Analysis of the perception of HIV/AIDS as it relates to sexual behaviors, cultural norms and economic factors among women in Cameroon, West Africa

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ABSTRACT

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ANALYSIS OF THE PERCEPTION OF HIV/AIDS AS IT RELATES TO SEXUAL BEHAVIORS, CULTURAL NORMS AND ECONOMIC FACTORS AMONG WOMEN IN CAMEROON, WEST AFRICA

Advisor: Robert W. Waymer, Ph.D.

Dissertation dated May 2008

This study analyzed the perception of HIV/AIDS as it relates to sexual behaviors, cultural norms, and economic factors among the women in Cameroon, West Africa. Ninety-one survey participants were selected for the study utilizing non-probability convenience sampling. The survey questionnaire utilized a four-point continuum Likert scale. Findings from the study revealed that 30% of the respondents did not have any personal knowledge of HIV/AIDS. However, 70% of the respondents indicated that they did have some level of personal knowledge about HIV/AIDS. As well, 53.4% stated that their sexual behavior was influenced by their personal knowledge of HIV/AIDS.
ANALYSIS OF THE PERCEPTION OF HIV/AIDS AS IT RELATES TO SEXUAL BEHAVIORS, CULTURAL NORMS AND ECONOMIC FACTORS AMONG WOMEN IN CAMEROON, WEST AFRICA

A DISSERTATION
SUBMITTED TO THE FACULTY OF CLARK ATLANTA UNIVERSITY IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF DOCTOR OF PHILOSOPHY

BY
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CHAPTER I
INTRODUCTION

This study provides an analysis of the perception of Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) as it relates to sexual behavior, cultural norms and economic factors among women in the Republic of Cameroon, West Africa. The devastation caused by HIV/AIDS has deprived families, communities and entire nations of their youth and many of the most productive people in society. The HIV/AIDS epidemic has the potential of deepening poverty, retarding human development and achievement, worsening gender inequalities, and disrupting the ability of government to maintain essential services, reducing labor force for the demand for the supply of goods and services, and putting a break on the country’s economic growth (Barnett, 2002).

According to a study by the National AIDS Control Committee on HIV/AIDS, Cameroonian women account for 6.8% of the estimated number of women diagnosed and living with HIV/AIDS between the ages of 15 through 24, and the men account for 4.1%. HIV/AIDS continues to remain a significant problem, particularly among young women and girls. Topics and issues related to sex and AIDS have been avoided in the Cameroonian community. The principal governmental structures have failed to be
incorporated into the political discourse strategies and programs designed to combat the HIV/AIDS epidemic (Samba, 2006).

Another report by the Cameroon Post stated that for every 100 men infected by the disease, 170 women are also infected. However, this revelation is different in the nation’s average of 6.8% in the North West province, with an increase rate of 204 women infected as compared to 100 men diagnosed with the illness (Mbunwe, 2007). According to nationwide statistics, women from the north West province are topping the list with a high prevalence rate of 11.95% almost doubling the nation’s rate at 6.8% (Mbunwe, 2007).

Despite all the efforts made in reducing the widespread infection of HIV/AIDS, several factors continue to contribute to the prevalence among women and young girls in the North West province in Cameroon. Practices such as wife inheritance make it difficult to decrease and succeed in the fight against HIV/AIDS (Mbunwe, 2007).

Currently conceived global HIV/AIDS prevention measures consist of three interrelated strategies which are: (1) encouraging people to reduce the number of their sexual partners; (2) promoting the widespread use of condoms; and (3) treating concurrent sexually transmitted diseases (STDs) in population at risk of HIV (Heise & Elias, 2000).

However, these three strategies have been inadequate in meeting the protection needs of many women globally (Heise & Elias, 2000). The report further stated that these women are often very poor and disproportionately unable to negotiate the terms of their sexual encounters. Women do need a new strategy and new commitment to address the
underlying inequalities that heighten their risk of contracting HIV/AIDS (Heise & Elias, 2000).

The international health community, as a struggle, has described a woman’s role as an organizer of civil society and in the shaping of cultural expectations, especially against the spread of HIV/AIDS. Women have always performed multi-dimensional roles in society as individuals, spouses, and mothers; and these roles vary according to local culture and tradition (Avert Organization, 2005).

It is not unusual for poor women in the developing world to play dual roles, as mentioned in this study. These exhausting tasks are performed by many of these women from sun rise to sun set and yet women as a whole have never been given enough credit for the dual roles they play in the society. Women in developing countries work longer hours than men and they do so throughout their lives. In rural sub-Saharan Africa, it is estimated that the average woman works between 15 and 18 hours per day (Anunobi, 2003; Weekes, 1985).

The diversity of cultures in Africa is evident in the work of the first pan-African organization in the fight against HIV/AIDS which was developed by the Society for Women and AIDS in Africa (SWAA). In sub-Saharan Africa, women across 36 countries have opened local chapters of SWAA. HIV/AIDS education and services are only now gaining recognition in many African countries with the increasing illness in the number of people with HIV. In the absence of a massive and expanded prevention, treatment and care efforts, it is expected that the AIDS death toll in sub-Saharan Africa will continue to rise (Avert Organization, 2005).
In January 2002, during the meeting of the International Women's Health Coalition, the United Nation (UN) Secretary Kofi Annan stated that for the first time, women represented half of the HIV-positive individual worldwide. The UN Secretary emphasized and strongly urged the international community to develop programs that would help women in the prevention of HIV/AIDS (Lundu, 2006).

According to Kaptue, Tagne and Kenmogene (2002), despite the vigorous sensitization campaign against the HIV/AIDS epidemic since its beginning, the prevalence rate continues to grow in Sub Saharan Africa, particularly in Cameroon. According to these authors, the prevalence rate rose from 0% in 1984 to 11% in 2001. The study emphasized the remarkable increase, and the urgent need to bring awareness and solutions to the HIV/AIDS crisis (Kaptue, Tagne, Deffo, & Kenmogene, 2002).

Cameroon is one of the most diverse African nations with over 18 million people, three major religions, and several languages and dialects. This diversity creates multiple and distinctive cultural traditions. Unfortunately, many of these traditions help to exacerbate the spread of HIV. In certain regions of Cameroon, a number of unconventional traditional practices and beliefs prevail (Avert Organization, 2005).

For example, in some areas tradition dictates that when a man marries a woman, it is acceptable for him to have or engage in sexual relations with his wife's younger sisters. In some other areas, a woman may be required to marry her former husband's brother following her husband's death. Utilization of such practices increases the likelihood of HIV transmission for all, especially if few people are getting tested or using appropriate protection (Avert Organization, 2005).
In situations where the wife refuses to follow the traditional or customary rules, she might be banished, deprived of seeing her children or stripped of her rights as a member of the community. The lifestyle of Cameroonian women is not only characterized by poverty, inadequate medical care and unequal gender roles, but also by traditional practices, all of which contribute to women's health risk. Many of these women believe that if they do not rigorously comply with their gender roles and the tasks prescribed upon them by tribal norms, they will be bewitched into illness or even death (Weinger, 2007).

The widespread infection of HIV/AIDS among women in Africa, and especially among Cameroonian women, is equally exacerbated by the practice of female genital mutilation, the delivery of children at home, with the use of crude equipments that might harm both mother and the child. Abortions are also another leading cause of death among African women especially when it is done outside the hospitals and away from conventional trained personnel that have the experience and knowledge to perform this type of procedure (Weinger, 2007).

Examples of these types of practices may be seen in a study done in the cross-River state in Nigeria, among 140 randomly selected birth attendance to assess their knowledge of HIV/AIDS. Findings from this study revealed that 44.3% of the birth attendance had no formal education. However, 31.4% had primary education and 13.6% had secondary education (Bassey, 2007).

Bassey further stated that during this birth process, only 43% used safety protection procedures during delivery by the women, and only 10.7% used sterilized blades. The study further revealed that only 2.1% of the birth attendance had prior
knowledge of the HIV/AIDS status of the women who were about to give birth (Bassey, 2007).

These types of practices are known not only to kill the individual due to excessive bleeding, but also to infect the person performing the services, particularly if the individual was infected with HIV/AIDS and lacked protective devices, such as gloves, to prevent the transmitting of blood from the victim to the person performing the procedure (Weinger, 2007).

The impact of HIV/AIDS epidemic is felt most strongly within the Sub-Sahara region of Africa. In 2003, there was an estimated 26.6 million people living with HIV/AIDS, and 3.2 million newly infected cases. An estimated 2.3 million deaths have been reported in this region. The death toll is felt in the health sectors, but mostly in the social, industry, agriculture, transportation, human resources, and the economy, in general (Avert Organization, 2007).

The Cameroon Post, a well-known newspaper in the country, announced, in May 2007, that the population of Cameroon had grown from 16 million to 18 million. Of this population, 510,000 individuals were living with HIV/AIDS. Women age 15 and above were infected and living with the disease; whereas 290,000 was the overall, an average of 5.4 percent of the entire population was living with the disease. This slight improvement of over 50 percent since 2002, came as a result of the formation of the national program for the fight against AIDS in 1998 and also the continuous reductions in price of the antiretroviral (ARV) drug (Mbunwe, 2007).

As a result of this minor progress made in combating the illness, the National Strategic plan for 2006-2010 addresses the full continuum of HIV and AIDS strategies,
including care prevention, support and treatment. However, in the same report, it was revealed that reality on the ground is often different because services are difficult to access in rural areas. It often involved long distance traveling and people are sometimes reluctant to visit the centers due to the stigma associated with HIV/AIDS (UNFP, 2005).

HIV/AIDS, in Cameroon, is still the leading cause of morbidity and mortality, with an estimated 1,000,000 HIV infections and increasing. Researchers, such as Lukong, used Geographic Information System (GIS) to investigate geographic patterns of HIV infection among 8,452 pregnant women screened at 24 health clinics in the Northwest Province of Cameroon between February 2000 and June 2002 (Lukong, 2004).

According to this study, acceptance of same-day HIV testing was 93.0%. To facilitate access to the population, information was obtained regarding roads, subdivisional boundaries, health clinics, and villages, as well as data from the Cameroon Baptist Convention Health Board Program for the Prevention of Mother-to-Child HIV Transmission (PMTCT). The results from the analysis in 28 subdivisions in the study showed that HIV prevalence was between 3.5% and 16.8% in Northwest Province, and was high among participants that were living in the identified study areas (Lukong, 2004).

The small analysis in the village showed a number of 'hot-spots' with HIV prevalence at 20% or higher. The study concluded that the residential areas along the rings roads and hot spots were in dire need of enhanced prevention and HIV clinical care services (Lukong, 2004).

In most of rural sub-Saharan Africa, HIV analysis is an innovative and useful approach to identify high-risk areas of HIV transmission among women attending
antenatal clinics. Integration of spatial HIV data and small service data allowed for targeted allocation of scarce prevention and care resources to those communities that were in greatest need (Lukong, 2004).

Statement of the Problem

Unlike women in other regions of the world, African women are at least 1.2 times more likely to be infected with HIV than men (UNAISDS, 2005). Globally, just under half of all people living with HIV are female (UNAIDS, 2004). Knowledge and misconception are important prerequisites for prevention programs that would focus on increasing people’s knowledge about sexual transmission, and enable them to overcome the misconception that acts as a disincentive and barrier to behavior change (UNAIDS, 2004).

About 60% of women in the target population have some knowledge on HIV infection. They know more about sexually transmitted diseases (STD) and seek information in the health centers, which they perceive as most credible. However, 90% of the women are not convinced, nor confident that they could prevent the transmission of HIV infection. This is in part due to the prevailing norms and beliefs that characterize sexual encounters of women, and their partners, within the Cameroonian culture (Affana, 1996).

Purpose of the Study

The purpose of this study is to analyze the perception of HIV/AIDS as it relates to women in Cameroon, by examining their perceived knowledge, culture, and socio-economic factors that contribute to the sexual behavior among the identified group.
This study was developed in an effort to gain further knowledge about the fastest growing group contracting HIV/AIDS among the citizens in the Republic of Cameroon. Despite all of the efforts undertaken to educate the population about ways to protect themselves from contracting the disease, women in Cameroon continue to participate in risky sexual activities.

The study will analyze the sexual behaviors and knowledge, in terms of awareness, and the existence of HIV/AIDS. It will assess the relationship between sexual behavior of these women, and the economic factors. Finally, the study will assess the relationship between the knowledge of HIV/AIDS and the cultural norms to ascertain whether or not their awareness contributes positively or negatively to the sexual behaviors among the sample population.

Research Questions

The research questions of the study were as follows:

1. Is there a relationship between sexual behavior and knowledge of HIV/AIDS among women in the Republic of Cameroon, West Africa?
2. Is there a relationship between economic factors and sexual behavior among women in the Republic of Cameroon, West Africa?
3. Is there a relationship between cultural norms and knowledge of HIV/AIDS among women in the Republic of Cameroon, West Africa?

Hypotheses

The null hypotheses for the study were as follows:
1. There is no statistically significant relationship between sexual behavior and knowledge of HIV-AIDS among women in the Republic of Cameroon West Africa.

2. There is no statistically significant relationship between economic factors and sexual behavior among women in the Republic of Cameroon West Africa.

3. There is no statistically significant relationship between cultural norms and knowledge among women in the Republic of Cameroon, West Africa.

Significance of the Study

Inequality is a major problem between women and men in many parts of the world, including the Republic of Cameroon in West Africa. This inequality exists in all aspects of living, from employment opportunities to power inequalities within relationships. Therefore, this gender role does confine women to positions where they lack the power to protect themselves from HIV/AIDS infection. These women are typically put in a position where they could not adequately negotiate the terms of any sexual agreements, mostly due to lack of economic resources, their cultural norms, and their lack of knowledge with regards to HIV/AIDS transitions.

Therefore, with the disproportionately higher prevalence of new HIV/AIDS cases among women in the Republic of Cameroon, West Africa, it is imperative that studies should be conducted including women from this region and focus on their sexual behaviors, cultural norms, and economic factors which contribute to the higher incidence of the spread of HIV/AIDS among this particular population. Historically, members of minority populations have been underrepresented in clinical trials. There are many
difficulties associated with enrollment of minority individuals in research studies and clinical trials. Cultural and language barriers must be overcome, and ways to inform individuals of the studies and trials available and their potential benefits for education, prevention, and improvements in health must be found.

