamela, 18 years

"In our African context, I will be treated like an outcast if seen buying a condom. You should know that our African beliefs sometimes represent an obstacle to us girls.

Pamela gives the impression that being African is an obstacle to obtaining a condom and asking for sex. I wonder if truly we should blame our African beliefs. The behaviour of Africans with regards to HIV/AIDS should not be entirely imputed to African traditions and beliefs.

CASE FOUR: - Lydia, 21 years

"We are always ashamed to buy condoms even from a woman because we do not want to give the impression that we are desperate for sex. Our mates also say it is morally wrong for a girl to buy condoms."

Even though as girls, women shun them as well and they think this even discourages them even more. Apart from moral, what they fear is being shamed and labelled. In general, these young girls do not want to be looked at as bad girls with low morals or as badly brought up children.

The local idioms for condoms include 'kapot', 'godaz', 'rubber', and 'socks'. Although they are the most effective and affordable way to reduce the risk of contracting a sexually transmitted disease, they are not taken seriously and girls are culturally dis-empowered by the fact that they cannot easily negotiate the use or impose the use of condoms on their partners. What most girls are not yet aware of in Njinikom is that it is worse to contract HIV/AIDS than to buy a condom. When girls do not protect themselves, the consequences could be frightening: being infected with HIV/AIDS. Paying 25 CFA Frs. for a condom is a small price to pay for a life so great and precious. A medical doctor in a rural council insists that girls can make the difference if they have strength of character and are fully empowered to deny sex without a condom. This is what Dr. Nkwescheu Armand said 'if girls have to start thinking of building a better future for themselves, then sex must be with a condom. Safe sex today is a safer tomorrow for you.'

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13 These are common words used to refer to condoms. In general they mean protection from something or a defence mechanism.
Below are two stories of young girls — Reneta and Beatrice — in Kom who will tell us about their sexual life and what their fears are. The first story of Beatrice explains how most illiterate young girls in Njinikom will ignorantly react to news of a pregnancy as well as a being positive. Their neglect and sufferings go a long way to make life difficult and stressful. Beatrice’s story will provide more insight to some of the experiences of young unmarried illiterate girls who live in rural areas.

B. BEATRICE’S STORY

‘When I realised I was pregnant, I came to the hospital for consultations and tests. It was then that I learnt of my health status. The doctor who attended to me asked that I call Arnold who was responsible for the pregnancy to come forth for screening and testing. At first he objected and after some thought we both went to the hospital. When the results were out, we were called into the doctor’s office. Arnold’s test was negative and we received counselling’.

The part played by hospitals and their staff is quite crucial in the kind of financial and emotional support and advice they provide to HIV positive patients especially mothers. Such assistance is rarely shown in government hospitals where money can buy health.

‘As we walked home nothing was said but when we got to the point where either of us had to take our paths home, Arnold said the relationship was over and said he was not sure if he was also the father of the child. When I asked why the sudden change in what the doctor said, he said he accepted because he was not in his senses. He said after some thought on the road, he had decided to end the relationship with me and he walked away’.

Such a health situation as that of Beatrice whose partner is not positive can cause a lot of strain in their relationship and neglect on the part of the boy who believes he is not responsible for her pregnancy. He would eventually blame her for her promiscuous nature and health status.

‘Since the death of my parents I have been living alone in the house my parents left behind. Arnold has paid the baby and I three visits. On the first occasion, I was 7mths pregnant and he brought some clothes for the baby. On the second
occasion, he heard I had put to bed a son through caesarean section. My hospital bill amounted to 85,000 FRs and I could not afford it. I talked with Arnold about it and he suggested I ask someone to sign the payment form and when he had the money, he will refund it. I was former a seamstress. I went to the workshop, collected all the items that belonged to me and sold. It was not sufficient so I had to borrow some money to make up the rest of the money. I was also able to get some assistance from my three senior sisters who are all married. On the third occasion, Mr. A happened to be in the village and brought two blocks of laundry soap and a kilo of rice. When I asked him about the money I had to refund, he said he was not able to make more money. Ever since the third occasion I have not seen him and I learnt he has moved from Bambui to Douala'.

