One size fits all? Promoting condom use for sexually transmitted infection prevention among heterosexual young adults

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Abstract

The aims of this exploratory qualitative study were to increase our understanding of heterosexual young adults’ knowledge and beliefs about sexually transmitted infections (STIs) other than HIV, to explore their beliefs about the factors that influence condom use for STI prevention, and to explore their ideas about how best to promote condom use for STI prevention. Data came from a qualitative study that used 11 group discussions with 53 heterosexual men and women aged 18–25. Respondents thought that STI infection and unplanned pregnancy were equally likely, but were less concerned about STIs than unplanned pregnancy. Respondents gave several reasons for their low levels of concern about STIs. They also suggested several means to promote condom use for STI prevention. They supported multi-faceted condom promotion campaigns, using multiple styles of communication and a variety of media. The range of suggestions given by participants suggests that rather than employing a ‘one size fits all’ strategy, a variety of different approaches are needed to promote condom use for STI prevention.

Introduction

In the last 20 years hundreds of studies have examined condom use for HIV/AIDS prevention among heterosexual young adults. In contrast, few studies have examined condom use to prevent other sexually transmitted infections (STIs), despite the fact that in developed nations HIV is much less prevalent than other STIs (Public Health Laboratory Service, 2001; National Centre in HIV Epidemiology and Clinical Research, 2002; Weinstock et al., 2004). The fact that HIV/AIDS is incurable and ultimately fatal undoubtedly influences the different levels of research interest. However, many STIs can have serious long-term consequences for sexual and reproductive health, including infertility. Although bacterial STIs such as gonorrhea and chlamydia may be treated with antibiotics, they can have serious consequences if left untreated. Furthermore, there are no effective cures for viral STIs. In the absence of vaccines for most STIs, preventive behaviors such as condom use are essential for limiting the spread of STIs.

The difference in research activity is reflected in the fact that condom promotion materials are more likely to address HIV/AIDS than other STIs (Abraham et al., 2002). However, there is a clear need to promote condom use for STI prevention, because around 10% of young adults have ever been diagnosed with an STI, with young adults more likely than older adults to have been diagnosed in the last year (Warszawski, 1998; Grulich et al., 2003a). Indeed, a recent American study suggested that young people acquire nearly half of all new STI infections (Weinstock et al., 2004).
The higher prevalence of recent STI infection among young adults exists despite the fact that young adults report more consistent condom use than older adults (Laumann et al., 1994; Dubois-Arber and Spencer, 1998; de Visser et al., 2003). This paradoxical result arises because although condoms can be used for prevention of pregnancy and/or HIV/STIs, young adults’ condom use is governed more by concerns about pregnancy than STI infection, such that when other forms of contraception are used, condom use is significantly less likely (Kirkman et al., 1998; Cooper et al., 1999; de Visser and Smith, 1999; Ott et al., 2002). Low levels of condom use for STI prevention may be due to misconceptions about STI prevalence, consequences and treatment or they may be due to a disregard of such knowledge as not personally relevant (Crosby et al., 2000; Garside et al., 2001; Grulich et al., 2003b).

Most quantitative studies of condom use for HIV/AIDS prevention focus on individual rational decision making as the best predictor of condom use. Although such studies provide little evidence that condom use is related to greater knowledge or greater perceived susceptibility to infection, condom use is related to attitudes toward condoms, normative beliefs, self-efficacy and intentions (Sheeran et al., 1999). In addition to these intra-individual factors, condom use is influenced by the relationship between sexual partners (Sheeran et al., 1999). The fact that condom use involves two people means that it is important to consider the relationship between sexual partners, gendered power relations, and the way in which feelings of love or trust may affect perceptions of risk and intentions for condom use (Amaro, 1995; Willig, 1997; Holland et al., 1998; de Visser and Smith, 2004). For example, heterosexual young adults’ decisions to use condoms or the pill depend on partner type and risk perception (Ott et al., 2002).

The lack of research into STIs other than HIV makes it difficult to determine whether predictors of condom use differ for HIV and other STIs. It is possible that the results of studies of condom use for HIV/AIDS prevention may help to explain low levels of condom use in spite of a high prevalence of STIs. However, there is no evidence to suggest that this is necessarily so.

