‘What do you think?’
An evaluation of the Ceredigion “C” card scheme: the perceptions of the young people and distributors
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1. Summary

The aim of this qualitative research was to evaluate the Ceredigion* “C” card scheme to determine whether it has been successful in delivering its objectives.

Data was collected using focus group discussions and semi-structured interviews. A total of twenty young people (n=20) and sixteen distributors (n=16) took part.

Thematic analysis of the data indicated that within Ceredigion young people are faced with barriers to accessing local sexual health services and condoms (embarrassment, cost, transport and family planning clinics); aspects of the “C” card scheme reduce the barriers to accessing condoms (free condoms, confidentiality, location, familiarity and communication); gaps in young people’s sexual health knowledge exist and there is inconclusive evidence on whether or not schemes such as the Ceredigion “C” card scheme encourage young people to have sex.

As a result of these findings the researcher recommended that the Ceredigion “C” card scheme continues and is extended to other organisations and young people within Ceredigion. Along with the recommendation that further research is conducted with young people specifically, to investigate what they perceive to be barriers to accessing local sexual health services and condoms; reasons for the inconsistent use of condoms; their sexual health knowledge and whether or not schemes such as the “C” card scheme encourages young people to become sexually active.

* Ceredigion is part of the Dyfed Powys region, which covers an area of 10,500 square kilometres. It is mainly a rural county with a registered population of 93,000 and a resident population of around 78,000. Compared with Wales Ceredigion has an unusual population structure because of the large numbers of mainly 18-24 year old students in the university towns of Aberystwyth and Lampeter.
2. Introduction

According to the National Public Health Service (2004) sexual health is a matter of great concern in Wales. Above all the poor sexual health experienced by young people (up to the age of 24). There are worrying increases in the number of sexually transmitted infections amongst young people, particularly 16-19yr olds and teenage conception rates in Wales are the ‘highest in Europe’ (National Public Health Service 2004, p. 5). While, according to the FPA (2007) the United Kingdom has the highest rate of teenage abortion rates in Western Europe. As a result of this a number of public health initiatives have been put in place with the aim of reducing both STIs and teenage conceptions. Initiatives have ranged from national to local awareness campaigns. An example of the former being the Health Challenge Wales campaign that produced a poster campaign encouraging the use of condoms. With an example of the latter being Condom Card schemes – “C” card schemes.

“C” card schemes aim to increase the accessibility and availability of condoms to young people. The first scheme was developed in 1989 by the Harm Reduction team in the Edinburgh Healthcare NHS Trust. Other public health organisations followed suit and introduced similar schemes during the following years. In 2006 the scheme was running in a total of nine counties in Wales. This included the scheme running in the county of Ceredigion – the Ceredigion “C” card scheme. Early evaluations identified that “C” card schemes were regularly accessed and used by young people and welcomed by workers as an initiative to increase access to sexual health information and support to young people. However, the evidence base for “C” card schemes and in essence the free provision of condoms is mixed.

Payne & O’Brien (2005) state that free condom provision is cost effective and, importantly, a cost saving intervention aimed at promoting sexual health. Fortenberry (2002) found that programmes, which provided free condoms, could increase access and use, while other studies according to Ellis and Grey (2004) have appeared to show a decrease in condom use. Due to this inconsistency of studies that aim to show the effect of schemes such as the “C” card scheme, Ellis and Grey (2004) state that there is insufficient level of evidence to support or discount the effectiveness of free condom distribution schemes. Ellis and Grey (2004) also state that much more UK based evidence is needed in relation to the effectiveness of condom provision in community settings and of providing condoms in school – both of which are elements of the Ceredigion “C” card scheme. Finally, Kavanagh (2005) states that despite its widespread use throughout the UK and its potential public health importance no controlled evaluation studies could be identified which could provide evidence of the impact of “C” card schemes.

Ad hoc evaluation of the Ceredigion “C” card scheme which has been carried out previously appears to be positive. During their inspection of Ceredigion Young People’s Partnership, Estyn stated that:
Health partners collaborate well with other partners to use innovative approaches to prevent teenage pregnancy and to meet the needs of young people requiring advice on sexual health matter and contraception. These projects include the Ceredigion “C” card scheme…” (Estyn 2006, p.12)

Evaluation is a ‘process that attempts to determine, as systematically and objectively as possible the relevance, effectiveness and impact of activities in light of their objectives’ (Last 2001, p.9).