This study will shed some light on sexual behaviors, cultural norms, and economic factors that lead to the disproportionately higher prevalence of HIV/AIDS infection among women in the Republic of Cameroon, West Africa. It is therefore of great significance to demonstrate, with these data, whether the aforementioned factors influence the disproportionately higher incidence of new HIV/AIDS cases among this particular population.
CHAPTER II

REVIEW OF LITERATURE

This chapter reviews current literature on the analysis of HIV/AIDS as it relates to sexual behaviors, cultural norms and economic factors among women in the Republic of Cameroon West Africa. In order to explain the impact of HIV/AIDS among women in Cameroon, one has to first understand what is HIV/AIDS and how the disease is being transmitted from one person to another.

Overview of HIV/AIDS

HIV/AIDS is a communicable disease that affects individuals of all ages. The immunodeficiency acquired immunodeficiency syndrome (HIV/AIDS) is a sexually transmitted infection (STI). This illness has been described on the international level as an epidemic. Within the past 25 years, this disease has affected individuals across all age groups, ethnic, social, racial and socioeconomic classes (Reingold & Phares, 2001). It was first identified within the homosexual population and, in 1981, Michael S. Gottlieb made the discovery as a result of treating four homosexual men (Free & Brown, 2006).

Upon this discovery of the virus, Gottlieb submitted his findings to the Morbidity and Mortality Weekly Report through the Center for Disease Control (CDC). He later informed the private and public health sectors of his finding, which was published in the
New England Medical Journal describing the nature and transmission of this disease through sexual intercourse (Free & Brown, 2006).

Subsequent to Gottlieb making the discovery known, June 5, 1981 was recognized as the first significant milestone for the AIDS epidemic. During this same period, CDC announced a rare skin disease called Kaposi Sarcoma, which was related to HIV/AIDS. At this time, HIV/AIDS was only associated with specific groups, such as intravenous drug users, individuals with hemophilia, Haitians and homosexuals (Aragon & Kates, 2002). Researchers, such as Lue Montagnien and Robert Gallo, had isolated the Human Immunodeficiency Virus (HIV) by 1983. With this new discovery, it helped opened the doorway for the initial HIV Test in 1985 (Arogon & Kates, 2002).

Six years after the silence of the disease, in 1987, the then U.S. president Ronald Regan established a presidential commission, to address the HIV/AIDS issues. During this same period, the Federal drug Administration (FDA) approved an antiviral agent, Zidovudine (AZT), the first AIDS treatment, and condoms were also recognized as the primary means to prevent HIV/AIDS during sexual intercourse (Arogon & Kates, 2002).

In 1987, also, CDC led the first national conference, which focused on HIV/AIDS' impact on racial/ethnic communities. As a result of this conference, the African American community responded by forming The National Black Leadership Commission on AIDS and the National Minority AIDS Council (Arogon & Kates, 2002).

According to Arogon and Kates (2001), public policies encompassed the development of the office of AIDS Research through the National Institute of Health (NIH) by 1988. The office did acknowledge the role of intravenous drug use in the transmission of the HIV virus and the first comprehensive needle exchanged program
(NEP) was initiated in Tacoma, Washington; New York and the nation’s largest NEP emerged in San Francisco, California (Arogon & Kates, 2002).

Women were not involved in frontline issues as far as HIV/AIDS was concerned. But, by 1992, AIDS had emerged as the number one killer for both men and women between the ages of 25-44 years old. However, by 1993, the impact of HIV/AIDS was established; and the National AIDS Women Interagency HIV study was formed in collaboration with the HIV Epidemiology Study of Women and AIDS (HER) and the CDC’s HIV Epidemiology Study of Women and AIDS. A year later, NIH demanded the inclusion of women, as well as minorities, in clinical research (Arogon & Kates, 2002).

Transmission of HIV/AIDS

The HIV/AIDS virus infects the cells of living organisms and replicates new copies of themselves within those cells, which is one of the reason why an infected creature becomes ill (Avert Organization, 2007). Research further reveals that the human immune system usually finds and kills viruses fairly quickly. Thus, if the body’s immune system attacks and kills viruses, different viruses attack different parts of the body. Some may attack the skin, others the lungs, etc. The reason that HIV is rather dangerous is that it attacks the immune system itself, the very thing that would normally get rid of a virus. It particularly attacks a special type of immune system cell known as the CD4 lymphocyte (Avert Organization, 2007).

It has been reported that HIV has a number of tricks that help to evade the body’s defenses, including very rapid mutation. This means that once HIV has attacked the immune system, the body can never fully rid itself of the disease. When a person
becomes infected with HIV, they may look and feel perfectly well for many years and may not know that they are infected. But as the person’s immune system weakens, they become increasingly vulnerable to illnesses, many of which they would previously have fought off easily (Avert Organization, 2007).

A damaged immune system is not only more vulnerable to HIV, but also cannot attack other infections. The body becomes ineffective in fighting off illnesses and minor infections that, in the absence of the of HIV/AIDS disease, the body could have possibly fought off. The report further states that with time however, the person who has been infected with HIV is likely to become more ill often for several years even after the initial manifestation of the HIV/AIDS infection (Avert Organization, 2007).

Studies have shown that different countries have slightly different ways of defining the point at which a person is said to have AIDS rather than HIV. AIDS is an extremely serious condition, and at this stage the body has very little defense against the infection (Avert Organization, 2007). According to research in this area, HIV is found in the blood and the sexual fluids of an infected person, and in the breast milk of an infected woman. The transmission is said to occur when a sufficient quantity of these fluids gets into the infected person’s bloodstream. This occurs in a number of ways, such as having sexual intercourse without the use of a condom (Avert Organization, 2007).

In many parts of the world, particularly the United States of America (USA), the best form of safe sex is preached as no sex, also known as abstinence. Abstinence isn’t a form of sex at all, since it involves completely refraining from all sexual activities. Usually, young people are taught that they should abstain from all sexually activities until marriage and remain faithful to their partner. However, this practice works as long
as the husband or wife remains completely faithful to each other (Avert Organization, 2007).

Safe sex often means using a condom for sexual intercourse. This practice is said to make it hard for the virus to pass between people when they are having sexual intercourse. A condom, when used properly, acts as a physical barrier that prevents infected fluid from getting into the other person's body. Unprotected sex, for example, is only risky if one partner is infected with the virus. If a partner is not carrying HIV, then no type of sex or sexual activity between the two would cause the other to become infected (Avert Organization, 2007).

Global HIV/AIDS Infections

The United States of America was the first country to identify AIDS in 1981. Ever since, millions of people have become infected and by the end of 2005, half a million people had died from the disease (Avert Organization, 2005). In the United States alone, 40,000 citizens are diagnosed with AIDS every year. AIDS affects everyone in America, women, young old, black, and white, homosexual, straight, poor, and rich (Avert Organization, 2005).

Globally, early epidemic of HIV infection and AIDS were diagnosed in relatively few women. Most of the women who were infected at the time were not properly diagnosed and they got infected through injecting drugs especially in the United States of America (CDC, 2007). However, women accounted for 26% of the newly infected cases. The report indicated that HIV/AIDS was the leading cause of death among African women between the ages 25- 34 years old (CDC, 2007).
In the United States of America, there was an estimated 40,608 AIDS diagnosed cases within the 50 states and in the District of Columbia; 10,774 women were HIV/AIDS positive, which accounts for 27% of females living with HIV/AIDS (CDC, 2007). Data collected from all 50 states in the U.S. disclosed that an estimated 95,959 women were living with AIDS, and an estimated 4,128 women have died from this illness, representing 25% of women killed since the epidemic began in 1981 (CDC, 2007).

The communicable disease, HIV/AIDS, has dramatically affected the United States, and has been defined as a public health epidemic. Because of the prevalence throughout the world, HIV/AIDS has been recognized as a pandemic (Reingold & Phares, 2001).

According to the Henry J. Kaiser Family Foundation (2004), since the first cases of HIV/AIDS were reported in June of 1981, approximately 1.5 million people have been diagnosed with the virus, while 500,000 African American individuals have died. The research also revealed that HIV/AIDS has disproportionately affected the African American community.

African Americans suffered the lowest survival rate compared to racial/ethnic groups. They represent only 13% of the country’s population, with 49% of the HIV/AIDS cases, but they did account for 55% of the AIDS death tolls in 2002. In 2003, the African American rate of AIDS cases per 100,000 was 9.5 times that of European Americans (Henry J. Kaiser Family Foundation, 2004).

Meanwhile, European Americans were 69% of the population, with only 28% of the AIDS cases. However, simultaneously, Latinos/Hispanic, who were 14% of the
population, accounted for 20% of the estimated diagnosed AIDS cases. While AIDS was identified as the third leading cause of death for African Americans, AIDS was also identified as the sixth leading cause of death for Hispanic/Latinos and European Americans (Henry J. Kaiser Family Foundation, 2004).

Statistically, the African American females population was significantly infected with this disease. Between 1995 and 1998, 1 out of 60 African American females was diagnosed with HIV infection virus; as compared to 1 out of 3,000 European American females (CDC, 1999). Another study done by Mize, Robinson, Bockting and Scheltema (2002) revealed that, within the first 6 months of 1999, African American women accounted for 57% of all female AIDS cases reported in the United States.

By 2001, AIDS had emerged as the number one cause of death among African American women within the age range of 24-34 years old (Henry J. Kaiser Family Foundation, 2004). HIV/AIDS had invaded the African American community and, within three years, women accounted for 67% of the newly diagnosed cases as compared to 17% and 15% of new cases for Latinos/Hispanics (Kates & Carbough, 2006).

Between 1996-2000, nearly as many older Americans were diagnosed with HIV/AIDS as compared to young people who were in their twenties. Winningham, Corwin, Moore, Richter, Sargent, and Gore-Felton (2002) noted that existing data had established HIV/AIDS as a crisis within the older population 50 years and older, with the results of 10-11% cases diagnosed with AIDS.

African American women 50 and older have been disproportionately affected by HIV/AIDS. Approximately 52% of African American women, 50 years of age and older, were diagnosed with AIDS through December 2000. They represented only 11% of the
older females population in United States, meanwhile, senior African American women account for more than half of the AIDS cases among older women (Health Watch, 2002).

According to a research study by Emlet and Farkas (2001), most individuals believed that older persons were not at risk for HIV/AIDS. Efforts to execute HIV/AIDS prevention and treatment interventions had been negatively impacted by: (1) older patients’ difficulty in discussing their sexual activities with health care providers; and (2) health care providers’ failure to initiate discussions regarding safe sex practices with their geriatric patients (due to their own beliefs, perceptions and inexperience). Therefore, older citizens were less likely to be tested, which, in turn, delayed recognition of symptoms and treatment (Emlet & Farkas, 2001).

Globally, 39.4 million people were infected with HIV/AIDS and 3.1 million individuals had died from the illness in 2004 alone. Globally, by the end of 2002, 42 million people were living with HIV/AIDS, including 19.2 million women and 3.2 million children under the age of 15 (Avert Organization, 2005). Among the 39.4 million people living with the disease, there was a record number of 5 million newly infected cases and with these newly infected cases, 2 million were women and 800,000 were children alone (Avert Organization, 2002).

Thus far, an estimated 50% of the people living with HIV/AIDS are women, and they are several times more likely to contact this disease due to their biological differences as well as their socio-economic inequalities per some research experts. The reason for this increased likelihood is that women are vulnerable and do not negotiate the use of condom during sexual intercourse. Most women who are considered poor, have fewer economic options as compared to most men (Avert Organization, 2005).
Further findings revealed that 56 million people worldwide had died from HIV/AIDS in 2001. Of these, 10.6 million were children, 99% of whom lived in low and middle income countries. The report further stated that more than half of the children’s deaths in 2001 were attributed to acute respiratory infections (Lancet, 2006). Lancet further stated that malnutrition remains the leading risk factor health loss, and an estimated 45% of the global mortality and 36% of global disease burden were attributed to the joint hazardous effects of the 19 risk factors studies (Lancet, 2006).

Statistics further revealed that more than 25 million people have died from AIDS since 1981, and Africa only had 12 million orphans. Experts say that AIDS will continue to be the primary cause of death in the world, especially in Africa (Yufeh, 2007).

**HIV/AIDS in Sub-Saharan Africa**

Sub-Saharan Africa is made up of 38 countries and it is the continent most severely affected with the HIV/AIDS disease. And within this same region, East and southern Africa are the most affected within the sub-Saharan Africa. Despite all the rigorous campaign against HIV/AIDS in Africa, the prevalence continues to rise with a prevalence rate of over 7 million people infected since the epidemic began (WHO, 1992). Among the 40 million people who were living with HIV/AIDS globally, 70% are from sub-Saharan Africa (Lancet, 2002).

The first case of HIV/AIDS in Africa to have appeared in Uganda and Tanzania, shortly after the war in Uganda began from 1978 to 1979 (Lancet, 2002). While in Congo, Cameroon and Gabon, studies have shown that this virus had existed long before a name was given to its existence based on evidence found in these countries. And
because of this evidence, a name was given to the new virus called HIV-1 strains suggesting that there had been an earlier existence of the virus long before the world would know of AIDS (Lancet, 2002).

In the 1990’s, HIV-1 epidemic seemed worst in the Togo and Uganda, and, to a lesser extent, in neighboring countries in east and southern Africa (Lancet, 2002). This study by Lancet drew attention to the high prevalence, especially among young women in many parts of Sub-Saharan Africa. Lancet stated that 23% of women in Kenya, age 15 to 19 years old, were infected with HIV-1 and 3.5% for men in the same age group (Lancet, 2002).

Differences in the spread of the epidemic may be accounted for by the complex interplay of sexual behavior and biological factors that affect the probability of HIV-1 transmission per sex act (Buve, Bishikwabo, Mutangadura, & Lancet, 2002). In sub-Saharan Africa, sexual behavior patterns are determined by cultural and socioeconomic context. These types of traditions have contributed to the extensive spread of HIV-1 infections, which include the subordinate position of women, impoverishment and decline of social services, rapid urbanization and modernization, and wars and conflicts (Buve, Bishikwabo, Mutangadura, & Lancet, 2002).

