Interest for men's attitudes and practices regarding sexual and reproductive health is relatively new. Most academic production on this subject is from the last decade. Until then, the vast majority of research studies as well as reproductive health policies and programs had focused almost exclusively on women, deliberately excluding men. It was only after the IV Conference on Population and Development (Cairo, 1994) and the V World Conference on Women (Beijing, 1995) that male participation and shared responsibility in matters of sexual and reproductive health began to be discussed and promoted. This occurred as it became clear that without understanding men's attitudes it would be impossible to change risky behaviors that are harmful for both men and women (Collumbien and Hawkes, 2000; Mundigo, 1998). Also, the spread of the AIDS epidemic and the use of condoms as the sole method available to prevent infection through sexual intercourse was an important factor that directed attention to the role of men in sexual and reproductive health (Gogna et al., 1997). Finally, the recognition that men's attitudes and opinions regarding the use of contraception by their female partners had a significant impact on the effective adoption of contraceptive methods - and therefore on the reproductive risks faced by women - could no longer be ignored.

Dual protection refers to the simultaneous prevention of unwanted pregnancy and sexually transmitted diseases (STDs) including HIV/AIDS. It can be achieved by using condoms (female or male) alone or in combination with another contraceptive method such as hormonal contraceptives or the IUD. It has been extensively proven and documented that when used constantly and correctly male latex condoms are an efficient dual protection method (CDC, 2000; Pinkerton and Abramson, 1997; WHO/HRP, 2002)

Sexually active adolescents have special needs for dual protection for two basic reasons: 1) in general adolescents do not purposely seek to reproduce, and 2) given the characteristics of sexual activity during this life stage, adolescents are particularly vulnerable to contracting STDs and HIV/AIDS. Nearly half of people infected with HIV in the world are under age 25, and an important proportion of AIDS cases became infected during adolescence. Adolescent women present a higher risk of contracting STDs and HIV than older women due to specific biological characteristics that make them more vulnerable. Also, early sexual initiation is associated with higher number of sexual partners and greater risk of contracting STDs and HIV/AIDS (WHO, 2002)

This paper describes the different factors that affect the use of male condoms as a dual protection method among adolescent men (15-19). The first section presents part of the

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1 Nearly half of people infected with HIV in the world are under age 25, and an important proportion of AIDS cases became infected during adolescence. Adolescent women present a higher risk of contracting STDs and HIV than older women due to specific biological characteristics that make them more vulnerable. Also, early sexual initiation is associated with higher number of sexual partners and greater risk of contracting STDs and HIV/AIDS (WHO, 2002)
results of a qualitative study that explored the social representations about the different contraceptive methods among men from low income urban sectors of the Greater Buenos Aires Area. The second section addresses the role of health care services in the promotion of dual protection among youth.

**Gender and vulnerability in adolescence**

The gender dimension is fundamental for understanding adolescent sexual behavior and its consequences on health. According to Marta Lamas, gender refers to “the symbolization that the different cultures elaborate regarding sexual differences, setting rules and expectations about specific roles, behaviors and conducts based on the biological differences expressed in the body. Through the process of gender constitution, society produces the ideas about what men and women should do, what is proper for each sex” (Lamas, 1991, p.8).

Gender relations imply unequal power relations by ranking female and male attributes and activities in such a way that those related to men are generally valued more than those related to women (Benería and Roldán, 1992). Therefore, gender is one of the fundamental principles that rule society and social interactions, working as the pillar that supports power relations and submission, the unequal treatment of people based on their sex and supposed innate differences, and the discrimination of women from the spheres of real power (Raguz, 1994).

The construction of gender identity is understood as the process through which individuals learn what it means to be either a man or a woman and the behaviors considered appropriate for each sex. Men have to constantly prove and confirm their masculinity by taking risks, showing physical strength and sexual power, and most importantly by clearly differentiating themselves from women, since any association with femininity and homosexuality directly threatens their virility (Butler, 1993; Fuller, 1997).