Beatrice feels more frustrated when she cannot meet up to medical and basic needs. She even feels more frustrated due to the death of her parents who she believes would have given her the attention she would need. She might be frustrated but hopes that Arnold will come back with help and to take care of their child.

‘The baby has been sick once and I had to pay a bill of 14,650 FRs. There are days when my body aches (ee don di bad) and when I feel really sick (die don di near) I can send word to one of my sisters to come. Thanks to some free drugs given in the hospital, I am able to pay to a certain percentage of my bills. I cannot tell if my son has the disease but he will be screened and tested when he is 18mths’.

Her finances are few but one of her other fears is how she is beginning to feel. Whatever pain or uncomfortable situation she thinks is linked to the fact that she is positive and would soon die. She probably is not aware of how long the disease takes to manifest and what she can do to feel better.

‘I began to engage in sexual activity when I turned 20 years. I have had two sexual partners. Today I am not looking forward to any relationship for fear of passing on the disease. I was shocked when the hospital results for Mr. A were negative. I have visited some traditional doctors and I know it is possible that I could have contracted the disease on one of those visits. Knowing that it is a disease that kills, I await death (I di wait die). I am certain that when I die one of my sisters will take care of my son. I will hate to see a friend or relative find herself in the same situation like myself today. The best I can say is that no one but them can control their sexual activity so they should take care of themselves and be careful.'
My advice to young girls who wish to get married at all cost is for them to do the HIV test before marriage and also to die in their marital homes’.

Beatrice also believes that if she is positive and Arnold is negative, it is possible that during one of her visits to see a traditional doctor, she got infected. Unlike some girls, she does not want to have any sexual relationship and she has some advice for her friends who are out having fun and maybe making the same mistakes which she made before.

Beatrice’s story is one of ignorance, desperation, frustration, uncertainty, regret and blame yet she shows maternal devotion to her son and concern for her fellow friends. At her age, she has experienced a lot of things and believes that despite her fear of death, she can make the best of her last days on earth.

C. Reneta’s story

‘I am a bartender and I have been working in the Continental Cool Centre for over a year since I stopped going to school. Education is not meant for everybody so I decided to get involved in any petty business that would help me make some extra money. I love my work and the business is good because I meet people everyday especially new faces and I often get little tips from men. There are times when business is not moving and there are times when it is very demanding. Some clients continuously place orders for more drinks and stay in the bar till about 5am. I barely get 4 hours of sleep and I have to be at the bar.

While selling at this bar, I have dated some of my clients. With some clients, it is simply a matter of a one-night stand. With others, the relationships can last for up to three weeks and I make sure nothing comes between my work and me. If these men refuse to understand, then the relationship has to end. After all there will always be men available. Since I began to engage in sexual relations, I cannot determine approximately how many men I have dated. My private part is not a reading meter, which can keep records of how many men I have slept with’.

Unlike Beatrice, Renata has some form of elementary education, loves her job and sometimes dates her clients. She is also smarter and is careful about her dealings. She also uses very obscene language, which gives the impression that she is uncouth.
Most men consider me a ‘chop am fool am’ but I don’t care. They want to show that they can spend money so I will help them spend it. When I engage in these sexual relations, I try as much as possible to protect myself. Anyone who chooses not to protect himself or herself does not like their lives and will miss out on many wonders of this life. I have received offers for unprotected sex. I accept and later I endeavour to do a test and take all my medications. Any girl above 15 years who does not know about condoms is a foolish girl. I always move around with my ‘godaz’

Dating strangers is not a good thing but I have slept with many of them. I hear it can cause barrenness. If I cannot have children in the future, I will not be surprised. I have lived in a house of girls and watched my senior sisters sneak out of the house and I think I admired them. I often covered up for them. Today I can step out when I want because of the nature of my work. Because everyone needs money to survive, I will try to maintain my job and make some extra money in any decent way’.

