

The Social History of Chronic STIs in Africa: Experiences from Cameroon

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Abstract

The emergence of chronic sexually transmitted infections (STIs) in Africa has been nightmare to medical scientists who experience different clinical, therapeutic and social challenges around these infections. Medical history show that HIV/AIDS and hepatitis B virus (HBV) are the only chronic STIs for the moment. This study narrates the life experiences of some patients who have lived with these infections above a decade. A public awareness of the trauma that HIV/AIDS and HBV infections have crown on the social lives of infected persons. A contribution of this current literature on health beliefs and social responses around chronic STIs in Cameroon. This qualitative study use the comparative approach of the grounded theory using focus group discussions (FGD), in-depth interviews and participant observations to collect data from a sample of 158 persons living with HIV and HIV/HBV co-infections. Data collected from patients selected amongst those with therapeutic complications, a FGD with patients found in social networks of infected persons and in-depth interview with care-providers and care givers. A content analysis and interpretation using the Social Dynamic Analysis theory and Cultural interpretative theory. Infected persons with HIV/AIDS have life experiences different from those with HBV and other infections at large. Their life experiences have over the years HIV patients leave from doubt to fear and rejection and presently shame, insult, accusation, and stigmatization that caused a new form of social life through networking. Some patients refused to seek for medical care due to psychological traumas from their entourage. New experiences as a result of the loss of loved ones, broken relations and emotional pain has become a new way of life. Ignorance about HBV and it modes of transmission makes it stigma-free. This study recommends a health system capable of integrating cultural beliefs.

Keywords: Social history, chronic STIs, experiences, Cameroon

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Introduction

This study describes the new social set-ups that have been created within the individual and collective way of life of infected and affected Cameroonians since the outbreak of chronic STIs such as HIV/AIDS and Hepatitis B virus (HBV). Acknowledging that the outbreak of these infections have created different types of histories in the clinical, biological, therapeutic, and immunological perspectives, the social aspect of HIV/AIDS could not be underscored. The social modifications that have taken place in the history of infected and affected person with HIV/AIDS and HBV in Cameroon are quite different from the social history of other chronic infections such as; leprosy, cancer, renal failure, diabetes, hypertension etc just to cite a few. A lot of negative perceptions, beliefs and social responses have taken place in the individual and collective lives life styles of the infected persons and their entourage. This paper describes the historical evolution in the social and behavioural set-ups in a context where sexuality is still a taboo and the therapeutic challenges from the scientific and alternative medicines keep rising in the fight to find a proper cure to these infections. The negligence of the cultural reality in the practice of preventive and protective measures implicates the present focus of knowledge in this study. The role that culture plays in the history of chronic STDs in Cameroon cannot be overemphasized in the sense that most of the STDs (syphilis, chlamydia, gonorrhoea etc) were treated by alternative therapies in the different ethno medicines according to ethnic realities. The chronicity of HIV and HBV becomes a problem at the moment when health beliefs have rejected these infections.

Due to the inability to recognize these infections in these semi-modern communities, this study came with the conclusion that, the rejection of these infections originate from the fact that, no community in this country is able to find a local name for HIV or HBV. Consequently the belief that, they are 'strange' or 'foreign' infections fabricated to destabilize the social peace of Africans. Thus denial and rejection of this reality have been responsible for the persistence of new infections, therapeutic challenges such as viral resistance and the general instability in the managerial situation of this public health problem. A lot of studies have been done on social impacts on HIV/AIDS in Africa such as that of OBBO, C 1993, 1995, 1997, Paul Farmer 1992, 1996, but few of these works examine the case of Cameroon. Moreover, these studies were limited to social, economic, and political impacts. The present literature describes the new social set-ups that have been created in the individual and collective lives in the meso- community through new forms of social networks as measures to overcome the social stigma. Previous studies have neglected the inability to examine the new forms of social relationships within these communities as a result of infections. New forms of families, social statuses, friendships, marriages, relationships and way of lives are rising as a result of these infections. The issue of self or public accusations, blame, prejudgments and guilt to infected and affected persons has caused this mechanism as a way to overcome the social stigma by infected person. Attitudes of denial by infected persons has been a cause of great re-occurrence of co-infections with other STIs and sero-different partners becoming all sero-positive in the nearest future.