Sexuality, as gender, is a social construction with defined different norms for men and women (Dixon-Muller, 1993). Individuals learn gender-specific cultural "scripts" regarding how, when and with whom to relate sexually (Laumann et al., 1994). Within the traditional gender model, male sexuality is characterized as naturally uncontrollable, insatiable and aggressive. Men are expected to have an early sexual initiation, to control female sexuality, to show sexual prowess, conquer women and be “always willing” to have sex. Consequently male sexuality is more related to physical pleasure than to love or emotions (Shepard, 1996). For women, gender norms prescribe sexual innocence, lack of experience, passivity, reproduction, submission to men and dedication to caring for the family and the home.

In marked opposition to what is expected from women, for men, virginity constitutes a negative load of which they must get rid of as early as possible. Since there is no clear physical landmark to identify the transition between childhood and adulthood, the sexual debut is considered a passport to adulthood and a proof of virility. Adolescent boys are pressured by their peers and adult relatives to prove their manliness by having sex, which many times forces them to take risky behaviors and/or to act against their own will.
This model of male sexuality not only leads young men to early sexual initiation experiences dissociated from affection, that often imply sexual abuse and violence against women, but it also contradicts safer sex practices such as the use of condoms, sexual abstinence and non-penetrative sex (Paiva, 1993; Mundigo, 1995). There is little place for rational preventive practices in a model of aggressive, naturally uncontrollable and instinct-driven male sexuality. As Paiva points out, “condom use confronts the most basic notions of male virility, that being a man means ‛naturally’ to have less control over sexual and aggressive impulses and to feel them more strongly than a woman. To wear a condom, to be rational, to control sexual drives or to take a woman partner’s needs into consideration is to betray maleness” (Paiva, 1993, p.100).

Adolescent boys: key actors for dual protection

Of all available contraceptive methods, condoms best serve the needs of the adolescent population for three basic reasons: 1) they are widely known and easily accessed; 2) no medical consultation or contact with a health care service is needed; and 3) the condom is the only method that provides simultaneous protection against unwanted pregnancy and STDs/HIV.

Adolescent boys are key actors in the practice of dual protection since they control the use of condoms in their sexual relationships and, according to gender roles, they are the ones who most often decide when to have sexual intercourse and the ways to do it, directly affecting the health of their female partners.

Women can use contraceptive methods without having the consent of their partners, however, to prevent STDs and HIV/AIDS they not only need the consent of their male partners but also their cooperation and action (Campbell, 1995). Within the traditional gender model, using condoms implies questioning power relations and many women face difficulties in negotiating the use of condoms with their male partners. Also, women who carry condoms with themselves or actively propose their use can be stigmatized as "loose" or "sexually available" and labeled as “street women” (Paiva, 1993). On the other hand, access to other contraceptive methods, such as oral contraceptives, is more limited for adolescent women since it requires taking several specific steps -contacting a health care provider, obtaining a prescription and purchasing the pills- that imply a conscious public recognition of being sexually active, a condition socially repressed for adolescent girls. Therefore, for pregnancy prevention, young women also depend to a great extent on the will of their male partners to use condoms or to practice withdrawal.

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2 A study on sexual behavior of young adults reported that 17% of young men (20-29) who had become sexually active around age 16 had been pressured by their peers and in some cases by older female partners at the time of their first sexual intercourse. On the other hand, 12% of them had pressured their female partners during sexual initiation (Geldstein and Schuffer, 2002).

3 The female condom has not been widely promoted in Argentina nor is it available in the market and therefore it is not an option accessible for women.
The Argentine context

Historically, sexual and reproductive health and rights in Argentina have been unattended by government authorities that responded to the the hierarchy of the Catholic Church and the most conservative sectors of society -to the extent that family planning activities were prohibited in public health facilities between 1974 and 1986-. Similarly, AIDS prevention did not constitute a public health priority. A national AIDS prevention project (LUSIDA) was launched in 1997, however the government refused to incorporate the promotion of condoms until 2001 (CELS, CLADEM; FEIM; ISPM, 2002).

