"CONDOMS ARE RELIABLE BUT I AM NOT": A QUALITATIVE ANALYSIS OF AIDS-RELATED BELIEFS AND ATTITUDES OF YOUNG HETEROSEXUAL ADULTS IN BUDAPEST, HUNGARY, AND ST. PETERSBURG, RUSSIA

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SUMMARY

HIV and STD prevention is an essential component of public health initiatives in countries throughout Central and Eastern Europe. Liberalization in sexual values, declining age at first sex, higher levels of sexual activity, and inconsistent condom use have been well-documented among young people in the region following the political, economic, and cultural transitions after the end of the state socialism era. Less well-understood are the reasons for high-risk sexual behavior and psychosocial factors that must be addressed in the development of effective HIV/STD prevention programs. This study recruited members of 12 high-risk social networks of young adult men and women (n= 66 participants) in two cities, St. Petersburg, Russia, and Budapest, Hungary. In-depth focus groups were conducted with all members of each network, and qualitatively analyzed to examine factors surrounding high-risk sexual behavior. Main themes that emerged were that STDs are less known and less feared than AIDS, HIV risk factors were relatively well known among young adults in both countries but vulnerability is perceived differently, pregnancy prevention is a more immediate concern than protection from HIV or STDs, condom use declines quickly following first sex with a new partner, reintroducing condom use in a relationship is very difficult, and young adults report many barriers to condom use including those related to alcohol or other substance use. HIV/STD prevention programs are needed that extend beyond risk education alone and that also address critical psychological, social, and relationship factors related to sexual risk behavior.

Key words: HIV/AIDS, sexually transmitted diseases (STDs), sexual risk behavior, condoms, Hungary, Russia

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INTRODUCTION

HIV infection and sexually transmitted diseases (STDs) emerged as public health threats more recently in Eastern Europe than much of the rest of the world. Many Soviet-era health authorities believed that AIDS would never pose a serious threat to socialist countries in Central and Eastern Europe. However, the region witnessed a rapid social transition during the 1990s from authoritarian controls and state socialism to consumer capitalism with increased availability of means to distinguish one's individuality and status. The institutionalization of market economies went hand in hand with increased personal freedoms and mobility opportunities, as well as the liberalization of formerly conservative sexual behavior values. However, these changes were often accompanied by worsened access to health care, inadequate sexual and contraceptive education, increased drug use, and growth in commercial sex trade. Rates of HIV and STDs increased dramatically in post-Soviet countries and in some of the region's other former socialist republics (1–2). A public health priority is the development of approaches to reduce the incidence of STDs and sexually transmitted HIV infection. However, developing effective HIV and STD prevention strategies first requires an understanding of the social context surrounding risk behavior and of factors that contribute to risk. The purpose of this study – conducted in St. Petersburg, Russia, and Budapest, Hungary – was to use qualitative focus groups to understand critical HIV/STD risk issues that must be addressed in prevention programs designed for high-risk heterosexual young adults in the region.

STDs, HIV, and Prevalence of High-Risk Sexual Behavior among Young People in Russia

During the Soviet era, Russian authorities maintained strict HIV and STD control systems. However, the past decade's socioeconomic transitions coincided with a collapse of the HIV/STD control system and infrastructure. The prevalence of STDs increased in Russia throughout the 1990s. For example, syphilis rates grew from 4.2 to 165 cases per 100,000 between 1988 and 2001 (2–3), with most new cases diagnosed among young peo-

ple. Syphilis rates among 15- to 17-year-olds increased 99-fold between 1988 and 1997 (3), while gonorrhea rates increased from 75 to 296 cases per 100,000 between 1987 and 1997 (4).

Only 1,062 HIV infections had been officially recorded in Russia by 1995 (5). During the 1990s, drug use became common and Russia now has 2 to 3 million injection drug users (IDUs), most of them young (6–7). Since the mid-1990s, HIV rates also began doubling annually and reached a total of over 300,000 recorded cases by 2004 (8), primarily among drug users. However, the estimated true number of HIV cases in Russia is believed to be between 860,000 and two million (9–10). HIV prevalence reached 1.3% in the overall population, suggesting that Russia now has a generalized epidemic as defined by World Health Organization criteria (11). In St. Petersburg alone, the number of HIV cases increased 100-fold between just 1998 and 2003 (12) and accounted for almost 17% of the country's total in 2004 (13). While the Russian HIV epidemic at first overwhelmingly affected IDUs, sexual HIV transmission is growing rapidly. Unprotected heterosexual intercourse acts now account for about half of Russia's new infections (14). High-risk behavior is especially prevalent in youth (15–16). Two studies in St. Petersburg showed that school students ages 15 to 17 had only limited AIDS knowledge (17–18) and that few young people consistently used condoms. Large proportions of teenagers in these studies reported multiple sexual partners.