In many parts of Africa, the population has become trapped in a vicious cycle as the HIV-1 epidemic, which leads to the high mortality rates among young and economically productive age groups, and thus, leads to further impoverishment. Lancet and his research partners suggested that interventions to control HIV-1 should not only target individuals, but should also seek to change those aspects of cultural and
socioeconomic contexts that increase the vulnerability of people living in communities with HIV-1 strains (Buve, Bishikwabo, Mutangadura, & Lancet, 2002).

According to Lancet, in sub-Saharan Africa, HIV-1 prevalence was 8.4% as compared to only 1% in other continents, except the Caribbean regions with 2.2% (Lancet, 2002). The continuous rise of HIV/AIDS in some areas, within the sub-Saharan nations, is due to some cultural myth. For example, in sub-Saharan Africa, men have multiple partners. This gives them an upper hand to exercise power at all levels, including sexual activities (Moore & Williams, 2005).

In many parts of sub-Saharan Africa, extramarital affairs by both sexes are tolerated. However, most of the rules also require that women have very little sexual experiences before marriage and are monogamous; whereas, for men, premarital sex is expected. As a result of these traditional norms, women, especially those that are married, are highly vulnerable to HIV-1 infections (Buve, Bishikwabo, Mutangadura, & Lancet, 2002).

Wives are not allowed to withhold sex from their husbands, or to use condoms, even if the husband is infected with HIV/AIDS. The subordinate positions of women also have implications for safe sex education. The traditions also dictate that men are supposed to know everything and cannot admit ignorance; whereas, women, on the other hand, are not supposed to be aware of issues related to sex (Buve, Bishikwabo, Mutangadura, & Lancet, 2002).

These women within the sub-Saharan African nation face restrictions, such as discriminatory laws, traditions, and values when they access education, knowledge, land, capital, and employment. As a result, women are economically dependent on their male
partners, which makes negotiation of safe sex difficult (Buve, Bishikwabo, Mutangadura, & Lancet, 2002).

In this same study, it was reported that, for women who are unmarried and women who are widowed or separated, sex in exchange for money could be a strategy for survival or acquisition of goods. These researchers reported that 40% of women in Kisumu and Ndola who reported non-spousal partnerships in the previous year, stated that they had exchanged sex for money or gifts, and this was a corresponding figure for Cotonou and Yaounde where 6% and 14% of the women also reported that they have exchanged sex for money and gifts, as well (Buve, Bishikwabo, Mutangadura, & Lancet, 2002).

A study conducted by Moore and Williams (2005) in Togo found that men do have the option to practice polygamy or have mistresses outside the marriage. This makes it very difficult for women who, in most African nations, are expected to be submissive to their men and are, therefore, unable to bargain for safe sex with their husbands or partners. Their only hope would be that these men are not HIV positive (Moore & Williams, 2005).

Moore and Williams also found that economic factors lead women in sub-Saharan Africa to engage in risky sexual behavior, such as having unprotected sex with men, regardless of their knowledge of HIV/AIDS awareness. As well, findings further revealed that these women engaged in risky sexual behavior due to the lack of socio-economic means in order to gain most needed resources (Moore & Williams, 2005).

In Africa, young people who grew up in poor conditions have little access to schools and few prospects for their future. They lack recreational facilities and sex
becomes a way to pass time (Buve, Bishikwabo, Mutangadura, & Lancet, 2002). Poverty has also driven women into exchanging sex for money, food and other commodities as stated earlier. As a result of this poverty, these individuals are force to migrate from rural areas or cities in search of work, leaving their family and entering an environment where sexual risk taking are common (Buve, Bishikwabo, Mutangadura, & Lancet, 2002).

According to Plummer (2006), most people living with HIV/AIDS have neither a biomedical diagnosis nor antiretroviral medication, which leads to the question of how these individuals would manage and treat this illness. He found that young girls in Tanzania delayed or avoided seeking treatment due to the stigmatization or the interference of cultural belief of witchcraft. However, when these young women decided to get any type of help, they preferred Health Clinics due to familiarity, trust, accessibility, expense, and payment plans for the medications (Plummer, 2006).

A study on microbiocides, conducted by Stadler, Delany, and Mntambo (2008), revealed that HIV/AIDS and sexual risk could have profound implications in shaping community responses to clinical trials because it does affect the enrollment and retention of participants (Stadler, Delany, & Mntambo, 2008).

According to the latest report issued by the World Health Organization (WHO) and the Joint United Nations Program on HIV/AIDS (UNAIDS), the number of patients with HIV infections in low and middle income countries receiving antiretroviral (ART) treatment has increased from 400,000 in December 2003 to 1.3 million in December 2005. The report stated that lessons should be learned in order to guide future global efforts to provide universal access to treatment by 2010 (WHO, 2006).
According to the most recent findings by Lancet and her research group, in Uganda, the prevalence of HIV-1 infection has fallen since early 1990, which has attributed to changes in sexual behavior. Lancet also stated that more recent, similar declining trends in HIV-1 prevalence have been noted in Zambia. However, in other parts of southern Africa, the epidemic continues to spread unabated with the worst affected country so far being Botswana, where an estimated one in every three adults are infected (Buve, Bishikwabo, Mutangadura, & Lancet, 2002).

HIV/AIDS in Cameroon

Cameroon is identified as one of the sub-Saharan African nations with the existence of the HIV-1 strain virus. This means that there had been an existence of the identified virus long before it would be known around the world as HIV/AIDS (Lancet, 2002). According to studies done in Cameroon, poverty, migrations, sexual abuse of young girls, traditional practices and women depending on men for economic support help to foster the spread of HIV/AIDS within the Cameroonian community (Kaptue, Tagne, & Kenmogne, 2002).

According to Lancet, et al., in the Democratic Republic of Congo, Cameroon, and Gabon, HIV/AIDS-1 prevalence has remained fairly stable for many years, and only recently has a worrying increase in prevalence in Cameroon suggested that the epidemic is entering a new phase (Buve, Bishikwabo, Mutangadura, & Lancet, 2002).

In 1999, HIV-1 prevalence among adults in Cameroon was estimated at 7.75%, and in 2000, a prevalence of 11% was noted in a nationwide survey of pregnant women. This relatively slow and recent increase contrasts with the situation in many parts of east
Africa and most of southern Africa where the HIV-1 epidemic has run an explosive course since the early 1990s. Meanwhile, in many large cities in Cameroon, HIV-1 prevalence in pregnant women has exceeded, and still exceeds, 25% (Buve, Bishikwabo, Mutangadura, & Lancet, 2002).

A study conducted by Nathan Wolfe (2003) from John Hopkins University reported that in Cameroon, HIV genetic diversity emerges not only through the cross-species transmission of entire simian immunodeficiency virus (SIV) genomes, but also through the emergence of individuals' genes or genomic segments during the recombination of events between nonhuman retroviruses and the fully human adapted virus HIV-1 (Wolfe, 2003).

Another study by Nyambi reported that the SIV and HIV-1 viruses are found in Cameroon. The study revealed that, due to the genetic diversity in Cameroon, the recently introduced SIV/HIA-1 strains could be evolving separately in small and remote communities before spreading and further evolving in urban centers where the human genetic environment consists of a composition from various groups and locales (Nyambi, 2003).

In the Republic of Cameroon, scientists detected the first human cases of two retroviruses between two people in rural Cameroon who hunt monkeys and other primates (Kaiser, 2005). This discovery came as a result of a study conducted on 930 residents in Cameroon who were in frequent contact with monkey meat. The findings indicated that there has not yet been any direct link of this Human T-cell Lymphotropic Virus (HTLV-3 or HTLV-4) transmission from human to human (Kaiser, 2005).
According to the Center for Disease Control (CDC), about 22 million people worldwide have the HTLV-1 virus which is known to cause leukemia and inflammation, or the HTLV-2 which has been linked to neurological problems. The CDC further reports that about 5% of people infected with HTLV-1 or HTLV-2 develops related illness; and, although HTLV-3 and HTLV-4 have not been associated yet with disease among people, the HTLV viruses like HIV could have an incubation period that would last for decades just like the HIV infection that first put AIDS virus into human beings (Kaiser, 2005).

In Cameroon, there have been out cries to stop the exploitation of women in the country as guinea pigs for drug testing. Exploitation by a U.S. pharmaceutical company has been conducting a clinical trial on an anti-AIDS drug using 400 sex workers who were free of the HIV/AIDS infection virus. During this trial of the drug, half of the women were given a daily pill of Tenofovir, and the other half a placebo. In order to see the effectiveness of the drug, the participants were encouraged to have unprotected sex with their partners and to be retested. To make matters worse, the pharmaceutical company refused to offer any drug treatment for women who became HIV positive (Makiniki, 2005).

The reason given by the company for non-compensation was that it would compromise the study as being an inducement to take part of the study. However, the company did give three dollars for each participant as a sign on fee, but most of the women did not know what they were becoming involved in and many thought they were getting a drug to protect them from HIV/AIDS infections (Makiniki, 2005).

With an estimated population of 18 million people living in the Republic of Cameroon, 6% were infected with HIV/AIDS (USAIDS, 2004). According to the
Ministry of public health in Cameroon, the first reported case of HIV/AIDS was reported in 1986 (USAIDS, 2004). Among the seropositive, there are two men to every three women, the ratio is said to be higher in urban areas than in rural areas (Ntangsi, 2005).

According to Ntangsi, in response to the growing social and economic threat of the epidemic, the government in Cameroon launched the strategic initiative to fight against HIV/AIDS in Cameroon. This was included in the Cameroonian National Plan of 2000-2005. The purpose of this project was to achieve a collaborative effort between the national government and the different provinces in Cameroon to fight the epidemic. HIV/AIDS has become a social issue that affects the entire world's population. This is one illness that is not immune to a particular group or genetics. It affects every one when the right preventive methods are not used (Ntangsi, 2005).

Research indicates that the high level of poverty, unemployment and inadequate family support system or government welfare support have been instrumental in widening the spread of HIV/AIDS in Cameroon. The entire population has become vulnerable to contracting the disease. The related feelings of worthlessness, desperation and helplessness in the face of the deadly new disease — HIV/AIDS — has only made the matter worse (Ntangsi, 2005).

According to Nyambi, all different groups of HIV/AIDS are found in Cameroon. Due to the genetically diverse population in Cameroon, with more than 250 ethnic groups, there is infection of multiple HIV groups or subtypes, or recombinant viruses that have been documented in urban areas of Cameroon; yet, little is known of the evolution of these viruses (Nyambi, 2004).
In Cameroon, most deaths are from HIV/AIDS among young adolescent who are still in their prime. HIV/AIDS has become a public health problem that poses social, cultural and economic problems to immediate family and the communities at large. According to Ngufor, the national HIV/AIDS prevalence rate in Cameroon is 5.5%, with a prevalence rate of 6.8% among women and 4.1% among men. She further elaborated that, between the ages of 15 and 19 years old, two girls out of every 100 are HIV positive, while for boys, one out of every 100 is HIV positive (Ngufor, 2006).

Ngufor also stated that between the ages of 20 and 24, 8 girls out of every 100 were HIV positive and for boys in the same age group, 5 boys out of every 100 are HIV positive. These figures indicate that there is a threat to the Cameroonian population and especially a threat to the increasing number of women infected with HIV/AIDS.

In Cameroon, about 55% of the inhabitants live in rural areas, with an adult literacy rate of below 40%. This is particularly difficult with regards to the dissemination of written information. In addition, more than 80% of the rural areas in the country lack access to a television or radio to obtain new information relating to HIV/AIDS for those who cannot read due to high illiteracy (Ngufor, 2006).

In the Republic of Cameroon, the private sector is the dominant sector of the economy, contributing 65-85% of the employment opportunities. In view of the fact that agriculture is one of the major components of the Cameroonian economy, and that Cameroonian women cultivate most of the cash crops that are used for food, the economy is presently suffering as a result of the AIDS epidemic. These women lack basic knowledge on how to stay protected or how to live with the disease, if infected (Ntangsi, 2005).
The spread of HIV in sub-Saharan Africa is believed to be driven by unsafe sex and a modifiable risk factor of the latter is needed for comprehensive HIV prevention. Some previous studies had suggested an association between alcohol abuse and behavior, such as multiple concurrent sexual partners and inconsistent spousal non-cohabiting partners (Shey, 2007).

A Brief History of Cameroon

Cameroon is located on the west coast of Africa in the Gulf of Guinea. Due to its complex cultural diversity, it is sometimes referred to as “Africa in Miniature.” Cameroon has an estimated population of about 18 million people with some 250 ethnic groups, making it a racial crossroad in Africa. Cameroon is the only African country that has two official languages, French and English. It holds a record of political stability within the sub-Saharan African nations with no major coup d’état since obtaining it’s independence from England and France in 1960 (Ntangsi, 2005).

After World War two (WWII), political parties started to emerge in both the French and British sectors of Cameroon. Most of the political parties demanded independence and some wanted the two parts of the country to be united. Other movements in British Cameroon aspired to join (English-speaking) Nigeria. In 1955, a revolt started in the major towns of French Cameroon. The uprising was organized by Union des Populations Camerounaises (UPC). The revolt was minimized by the French with the loss of several hundred lives and massive destruction in the towns. These events only triggered more violence by the UPC and a growing demand for independence (Ntangsi, 2005).
In 1956, the French government banned the UPC. The party continued as an illegal freedom movement. During the same period, Ahmadou Ahidjo formed the party l'Union Camerounaise. He became prime minister of the Assemblée Legislativedu Cameroun in 1958 and worked closely with the French system, but called for complete independence and reunification of the two colonies (Ntangsi, 2005).

Ahidjo proclaimed independence of the Republic of Cameroon in the former French Cameroon. On January 1, 1960, he was inaugurated as president and started working to reunite the British and French territories. From 1961-1963, frequent riots and uprisings were stopped with help from French military. In May 20, 1972, the federal structure was dissolved and a new constitution was developed with the formation of the United Republic of Cameroon (Ntangsi, 2005).