She might be promiscuous in her sexual relationships and does not think she sleeps with men for nothing. She does not date men because she likes them she dates them in order to make some money yet she does not term it prostitution. She also gives the impression that one’s surrounding or environment in which they grow can be very influential on the future lives.

‘I have been to the city and life is difficult. All the little money one makes goes to rents, bills and basic needs. I would rather come to the village, live with my grand aunt and work at the bar. AIDS is a deadly disease and I hope and pray that despite my high sexual appetite, I will not contract the disease. I hardly ever get to sleep with the same man twice. I have a history of sexually transmitted diseases and I hate it because I know it has many bad effects for a woman. I have been insulted and called names like ‘nkane’ or ‘ashawo’ to mean a free girl. Most people consider that selling at a bar is related to a free life and indiscriminate sex. But I don’t care.

It is true that this life is too short and one has to make the best of it. I wish for a better life but the village does not offer many opportunities for youths. Life is what we make it and so women can decide to shape their lives in a particular way’.

Reneta’s independent life and past experiences put her on the advantage yet it does not make her perfect. She has her own fears, which are disease infection, inability to have

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14 When a woman especially takes delight in dating men and never maintains any relationship for a considerable period of time. It can also happen when a woman deceives a man, get away with his money and still not have sex with him.

15 Another local word for condoms. It is a borrowed French term in football to mean ‘boots’
children and get married. She has chosen to live her life as best as she can regardless of what people say or how she is called sometimes.

Reneta's story is amazing as it is a contrast of Beatrice's story. Reneta has a carefree attitude and she shows more experience and knowledge of sexual relationships. She portrays the picture of a 'local hero' and chooses not to miss out on situations in life.

**Nightlife in Njinikom**

It is relevant to look at the nightlife in Njinikom so that we can understand the circumstances under which there is increased contact and sexual activity that can result to infection. In Njinikom, every corner is lit with dim colourful lights making the scene beautiful yet unpredictable especially as it is difficult to make out faces. Music can be heard in the different bars while video clubs are showing pornographic movies. Idlers and people without money roam hoping to be invited for a drink or to take a seat for a chat. During the weekend, young children sell till late into the morning. Whatever money they make, serves as part of their school fees or it is a means to survival. Sometimes cars can be seen coming in or leaving Njinikom. At night and in dark corners where abandoned cars can be found, coffee farms, and neglected or uncompleted buildings all serve as hiding places for lovers without proper accommodation. Such lewd behaviour goes with indiscriminate sex, vulnerability and infection.

My observations were crucial in understanding a certain kind of behaviour and interaction going on in the community and what could be possible reasons for indulging in risk behaviour that can lead to infection. The situation was quite clearly confirming what I thought was taking place. After school hours, young girls from secondary schools in Njinikom would roam around public places such as '3 Corners'¹⁶, meet people in bars or visit these places to keep an appointment. Most of the time these young girls do not go

¹⁶ Three corners Njinikom is a meeting point of three major roads. See the description in the first part of this chapter.
home after school but hang around in the hope of establishing a casual relationship at ‘3 Corners’. I carried out these observations discreetly.

With a topic such as ‘Migration and HIV/AIDS in a rural area in Cameroon’, it was important to know how nightlife in Njinikom operates. Njinikom by night is another world of its own characterised by noise, music, drinking, dancing and women. To some people, the day begins after 7pm. Hanging around ‘3 Corners’ to do some observation was helpful in understanding to what degree, nightlife as compared to the actions during the day can lead to vulnerability and infection. During the day ‘Njinikom 3 Corners’ is filled with people but at night there are twice as many people as during the day. If you do not know the secret password or code for ‘rest houses’ (secret hideouts) that function only at night, then it will be difficult to assess the degree of activity at night and to understand what is taking place in the late hours of the night.

