Session Theme: 402 AIDS Pandemic
Title: *"I Know Where She Goes"* - The Construction of Trust in Risk Assessment of HIV/AIDS Among Male Labor Migrants in Goa, India.
Organizer: Susan Watkins
Authors: Ajay Bailey[1] and Inge Hutter [1]

Abstract
India with more than a billon population has an HIV infection rate is at 0.7%. In 2002 alone, 4.58 million people were infected with HIV/AIDS (NACO, 2003). The present qualitative study investigates how male labor migrants assess their HIV-related risk in sexual interactions. The Health Belief Model and the Social Amplification of Risk Framework form the theoretical focus. This paper aims to comprehend the role of trust in the risk assessment of HIV infection. Trust is a heuristic, which men applied in assessing the risk of HIV infection from a partner. The higher the trust placed the lower the risk perceived and vice versa. Trust is constructed based on heuristics of vigilance and cultural schemas on fidelity and gender role behaviour. The migrant's construction of trust led to attenuation of the risk of HIV infection from spouse and other extra marital relations within the community.

Extended abstract

Description of the topic
The first case of HIV/AIDS in India was reported in 1986. Since then the epidemic has grown and spread all over India. In a country, which has more than a billon population, the present HIV infection rate is at 0.7%. At the end of 2002, 4.58 million people in India were infected with HIV/AIDS compared to the 3.97 million at the end of 2001(National AIDS Control Organization (NACO), 2003). The present study was conducted in the state of Goa among migrant men from Karnataka. Based on the prevalence of HIV, Goa is classified as a state with moderate prevalence of HIV. The moderate prevalence is defined as the states where the HIV infection has crossed the five percent level among high-risk groups(commercial sex workers, intravenous drug users, patients attending sexually transmitted disease clinics and men who have sex with men) and the infection being one percent among the antenatal women low risk group (women in antenatal clinics) (PRB and PFI, 2003).

Figures at the national level suggest that the primary route of HIV transmission is the sexual route then followed by mother to child transmission and then through blood transfusion (NACO, 2003). From the dominant routes of transmission it can be interpreted that the men are acting as bridge populations, which are transferring the virus to their spouses, who then unknowingly pass it on to the child during pregnancy.
This also shows that the dominant mode is because of risky sexual behaviour of men. It has been found that in India higher percentages of men have high-risk behaviour and the disease is more common among men than in women. Currently out of four reported cases, three are men (NACO, 2003).

With this background in the present paper we look at how the migrant men assess their HIV-related risk from sexual interactions. We further investigate the role of trust in acting as an attenuator of risk. The construction of trust is based on heuristics of vigilance and cultural schemas on fidelity and gender role behaviour.

[1] Population Research Centre, University of Groningen.

Theoretical framework

Trust is always a risk given the partial knowledge we always have of other people's values, behaviour, motives and psychology (Baier, 1986). According to Sztompka (1999) when we have to act in an environment of uncertainty and risk, trusting becomes a crucial strategy for dealing with an uncertain and uncontrollable future (p.25). In interpersonal interactions trust is a reliance on other's competence and willingness to look after rather than harm something we care (Baier, 1986). In the present paper we look at how trust acts as a strategy to act in an uncertain environment of HIV/AIDS where risk to HIV infection is involved. The construction of trust plays a role in the assessment of the partner for the risk of HIV infection. In a study conducted by Chin (1999) among Asian /Pacific Islander women, the women constructed the trust based on indirect information on how the partner behaved, the length of time together and the partner sexual history. The construction of the trust determined if the women used protection in sexual interactions. The construction of trust differs with different partners and so does the assessment of risk.

The concepts perceived susceptibility and perceived severity from the Health Belief Model (HBM) (Rosenstock and Strecher, 1997) come together to form the risk assessment. To further understand how risk information is changed at different levels we incorporate in this paper the Social Amplification of Risk Framework (SARF). The social amplification of risk framework was first introduced in 1988. The developers of SARF adopt the metaphor of amplification from the classical communication theory and use it to analyse the ways in which various social agents generate, receive, interpret and pass on risk signals (Kasperson et al, 2003). Kasperson et al.(2001) argue that such signals are subject to transformations as they filter through various social and individual amplification levels. Some of the signal transformations serve to increase (intensify) or decrease (attenuate) the amount of information about an event or hazard leading to a specific interpretation and response by the receivers of the messages.