Sexual mixing and overlap between multiple at-risk populations facilitates the transition of HIV infections between groups. For example, IDUs in Russia often engage in commercial sex and rarely use condoms (19), amplifying risk to their other sexual partners. Another mixing pattern has been found among young Russian men who have sex with men (MSM). A recent St. Petersburg study found that 37% of MSM had sex not only with males but also often with females, rarely using condoms on a consistent basis (20).

STDs, HIV, and Prevalence of High-Risk Sexual Behavior among Young People in Hungary

HIV and STD prevalence is much lower in Hungary than in Russia. 1,242 HIV infections were officially registered by 2005 (21), although the estimated true number is believed to be three to five times higher. In Hungary, the main exposure risk factors for HIV infection are sex between men and, increasingly, heterosexual contact.

Hungary's gonorrhea incidence decreased from 46.9 cases per 100,000 population in 1990 to 8.9 per 100,000 in 2003 (22), most among adults between ages 25–44, but more than a third in young people under age 24 (23). Syphilis data show a different tendency. While new syphilis cases steadily decreased from the 1970s until 1990, a sharp increase occurred between 1990 and 2002. In 2002, more than half of new syphilis infections affected people ages 25–44, with 21% among those under age 24 (22).

There has been only limited research on sexual behavior in Hungary. However, changes in social and cultural norms associated with the rapid social transitions of the 1990s have resulted in the earlier start of sexual activity and an increase in the number of sexual partners especially among younger age cohorts (24). Decreasing marriage rates, delayed age at first marriage, and rising divorce rates also reflect changes in sexual lifestyles. For example, the average age at first marriage increased from 22 in 1990 to 25.7 in 2002 for women and from 24.7 in 1990 to 28.2 in 2002 for men, leaving more time for sexual experimentation before establishing first marriage (25).

Young people start sexual activity at an earlier age than in the past. According to data from a 2004 national survey of 8,000 Hungarian youth, 54% of young people ages 15–19 were sexually experienced, increasing to 93% of young people ages 20 to 24 (26). The average age of first sexual experience was 17, but 15.9 in the youngest age group and 17.3 among persons ages 25–29. Approximately 60% of sexually active Hungarian teenagers living in Budapest were found to not consistently use condoms for vaginal sex in the past five weeks (24).

The great social, cultural, and lifestyle transitions of the past two decades in Central and Eastern Europe – together with high STD and also growing HIV rates – underscore the importance of better understanding the AIDS- and STD-related beliefs and perceptions of young adult men and women. Several prior studies have used written surveys to examine the prevalence of population-level sexual risk behaviors among young people. However, such approaches do not shed light on the contextual, attitudinal, social, and motivational factors underlying these behaviors. For that reason, our study employed in-depth focus groups and performed qualitative analyses of focus group interview data obtained from high-risk heterosexual men and women. Each focus group was composed of a single natural and intact social network of friends who already knew one another. Our decision to carry out focus groups each composed of an entire social network rather than unrelated individuals was based on past research showing that sexual risk behavior and STDs are often clustered within high-risk social networks (27–29).

METHODS

Settings and Participants

Data collection was carried out during 2003–2004. We chose Budapest, a city of 1.8 million residents, and St. Petersburg, Russia's second largest city with over 4.5 million residents, because each is an urban HIV and STD epicenter in its respective country. Data collection procedures followed a protocol approved by the IRBs of the collaborating institutions. Participants were the members of 12 social networks, six recruited in St. Petersburg and six in Budapest. The networks consisted of 66 young heterosexual adults, ages 16 to 27, 36 (24 men and 12 women) in Budapest and 30 (14 men and 16 women) in St. Petersburg. This sample size meets recommendations for number of participants needed in qualitative research to achieve saturation in uncovering new themes (30).