Regardless of which factors emerge as significant influences on condom use for STI prevention, there is a need to consider how best to use this information in interventions to promote condom use (Bryan et al., 1996; Abraham et al., 2002). Issues to be considered include the means by which the message is to be delivered (e.g. by parents, teachers, health professionals, mass media) and the style of presentation (shock, realism, humor, etc.). For example, there is debate about the effectiveness of shocking images for health promotion (Witte et al., 1998; Ruiter et al., 2001).

There are several avenues for enquiry related to promoting the use of condoms to prevent STIs other than HIV. The aims of this exploratory qualitative study were to increase our understanding of heterosexual young adults’ knowledge and beliefs about STIs other than HIV, to explore their beliefs about the factors that influence condom use for STI prevention, and to explore their ideas about how best to promote condom use for STI prevention.

### Methods

The qualitative data come a series of group discussions conducted by a male facilitator with heterosexual young adults resident in Melbourne, Australia. The 11 single-sex group discussions (five with men, six with women) involved 53 participants aged 18–25 years (with few aged over 20). Participants were recruited via advertisements placed on an urban university campus with a socio-economically diverse student population and via advertisements in a free youth-oriented newspaper. Interested people contacted the researcher via E-mail or telephone to receive a description of the study. They were informed of the requirements of the study, including the requirement that they be sexually active. The sample included students and young adults who were working or unemployed. All participants had used condoms. Participation was voluntary, with informed consent. Participant received AU$15 to reimburse them for costs (e.g. travel) associated with taking part in a 1-hour discussion.
Initially respondents were asked what ‘safer sex’ meant to them. If they did not mention STIs other than HIV, they were asked directly about this topic, which led into a discussion of concerns about the likelihood and consequences of infection. The discussions were then directed to focus on participants’ beliefs about how to promote condom use to prevent STIs. The facilitator made minimal interventions into the discussions, e.g. to ask for more detail or to invite another participant to speak. In response to the initial question about ‘safer sex’, participants used the acronym STD rather than STI. The term STD was therefore used by the facilitator.

Audio recordings of group discussions were transcribed verbatim. Names were replaced with pseudonyms. Thematic analysis was conducted (Wilkinson, 1998). Repeated reading of each transcript enabled the identification of themes that were logically coherent, and which focused on beliefs about STI risk, condom use and/or ideas for promotion of condom use for STI prevention. When individual transcripts had been coded, comparisons were then made between transcripts to identify common and disparate themes in young adults’ discussions about these topics. Because the discussion was largely directed by the participants, not all themes were addressed in all group discussions. The thematic analysis presented here takes at face value what participants said because of an interest in the implications for health promotion efforts of what was said. Alternative readings of the themes that were identified are possible (e.g. focusing on motivations for particular utterances).

Results

Risk perception and concern about STIs

Participants acknowledged that, in their experience, STI infection is at least as common as unplanned pregnancy, as illustrated by the following quote:

_int_: Do you think that most people think that they are as likely to get an STD as to get someone pregnant when they don’t mean to?

Darren: No. It depends. The risk of getting an STD is higher I think.

_int_: What do others think about that, do you think you are more likely to get an STD or get someone pregnant?

Greg: Probably STD. ’Cause you can get an STD any time of the month.

Here respondents acknowledge that the risk of transmission of STIs from an infected partner may not vary over time, whereas the risk of unplanned pregnancy varies across the menstrual cycle. However, despite acknowledging that STI transmission and unplanned pregnancy have equivalent likelihoods of occurrence, respondents expressed greater concern about pregnancy than STIs:

_int_: Do you think people are more concerned about one or the other?

Kate: Pregnancy.

Cath: Pregnancy.

Amy: Probably pregnancy.

Cath: Because it’s a lot more than an infection—

Eva: —not necessarily—

Cath: —I don’t think people see STDs as much as they see the consequences of pregnancy. I think like, you know, the various STDs aren’t as in our faces as having a friend at school who at 17 fell pregnant.

Kate: Yeah.

Eva: It’s kind of hidden from the public. If you have an STD you go to the doctors and all that stuff, and you sort of keep it confidential. But you can’t keep a pregnancy confidential unless you abort it.

Liz: You sort of you think you’re not going to.

_int_: That STDs aren’t going to happen?

