

Adolescent Sexual Behavior and the HIV/AIDS Risk in the Czech Republic*

LADISLAV RABUŠIČ
KATEŘINA KEPÁKOVÁ**
School of Social Studies
Masaryk University
Gorkého 7, 60200 Brno
Czech Republic
E-mail: rabu@fss.muni.cz

UDK 316.6-053.6:612.2](473.1)
Pregledni rad
Primljeno: 1. lipnja 2003.

Although the number of HIV-infected persons registered in the Czech Republic might appear very low, the authors caution against false optimism. They point to the risky sexual behavior of Czech youth, who, in spite of having solid knowledge about HIV/AIDS prevention, do not consistently apply it to their sexual practice. From the analysis of this paradox, based primarily on data collected in the city of Brno in 1997, the authors suggest replacing the so-far preferred rational choice theory or the Health Belief Model, as models explaining human behavior, with the more adequate theory of expected utility. While the former theories assume that individuals will make rational decisions and practice safer sex once they are better informed about HIV infection and ways to protect themselves, the latter one allows for the existence of "rationality of intimacy", which differs from the scientific "rationality of the health system". The theory maintains that, within the realm of intimate relationships, it might appear rational to practice unsafe sex if this is compensated by other benefits. In order to be able to reconcile the two rationalities and understand unsafe sexual behavior; the general context of an intimate situation must be analyzed, including the social norms and values involved, the emotional load, individual intentions and goals of the partners, and also the complex mechanisms of interaction and "power" negotiation between sexual partners.

Key words: ADOLESCENTS, SEXUAL BEHAVIOR, SEXUAL RISKS, RATIONAL CHOICE, HIV, AIDS

Introduction

At present, there are approximately 39 million adults and 3 million children worldwide living with HIV infection or AIDS, in addition to the 20 million persons who have already died of AIDS since the epidemic began (Lamprey et al., 2002). HIV/AIDS might thus soon become the fiercest worldwide epidemic in history, surpassing even the medieval plague, which caused about 20 million people to die, and the Spanish flu epidemic, in which the death toll reached 25–50 million between 1918 and 1919 (Rockett, 1994).

Not only is HIV/AIDS one of the most devastating and most feared contemporary diseases. It is also a new and unique social phenomenon affecting nearly every dimension of social and economic life. Advanced societies are no longer used to the concept of an infectious disease that modern medicine cannot readily get under control, especially if the disease transmission mechanisms have relatively clearly been described and preventive measures are

* This article is a part of a research supported by the RSS grant (Research Support Scheme of the Open Society Institute /Higher Education Support Programme), no 1507/784/1996, titled *The Youth and AIDS*, by a grant of the Grant Agency of the Czech Republic (GAČR), no 403/96/K120, titled *Social Trends* and by the grant CEZ 307/98 no 142300002 titled *Children, Youth and the Family in Transition*. The article is based on a paper delivered by Ladislav Rabušič at an international congress for anthropology and ethnology in the American city of Williamsburg in July, 1998, under the title *Sexual behavior of Adolescents and HIV Risk in the Czech Republic*.

conceivable and almost universally available (in the industrialized world, at least). Societal reaction to AIDS has been marked by fear, taboo and stigmatization and produced a variety of myths that had far-reaching consequences for the relationships between various social subgroups (e.g. gay/lesbian community, African populations, etc.) and mainstream societies. HIV/AIDS posed new challenges for educational systems, employment policies, insurance systems, national economies, as well as interpersonal relationships and the life of families and communities.

While epidemiologists, biologists and demographers have contributed a great deal to increasing our understanding of the patterns of HIV transmission, it is the task of sociologists and other social scientists to study social constructions of HIV/AIDS and identify the social and cultural determinants of HIV/AIDS occurrence, including identification of social groups at greatest risk, specific social norms and values that encourage risk-taking, as well as those that discourage it, and underlying HIV/AIDS-related health beliefs and stereotypes in operation within distinct social settings. Understanding the social context of transmission situations is a key to behavior change as the most effective primary prevention.¹

International research has made it clear that no HIV/AIDS prevention program can be applied flatly in just any social environment. On the contrary, it is evident that we need to pay attention to specific population subgroups, such as, of course, intravenous drug users, gay/lesbian community, individual socioeconomic groups, racial and ethnic groups, urban vs. rural populations, as well as persons at different stages of their life course – and maybe most importantly, adolescence. Since most HIV transmission worldwide is through sexual intercourse, with the degree of risk depending in part on the number of a person's sexual partners, and since sexual promiscuity is highest at the very beginning of a person's sexual life, it is evident that the adolescent population, aged 15–20 years, potentially represents the highest risk group.²

In this article we will present data on sexual behavior of Czech adolescent population with respect to the risk of HIV/AIDS. We will analyze Czech youth's knowledge about HIV/AIDS and its practical application in the teens' sex lives. Finally, we will point out and try to explain certain paradoxes that emerge from such analysis and conclude with implications for preventive HIV/AIDS programs.

To better understand the framework of sexual behavior with respect to HIV/AIDS in this country, let us first present basic data about the disease in the Czech Republic.

HIV/AIDS in the Czech Republic

So far, figures reported from countries of the former communist block seem much less threatening than elsewhere in the world, owing to the recent history of closed borders. In the end of 2001, Romania with its 7.162 AIDS patients had the lead, followed by Poland (1.004) and the former Yugoslavia (Serbia and Montenegro) with 922 reported cases. Hungary claimed 389 AIDS cases and Slovakia 29 (Joint United Nations Programme on HIV/AIDS). In the Czech Republic, 163 persons diagnosed as having AIDS were reported at the end of

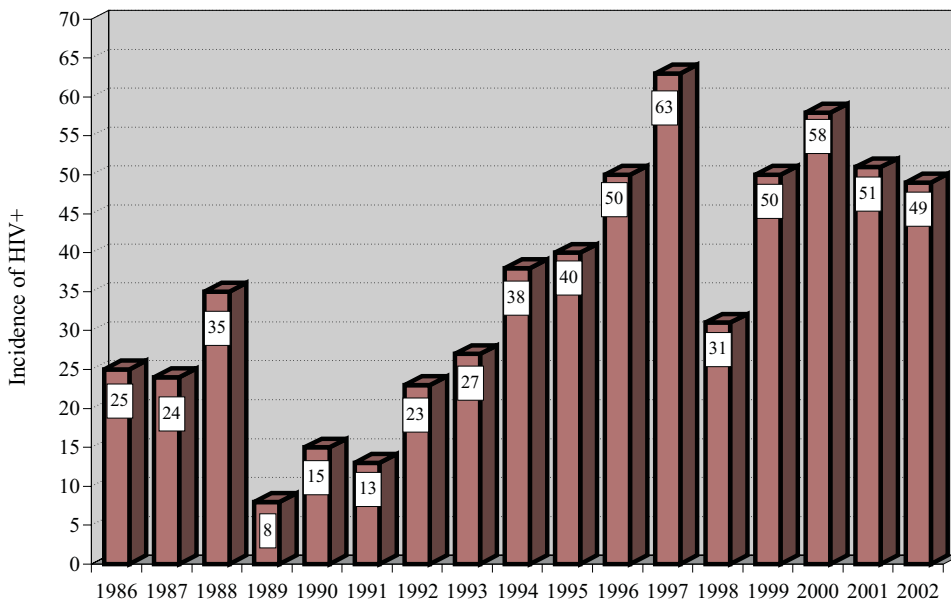
¹ We are aware that in addition to individual risk factors there are also social and economic factors beyond the control of individuals that cause HIV/AIDS to spread. In large parts of the world, preventing the HIV/AIDS epidemic requires changing societal conditions that make some social groups (such as women, the poor and marginalized, illiterate populations, etc.) more vulnerable. However, analysis of such factors is beyond the scope of this article.

