

# Health and Cultural Values



Health and Cultural Values:  
Female Circumcision within the Context  
of HIV/AIDS in Cameroon

By

Ngambouk Vitalis Pemunta

**CAMBRIDGE  
SCHOLARS**

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P U B L I S H I N G

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In memory of Mangi Martha Manga who first thought I could study culture and began teaching me informally and to my mum, Rikeh Juliana for foregoing her own education to take care of me. I hope she and Ngamboug Nkeme Alfred will find in the outcome of this scholarly venture ultimate satisfaction for their many sacrifices in my regard.



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Ngambouk V. Pemunta, Ph.D  
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## PRELUDE

These White peoples have put our vaginas on the internet for everyone to see while they hide those of their women. Now they say that if we cut women, they will contract AIDS. Circumcision instead protects the dignity of a woman and makes her a standard woman. Those who are not cut can easily be tempted for a man and can contract AIDS (George, 35 years old).

This study grew out of my doctoral thesis on the renegotiation of the ritual practice of female circumcision (herein after FC) as a larger process of socio-cultural changes in gender roles in general and changes in health, values and practices in particular, orchestrated by the moral paranoia that accompanied the advent of the HIV/AIDS pandemic among the Ejaghams of Cameroon. As an anthropologist, I was rather shocked and bewildered by the disdain that Bayang female students were treated with at the University of Yaounde1, Cameroon. Even though the Bayangs, immediate neighbours of the Ejaghams had given up female ritual circumcision in the 1950s, the stigma of ritual FC still haunts them in the popular imagination in present-day postcolonial Cameroon. They are often rumoured to have insatiable appetite for sex because of their presumed lack of clitorises resulting from the ritual cutting practice of FC. Then came the groundswell of Western media frenzy that greatly shaped my initial views on the ritual practice as a meaningless ‘barbaric and dangerous’ practice presupposing lack of autonomy, power and subservience to patriarchy, depicting participants as “barbaric and uncivilized”, “tradition-oriented” and “prisoners of ritual”. This colonization of the voices of “African women” has attracted the attention of African feminist scholars (Njambi, 2004, Oyewumi, 2004, Nnaemeka, 2005). Njambi (2004) rightly describes anti-FGM discourse as replete with conceptual oppositions: science/superstition, medical knowledge/tradition, civilized/barbaric healthy bodies/unhealthy bodies, normal/abnormal sexuality, expert/non-expert, educated/ignorant. This shows inequality in the power of cultural representations as the ultimate ‘other’ is negatively represented since the subaltern cannot speak. The representer through this process acquires an improved self-image. Oyewumi (2004) for instance, takes issue with Walker (1992) by noting that her tale of the horror of FC is couched in the Western/Non-Western binary opposition. Additionally, Alice Walker invents and presents a rather voyeuristic and groin-centered preoccupation

with Africa, thereby making her book "... a veritable evangelical tale". In 1993, alongside Parmer, they exposed African women's genitalia as an anomaly in their film project *Warrior Marks*. This sexualization presents the African woman as being nothing other than hypo-sexual because of her presumed missing part (the clitoris<sup>1</sup>), "a collection of sexual parts". Whatever, the realities of Africa and African bodies they are liable to be paraded to suit the Western mind/body of its sexual predilections *du jour*. This mirrors the unequal cultural power and the Western tradition of employing stock images and ideas about Africa (2004:3). Alice pathologizes difference, as her vision is that society is a reflection of the physical bodies to be found in it. Phenotypical differences between Africans and Europeans has led to the pathology of difference and African women are consequently presented as the ultimate other. Oyewumi further notes that feminist purveyors of global sisterhood based on a common genitalia- are untenable because "*even apparently similar body parts have different histories and locations. It is similar histories and common interests, and not body parts, which should be the focus of alliances.*" Alice further homogenizes African women's lack of sexual pleasure despite the diversity of the ritual procedures (clitoridectomy, infibulation, excision etc), nations, cultures, and societies. This is a unilineal view, or what Hountounji calls the "myth of Unanimism"- wherein it is believed that in "primitive" societies, there is universal agreement, no individual beliefs/opinions but only collective systems of belief exist (see also., Fanon.,1963). (cf Oyuwemi, 2004: 5), even when there is no consensus within a given culture, but rather contestation, disagreement, negotiation and renegotiation of cultural values and practices. In other words, view points even within the same cultural complex are never monologic but rather, polyphonic since even the concept of culture is characterized by contestation, negotiation, renegotiation and disagreement. Initiate's voices do not seem to bear Alice Walker and other activist scholars out<sup>2</sup>. Human rights studies that also use

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<sup>1</sup> The clitoris seems to be a symbolism for women's political power since by lacking it, African women are said to lack agency and need to be saved. But as Abusharaf (2000, 2001) shows, women use their "Bottom power" (circumcision status) as a source of power by being able to resist sexual demands from their husbands and in the process to get them to do what they like. The Freudian concept of penis envy seems to be appropriate here.

<sup>2</sup> See Abusharaf (2000, 2001), and EL Dawla (1999) whose informants present the ritual as a symbol of their power. They are able to use their circumcision statuses to garner for resources from their husbands and to get their voices heard. Emic contextual personal accounts have equally been rendered by Kratz (1994), Ahmadou (2001), Njambi (2004) and others.

a biomedical model equally present FC using harmful effect as the unit of analysis. Within this framework, sexuality becomes a static object of enquiry, decontextualised from wider historical changes.