According to Meyrick (2002) evaluation is a very valuable tool and is undertaken for a number of reasons. These include:

- inform programme planning;
- provide funders with evidence of success;
- provide feedback for those involved;
- contribute to the evidence-base.

For this particular research a formative evaluation was undertaken which involved the ‘collection of data while the organisation or programme is active, with the aim of developing or improving it’ (Bowling 1997, p.9). Although evaluation often contains a mix of quantitative and qualitative data, for this particular research only qualitative data was obtained.
2.1 Aim

The aim of the research was to evaluate the Ceredigion “C” card scheme to determine whether it has been successful in delivering its objectives.

2.2 Objectives

The objectives of the research were:

- to assess whether or not the Ceredigion “C” card scheme has increased the accessibility, availability, acceptability and use of condoms amongst young people along with providing verbal and written sexual health information;
- to investigate whether or not the Ceredigion “C” card scheme has encouraged young people to have sex;
- to provide recommendations for the future running of the scheme;
- to contribute to local and national evidence-base policy and practice.
3. Literature Search Strategy

Various literature searches were conducted to inform each section of the research. The literature search identified for papers published (and unpublished from websites) between 1990-2007. This broad year range was decided upon as a number of research undertaken with regard to condom card and distribution schemes were undertaken during the 1990s. All papers focused on research carried out in the United Kingdom, Europe and United States. Full text and English language papers only were sought, with additional papers being found when cited elsewhere.

Finally, informal contact was made with other “C” card scheme co-ordinators within the UK through the Condom Card Scheme UK Network.

One of the literature searches undertaken, specifically looked for evaluation of “C” card and condom distribution schemes. Only five papers were identified (Brown, Pennylegion and Hillard 1997; Kirby, Brener, Brown, et al. 1999; Gibbins, Connell, Lester, et al. 2001; Martinez-Donate, Hovell, Zellner, et al. 2004; Dolan, Lowe and Shearer 2004) and these were not particularly helpful. Two of the research papers (Brown, Pennylegion and Hillard 1997; Kirby, Brener, Brown, et al. 1999) were published 8-10 years ago and therefore are of a questionable relevance today and also used different methods of data collection. While, the setting and target groups of the three remaining papers (Gibbins, Connell, Lester, et al. 2001; Martinez-Donate, Hovell, Zellner, et al. 2004; Dolan, Lowe and Shearer 2004) varied considerably from those of this particular research, for example one was carried out with a prison population and another in a GP surgery. As a result of this lack of published research, informal contact was made with other “C” card scheme co-ordinators within the United Kingdom through the Condom Card Scheme UK Network. On contacting these people, several un-published evaluation were obtained.
4. Background

Sexual health is more than the absence of disease. It is about the physical and mental health and well-being of an individual. As defined by the World Health Organisation (WHO 1975) sexual health is a:

“State of physical, emotional, mental and social well-being related to sexuality. It is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be maintained the sexual rights of all persons must be respected, protected and fulfilled”

Over recent years sexual health, in particular poor sexual health, has become an increasing public health issue. Better Health, Better Wales (1998) highlighted concerns about the high rates of teenage pregnancies and sexually transmitted infections in Wales. In 2000, a Strategic Framework for Promoting Sexual Health in Wales was launched, followed by Sexual Health in Wales (2004), Sexual Health Services in Wales (2004) and the consultation document Draft Quality Requirements for Sexual Health Services in Wales (2007). All of which emphasised the importance of sexual health of the population as a whole with the overall aim of improving the sexual health of the population by ensuring that the people have ‘access to sexual health information, advice and services’ (Welsh Assembly Government 2007, p.8).

Sexually transmitted infections

Sexually transmitted infections occur as a result of poor sexual health and cause significant burden on individuals and the health services. After sustained declines of STIs incidence observed during the first 15 years of the HIV/AIDS pandemic disease incidence is again rising.