This study describes the effects of rejection in the context of Cameroon and negative attitudes have made a social history. It also examine the main social modifications that have taken place since the outbreak of this infection and why the social history of HIV/AIDS is different from that of other chronic diseases. This study describes the social history that has been created in the social life of Cameroonians especially amongst persons infected with HIV/HSV. It a narration of the behavioral dilemma as far as sexual matters are concerned with person infected and affected with chronic STIs.

Brief background of this study

This study was carryout in the University Teaching Hospital Yaounde in Cameroon. This health institution is a referent center of the first category that receives patients from the four corners of this country. It has a technical platform that is adapted to manage complicated cases of infections and most often opportunistic infections from HIV and Hepatitis virus in general. It is also amongst one of the pioneer centers for the management of Hepatitis B virus and other forms of severe infections in Cameroon.

Literature review

The literature used in this study is mainly empirical literature. The main review approach is thematic approach. A summary of the existing empirical literature shows that, a landscape literature exist on HIV/AIDS in the world and Africa in particular and little on Hepatitis B. But a laborious amount of these works are mostly on clinical, biological, immunological and therapeutic literature in the domain of medical science. As far as social sciences is concern, the volume of scientific work done on HIV/AIDS is still evolving and few works exist on HSV. The general strength of the existing literature in social sciences tackles the question of HIV/AIDS from the methodological and disciplinary issues (DOZAN et VIDAL, 1993), social construction and implication of AIDS, Social sciences, support and prevention of AIDS (ANRS-ORSTOM, 1997). According to these works, social sciences were not much implicated in the management of HIV in the past decades. This could have contributed to some of the challenges faced by medical scientists since the problem of HIV prevention is mainly behavioral. Authors like (Paul Farmer 1992 and 1996, Christine Obbo 1993, Lurie, Hintzen, Lowe 1995, Millen and Lederer 1998) have written laborious works that critically reflects on AIDS in the context of Africa and some parts of the Western world. These works are mostly based on understanding AIDS and it implication in the domain of social sciences. But little has been done in the historical aspects of these infections. Such efforts as that of Nancy Rose 1994, who worked on the historical derivatives of STDs in Congo-Zaire are still having inconsistencies in the sense that, STDs and chronic STIs have a great difference in the perceptions and health beliefs as far as Africa is concern. The former are sexually transmitted infections that are cured or treated with indigenous therapies in various ways depending on the ethnic group and it indigenous potentials. Meanwhile the later have not yet have any specific therapy to eradicate or properly treat it. The fact is that, the former could be handled without a scandal as far it sexual origin is concern, whereas the later has always create a scandal since the medical scientists prescribes a lot of behavioural modifications to adopt in order to prevent or protect transmission. The

present literature tries to contribute to the epistemological gap that exist in the historical perspective of HIV/AIDS, while comparing it with Hepatitis B which is an infection with similar etiological and pathogenic characteristics like HIV/AIDS. It is not only tracing the history but showing the social modification that these infections have made in the social lives of the infected and affected persons in the context of Cameroon with a health belief different from that of the western context.

Statement of the problem

Chronic infections have always been a health burden to both the health care provider, the care-giver and the patient at large over the years. This challenge is a general problem across the globe. The therapeutic management of chronic illnesses demands not only the management of clinical symptoms, but a holistic care of the patient in his/her psychological, social, financial, emotional and nutritional domains. While this norm is general for other type of chronic infections, it has been noted that, there is a deviation from the norm as far as chronic infections are concerned in Black Africa and Cameroon in particular. As far as chronic STIs are concern, there has been an exception in the health beliefs and social responses surrounding these infections in the context of Africa whose cultural beliefs about sexuality and it practices makes a taboo.