The 1990's has been a decade of incipient transformations in issues of sexual and reproductive health in Argentina, and gradual changes in public policy are being implemented. After fifteen years of struggle by the women’s movement and sexual and reproductive rights advocates, the National Congress recently passed a law which creates the Sexual Health and Responsible Procreation Program within the Ministry of Health. Program goals include, among other things, to reduce maternal and child morbidity and mortality; prevent unwanted pregnancies; promote adolescent sexual health; contribute to the early detection and prevention of STDs and HIV/AIDS; guarantee universal access to family planning information, methods and services; and promote women's participation in decisions concerning sexual health and responsible procreation. It is important to note that one of the most contentious issues that triggered much parliamentary debate and delayed the sanction of this law was the right of adolescents to receive sexual and reproductive health information and services without parental authorization.

The condom paradox: "It's the best but we hate it"

This section summarizes part of the findings of a wider qualitative research study carried out by the author that analyzed the social representations of heterosexual men vis-a-vis sexuality, reproduction and contraception. The study was descriptive and exploratory and included in depth interviews and focus groups with low income men (15-19) residents of the Greater Buenos Aires Area.

- The adolescents interviewed had been sexually initiated between ages 14 and 16 with a non-steady partner such as a friend, neighbor or cousin in situations that had not been planned.
- Even though they presented differences in the quality and quantity of knowledge, study participants knew that sexual activity could lead to pregnancy, they could mention two or more contraceptive methods and they also identified heterosexual intercourse as a means of HIV infection. However, they had extremely confusing notions regarding the menstrual cycle and the time during which a woman can become pregnant. They had a vague idea about days when pregnancy is more likely to occur but they could not identify them correctly. Associations between menstruation and fertility were common, even among young men who reported practicing periodic abstinence for contraception.

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4 Qualitative studies report an average age of male sexual initiation between 14.6 and 15.6 years of age (Pantelides et al., 1995; Geldstein and Schuffer, 2002)
Another common belief (also present among older men) is the idea that a woman cannot get pregnant during her first act of sexual intercourse.

“No, the first time she can never get pregnant, I don’t think so, people say so, that she just bleeds” (Focus group)

- The main source of information regarding sexual matters was the peer group followed by the mass media, while the role of the family and the school was rarely mentioned.

“[…] when you are standing at a corner you see, you listen to the foolish things that people say and you begin to think … in the streets there is always someone who knows more than you, and you listen and that way you learn” (Facundo, 17).

“Some guys try to copy what they see in the movies or in soap operas, they want to do the same things. That’s how they learn” (Focus group).

- Talking about sex is more common among same-sex friends than between sexual partners. Boys did not openly and clearly talk with their female partners in order to decide together how to protect themselves. When they reported shared decisions, it usually referred to admitting that preventing pregnancy is a responsibility of both partners, however it did not necessarily mean that both partners would use a contraceptive method nor that they would abstain from sex until a method was adopted. In many cases, contraceptive use started only after the girl experienced a menstrual delay or when a pregnancy was suspected or confirmed. In casual relationships partners rarely talked about how to avoid pregnancy and prevent STDs or HIV. In these situations boys assumed and expected that “loose” and sexually experienced women would take the necessary precautions to avoid pregnancy by themselves, and if they thought they were at risk for HIV they unilaterally decided to wear a condom.

“Girls who sleep with one guy today and with another guy tomorrow are clever, they won’t get pregnant, they know what to do, they take pills... you don’t need to tell them ” (Nacho, 19).

- Young men’s perceptions about condoms are marked by double standards. They give stereotyped responses about what they “must do” -what is socially expected as “responsible behavior”- that does not necessarily correlate with what they ultimately do in practice.

- Knowledge of condoms is high and widespread among young men who have easy access to them. They know where they can obtain or buy condoms, they know the different commercial brands, presentations and prices and they do not report feelings of embarrassment when buying or requesting them.

“I don’t have problems in going to a gas station to buy a condom” (Darío, 17).

“… the box of for condoms costs one peso, you can get them at any kiosk …” (Facundo, 17).
"... they cost $1.50 or $1.00, the box brings three, "Tulipanes" are the best ones and they cost $2.50 or $2.70 for the box of two. There are other brands that cost $1.00 but they are no good... they are too thin ..." (Pancho, 17).

- Boys identified several positive features of condoms, particularly the high contraceptive effectiveness, low cost, easy access, male control and dual protection. However, they also reported numerous disadvantages related to reduced sensitivity and sexual pleasure, discomfort, lack of spontaneity and interruption of the "natural" dynamic of sexual intercourse that discouraged them from using condoms.