Simultaneously, the human rights discourse has paradoxically been appropriated against FC by some circumcised women. Two practical cases will illustrate this point of view. Ms Ayaan Hirsi Ali, originally from Somalia, has become an icon in championing the human rights of women in Islamic societies. Clitoridectomised at the tender age of five, she later escaped an arranged marriage by immigrating to the Netherlands in 1992 where she subsequently sought and received political asylum. She served as a member of the Dutch parliament from 2003 to 2006, during which time; she worked relentlessly on furthering the integration of non-Western migrants into Dutch society and on defending the rights of women in Dutch Muslim society. In 2004 alongside Theo van Gogh, she co-produced the film *Submission* about the oppression of women in Islamic cultures. The airing of the film on Dutch television led to the assassination of Van Gogh by an Islamic extremist, Mohammed Bouyeri because the film was alleged to have ‘blasphemed’ Islam. This murder horrified and sent shock waves across Holland, Europe and around the world. This story represents the clash of political Islam with western secularism, militant Islam and infidels and marks the very limits of tolerance within multiculturalism. The preservation of archaic values such as religious and male dominance are responsible for the oppression of Islamic women and the lack of individual rights, at the same time, it sustains the deeply entrenched poverty of Muslims within their communities and abroad. It is above all, a call for equality and the reformation of conservative religious pillars, a shift of values in modern Islamic societies. Hirsi Ali, as detailed in her memoir *Infidel*, shows that she became defiant of customary rules, rules that had shaped her habitus. She fled from a secret pre-arranged marriage to her cousin that endangered her family’s honour so as to attend secretarial school and to work out of the private sphere of the household. Her personal transformation against her own culture offers an illuminatingly deep understanding and a promising message of resilience and renewal. As she points out “*We in the West would be wrong to prolong the pain of [a transition to the modern world] unnecessarily, by elevating cultures full of bigotry and hatred toward women to the stature of respectable alternative ways of life*”. For detailed and elaborate accounts of the development of Hirsi Ali’s habitus and the murder of Van Gogh, see Buruma (2006) and Hirsi (2007) among others.

The second case took place in the USA where the issue of FC is framed in terms of asylum law. The US passed anti-FC laws in 1996 partly prompted by the Kassinja case. Kassinja, 23 years old, of Togolese nationality had arrived the US under a false passport. She was duely arrested, subsequently detained and her application for asylum against ‘mutilation’ turned down. Upon appeal, she was given US citizenship as her lawyers argued her case on the basis of gender-based discrimination and “cultural punishment”. This decision marked a precedence in US jurisprudence. The US thereafter passed federal anti-FC law in 1996<sup>3</sup> (Boyles & Preves 2000: 721) sponsored by Congress woman Patricia Schroeder who stated that “*Over 100 million girls and women in the World have undergone some form of FC*” and thereafter categorically stated that it is happening here (in the US). By focusing the searchlight of the Western media to Kassinja’s fear of having an ‘abnormal’ genital should she set foot in Togo, Rosenthal, a New York Times columnist advised President Bill Clinton to resolve the ‘genitalia plague’ in these words:

He called on President Bill Clinton to endorse a three –point plan, including designating \$100 million of the American foreign aid budget for local campaigns against ritual mutilation, giving more aid to countries that actively work to eradicate female genital mutilation and less, or nothing to those that don’t, and making the issue a top priority for American delegations to the United Nations (Gollagher, 2000:188).

Fears and media speculations thereafter mounted that African women will inundate America as an escape from the horrors of FC, as an alibi against poverty. This is partly how America came to link aid with FC eradication (as if it is a plague) in particular and human rights protection in general for most states where the ritual cuttings go on. Boyle & Preves (2000) however debunk this “responding to massive immigration argument” by conceding that despite massive migration to the US between 1955 and 1995, less than 4% of immigrants came from the FC-endemic zones of Africa<sup>4</sup>. And most immigrants are males with a probable western orientation. Certain US states such as California, Delaware, Illinois, Michigan, Minnesota, North Dakota, Rhode Island, Tennessee and Wisconsin, immigrant bastions had already outlawed FC well before the

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<sup>3</sup> It appears in my view that since the national ban came only after the Kassinja incident, the aim of legislation was to stem the tides of immigration and asylum claims on gender-based claims of persecution from ‘infected countries’.

<sup>4</sup> These are countries such as Ethiopia, Egypt, Liberia, Somalia and the Sudan where the invasive form of the procedure is visited on females.

Federal ban went into action (Dugger, 1996). Detailed and illuminating documentation of the Kassinja and other 'FC-flight' cases have been various provided by Njambi (2004), Kratz (2003) Egan (1994) and Dugger (1996) among others.