Since HIV was declared to be mainly a sexually transmitted infection besides other means of transmission such as; mother-to-child, blood transfusion, use of sharp unsterilized objects, it has created a historically reconstruction as a shameful, racialized, promiscuous (Nancy Rose, 1996) and most often categorized and feminized in the context of Cameroon. Hepatitis B on the other hand is still an emerging infection in this context and is fast becoming a public health problem in Cameroon due to the number of new infections and it prevalence curve similar to HIV. It is a major cause of morbidity and mortality in this country as the number of patients diagnosed at the terminal phase are rising in a same way as HIV/AIDS in the late 80s to early 2000s. This is because, many patients are ignorant of the existence and the modes of transmission of HBV and most often arrive the health units at the terminal phase where little medical help could be given.

For more than three decades, the government of Cameroon has been putting enormous financial and human resources as efforts to arrest the situation. These efforts have not been yielding good fruits in relation to the new incidence rate that continue to be at a rise (7600 new pediatric cases in 2015, PLAN: PTME), the average co-infection HIV/HBV prevalence rate stands at 8-10% (WHO, 2014), the prevalence rate of HIV in the general population stands at 4.3% (EDS, 2011), the prevalence rate in pregnant women stands at 7.6% (Plan eTME 2012).

Not with standing, there seems to be a great disparity in the perception of HIV and HBV which are both chronic STIs with the same modes of transmission and chronicity with respect to other chronic infections which are not sexually transmitted. These disparities in perceptions between these two infections have negatively influenced their therapeutic

management and consequently creating therapeutic challenges that are mainly of behavioral origin.

Objectives of the study

The main object of this paper is to show how cultural beliefs and practices have played a great role in the creating a new form of social life amongst persons living with these infections. This has also contributed to the therapeutic challenges that the scientific medicine is facing in some parts of Africa and Cameroon in particular in the management of these chronic STIs. Given the fact that, these infections according to history were first discovered in the Western countries, and later speeded to Africa, the situation is known to be stabilized in the Western countries. Studies talked of infected persons who leaves for more than ten years without presenting any clinical symptoms, or hardly hear of sero-different couples who suddenly become all infected in the Western countries as is the case in Cameroon. It is current and frequent in the context of Cameroon to receive a sero-different couple who in the near few months become all sero-positive. Sexuality in general is still a subject of taboo despite the concept of modernization that is ravaging the continent of Africa. Modernization entails the enculturation of the Western way of life which in this case should have led to the open-conversation around issues of sexuality amongst different social strata in a normal or vulgarized way. This is not yet the case as far as the subject of sexuality and HIV/AIDS is concerned. The different social strata in the context of Cameroon perceive this subject differently and have different ways of looking at it. Meanwhile the elderly belief it to be a subject of youths who are sexually active and at time practice deviant sexual behaviours, the youth believe that HIV is a means to limit the enjoyment of their sexual lives. This paper describes the various social modifications that have occurred in the lives of the infected and affected persons in particular and the meso- communities. This makes a social history of chronic STIs different from the clinical and therapeutic histories that are widely known.

Methodology

This is a qualitative study that uses the grounded theory approached. The core methodological strategies in the grounded theory is the constant comparative method and theoretical sampling. The term constant underscores the repetitive nature of the process which comes to a close when repeated comparison yields no additional categories. This qualitative study made use of the qualitative approach in data collection and data analyses. While trying to examine the influence of socio-cultural factors on a biological phenomenon, a comparative study of our subjects helped us to better show the differences in perceptions and representations of infections of the same etiology (virus), pathogenic form, main mode of transmission (mostly sexual intercourse), and their chronic nature. The objective is the generating of new awareness, knowledge from the research gaps dictated from the existing literature. A comparative constant approach enabled us to understand the differences in life-styles and therapeutic responses that have resulted from the social and cultural differences among the different social strata. Given the clinical and epidemiological similarities that exist in our study subjects, a historical approach enabled us to bring up historical facts about these infections and how the therapeutic process have

been influenced by health beliefs of Cameroonians in general and on chronic STIs in particular in their social-cultural specificities and similarities

Study Population

Our study population was regrouped in to four categories: the first category drew samples from the lots of patients who for came for their clinical follow-ups for HIV/Hepatitis B and were faced with some clinical, therapeutic, social or psychological problems. The second category are those who are infected with HIV/HBV and have jointed some social networks. The third category of our study population were care-takers who accompany their relations to the care units. And last category were health care providers engaged in the care-process of these patients.