² More than a half of all new infections worldwide occur among people under the age of 25 (Lamprey et al., 2002). Besides, current trends in the spread of HIV in Western Europe reflect increasing incidence among the youngest age groups (Brůčková et al., 1999).

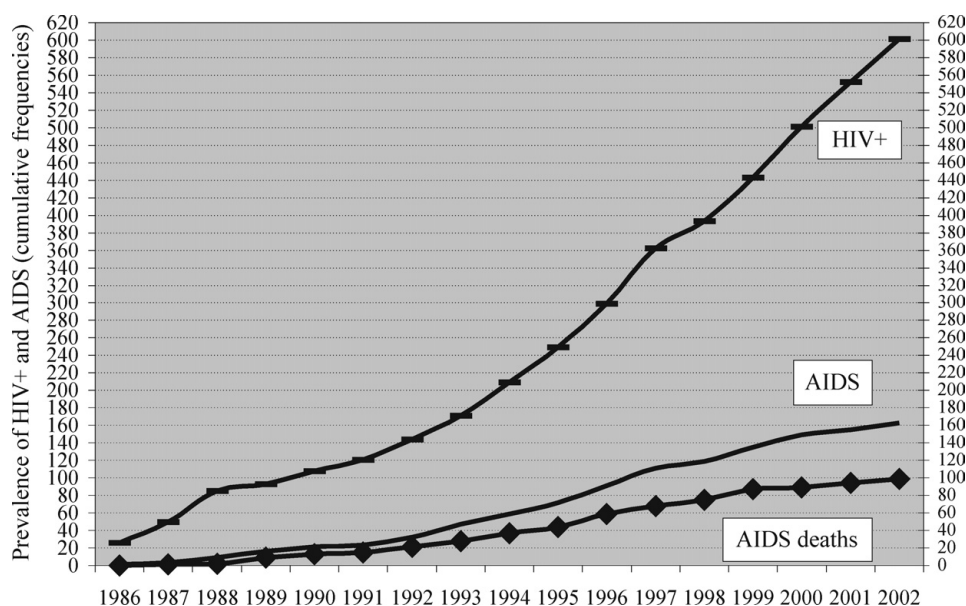
2002 (National Health Office, 2003). Nevertheless, experts caution the whole of Eastern Europe against complacency, as the epidemic has so far only reached its earliest stages. Various pieces of evidence suggest that the difference in rate of infection among the former communist countries and their western European neighbors may soon begin to even up.

In the Czech Republic, neither the incidence of newly registered HIV cases, nor the overall prevalence of HIV/AIDS in the country's population have as yet reached any truly dramatic level (see Fig. 1 and 2). There were 601 persons with HIV/AIDS registered in CR at the end of the year 2002, of which 79% were males and 21% females. Nonetheless, the increase in total number of cases is clearly exponential in character, although incidence of new cases seems to have stagnated recently (with a temporary decline in 1998). The same exponential character also applies to the increase in the number of infected females, as compared with males. While in 1990, there were 16 HIV positive men to each positive woman, the proportion decreased to 4 : 1 in 2002.

Figure 1: New cases of HIV+ in CR between 1986-2002



Source: National Health Office, www.aids-hiv.cz

Figure 2: Persons with HIV infection or AIDS and persons who died of AIDS in CR between 1986 and 2002 (cumulative frequencies)

Source: National Health Office, www.aids-hiv.cz

Homosexual intercourse represents the most frequent channel of HIV transmission, with heterosexual intercourse as the second most frequent (see Table 1). In this respect, the Czech data are quite unusual, since heterosexual contacts are responsible for about 60% of HIV/AIDS cases worldwide (Ahlemeyer and Ludwig, 1997).

Table 1: Reported means of transmission of the HIV virus in the Czech Republic (cumulative frequencies as of December 31, 2002)

Means of transmission	%
homo/bisexual intercourse	52.9
heterosexual intercourse	30.0
Hemophiliacs	2.8
blood transfusion	2.3
drug needles	3.7
from infected mother to fetus	0.5
nozocomial transmission	0.3
homo/bisexual + drug needles	1.2
not known	6.3

Source: the National Health Office, <http://www.AIDS-HIV.cz/>

These statistics might support the view that the HIV/AIDS situation has so far been relatively less serious in the Czech Republic, and that the danger of a full-scale epidemic is negligible.³ For many reasons, however, this optimism must be cautious. In the paragraphs below, we will show that in the Czech Republic, as is also the case in all advanced countries, a large proportion of the adolescent population is sexually active. In spite of having solid knowledge about the HIV/AIDS threat, adolescents are failing to apply it to their own sexual practice.

Adolescent Sexual Behavior, Knowledge about AIDS and Prevention

Owing to biomedical research, information on HIV transmission channels is well known today. Sexual intercourse is by far the most critical means of transmission, and is the cause of the highest proportion of new infections. Besides, current trends in the spread of HIV in Western Europe reflect increased incidence among the youngest age groups (Brůčková et al., 1999).

Data about the sexual behavior of Czech adolescents is relatively rich today, thanks to increased research efforts in this field since 1989. In 1993, a representative survey of the Czech female population aged 15–24 (N = 4.497) concluded that by the age of seventeen, 36% of the respondents had already engaged in sexual intercourse, by the age of eighteen it was 64% and by the age of nineteen 82% (Kraus, Tomek, Velebil, 1996). According to a representative survey of Czech youth aged 12–18 (N = 1.011) conducted in 1994, 26% of fifteen-year old boys and girls have had sexual intercourse, among sixteen year olds the figure was 50%, among seventeen year olds 64%, and among eighteen year olds it was already 75% (Weiss, Kučera, Svěráková, 1995). According to a review article by Weiss, Urbánek and Procházka (1996), the sexual experience of the Czech youth is characterized by two trends: a decrease in age at the time of becoming sexually active, particularly in the female population, and a narrowing age gap at the time of sexual initiation for boys and girls.

In 1997, we found that among students in Brno⁴ attending the third year of secondary school (N = 805),⁵ by the age of sixteen, 38% of the boys and 33% of the girls (36% overall) had engaged in sexual intercourse, by the age of seventeen it was 44% of boys and 43% of girls (a total of 44%), and by the age of eighteen it was 56% for boys and 52% for girls (a total of 54%). Among these sexually active adolescents, who represented 44% of our sample (that is 45% of the boys, and 44% of the girls), the mean age of first sexual intercourse was 15.7 years for boys and 15.8 years for girls.