Both cases discussed above show the appropriation of human rights norms by individuals and the intersecting arena in which the issue of FC has become entangled. Here cultural actors are contesting their own culture showing lack of consensus over cultural norms. Feminist and human rights groups have always appropriated Western human rights concepts to make their case for the need to grant refugee status to 'victims' of FC. Furthermore, the human rights framework which most activist-scholars use evades cultural specificity or take the standards of one culture as universal when in reality, they are not. It also glorifies but the individual unlike the societal context in which the practices are visited on young females<sup>5</sup>, which prioritizes but the group. In other words, initiates sacrifice their individual needs for that of the social group. Ironically, the practice is done for the very best of intentions, as a sign of motherly or self-love. Mackie (2001) compares FC to dentistry whereas Abdullahi (1999) maintains that it is like the Christian rites of "first Holy Communion and Baptism in the West". Among the Ejaghams, "undergoing female circumcision is like graduating from a University with a degree" (MA Sophi, interview of 06/06/2006). Racialized representations contradict the lived experiences of the initiates who feel empowered, and proud that they have attained womanhood and are therefore exposed to the special knowledge, wisdom of elders and special treatment (Robertson, 1996: 21, see also Dellenborg, 2004, Ahmadou, 2000, Lori, 2000). These static representations suggest that ritual FC is cast in stone, is unchanging whereas practitioners are making procedural reforms all the time. When Green (2000) discussed the prospects for cultural resistance to male circumcision as protection against HIV/AIDS among non-circumcising groups with a South African healer, the latter observed that "When tradition and the health of our people are in conflict, it is tradition we must sacrifice."

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<sup>5</sup> The adoption of FGC by girls among the Sara partly attracted by the feasting and pleasure they derive from it is an interesting case. They mobilize the necessary resources and recruit circumcisers by themselves and do it despite refusal by significant social others in their community and in the process declare their own self-autonomy by institutionalizing and bureaucratizing the procedures. (see Lori, 2000, see also Dellenborg, 2004.) They may be seen as vectors of 'negative change'.



Research has demonstrated that traditional healers are in line with sexually transmissible disease (STD) and HIV/AIDS prevention strategies from the logic of transmission and causation: limiting the number of sexual partners, wearing protective charms or tattoos, having “strong blood”, using condoms to reduce the risk of “pollution”, or undergoing a “traditional vaccination” consisting of introducing herbs in skin incisions (Green, 1992, Green et al., 1993, Nzima et al., 1996, Schoepf, 1992), as well as female and male circumcision. Some studies have reported that the spread of HIV/AIDS could be prevented by upholding traditional values regarding abstinence such as FC, observation of sex taboos and strengthening the roles of women’s societies such as Anankungwi in Malawi, which plays a strong role in counselling girls to observe local traditions pertaining to respect of elders and dressing (Bowa et al. ND, see also Orubuloye et al. 1994). In most cases, condoms have become acceptable to traditional healers, especially when they dovetail with their belief system. For instance, many African healers consider semen an important nutritional element for the nourishment of a growing foetus, for the maintenance of the mother’s health and beauty, but their concern for family and cultural survival can supersede this belief and allow them to promote condom use (Green et al., 1993, Schoepf, 1992). Traditional practices are neither impermeable to change nor incompatible with modern rational science- both can be harnessed and the outcome will be democratic.

My reaction as an African male anthropologist to the sensationalized and moralizing Western discourse that underpin and “influence Western media, law and feminist thought: ignorance and oversimplification of African history, cultures and religions and exaggerations of the extent and geographical distribution of the various female genital cutting procedures performed” (Stanlie and Robertson, 2005) as unchanging was to find out through local level ethnography from participants in Ejagham land what had changed over time in this ritual practice especially within the context of the moral panic generated by the HIV/AIDS pandemic. What are their diverse reactions and how are they responding to the huge mediatization of the ritual practice? How are they negotiating change in the face of intercultural contact and opposition from local anti-FC NGOs and their external allies? But, above all, do participants really have any agency?

Despite my black skin, I was often seen as an agent of neocolonialism by virtue of studying in Europe. This is of course a reaction to Western criticisms of the ritual practice which often borders on hygiene and health. I was therefore caught up in “the chains of translations”, in the cross-fire of this huge debate as a “Whiteman with black skin” (see Pemunta, 2009, 2010). I however remain deeply aware that the mere mention of FC in the

West attracts outrage, surprise glances and deep embarrassment. While in the field, I quickly came to the realization that this huge debate is based on nothing else- but on the conflation of several universalisms: particularly health and sexuality, even when these are dynamic, socially and culturally constituted realities (Foster and Anderson, 1978, Kleinman, 1980, Romanucci-Ross, Merman et al. 1991, Hahn, 1995). And even when local knowledge and modern science are not antithetical to each other-both can be harnessed together and the outcome will be both democratic and progressive. Ironically, FC has become part of the trope used both in wider political debates about an immutable and unchanging, famine-stricken, war-torn and AIDS-infested Africa and about the need to rescue and 'civilize' African women who are often described as having no agency of their own, as chattel imprisoned by ancient patriarchal customs. Regarding FC in particular and the politics underpinning political representation in general, Winter notes this misplaced priority and manipulation of women by feminists and sensationalists thus:

as is often the case, the debate concerning these women is less about the women themselves than about the appropriation of women as political symbols. In other words, it is about the use of women as ammunitions in a polemic of central concern to their lives, but where the issue is not the women's own interests but rather the consolidation of the power of others to define those interests (1994:939).