In a situation where men drink in bars, women are usually a topic of discussion. Where it is a group of men with their sexual partners, the discussion can be centred on politics and football. One of the informants has this to say: ‘Company is considered relieving as women are regarded as shock absorbers or pain killers’. Women are believed to relieve men when they are stressed out or worried. During drinking sessions, a girl can call on her friend or friends to meet her ‘man’ and this can give room for making more friends. This is how people establish a friendship that can lead to a sexual relationship. Apart from meeting at bars, some migrants prefer to go to a ‘drinking parlour’ where they can be served with a meal and can drink ‘afofo’ (locally brewed hot drink) or ‘nkang’ (locally made corn beer). Very often, on separating, a night outing is arranged by the different couples, neither couple disclosing their plans to the other.

Individual behaviour (unprotected sex, multiple sex partners, indecent dressing, idleness, night outings, alcoholism, smoking, promiscuity, peer pressure and scarification) and outer circumstances (joblessness, ignorance, cultural practices and poverty) coupled with mobility and increased contact can expose vulnerable groups of people to infection of sexually transmitted diseases and HIV/AIDS. Christmas, New Year, funerals, weddings
and other occasional cultural events increase social communion and the spread of AIDS in Kom. Because the economy offers little incentive to the youthful populations, life is difficult. Youths use all ways of survival. Sexual favours are just one of those means of survival but this leads to increase in vulnerability.

External influence on the Youths
In this section, my research attempts to understand the role families, friends, neighbour and the community. Most of the respondents admitted that peer pressure has a strong impact on the sexual life of an individual. But families generally do not condone with the lifestyle of their adolescent children that is not conducive to good morals with respect to sexual matters. One respondent said parents give birth to children and not their character or mindset - 'papa and mami di born pikin, they ney di born ee heart'. Parents or families have an important role in shaping the character of young people. Although young people have been told of the dangers of HIV/AIDS, they are not changing their behaviour; the youths do not listen to the elders.

Young people rebel against parents and families over matters of behavioural control. Parents and older people assert youths are not patient enough to learn. Parents also find it difficult to talk to their children about their sexuality. Children from broken homes especially the girl-child, hardly survive. Sometimes they run away from home to fend for themselves and end up with the wrong partner. Others are sent away from home to go and bring home some ‘daily contribution’ like food or money. Sometimes girls from such homes easily indulge in risky sexual behaviour in order to provide a meal for the family. For girls, this may also lead to an unwanted pregnancy. Some mothers change partners and run the risk of being infected while children from broken homes run the risk of not having a good moral upbringing. One informant confirmed this in pidgin when she said fowl no fit born duck fowl – a duck cannot be the offspring of a hen. The character of a child reflects that of the parents.

Those who share a close relationship with their parents especially their mothers, often get to talk openly with them. These fortunate young girls get advice from their mothers as
well as share anything new with their mothers. It is rare that these children can go astray or indulge in indecent and risky sexual activities. Some mothers often are the crucial link in the socialization for their children. Friends do have a strong influence on their peers and their sexual life. Peer pressure (‘njakri’\textsuperscript{72}) tells the degree to which friends can either encourage or discourage their friends. Some would encourage because of the financial benefit and satisfaction while others would discourage because they are aware of the traumatizing consequences like disease infection, unwanted pregnancies and stigma. Some boys are indifferent to the behaviour of their female friends and leave them to discover for themselves what life can be like. This is usually because some girls do not like to be lectured by their peers. They may often interpret this interference as jealousy; they fear being threatened when it comes to men or interpret this, as ‘they do not want to have the same fun as them’. There are some cases where a certain amount of jealousy erupts that can lead to enmity. Imitation is one behavioural factor that is very common among youths. Imitation often results from admiration, gradually leading to competition, which can be sexual and material.