Socio-demographic, sexual risk, and substance use characteristics of participants are shown in Table 1. Most participants were 19 to 21 years old, had completed approximately 11 years of education, were never married, and were not permanently employed. All males and most females reported only heterosexual behavior in the past year. St. Petersburg participants had a mean of approximately 9 (median=5) lifetime sexual partners and Hungarians a mean of about 16 (median=10) lifetime partners. In both countries, males had considerably greater numbers of sexual partners during their lifetimes and during the past year than females. Approximately 80% had frequent unprotected

Table 1. *Demographic, Sexual Risk, and Substance Use Characteristics of Focus Group Study Participants, by Gender and by Country*

	St. Petersburg, Russia Sample			Budapest, Hungary Sample		
	Total (n= 30)	Males (n=14)	Females (n=16)	Total (n=35)	Males (n=24)	Females (n=11)
DEMOGRAPHIC CHARACTERISTICS						
Mean age in years	18,8	19,4	18,9	21.0	21,4	20,3
Mean years of education	11,4	11,8	11,1	10,9	11,2	10,4
Percent (n) single and never married	96.7% (29)	100% (14)	93.8% (15)	100% (35)	100% (24)	100% (11)
Percent (n) permanently employed	23.3% (7)	7.1% (1)	37.5% (6)	25.7% (9)	29.2% (7)	18.2% (2)
Percent (n) currently in school	53.3% (16)	21.4% (3)	81.3% (13)	42.4% (14)	34.8% (8)	60.0% (6)
Percent (n) reporting same-sex activity, past year	3.3% (1)	0% (0)	6.3% (1)	8.6% (3)	0% (0)	27.3% (3)
SEXUAL BEHAVIOR PRACTICES						
Mean (median) number of lifetime sex partners	8.8 (5)	14.1 (14.5)	4.1 (3)	16.5 (10)	19.1 (11)	10.8 (6)
Mean (median) number of sex partners past year	2.7 (2)	3.6 (3.5)	1.8 (1.5)	4.5 (4)	4.6 (3.5)	4.2 (4)
Percent (n) reporting unprotected vaginal intercourse, past 3 months	76.7% (23)	92.9% (13)	62.5% (10)	82.9% (24)	83.3% (20)	81.8% (9)
Mean (median) number of unprotected intercourse, past 3 months	13.4 (5)	12.9 (7)	14.0 (3.5)	21.6 (15)	21.3 (12)	22.1 (21)
SUBSTANCE USE, PAST 3 MONTHS						
Percent (n) drinking alcohol	100% (35)	100% (14)	100% (11)	100% (35)	100% (24)	100% (11)
Mean (median) days of alcohol use	27.9 (20.5)	27.7 (25)	28.1 (20.5)	28.4 (30)	30.5 (30)	23.6 (22)
Percent (n) using marijuana/hashish	33.3% (10)	50.0% (7)	18.8% (3)	74.3 (26)	79.2% (19)	63.6% (7)
Mean (median) days using marijuana/hashish	3.5 (0)	7.1 (0.5)	0.3 (0)	6.7 (4)	8.5 (4.5)	3.0 (2)
Percent (n) using ecstasy	13.3% (4)	21.4% (3)	6.3% (1)	28.6% (10)	25.0% (6)	36.4% (4)
Mean (median) days using ecstasy	0.7 (0)	1.4 (0)	0.1 (0)	0.7 (0)	0.8 (0)	0.7 (0)

intercourse during the past 3 months, noteworthy because most also had multiple recent sexual partners. No participants reported personally injecting illicit drugs during the past 3 months.

Data Collection Procedures

Participants were recruited in bars and nightclubs that could be considered access points for reaching high-risk segments of the YHA population. Recruitment was preceded by ethnographic observations to select venues characterised by young adult men and women of lower socio-economic status.

Ethnographers first identified "social circles" (31) by observing the social interactions of people in the settings. Following procedures described in detail elsewhere (32), staff identified the "index" of each circle, defined as the group's central attention figure. Indexes were approached and, during an interview, identified the first names of their closest friends. Most identified between 5 and 7 network members. The index invited all members of his or her social network to participate in the research. Both male and female indexes were recruited in equal numbers. The social networks of male indexes were primarily other males, while female indexes primarily named other females as network members. Recruited network members were invited to the teams' offices. Following an explanation about the research project and provision of informed consent, an HIV/AIDS risk assessment individual interview was privately conducted with each network member.