At the individual level the amplification process is based on the perceptions of the individual regarding the risk. According to Slovic (2001), this intuitive risk assessment or specifically risk perceptions are based on the people's previous experience with a particular hazard and from the threats that are occurring around them in the world. Though factual knowledge maybe presented to them, they rely on mental images and intuitive devices to assess their personal risk (Hart, 1995; Slovic 2001). Heuristics help individuals to take decisions and quickly assess the risks, which would not have been possible if they would go into a cost-benefit analysis.

Trust is a heuristic, which men and women apply in assessing the risk of HIV infection from a partner. The higher the trust placed the lower the risk perceived and vice versa. Thus it is vital to understand how men and women construct this trust while engaging in sexual interactions. In sexual interactions trust acts as an attenuator to the risk of HIV Infection. We term it as an attenuator because the individual in the process of assessing the risk of HIV uses cultural schemas (D'Andrade, 1992, Hutter and Ramesh, 2003) and visual heuristics first to assess the partner. Here if he trusts the partner then he does not have protected sex thereby attenuating the risk that he is putting himself and the woman in.

Data and research methods

The construction of trust and risk assessment as explained above are illustrated by empirical qualitative data from a fieldwork carried out in Goa (India), in September to October 2003. The study is work in progress and is funded by University of Groningen and Ministry of Foreign Affairs, The Hague. In this paper we share the findings from this study.

The techniques used for collecting the data were in-depth interviews. A semi- structured interview guide was prepared based on the research questions and the theoretical framework.

The semi-structured interview guide was pre-tested in a village in Dharwad district, where return migrants from Goa are found. In Goa, the in-depth interviews were conducted in five sites among 14 respondents (see limitations of the study in the conclusion). The in-depth interviews were recorded on tape. The interviews were conducted both in Kannada and Hindi. Prior consent was taken both for the interview and for the recording of information. The key informant interviews were carried to better understand the context in which the migrants sought employment and also the dynamics of the communities in which they lived. Three people from the five sites were selected as key informants. They included an out reach worker (NGO), a labour contractor and a scrap metal employer.

The in-depth interview data was transcribed from the tapes and the translated into English. The resultant data was fed into a word processor and the coding and arrangement of data was done manually. The coded data were analysed to bring out the general patterns(according to Grounded Theory). The analysis moved to and fro from the coded data to the original transcripts for the better understanding of the context.

Findings

In this explorative study we found that the construction of trust differed with the partner and risk assessment was not directly related to the HIV virus but to the characteristics of the partner. In the following sections we discuss the construction of trust in different sexual interactions or relationships.

Trust within marriage was seen to be the sole factor on which the risk was perceived to be low. The low perception of risk has underlying factors. These factors range from partners fidelity to the respondent's knowledge of where his wife went and with whom she interacted. The trust in wife's fidelity was connected with the respondent's belief that infidelity was the result of unsatisfactory sexual relations. Hence, the respondents believed that, as his sexual relationships with his wife were satisfactory to her, so she would not go to other men. The low perception of risk was also based on the perceived etiology of the disease. Men also believed that HIV infection spreads only from the Commercial Sex Workers (CSW). They classified women into normal women and other women. Normal women here referred to their wives. The normal women were supposed to be at home, look after the family and not to talk to strangers. The cultural schemas about gender roles are reflected in this classification. The attenuation of risk then is because of the beliefs of fidelity and understanding of the social behaviour of the wives.

The construction of trust within extramarital relations with other women in the community was also based on similar heuristics that were used for the wives. These other women in this discussion refer to women who do not engage in commercial sex and who are not married to the respondent. Risk assessment of getting infected from other women was perceived to be low. These women resided in the communities or in communities surrounding the research area. The men assessed the risk to be low and this led them to not to use condoms. The reported reasons for the non-use were that the respondent believed that these women had sexual relations only with him. The respondents attenuated the risk of HIV infection from these other women based on the heuristics they used to assess the risk. The respondents based this low perception of threat on the belief that he knew with whom this woman interacted and her whereabouts. The belief that these women were faithful to the men was base of the trust. The trust is further validated by the men on the beliefs of vigilance and understanding of the social behaviour of the women. A comparison was made between these women and the CSWs; the respondents felt that the threat was more from the CSW as she had multiple partners.