Some mothers realising that the sexual life of a neighbour’s child, can push their daughters to find out what the secret is in order to improve their standard of living as well. Girls, who are ignorant, often get infected with STDs, get pregnant or never get sufficient money to improve on the living standards of their families. It is believed that bad news spreads like wild fire. When the news about a new AIDS patient reaches the community, the consequences are traumatizing for the infected and the affected family. The infected person and his/her affected family is labelled, isolated, discriminated against and branded as ‘unworthy’. This leaves them with no friends but negative remarks. Stigma can even take place within the family and can be directed at the affected in the most subtle and debilitating way.

Another important issue was the dating of older people by young girls. We found that older men dating young women were common but older women dating younger boys were rare. When young girls date older men, it is what they get out of the relationship

\textsuperscript{72} A kind of hypocritical language that can be provocative.
that counts, financial security and survival. This, they cannot get it if they date boys of
the same age group. These older men are often married men and they are capable of
being their fathers or of the same age group as their fathers.

Some inhabitants believe that this early sexual activity is often imputed on parents and
the community. Because parents do not discuss sexuality with their children, this lack of
parental guidance leads to sexual experimentation and to the high increase in sexually
transmitted diseases. Boys are accused of pushing young virgins into early sexual
activity.

My research findings also showed that the age of first sexual experience has dropped
from 18 years to 13 years over the last three decades. Some girls have indulged in sexual
activity much earlier than their mates (Sam-Abbenyi, A. et al, 1994). One informant said
that ‘virginity is considered old-fashioned’. Her friends, made fun of and given names,
laugh at any girl involved in a relationship who has not yet indulged in sexual
intercourse. In Njinkom, youngsters refer to the kind of sexual relationship that a girl
holds with pride as ‘wayo’ love (cunning love). If it is a relationship where the girl is not
pride of and does not want her family, friends and the community to know, it is referred
to as cache-cache\textsuperscript{18}. Virgins usually do not engage in sexual activity with foreigners or
causal people. From the data collected in Njinkom showed that the first sexual
experience always occurs with persons the girls know and they live in the community.

I believe that educational administrations especially female teachers are not always sure
when it is appropriate to impart sex education to students. Although government has a
policy on sex education, it is not efficiently carried out because of lack of appropriate
tools; equipment and teachers. Sufficient sensitisation programs depend on international
donors. The Family Life Education policy has not come to full implementation for lack of
adequate resources.

\textsuperscript{18} When a relationship is not openly accepted. It is derived from the French term ‘cacher’ which means ‘to
hide’.
Many of the respondents did not realise the dual advantage of using condoms. Safe sex using condoms does not only prevent a person from infection but it also prevents unwanted pregnancies. Stigma remains arguably one of the greatest obstacles to overcome in the fight against HIV/AIDS. Stigma is characterised by silence, fear, discrimination and denial that has helped fuel the spread of the disease. In Njinikom, stigma involves negative thoughts, ‘undesirable differences’ and ‘spoiled identities’ created by individuals and their communities.

It is interesting to note that a father of 8 children and a renowned teacher, Mr. Wallang, asserted that ‘if sexual activity has increased greatly in Kom, it is because of students’ knowledge in biology. Those youths who are going to school want to share with their friends what they have learned in school and experiment what they learn in school’. Yes, Reproduction is a topic in biology lessons in secondary schools. During biology classes, there is usually laughter and giggles when the sexual reproductive parts are mentioned. Among themselves, they refer to the verb experiment as ‘practicals’. The informant further asserts that this experimentation occurs after school hours, during the weekends and in dark corners. Most teachers are not adequately trained to teach without appropriate tools and equipment.

This high prevalence of HIV/AIDS is related to the changes that have occurred in Njinikom since the construction of the road. Kom migrants get infected while away from home and return to infect their loved ones when they are back in the rural areas. Migration is, by its nature, highly dynamic and has changed dramatically in scope, scale and diversity. The point is that movement or mobility increases contact and brings new ideas, services and change in behaviour as well as infections. A good road infrastructure can therefore serve to increase benefits but also increase risks.