2.5 – to 3-hour long focus group interviews were then conducted with each of the six Hungarian and each of the six Russian networks, facilitated by male and female teams with social science backgrounds experienced in focus group techniques. Groups followed a standard topic guide with open-ended questions and probes arranged around the following main themes: (1) knowledge, beliefs, perceptions about HIV/AIDS and STDs; (2) safer sex and condom use perceptions; (3) substance use in relation to risky sex; and (4) communication about HIV/AIDS and STDs. All group sessions were tape-recorded.

Data Analysis Procedures

The recorded material was first transcribed verbatim. Coding was conducted by grouping narrative text into categories that reflected the main themes of our research interest in accordance with a guideline protocol. Coding was performed and the coding guidelines were reviewed by social science researchers with expertise in qualitative data analysis at both sites. All data pertinent to one or more coding categories were collected under the appropriate categories and subcategories, resulting in a Hungarian and a Russian code book. Each was translated into English. The data analysis was produced by a qualitative analysis of these code books' contents.

Results of the analyses that follow are grouped by themes. Verbatim narrative text (participant responses) are shown in italic font. Narrative quotations are followed by indicators showing country of the respondent (R= Russia, H= Hungary), the respondent's gender (m= male, f= female), and the respondent's age.

RESULTS

STDs are Less Known and Less Feared than AIDS/HIV-related Risks

Both Hungarian and Russian respondents had relatively high levels of knowledge concerning AIDS, HIV, and HIV transmis-

sion. Most were aware of differences between AIDS and HIV: *HIV is a virus and AIDS is the disease. When you have AIDS, your immune system is very weak and you will be vulnerable to all kinds of infection (H, m, 20).* Most respondents also knew about the latent period of HIV infection: *I heard that if a person became infected, then this will show up only after 6 months. I do not know if this is true or not. In any event, one cannot know about it right away (R, f, 17).*

Level of knowledge about STDs was much lower than about AIDS. Most respondents knew that sexually transmitted diseases exist; knew colloquial or common names of the most widespread STDs such as hepatitis, "the clap", "the pox", and "some fungus;" but were otherwise not familiar with them: *Basically everybody knows that [these diseases] exist and that they can be infected by them. But about details and symptoms, only a few [know] (R, f, 17).* STDs were thought to be the concern mainly to those who had already gotten infected, and they tended to be seen as affecting "older people" with more sexual experience: *In my view, people know mainly about AIDS, maybe older people know more about the other STDs (H, m, 20).*

STDs were seen as not posing serious threats for people's health, especially compared to "the lethal AIDS". STDs were not feared as much as AIDS, there was less awareness about them, and both STDs and AIDS were seen as equally distant: *Many people think that this will happen to anybody but not to them. [With STDs], there is no danger of death. There will be more problems but these can be solved – and that's it (R, m, 17).*

Some people tried to distance themselves from this topic by referring to other places where AIDS is more common than in their own environments. A few Hungarian respondents described AIDS as a specific African or "third world problem": *Nowadays, it is like the plague used to be in the old times. ... But it is mainly a problem in Africa and other poorer underdeveloped countries... (H, m, 18).* On the other hand, Russian respondents had more awareness about AIDS and HIV as part of everyday reality. As one of them pointed out: *maybe one should do something so that everybody would think that this not a thing beyond the clouds, but it is rather located very close, near, and everywhere (R, f, 18).*

Study respondents were well-informed about how HIV infection can be transmitted. Most transmission routes were correctly identified including the risk posed by different sexual practices; transmission via blood during IDU drug use, tattooing, piercing or non-hygienic blood transfusion; through other body fluids such as sperm, pre-ejaculatory fluid, vaginal secretion, and breast milk; as well as transmission from an HIV-infected mother to her child. Some respondents misperceived the possibility of HIV transmission especially via saliva and airborne routes: *[It] can be transmitted also by saliva – through a big amount of saliva (R, m, 18); By aerosol infection you can get it. But I am not sure about mosquitoes. Allegedly, mosquitoes can transmit it, but if it were true, the whole world would have died out by now (H, f, 22).*

We also asked whether HIV transmission during sexual practices depends on the sex of the partner. Only one man stated that *women will get infected by men without exception, but men will not necessarily get it from women (H, m, 27).* Otherwise, almost everyone expressed the view that transmission depends not on the sex of the partner, but on other factors such as promiscuity and having unprotected sex: *If partners are changed all the time and there is no protection, then anyone can get it from anybody (H, m, 20).*