During 1973, saxophone player and singer Manu Dibango released the album "Soul Makossa." The music was influenced by jazz and soul, but did not have much to do with traditional Makossa from Cameroon. The album was a hit and paved the way for more exportable dance rhythms from Cameroon.

With success, Ahidjo developed agriculture in Cameroon and then focused on industry in 1970. This development, together with the discovery of oil, made way for economical and political stability. The country was rich in natural resources (oil, cocoa, coffee, timber) and had fertile soil. Cameroon did better than most of the neighboring countries and was a favorite of the European governments.

Under President Ahidjo, human rights abuses and political arrests were mostly ignored or tolerated. Ahmadou Ahidjo, like many other African presidents, held power and became unwilling to make way for reforms and true democracy. Corruption grew in
Cameroon. In November 1982, Ahidjo suddenly stepped down from office and left his post as president. The reason that was circulated was bad health (Ntangsi, 2005).

The then Prime Minister, Paul Biya, who was 49 years old at the time, took over the presidency. The people of Cameroon started experiencing a new side of Paul Biya, which emerged with his increased power in 1983. Biya fired several members in his government on the pretext that they had plotted to overthrow his government. Paul Biya remains the president of the country, having held power for twenty-five years (Ntangsi, 2005).

Women in Cameroon

Sexuality is an area that has long attracted sociologists and anthropologists, as well as demographers, because of the identified relationships between sexual behaviors and certain reproductive health problems (Mburano, 2000). Notwithstanding the massive prevention efforts, AIDS continues to pose a serious health problem and threatens the Cameroonian population. New accounts of public denial of HIV/AIDS continues to stand in direct contradiction to published evidence of change in certain behaviors and practices among Cameroonians (Jipguep, 2001).

Mutapola is the name of a woman being used by the campaign to give a human face to the sufferings and struggles of women and girls infected and affected by the HIV/AIDS pandemic. The name continues to be used to represent the plight of all women and girls who are in need of treatment and comprehensive care. On December 1, 2004, Action Aid, which relocated its headquarters from London to Johannesburg, launched a campaign called ‘The Mutapola’ to coincide with World AIDS Day. In Cameroon, the
Martin Luther King, Jr. Memorial Foundation (LUKMEF) was commissioned by Action AIDS/International Partnership Against AIDS in Africa (IPAA) to carry out preliminary groundwork to launch Mutapola in Cameroon from July 25, 2005 to September 9, 2005.

This campaign provided the opportunity to focus on HIV/AIDS and to put women and girls at the center of the response. It was used to affirm the inalienable rights of women. It was used to question the relevance of current development practices and questioned whether they addressed the key issues about HIV/AIDS, and whether they, in fact, perpetuate the status quo and further entrenched women's discrimination and exploitation (Mpoundi, 2005).

Historically, women have always been treated as second class as compared to men, especially in the developing country. In Cameroon, for example, a man can marry more than one wife, which is part of the tradition as previously stated. Women are sometimes treated as a man's property. The high poverty rate in Cameroon has, thus, helped to place some women in precarious positions where they often compromise themselves and, thereby, increase their chances of being infected with the disease by doing any thing that would help make ends meet, or trying to keep the relationship together by dancing according to their male partners tunes (Mpoundi, 2005).

As poverty continues to be a major factor for women in Cameroon, it is evident that these women continue to engage in risky sexual activities, which only increase the spread of HIV (Mpoundi, 2005). Although some of these women could be empowered and taught how to cultivate their own crops or learn skills that would render them functional in the society, and eventually become independent, it is not clear if that will
provide them the incentive or means of helping them avoid their risky sexual involvement with men who, in some cases, are much older than them (Gruber, 2006).

The sugar daddy syndrome is a phenomenon called the “cross generation sex,” aimed at a non-marital sexual relationship between partners with at least a ten-year age difference (Luke & Kurtz, 2002). The Population Services International (PSI) is currently campaigning in Africa, including Cameroon, to decrease cross-generational sex by empowering young women to say no to dangerous sexual relationships and changing societal view of the practice (Luke & Kurtz, 2002).

This study was conducted as a result of PSI’s research records of sexual partners in sub-Saharan Africa which revealed that 12% to 25% of young women’s sexual partners were at least ten years older. As a result of this practice, more than one-third of teenage girls in some regions of eastern and southern Africa are living with HIV (Luke & Kurtz, 2000).

According to a study conducted in Togo, which has the same cultural characteristics as Cameroon, the sugar daddy syndrome is very much alive and continues to be a part of the societal norms. The women from Togo, because of their economic status, sometimes date older men, or date outside of their relationships with regular boyfriends, to procure valued amenities (Moore & Williams, 2005).

By the definition of these types of practices, these women are not considered as prostitutes as defined by westerners, but these women do play a particular social role due to economic exigencies (Moore & Williams, 2005). During these types of situations, it has been noticed that women do not have the latitude of imposing the use of condoms for
safe sex practice, especially if their partners are unwilling to wear condoms (Moore & Williams, 2005).

A study conducted in Togo revealed that men have autonomy that women lack, with greater financial independence. Therefore, women are in greater subservient positions that do not allow them to negotiate sexual activities, but merely to accept or refuse sexual intercourse (Moore & Williams, 2005). Women in Togo, as well as women in Cameroon, do not have the possibility to negotiate the use of condoms. Polygamy is acceptable when a man has more than one wife or sexual partner, as this becomes a sign of virility. Meanwhile, when a woman has more than one partner, she is considered a slut. This type of practice does not help in combating the widespread infection of HIV/AIDS (Moore & Williams, 2005).

In Cameroon, a similar study was conducted and the findings revealed that older men seek status and prestige among their peers by having young girlfriends; a practice motivated, in fact, by the belief that these young women are cheaper (Gruber, 2006). The findings also revealed that financial gain was the biggest incentive for women to engage in cross-generational relationships. According to Gruber, mothers have been known to encourage this type of relationship so that their daughters could earn money to help support the family. He further noted that the Cameroonian society appears to be in acceptance of this type of practice (Gruber, 2006).

Rarely mentioned among Cameroonian women is the breast ironing which involved the disappearing of this sexual organ by using a hammer or spatula that has been heated (Ndonko, 2006). A campaign launched by the German agency, GTZ, and the local nongovernmental support for young mothers has warned that using this practice is
dangerous and it is not working in the manner in which it was meant to accomplish (Ndonko, 2006).

According to Ndonko’s report, the main objective for breast ironing was to protect young girls from being noticed by men, especially with the HIV/AIDS epidemic. The report disclosed that young people comprise 5.5% of the population with HIV, and teenage pregnancy has become a growing concern within the communities in Cameroon (Ndonko, 2006). Topics regarding sex are considered taboo and these young girls remain ignorant of how to appropriately protect themselves from HIV/AIDS (Ndonko, 2006).

There are some good examples of how women in the Republic of Cameroon could mobilize and help decrease the widespread infection of HIV/AIDS. Takumbeng and the Anlu women’s traditions groups in the North-West Province of Cameroon is a case in point. The Takumbeng women made their appearance on the Cameroon political scene in the 1990s to reinforce the ghost town and civil disobedience campaigns aimed at expanding their role and position in the country’s democratic process. They barricaded the residence of the main oppositional leader, John Fru Ndi, whose life was in danger in the aftermath of the October 1992 presidential elections in Cameroon, in which the oppositional leader had apparently won (Gruber, 2006).

These women set up twenty-four hours guard, rotating every twelve hours. These women stripped naked, knelt down and held out their breast long as a sign of women’s power (Awasom, 2002). These women were able to throw their weight behind their leader and, as a result of their actions, prevented Mr. Ndi from being arrested by government officials. Meanwhile, history had been made prior to the Takumbeng incident.
Cameroonian women had shown, even much earlier, their force of power during the country’s colonial rule when the Anlu women in the North West Cameroon launched a three-year period of revolt from 1958 to 1961, which was then known as the Anlu rebellion. This incident was provoked by the colonial imposition of vertical contour farming. The women protested through public singing, verbal insults, dancing and demonstrating in public and seizing control of resources. These women signaled the intensification of their anti-colonial protest and seized political power from the Kom men during the three-year struggle of power to gain control of their land (Tadesse, 2002).

As shown by the two groups of traditional women and their leadership strength, women in Cameroon could use these examples of women’s power to educate their fellow women to protect themselves from the HIV/AIDS epidemic. They could do so by talking openly about safe sex and the use of protections by their partners/husbands. Reinforcement along these lines coming from influential women’s group would help to bring a much more positive message, as well as help in preventing the widespread infection of this disease among Cameroonian women.

The likes of these types of influential groups of women are in a much better position to address any sexual issues and bring a stop to the silence surrounding sexuality in most African cultures. Strong messages about sex coming directly from influential women’s group will help encourage more women to carry out discussions on sexual topics and diseases associated with it. It would, hopefully, also begin to help them learn about ways to prevent contracting and transmitting this disease and subsequently would eventually decrease the widespread transmission of AIDS.
Sexual Behavior of Women in Cameroon

In the Republic of Cameroon in West Africa or within the African continent, there is no set definition of sexual behavior. Some nations have used protective sexual activities, unprotected sexual activities and the role of male and female in what they constitute as sexual behavior per research findings. Inequities exist between men and women with respect to their number of sexual partners in industrialized countries and developing nations (Lancet, 2006).

Men and women in Australia, France, Britain, and the United States tend to report the same number of sex partners, whereas in Cameroon, Haiti and Kenya, men tend to have multiple partners while women usually only have one; an imbalance that could have significant public health implications (Lancet, 2006). Lancet stated that in countries where women are beholden to their male partners, they are likely not to have the power to request condoms use, and they probably would not know about their husbands' transgressions. Lancet warned that, as a result, due to the diversity of sexual habits worldwide, no uniform approach of sexual behavior will work everywhere (Lancet, 2006).

For example, in the Republic of Cameroon, polygamy is an acceptable tradition where a man can marry more than one wife. In a polygamous union, the man and his multiple wives may live in the same household or live in separate linked households. A linked household is one in which the husband has wives living in more than one compound (house). Consistent with other research, some women are now concerned about their husband’s risk related behavior as influence on their HIV/AIDS knowledge (Beyond, 2004).
Even though there are no direct studies done in Cameroon regarding polygamous marriages, there is a study that was conducted in Uganda, which is an African nation just like Cameroon that also practices polygamy. According to Beyond, a new finding revealed that women in polygynous unions are now concerned about their co-wives’ behaviors (Beyond, 2004).

Mishra Vinod (2007) conducted a study regarding husband’s wives and AIDS in eleven African countries. The findings revealed that in four of the eleven countries, women were the infected partner in the majority of the cases. The result was true in 62% of the couples living in Ivory Cost, Kenya, including Ethiopia and Cameroon, the prevalence was high because the women were becoming infected from a person other than their husband (Vinod, 2007).

Mpoundi (1996) explored the perception of the Cameroonian women's behaviors as they related to HIV/AIDS and their dependence on their sexual life to prevent HIV transmission. Mpoundi used a focus group discussion and randomly selected 30 groups in 10 sites, with a total of approximately 900 individuals. In the study, each site provided 3 focus groups of younger women, 2 of older women, 1 of married men and 1 of single men. A trained moderator, in local language, led each focus group and each speaker was identified by an anonymous code.

The results from the study indicated that about 60% of the women in the target population had average knowledge on HIV infection. They knew more about STD’s and sought information in the health centers, which they perceived as most credible. However, 90% of the women in the study were not convinced that they possessed the power to prevent the transmission of HIV infection because of the norms of behavior
governing sexual encounters of women and their partners, in the Cameroonian culture (Moundi, 1996).

According to Moundi, the only strategy to influence sexual behavior in the whole population would be through education and to send information through community outreach workers, and mass media in local language, about clinical features of HIV/AIDS transmission and prevention. In conclusion, Moundi recommended that it seemed obvious that more information and sensibility about AIDS, integration of the debased condition of women in local development areas, and AIDS programs will increase their responsibilities in the household and certainly alter the risky sexual behaviors (Moundi, 1996).

Cultural Norms of Women in Cameroon

As stated earlier in the study, there are no set definitions of sexual behavior within the African or Cameroonian culture. This same theory applies to the definition of cultural norms in Cameroon. Due to the diversity of the various ethnic groups and the 250 different languages in Cameroon, each tradition is detected by norms set by the guidelines and regulation of the roles governing the villages.

According to Ian Harris (1994), cultural background surely plays a part in shaping identity, but it does not determine identity. Cultural background may well create differences that must be honored; it may also occasionally style an orientation that must be understood, or give rise to tastes, values, even prejudices, that must be taken into account (Harris, 1994).
In most communities in Cameroon, traditional norms mandate that rural women fulfill the reproductive roles of child bearing, home management and food provision for the family. Thus, most Cameroonian women are unable to exercise any influential economic voice because they can hardly earn incomes. Cash agriculture, like rice production, provides a possible outlet for the empowerment of these women in rice producing areas. However, this agricultural work would solve one problem for the women and create another. Any attempt to encourage women to work outside their homes may increase their workload and would not be accepted by their partners (Lotsmart, 2007).

In many African countries, according to United Nations Program on HIV/AIDS (USAIDS), women do not have the same property rights as their men (Avert Organization, 2007). It is stated that in sub-Saharan Africa, men typically own property and even when married, their wives still do not have the rights to their property. In a situation where the husband dies, his property goes to his side of the family and the wife has no right to inherit his belongings. This type of practice would help to increase the women’s vulnerability to HIV/AIDS due to the lack of economic stability and limited resources to serve (Avert Organization, 2007).

Another cultural norm and practice that helps to spread the HIV/AIDS among the identified population is men not willing to wear condoms because of the belief that sex without condoms is equated with masculinity and a strong association of unfaithfulness, lack of trust and love between the couples (Avert Organization, 2007). In cultures where virginity is a condition for marriage, girls protect their virginity by having anal sex with
the belief that their virginity is still intact and most importantly they would not contract HIV/AIDS since they did not have sex vaginally (Avert Organization, 2007).

In most communities, HIV/AIDS has been a pandemic as Africans face a large number of deaths weekly. In Cameroon, and many parts of Africa, the deaths of AIDS patients have often been linked to witchcraft. The assumption posed by someone is that black magic is the cause of all the illness and deaths in the community (Balbina, 2005).