To understand how diseases can be prevalent in a community as a result of migration or mobility is the focus of my study. AIDS is a communicable disease and the vicious cycle (see appendix: Vicious Cycle) gives us a picture of the HIV/AIDS infection during mobility. Communicable diseases cannot spread from one area to another unless people...
who move from place to place carry them. The infection begins when discordant couples meet, especially during seasonal migration, and they later infect their regular partners or wives back home. The cycle will continue for as long as their high-risk sexual practices and highly mobile lifestyle ensure rapid transmission of the disease along major transportation routes.
Chapter V

CONCLUSION AND THE FUTURE

Suggestions and Recommendations

Being infected with HIV in Cameroon is like having a cold in the North Pole (Lukong, 2003). HIV has become very common and Cameroon is amongst the countries in Africa with the highest percentage of infected people in both urban and rural areas. The latest HIV/AIDS surveillance results (September 2000) indicate an HIV prevalence of 11% among the sexually active population, representing an estimated number of 937,000 people.

HIV infections in rural areas have often been lower than in the urban areas and migration has often been found to be one of the main risk factors. My research has shown that a large majority of rural dwellers in Njinikom are aware and have accurate knowledge of AIDS and its modes of transmission. Young people have unquestionably demonstrated that they are capable of making responsible choices to protect themselves.

The association between migration and HIV is evident. Unless we are equipped with a better understanding of the social, behaviour and psychological consequences of particular forms and patterns of migration, it will be impossible to understand the consequences of migration for the spread of HIV and the vulnerability migrants and their sexual partners. However, all is not lost. The role of the community in motivating, educating and encouraging its members constitutes an important factor in the fight against HIV/AIDS.

Sensitisation programs such as the distribution of leaflets have been distributed and putting up posters with the assistance of the National Committee for AIDS led to the awareness creation among Cameroonians. Although the Catholic Church has continued its moral teaching on abstinence, it is fully aware of its rising prevalence. Measure taken
outside the churches’ jurisdiction to reduce risk behaviour has been the promotion of the use of condoms, encouraging voluntary testing and counselling and dealing with social stigma. These measures have been implemented to bring down the rate of infection in Njinikom.

The functionalist theory highlights the important role of each component part to maintain a system as a whole. In a particular institution, all the parts are interrelated and each part contributes to the entire system. If HIV/AIDS was analysed from a functionalist perspective, it would be interesting to know how the component parts of a small community like Njinikom needs to activate its parts to deal with the pandemic by curbing the rate of infection. Certain obstacles impede the reduction of the spread of AIDS. These include peer pressure, idleness, lack of resources, poverty laziness, bad friends, competition and fear of parental rejection. The young and the old, the rich and the poor are constitutive components of the community and each must play its part to deal with the pandemic.

In Kom, stigma confronts and undermines prevention, care and support thus increasing the impact of the epidemic on individuals, families, the community and the nation in general. The social stigma was seen in this study as a challenge to different institutions in Njinikom if the pandemic is to be reduced to manageable proportions.

Study found out that stigma makes disclosure within the family difficult because there is no open and honest communication. Without disclosure, care and prevention are almost impossible. Study also discovered that the health care system could sometimes perpetuate stigma by using strategies that expose patients. Health institutions can assist patients without stigmatising them. The church can play an important role in dealing with stigma by disseminating messages that are non-stigmatising and appropriate. Considering that the church has a far-reaching influence, they have the responsibility to promote, prevent and provide care, comfort and spiritual support to infected and affected persons. From the findings, the mass media can unintentionally promote stigma although at the same time it can serve as powerful tools reducing it. The development of media standards and ethical
principles becomes vital and important on HIV/AIDS reporting in a non-judgemental manner.