Liz: Yeah.

Sam: You know they’re out there, but you think of pregnancy more than STDs.
Given the discrepancy between STI risk perception and STI risk concern, attention was given to reasons for low levels of concern about STIs. Respondents’ lack of concern about STIs was to some extent influenced by the perception that STIs are easy to treat and would not disrupt their lives. The perceived minor consequences of STI infection were contrasted to the major consequences of unplanned pregnancy:

Int: Why do you think people are more worried about getting someone pregnant than getting an STD?

Darren: Obviously pregnancy is a long-term thing. Like STDs most of the time you can take something for it and get over it whereas a child is something for the rest of your life.

Greg: It’s a lot more serious. You’ve got to think about having a kid or getting an abortion. It’s a bit more serious.

Pat: I think that pregnancy is more serious than STDs because you can go to the doctor and the problem is OK. But in pregnancy it’s different, it’s a life.

Many respondents suggested that the low visibility of STIs in society and the fact that STIs are not talked about may influence the perception that they are not serious:

Mandy: You just don’t hear of people getting STDs. You hear of like a few friends who are having abortions or that sort of thing—

Suzie: —exactly—

Mandy: —and that’s sort of more in the forefront of your mind rather than, you know, getting syphilis or AIDS.

Some participants suggested that lack of concern about STIs may be related to a lack of knowledge of the effects of STI infection. It was suggested that the possibility of asymptomatic infection may help to explain lack of concern about STI infection:

Paul: But that difference, that time lag—it’s not like you wake up the next morning and your dick’s dropping off.

Max: Well if you heard stories like that you’d go ‘What! No way am I going to have sex without a condom’.

Some women suggested that men may ‘turn a blind eye’ and be prepared to take what is incorrectly perceived to be a low risk of STI infection, so that although they know the risks, they refuse to act accordingly. Some men agreed with this assertion, thereby showing that there is not necessarily a link between knowledge of STI risk and precautionary behavior [cf. (Sheeran et al., 1999)]:

Max: It’s sort of like running a red light, isn’t it. You take the risk, you know. You’ve got that one in 10,000 chance.

Thus, although many respondents suggested a lack of public visibility of STIs, at times they appeared to deliberately disregard the possible consequences of their sexual behavior. The likelihood that young adults may ‘turn a blind eye’ to this possibility may be influenced by the relationship between the two sexual partners. In accord with the findings of studies of HIV/AIDS prevention [e.g. (Willig, 1997)], respondents suggested that concerns about STIs may be lower during encounters with regular partners than with casual partners:

Mandy: It depends on who you are with and what the circumstances are. So if you are with a regular partner, then your—well my main concern would be to protect myself against pregnancy rather than STDs.

Gender, STIs and condom use

In line with the findings of studies of HIV/AIDS preventive behavior (Amaro, 1995; Holland et al., 1998), this study revealed that there may also be enduring sociocultural factors that present resistance to condom use for STI prevention. Women talked at some length about gender differences in responses to the possibility of STI infection, indicating that most men are not concerned about STIs:

Cath: I think some guys still have the attitude though that ‘Oh, it’s her problem. I won’t have to deal with it’—
Amy: —or ‘It won’t happen to me’.

Cath: And if the girl brings it up then they will probably say ‘Oh, OK, whatever you want’.

Some men also acknowledged that women would generally be more concerned than men about STIs:

Max: They just tend to worry more, generally. And they’ve been brought up throughout their lives to always—even before condoms were around, it was always girls who had to worry about it.

Brad: They might be the ones left holding the baby.

It is also important to consider gender differences in the ability to negotiate condom use. Many women felt uncomfortable asking their partners to use condoms, but both men and women agreed that empowering women to negotiate condom use would prove beneficial:

Sarah: Maybe that’s the thing: empowering women to say it. I’ve never had a guy refuse. You could do it along those lines as well.

Phil: If a woman insists on a condom, it’s more likely to happen. If women were generally more forward about that. That is something that would make a difference.

However, it is unclear whether all women would be able to challenge existing gendered relationships and ask their male partners to use condoms.