Experts on HIV/AIDS emphasize the key role of information dissemination and education in the efforts to get the spread of the virus under control. This rationale assumes that

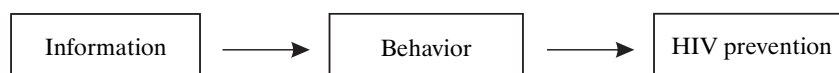
³ While in 1998, Brůčková claimed that the HIV/AIDS situation had been relatively favorable in the Czech Republic and that chances were high of preserving the current state by using and applying international knowledge and experience (1998), a year later she warns that “complacency about the achieved results and about the current relatively favorable situation might lead to the underestimation of further epidemiological development, bringing about serious negative consequences” (Brůčková et al., 1999:23).

⁴ Brno is the second biggest city in the Czech Republic, with population of 400.000 inhabitants.

⁵ The research was entitled *Youth and AIDS*, and was conducted in the spring of 1997, as part of an international comparative survey in cities of the former Soviet block. Among the participating countries, there were Bulgaria (Sofia), the Czech Republic (Brno), Croatia (Zagreb), Poland (Warsaw), Slovenia (Ljubljana) and the Slovak Republic (Bratislava). In each of the countries, a survey was conducted on a representative sample of third year secondary school students chosen by means of multistage random selection. The data was obtained from questionnaires distributed in classrooms, and completed in the researcher's, rather than teacher's, presence and collected within a fixed period of time. After data cleansing, 805 questionnaires were obtained. The respondents' ages ranged between sixteen and eighteen.

easily available and fully internalized information about the channels of HIV transmission will encourage duly responsible behavior. This is the ultimate method for the prevention of an HIV epidemic. The logic might be illustrated as shown in Figure 3:

Fig. 3: Causal model of elements which determine the prevention of HIV infection



Empirical data collected by sociologists and epidemiologists in the developed world suggest that the level of knowledge about HIV transmission channels and an overall familiarity with the HIV/AIDS issue is relatively high within these populations.⁶ Conclusions of surveys conducted among various segments of the Czech population are relatively satisfactory as well (see Tables 2 and 3).

Table 2: Knowledge about AIDS in the Brno youth population by age (in %)

Knowledge about AIDS (% of affirmative answers)	Age		
	16	17	18
AIDS cannot be cured	85	85	86
One can be HIV positive but does not need to look sick	100	100	100
One can be HIV infected for many years before getting sick	96	95	96
One can be HIV positive but does not need to have AIDS	77	74	75
HIV infection can be found immediately after transmission	78	74	76

Source: Rabušic – data file *The Youth and AIDS* (N = 805), 1997.

Nevertheless, even the Czech population supports findings of international studies that state “there is empirical evidence that the level of knowledge and attitudes towards safer sex show little or no direct connection to behavior” (Ingham, van Zessen, 1997:86). Likewise, Moatti, Hausser and Agrafiotis (1997) maintain it is true that educational and media campaigns improve people’s knowledge about HIV/AIDS, their awareness of risk, and increase their support for infected individuals. However, it has been impossible to prove that these campaigns affect sexual behavior in any significant way, or that they are responsible for real changes in behavior patterns.

⁶ See for example Table 6.1 in an highly inspirational article by Moatti, Hausser and Agrafiotis (1997).

Table 3: Distribution of correct answers (in %) about HIV transmission channels in the Czech population (1994) and a proportion of the Brno youth who assessed certain situations as highly risky with regards to HIV infection (1997) by age

Ways of getting infected	CR (correct answers) Age in years			Brno (high risk of infection) Age in years		
	16	17	18	16	17	18
by sexual intercourse	97	98	98	99	99	100
by shared needles	88	93	91	100	100	100
by kissing	79	78	85	14	12	11
by mosquito bite	81	76	75	–	–	–
by shared WC	90	91	93	–	–	–
by handshake	94	94	98	–	–	–
by petting	–	–	–	26	21	19
by drinking from the same glass as HIV positive	–	–	–	3	4	6
by swimming in pool together with HIV positive	–	–	–	3	3	4
by taking care of AIDS patient	–	–	–	19	18	14
by coitus with condom	–	–	–	28	14	12
by living in the family where there is an HIV positive member	–	–	–	8	10	10

Source: CR: Weiss, Kučera, Svěráková (1995); Brno: Rabušic – data file *The Youth and AIDS* (N = 805), 1997.

Similarly, the Czech adolescent population seems to be well informed about channels of HIV transmission; unfortunately, they do not adhere to the principles of safe sex in their own sexual practice. Furthermore, they appear to be somewhat more promiscuous than their peers in western countries. According to Weiss, Kučera and Svěráková (1995), while a mere 14% of girls and 23% of boys among the sexually active American youth aged 15-18 reported having had four or more sexual partners, the respective figures in the Czech population were 34% and 37% (see Table 4). Adolescents in Brno, particularly boys, have similar experiences: 17% of the girls and 36% of the boys reported having had 4 or more sexual partners.

Table 4: Number of partners of sexually active adolescents in 1994 in the Czech Republic (15-18 year olds) and in 1997 in Brno (16-18 year olds) by gender (in %)

Number of partners	CR (N = 356)			Brno (N = 309)		
	boys	girls	altogether	boys	girls	altogether
1	25	29	27	24	48	36
2	19	23	21	18	18	18
3	19	15	17	22	16	19
4	11	15	13	11	5	8
5-7	17	14	15	13	7	10
8 and more	9	5	7	12	5	8

Source: CR: Weiss, Kučera, Svěráková (1995); Brno: Rabušic – data file *The Youth and AIDS* (N = 805), 1997.

Higher sexual promiscuity might not necessarily be a problem in and of itself, were it counterbalanced, in the context of HIV infection risk, by adhering to the principles of safer sex, particularly to using a condom. Czech reality is not favorable in this respect. For example, according to a representative survey of Czech youth aged 15-18, which was conducted in 1994, only 8% of sexually active boys and girls use condoms during each and every sexual encounter, and nearly a third (31%) never use them (Weiss, Kučera, Svěráková, 1995). Research conducted in 1993 found that only 15% of the population of Prague between the ages of 15-29 had every used condom (Weiss and Zvěřina, 1994). Data from another survey conducted in 1994 is somewhat more favorable: in the 15-17 age group, 21% of girls and 52% of boys used condoms during their first sexual encounter.⁷ However, less than two thirds of the respondents (65%) reported that they use condoms during each casual sexual encounter, and 31% of the girls and 16% of the boys never use one when having casual sex (Weiss and Zvěřina, 1997).