Our sample and sampling consisted of a patient suffering from a chronic infection, a health care provider, and a patient's relation. Our sampling method was the convenient sampling which took in to account the convenience sake of the study units that happened to be available at the time of data collection. Although it had it drawbacks in that the sample population was not quite a representation of the study population. . Our sample size was 158 informants and depended on the saturation point of information. Since we were working on social responses and health beliefs on chronic STIs in the context of Cameroon, we needed a representation of all or most ethnic groups in Cameroon to draw conclusions on our hypotheses.

We used two major methods to collect our data. These were the direct method and indirect methods. The direct method consisted of coming in contact with our informants for a face-to-face in-depth interview. The indirect method consisted of gathering information from participant-observations and documentary sources. The former method enabled us to proceed to a social construction of knowledge through the use of the content analyses of our research participants' declarations on their social responses and health beliefs around HIV/AIDS and Hepatitis B virus. Meanwhile, the later method enabled us to gather information through the observations of attitudes, gestures, body expressions, facial language from the research subjects.

Four principal techniques were used to collect our data. These are; documentary studies, in-depth-observation, face-to-face interview, and a focus group discussion. The documentary technique of data collection was facilitated by the use of some existing literature on HIV and Hepatitis B management in Africa and in Cameroon. This strategy consisted to gather books, articles, publications on chronic STIs or related documentaries from both libraries and Websites. The face-to-face interview technique was be facilitated with the elaboration of an interview guide organized in a thematic and sub-thematic forms corresponding to the main and specific research questions respectively. The participant-observation technique was facilitated with the use of an observation guide elaborated to observe how these patients do their clinical, social, and psychological follow-ups. We observed the how clinical consultations were being carried out, social consultations made and psychological follow-up done. A focus group was organized with patients who had regrouped themselves in associations or social networks. This was

achieved by the respect of Focus Discussion norms during the unfolding of this activity in order to collect data in a coherent manner. A discussion guide was elaborated to orientate the discussion session.

Ethical considerations

We respected certain ethical principles during this study since it involved human subjects and sensitive issues around their private or intimate life. After collecting the ethical clearance from the study institution, we adopted two main procedures to collect our data. For the direct method of data collection, we started by introducing ourselves on the field, explaining the purpose of our research, stated the type of research intervention and proceeded to the selection of our participants. After selecting our participants, we described our research process, told them the duration of our research, possible risks that our participants might encounter and how to manage them, the benefits of this research to the participants and the country as a whole, explained the procedure that we were going to adopt to collect our data and explained that participation was voluntary.

We proceeded to collect our data. The process involved the meeting of patients while on their waiting-seats to see the doctors, the reception of patients and their care-takers in therapeutic education sessions at the psycho-social post. We met the patients with the doctors to discourse resolutions concerning their therapeutic challenges, and kept appointments with patients with similar social, clinical and psychological problems for a focus group discussion aimed at confronting patients with similar problems and making them learn from each other's experience. We also booked appointments with health care-providers (doctors, nurses, social workers, counselors, psychologists, community relay agents, and members of associations of persons living with these illness), to interview them. We fixed a venue and time to meet our research participants. At our meeting point, we interviewed them on their health beliefs and social responses on these infections following our interview guide. This process was repeated over and over with different participants in order to verify some facts and coherency in ideas. We stopped the recruitment of participants when we noticed that, our data was saturated and information kept repeating itself. Our duration on the field lasted for approximately 12 months.

The right to refuse or withdrawal was allowed to participants. They could stop participating in the research at any time they wished without losing anything. Participants were allowed to ask questions immediately or later. They were also given the possibility to contact the Department of Anthropology, in the University of Yaoundé 1 if need arose. For the indirect method of data collection, we started by inquiring from our academic elders and supervisors from where we can get necessary documentation for this research topic. We then proceeded to the search of our documentation and screening them according to their importance. Since we could not get a large number of hard copies of our documentation, we looked for soft copies from the net.