Vulnerability to HIV Infection is Perceived Differently in Hungary and in Russia

Drug use was often cited as a factor that increases vulnerability to HIV infection by Russian respondents, while sex between men was frequently cited by Hungarian respondents. These perceptions correspond with reality as most registered HIV infections in Russia have resulted from infection drug use while the predominant exposure factor in Hungary is unprotected sex between men. However, both Hungarian and Russian respondents' knew that heterosexual transmission is rising in both countries: *The virus is not choosy. Men can get it from women, women from men, and guys can get it from each other … (H, m, 20).*

It was also clear that drug users and men having sex with men are perceived to be more vulnerable to HIV infection, not because they share a certain category membership but because of high-risk behaviours: *OK, there is a lot of AIDS among gays, but of course it does not just spread between them, but they are more inclined to go in for risky sex (H, m, 19).*

While primary risk factors were perceived as intensive sexual activity, frequent changes of partners, having many partners, unprotected sex, and the lack of clean needles during injection drug use, other views could also be detected. For example, one Hungarian woman asserted that HIV is *transmitted more frequently by foreigners (H, f, 20)*. In a Russian woman's view, people from the Caucasus are more vulnerable because *they share drugs and diseases (R, f, 18)* and, according to a Russian male, people should *try to have relations with younger partners, they are cleaner (R, m, 20).*

Pregnancy Prevention is a More Immediate Concern than is Protection from HIV or STDs

Preoccupation with avoiding pregnancy was very much present in how people interpreted the meaning of safer sex: *If you love someone it also means that you trust him. If you use condoms, it is not the same! Of course, you must protect yourselves but it can be done also by taking the pill (H, f, 18); You must use condoms until you know her well enough. After that, it is enough if she takes the pill or you end sex before ejaculation. I do that because I don't want to have children, yet (H, m, 20).*

Respondents mentioned several HIV infection risk reduction techniques including condom use and keeping condoms available all the time, having safer sex or even virtual sex, practicing abstinence, having sex with a partner only after negative AIDS tests, and avoiding casual sex or sex with partners one does not really know. However, incorrect references to the use of a diaphram (H, m, 20) or having a vasectomy (H, m, 24) to reduce HIV infection risk indicate that some young people perceive unwanted pregnancy to be the main risk associated with having sex. Therefore, they tend to interpret risk reduction somewhat automatically in the pregnancy prevention framework.

Others referred to safer sex as *sex with condom (R, m, 20); responsibility and care for myself and the other; protection (H, f, 26); responsible condom use (H, f, 19); or oral sex and masturbation – when there is no chance of getting a serious disease (H, m, 20)*. Only one participant in the entire sample specifically pointed to the importance of using condoms concurrently with other contraceptive devices to protect against disease as well as pregnancy: *I think you must use contraceptives and condoms at the same time (H, f, 18).*

"Protection" or *that relaxing feeling of being safe* were the main positive aspects of condom use although some participants also noted that the condom *doesn't have any side effects like the pill does* (H, f, 20), primarily interpreted in the context of avoiding unwanted pregnancy. Accordingly, for most respondents, the main motivation of condom use was avoiding pregnancy: *Personally, I use condoms not to become pregnant, and about diseases I think [only] in the second place (R, f, 18); [I use condoms] mainly to prevent pregnancy and not because of the infections (H, m, 18).*

Condom Use Declines Very Quickly in the Life of a Sexual Relationship

Condom use was perceived by most of the respondents to be an issue of trust. They agreed that, at least in theory, one should always use condoms when having sex with casual partners or when having sex for the first time with a partner. However, once a steady relationship is established, the importance of condom use diminishes: *You should always use condoms when you have sex with someone for the first time. (H, m, 20); At the beginning of relationships, it is necessary to use it, and after that you don't have to use it. You can trust each other and then can discontinue it (R, m, 17); All those people [should use condoms] who do not have a steady sexual relationship and like to sleep around. Prostitutes have to protect themselves, for example (H, f, 19).* Very few references were made to the necessity of condom use within steady relationships. Only one respondent argued that *those who have a permanent boyfriend can never know when he will cheat on you; I don't think that you can completely trust anyone (R, f, 17).*

Open to interpretation was what constitutes a steady relationship, especially if we take into consideration the answers given to the questions of how well and for how long one has to know his or her partner to have sex without using a condom. According to most of the young male respondents from Russia, it can be *one day, two weeks, a month* or *it can depend on the relationship. If you frequently communicate, the maximum is two months (R, m, 21)*, or it can happen after having sex with condoms once or twice. Young Russian women were more cautious. They mentioned longer periods of time – *three or four months, half a year* – or simply said that a time period cannot be determined until the partner's lifestyle is observed. Most Hungarians tended to be more cautious and preferred not to refer to exact time frames: *You must try to get to know her a bit better. It is useful to find out how much she looks after herself and how long her previous relationships lasted. (H, m, 20); Trust is very important but it is even better to go for an AIDS test (H, m, 18).*