"[wearing a condom] doesn't give pleasure, in fact, it reduces pleasure [...] When you are concentrated in the foreplay and have to stop to put on a condom it kind of stops the normal flow of things [...]" (Julián, 18).

"It's not the same, with a condom you can't feel anything, it's like you have something in between separating you from her and it does not let you feel anything " (Marcos, 19)

"I never wore a condom and I never will, people say that you feel nothing " (Fabían, 18)

- It is interesting to note that withdrawal, a contraceptive practice very negatively evaluated for reasons that have to do with its low effectiveness, interference with the sexual act and reduced pleasure, is actually much more widespread than condoms that are more positively evaluated. Therefore, the method most favorably ranked (condom) is used less than the most unpopular method (withdrawal). One hypothesis to explain this contradiction could be that, as adolescent sexual activity is usually not planned, and therefore neither boys nor girls might have condoms at hand when they have sexual intercourse, they choose withdrawal (although they dislike it) as a last resort.

- The different types of relationships that young men establish with their sexual partners translate into different levels of commitment not only in terms of care and affection, but also regarding their interest for preserving their partner's health and in the application of contraceptive and safer sex practices. Consequently, condom use is deeply related to the type of relationship, the level of trust between partners and the amount of time they have known each other. Condom use is more frequent in casual relationships that involve women they do not know well or women who are "marked" or identified as "fast" with whom they believe they are at risk of infection of STDs or HIV/AIDS. "Knowing" the woman does not necessarily imply asking about her past or sexual history but rather having some reference about her based on her social reputation and physical appearance. This information is considered enough to judge whether the person is safe or not to have intercourse with and whether or not a condom is needed.

"Condoms are for when you do not know the girl, when you see that she sleeps around and has sex with many guys... you cannot trust those girls, you never know if they are sick or not. But when you met a nice girl, and you wait about a month before having sex like I do ... First I get to know them well, and then after a month or so I have sex .... I only wear condoms when I don't know the girl and if I know her I don't need to wear one" (Darío, 17)
“You can have sex with your girlfriend without a condom because you know she will only be with you, but when you have casual sex with a girl you just met you must wear a condom” (Julián, 17)

“... I had sex with many girls, girls that I met at nightclubs. In those cases I had no option but to wear a condom even if disliked it because if I got AIDS it would be bad not only for me but also for my girlfriend” (Tino, 17).

“..... Condoms are used with casual partners, with women other than your girlfriend... to prevent AIDS and other diseases... I wouldn't be so worried if I didn't have a condom when having sex with my girlfriend but I would worry if I met someone one day and end up having sex with her and don't have a condom at hand.... ” (Marcos, 19)

• In steady relationships that are considered free of STD and HIV/AIDS risk, the use of condoms can be understood as a sign of mistrust or infidelity. Couples who used condoms during their first sexual encounters generally abandoned them as they got to know each other and the fear of HIV vanished. Between the moment they stopped using condoms and the adoption of a female contraceptive method there is usually a period of time during which young couples do not practice any type of consistent contraception, alternating unprotected sex and withdrawal, which in many cases leads to unwanted pregnancy.

... Sometimes we use condoms, but sometimes we don't ... maybe we do one week and then the next one we don't, and so on... she asks me to come outside or to wear a condom, but sometimes she doesn’t ... (Daniel, 17)

“The first time I had sex with her I told her to go to a hospital so she could get pills but she didn’t want. She would say ‘OK, I'll tell my mother tomorrow and she will go with me to the hospital’ until one day she got pregnant.” (Tino, 17).

“We didn't take care until she got pregnant. Only after that we began to take care. She used to ask me to wear condoms, but by the way she used say that, for her it was the same if I wore a condom or if I didn't ... She asked me to wear a condom and if I didn't we still had sex, so for me it was the same” (Emilio, 18)

• The use of condoms for contraception is rare, and limited to young men who do not trust their female partners and want to avoid possible "claims" from women who might purposely get pregnant in order to "catch" them and force them into marriage, or who might want to make them responsible for fathering a child who was not theirs.