Comparative presentation of HIV/AIDS and Hepatitis B

HIV/AIDS has been existing in Sub-Saharan Africa and Cameroon in particular for more than three decades now with respect to Hepatitis B which that made it way in less than a decade. These two infections share etiological boundaries in many aspects. Firstly, they are all viral infections and chronic in nature. In other words, they cannot not be cured or eradicated completely as for the moment due to scientific limitations. But Hepatitis B in this case differs from HIV/AIDS in the sense that, it could also be caused by toxic infections. But this study was based on Hepatitis B from the viral origin.

Secondly, HIV/AIDS is similar to Hepatitis B through their modes of transmission. These infections are mainly sexually transmitted, although other sources such as mother-to-child transmission, blood transfusion and the manipulation of unsterilized or blood-stain objects do exist. And thirdly, these two infections when in the human body, evolve following different phases that give them different scientific names. The first phase of HIV infection that is usually asymptomatic is called the healthy carrier phase, meanwhile in the case of HBV the case is also the same. The infected person shows no clinical signs and cannot be suspected. When these viruses have stayed in the human body and have gain their place in the body defense system, they start to produce clinical signs which most often could not be clearly distinguish in the case of HIV. Infected persons could loss body weight which is not generally the case, present other clinical symptoms or frequently fall sick. But in the case of HBV, the infected person starts to have yellowish eyes and symptoms of body fatigue. The third phase of these infections that is usually called the terminal stage for HIV infected persons is called AIDS, meanwhile for HBV it is called liver Cirrhosis which is another way of calling liver Cancer. Meanwhile for AIDS patients, the situation could be rescue if proper medical care is given to the patient, for HBV only palliative care is possible. This is care meant to reduce the discomfort of the patient and to prolong life for some time. But the end results for all HBV patients who have reach the terminal phase is death. The above reasons have motivated us to pair these infections in the same cage. As far as social responses are concern, the following facts were noted:

Findings

A 100% of persons living with HIV who are members of social networks of persons infected with HIV/AIDS are found in the urban zones or big cities in Cameroon. There are not social networks in the rural communities where individuals are known or identified by their names. The massive creation of associations of persons infected with HIV/AIDS in urban cities is as a result of the hiding of personal identities. 90% of these associations are made of women although some associations are purely feminine associations, the association for mix sexes are still filled with women. This shows that, women are bold enough to share their experiences with others than men in these communities. Secondly, many survivals who have lived with HIV/AIDS for above a decade are mostly women who are today widows. During this study, more than 66% of our respondents were widows. Most of them discovered their HIV status only after the death of their husband. Since the husbands have the cultural right of practicing polygamy,

they had multiple sexual partners were predisposed to be infected with the HIV virus before their women. Most of them knew their HIV statuses after the deaths of their husbands and decided to seek for care in order not to die and leave their children total orphans as was the case of their husbands. Many of these widows had this experience between the late 80s to early 90s when HIV/AIDS was diagnosed on some persons in Cameroon. Many people manifested the attitude of doubts, especially the men who refuse to seek for medical advice and consequently lose their lives.

Although some women also lose their lives, a greater number of survival are the women. A conclusion could be drawn that; women are more resistant to opportunistic infections than men. A good number of these women have remained single and never made any attempt to rebuild a permanent intimate relationship. Most of their intimate relationships are temporal and adventurous. Some of them have remained childless for the fear to infect others if they perform unprotected sex with the aim to have children. Those who are trying and willing to have a permanent intimate relationship such as marriage would prefer to contact social networks of infected persons to pose their candidature for a search of an infected partners with certain characteristics such as; age, ethnic group, profession and religious belonging. These are the new forms of social set-ups that have been created within the context of HIV.

They could not believe that, an infection that was first diagnosed in the USA amongst the socially devalued class (Hess et al.1988), that is intravenous drugs users and homosexual could be a reality in Cameroon. It was also stated that it was a disease that was sometimes fatal and almost always a precursor of AIDS (New week, Nov. 24, 1986, p. 31). More to that, Westerners practice sexual pervasiveness or deviance as pornographic films show how people have sex with animals. This was the source of this doubt and consequently, HIV was denied, refused, rejected and believed to be a slow poison, illness from witch craft or sorcery. The attitude led to the death of many people since there was no adequate scientific therapy for it. Social relations were in total confusion and disarray. The quest for alternative therapies was at its greatest height. By then HBV was not yet existing in Cameroon.