In Cameroon, much has been done to educate the population on the methods of transmission and the management of the symptoms of this illness, but the society continues to be resistant and believes HIV/AIDS is the result of witchcraft, and very little has been done to protect themselves from acquiring the disease (Balbina, 2005).

In a society such as Cameroon, a women’s life has always been structured around her children. Historically, women have been linked to dual oppressions, gender as well as racial and ethnic discrimination. In Cameroon, when a man dies, his widow is inherited by his brothers or close male relatives. Wife-inheritance is closely linked to the bride’s wealth paid by the man upon marrying the woman. The bride’s price effectively signals that a woman becomes the property of her husband and his clan. Wife inheritance greatly facilitates the spread of HIV/AIDS and has the potential of infecting several families very rapidly. This occurs in cases that the husband is infected prior to his death, and the late husband’s brother inherits the widows. The individual who is put in such a position is in high risk of not only getting the HIV/AIDS infection, but of infecting his other wife or wives. If any of the late widows had children, they may also be infected with HIV (Ntangsi, 2005). Leaders of some African nations, once unable to acknowledge the
presence of HIV/AIDS, now publicly address HIV prevention and have appointed various task forces to mobilize and coordinate efforts against the epidemic (Tawa, 1999).

Economic Factors of Women in Cameroon

In order to get a better understanding of the economic factors regarding the women in Cameroon, one has to first analyze how the economy is defended or measured. Among some of the earliest and most famous definitions of economics, was that of Thomas Carlyle, who in the early 19th century termed it the “dismal science” (Schenk, on-line). According to Carlyle, many people believe that a society of abundance without conflicts is possible (Schenk, on-line).

Meanwhile, Alfred Marshall’s principles of economics define economic as a study of mankind; in the ordinary business of life it examines that part of individual and social action, which is most closely connected with the attainment and use of the material requisites of well-being. Thus, it is on the one side a study of wealth, and on the other, and more important side, a part of the study (Schenk, on-line). This definition is in line with the economic perceptions in Cameroon or within the African context that equates economic status with education and income.

Agriculture is the mainstay of the Cameroonian economy, accounting for a large portion of production and a majority of employment. In Cameroon, nearly 45% of HIV positive individuals are between fifteen and thirty-four years old (Ntangsi, 2005). In 2005, Memfih responded to the growing social and economic threat of the HIV/AIDS epidemic to the population, by stating that HIV/AIDS is felt first by individuals and their families, then by firms, businesses and the macro-economy. The impact in the household
begins as soon as a member of the household starts to suffer from HIV/AIDS related illnesses. The loss of a few workers at the crucial period of planting and harvesting thus significantly reduces the size of the harvest in the season which the employees get sick (Ntangsi, 2005).

HIV infected men or women would be unable to engage in agricultural activities as they grow weaker and eventually abandon the farms. Once this happens, the affected family immediately becomes a burden to other relatives who may also be sick, but on a much lesser level. According to Jipuep, Cameroon’s stagnant economic growth also could be another important factor behind the spread of the epidemic among specific populations as stated earlier in the study. The poor economy makes it difficult for young people to marry and form stable relationships. In addition, economic constraints also push many young women into commercial sex or to exchange sex for food and services (Jipuep, 1995).

In the United States of America, studies indicate that risk occurs commonly among socioeconomic challenged women (Center for Disease Control, 1991). According to Barker and Cummings, there is a direct correlation between socioeconomic status and risky sexual behaviors. Their samples included 150 low-income African American women. An overwhelming number of African American women infected with HIV/AIDS in the study were poor, not well educated, and lacked connection to community resources and health care (Cochrane & Mays, 1993; Poppen & Reisen, 1994).

In addition, another key factor that contributes to risky sexual behavior among African American women, just like the Cameroonian women, is that they are economically dependent on their sexual partners. This economic dependency leads to
fear of jeopardizing the relationship and keeps these women from exercising their rights to protect themselves (Peterson & Martin, 1998).

In Cameroon, women continue to perform domestic tasks as well as working outside of the home, without having any boost to their status (Nana-Fabu, 2006). Stella Nana-Fabu stated that most women in Cameroon are subsistence farmers; others are self-employed in the informal sectors as dressmakers, petty traders, domestic servants and prostitutes. These women lack the chances of acquiring substantial wealth due to limited access to critical resources to enhance their businesses, such as bank loans (Nana-Fabu, 2006).

Theoretical Framework

In order to explain why women in Cameroon participate in risky sexual behavior, it is important to review and examine the theoretical framework for this study. The effectiveness of behavioral interventions to reduce HIV/AIDS disease transmission is dependent upon the incorporation of the Theory of Reasoned Action and the Feministic Theory of Empowerment. The Theory of Reasoned Action was developed by Ajzen and Fishbein, (1980), and is a cognitive learning theory that is used to explain how a person makes certain decisions.

It has been used to explain health-related behaviors such as cigarette and marijuana smoking (Ajzen & Fishbein, 1980). This theory suggests that a person’s behavior is directly related to their intention to perform that behavior and that intention may be influenced by perceived consequences, social norms, attitudes, and self perceptions (Ajzen & Fishbein, 1980). For example, a woman’s decision to participate in
sexual behavior is influenced by what she considers as her perceived consequences, social/cultural norms, economic status, attitude, and self-perceptions. Furthermore, it is important to note that the act of participating in sexual behavior is the observable result of the cognitive process that has taken place prior to any decision.

The Theory of Reasoned Action suggests that intentions are based on perceptions of social pressures and that these intentions can be influenced by any of the groups that a person identifies with. Some of these groups may include parents, partners, church members, family, and friends. For example, a woman's decision to use a condom may be related to her perceptions of what her partner wants or feels about using a condom. The portion of the theory that is most integral to this study is the concept, which states that in order to change behavior, the model components that influence decision-making must be addressed. For the purpose of this study, it was hypothesized that sexual behavior, cultural norms, and economic factors and HIV/AIDS knowledge are the model components that needed to be addressed in effort to influence sexual behavior change among women in Cameroon.

Another theory that was applied to this study was the Feminist Theory of Empowerment. The theory, which is in line with the behavior among the women in Cameroon, involves a process by which individuals and groups gain power, access to resources, and control over their own lives (Robbins, Pranab & Edwards, 1998).

In doing so, the individuals or group gain the ability to achieve their highest personal and collective aspiration and goals. The empowerment theory is based on the idea that society consists of stratified groups possessing different and unequal level of power and control over resources (Robbins, Pranab, & Edwards, 1998).
This theory helps to explain the struggle among the women in Cameroon who subject themselves to men for the acquisition of needed resources. These barriers include, for example, the unequal distribution of wealth and power inherent in postindustrial economies, as well as the effects of prolonged powerlessness on oppressed and marginalized individuals and groups (Robbins, Pranab, & Edwards, 1998).

The feminist theory is also used in this study to help analyze and understand specific ways women think and act to achieve women’s liberation, thereby eliminating the oppression of women in society (Robbins, Pranab, & Edwards, 1998). The theory stresses the need to identify and name those attitudes, expectations, languages, behaviors and social arrangements that have contributed to the oppression and marginalization of people (Robbins, Pranab, & Edwards, 1998).

Summary

Findings from the literature show that there is a crisis in the Republic of Cameroon with an increasing number of people, especially women, infected and dying from HIV/AIDS epidemic (USAIDS, 2004). Some studies have shown that HIV/AIDS education information alone does not appear to prevent or discourage women in Cameroon, from their decision to participate in sexual activities. People in Cameroon practice polygamy, whereby one man can marry more than one wife. Most studies conducted regarding HIV/AIDS show that women are still the only group that continues to show an increase rather than decrease in the HIV/AIDS diagnosed cases. Of the overwhelming majority of people with HIV, some 95% of the global total, live in developing countries (USAIDS, 2004). Sub-Saharan African is by far the worst affected
in the world by the AIDS epidemic. The region has over 10% of the world’s population, but is home to over 60% of all people living with HIV (Avert Organization, 2004).

This chapter reviewed existing literature related to this study, as well as discussed the limitations of the literature. The variables discussed included sexual behaviors, cultural norms, and economic factors and HIV/AIDS knowledge, as they relate to sexual behavior among Cameroonian women. The chapter also presented a discussion of this study’s hypothesis and it’s theoretical framework. The following chapter will provide a discussion of the methods to carry out the study.
CHAPTER III
METHODOLOGY

Chapter III presents the methodology that was used to carry out the study. The following are described: research designed; description of site; sample selection and population; instrument; treatment of data, and limitations of the study.

Research Design

A descriptive and explanatory research design was employed in this study. The study was designed to obtain data and information to describe and explain the perception of HIV/AIDS relative to sexual behavior, cultural norms and economic factors among the women in the Republic of Cameroon, West Africa.

The explanatory research design allowed for the descriptive analysis of the demographic characteristics of the respondents. As well, this research design facilitated the explanation of the statistical relationship between the perception of HIV/AIDS as it relates to sexual behavior, cultural norms and economic factors among the women in the identified study.

Description of the Site

The data were collected in Buea, Cameroon in West Africa. This location was purposely selected for the study for the following reasons: (1) convenience; (2) easy to
administer survey questionnaires; and (3) it is a college town which includes the University of Buea, Bilingual Grammar School, and a Government Technical College, where a large pool of young females and students were targeted randomly for this study.

Sample and Population

The target population sampled was composed of a wide range of students from secondary, high school, the University of Buea, and other women living in the nearby communities. One hundred respondents were selected utilizing non-probability convenience sampling from among the participants of the selected site in Cameroon.

Instrument

The research study employed a survey questionnaire entitled, Analysis of the Perception of HIV/AIDS among Cameroonian Women. The survey questionnaire consisted of five sections with a total of twenty-six (26) questions. Young girls and women were contacted to answer the questions. The first section solicits demographic information about the character of the respondents.

Section I of the survey questionnaire consists of 10 questions (1 through 10). The ten questions selected provided information for the presentation of a demographic profile of the respondent. The questions in Section I were related to age and marital status, educational level and income/salary.

Section II consisted of fifteen questions (11 through 26). Section II measures the knowledge and awareness of HIV/AIDS among the participants. The questions in section II dealt with the participants’ knowledge about HIV/AIDS information. Section I and
section II focused on the demographic profile of the respondents of the research study. They served as the independent variables.

Section II consisted of a four-point continuum Likert scale. The scale is as follows: 1 = Strongly Disagree, 2 = Disagree, 3 = Agree, 4 = Strongly Agree. In this same section, the major variables that were studied were also broken down into four sub sections. The first sub section (I) in the questionnaire pertained to the respondents’ knowledge of HIV/AIDS and it consisted of four questions (11 through 14). The second sub section pertained to the respondents’ sexual behavior and HIV/AIDS, and it consisted of four questions (15 through 18).

Section III consisted of four questions (19 through 22) relating to the respondents’ cultural norms and HIV/AIDS among the women in Cameroon. It used the same response scale (strongly agree to strongly disagree) and finally, section IV consisted of four (4) questions (23 through 26) and it dealt with the respondents’ economic factors and HIV/AIDS.

Treatment of Data

Statistical treatment of the data employed descriptive statistics, which included measures of central tendency, frequency distribution, and cross tabulation. The test statistics for the study used was Phi and Chi Square.

Frequency distribution was also used to analyze each of the variables of the study in order to summarize the basic measurements. A frequency distribution of the independent variables was used to develop a demographic profile and gain insights about the respondents in the study.
Cross tabulation was utilized to demonstrate the statistical relationship between independent variables and the dependent variable. Cross tabulation was used to finalize the relationship between the sexual behavior and knowledge of HIV/AIDS, the relationship between economic status and sexual behaviors, and the knowledge of HIV/AIDS and the cultural norms among women in Cameroon.

Two-test statistic was employed. The first test was the Phi ($\Phi$), which was a symmetric measure of association that was used to demonstrate the strength of the relationship between two or more variables (Bromstead & Knoke, 1995). The following are the variables associated with Phi ($\Phi$):

- .00 to .24 no relationship
- .25 to .49 weak relationship
- .50 to .74 moderate relationship
- .75 to 1.00 strong relationship

The second test employed in this research study was the chi square. Chi-square was used to test whether there was a statistical significance at the .05 level of probability among the variables in the study.

Limitations of the Study

There are several basic limitations of the study. The first one was the limited number of sites and participants available for the study. The second limitation was the discussion or disclosure of HIV/AIDS since this is an emotional and sensitive topic to openly discuss in public due to the sensitivity of the subject and stigmatization. Thirdly, the study was limited by the inability to access women directly on the study without first
going through husbands or partners. Finally, the study was limited by the data and studies specifically targeting the critical variables -- women in the Republic of Cameroon.
CHAPTER IV
PRESENTATION OF FINDINGS

The purpose of this chapter is to present the findings of the study. More specifically, to describe and explain the analysis of the perception of HIV/AIDS as it relates to sexual behaviors, economic factors and cultural norms among women in the Republic of Cameroon. The findings are organized into two sections: demographic data and the research questions and hypotheses.

Demographic Data

This section provides a profile of the study respondents. Descriptive statistics were used to analyze the following: age group, ethnicity, marital status, education, employment, income, and knowledge of HIV/AIDS.

The target population for the research was composed of both men and women, among the Cameroonian population in Africa. One hundred males and females were selected utilizing convenience sampling from among participants of the selected sites. A total of ninety-one valid questionnaires were selected for utilization in the study.

Table 1 is a frequency distribution of the respondents participating in the study. It denotes the demographic profile of the respondents and enables the researcher to identify the typical respondent of the study.