“I prefer to take care myself instead of trusting women. It is safer. If she tells me ‘don't worry I'm on the pill’ I can't be sure of that because if we don't live together I can't watch her take the pill every day and I don't know whether she takes it or not” (Facundo, 17).

“... I wear condoms because girls sometimes have sex with many guys and then they tell you the baby is yours and it's a lie, and you know that she lies because you wore a condom...” (Focus group).
• Even though adolescent men recognized that condoms are the only way to avoid HIV infection and reported using them (despite disliking them) in sexual relations that they considered risky, they also admitted that this did not happen in all cases where they believed they were exposed to HIV. This behavior -of which many of them were conscious- is associated with the stereotype of male sexuality as hard to control and the mandate to never let go the possibility to have sex, valuing the search for sexual pleasure over the perception of risk. Some adolescent men who reported having consciously exposed themselves to HIV also reported feelings of anxiety and uncertainty after having sexual intercourse.

• Adolescent boys are more concerned with preventing HIV than avoiding pregnancy and this becomes evident in their preventive behaviors and practices. They are reluctant to use condoms for contraception, however they accept them for AIDS prevention.

  “... If it is a one night stand, a girl I don't know well, I don't really care about doing something so that she doesn't get pregnant, but I'm worried about AIDS because in that type of relationships the man is at risk of getting AIDS” (Focus group).

  “I think condoms are a pain, they are uncomfortable and you cannot feel the same as when you have without a condom [...] but if I do not know the girl I would wear one, no matter how uncomfortable it is, I would wear a condom” (Tino, 17).

• AIDS is regarded as an irreversible and fatal disease that affects their own bodies, while pregnancy takes place in the female body, and even though adolescent fatherhood represents new responsibilities, or in their own words, ”the end of unmarried men's freedom”, it does not scare them as much as AIDS. This is understandable in a context where teen pregnancy is high and regarded as a normal and frequent situation which is part of their daily lives. Finally, while AIDS is directly related to death and disease, a pregnancy implies a new life and constitutes a proof of fertility and virility.

Gaps in dual protection

Based on the study results summarized above, it becomes evident that, in the first place, the risk most clearly perceived by adolescent boys is unwanted pregnancy while the risk of contracting STDs or HIV depends on the type of sexual relationship in which they are involved. Secondly, testimonies show that despite the high knowledge about condoms’ dual protection, they are used mostly as a means of self-protection against HIV/AIDS and only in few cases for contraceptive purposes.

The data analyzed points out the existence of two gaps that hinder the use of condoms for dual protection: 1) Condoms are generally not used with partners considered “safe” who do not represent risk for HIV infection. Since other contraceptive methods are not used either or are used in an irregular and inconsistent way, exposure to unwanted pregnancy is high. 2) In casual relationships boys are usually not concerned with contraception and their perception of the risk of HIV infection is not precise since they believe that by ”knowing the woman” they are automatically protected, placing the risk of
infection only in the most extreme cases such as drug users or commercial sex workers. Therefore, we can state that both in steady and casual relationships, adolescent men rarely perceive the need to do something themselves to simultaneously prevent unwanted pregnancy and STDs/HIV infection. This portrays a particularly alarming picture for adolescents who, given the characteristics of sexual activity during this period in life, are highly vulnerable to the dual risk of unwanted pregnancy and STD/HIV infection.

The role of health care services in the promotion of dual protection

Although the definition of reproductive health includes preventing not only unwanted pregnancy but also STDs and HIV/AIDS, sexual and reproductive health services and programs have traditionally approached family planning and STD/HIV/AIDS prevention as separate issues. Family planning services have targeted almost exclusively women without taking into account their risks of STDs and HIV/AIDS infection, while the prevention and treatment of STDs and HIV/AIDS has mostly targeted the male population without considering their contraceptive needs (Berer, 1997; O'Reilly et al., 1999). This division evidences the lack of an integral approach to sexual and reproductive health and the existence of a stereotyped gender logic in programs and services defining different risks for men and women. In addition, family planning services give priority to highly effective female contraceptive methods like oral contraceptives and IUDs, giving less importance to condoms due to their greater failure rate. Although the higher failure rate of barrier methods cannot be discussed, it is worth noting that the main reason for condom contraceptive failure is incorrect and inconsistent use (Ritchers, 1994; Steiner et al., 1999).