By the late 90s to early 2000s this HIV/AIDS had killed many Cameroonians till the point that, it was difficult to point out a family that was not affected or infected in one way or the other. HIV/AIDS started gaining its effective presence in the minds of Cameroonians who started believing that, it was a reality. The attitudes of doubt started changing to fear. Fear for death because HIV/AIDS was believed to be a killer disease, a strange illness, a disease of the 'White-man', the slim disease, end of social life, a bad sick and a foreign disease (that is not recognized in this cultural universe). Fear of death was manifested by the rejection of infected persons by affected ones. With the efforts of the government through the Ministry of public health, Anti-retro-viral therapy was introduced in the management measures although it was very expensive to the extent that only a few Cameroonians could afford for this drug. The number of persons who die of HIV/AIDS continued to be alarming. Still HBV was still unknown in this context.

From the late 2000s till date, the attitude of fear changed to shame and guilt although some infected persons after taking the ART for some felt that, this drug could cure the HIV virus (Ingham 1995). This is because, the respect of this treatment for about six months as medical practitioners say, is capable of assisting in the proper eradication of some opportunistic infections, making the patient to be clinically well and physically healthy. But bearing in mind the modes of transmission of this infection which is mainly through sex, many infected persons are still unable to accept that they were infected through sex. Others means could be attributed for the contraction of this infection except through sex. Meanwhile HBV entered the scene of chronic STIs in the last ten years. Although much sensitization has not been done on this infection with respect to HIV/AIDS, many patients deny to acknowledge that HBV is similar to HIV in many ways as far as it modes of transmission is concern and viral evolution.

Discussions

In this study we had three variables that intervened at various levels to bring out the above results. As shown on figure 1 below, the operationalization of variables shows that the intervening variable here is HIV/AIDS and HBV that intervenes in a community with cultural beliefs that produce a corresponding social responses which are dependent variables.

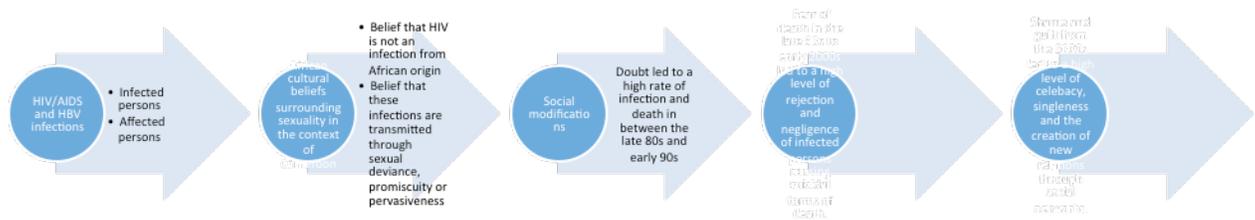


Figure 1. Theoretical model for operation of chronic STIs in the behavioral modification of infected and affected persons in the context of Cameroon.

The arrival of HIV/AIDS and HBV in Cameroon has created a social history in the behavioral modification of the lives of infected and affected persons that is very different from that in the Western context where these infections first generated. From the beginning, the doubt of the true existence of the HIV infection led to a high rate of transmission and consequently, the death of many as a result of the absence of ART or any adequate drug to manage its evolution. This led many widows, widowers and orphans of HIV. There used to be a total phobia among the people that created a state of confusion and the fear of the end of social life.

But as time went on, this doubt turned to a permanent fear of death as soon as the name HIV is mentioned. Consequently, fear led a rejection and negligence of loved ones and friends because of the conviction no matter the efforts made towards the infected ones, they end up dying. Because HIV has no cure.

Since the arrival of ART in Cameroon and the free grant to patients, fear of death has been transformed to partial acceptance of self-confidence to live as far as a good follow-up is done. But at the level of social relationships, there is still that stigma of rejection, accusation, labeling and name calling. These have created a new form of social network that manifest in associative life where new intimate relations are created, new or organized marriages are made and where a new family is formed. This is not yet the same with HBV for many are still ignorant of the gravity of the infections and its mode of transmission. This is a brief sequential events that have taken place or made a remark in the individual/collective way of life of the Cameroonians since the arrival of HIV/AIDS and HBV.