54
Table 1

Demographic Profile of the Study Respondents (N = 91)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>18</td>
<td>19.8</td>
</tr>
<tr>
<td>Female</td>
<td>73</td>
<td>80.2</td>
</tr>
<tr>
<td>Age Group</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 30</td>
<td>3</td>
<td>3.3</td>
</tr>
<tr>
<td>20-24</td>
<td>19</td>
<td>20.9</td>
</tr>
<tr>
<td>25-29</td>
<td>26</td>
<td>26.6</td>
</tr>
<tr>
<td>30-34</td>
<td>18</td>
<td>19.8</td>
</tr>
<tr>
<td>35-39</td>
<td>9</td>
<td>9.9</td>
</tr>
<tr>
<td>40-44</td>
<td>5</td>
<td>5.5</td>
</tr>
<tr>
<td>45-49</td>
<td>3</td>
<td>3.3</td>
</tr>
<tr>
<td>50-54</td>
<td>4</td>
<td>4.4</td>
</tr>
<tr>
<td>55 up</td>
<td>4</td>
<td>4.4</td>
</tr>
<tr>
<td>Marital Status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>36</td>
<td>39.6</td>
</tr>
<tr>
<td>Never Married</td>
<td>45</td>
<td>49.5</td>
</tr>
<tr>
<td>Divorced</td>
<td>4</td>
<td>4.4</td>
</tr>
<tr>
<td>Widow</td>
<td>6</td>
<td>6.6</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary</td>
<td>18</td>
<td>19.8</td>
</tr>
<tr>
<td>Secondary</td>
<td>26</td>
<td>28.6</td>
</tr>
<tr>
<td>High School</td>
<td>30</td>
<td>33.0</td>
</tr>
<tr>
<td>Some College</td>
<td>5</td>
<td>5.5</td>
</tr>
<tr>
<td>College Graduate</td>
<td>7</td>
<td>7.7</td>
</tr>
<tr>
<td>Higher Degree</td>
<td>5</td>
<td>5.5</td>
</tr>
<tr>
<td>Employment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>71</td>
<td>78.0</td>
</tr>
<tr>
<td>Yes</td>
<td>20</td>
<td>22.0</td>
</tr>
</tbody>
</table>
As indicated in Table 1, the typical respondent in the study was a female in Cameroon who was between 25 to 29 years of age, was never married, and had a secondary or high school education. As well, the typical respondent was unemployed and had an annual income of less than 100,000 CFA ($230 USD).

Knowledge of HIV/AIDS

The study of the knowledge of HIV/AIDS among the women in Cameroon was based on the perception of the amount of information about HIV/AIDS and awareness that the women of Cameroon exhibited about risky sexual activities related to the HIV/AIDS disease within their communities. A study conducted by Balbina Ebong (2005) revealed that much has been done in Cameroon to educate the public on the modes of transmission, symptoms and management of HIV/AIDS with very little impact (Ebong, 2005).

The awareness of HIV/AIDS among the Cameroonian women was explained utilizing the following variables that reflect their personal knowledge of HIV/AIDS. The

<table>
<thead>
<tr>
<th>Variable</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Income</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 100,000 CFA</td>
<td>64</td>
<td>74.4</td>
</tr>
<tr>
<td>100,000 – 149,000 CFA</td>
<td>9</td>
<td>10.5</td>
</tr>
<tr>
<td>150,000 – 199,999 CFA</td>
<td>6</td>
<td>6.6</td>
</tr>
<tr>
<td>200,000 – 299,999 CFA</td>
<td>4</td>
<td>4.4</td>
</tr>
<tr>
<td>300,000 – 399,999 CFA</td>
<td>2</td>
<td>2.2</td>
</tr>
<tr>
<td>400,000 - 499,999 CFA</td>
<td>1</td>
<td>1.2</td>
</tr>
</tbody>
</table>
variables utilized were as follows: 1) KNOW: Do you know about HIV/AIDS?
2) HEARD: Have you heard about HIV/AIDS?; 3) ANYBODY: Do you know anybody with HIV/AIDS?; and 4) INFOR: Do you have any information on HIV/AIDS? The four variables were computed as the variable INFOHIV.

Table 2 is the frequency distribution of the respondents' personal knowledge of HIV/AIDS among the female participants in the study. Table 2 indicates whether or not the respondents disagree or agree with their awareness of this disease.

<table>
<thead>
<tr>
<th></th>
<th>Disagree</th>
<th>Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>#</td>
<td>%</td>
</tr>
<tr>
<td>KNOW: Do you know about HIV/AIDS?</td>
<td>3</td>
<td>3.3</td>
</tr>
<tr>
<td>HEARD: Have you heard about HIV/AIDS?</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>ANYBODY: Do you know anybody with HIV/AIDS?</td>
<td>36</td>
<td>39.6</td>
</tr>
<tr>
<td>INFOR: Do you have any information on HIV/AIDS?</td>
<td>1</td>
<td>1.1</td>
</tr>
</tbody>
</table>

As shown in Table 2, the women in Cameroon have knowledge regarding HIV/AIDS. Of the 91 respondents, 96.7% did know about HIV/AIDS; and all or 100% of the respondents had heard of HIV/AIDS. The majority or 60.4% knew somebody with HIV/AIDS, and 98.9% of the respondents had information about the disease.
Table 3

INFOHIV: Personal knowledge of HIV/AIDS (N=91)

<table>
<thead>
<tr>
<th>Value</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>38</td>
<td>41.8</td>
</tr>
<tr>
<td>Yes</td>
<td>53</td>
<td>58.2</td>
</tr>
<tr>
<td>Total</td>
<td>91</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Mean 2.26  Std. Dev .352

Table 3 is a computed variable regarding the personal knowledge that the respondents had about HIV/AIDS. The majority of the 91 respondents stated that they knew about HIV/AIDS, or had heard about the disease, or knew somebody with HIV/AIDS, and that they had information about the disease when asked individual questions. The computed variable revealed that the majority or 58.2% of the respondents had personal knowledge of the disease. However, a very significant percent or 41.8% of the respondents did not have personal knowledge of HIV/AIDS.

Sexual Behavior and HIV/AIDS

Sexual behavior was defined as the frequency with which women engage in sex with knowledge of the HIV/AIDS epidemic. The questions posed were: 1. I have sex about two times or more each day; 2. I have sex about one time each day; 3. I do not have sex anymore; and 4. I am not afraid of contracting HIV/AIDS.
Table 4 is frequency distribution of the sexual behavior among 91 respondents.

Table 4 is the frequency distribution of the sexual behavior among the women in Cameroon with regards to the number of times they have sex.

Table 4

Sexual Behavior among the Women in Cameroon (N = 91)

<table>
<thead>
<tr>
<th></th>
<th>Disagree</th>
<th></th>
<th>Agree</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>#</td>
<td>%</td>
<td>#</td>
<td>%</td>
</tr>
<tr>
<td>1: I have sex about two times or more each day</td>
<td>82</td>
<td>90.1</td>
<td>8</td>
<td>8.8</td>
</tr>
<tr>
<td>2: I have sex about one time each day</td>
<td>69</td>
<td>75.8</td>
<td>21</td>
<td>23.1</td>
</tr>
<tr>
<td>3: I do not have sex anymore</td>
<td>63</td>
<td>69.2</td>
<td>27</td>
<td>29.7</td>
</tr>
<tr>
<td>4: I am not afraid of contracting HIV/AIDS</td>
<td>77</td>
<td>84.6</td>
<td>14</td>
<td>15.4</td>
</tr>
</tbody>
</table>

As shown in Table 4, women of Cameroon acknowledged their sexual behavior. As indicated the majority of the respondents disagreed (90.1%) that they had sex about two time or more each day; they disagreed 75.8% of the time that they had sex daily; 69.2% of the respondents indicated that they did not have sex anymore; and a majority or 84.6% disagreed that they were not afraid of contracting HIV/AIDS because of their sexual behavior. A significant percent (23.1%) of the respondents indicated that they had sex at least one time each day while 29.7% of the respondents indicated that because of the information they had about HIV/AIDS that they did not have sex anymore.
Table 5

SEXBAVR: Sexual Behavior and HIV/AIDS (N = 90)

<table>
<thead>
<tr>
<th>Value</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disagree</td>
<td>84</td>
<td>93.3</td>
</tr>
<tr>
<td>Agree</td>
<td>6</td>
<td>6.7</td>
</tr>
<tr>
<td>Total</td>
<td>90</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Mean 2.07     Std. Dev 3.40

Table 5 is the frequency distribution for the computed variable (SEXBAVR) reflecting the sexual behavior of the respondents. As shown in Table 5, the computed variable confirmed that the majority of the respondents (93.3%) disagreed that they practiced risky sexual behavior and they were not afraid of getting the HIV/AIDS disease. However, a small percentage or 6.7% of the women did indicate that they were involved in risky sexual behavior that could lead to contracting and/or spreading HIV/AIDS to others in the population.

Cultural Norms and HIV/AIDS

Cultural Norm was defined by the researcher as the use of cultural expectations for protecting oneself during sex from contracting HIV/AIDS. To this end, cultural norm is best measured and explained by utilizing the following variables: 1. I always use condoms during sexual intercourse; 2. My sexual partner does not like to use condoms
during sexual intercourse; 3. We never use condoms during sexual intercourse; and 4. Using condoms will not protect me from getting HIV/AIDS.

Table 6 is a frequency distribution of the variables of cultural norm and HIV/AIDS among the women in Cameroon. Table 6 indicates whether or not the respondents disagree or agree if their culture influenced their decision to protect themselves from HIV/AIDS.

Table 6
Cultural Norms and HIV/AIDS (N = 91)

<table>
<thead>
<tr>
<th>Cultural Norm</th>
<th>Disagree</th>
<th>Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1: I always use condoms during sex</td>
<td>39 (42.9%)</td>
<td>51 (56.0%)</td>
</tr>
<tr>
<td>2: My partner does not like or use condoms</td>
<td>56 (61.5%)</td>
<td>32 (35.2%)</td>
</tr>
<tr>
<td>3: We never use condoms during sex</td>
<td>67 (73.6%)</td>
<td>22 (24.7%)</td>
</tr>
<tr>
<td>4: Condoms will not protect from HIV/AIDS</td>
<td>60 (65.9%)</td>
<td>29 (31.9%)</td>
</tr>
</tbody>
</table>

As shown in Table 6, 56% of the respondents in Cameroon agreed that their cultural norms did influence their decision to use condoms during sexual intercourse, while 61.5% revealed that their sexual partners disagreed with the use of condoms during sexual intercourse. A majority of the respondents (73.6%) indicated that they never use condom during sexual intercourse, and 65.9% did not believe that using condoms will protect them from contracting HIV/AIDS.
Table 7

CULTNOM: Cultural Norms and HIV/AIDS among Cameroonian Women (N= 91)

<table>
<thead>
<tr>
<th>Value</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disagree</td>
<td>83</td>
<td>90.9</td>
</tr>
<tr>
<td>Agree</td>
<td>8</td>
<td>9.1</td>
</tr>
<tr>
<td>Total</td>
<td>91</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Mean 2.09 Std. Dev .289

As shown in Table 7, the majority of the respondents indicated that their cultural norms did play a part in their decision to protect themselves by using condoms during sexual intercourse. Of the 91 respondents, 90.9% indicated that cultural norms did influence their decisions. Although the majority of the respondents indicated that they were influenced by cultural norms, a significant percentage or 9.1% indicated that they were not influenced by their cultural norms to protect themselves from contracting or spreading HIV/AIDS.

Economic Factors and HIV/AIDS

Economic factors were defined by the researcher as one of the conditions that force Cameroonian women to trade themselves for sex. Economic factors and HIV/AIDS can best be explained by utilizing the following variables: 1. Sometimes I trade sex for food; 2. Sometimes I trade sex for money; 3. I have traded sex for job; and 4. I will have sex with a man or woman or (same sex) for money.
Table 8 is a frequency distribution of the Economic Factors and HIV/AIDS among Cameroonian women. Table 8 revealed whether or not respondents disagreed or agreed that the economic factors are linked to the spread of HIV/AIDS among women in Cameroon.

Table 8

Economic Factors and HIV/AIDS (N = 91)

<table>
<thead>
<tr>
<th>Economic Factors</th>
<th>Disagree #</th>
<th>Disagree %</th>
<th>Agree #</th>
<th>Agree %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sometimes I trade sex for food</td>
<td>83</td>
<td>91.2</td>
<td>8</td>
<td>8.8</td>
</tr>
<tr>
<td>Sometimes, I trade sex for money</td>
<td>76</td>
<td>83.5</td>
<td>15</td>
<td>16.5</td>
</tr>
<tr>
<td>I have traded sex for a job</td>
<td>78</td>
<td>85.7</td>
<td>13</td>
<td>14.3</td>
</tr>
<tr>
<td>Have sex with same sex for money</td>
<td>79</td>
<td>86.8</td>
<td>12</td>
<td>13.2</td>
</tr>
</tbody>
</table>

As shown in Table 8, the women of Cameroon acknowledges that there were economic factors related to their sexual behavior. As indicated, the majority disagreed (91.2%) that they traded sex for food; they disagreed (83.5%) that they traded sex for money; they disagreed (85.7%) that they traded sex for a job, and a majority or 86.8% disagreed when asked if they would have sex with a man or woman (same sex) for money. However, a small but significant percentage of the respondents (8.8%) indicated that they had traded sex for food; traded sex for money (16.5%); traded sex for a job (14.3%); and had sex with a man or woman for money (13.2%).
Table 9

ECOFACT: Economic Factors and HIV/AIDS (N = 91)

<table>
<thead>
<tr>
<th>Value</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disagree</td>
<td>82</td>
<td>90.1</td>
</tr>
<tr>
<td>Agree</td>
<td>9</td>
<td>9.9</td>
</tr>
<tr>
<td>Total</td>
<td>91</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Mean 2.10  Std. Dev .289

As shown in Table 9, the majority of the survey respondents acknowledged that they did not engage in risky sexual behavior for economic reasons. Although the majority or 90.1% disagreed that they traded sex for economic reasons, it is significant to note that 9.9% indicated that, on occasions, they had traded sex for food, money or a job. As stated earlier, the majority of the women are poor and the average woman lived in poverty. In order to survive and maintain the status quo, many of these women would do whatever is necessary to support their livelihood. The typical respondent was unemployed and earned an average income of under a 100,000 CFAs annually ($230 USD).

Research Questions and Hypotheses

The study contains three research questions and three hypotheses. This section provides an analysis of the research questions and presents the statistical tests and results obtained for the hypotheses tested.
Sexual Behavior and Knowledge of HIV/AIDS

Research Question 1: Is there a relationship between sexual behavior and knowledge of HIV/AIDS among the women in the Republic of Cameroon, West Africa?