The blatant failure to listen to "African women", take social change into account and to contextualize the practice of FC is reflected in most studies undertaken by activist-scholars (Walker, 1992, Walker and Parmar, 1993, Hosken, 1986, Daly, 1978). Paradoxically, although these activist-scholars have fuelled worldwide activism against FC, they have simultaneously, but inadvertently frustrated trans-cultural dialogue through their sensationalism, and have ironically become enemies to the very women they want to "save" through the benevolence of "civilization" because the needs of these 'victims' have been universalized and are being determined for them. Frank Hosken (1986) for instance, condemns female genital mutilation on one main count: the aim of genital mutilation is "to mutilate the sexual pleasure and satisfaction of women". If women are already mutilated before their debut of sexual life, then they have no other sexual pleasure and satisfaction other than the one after circumcision. They have no prior experience of 'normal sexuality' on the basis of which to judge or compare their experiences after circumcision against. It is like telling somebody who has never eaten pork (devout Muslim) and will never eat it, about the pleasures of consuming it. Her Euro-American

concept of sexual pleasure begs the question at best. From this premise, she then concedes that women's sexuality is controlled, as is their reproductive potentials. Contrary to her position, Boddy (1982) locates women as central and strategic actors and interprets FC and the covering or closure as symbolic acts that serve to foreground women's fertility by de-emphasizing their sexuality, and defining and creating women as potential mothers rather than as sex partners. FC becomes a barometer for assessing fitness and reproductive capacity. Nici Nelson (1987) has pointed out that among the Kikuyu; sexuality for women is not about sexual enjoyment. Rather, it has more to do with procreation than with pleasure and more specifically, social reproduction for the continuity of the patrilineage (see also Spaulding, 1992., Waly, 1997, MacGaffey., 1996). Ritual FC therefore controls and channels female sexual desire towards social and biological reproduction. Hosken homogenizes male sexual politics in Africa and worldwide: 'to assure female dependence and subservience by all means' (1981: 3-24). Physical violence against women such as rape, sexual assault, excision, infibulation among others is perpetuated 'with an astonishing consensus among men in the World'. Here women are described as victims of patriarchal control- the sexually oppressed. Although male violence is a truism, defining women as archetypal victims reduces them into "objects-who-defend themselves" and every society into a binary opposition between powerless (women) and powerful (men), even when power is unevenly distributed within every given society. Abusharaf (2001) has argued that 'virtuous cuts', FC, is considered as an act of ritual empowerment by her respondents. The concept of patriarchy like power, should be seen as relational and dynamic, with spaces for the multiple deployment of power. Bordo (1993:23) has pointed out that dichotomies such as oppressed/oppressor, powerful/powerless are inadequate for capturing 'the social and historical complexities of the situations of men and women'. She cites the Pokot of Kenya among whom circumcision empowers women by equating them with men in terms of status. Patriarchy by demonizing men, she notes, fails to highlight the complexities of race, class and the sexual situations of both men and women who find themselves embedded in institutions that they neither created nor are in control. Male violence must be circumscribed, theorized and interpreted within specific societies so as to provide for both better understanding and to put in place effective mechanisms towards change (Mohanty, 1986., see also Chatterjee., 1993).

## HIV/AIDS and the Politics of Exoticism

The advent of the HIV/AIDS pandemic and the continuous elusive search for a medical solution to the threat of this terminal disease has led to an increased focus on the social and cultural context of the disease, especially in Africa- the very epicentre of the scourge. A wide range of sex-related cultural and social practices including- but not limited to- wife exchange, widow inheritance, polygamy, dry sex, sexual cleansing and female genital mutilation have accordingly, come under the epidemiological microscope and attracted outrage. For a detailed analysis of cultural practices contributing to the transmission of HIV in Africa (see Hrdy, 1987, Piot et al, 1984, D’Costa et al, 1985). These practices simultaneously serve as a rallying point for blanket condemnation in the public health community- among policy makers, activists, academics and governmental and non-governmental actors- who are unanimously calling for the eradication of these practices because of their presumed incompatibility with the health, social well-being, human security and human rights of both women and children. Harmful myths from colonial times still maintain that all African women are circumcised and with the advent of AIDS, all Africans are HIV carriers. Following Stanlie and Robertson, popular Western perceptions reduce Africa and African women into “Three Rs”:

First, they reduce Africa’s fifty-four countries and hundreds of cultures to one uncivilized, “traditional” place outside of history to be compared with the “modern” “West”. Second, they reduce Africans and African women in particular, to the status of their genitals, to being malicious torturers or hapless victims. Finally, uniform depictions reduce all cutting of female genitals to the most severe practice-infibulation. The cumulative effect of these reductions is that all African women are represented as having been infibulated due to unreasoned adherence to tradition and/or malicious ignorance. (2005:5).

This reductionism actually conflates the myriad problems of “African women”. As the Position Paper of the African Studies Association poignantly states “many African women need food for themselves and their children, greater control over the means of food production, access to clean water, a secure fuel supply, access to health care including family planning and ways to acquire cash income”. *Heightened concern regarding clitoridectomy and infibulation as the sole obstacle to the achievement of the status of women may be a luxury that only the West can provide* (emphasis mine). The paper admonished benevolent humanitarian efforts to energetically support internal social change through collaborative

research, discussion and dissemination of information about progress and technical support, instead of adopting a militant position that forbids aids to countries with FC practicing ethnicities. This was in the 1980s before AIDS came to add another burden to the problems of women and to re-energize colonial ideas and perceptions of, and demonization of Africa and Africans.