According to the National Public Health Service (2004) there are more than 25 diseases, which are spread through sexual activity with the trends of each disease varying considerably. Despite the varying trends and although the rates of sexually transmitted infections in Wales remain lower than those observed in many parts of the UK, sexually transmitted infection rates are still a cause of public health concern.

Sexually transmitted infections affect people of all ages, however incidence is greater among people under 25 – ‘the highest burden is borne by women, gay men, teenagers, young adults and black and minority groups’ (Ellis & Grey 2004, p. 2). Young people are more susceptible to sexually transmitted infections for a number of reasons. These include higher number of sexual partners; greater number of concurrent partnerships and changing partners more often than older adults. Although it should be noted that STIs among older people are currently on the increase. Re-infection is also an issue with young people, with the risk (of re-infection) decreasing with age.
The most common STIs amongst young people in Wales are:

- chlamydia;
- gonorrhoea;
- genital warts;
- genital herpes.

According to the Health Protection Agency (HPA) (2006) genital chlamydia infection was the most commonly diagnosed sexually transmitted infection in the United Kingdom during 2006 with rates of diagnosis highest in the 16-19 years women age group and the 20-24 years men age group. Numbers of diagnoses have risen steadily since the mid-1990s although this rise is thought to reflect at least in part to the improving access to testing, improved diagnostic tests and possibly changes in sexual behaviour – increase in risky sexual behaviour.

Gonorrhoea is the second most common bacterial STI in the United Kingdom and as with chlamydia rates of diagnosis were highest in the 16-19 years women age group and in the 20-24 years men age group. According to the HPA (2006) 40% of infections in women were in teenagers.

Rates of first episode genital warts and herpes have also been rising steadily with again the highest rates in the 16-19 years women age group and 20-24 years men age group. Genital herpes has increased by 16% in the 16-19 years women age group and by 10% in 20-24 years men age group.
Figure 1: Rates of genital chlamydia, gonorrhoea, syphilis, genital warts and genital herpes in young people (aged 16-24). United Kingdom: 1996-2005

1 Uncomplicated. 2 First attack.

Data Sources: KC60 and STIS/SD(C)5 returns from CUM clinics.

Source: Health Protection Agency (2007, p. 98)
As table 1 indicates. Within Ceredigion the rates of some STIs amongst young people has remained relatively stable over the past 5 years whilst others have increased. In 2006 the incidences of chlamydia, genital warts and gonorrhoea were at their highest since 2002.

<table>
<thead>
<tr>
<th>STI</th>
<th>2002</th>
<th>2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chlamydia</td>
<td>23</td>
<td>48</td>
</tr>
<tr>
<td>Genital Warts</td>
<td>37</td>
<td>44</td>
</tr>
<tr>
<td>Gonorrhoea</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Genital Herpes</td>
<td>6</td>
<td>6</td>
</tr>
</tbody>
</table>

Source: National Public Health Service (2007, p.1)

However, the continuous rise in the rates of sexually transmitted infections is likely to be underestimated due to the fact that sexually transmitted infection data is derived from KC60 form returns from genitourinary medicine clinics only and therefore do not take into account sexually transmitted infection testing which takes place at general practitioner surgeries, family planning clinics and at home (due to the introduction of home testing kits). In addition, due to the asymptomatic nature of the majority of sexually transmitted infections a number of young people go undiagnosed and do not seek medical advice. Consequently, the physical health costs of dealing with the consequences (of not been diagnosed and treated) are considerable. They include pelvic inflammatory disease, which can cause ectopic pregnancies and infertility, cervical and other genital cancers, hepatitis, chronic liver disease and liver cancer, recurrent genital herpes, and bacterial vaginosis and although rare, epididymitis and Reiter’s Syndrome in men. Not only do these consequences create a health and wellbeing cost they can create a heavy financial burden on the NHS. The cost of infertility treatment can cost between £1000 and £4000 per cycle with a person on average having to undergo 1-3 cycles of treatment.
Teenage conceptions

In addition to sexually transmitted infections, and although one of its consequences is infertility, unintended teenage conceptions can occur as a result of poor sexual practices. Unintended conception and parenthood amongst teenagers are associated with both social and psychological consequences. The teenage mothers themselves are less likely to finish their education and are less likely to find a good job, as is also the case with their partner, which reduces their standard of living. In addition, according to the Department of Health (DoH) (2004) teenage mothers suffer from poorer mental health in the three years after their birth compared with other mothers. They are also more likely to end up as single parents in poverty and come from poor areas and disadvantaged backgrounds. Whilst children of teenage mothers, those of which survive as infant mortality rates for babies born to mothers under 18 years old are ‘twice the national average’ (Kraszewski 2006, p.38) according to the DoH (2004) suffer as young adults. In terms of lower educational attainment (which is thought to be associated with the low birth weight of babies born to teenage mothers), have a higher risk of economic inactivity and of becoming teenage mother themselves.