Hypothesis 1: There is no relationship between sexual behavior and the knowledge of HIV/AIDS among the women in the Republic of Cameroon, West Africa.

Table 10 is a cross-tabulation of sexual behavior by personal knowledge of HIV/AIDS. Table 10 shows the strength of association between sexual behavior and the personal knowledge of HIV/AIDS and indicates whether or not there was a statistically significant relationship between the two variables.

As shown in Table 10, 36.7% of the respondents indicated that their sexual behavior was not influenced by their personal knowledge of HIV/AIDS, while the majority of the respondents (56.7%) indicated that their sexual behavior was influenced by their personal knowledge of HIV/AIDS.
Table 10

Sexual Behaviors by Personal Knowledge of HIV/AIDS

<table>
<thead>
<tr>
<th>Sexual Behavior</th>
<th>Personal Knowledge of HIV/AIDS</th>
<th>#</th>
<th>%</th>
<th>#</th>
<th>%</th>
<th>#</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NO</td>
<td>33</td>
<td>36.7</td>
<td>51</td>
<td>56.7</td>
<td>84</td>
<td>93.3</td>
</tr>
<tr>
<td></td>
<td>YES</td>
<td>5</td>
<td>5.6</td>
<td>1</td>
<td>1.1</td>
<td>6</td>
<td>6.7</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>38</td>
<td>42.2</td>
<td>52</td>
<td>57.8</td>
<td>90</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Φ = .22         df = 1    p = .03

As shown in Table 10, the test statistic Phi (Φ) was employed to test for the strength of association between the sexual behavior and personal knowledge of HIV/AIDS among the respondents in the study. There was a weak association (Φ = .22) between the two variables, i.e., sexual behaviors and personal knowledge of HIV/AIDS. When the chi-square statistical test for significance was applied, the null hypothesis was rejected (p = .03) indicating that there was a statistically significant relationship between personal knowledge of HIV/AIDS and sexual behavior at the .05 level of significance.

Economic Factors and Knowledge of HIV/AIDS

Research Question 2: Is there a relationship between economic factors and knowledge of HIV/AIDS among the women in the Republic of Cameroon West Africa?
Hypothesis 2: There is no relationship between economic factors and knowledge of HIV/AIDS among the women in the republic of Cameroon West Africa.

Table 11 is a cross-tabulation of economic factors and the personal knowledge of HIV/AIDS among the women in the Republic of Cameroon, West Africa. Table 12 shows the strength of association between economic factors and the personal knowledge of HIV/AIDS and also indicates whether or not there was a statistically significant relationship between the two variables.

Table 11

Economic Factors by Personal Knowledge of HIV/AIDS

<table>
<thead>
<tr>
<th>Personal Knowledge of HIV/AIDS</th>
<th>NO</th>
<th>%</th>
<th>YES</th>
<th>%</th>
<th>Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Economic Factors</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disagree</td>
<td>32</td>
<td>35.2</td>
<td>50</td>
<td>54.9</td>
<td>82</td>
<td>90.1</td>
</tr>
<tr>
<td>Agree</td>
<td>6</td>
<td>6.6</td>
<td>3</td>
<td>3.3</td>
<td>9</td>
<td>9.9</td>
</tr>
<tr>
<td>Total</td>
<td>38</td>
<td>41.8</td>
<td>53</td>
<td>58.2</td>
<td>91</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Φ = .16          df = 1          p = .11

As shown in Table 11, 35.2% of the respondents indicated that their economic factors were not influenced by their personal knowledge of HIV/AIDS while a majority
of the respondents (54.9 \%) indicated that their sexual behavior was influenced by their personal knowledge of HIV/AIDS.

As depicted in Table 11, the statistical measurement Phi (\( \Phi \)) was employed to test for the strength of association between the economic factors and personal knowledge of HIV/AIDS among the women in the study. There was a weak association (\( \Phi = .16 \)) between the two variables. When the chi-square statistical test for significant was applied, the null hypothesis was not rejected (\( p = .11 \)) indicating that there was not a statistically significant relationship between the two variables at .05 level of probability.

Cultural Norms and Knowledge of HIV/AIDS

Research Question 3: Is there a relationship between the cultural norms and knowledge of HIV/AIDS among the women of the Republic of Cameroon, West Africa?

Hypothesis 3: There is no relationship between cultural norms and knowledge of HIV/AIDS among the women in the Republic of Cameroon, West Africa.

Table 12 is a cross-tabulation of cultural norms and the personal knowledge of HIV/AIDS among the women in the Republic of Cameroon, West Africa. Table 12 shows the strength of association between cultural norms and the personal knowledge of HIV/AIDS that indicates whether or not there was a statistically significant relationship between the two variables.
Table 12

Cultural Norms by Personal Knowledge of HIV/AIDS

<table>
<thead>
<tr>
<th>Cultural Norms</th>
<th>Personal Knowledge of HIV/AIDS</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NO</td>
<td>%</td>
<td>YES</td>
<td>%</td>
<td>Total</td>
<td>%</td>
</tr>
<tr>
<td>Disagree</td>
<td>33</td>
<td>36.5</td>
<td>47</td>
<td>53.4</td>
<td>80</td>
<td>90.9</td>
</tr>
<tr>
<td>Agree</td>
<td>4</td>
<td>4.5</td>
<td>4</td>
<td>4.5</td>
<td>8</td>
<td>9.1</td>
</tr>
<tr>
<td>Total</td>
<td>37</td>
<td>42.0</td>
<td>51</td>
<td>58.0</td>
<td>88</td>
<td>100.0</td>
</tr>
</tbody>
</table>

$\Phi = .05 \quad df = 1 \quad p = .63$

As shown in Table 12, 36.5% of the respondents indicated that their sexual behavior was not influenced by their personal knowledge of HIV/AIDS, while a slight majority of the respondents (53.4%) indicated that their sexual behavior was influenced by their personal knowledge of HIV/AIDS.

Also reflected in Table 12, the statistical measurement Phi ($\Phi$) was employed to test for the strength of association between the sexual behaviors and personal knowledge of HIV/AIDS among the women in the study. There was a weak association ($\Phi = .05$) between the two variables. When the chi-square statistical test for significant was applied, the null hypothesis was not rejected ($p = .63$) indicating that there was not a statistically significant relationship between the two variables at .05 level of probability.
In summary, the research was designed to get the perception of HIV/AIDS as it relates to sexual behaviors, cultural norms, and economic factors among women in Cameroon, West Africa. The majority of the study participants were females, however 19.85% of the respondents were male. The results of the statistical test indicated that the decisions the respondents made were based on their cultural beliefs, which still had a very strong hold on what was told to them in the media (radio, newspaper, etc.), regarding HIV/AIDS in relationship to what the norms in the society are and customary beliefs. The suspicions surrounding HIV/AIDS illness among some community leaders, including some heads of states within the African continent, are certainly not helping the matter or helping in tackling the seriousness of the epidemic, despite all the efforts made by the international bodies in bringing awareness about the seriousness of HIV/AIDS disease. The respondent’s cultural norms continue to play major roles as shown in the study.

In the study, the women in Cameroon disagreed with many of the sub-facets that composed their personal knowledge base towards HIV/AIDS. However, when the sub-facets were combined to compute an overall score for the respondents’ cultural norms, it only showed a moderate relationship of .633%, indicating that this variable nevertheless had a statistical relationship between the cultural norms and the personal knowledge with regards to the prevalent of HIV/AIDS among the women in Cameroon.

Conclusions and Summaries on HIV/AIDS Findings

This portion of the research is very significant because it helps to provide much more clarity to the contradictions found between the literature review and the research
findings. Perhaps the respondents were deceptive during the process of answering the questionnaire. The findings are strange in that they are inconsistent with the literature review.

Men in Cameroon have always been the dominant figures in the society at large. The man, being the head of household, has the power and control of his wife or women, and what he says is fully accepted with no arguments from the majority of the women.

As indicated in Table 7, the majority of the female respondents indicated that their cultural norms did influence their decision to protect themselves from contracting or spreading HIV/AIDS. However, a small but significant number of 9.1% of the respondents indicated that their cultural norms did not influence their decision to protect themselves during any sexual activity and that they were not afraid of contracting HIV/AIDS. This is a typical example of the contradictions between the findings from the literature review and the findings in this study. The literature indicates that cultural norms play a significant role relative to women not being able to protect themselves from their significant others. For example, the wife’s inheritance noted in the literature review reveals that the man, upon the death of his brother, is entitled to marry his late brother’s wife. As well, the practice of polygamy also enables the man to marry more than one woman simultaneously. These types of practices make it virtually impossible for these women to appropriately negotiate the terms of sex with their partners.

As revealed in the literature, the diversity and traditions create multiple and distinctive cultural threats which exacerbate the spread of HIV/AIDS, even though the findings state otherwise. Female genital mutilations and childbirth deliveries at home, rather than the utilization of a medical facility, help to reflect more contradictions
between the literature and the findings. The literature indicated that female mutilations and the delivery of children at home places the individuals at risk. The literature review studies regarding this issue indicated that, during female mutilations or childbirth, instruments used to perform these rituals are not sterilized, nor are gloves worn for protection. This is one of the principal issues in dealing with cultural norms and HIV/AIDS knowledge. While this is so, respondents gave a different answer when completing the questionnaires, thus resulting in another contradiction between findings in the literature review and findings from the study.

Still another possible explanation from the contradictions between the literature review and the findings from the study may be that the respondents were too embarrassed to tell the truth since the culture does not openly discuss sexually related issues in public nor behind close doors. The culture does not permit women to ask their husband or partner to use condoms because if a woman dares mention condoms use, it may raise concerns, from the man’s perspective, that the wife or partner has cheated or is cheating. In cases where the wife cheats on the husband, the woman may be deprived of food, shelter or money to care for her children. Therefore, most women refuse to suggest the use of condoms, even when they are fully aware of the risks involved. This is another clear example revealing the deception between the respondents’ answers and actions and beliefs revealing the literature review and contradictions in the findings.

In reference to condoms use and cultural norms, 56% of the respondents agreed that their cultural norms did influence their decision to use condom during sexual intercourse; 61.5% indicated that their sexual partners did not like to use condoms. Meanwhile, 65.9% of the respondents did not believe that using condoms would protect
them from contracting HIV/AIDS. Again, the findings are different from what the literature reveals because of what may be attributed to the deception on the part of the respondents. People are perhaps more aware of the implications of acknowledging the truth today than they were during the past when dealing with issues such as HIV/AIDS. The stigma, shame and fear of the disease seems to be a major problem as to why individuals are less likely to come forth with accurate answers regarding their sexual involvements. Some women in Cameroon subject themselves to risky sexual activities due to the economic hardship. If these women could be empowered to provide for themselves and not be dependent upon their men, the widespread infection of HIV/AIDS would significantly decrease. Though some women indicated that they would not have sex with a man for food or money, their actions tell exactly what the literature review has stated.

As indicated in Table 9, a majority of the respondents (90.1%) acknowledged that they did not engage in risky sexual behaviors for economic reasons. Meanwhile, the literature, again, states otherwise. The poverty rate in Cameroon is so high that a majority of the women are willing to do whatever it takes to provide food, clothing and shelter for their family. The literature talks about women putting themselves at risk by having sex with men for money; however, the findings indicated that the respondents did not have sex with men for money or food/jobs, which showed another major contradiction between the literature and the findings. The respondents, however, did indicate verbally and acknowledged that they do have risky sexual activities with men for money, but when given the questionnaire, they indicated something totally different from what the norms are. This, again, shows another clear indication that the respondents were
deceptive with their answers, even after the researcher had mentioned that the questionnaires were to be used for the sole purpose of the research study. There is a greater need for further studies among women in Cameroon, whereby these women could be honest about their real sexual behaviors when participating in a research study.
CHAPTER V
CONCLUSIONS AND RECOMMENDATIONS

The research study was designed to answer three questions regarding the perception of HIV/AIDS as it relates to sexual behaviors, cultural norms, and economic factors among women in Cameroon, West Africa. The conclusions and recommendations of the research findings are presented in this chapter. Recommendations are also made for future discussion on the topic for policy makers, social service providers, practitioners and the Cameroonian government administrators. Each research question is presented in order to summarize the significant findings of the study.

Research Question 1: Is there a relationship between sexual behavior and knowledge of HIV/AIDS among the women in the Republic of Cameroon, West Africa?

In order to determine if there was a relationship between sexual behavior and the women in Cameroon, knowledge, sexual behavior, cultural norms and economic factors were computed and analyzed based on a calculation of these four facets.
Table 10 shows the strength of association between sexual behavior and the personal knowledge of HIV/AIDS and indicates whether or not there was a statistically significant relationship between the two variables.

As shown in Table 10, a minority or 36.7% of the respondents indicated that their sexual behavior was not influenced by their personal knowledge of HIV/AIDS, while a majority or 56.7% of the respondents indicated that their sexual behavior was influenced by their personal knowledge of HIV/AIDS.

As depicted in Table 10, the test statistic Phi ($\Phi$) was employed to test for the strength of association between the sexual behavior and personal knowledge of HIV/AIDS among the respondents in the study. As indicated, there was a weak association ($\Phi = .22$) between the two variables. When the chi-square statistical test for significant was applied, the null hypothesis was rejected ($p = .03$) indicating that there was a statistically significant relationship between the two variables at .05 level of probability.

Of the 91 participants surveyed, a minority of the respondents (36.7%) indicated that they did not have personal knowledge or changing their sexual behaviors towards HIV/AIDS. However, the majority of the respondents (56.7%) indicated that they agreed on having personal knowledge of HIV/AIDS towards sexual behaviors.

Research Question 2: Is there a relationship between economic factors and knowledge of HIV/AIDS among the women in the Republic of Cameroon West Africa?
Table 11 is a cross-tabulation of economic factors and the personal knowledge of HIV/AIDS among the women in the Republic of Cameroon West Africa. Table 11 shows the strength of association between economic factors and the personal knowledge of HIV/AIDS and also indicates whether or not there was a statistically significant relationship between the two variables.