The advent of AIDS only came to re-ignite and re-enforce stereotypical images and representations of Africa and Africans since the authority of epidemiological statistics on AIDS in Africa has actually magnified because of what David Cohen (2004) calls an “epistemology of certainty” that affects the way “Africa” is studied. Simultaneously, ritual FC (a blanket term for a diverse set of polythetic social and cultural practices) continues to generate unending ideological debate because of its presumed association with the transmission of the human immuno-deficiency virus through the bloodletting that it entails. As pointed out by Hrdy (1987:112) FC might be an inadequate explanation for enhanced heterosexual AIDS transmission because “although the presence of lesion in the vagina may increase male-to-female transmission, it is unclear how female-to-male transmission would be enhanced in this situation”. He further points to lack of correspondence of the distribution of AIDS and FC and although data are sketchy FC is not practiced in areas with the highest level of HIV seropositivity.

Representations of African women as powerless and unable to negotiate safer sex have also been correlated to their greater risk of HIV infection, even when the evidence base is shaky and speculative. Research has shown that there is wide variation in the relationship between HIV and income (Piot, Greener, Russell, 2007). Findings from surveys in eight African countries (Burkina Faso, Cameroon, Ghana, Kenya, Lesotho, Malawi, Uganda and then United Republic of Tanzania) demonstrate higher HIV prevalence among adults in the wealthiest quintile than among those in the poorest quintile (Mishra et al., 2007). Available survey data from five of six West African countries shows that women living in the wealthiest households have higher HIV prevalence than other socioeconomic groups of women, but the relationship between wealth and HIV is less clear for men in the sub region (Lowndes et al., 2008).

## **Female Circumcision, AIDS and Male Circumcision**

Several researchers have been preoccupied with the relationship between AIDS and the presumed protective effects of male circumcision (Hirozawa, 2001, Bloemenkamp et al. 2000), as well as the medical

complications resulting from FC (Althus 1997, Jones et al. 1995, Larsen et al. 2000, Obermeyer, 1999), partly because the ritual practice is hypothetically assumed among other harmful medical effects to be capable of transmitting AIDS, despite shaky and inconclusive biomedical evidence. On the basis of data from 28 studies conducted in eight African countries, Hirozawa (2001) concludes that circumcised men are only about half as likely to contract HIV as uncircumcised men, and that circumcision confers a protective effect on men at higher risk of HIV infection. He further reports that population-based representative cohort study undertaken in Southwestern Uganda found a lower incidence of HIV infection among circumcised than among uncircumcised men.

Bloemenkamp et al (2000) found a reduced risk of female-male transmission of HIV in circumcised men in high risk populations in Sub Saharan Africa, while Kirby and associates (1991), report more efficient male-to-female transmission of HIV than female-to-male because women have a higher risk of infection than their male partners-they are unable to negotiate safe sex-despite their lower risk behaviour. But Hunter et al.(1990) report that women with constant, uncircumcised sexual partners in Nairobi, Kenya had a statistically significant higher risk (OR of 3.7 (95 % CI 1.5-9.0) of seropositivity. Though surprising, nothing is said about the risk of infection per sexual episode. Seidlin et al (1992) through discordant partnership research found out that there does not appear to be a reduced risk of transmission from an infected, circumcised man to his female partner. Yet, a New York study of 142 women of HIV infected index cases showed that partner serostatus was unrelated to the circumcision status of index case. Studies from Brazil and Uganda respectively, show that lack of circumcision and a history of genital sores were significantly associated with HIV seropositivity in male sexual partners of HIV positive women but no association was found between male circumcision status and seropositivity of female partners. One key finding of the latter study is that viral load may affect the protectiveness of male circumcision when considering male to female transmission of HIV (Hellman, 1991, Seidlin, 1992). On the other hand, a few studies have investigated male-to-male transmission of HIV through receptive anal intercourse. Buckfinder et al (1998) for instance, found a relationship between lack of circumcision and seroconversion while Kreiss' (1992) cross sectional study in the same country found a significant association between seropositivity and being uncircumcised- a status, implying an increased risk of HIV infection in the insertive partner among men who have sex with other men. These studies suggest that the main problem with assessing infectiousness and susceptibility in relation to circumcision

status in male sexual encounters is ascertaining the portal of the entry of infection.

However, this male-circumcision based intervention strategy to HIV/AIDS advocated for by the scholars mentioned above has been opposed. For instance, Bonner (2001) maintains that there are very diverse circumcision practices even among geographically proximate groups casting doubt on how much prepuce must be removed to confer immunity against HIV/AIDS. He further points to a loss of immunity at different ages and that there are different cultural and religious rationales for circumcision implying that there are religious and cultural barriers for implementing it as a public health intervention. To compound matters, circumcision, he points out, does not appear to have any impact on transmission from HIV positive men to their partners. Although research by Salamon (1999) shows attenuation in the protective effects of circumcision at later ages, Klouman et al (2005) did not find any positive association between female genital surgery, HIV infection, other STIs or infertility but rather, a positive, though non-significant association between female genital cutting and bacterial vaginosis was found with a crude odds ratio of 4.6. This however, warrants further investigation.