Condom use was generally perceived to be initiated by the *partner who worries more (R, m, 17)* about protection against pregnancy and diseases, and this role was mainly cast to women. Men's responsibility for condom use was also acknowledged, especially in the practical sense that—because female condoms are unknown and largely unavailable in Russia and Hungary—men are the ones who have to wear condoms. In fact, people stated that men had great – at least as much as women, if not even greater – responsibility for condom use, and in an optimal case, women wouldn't even have to mention anything as the *condom only needs to be spoken about if one of the couple does not want to use it (H, m, 20).*

However, some men noted that condoms were not a popular topic to discuss because condom use was seen as unnecessary within a steady relationship, especially if the female partner takes contraceptives: *At the start of the relationship, when it is necessary [to bring up the topic of condom use], or again as a matter of necessity, in casual affairs. But, it is not a popular topic (H, m, 20); It only comes up if the girl doesn't take contraception (H, m, 20).*

When the male partner does not consider condom use to be necessary, the woman can still – and according to most respondents, should – *take the initiative into her own hands (R, f, 20).* However, women often shared the belief with their male partners that condom use is needless and consequently *those who take the pill will not use a condom (R, f, 17).*

Reintroducing Condom Use in a Relationship is Perceived to be Very Difficult

Initiating condom use with a partner with whom one already had unprotected sex was considered to be problematic by almost everyone: *He will start asking questions: why does she start distrusting him? Or, he will think that she is sick or cheated on him. (R, f, 17); I would be suspicious. Perhaps she whored around in the meantime or sometime in the past (H, m, 18).*

In relationships – or in relationships not yet considered to be steady – men were seen as more likely to initiate sexual activity reflecting gender roles in a male-centred sexual culture, though to a slightly larger extent on the Russian side and to a lesser extent on the Hungarian. In Russia, females particularly believed that proposing condom use was mainly the man's responsibility *because they should take care of the girl (R, f, 17)*, while others had mixed opinions.

Initiating condom use in the course of a steady relationship was seen as very difficult because such a proposal would so much undermine trust that it could practically mean the end of the relationship: *If I have even a little doubt, I will not sleep with him at all (R, f, 17); She would smell trouble: either I cheated on her or I don't trust her anymore (H, m, 20).*

Concerns over protecting oneself and one's sexual partner from STDs and HIV infection tended to diminish, if not completely disappear, once people started defining their relationship as steady. Avoiding unwanted pregnancy remained the main concern. A steady relationship was defined in terms of perceived needlessness to use condoms. Within steady relationships, condom use was not preferred, and when a casual partner became defined as a steady partner who "one can trust", initial condom use is discontinued. Once condom use is given up in a relationship, "there must be a serious reason" for trying to reintroduce it again: *If there is a permanent partner with whom you had sex already without condoms, and then if he suddenly wants to use condoms again, it puts me in shock a little bit. Perhaps he cheated and got infected with something… But if this is the first sexual act with a person, I will even offer [condom use] myself (R, f, 17).*

Outside of a steady relationship, condom use was easier to negotiate. Several examples were presented by respondents about how to persuade their sexual partners to use condoms: a man can stress that he wants to avoid pregnancy this way and should point to the fact that *condoms protect against STDs as well (H, m, 20)* and *go on to say that sex is good this way, too*; he can argue, for instance that *I recently had casual sex [with someone else] and*

I want to protect you (R, f, 17); he can also offer a kind explanation highlighting the possible dangers of having unprotected sex, or he can give an ultimatum such as *these are my conditions (R, m, 20)* and, if the female partner does not agree, she can leave without having any sex. According to study respondents, women can convince their male partners to use condoms in very similar ways, though women were thought to have more authenticity when citing pregnancy concerns in pro-condom arguments such as *I don't trust the pill, I don't take the pill, or it is not possible for me to take the pill (R, f, 20)* which would be hardly contestable by their partner. Still, the most often mentioned – and probably the most effective – solution was to confront the male partner with the ultimatum of *no sex without condoms – that always works (H, f, 19)*.