**Beliefs about how to promote condom use for STI prevention**

Having identified some reasons for low levels of STI-related concern and condom use, attention is now given to what young adults think can be done to increase condom use for STI prevention. Participants suggested that school sexuality education should start earlier, and should focus less on HIV/AIDS—which is dismissed as irrelevant—and more on STIs other than HIV/AIDS. They suggested that teaching about sexuality and safer sex should not only occur in schools, but that parents should also play a role:

Anne: More parental education rather than school education.

Cath: If you’re in a classroom with all kids—

Julie: —you’re being silly—

Cath: —you laugh. But if you’re talking about it with your parents—

Eva: —you’d run kicking and screaming—

Cath: —but if you start from an early age, by the time it actually gets serious and you talk about it seriously then you don’t care, because you’re used to it.

Helen: I totally agree.

Although some participants suggested that parents could be good sex educators, others indicated that they would be uncomfortable or embarrassed if their parents discussed sex. Many participants were satisfied never to have spoken to their parents about sex. Although many participants agreed that parents could play a greater role in sexuality education, most attention was given to formal education and health promotion campaigns.

Some women noted that access to some information about STIs is stratified along the lines of gender, with girls’ and women’s magazines frequently containing information about STIs to which men may not have access:

Olivia: Girls have magazines and they read through their magazines, and they see the pictures of having gonorrhea and this and that, and it screws up your face. You feel awful. So of course you’re not going to make an effort to get these STDs. Whereas guys don’t necessarily have the same sort of encounter.

The implication of this suggestion is that more widespread publicity of the likelihood and consequences of STIs will lead to greater awareness and more condom use. Participants highlighted the near absence of STIs, condoms and safer sex on television screens. However, they noted that the universal
appeal of television could be used more effectively to promote condom use among both men and women:

Nicole: Everyone watches TV, and you need to use a form of communication that everybody has access to.

Whatever the medium used, the style and content of condom promotion are crucial. Some participants suggested that condom promotion would be more effective if it were based on frank, realistic presentations of the detrimental effects of STIs on sexual pleasure. Participants suggested that constant reminders are needed of the likelihood and consequences of STIs, because STIs are not spoken about and are not visible in society:

Nicole: I think one thing that would make a difference is if it was more like in people’s faces then they might—

Jenny: —Yeah, I suppose there is advertising. Like advertising campaigns. Like they have the TAC [Transport Accident Commission] ads and smoking ads, and they seem to be pretty effective. They don’t really have anything targeted to STDs and that sort of thing. I suppose bringing on a sort of, I don’t know...

Olivia: Yeah I know. Yeah you already know, but it needs to be reinforced.

Nicole: You forget.

Some participants suggested that the best way to keep STIs in people’s minds and encourage condom use would be shocking images. In the extract above, women referred to Australian Transport Accident Commission road safety advertisements which graphically depict traffic accidents and their consequences. Although most participants agreed that shock may have an initial impact on awareness, many questioned whether simply raising awareness leads to behavior change:

Int: Do you think a more graphic ad might have any effect?

Brad: It definitely would, but I just don’t know if it would have a lasting effect. I think those traffic ads work—otherwise we wouldn’t be talking about them. They do stick in your head.

Max: They might stick in your head, but they don’t change the behavior.

It was suggested that people become desensitized to shocking advertisements, so that their initial impact is lost, making it more difficult to sustain behavior change. Furthermore, shocking images may have the paradoxical effect of making some people avoid the issue rather than acting to reduce the risk of infection:

Sally: But you’ve got to look at the ads that are out there at the moment, like the smoking ads and the drug ads, right. People that are watching those—I’m watching those and I flick it off. It shits me. I don’t want to see them.

Emma: But you still remember it, don’t you?

Sally: I remember it, but I will not listen to the message, because I don’t like what I’m seeing. You know what I mean?

Kate: It’s easy to be cynical.

Sally: If I saw that—if that was presented to me in a much nicer way, I would be much more willing to listen to the message, and it would sink in, what they’re trying to tell me.

Emma: But that’s proven wrong I think. The more impact, the more frustrating it is for you—

Liz: —The more you don’t want it.