Studies that use a biomedical model equally present FC using harmful effect as the unit of analysis. These studies are replete with methodological problems, including, but not limited to non-representative samples, lack of control groups, the infeasibility of conducting interdisciplinary large scale research at a population level, the diversity of FC practices and the perception that problems resulting from the ritual procedures is part of womanhood- factors that all compound rigorous research. For instance, through analysis of DHS data for the Central African Republic, Cote D'Ivoire, Egypt, Eritrea, Mali and Sudan respectively, it is not clear how frequently presumed harmful effects (medical complications) occur. And in societies in which almost every woman is circumcised, problems resulting from circumcision may well be perceived as natural and part of a woman's life cycle (Althus, 1997). However, a comparison of genital cutting practices in both Burkina Faso and Mali show a significant positive relationship between the severity of genital cuttings and the chances of a woman having both gynecological and obstetrical problems. They cite an unpublished report in Mali showing that women who have undergone FC are almost 7 times more likely than those who have not to experience complications at parturition (Jones et al. 1995). The study population was however limited only to women who had undergone FC. A comparison with women who had not undergone the ritual procedures would certainly have made the results more valid. A comparison of DHS data from the

Central African Republic, Cote D' Ivoire and Tanzania among other findings, concluded that circumcised women in Cote D'Ivoire and Tanzania had lower levels of childlessness, lower infertility rates by age and higher total fertility rates than uncut women. A reverse pattern prevailed in the Central African Republic. There was however, no statistically discernible impact on women's ability to reproduce. A further finding was that knowledge of complications are based on observations of clinical cases and that no studies have been undertaken at the level of a population with the aim of documenting complications (Larsen et al. 2000). There is, for instance, no comparison of uncut women for their study and they relied on self-reports without any comparison with medical examination.

A meticulous review of publications dealing with the so-called harmful effects of FC by Obermeyer (1999), shows that the evidence base is shaky. According to her, original reports are replete with numerous methodological errors (small or unrepresentative samples, lack of control group and vague descriptions of supposed medical complications). Only 8 studies lived up to standard epidemiological control criteria for scientifically validating evidence. She concludes that medical complications are the exceptions and not the rule, and "that female genital surgeries are not incompatible with sexual enjoyment". Research has also been undertaken on presumed male sexual complications resulting from FC. Almroth et al (2001) for instance, report penetration difficulties, exposure to wounds and infections on the penis as well as psychological problems when having intercourse with circumcised women by men in the Gezira scheme along the Nile Valley in the Sudan. Furthermore, more young men showed the willingness to accept a woman who had not undergone FC as a spouse and 55% of young men preferred marriage to a woman without FC, unlike 13% of grand fathers. However, by not capturing women's voices and perspectives, they failed to produce a balanced account.

A hypothetical association exists between FC and HIV/AIDS: the ritual cutting practice can facilitate HIV/AIDS transmission because pharaonic circumcision narrows the vagina and in an attempt to penetrate, men are likely to be wounded and therefore to be exposed to HIV/AIDS transmission (Kun, 1997). He points to the use of the same instrument for 5 to 10 females simultaneously during a circumcision session. He rather seems to hold a hardened view of culture as unchanging since practicing societies are increasingly making procedural and hygienic changes such as: the use of a fresh blade for each initiate in the wake of the incurable HIV/AIDS pandemic. Curiously enough, there is no scientifically established correlation between HIV endemic zones and circumcising



societies in Africa. This is, however, not to downplay the fact that FC can fuel the spread of HIV transmission and is a likely risk factor.

In reaction to the perceived risk of FC, particularly its ability to transmit AIDS, Shell-Duncan (2001), while perceiving a double standard in the condoning of male circumcision and medically unnecessary cosmetic surgeries by the same institution prohibiting FC while simultaneously indulging in male circumcision and unnecessary surgeries as hypocrisy, advocates for medicalisation as the way forward towards effective eradication. However, opponents of a harm reduction strategy mention lack of consent from the initiate, reject both sanitation and medicalisation of the procedures on grounds that it is performed on minors who are unable to grant “informed consent” (see among others, Price 1997, Bartow, 1999, Mason, 2001). Mason in particular takes issue with criminalization because it clashes with consent and capacity and yet, male surgery is not forbidden. She attributes the prevailing situation to a “legal gender bias”, the very outcome, in her viewpoint, of a liberal conception of “tolerance” and the limits of consent in Australia. Any act of circumcision (male or female) is an unnecessary act of violence, is ‘non-therapeutic’ and circumcision lacks consent since rights reside in children with parents acting only as custodians and executors (Price (1997). These scholars however overlook the fact that in some societies like among the Ejagham who are the focus of this study, there are several categories of initiates among which are mature women. Furthermore, the whole notion of rights is relative: human rights have a Western constituency. Women will rather choose community membership through circumcision than to exercise their human rights at the risk of their gendered personhood and marriage. Ironically, there are few cultures the world over in which only girl’s genitals are modified. There also exists kinship, religion, economy, family life and ceremonial differences among African ethnic groups that practice circumcision for both sexes. Some of these groups are matrilineal, some Islamic, some puritanical. Shweder accuses the West of using its own anatomical folk concepts about proper female bodies and aesthetics in presenting African mothers as torturers (Schweder, 2005).