The findings from the 1997 Brno survey were somewhat more optimistic. Only 34% of males and 35% of females did not use any birth control during their first sexual encounter, while two-thirds reportedly used some form of contraception. Of the latter group, 80% of boys and 69% of the girls relied on a condom. Moreover, most girls (80%) had their first sexual encounter with a steady partner, and around two-thirds of the females consented to intercourse after having dated the partner for at least over a month. The males' behavior was more adventurous: only 56% first had sexual intercourse with a steady partner,⁸ and for 55% of them the relationship had only lasted for 1-4 weeks.

From the questionnaire, data on respondents' last sexual encounter was recorded. By the time they last had sexual intercourse, the proportion of those not using contraception had dropped significantly – to 22% of the males and 20% of the females.⁹ However, the frequency of condom use decreased as well – to 71% of boys and 46% of girls. This decrease might exist for two reasons. First, the girls started to rely more on hormonal contraceptives, which would after all contribute to the decrease in reported male condom use as well. The second reason might be that this sexual activity took place with a fiancé, a steady partner, or someone the respondent had known for a long time.¹⁰ International literature (for example Cohen and Hubert, 1997) presents as a proven fact that in long-term relationships, the level of cautiousness regarding the threat of HIV infection decreases, which brings about certain riskier sexual behaviors.

Does the above data collected in Brno signal a shift to more responsible behavior regarding the AIDS epidemic? The answer is not unambiguous. It seems that the use of condoms is not sufficiently associated with awareness of the AIDS threat. For instance, this can be illustrated by the fact that only 5% of the boys and 2% of the girls said that they had at least once insisted on the use of a condom purely to protect themselves from HIV infection.

⁷ According to the data from Great Britain, as of 1991, 24% of females and 31% of males between the ages of 16-24 used no birth control during their first sexual encounter. Finland reports even lower figures as of 1992, which, however, apply to the 18-24 age group: 13% of females and 17% of males. 1993 data from France suggest that 16% of females used no contraception during their first sexual encounter (Bozon and Kontula, 1998).

⁸ We are aware that the females' and males' definition of a "steady" partner might differ, which, however, the questionnaire data makes impossible to verify.

⁹ Besides asking about birth control use when respondents had last engaged in sexual intercourse, we were interested in the overall regularity of contraceptive use throughout respondents' sexual life as a whole. 50% boys and 55% girls said they had always used birth control during sexual intercourse, while on the other hand, 22% boys and 18% girls reported they had used it hardly ever or never.

¹⁰ A mere 18% of the sexually active males and 6% females admitted they had last had intercourse with a casual partner.

27% of boys and 32% of girls reported that they had at some point insisted on the use of a condom in order to prevent both pregnancy and HIV infection. 27% of the boys and 26% of the girls had never insisted on using a condom.

Similar trends applied to other indicators as well: whether boys and girls thought of AIDS during their first and last sexual encounter, whether they talked about AIDS with their partner prior to engaging in intercourse, and whether the threat of AIDS made them alter their sexual behavior in any way. Our findings are presented in Table 5:

Table 5: Reflections of the AIDS threat before the first and the last sexual encounter in 1997 in Brno (16-18 age group) by gender (in %) – “No” answers

Thoughts on AIDS Negative answers	First coitus		Last coitus	
	boys	girls	boys	girls
Did they think about AIDS?	67	68	64	78
Did they talk about AIDS?	63	53	57	46
Did they do something differently because of AIDS	93	92	86	91

Source: Rabušić – data file *The Youth and AIDS* (N = 805), 1997.

The data suggest that a considerable proportion of adolescents do not think about the AIDS threat at all, neither during their first sexual encounter, nor later in their sexual life. They do not talk about it with their partner before engaging in sexual intercourse, and do not take any precautions. AIDS is apparently not a factor that has a significant influence over their sexual behavior (see Table 6).

Table 6: AIDS and sexual behavior of the secondary school youth in 1997 in Brno (16-18 age group) by gender (in %) – “No” answers

Sexual behavior with regard to AIDS	Negative answers	
	Boys	Girls
Is AIDS a topic which you are personally concerned with at present?	57	40
Have you found yourselves in a situation in which you were afraid about being infected by HIV?	76	77
Have you ever taken the HIV test?	93	97
Have you ever asked your partner to get HIV tested?	98	93
Have you asked whether your partner is HIV positive?	83	76
Have you ever limited your intimate life because of AIDS ?	67	74
Had it not been for AIDS, would there be a difference in your sexual life?	69	78
Do you think that the danger of AIDS has any impact on sexual behavior of the young?	87	90

Source: Rabušić – data file *The Youth and AIDS* (N = 805), 1997.

HIV/AIDS as a topic is not completely ignored by Brno secondary school students (which applies much more to females than to males). Nonetheless, since almost none of them have ever believed themselves to be at risk of HIV infection, they have never asked their partner whether he or she was HIV positive. They never required their partner to have

an HIV test before engaging in sexual intercourse, nor undergone a test themselves. Moreover, most boys and girls do not believe that the AIDS threat has any real effect on adolescent sexual behavior, that is, the behavior of their peers. However, it does appear that the AIDS threat has had at least some effect on the actual sexual behavior of some respondents – about a quarter of both boys and girls have already resorted to altering their intimate life because of the existence of AIDS. About a third of the boys and girls admit that it has necessitated a change in their sexual behavior. Thus, should AIDS not exist, their sexual life would be different.

Despite this, the respondents overall still hold the conviction that they themselves cannot get infected with HIV. 88% of the sexually active boys and 85% of girls believe their chances of becoming infected to be very low. 41% of the boys and 36% of the girls believe that, as compared with their peers, the probability that they would get infected is the same. On the other hand, 46% of the boys and 55% of the girls think it less probable that they themselves would become HIV positive than their peers.

Taking into account all the information presented above, it seems that the sexually active respondents, who at ages 16–18 studied at secondary schools in Brno, had not yet let the threat of the HIV/AIDS pandemic enter the realm in which they live. And even though the conclusions of this research conducted in Brno and its outskirts cannot be applied to the whole of the Czech population, they point to some distinct national symptoms.

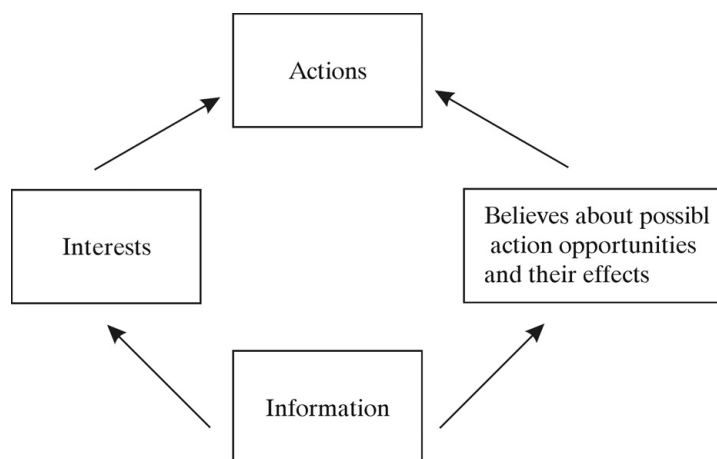
With reference to our model, we find ourselves in a situation well-known to researchers from other countries: their surveys lead repeatedly to the same paradoxical conclusion which is that individuals again and again expose themselves to the HIV risk, even though they are clearly aware that the risk does indeed exist (Moatti, Hausser, Agrafiotis, 1997). As Ahlemeyer and Ludwig observed: “AIDS has obviously changed a lot in heads but little in beds” (Ahlemeyer and Ludwig, 1997:129).