According to the cultural interpretative theory of Geertz Clifford, an anthropological study needs a thick description in the direction of any study that asserts the essentially semiotic nature of culture that implicates for the social sciences in general. In the case of this study, the persistence of HIV in Cameroon could be attributed to the belief that individuals and collectivities give to this infection. From the beginning, HIV was never accepted in Africa and Cameroon because it was believed that, it is an infection that is mostly meant for people with sexual pervasiveness or those who practice sexual deviance. Sexual deviance in this study is the practice of sexual behaviors that are out of the cultural norms. Given that sexuality is cultural. This is why most infected persons were afraid to share their HIV sero-positive status to their sexual partners and consequently, their uninfected partners become infected along the line.

In the same perspective, most sero-different partners who become infected along the line after the infection of one of the partners are women. In this cultural universe, women are of the weaker sex, that is, do not have the right to deny sex from their husbands or impose the use of condoms to their husbands. In the same light, in most households, the men have the financial power that permit them to dictate the fate of their form of sex (Adomako Ampofo 1995, 1996; Anarfi and Fayorsey 1995; Ankomah and Ford 1993). They may be infected and never tell their wives or in case their wives are weak to resist the decision of the husband not to use condom or the marriage breaks.

The Social dynamic analysis of George BALANDIER state that change does not constitute a transitory stage but is a permanent state that can be endogenous or exogenous (or “out-side”). We use the exogenous factors that HIV and HBV have brought on the behavioral modifications of persons infected in Cameroon and their entourage. From the beginning of the history of HIV, infected persons in this community were afraid to continue with their social life in the areas of marriage and child bearing. This is how many people who were infected with HIV for more than two decades have either remained widows/widowers because they lost their partners from this infection, some are single women/men because they were conscious not to get married to someone who will

be infected later and others childless because they could do unprotected sex that could lead them to be pregnant. Today, although the medical scientist preach the practice of unprotected sex among couples who are on ART, the breast feeding of children born by infected mothers, the stigma still exist and has not been eradicated. But this society has developed other labels or coded language to discuss issues surrounding HIV/AIDS amongst infected persons who form a category of social strata.

The Health Belief Model of BECKER highlights the function of beliefs in decision-making. According to this theory, for a behavior change to take place, individuals; must have an incentive to change. A change in the sexual behavior of most Cameroonians entails a reduction of the number of sexual partners for those who culture prescribes it. It also entails the way of practicing sex which means the use of condoms or abstinence. But if the individuals concern do not see any incentive in adopting new behaviors, they would not do so. In the light if they do not feel threatened by their current behavior, they will still continue with their old behavior that promotes the propagation of these virus. The case of the traditional rulers is a good example in this society where the culture stipulates the marriage to many wives. The feeling that a change would be beneficial to some way and have few adverse consequences is not enculturated in this cultural universe. Thus the propagation of social stigma which is a major factor to the spread of these infections.

Significance of this study

This study is going to enrich the theoretical knowledge on chronic STIs in general and HIV and HBV in particular. It is also going to show how the process of acquisitions of new or adapted behaviors and attitudes has taken place over the years since the HIV/AIDS and HBV started the chronic STIs history. The study is going to give practical modalities for policy development on social management of risky HIV/AIDS and HBV behavior in Cameroon.

Conclusion

For over three decades that HIV/AIDS has existed in Cameroon, it is still making news and new stories amongst individuals and collectivities. The announcement of a sero-positive status still brings fear, shame and prejudice from the newly infected and affected since the belief that sexual promiscuity is at its origin. Another new scene arises from children born with this infection at the age of school and especially adolescent age when they have to know why they are on ART. Despite the fact that, the financial cost of the medical follow-up of HBV outweighs that of HIV, many patients seem to be motivated and curious to know more about the treatment process of HBV than HIV. They question of why me and a blame on my late parents.

The reliability and trustworthiness of this study is found in the research method that uses the participant observation technique to collect rich data in a short time and from a small sample. The data is verifiable and less costly. The study is limited to the context of Cameroon and the research methodology and data collection tools which are mainly qualitative.

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