"Condoms are Reliable but I am not": Barriers to Condom Use

Respondents reported on several negative experiences of their own condom use. The main negative aspect of condom use about which both young men and women complained was inconvenience: *it can be really complicated to get it, to open it, to put it on at the right time without the feeling of being interrupted (H, f, 22)*; and the diminished sexual sensitivity caused by condoms: *It is not the real experience, only a worse version (H, m, 24), there is less sensation with a condom (R, f, 17)*. Men, particularly from Hungary, more often referred to condoms being expensive, and women, particularly from Russia, more often expressed doubts about their reliability.

Some of the negative aspects mentioned by respondents related to poor practical knowledge about condoms and their use. Complaints like *it is embarrassing (R, m, 20)*; *it is so tight that it can harm your health (R, m, 19)*; *it can remain 'there' (R, f, 16)*; *some of them are so stinky that it is impossible to use them (R, f, 17)*; and *it would be useful if it was easier to open it (H, m, 24)* reflect that young men and women can often face practical difficulties when they want to use condoms. As one respondent pointed out *condoms are reliable but I am not. Sometimes, I am not really clever in putting it on (H, m, 20).*

Substance Use Increases the Probability of High-Risk Sexual Practices

In order to contextualise substance use in relation to high-risk sexual practices, we examined perceptions of alcohol and drug use in our respondents' social environments as well as the types of sexual risks associated with drinking and drug use.

Alcohol use was widespread among respondents, their friendship circles, and people they knew. Most reported regularly drinking with their friends; alcohol consumption was seen as an essential element of social activity. A main motivation of drinking is *enjoying ourselves (H, f, 19)*, and sexual relationships are then established under the influence of alcohol. Alcohol was reported to stimulate sexual appetite and to liberate sexually or otherwise inhibited persons: *As boys say, there are no unattractive women, only not enough vodka. When you drink enough, courage and eloquence will appear (R, f, 18); If the girl is ugly, then drink is a must (H, m, 20).* On the other hand, alcohol consumption was seen to increase the *probability of disorderly sex (R, f, 23)* and lead to relationship break-up: *The main reason for breaking up is cheating, and cheating happens when you are drunk (R, m, 21); Alcohol relaxes and dissolves inhibitions. If the person does not know where to draw the line, then it can mean the end of a relationship (H, f, 18).*

One consequence of having sex while drinking is the tendency to forget about protection and condom use. Almost everyone agreed that alcohol consumption *increases lust (H, f, 20)* and, at the same time, decreases intentions to practise safer sex: *Under the influence of alcohol, you particularly do not think about diseases. Generally, you don't think about anything. You completely concentrate on her, and that's all (R, m, 20); They concentrate only on sex, they don't think of safety and they don't use condoms (H, m, 20); [Alcohol] can reduce the use of condoms to a large extent, sometimes to zero (H, f, 26).* Alcohol was seen to reduce the defenses even of those who originally intended to use condoms, especially if there is pressure from the partner: *If the partner doesn't want [to use a condom], she will give up and have sex without it (R, f, 17); Inhibitions melt away and they will more easily go in for casual sex (H, f, 18).*

Respondents reported that different drugs have differing effects on condom use intentions. Their source of information was mainly hearsay, rumours, and popular films on drug users, but some participants referred to varied effects in their own personal experiences: *Hashish, for example, does not affect attitudes toward condoms (R, m, 21); I don't know about marijuana, [but] ecstasy reduces the willingness to use a condom (H, m, 18); As I don't like to use condoms otherwise either, it [smoking grass] will reduce the chance (H, m, 20).*

Close Friends are Seen as Trusted Sources of Sexual Health Related Advice

Most participants reported that sexual matters were more likely to be discussed in the company of friends of the same gender, or even more so in the company of only one of them. Though both young women and men tended to discuss similar sexual topics *– relationships, sexual experiences, and fear of pregnancy (H, m, 20)* – women more often focused on topics like relationship issues and the use of contraceptives, while men more often shared with each other details of their sexual adventures and sexual jokes. Very few people spoke about intimate matters with a different-sex friend. Preference for discussing sexual matters with persons of the same gender was explained in terms of convenience and the biological difference between the sexes. Most respondents took it for granted that *girls speak with girls and guys with guys (R, m, 17)*.