As shown in Table 11, a minority or 35.2% of the respondents indicated that their economic factors were not influenced by their personal knowledge of HIV/AIDS while a majority or 54.9% of the respondents indicated that their sexual behavior was influenced by their personal knowledge of HIV/AIDS.

As shown in Table 11, the statistical measurement Phi (Φ) was employed to test for the strength of association between the economic factors and personal knowledge of HIV/AIDS among the women in the study. As indicated, there was a weak association (Φ = .16) between the two variables. When the chi-square statistical test for significant was applied, the null hypothesis was not rejected (p = .11) indicating that there was not a statistically significant relationship between the two variables at .05 level of probability.

Research Question 3: Is there a relationship between the cultural norms and knowledge of HIV/AIDS among the women of the Republic of Cameroon, West Africa?

Table 12 is a cross-tabulation of cultural norms and the personal knowledge of HIV/AIDS among the women in the Republic of Cameroon West Africa. Table 12 shows the strength of association between cultural norms and the personal knowledge of
HIV/AIDS that indicates whether or not there was a statistically significant relationship between the two variables.

As shown in Table 12, a minority or 36.5% of the respondents indicated that their sexual behavior were not influenced by their personal knowledge of HIV/AIDS while a slight majority or 53.4% indicated that their sexual behavior was influenced by their personal knowledge of HIV/AIDS.

As shown in Table 12, the statistical measurement Phi ($\Phi$) was employed to test for the strength of association between the sexual behaviors and personal knowledge of HIV/AIDS among the women in the study. As indicated, there was a weak association ($\Phi = .05$) between the two variables. When the chi-square statistical test for significant was applied, the null hypothesis was not rejected ($p = .63$) indicating that there was not a statistically significant relationship between the two variables at .05 level of probability.

Recommendations

Studies concerning women in Cameroon are limited in terms of analyzing specific needs to the identified population. The decision by the Cameroonian government to place the responsibility of the care of its constituents on individuals rather than the government, and the country as a whole, appear to be a barrier in combating the widespread infection of HIV/AIDS among women in Cameroon. More research and intervention is needed to deal with this crisis and, most importantly, the government needs to focus on the social as well as cultural aspects of this illness and not just the medical and economic aspects of the disease in order to bring about changes in the focus
and direction of research on HIV/AIDS in Cameroon and in other developing countries of Africa.

As a result of the findings of this study, the researcher is recommending the following:

1. Research should continue in order to develop baseline data for women in Cameroon;
2. Policy makers should encourage the use of research of HIV/AIDS within the Cameroonian culture and develop appropriate programs that would be beneficial and accessible in helping to combat the HIV/AIDS crisis in the country;
3. Programs should be developed specifically geared towards research and services that will help women understand how to prevent HIV/AIDS and make these services accessible to all areas and reach every woman in Cameroon;
4. Social service providers should become advocates for women to insure that they receive equal and adequate training and care to counsel women infected with the disease. These services should be free and universal, including counseling, to deal with their mental health problems brought about as a result of this illness;
5. Social workers should engage in research that would provide data on this population group that would be helpful to facilitate delivery of services, foster better relationships and communication between various charitable, private and government providers helping to combat the disease;
6. The community should begin to openly discuss sexually related topics without the restriction and servicing that often surrounds the topic of sex and individual sexuality; and
7. Community leaders, elders, chiefs, and churches should all be involved as a team in helping to create awareness and encourage their constituents to protect themselves by holding focus group meetings on HIV/AIDS topics, and explaining in languages that would be understood by the masses.
APPENDICES
APPENDIX A

SURVEY QUESTIONNAIRE

A STUDY OF HIV/AIDS AMONG WOMEN OF CAMEROON

Dear Sir/Madam/Ms:

I am a student in the Ph.D. Program at the Whitney M. Young, Jr., School of Social Work at Clark Atlanta University in the United States of America. I invite you to participate in a study of HIV/AIDS among the women of Cameroon. The questionnaire will take only five minutes to complete. The purpose of this study is to learn about the perceptions of HIV/AIDS as it relates to sexual behavior, cultural norms and economic factors among the women in the Republic of Cameroon. The findings of the study will be used in an analysis for my dissertation. Because we want to keep all responses confidential, please do not put your name on the answer sheet. Again, thank you for your time and cooperation.

Elizabeth Elad
12-7-07

Section I: Demographic Information

Place a mark (x) next to the appropriate item. Choose only one answer for each statement.

1. My age group: 1) ______ Under 20 2) ______ 20-24 3) ______ 25-29 4) ______ 30-34 5) ______ 35-39
   6) ______ 40-44 7) ______ 45-49 8) ______ 50-54 9) ______ 55 & up

2. My gender: 1) ______ Male 2) ______ Female

3. Marital status: 1) ______ Married 2) ______ Never Married 3) _____ Divorced 4) ______ Widowed

4. My highest education: 1) ______ Primary 2) ______ Secondary 3) ______ High School
   4) ______ Some College 5) ______ College Grad 6) ______ Higher Degree

5. Employment (Are you currently working?) 1) ______ No 2) ______ Yes

6. My Annual Income: 1) ______ Under 100,000 CFA 2) ______ 100,000 – 149,999 CFA
   3) ______ 150,000-199,999 CFA 4) ______ 200,000-249,999 CFA 5) ______ 250,000-299,999 CFA
   6) ______ 300,000-349,999 CFA 7) ______ 400,000-449,999 CFA 8) ______ 500,000 CFA & UP

7. Do you know about HIV/AIDS 1) ______ No 2) ______ Yes

8. Have you heard about HIV/AIDS 1) ______ No 2) ______ Yes
APPENDIX A (continued)

9. Do you know anybody with HIV/AIDS 1) _____ No 2) _____ Yes

10. Have you had any information on HIV/AIDS 1) _____ No 2) _____ Yes

Section II: Instrument
The following statements are designed to get your opinion about your college experience. Write the appropriate number ( 1 thru 4 ) in the blank space in front of each statement on the questionnaire. Please respond to all questions.

1 = Strongly Disagree  2 = Disagree  3 = Agree  4 = Strongly Agree

Knowledge of HIV/AIDS
_____ 11. HIV/AIDS is the cause of many people dying in Cameroon.
_____ 12. I knew someone who died from HIV/AIDS
_____ 13. Cameroonian musicians sing and speak about HIV/AIDS
_____ 14. Only people who look sick can spread HIV/AIDS

Sexual Behavior and HIV/AIDS
_____ 15. I have sex about two times or more each day.
_____ 16. I have sex about one time each day.
_____ 17. I do not have sex anymore.
_____ 18. I am not afraid of getting HIV/AIDS.

Cultural Norms and HIV/AIDS
_____ 19. I always use condoms during sexual intercourse.
_____ 20. My sexual partner do not like to use condoms during sexual intercourse.
_____ 21. We never use condoms during sexual intercourse.
_____ 22. Using condoms will not protect me from getting HIV/AIDS
Economic Factors and HIV/AIDS

23. Sometimes, I trade sex for food.


25. I have traded sex for a job.

26. I would have sex with a man or woman (same sex) for money.
APPENDIX B

SPSS PROGRAM ANALYSIS

TITLE 'A STUDY OF HIV AIDS AMONG WOMEN OF CAMEROON'.
SUBTITLE 'ELIZABETH ELAD SOCIAL WORK PhD PROGRAM'.

DATA LIST FIXED/
ID  1-3
AGEGRP  4
GENDER  5
MARITAL  6
EDUC  7
EMPLOY  8
INCOME  9
KNOW  10
HEARD  11
ANYBODY  12
INFOR  13
KNOWLD1  14
KNOWLD2  15
KNOWLD3  16
KNOWLD4  17
SEXUAL1  18
SEXUAL2  19
SEXUAL3  20
SEXUAL4  21
CULTUR1  22
CULTUR2  23
CULTUR3  24
CULTUR4  25
ECONOM1  26
ECONOM2  27
ECONOM3  28
ECONOM4  29.

COMPUTE KNOWBAS = (KNOWLD1+KNOWLD2+KNOWLD3+KNOWLD4)/4.
COMPUTE SEXBAVR = (SEXUAL1+SEXUAL2+SEXUAL3+SEXUAL4)/4.
COMPUTE CULTNOM = (CULTUR1+CULTUR2+CULTUR3+CULTUR4)/4.
COMPUTE ECOFACT = (ECONOM1+ECONOM2+ECONOM3+ECONOM4)/4.
COMPUTE INFOHIV = (KNOW+HEARD+ANYBODY+INFOR)/4.

VARIABLE LABELS
ID 'Case Number'
AGEGRP 'Q1 Age group'
GENDER 'Q2 Gender'
APPENDIX B (continued)

MARITAL 'Q3 Marital Status'
EDUC  'Q4 Highest Education'
EMPLOY 'Q5 Employment - Are you currently working'
INCOME 'Q6 Annual Income'
KNOW 'Q7 Do you know about HIV/AIDS'
HEARD 'Q8 Have you heard about HIV/AIDS'
ANYBODY 'Q9 Do you know anybody with HIV/AIDS'
INFOR 'Q10 Have you had any information on HIV/AIDS'

KNOWLD1 'Q11 HIV/AIDS is the cause of many people dying in Cameroon'
KNOWLD2 'Q12 I knew someone who died from HIV/AIDS'
KNOWLD3 'Q13 Cameroonian musicians sing and speak about HIV/AIDS'
KNOWLD4 'Q14 Only people who look sick can spread HIV/AIDS'
SEXUAL1 'Q15 I have sex about two times or more each day'
SEXUAL2 'Q16 I have sex about one time each day'
SEXUAL3 'Q17 I do not have sex anymore'
SEXUAL4 'Q18 I am not afraid of getting HIV/AIDS'
CULTUR1 'Q19 I always use condoms during sexual intercourse'
CULTUR2 'Q20 My sexual partner do not like to use condoms during sexual intercourse'
CULTUR3 'Q21 We never use condoms during sexual intercourse'
CULTUR4 'Q22 Using condoms will not protect me from getting HIV/AIDS'

ECONOM1 'Q23 Sometimes I trade sex for food'
ECONOM2 'Q24 Sometimes I trade sex for money'
ECONOM3 'Q25 I have traded sex for a job'
ECONOM4 'Q26 I would have sex with a man or woman same-sex for money'

KNOWBAS 'KNOWLEDGE BASE ABOUT HIV AIDS - Computed Variable'
SEXBAVR 'SEXUAL BEHAVIOR TOWARD HIV AIDS - Computed Variable'
CULTNOM 'CULTURAL NORMS AFFECTING HIV AIDS - Computed Variable'
ECOFACT 'ECONOMIC FACTORS CONCERNING HIV AIDS - Computed Variable'
INFOHIV 'PERSONAL KNOWLEDGE ABOUT HIV AIDS - Computed Variable'.

VALUE LABELS
AGEGRP
  1 'Under 30'
  2 '20-24'
  3 '25-29'
  4 '30-34'
  5 '35-39'
  6 '40-44'
  7 '45-49'
  8 '50-54'
  9 '55 up'/

GENDER
  1 'Male'
  2 'Female'/
APPENDIX B (continued)

MARITAL
1 'Married'
2 'Never Married'
3 'Divorced'
4 'Widowed' /

EDUC
1 'Primary'
2 'Secondary'
3 'High School'
4 'Some College'
5 'College Grad'
6 'Higher Degree' /

EMPLOY
1 'No'
2 'Yes' /

INCOME
1 'Under $100,000 CFA'
2 '100,000-149,000 CFA'
3 '150,000-199,999 CFA'
4 '200,000-249,999 CFA'
5 '250,000-299,999 CFA'
6 '300,000-349,999 CFA'
7 '400,000-449,999 CFA'
8 '500,000 CFA up' /

KNOW
1 'No'
2 'Yes' /

HEARD
1 'No'
2 'Yes' /

ANYBODY
1 'No'
2 'Yes' /

INFOR
1 'No'
2 'Yes' /

KNOWLD1
1 'Strongly Disagree'
2 'Disagree'
3 'Agree'
4 'Strongly Agree' /

KNOWLD2
1 'Strongly Disagree'
2 'Disagree'
3 'Agree'
4 'Strongly Agree' /

KNOWLD3
1 'Strongly Disagree'
2 'Disagree'
3 'Agree'
4 'Strongly Agree' /
KNOWLD4
  1 'Strongly Disagree'
  2 'Disagree'
  3 'Agree'
  4 'Strongly Agree'/
SEXUAL1
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  4 'Strongly Agree'/
ECONOM1
  1 'Strongly Disagree'
  2 'Disagree'
  3 'Agree'
  4 'Strongly Agree'/
APPENDIX B (continued)

ECONOM2
1 'Strongly Disagree'
2 'Disagree'
3 'Agree'
4 'Strongly Agree' /

ECONOM3
1 'Strongly Disagree'
2 'Disagree'
3 'Agree'
4 'Strongly Agree' /

ECONOM4
1 'Strongly Disagree'
2 'Disagree'
3 'Agree'
4 'Strongly Agree' /

KNOWBAS
1 'Strongly Disagree'
2 'Disagree'
3 'Agree'
4 'Strongly Agree' /

SEXBAVR
1 'Strongly Disagree'
2 'Disagree'
3 'Agree'
4 'Strongly Agree' /

CULTNOM
1 'Strongly Disagree'
2 'Disagree'
3 'Agree'
4 'Strongly Agree' /

ECOFACT
1 'Strongly Disagree'
2 'Disagree'
3 'Agree'
4 'Strongly Agree' /

INFOHIV
1 'No'
2 'Yes' /.

RECODE KNOWLD1 KNOWLD2 KNOWLD3 KNOWLD4 (1 THRU 2.99=2) (3 THRU 4.99=3).
RECODE SEXUAL1 SEXUAL2 SEXUAL3 SEXUAL4 (1 THRU 2.99=2) (3 THRU 4.99=3).
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RECODE INFOHIV (1 THRU 1.99=1) (2 THRU 2.99=2).
### APPENDIX B (continued)

MISSING VALUES  
AGEGRP GENDER MARITAL EDUC EMPLOY INCOME KNOW HEARD ANYBODY INFOR

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APPENDIX B (continued)

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END DATA.
APPENDIX B (continued)

FREQUENCIES
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/STATISTICS=.
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