It seems safe to maintain that the effect of circumcision seen in high risk population is not generalisable, cannot be extrapolated to other groups and that the protective effects of male circumcision varies. Furthermore, complications resulting from FC are the exceptions since they depend among other things, on the type of circumcision undergone. This calls on us to recommend risk reduction strategies of proven efficacy against HIV/AIDS such as condom use and hygienic environments for the performance of both male and female circumcision since potential

morbidity and mortality and the calculation of risk are some of the most serious considerations in developing countries where the prevalence of complications is patchy and anecdotal unlike in the developed world.

Ironically, despite mounting epidemiological evidence suggesting that male circumcision provides some modicum of protection against STD and HIV infection especially in resource poor countries with predominantly heterosexual transmission (Halperin and Bailey, 1999, Bradley 1998, Moses et al, 1994), public health officials have been ambivalent and have failed to promote male circumcision as a harm reduction strategy despite the rush for male circumcision in traditionally non-circumcising societies as protection against HIV infection. Mundhenk (2000, cf Green, 2000) reports that:

There seem to be a variety of motivations given when I ask people why they are getting circumcised. Apparently boys from the areas where circumcision is practiced have been boasting about the values of circumcision, mentioning two in particular. First, they claim that women get a lot more pleasure sleeping with a circumcised person than with an uncircumcised one. Second, they say that being circumcised helps to prevent you from getting various diseases, including venereal diseases and AIDS, so that after being circumcised one can sleep around with confidence.

Green (2000) has outlined six obstacles for this skepticism in public health programmes.

1. In resource constrained country settings, circumcision often takes place in non-medical settings, under conditions conducive to sepsis. If men in non-circumcising societies were to opt for circumcision, this might increase the chances of health problems as a result of dangerous surgical practices by poorly trained or untrained practitioners.
2. Circumcision might give men and their partners a false sense of security from HIV infection. They may consequently engage in riskier sexual behaviour (cf. Richens et al., 2000).
3. There is insufficient evidence that later circumcision in adulthood would protect men from STDs including HIV infection. In fact, the evidence suggests that the earlier the age of circumcision, the greater degree of protection against STDs and HIV (Kelly et al. 1999).
4. There is an anti-circumcision movement in the USA which equates male circumcision to useless genital mutilation, thereby indirectly linking this with the female genital mutilation issue in Africa.

5. Finally, some HIV/AIDS workers are simply unfamiliar with epidemiological findings related to AIDS and MC, or they are familiar with the evidence but they don't believe it.

## **Integrated HIV/AIDS and Anti-FC Programmes**

The emergence of FC in the global discourse on HIV/AIDS multiplied and led to a flood of integrated anti-HIV/AIDS and FC eradication programmes. These efforts are however misplaced because they focus on health alone, see local knowledge as antithetical to rational science and are based on a static notion of culture in FC practicing societies, even when culture is dynamic. They de-emphasize the fact that the ritual practice is open to modernization, sanitization and rationalization. These interventions by both state and civil society actors and their allies are therefore underpinned by dominant perspectives, the influence of material hegemony, and dichotomous ideological debates: local/global knowledge, culture/human rights, and tradition/law, primitive/civilized and inferior/superior among others. Circumcised females are represented as victims of a universal patriarchy, as casualties of male chauvinism whereas, patriarchy does not preclude both resistance and agency. These representations became increasingly prevalent in the decades of the 1990s as activist scholars diffused images of infibulated women through the mass media, thereby giving these diverse practices a new and transnational coherence, but simultaneously triggered a backlash of resistance in practicing societies who saw them as merely out to eradicate not only the practices but their social selves and cultural well-being.

While FC practicing societies vary in social structure-some are matrilineal, others are patrilineal, anti-AIDS and -FC activism has continued to scape-goat patriarchy and to place a high premium on health alone whereas, these are recognized social, economic, development and human rights issues. Influenced by sensational popular and academic texts that portray circumcised women as victims in need of rescue by the more 'civilized' world, individual activists have fuelled national and international activism with one aim- eradication, as if it is an epidemic, and not sanitization.

Yet, cultural insiders perceive eradication as imperialism and cultural corruption, especially within the medical and institutional context of the HIV/AIDS pandemic in which the concept of health risk has paradoxically been doubly appropriated among the Ejaghams (see Pemunta, 2007). The pandemic has instead provided a platform for both resistance and simultaneous practice of FC as children are increasingly being circumcised

at tender ages so as to forestall contestation at maturity under the influence of the “Whiteman”. Hardliners are arguing for the tightening of control over women through FC, whereas progressives point to the bloodletting that the ritual procedure entails as capable of spreading diseases with HIV/AIDS inclusive among participants. Simultaneously, sensationalized, fetishized and unitary representations which often times underpin eradication initiatives and materials have instead stonewalled benevolent eradication campaigns, thereby reinforcing resistance to change in the name of cultural authenticity among hardliners.