However, seeking sexual health-related advice and information on diseases was seen as a specific type of sexual communication, mainly determined by the level of trust and the perceived experience – and not primarily the gender – of the person serving as a source of advice. For advice on HIV, STD infection, or pregnancy-related issues, respondents most trusted their closest relatives – mothers, older sisters or brothers, or a good friend: *a person I know for a long time and trust … an adult who has faced [similar matters] (R, f, 17)*. Among other potentially important sources of knowledge and advice, specialist doctors, current partners, teachers, and the internet were mentioned. Most respondents did not trust media sources *because information is different everywhere* (R, f, 17).

The preference for discussing serious things with just one other person could also be explained by the "suspicious nature" of

these issues: *We try to avoid it [talking about these topics], even though it is not a taboo. If someone started to speak about it, the idea would arise in the company that that person was somehow involved in the thing (H, m, 20).* As one respondent pointed out, people tend to avoid these topics because *[they] are ashamed, because of prejudice, because of the shadow of suspicion. It is fashionable to be healthy, whilst those who speak about illness are perhaps ill themselves… This is what people can think, but this is crass stupidity (H, f, 20).* Consequently, sexual health and HIV/AIDS related topics were not common in conversations with friends. However, most people expressed their openness to discuss these topics once they are formulated as an important and/or an interesting issue which mainly *depends on whose initiative it is [in the company] (R, f, 18).*

DISCUSSION

In this sample of high-risk young heterosexual men and women, knowledge about AIDS, HIV, and HIV transmission exceeded knowledge about other STDs. The relative lower level of awareness about STDs can be explained on the one hand, by the perception that most STDs are easily curable as opposed to AIDS, and on the other hand by the main preoccupation with avoiding unwanted pregnancy. Most respondents underestimated their own vulnerability to HIV transmission and other sexually transmitted infections by distancing themselves from these issues, keeping unwanted pregnancy as the main risk associated with having sex.

Condom use was seen as acceptable during sex with a new partner but – once a relationship became defined as steady in terms of emotional ties and regular sexual encounters – condom use quickly lost its significance. Within steady relationships, condom use was not preferred. It is of crucial significance for prevention efforts that initial condom use is so quickly dropped when a partner is no longer defined as new or casual. Once condom use was given up in a relationship, reintroducing it was seen as very difficult.

In the context of communication about condom use with sexual partners, women were perceived to be more active agents of initiating condom use than men due to their increased concern with avoiding unwanted pregnancy. While shared responsibility of sexual partners for condom use was widely accepted, especially at the beginning of relationships or in casual sex, safer sex concerns diminished quickly once a partner became known. STD and HIV/AIDS prevention efforts targeting young heterosexual adults must focus on the process through which a new or casual partner becomes defined as a steady partner with whom condom use can be dropped, especially when other contraceptive methods are employed. In theory, our respondents were familiar with HIV risk reduction techniques, but references to their everyday lives reflected the imperfect or non-existent implementation of safer sex practices. Some participants lacked adequate practical knowledge and practical skills concerning condoms and condom use. Substance use was seen to have negative effects on condom use intentions and practices.

The most important sources of HIV/AIDS and sexual health related advice were trusted adults with appropriate levels of knowledge and experience including close relatives – especially mothers and older siblings – as well as close friends with whom young people could have private discussions. The preference for private as opposed to more public forms of communication resulted to a large extent from social stigmatization attached to STDs and especially HIV/AIDS. Young people were open to discussion about HIV/AIDS and sexual health topics once they were formulated and presented by a trusted member of their friends' circle as an issue of importance and interest.

The findings of this study point to the need to integrate prevention of STD and HIV-infections with avoiding unwanted pregnancy. If condoms are used at all, they are primarily used at present to avoid unwanted pregnancy, rendering protection from infections a fortunate by-product. Messages should be crafted to highlight that condoms are needed to also protect effectively against STDs and HIV infection; that non-barrier contraceptives and trust are not substitutes for condom use; that relationships are often judged as "steady" far too soon, leading to the dropping of condom use; and that, once interrupted in a sexual relationship, condom use is difficult to re-establish. There is also a need to convert theoretical commitments to condom use and into actual routine practice. Peer influence, especially trusted close friends, within naturally functioning social networks can play an important part in this process.

Recognizing that "condoms are reliable but we are not" accentuates the importance of raising awareness of STD and HIV risk reduction issues among young people. It also illustrates the need for effective implementation of practical trainings that can prevent the spread of AIDS and other STDs among young heterosexual adults in Central and Eastern Europe.

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