A study of reproductive health services for adolescents in the city of Buenos Aires found that these services are tailored for women and focused almost exclusively in the prevention of unwanted pregnancy, perceived as the greatest risk faced by adolescent women, while neglecting STD/HIV/AIDS prevention. Most of the health care providers interviewed thought that the "ideal method" for young people was the combined use of condoms with spermicides, but they prescribed mostly oral contraceptives as they found that girls already had difficulties in using correctly one contraceptive method and believed that it would be unrealistic to expect them to use two methods simultaneously (Gutiérrez et al, 2001).

Obstetrician-gynecologists in the metropolitan area of Buenos Aires considered oral contraceptives and condoms the most appropriate method for women under 19 in nearly equal proportions. When asked to rank the priority they assigned to different aspects of reproductive health for youth, the great majority mentioned the need for sex education programs for youth as well as HIV/AIDS prevention campaigns, including free condom distribution. However, they also recognized that safer sex practices call for behavior changes that are difficult to achieve in this age group and that go beyond the scope of their possible interventions (Ramos et al, 2001).

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5 Some adolescent services are part of the general gynecology service.
Health professionals from family planning services interviewed in a study by CEDES/Coordinación SIDA in the city of Buenos Aires expressed a strong commitment for promoting dual protection and encouraging condom use, particularly among adolescents who do not have steady partners. One barrier identified by these health care providers is that adolescent women usually demand the pill and do not perceive their own vulnerability to HIV. They also mentioned lack of articulation and communication between family planning and infectious disease departments within the same hospital; in some cases hospitals provide free condoms at their infectious diseases service but not at the family planning service.

Conclusions and recommendations

A dual protection strategy means concentrating both in men and women taking into account their needs for contraception and STD/ HIV/AIDS prevention. Dual protection must be "dual" in the sense that it intends to avoid two unwanted effects and protect both partners involved in a sexual relationship. Sexual education for adolescents and youth must emphasize shared responsibility and foster communication among sexual partners remarking the value of mutual care.

Reproductive health services must accept condoms as effective contraceptives and educate about emergency contraception in case of breakage or failure. Health care teams must be prepared to give information on how to use condoms correctly emphasizing the need to use them in all sexual encounters. Both men and women should be given this information, and when possible, condoms should be provided for no charge at health care services as well as at educational and recreational institutions.

Specific prevention messages should be directed towards both male and female adolescents, combining unwanted pregnancy prevention and STDs/HIV/AIDS prevention, including all STDs since they significantly increase the chances of HIV infection. Also, policy makers must view adolescents as a heterogeneous population with different characteristics according to age, marital status, and socio-cultural context, and therefore different skills and reactions regarding unwanted pregnancy prevention and STD/ HIV/AIDS prevention.

Adolescent men do not spontaneously seek information and services from the health care system that continues to be focused on women. Therefore, efforts must be made to reach them outside the health care services and the formal educational system by disseminating prevention messages and implementing educational activities in popular recreational and sports events like soccer games and music festivals that gather large number of young people, as well as the mass media and street campaigns. This obviously cannot be achieved by health care providers alone and must involve specific government policies and programs.

Attitudes and behaviors about condom use will only change if social and gender norms that push men to continuously prove their masculinity by taking risks and demonstrating uncontrollable sexual desire also change. The transformation of gender roles
would benefit the sexual and reproductive health of both men and women allowing women to practice, negotiate and demand responsible behavior to prevent STDs, HIV/AIDS and unwanted pregnancy, and letting men question the negative male stereotypes that put them and their partners at risk.

Most of the work that lies ahead in the promotion of sexual and reproductive health of adolescents and youth consists in making condoms socially and culturally acceptable in all types of sexual relationships. Changing the negative perceptions that surround condoms would undoubtedly help to increase their use. If condoms were perceived not only as a way to avoid STD and HIV infection it would be easier to accept them in stable unions. It is also necessary to develop other methods of dual protection to give men and women more options to choose from, and promote the female condom making it available at low cost.

Finally, dual protection is one of the first steps towards the integration of family planning and STD/HIV/AIDS prevention and treatment, and the achievement of a truly holistic and complete approach to sexual and reproductive health.
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