Examples from the Czech population illustrate that, even though information about the HIV/AIDS risk and HIV transmission channels does exist, and is sufficient, comprehensive and widely available, the actual sexual behavior of individuals does not reflect a concerted effort for the prevention of an HIV pandemic. Let us try to identify the possible explanations of such a paradox.

Irrationalism, or Rationalism of Another Kind?

The very purpose of the existence of the social sciences is to interpret human behavior in terms of its causes and effects.¹¹ In order to meet this goal, social science research is structured so as to first deduce a hypothetical causal model within which independent variables are influencing the behavior (variability) of a dependent variable in a number of direct and indirect ways. Within these efforts to explain human behavior, *rational choice theory* represents an influential heuristic approach. This theory of behavior maintains that, in principle, social life can be explained as a result of the rational choices of individual actors. It assumes that when making decisions about which of the available courses of action to take, actors will usually follow the one which best serves their interests. Individuals generally find themselves in situations where the decision to follow a certain course of action depends upon the information available, which is very often incomplete. Therefore, it can be said that actors must rely in part on their beliefs about the possible opportunities and their consequences. It is thus necessary to regard individuals’ actions as a result of three immediate causes: interests, beliefs and opportunities (Hedstrom, Swedberg, 1996) – see Fig. 4.

¹¹ We will disregard for the moment the fact that the post-modern scientific paradigm introduced a non-explanatory discourse in the framework of which it seeks primarily to interpret social phenomena.

Figure 4: Model of the rational choice theory

The rational choice theory (RCT) cannot claim to be capable of predicting what a real individual will do in a real situation. Nevertheless, it demonstrates what a typical actor would do in a typical situation. According to Hedstrom and Swedberg (1996), RCT might enhance the ability of sociologists to analyze the key sociological problem: in what way does social structure force, and at the same time facilitate, the social action of individual actors.

RCT's strong asset is that it uses the type of explanation that Elster (1983, in: Hedstrom and Swedberg, 1996) called an intentional explanation.¹² To be able to explain the intent of an action, it is essential to comprehend its intended consequences or results. In contrast with a causal explanation, this type of reasoning allows us to answer the question of why an actor chose a certain course of action and thus also to understand – in a Weberian sense – this action (Hedstrom, Swedberg, 1996).

The rational choice model has also been applied in epidemiological and medical studies, as well as in HIV transmission research. In this field, it was transformed into a *K-A-B-P* model (*Knowledge-Attitudes-Beliefs-Practices*) or the *HBM* model (*Health Belief Model*). The models assume that actors aim to optimize outcomes by balancing costs and benefits. In the context of AIDS, this cognitive perspective assumes that individuals will make rational decisions and practice safer sex once they know that (1) there is a danger of becoming infected with HIV and that (2) HIV leads to the fatal disease AIDS, that (3) HIV can largely be avoided through the practice of safer sex, and that (4) they have the resources to adopt appropriate behavior patterns (Cohen and Hubert, 1997). In other words, the assumption is that knowledge about the disease will affect the attitudes and beliefs of individuals, who will then, in a real situation, rationally select the most personally advantageous course of action. In the context of AIDS, the most rational course of action would of course be conduct that eliminates, or at least dramatically reduces, the danger of becoming infected with HIV, and thus will not put the actor at risk of contracting the fatal virus.

¹² Elster says that in social sciences, either causal, functional, or intentional explanations are used. The causal and intentional explanations are indeed the most frequent since the functional type can be converted to either of the two. In sociology, and particularly in its empirical form, causal explanations dominate.

Earlier in the text we showed that research on sexual behavior and AIDS revealed inconsistencies with regards to causal connections between beliefs, informed knowledge, and attitudes, and the actual behavior of individuals. Various data from research around the world suggest that even informed persons who profess preventive attitudes, in practice, do not follow the very principles to which they subscribe when it comes to protection (Bastard and Cardia-Voneche, 1997:127).¹³

How is it possible that not even when facing the risk of contracting an incurable fatal illness, people do not make rational decisions and do not take logical action? Does this mean then that, in the given context, we must once again ask to what extent is individual action in the realm of intimacy governed by the uncontrollable strengths of the "id"? Shall we settle with Hume's argument, which says that reason is a mere slave of passion?

The truth is, nevertheless, that even in the realm of intimacy, people behave rationally. However, in situations full of emotions and sexual desires another model of explanation must be adopted in order to systematically analyze behavior. We must acknowledge the existence of a "*rationality of intimacy*", which differs from the scientific "*rationality of the health system*" (Ahlemeyer and Ludwig, 1997). In the same line of reasoning, Guizzardi, Stella and Remy (1997) maintain that there exist two types of rationality – that proposed by medical knowledge, and a concrete, pragmatic, and subjective rationality worked out in small networks of social relationships.¹⁴

To understand individual sexual behavior from the point of view of the prevention of HIV infection, it is necessary to abandon the model which assumes that AIDS prevention represents a central priority in human sexual behavior. As Cohen and Hubert (1997) point out, for example, many actors balance a variety of risks and rewards and aim at more immediate goals rather than concerning themselves with the vague and long-term consequences of unprotected sexual intercourse. "Love and intimacy, partner and peer approval, and economic need are powerful pressures towards unsafe sex." (Cohen and Hubert, 1997:208). In the arena of sexual behavior, the rational choice model must be replaced with some other model.

¹³ Ahlemeyer and Ludwig (1997) present a paradigmatic example of the given problem from their qualitative research. During her vacation on Korfu, a single German woman aged 27 met a man whom she fell in love with and after a few days had sexual intercourse with. She met all the key criteria, which are defined in the literature, for practicing safe preventive behavior, that is 1) she was well informed about the AIDS threat and potential risks (she had *information*), 2) she considered the information important (she took *interest* in the information), 3) therefore she wanted to act accordingly, that is take preventive measures (she had *intention*), 4) she thus took an action and bought some condoms in advance since she knew that a condom is an adequate means of HIV prevention and wanted to have a condom ready at hand (*availability* of adequate preventive measures), and 5) she was even successful in addressing the issue of AIDS and condoms before actual sexual intercourse (*communication*). Despite all those precautions action did not take place and during intercourse, the condom stayed in her purse. As the researchers found out during an interview, this failure might be attributed to the young woman's fear that her insisting on using a condom might have been interpreted as a sign of distrust. More so, since the partner told her that he had not had sex for some time before and that he trusted her completely.