Study also revealed that poverty is a known factor in the spread of AIDS. The economic situation in Cameroon with its early structural adjustment programmes have left many youths without jobs or situations permitting the use of their talents and skills. Many youths remain frustrated and jobless. The girls, who can use their bodies to survive in a stagnant economy, do so against their will. In Kom, agriculture is the main occupation and source of income for most families but the traditional land tenure system does not permit young people to start an agricultural career. The AIDS-related programmes need to build in some economic activities to assist not only people living with HIV/AIDS, but should benefit a wide community.

Study fully agrees with Dr. Nkwescheu who said girls can make a difference. The willingness to accept condoms should be exploited by making them available at the health centres, in schools, in hotels and even in bars. If these young girls can have access to these condoms without being stigmatised then we can say we are one step forward in the fight against this killer disease and the negative consequences of risky sexual behaviour like unwanted pregnancies. Study showed that there is a low use of condoms among girls in Njinikom and empowering the girls in negotiating sex and taking decisions in matters of safe sex is critically important. The girls must take full control of their bodies and manage their sexual lives. For girls there are two options: you either abstain or you use a condom in every situation.

Negotiation is a process in which two or more people with different interests interact in order to arrive at a common goal. This entails compromise. Negotiating safer sex can be a difficult process for sexual partners especially women. This is as a result of gender inequalities, socio-economic status and lack of power. Promoting condom use and dual protection will serve, as a strategy for women to prevent STDs and unintended pregnancies through the use of condoms plus another contraceptive method or an emergency contraceptive, should the condom fail.
The family as the first agent of socialization has declined its duties of sex education. Parental attention, guidance and love seem the right ingredients for finding solutions to the many sexual problems of young people. Many parents do not know how to talk to their children or provide the basic sex education they need. This fear, leads to neglect of some parental obligations and duties. Neither the school alone nor the church can fully replace the family or the parents. Functionally speaking, these constitutive parts of the community must play their role in the upbringing of future citizens, the youths.

School administrators should know that by the time children get to secondary school, maturity increases especially as their environment affects them. Biology classes should not be a place for laughter and religious studies should include some amount of sex education. Coupled with proper upbringing from the home and the advice and counselling received at school, students will not only want to experiment but will do so with care and every necessary precaution.

Knowing what students do after school hours is important. The circulation and cheap sales of Nigerian movies in Cameroon and pornographic movies from Europe have worsened the situation through the uncontrolled opening of many video clubs. Usually a schedule is put up daily for which films will be played and at what time. No age restrictions are made. The fee is affordable and most children can afford it. Those who cannot afford the fee will bore a hole in the wall and come from time to time to watch whatever movie is going on. Awareness programs should encourage and propose other recreational activities which students can take part in apart from watching movies which are not always educative and lack parental guidance.

Research also identified some innovative programs that seek to assist youths deal with the HIV/AIDS pandemic. Emphasis in prevention programs should also be on the sexual behaviour of youths and safer sex promotion must remain the primary feature of prevention programs in the region. Youths often forget the risks and negative consequences attached to risky sexual behaviour. To shape the behaviour of youths is
very difficult and there is no doubt that you cannot straighten an old branch but you can find another way to put it in an upright position. The programs should provide youth-friendly services and equip young people with life skills to turn knowledge into practice.

Apart from the INTERCARE PROJECT HOPE, Njinikom, sponsored by INTERCARE, Britain, a youth health development organisation called Dor Shalom also began to operate in Cameroon in 2000. This is a Hebrew organisation and Dor Shalom means ‘to generate peace’. The organisation helps youths build capacities and develop skills for a better positive future as well as being very much involved with the fight against AIDS. They have opened in Njinikom an HIV/AIDS Resource and Counselling Centre to help in the education of those already infected with the disease, to live a healthier life, those still free of the disease to stay free, those families affected and those taking care of the infected. The organisation is working in partnership with PLAN, formerly known as Plan International, and the National AIDS Control Committee in the re-running of the Local Response Program for HIV/AIDS, which did not prove successful in its previous attempts. Another HIV-related program in Njinikom is HOLLAND HELP.