It is important to acknowledge that FC is an act of gender-based violence, but the tropes of male power and Western dominance in the debates as well as the monolingual construction of the different realities of FC have silenced, erased the voices of and demonized participants- who are in fact, their own change agents. In the same light, dichotomous models of power permeate AIDS prevention discourses- that is the colonized/colonizer binary of nationalist discourse as well as feminist discourses of masculine oppression and female subordination- re-inscribing stereotypical images of African women as downtrodden, passive and sexually exploited victims. It might be argued that the images of circumcised women in the minds of public health/social care experts, activists, and bureaucrats has more to do with anti-colonial and feminist politics than with the life world of FC.

But for a few anthropological studies that have provided detailed, perceptive and nuanced accounts of FC (Hayes, 1975, Boddy, 1982, Gruenbaum, 1982, Abusharaf, 2000, 2001), it is most often the case that participants are demonized, pathologized and spoken for. This calls for the need to wear ‘native spectacles’, to listen empathetically to these subalterns in both analysis and intervention research on this thorny and controversial issue. Although I do not claim spokesman status, it is possible to interrogate why the voices of these subalterns are silenced- unequal power to construct social reality about FC.

This study is based on nine months of multi-locale ethnography among Ejagham tribes in Southwest Cameroon. It provides an insider perspective on the series of intergenerational conflicts over cultural values and practices resulting from the moral panic engendered by the advent of the HIV/AIDS pandemic. It further documents transformations in the institution of FC orchestrated by the changing medical and institutional context of the HIV/AIDS pandemic and the implications for understanding the agency of participants. Their stories contrasts sharply with the simplicity of homogenizing representations and demonization discourses used to describe them, and ground an understanding of FC in the place it

matters most- life world of participants. It emphasizes the need for a nuanced 'transnational feminist standpoint'- to engage women inside, outside and *beyond* representations of a victim identity and to see them as constructing their world through an empathetic understanding that lays bare the fluidity and paradoxes of women's subjectivity *insitu* (See Law, 2000, Kempadoo, 2004). The overall lesson is that we should avoid representations that portray FC participants as having no agency (even when agency is structured). There is the need to avoid reductionism and to ground an understanding of FC in the lives of its participants, while simultaneously being aware that it is a multifunctional phenomenon calling for a multi-pronged development approach.

As a polythetic cultural complex, FC is intertwined with the whole cultural political economy of the Ejaghams, providing a social security network and gendered power to participants and not merely a health issue. By reducing the complexity and nuances of the ritual cutting to health alone, anti-FC activism has instead produced a backlash marked by simultaneous contestation and practice. Furthermore, the anti-FC campaigns have resulted in the privatization of FC on increasingly younger girls. However, the recent waiving of the ritual cutting as a precondition for membership into the Moninkim cult partly because of the ageing of the initial initiates, the health risk of the HIV/AIDS pandemic and anti-FC advocacy campaigns by local NGOs shows that change is underway. Simultaneously, inter-tribal marriages with members of non-circumcising tribes and romantic love relationships beyond the purview of the traditional patriarchal orbit have led younger lovers to be increasingly seeking mutually satisfying love relationships for which FC, a 'virtuous cut', becomes an obstacle.

This study argues for the need to tailor health education and social change initiatives with and not against the beneficiaries. Rather, change should be in the interest of the target population and not against them. Theoretically, I call attention to the need to look at local level processes and to trace resistance from below through an analysis of actor's multiple positioning, resources and their linkages to and alliances with other actors. Local processes are rooted in wider fields of power and are affected by forces at various scales calling for the need to look at the entanglement between local and global, economic, social, political and historical processes in the study of health and other cultural issues.

## Scope of Study

In line with the power-oriented vision of culture adopted for this study, in chapter one, I examine the concept of culture, power, agency, gender in the construction of the reality of FC. The penultimate section examines the methodological approach used in the data elicitation process.

Chapter two addresses the political economy of the Ejagham region. I highlight their historic place and embeddedness in the regional economy and explore the impact of larger global economic processes and the changes it caused with particular reference to women and youths, a situation that has generated unending conflicts between generations and the sexes. I factor in the analysis the dynamics of the traditional sexual organization of the Ejaghams while capturing the impact of patriarchy on women's bodies and their sexuality. I make note of, and account for changes in the institution of marriage and in the pattern of female socialization over time.

Chapter three examines the relationship between various male and female institutions among the Ejaghams and the conflict of authority between traditional and modern systems of rule given the present postcolonial context in which the people find themselves. It further examines the dynamics of Moninkimhood and the FC process as an instantiation of local patriarchy. The Moninkim cult is the centre of all the conflicts going on about FC among various loose segments of Ejagham society.

Chapter four examines how the moral panic generated by the advent of the HIV/AIDS pandemic became an ambivalent framework for support, resistance and contestation of FC. This contest pits western rational science represented by NGOs and the state against local culture and knowledge system represented by various loose actors in Ejagham community. Both knowledge systems, I argue, can be harnessed and the outcome will be both democratic and progressive. In line with my power-oriented vision of culture as contestation, I examine state and NGO initiatives geared towards change in the practice of FC and the position of local stakeholders such as Traditional Birth Attendants (TBAs), the medical corps, local community leaders and members of the Moninkim cult- the very source of all the conflicts going on among generations and sexes in the community.

Chapter five looks at the people's attitude towards FC and the factors militating both for and against change in the ritual procedures. Generally, their attitudes may be segmented into a fluid, tripolar but interwoven continuum- resistance and acceptance of the necessity for change and