¹⁴ These assertions agree also with Fee's and Krieger's study in historical interpretations of AIDS. The authors suggest that scientific understanding of AIDS has been driven by three successive paradigms of the disease. Originally, AIDS was misconceived of as a "gay plague". Later it was normalized as a chronic disease to be managed medically. Yet a third paradigm has emerged recently which emphasizes collective, social and historical aspects of the disease. It asserts that HIV/AIDS can only be understood with attention to its social context. Each of the three constructions implies a distinct view of the etiology, prevention and treatment of AIDS. And it was precisely the logic of the "infectious disease paradigm" that assumed sexual behavior to be a function of rational calculation and ignored the complex power dynamics of sexual relationships (Fee and Krieger, 2000).

Moatti et al. (1997) propose, as a more adequate model, the *expected utility theory* which was derived from economic theory. This theory provides a logical framework for understanding the behavior of rational people in an insecure world. It maintains that individuals will behave in such a way as to maximize expected benefits (Pearce, 1992). In the realm of intimate sexual relationships, the goal of maximizing benefits (that is to have sexual intercourse, to keep the partner one loves, and even to maintain one's peers' respect) might result in the "irrational" decision not to practice safer sex. Seen from another angle, actors construct a hierarchy of possible risks and then tend to disregard risks assessed as the least immediate and probable (Connors, 2000). The expected utility theory has, for example, demonstrated that individuals tend to reduce risky behavior in cases where perceived health risks are very high. However, where such a danger is low, the tendency to behave safely is much harder to notice (Moatti et al., 1997). As we know, the risk of becoming infected with HIV is statistically relatively insignificant for heterosexual partners in the Czech Republic. The motivations of individual actors might well be fully rational and logical from all possible perspectives, with the exception of the health perspective.

In an effort to analyze safer sexual behavior, we must also consider the general context of such a situation, including the social norms and values involved, the emotional load, the intentions and goals of the partners and also the complex mechanisms of interaction and "power" negotiation between the partners involved.

Every sexual encounter has a very complex structure,¹⁵ which is even more complicated for adolescents who are only at the beginning of their sexual "career", and are only just searching for their own identity as sexual beings. Sexual partners' values and social norms will determine the meaning they attribute to the given sexual encounter (affirmation of their mutual affection; a summer romance for one of the partners, whilst a big love for the other; intercourse which occurs only to please the male partner, etc.).

Moreover, adolescent sexual intercourse represents an extremely fragile situation. It may often take only some kind of trivial signal – a ringing telephone, creaking bed, or awkward manipulation with a condom – and it falls to pieces. Sexual intercourse appears to be primarily an act of communication. Through both verbal and non-verbal communication, ground is prepared for psychological systems, which allow for the physical approximation (Ahlemeyer and Ludwig, 1997). Communication "slip-ups" (an "unsuitable" comment, "strange" look, or mention of contraception, for example) are something actors wish to avoid. Creating a situation where adolescent sexual intercourse would conform to the principles of safer sex would be a small miracle.

Another influential factor detracting adolescents from the rational application of the principles of safer sex to their actual sexual practice, is the actors' tendency to underestimate the relevance of the risk to themselves, guided by a widespread magical thinking well documented in research (see e.g. Fee and Krieger, 2000): "It won't happen to me". Since the presence of HIV is only decoded once an individual develops full-blown AIDS, and since prevalence of AIDS is relatively low in the Czech republic (and much lower than the number of HIV+ persons), hardly any adolescent groups have direct experience with the threat. People tend to greatly underestimate the likelihood of low-probability events even where there could be a highly negative outcome. This leads us to one of the unintended effects of campaigns against AIDS, which emphasize, among other things, that a person should not have casual sex with persons they do not know. As most peers already know each other, and as none of them show any signs of the disease, it seems plausible not take precautions during

¹⁵ We draw on the Ahlemeyer and Ludwig's conceptual framework (1997) here.

sexual intercourse (it is quite common that members of the same peer group subsequently fall in love with each other).¹⁶

There is another way a peer group impacts upon the refusal to practice safer sex. It is a well-known fact that the peer group plays a crucial role in influencing adolescent sexual behavior. For adolescents, it is a reference group whose members are “the significant others” who set social norms and value preferences. Sexual activity, deeply embedded in the culture, is strongly shaped by the social context (Alan, 1989). In adolescence, an organic part of the social situation is the peer group. Since adolescents seek approval for their behavior by those whose opinions they regard most highly, it is the peer group that creates a specific micro-world, guiding male and female roles, sexual ideologies, and patterns of intimate relations. Such micro-worlds absorb stimuli from the broader outer world – including HIV/AIDS prevention campaigns. Their messages are interpreted within peer groups, and the process of interpretation seems crucial for establishing adolescents’ attitudes towards HIV and AIDS. Perhaps these are the aspects of sexual behavior, which make it appear so irrational and incomprehensible from the cognitive perspective.

Challenges to prevention

If we accept as fact that actual sexual behavior, in respect of the HIV risk, is far removed from the simple communicational rationality model of the type “*I’ll tell you what can harm you and you’ll act accordingly*” (Guizzardi, Stella, Remy, 1997:168), we must also – in accordance with empirical data – admit that risky sexual behavior is more or less an everyday reality. Thus, the main question becomes, through which mechanism or means is it possible to make the sexually active adolescent population practice safer sex?

It is clear that, from the viewpoint of averting the risk of HIV, the safest behavior – for the segment of the population not addicted to intravenous drugs – is abstinence. However, hardly anyone would object that this is a highly unrealistic goal to achieve. Somewhat more conceivable is to encourage minimizing one’s number of sexual partners. With regard to “secular acceleration of biological maturation” (Říčan, 1989:187), within which the acceleration of sexual maturation¹⁷ is a main part, and with regard to the increasing age of first marriage (which oscillates on average around 27 years for men and 25 years for women), the young population is very likely to engage in premarital sexual relations, and exhibit a certain level of sexual promiscuity.¹⁸ Consequently, even this method of HIV prevention, minimization of sexual partners, cannot be reliably applied. There thus seems to remain only one realistic solution: to institute social norms demanding the consistent use of condoms during all adolescent sexual contact.

Norms, one of the most fundamental sociological concepts, are prescribed patterns of behavior, which are internalized through the process of socialization. Sexual behavior is one

¹⁶ Cohen and Hubert (1997) present other examples. They say, for example, that after the danger of AIDS was first acknowledged, the media produced a stereotype, which implied that it was homosexuals and intravenous drug users who were most at risk of contracting the virus. All those who did not belong to these groups rationalized their sexually risky behavior by claiming “I am not one of them”. In Australia, an intensive media campaign produced an overestimated image of the actual threat, which then led to a certain loss of credibility and a potential for underestimating the risk.

¹⁷ According to Prokopec (1999), the average age of first menstruation for Czech girls was 15.08 years in 1895. By 1962, it dropped to 13.08 years and by 1991 to 13.0 years. In 1997, the average age of menarche among the respondents from Brno was 12.9 years.