Many approaches to STD/HIV prevention have been used in varying degrees of success. There is a general consensus, however, that successful STD/HIV prevention needs to go beyond information and awareness rising to directly address behaviour change. Sexual behaviour is not easy to change and it is not simply sufficient to tell youths that certain behaviour puts them at risk. Promoting hope and acceptance in a supportive environment is a key response to dealing with AIDS at all levels of the society and to help reduce the spread. Doing nothing about it can contribute to an increase in the death toll as well as distress thus reducing the quality of life for many.

Limitations
There were two major shortcomings during the research. The first one and most important was the limited financial resources. Therefore working on a tight budget was strenuous. The second shortcoming during the research was the limited time to do the fieldwork. Six weeks was designated for every student to make all contacts, conduct
interviews, do transcriptions, do participant observation and start the write up.
Fortunately the sample was a small one and I was familiar with the area of study.
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APPENDICES

Appendix 1

INFORMED CONSENT FORM

Introduction
My name is Nike Nkwi and I am a Master’s Student at the University of Amsterdam in Holland. I am interviewing young women about mobility on the new Kom road and how it has brought about disease to them in particular and the community in general.

Confidentiality and Consent
I am going to ask you some personal questions that some people might find difficult to answer. Your answers are completely confidential and your name will not be written on this form (unless otherwise). No information you will tell me will be used in connection to you. You do not have to answer questions that you do not want to answer but you are implored to endeavour to complete answering to the best of your ability.

Your honest answers to these questions will enable me better understand how people perceive the new road, its consequences and how the road has brought increased mobility and disease. I would greatly appreciate your help in responding to this questionnaire and it will take about one hour. Would you be willing to participate?

I certify that the interviewer gave informed consent and ensure confidentiality of the respondent.

Interviewer’s Signature

Interviewee’s Signature

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Appendix 2

INTERVIEW GUIDE

Interview Number:
Interviewer:
Date:
Duration:

Demographic Data
Name:
Age:
Position in the family:
Level of education:
Occupation/Leisure time activities:
Religion:
Ethnic Group:

Personal Data
1) Are you in a relationship?
   - If yes, for how long?
   - If no, why?

2) Where is your partner?
   - What is his profession?
   - How old is he?

3) Where and when did you meet him?

4) What are the circumstances under which you met him?

5) Who do you live with?

6) Do they know of your relationship?
   - If yes, what do they think of it?
   - If no, why?

7) How often do you see your partner?
   - If not everyday, what could be the reasons?
   - Are you comfortable with it?

8) Do you trust him?
   - If yes, why?
   - If no, why?
9) Is this your first relationship?  
- If not, how many others have you had and for how long?

10) Do you use condoms?  
- If yes, how many times and why?  
- If no, why not?

11) Have you ever heard of venereal diseases?

12) Have you ever contracted a venereal disease?  
- If yes, which one?

13) What did you do when you realised that you had one?

14) What necessary precautions do you take to avoid future infections?

15) Where do you get the money for treatment?

16) What do men give you after having sexual contact with you?  
- What do you do with their gifts?

17) What is the status of this relationship?  
- If permanent, how do you feel about it?  
- If temporal, Why and what do you want out of this relationship?

18) Have you ever heard of AIDS?  
- From whom and where?  
- What do you think of the disease?

19) Do you know anyone who has been infected with the disease?

20) Do you have any friends or know anyone in a sexual relationship?

Main Questions for All In-depth Interviews
- Perceptions of Sexual Relations  
- Perceptions of Unsafe Sex and STDs  
- Perceptions of Migrants and Mobile People  
- Role of Economic Pressure  
- Role of Social Network
Appendix 3

THE VICIOUS CYCLE

- RISKY BEHAVIOUR
- VULNERABILITY
- INCREASE IN CONTACT
- DISEASE INFECTION
- MOBILITY
Appendix 4.

Figure 2a: Fundong Road - Part of the Bambui-Kom-We Road.

Figure 2b: Sensitization Poster.