The possibility that some young adults may turn away from graphic depictions of STIs and the likelihood that the impact of shocking images may fade highlight the need for health promotion that does not rely solely on shock, but includes other elements. Some participants suggested that humor might be useful for breaching embarrassment about discussing safer sex. However, other participants suggested that just as different people may have different responses to shocking images, humorous advertisements may be effective for some people, but irritating or ineffective for others. Some participants suggested that realism might be more relevant
and more effective than shock or humor. However, other participants were cynical about the impact of television advertisements, because even realistic advertisements are not real:

Paul: When you see those ads on TV though, you automatically know ‘OK here are some young actors who are doing it very poorly, and yes we know’. You don’t get involved in it.

Some participants suggested that young adults may respond more favorably to condom promotion messages from celebrities. However, others noted that some celebrities may get involved in condom promotion for the sake of self-promotion and that such opportunism could be counter-productive.

In most cases where a participant suggested an idea for condom promotion, at least one person dismissed it. The consequences of the fact that any one advertisement or one form of health promotion will not engage all young adults were neatly summed up by one woman:

Mary: You need a number of different ads for different target audiences.

Furthermore, messages about condom use and safer sex may need to be dispersed using a variety of different media for different aspects of condom promotion campaigns. Participants suggested that in addition to posters, billboards, magazines and television, new electronic media could be used. The popularity of the Internet and free E-mail services such as ‘Hotmail’ may be an underused resource for health promotion, in general, and promotion of condom use for STI prevention, in particular:

Angela: An ad could pop each time you get new E-mail: ‘Use condoms’.

Whether advertising campaigns use information provision, shock tactics, actors, celebrities or other approaches, many participants questioned the ability of any health promotion campaign to produce widespread, lasting behavior change:

Olivia: If you’ve still got that ‘Yeah, it happens but it won’t happen to me’ mentality then the advertising campaigns are really like banging your head against a brick wall. ...Advertising would have to be pretty subtle to be able to get past that.

One area in which participants were unanimous was in suggesting that better access to free condoms would increase levels of condom use. Many participants’ support for easy access to free condoms stemmed from early experiences of being embarrassed buying condoms. This was especially so for young women. Although participants supported the concept of condom vending machines, many had never used them and some men doubted the quality of these condoms:

Paul: Often I’ll find that they’re not the ones you would see in pharmacies or whatever.

Max: Yeah, what’s with that? ’Cause like those little beaten up graffitied boxes look kind of dodgy sometimes.

Brad: Yeah. Haven’t been refilled since 1987.

Paul: And you can’t get anything out when you put your money in.

Int: I mean, that’s a question as well—whether the quality of the condoms is something that’s important as well.

Max: Well, I mean, you have a head full of choices when you walk into any store usually. And you have, like three choices when you’re in a bar. It’s like dodgy, dodgy or dodgy for her pleasure. [Laughter]

Discussion

The data suggest several avenues for interventions to raise awareness of the risks of STIs and to promote condom use among heterosexual young adults. Some of these would involve the provision of information about the prevalence and consequences of STI infection. Yet simply providing information is not enough, because there is no clear association between knowledge and condom use (Sheeran et al., 1999). Furthermore, respondents
noted that it is easy to turn a blind eye to the likelihood of infection or to believe that STI infection is something that happens to others. This may in part help explain participants’ more frequent reference to ‘you’—a generic young adult—than to themselves (compare Greg’s statement that ‘you can get an STD any time’ with Sally’s personal response to graphic television advertisements). One interpretation of the apparent preference for ‘you’ over ‘I’ is that individuals have one set of beliefs when talking about others and another set of beliefs when they talk about themselves, and that this allows them to distance themselves from expectations of the behavior of others. The use of the term ‘you’ rather than ‘I’ may also be an artifact of the group discussion situation. In such situations discussion of personal experience is less likely than discussion of more general issues: the term ‘you’ may be used by individuals to present their beliefs as universal, perhaps as a substitute for ‘we’. It would be interesting to examine whether participants would display a preference for ‘you’ over ‘I’ in individual interviews in which they were specifically asked about their own experiences.

Men and women suggested that condom use would increase if more women asked men to use condoms. To some extent men may prefer such an arrangement, as it divests them of responsibility for condom use and provides an excuse for not using condoms (‘She didn’t ask me to’). This approach is based on the assumption that women can convince men to use condoms. Yet, many women feel unable to initiate discussion of condom use because of a general embarrassment around discussion of sex in our society and the specific impact of cultural expectations of women not to take the initiative in sexual matters (Amaro, 1995; Holland et al., 1998). Greater efforts may be needed in school sexuality education classes to develop men’s and women’s skills for negotiating condom use.