¹⁸ Sexual promiscuity is not limited only to the adolescent phase of the life cycle. Many marriages have to deal with promiscuity, as well. Socio-biologists even go as far as to ask the question if people are capable of living life in monogamous relationships.

of the areas of human conduct which is socially regulated in the most detail and with the most force (Reiss, 1986, 1989; Weeks, 1997; Ahlemeyer and Ludwig, 1997). At the same time, however, it is behavior which is the most private, and in which individual norms, often differing from social norms, may prevail.

With regards to condom usage, negative norms seem to persist in many levels of the Czech adolescent population. We can only speculate concerning the causes of this kind of attitude. Qualitative studies which would give understanding regarding the connotation of the word condom or describe how a condom is perceived in intimate moments, is something we do not have as of yet (which is itself sociologically relevant information). Ahlemeyer and Ludwig (1997) quite correctly remind us that whether or not a condom is used during intercourse depends on how condoms are perceived. If condoms carry a purely sexual meaning, they are unacceptable to those for whom sexual intercourse symbolizes mutual sharing and deep love. If condoms are perceived as a "selfish" tool for self-defense against the other, they will be difficult to understand for those who look for confidence and trust in their partners. If condoms are a symbol of AIDS and death, they cannot be accepted by those who seek entertainment, excitement, and "life" in sex. On the other hand, condom usage can be eased as long as it symbolizes contraception (even our respondents used condoms during intercourse as contraception rather than as AIDS prevention). Fear of pregnancy can be a more acceptable motive for condom usage during intimate moments than HIV prevention, which evokes thoughts of illness, suffering, and death. Similarly, condom usage might be acceptable in situations where it is presented as an altruistic attempt to protect one's partner, although it might parallelly imply that the partner who brought the matter forward suffers from a sexually transmitted disease him/herself.¹⁹

Conclusions

The analysis presented here observed the complicated relationship between knowledge about HIV/AIDS and adolescent sexual behavior in the age of HIV/AIDS. Using data from an empirical research carried out among urban adolescent population in the Czech Republic, we have shown that, in the Czech Republic, adolescents become sexually active at a relatively young age. They do have solid knowledge about the channels of HIV transmission; however, they do not consistently apply this knowledge to their sex lives. It proves that providing facts about HIV/AIDS along with instructions for safe behavior can alert people about the dangers involved, but is insufficient to encourage behavioral change. We have attempted to explain this discrepancy by referring to two alternative types of rationality: rationality adhered to in everyday life, and rationality applied to sexual situations. This distinction results from contradictory objectives as well as risks involved. Despite knowledge about the seriousness of the disease, AIDS poses no immediate and serious risk relative to other risks present in the context of adolescent sexual encounters, such as disruption of intimacy, partner's distrust, loss of partner's respect, loss of peers' approval, etc.

No matter how unreal the HIV/AIDS risk might currently seem in the Czech Republic, where the numbers of registered HIV/AIDS cases have so far been relatively low, we warn against underestimating the situation. An exponential curve, which characterizes the increase in HIV/AIDS prevalence, is misleading. As is well known: even very low numbers in the beginning can spell disaster in the end.

Effective prevention of a pandemic apparently depends on strategies developed to study and identify all the complex issues involved in distinct high-risk settings. While condom

¹⁹ This strategy implies that the partner who proceeds with the suggestion has already had other sexual partners. Therefore, in societies which remain rather sexist, it can be more acceptable for men than for women to adopt this strategy.

promotion seems to be one of the few promising strategies to achieve desirable behavioral change (with regards to HIV transmission by means of sexual intercourse), for it to be successful, underlying stereotypes associated with the condom, as well as sexual partners' possible interests and social values must be addressed in any preventive effort. Mere spreading of factual information is not sufficient when it comes to changing high-risk behavior. Emotional, interpersonal, and cultural contexts in which the behavior occurs must be studied and addressed, too.

The challenge for HIV/AIDS prevention thus goes far beyond narrowly designed HIV/AIDS educational programs – it refers to a much more general goal to promote the individual capacity to learn about and respond to threats and pressures, to learn to accept responsibility for one's actions and to make informed and independent choices. Thus it poses new dilemmas not just for educators, but also for parents, the media, social policy designers, and any other group that delivers or creates conditions for teaching new social as well as personal skills.

REFERENCES

- Ahlemeyer, H. W., Ludwig, D. (1997) Norms of Communication and Communication as a Norm in the Intimate Social System. In: Van Campenhoudt, L., Cohen, M., Guizzardi, G., Hausser, D. (eds.) 1997. **Sexual Interactions and HIV Risk. New Conceptual Perspectives in European Research**. Taylor & Francis, London, pp. 22–43.
- Altman, L. K. (1998) AIDS Is on Course To Ravage Africa. **International Herald Tribune**, June 24, 1998.
- Bastard, B., Cardia-Voneche, L. (1997) From Rational Individual to Actor Ensnared in a Web of Affectivity and Sexual Relationship. In: Van Campenhoudt, L., Cohen, M., Guizzardi, G., Hausser, D. (eds.) 1997. **Sexual Interactions and HIV Risk. New Conceptual Perspectives in European Research**. Taylor & Francis, London, pp. 127–134.
- Berthelot, J.-M. (1990) **L'intelligence du social**. Paris: PUF.
- Bozon, M., Kontula, O. (1998) Sexual Initiation and Gender in Europe: A Cross-cultural Analysis of Trends in the Twentieth Century. In: Huber, M., Bajos, N., Sandfort, T. (eds.) (1998) **Sexual Behaviour and HIV/AIDS in Europe**. UCL Press, London.
- Brůčková, M. (1998) Současná situace ve výskytu a šíření HIV/AIDS v ČR (Current Situation in Incidence and the Spread of VIH/AIDS in the CR). **AIDS Newsletter**, 6 (1): 23–28.
- Brůčková, M., Jedlička, J., Malý, M. et al. (1999) Charakteristiky výskytu a šíření HIV/AIDS v ČR v roce 1998 (Characteristics of HIV/AIDS Spread in the CR in 1998). **Zprávy CEM**, No. 1, pp. 20–23.
- Cohen, M., Hubert, M. (1997) The Place of Time in Understanding Sexual Behavior and Designing HIV/AIDS Prevention Programs. In: Van Campenhoudt, L., Cohen, M., Guizzardi, G., Hausser, D. (eds.) (1997) **Sexual Interactions and HIV Risk. New Conceptual Perspectives in European Research**. Taylor & Francis, London, pp. 196–222.
- Connors, M. (2000) Risk Perception, Risk Taking and Risk Management Among Intravenous Drug Users: Implications for AIDS Prevention. In: Lemelle, A. J., Harrington, C., LeBlanc, A. J. (eds.) (2000). **Readings in the Sociology of AIDS**. Prentice Hall, New Jersey, pp. 67–79.
- Elster, J. (1983) **Explaining Technical Change.: A Case Study in the Philosophy of Science**. Cambridge University Press, Cambridge.
- Fee, E., Krieger, N. (2000) Historical Interpretations and the Limits of Biomedical Individualism. In: Lemelle, A. J., Harrington, C., LeBlanc, A. J. (eds.) (2000) **Readings in the Sociology of AIDS**. Prentice Hall, New Jersey, pp. 15–30.
- Guizzardi, G., Stella, R., Remy, J. (1997) Rationality and Preventive Measures: The Ambivalence of the Social Discourse on AIDS. In: Van Campenhoudt, L., Cohen, M., Guizzardi, G., Hausser, D. (eds.) (1997) **Sexual Interactions and HIV Risk. New Conceptual Perspectives in European Research**. Taylor & Francis, London, pp. 159–180.