The construction of trust in commercial extra marital relations was a mix of both trust and distrust. The respondents distrusted the CSW and perceived the risk to be the higher from them. Thus they used condoms but then they distrusted the condom to be an effective mode of protection. Hence they used two condoms. Another finding was that the men placed the trust on the female brothel owner (*Gharwali*). They believed that the brothel owner checked the girls and she would not keep any girls who were sick. The component of trust on the brothel owner shows a kind of patron-client relationship. The trust on the institutions (NGO) leads him to attenuate his risk as he generalizes that the screening is taking place for all the CSWs. This shows that the assessment of risk is also influenced by other people's role; hence assessment of risk is not necessarily individual but shared.

Conclusion

The illustrations above have shown that there exists a close relationship between the risk assessment and the construction of trust. The mechanisms on which the trust is constructed are based on partner assessment and this assessment is based on indirect measures. These measures can put both the men and the women at risk. The understanding of the link between risk and trust will improve HIV related risk assessment and prevention planning.

The paper includes certain limitations; this was a preliminary study of 17(14+3) respondents, more in-depth interviews will follow in October 2004 to February 2005,these results will be included in the final paper.

The paper will reflect on at the theoretical level whether the concept trust should be included in the Health Belief Model and the Social Amplification of Risk Framework. Also we reflect on whether the concepts used in the HBM and SARF are applicable in the context of developing countries. While in the present study we have taken the emic perspective through the qualitative inquiry into account. We will in the near future (as stated above) also quantify data by conducting a locally relevant survey on beliefs and risk behaviour. Thus, the paper also reflects on the combination of quantitative and qualitative research on risk perceptions and the role of trust.

References

Baier A.(1986) "Trust and Antitrust" in Ethics, Vol. 96 (Pp 231-260)

Chin D. (1999) " HIV-related sexual risk basement among Asian/Pacific Islander American Women: an inductive model" in Social Science and Medicine, Vol. 49, Issue 2, July 1999. (Pp241-251)

D'Andrade R.G. (1992), Schemas and motivation. In: R.G. D'Andrade and C. Strauss (eds.) *Human motives and cultural models.* Cambridge University Press, Cambridge, pp.23-44.

Hutter, I. And Ramesh B.M. (2003) The motivational role of cultural schemas behind demographic and reproductive health behaviour in South India. Paper presented at the 2003 Annual meeting of the Population Association of America, 1-3 May, Minneapolis.

Hart A. (1995) "Risky business? Men who buy heterosexual sex in Spain" in "Culture and Sexual Risk-Anthropological perspectives on AIDS" ed. Ten Brummelhuis H. and Herdt G. , Gordon and Breach Publishers, Amsterdam

Kasperson J.X., Kasperson, R. E., Pidgeon, N. and Slovic, P (2003) 'The social amplification of risk: assessing fifteen years of research and theory' in Pidgeon N., Kasperson, R. E. and Slovic, P (eds.) *The social amplification of Risk*, Cambridge University Press, Cambridge.

Kasperson, R. E., Renn O., Slovic, P., Brown, H.S., Emel, J., Goble, R., Kasperson J.X. and Ratick S.(2001) 'The Social Amplification of Risk: A conceptual Framework' in Slovic, P.(ed), *The Perception of Risk*, Earthscan Publications Ltd. UK.

National AIDS Control Organization (2003) http://www.naco.nic.in/indianscene/esthiv.htm. last visited on 15-12-03.

Population Reference Bureau and Population Foundation of India (2003) HIVAIDS India Chart book, New Delhi.

Rosenstock I.M. & Strecher V.J., (1997) 'The Health Belief Model', in: Glanz K. , Lewis F.M. and Rimer B. (eds.) Health Behaviour And Health Education, Jossey-Bass. San Francisco, CA.

Slovic P.(2001), 'Perception of Risk' , in Slovic P.(ed), 'The Perception of Risk' Earthscan Publications Ltd. UK.

Sztompka P. (1999), Trust – A Sociological Theory, Cambridge University Press, Cambridge.