Some participants suggested that parents could play a bigger role in STI education. However, participants were divided as to whether parents might be good sources of education. Many parents and children feel uncomfortable discussing sex (Feldman and Rosenthal, 2000) and even when they are willing to engage in such discussion, parents may not possess accurate knowledge about STIs (Grulich et al., 2003b). Parent–child communication about sexuality is an area which deserves further attention from both researchers and those involved in health promotion. There is a need to determine what parents might be able to teach their children, how they might go about this, and the best ways to develop parents’ skills and motivations for discussion of sexual health with their children.

Participants suggested that some level of shock may be required to alert heterosexual young adults to the likelihood and consequences of STI infection. However, fear campaigns are unlikely to be successful if members of the target audience do not possess condom use skills or have low self-efficacy for condom use. Rather than acting to control their risk of infection by using condoms, individuals with low self-efficacy may act to control their fear by denying or defensively avoiding the threat of infection (Witte et al., 1998; Ruiter et al., 2001). A range of messages presented in different styles and using different media—leaflets, billboards, radio and television advertisements—might be better suited to different components of a multi-faceted health promotion campaign. However, such approaches will be more expensive than less broadly based strategies.

Men and women agreed that cheap or free condoms should be readily available. Some men suggested that the perceived inferior quality of condoms in vending machines may lead to non-use of condoms. However, men were not reliant on vending machines and mentioned numerous places where they could obtain condoms. There are several responses to the finding that some young adults do not trust condoms from vending machines: (1) encourage young adults to carry condoms that they do trust so that they are not reliant on vending machines, (2) fill machines with condoms that young adults know and trust, and advertise this fact, and (3) inform young adults that not using a condom at all is more risky than using a condom that has a small chance of breaking (Steiner et al., 1999). The benefits of such an approach would be appreciated by young people themselves, health promotion professionals, and the manufacturers and vendors of condoms.
It is important to strike a balance between what young adults consider to be the best ways to promote condom use for STI prevention and what research suggests are the factors that most strongly influence STI preventive behavior (Silvestre et al., 2002; Kalmuss et al., 2003). Interventions based on social cognitive models of health behavior have been shown to produce significant changes in condom use for HIV prevention (Bryan et al., 1996; Abraham et al., 2002). Such findings may be applicable to condom promotion for STI prevention. Indeed, components of these models were acknowledged in participants’ references to attitudes toward condoms, condom use self-efficacy, perceived risk, negotiation of condom use and condom availability. However, interventions based solely on social cognitive models may be made more effective by considering suggestions from participants, particularly their suggestions for how best to present health promotion messages.

Although this study has provided useful information about how to promote condom use for STI prevention, it does have some limitations. Further qualitative or quantitative research may be needed before we can apply the results of this study to the general population or to populations in other countries. The study gathered information from a relatively small number of participants and only single-sex groups discussions were used. Future research may benefit from including young people from a more broad range of socioeconomic and cultural backgrounds. Use of mixed-sex groups may increase our understanding of similarities and differences between young men’s and young women’s beliefs about promoting condom use for STI prevention.

This study revealed some correspondence between influences on condom use for STI prevention and influences on condom use for HIV/AIDS prevention, such as the availability of condoms and negotiation of condom use. However, there were some issues unique to condom use for STI prevention stemming from the greater likelihood of infection, the possibility of treatment for some STIs, and the relative absence of STIs from public discourses on sexuality and sexual health.

A standard-sized latex condom stretches to fit most penises. However, it would be unwise to produce only one size of condom and hope that ‘one size fits all’. Promotion of condom use should not rely on a ‘one size fits all’ strategy which assumes that HIV prevention and STI prevention are synonymous, or that all young adults will respond appropriately to the same health promotion messages or messages distributed via the same medium. Respondents proposed numerous reasons for their lack of concern about STIs. They also provided a wide range of suggestions for how to promote condom use for STI prevention. The diversity of opinions expressed by young adults suggests a need for multi-faceted, multi-media approaches to promoting condom use for STI prevention.

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