- Hausser, D. (1997) New Conceptual Perspectives and Prevention. In: Van Campenhoudt, L., Cohen, M., Guizzardi, G., Hausser, D. (eds.) (1997) **Sexual Interactions and HIV Risk. New Conceptual Perspectives in European Research**. Taylor & Francis, London, pp. 234-245.
- Hedström, P., Swedberg, R. (1996) Rational Choice, Empirical Research, and the Sociological Tradition. **European Sociological Review**, Vol. 12(2):127-146.
- Ingham, R., van Zessen, G. From Individual Properties to Interactional Processes. In: Van Campenhoudt, L., Cohen, M., Guizzardi, G., Hausser, D. (eds.) (1997) **Sexual Interactions and HIV Risk. New Conceptual Perspectives in European Research**. Taylor & Francis, London, pp. 83-99.
- Kraus, J., Tomek, I., Velebil, P. (1996) Výsledky průzkumu reprodukce a zdraví (Results of Reproduction and Health Survey in the CR), 2. část. **Demografie**, 38(3):181-193.
- Lamprey, P., Wigley, M., Carr, D., Collymore, Y. (2002) Facing the HIV/AIDS Pandemic. **Population Bulletin**, 57(3).
- Lemelle, A. J., Harrington, C., LeBlanc, A. J. (eds.) (2000). **Readings in the Sociology of AIDS**. Prentice Hall, New Jersey.
- Mann, J., Tarantola, D., O'Malley, J. (2000) Toward a New Health Strategy to Control the HIV/AIDS Pandemic. In: Lemelle, A. J., Harrington, C., LeBlanc, A. J. (eds.) (2000) **Readings in the Sociology of AIDS**. Prentice Hall, New Jersey, pp. 302-310.
- Moatti, J-P., Hausser, D., Agrafiotis, D. Understanding HIV Risk-related Behavior: A Critical Overview of Current Models. In: Van Campenhoudt, L., Cohen, M., Guizzardi, G., Hausser, D. (eds.) (1997) **Sexual Interactions and HIV Risk. New Conceptual Perspectives in European Research**. Taylor & Francis, London, pp. 100-126.
- Pearce, D. W. (ed.) (1992) **Macmillan Dictionary of Modern Economics**. The Macmillan Press.
- Prokopec, M. (1999) Antropologické změny obyvatelstva České republiky ve 20. století. **Demografie**, roč. 41, str. 24-37.
- Ptáčková, H. (1998) **Percepce onemocnění AIDS u českých gymnazistů** (Perception of AIDS disease by Czech High School Students). Unpublished diploma theses, Masaryk University, Brno.
- Rabušic, L. (1997) **Youth and AIDS**. Data file.
- Říčan, P. (1989) **Cesta životem** (Journey through Life). Panorama, Praha.
- Reiss, I. (1986) A sociological journey into sexuality. **Journal of Marriage and the Family**, 48:233-242.
- Reiss, I. (1989) Society and sexuality: A sociological explanation. In McKinney, K., Sprecher, S. (eds.) **Sexuality in Close Relationship**. Hillsdale, NJ: Lawrence Erlbaum, pp. 3-29.
- Rockett, I. R. (1994) Population and Health: An Introduction to Epidemiology. **Population Bulletin**, 49 (3), 46 pp.
- Van Campenhoudt, L. (1997) Operationalizing Theories for Further Research. In: Van Campenhoudt, L., Cohen, M., Guizzardi, G., Hausser, D. (eds.) (1997) **Sexual Interactions and HIV Risk. New Conceptual Perspectives in European Research**. Taylor & Francis, London, pp. 181-187.
- Van Campenhoudt, L., Cohen, M., Guizzardi, G., Hausser, D. (eds.) (1997) **Sexual Interactions and HIV Risk. New Conceptual Perspectives in European Research**. Taylor & Francis, London.
- Weeks, J. (1997) **Sexuality**. Routledge, London.
- Weiss, P., Zvěřina, J. (1994) **Sexuální chování obyvatel ČR**. (Sexual Behaviour of Czech Population). DEMA, Praha.
- Weiss, P., Kučera, Z., Svěráková, M. (1995) Sexuální chování českých adolescentů a jeho rizikovost z hlediska infekce HIV/AIDS: výsledky národního výzkumu. **Československá psychologie**, 39(5):425-432.
- Weiss, P., Urbánek, V., Procházka, I. (1996) Koitální debut. (Coital Debut). **Československá psychologie**, 40(2):138-145.

Internet Resources:

Joint United Nations Programme on HIV/AIDS, www.unaids.org
National Health Office, www.aids-hiv.cz

SEKSUALNO PONAŠANJE ADOLESCENATA I RIZICI NA HIV/AIDS U ČEŠKOJ

LADISLAV RABUŠIĆ, KATEŘINA KEPÁKOVÁ

School of Social Studies, Brno, Češka

Iako se čini da je broj registriranih osoba inficiranih HIVom u Češkoj nizak, autori ipak upozoravaju na lažni optimizam; upitno je naime rizično seksualno ponašanje češke mladeži. Svoje solidno znanje o prevenciji HIVa/AIDSa mladi, smatraju autori, ne primjenjuju konzistentno na vlastitu seksualnu praksu. Taj se paradoksalni nalaz temelji na podacima prikupljenima u gradu Brnu 1997. godine; zbog toga autori sugeriraju zamjenu dosad preferirane teorije racionalnog izbora ili Health Belief Model kao modela koji objašnjavaju ljudsko ponašanje, primjerenijim modelom theory of expected utility. Dok prethodne teorije odnosno modeli pretpostavljaju da će pojedinci donositi racionalne odluke te prakticirati zaštićeniji seks jednom kada su informiraniji o infekciji HIVom i načinima kako da se zaštite, potonja dozvoljava postojanje racionalnosti intimiteta, a koja se razlikuje od znanstvene racionalnosti zdravstvenog sistema. Ta teorija drži da bi se, unutar polja intimnih odnosa, moglo zagovarati racionalnost prakticiranja nezaštićenog seksa ukoliko je ono kompenzirano drugim beneficijama. Da bismo omogućili pomirenje tih dviju racionalnosti i razumjeli nezaštićeno seksualno ponašanje, moramo analizirati opći kontekst intimnog stanja uključujući društvene norme i vrednote, emotivni naboj, individualne namjere i ciljeve partnera te kompleksnost mehanizama interakcije i moć pregovaranja između seksualnih partnera.

Ključne riječi: ADOLESCENTI, SEKSUALNO PONAŠANJE, SEKSUALNI RIZICI, RACIONALNI IZBOR, HIV, AIDS