However, it must be noted that not all unintended conceptions are ‘unplanned’ or indeed unwanted. Some may be ‘wanted and planned, others may be unplanned but wanted, and yet others may be unwanted and unplanned’ (Swann, Bowe, McCormick and Kosmin 2004, p.4). Indeed, several young parents have spoken positively about parenting and its impact on their lives. According to the Department of Health (2004) it increased their self-esteem and enhanced their lives, providing a sense of security and stability in lives characterised by transience, detachment and low economic aspirations.

Nevertheless, whether the conception is unintended or not the United Kingdom has the highest rates of teenage conceptions (those under 18 years of age) and teenage births in Western Europe (UNICEF 2001). Rates in Wales are consistently higher than England although the under 16 conception rate in Wales is reducing faster than in England.

In Wales in 2004 2,605 conceptions were to girls under 18 and 434 conceptions were to girls under 16. In the same year within Ceredigion, there were 29 conceptions to girls under 18 and five conceptions to girls under 16.

Abortion

The final aspect of poor sexual practices that affects young people is abortion. According to the FPA (2007) the United Kingdom has the highest teenage abortion rates in Western Europe. As illustrated in table 2 just over a third of under 18 conceptions in Wales in 2005 were terminated and half of the pregnancies of under 16 conceptions.
In 2005, Ceredigion had one of the lowest abortion rates in Wales (n=152). The highest number was in the 20-24 age group (n=58) (although this could be misleading as records obtained missing ages were assigned to the 20-24 age group) followed by the 18-19 age group (n=26) and the under 18s (n=17). However, in spite of having one of the lowest abortion rates in Wales, there has been a ‘marked increase in the number of requests for an abortion’ (Ceredigion Public Health Team 2007, p. 25) in Ceredigion in the past two years.

It is reported that there are physical and psychological problems associated with abortions (including teenage abortions). However, according to the British Pregnancy Advisory Service (2006) there are very few physical problems associated with abortions. Serious physical problems are rare with only 1 or 2 in every 1000 cases having complications and 1 in 100 abortions being repeated because fragments of the pregnancy remain in the uterus. While according to Cohen, Altshurer, Harlow, et al. (2006) much of the research surrounding the psychological impact of an abortion that has appeared to demonstrate a link between abortion and mental health problems has significant flaws. Nonetheless, whether or not there are physical or psychological problems associated with abortion, teenage abortion rates are high.

STIs, teenage conceptions and abortions are preventable. Barrier methods of contraception are the only protection sexually active people of all ages can use to prevent the acquisition of both STIs and unplanned conceptions. These barrier methods include femidoms, male condoms and dental dams (with the male condoms being considered for this particular research as these are the condoms distributed to young people on the “C” card scheme in Ceredigion).

For young people male condoms are the most popular form of protection due to the fact that they are ‘widely available and can be used without much planning and without the need for

<table>
<thead>
<tr>
<th>Conception (Number)</th>
<th>Abortion (Percentage)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 16</td>
<td>2,504</td>
</tr>
<tr>
<td>Under 18</td>
<td>455</td>
</tr>
</tbody>
</table>

Table 2: Number of conceptions and percentage of conceptions resulting in abortion to young people under 16 and under 18. Wales: 2005

Source: FPA (2007, p.2)
medical consultation’ (Parkes, Henderson and Wight 2005, p. 271). When used correctly male condoms are 98% effective. Nonetheless, with the high rates of STIs (amongst young people), teenage conceptions (including abortions) it could be said that young people fail to (i) access condoms and (ii) use condoms consistently. In fact research by Fortenberry, Tu, Harezlak, et al. (2002) concluded that young teenagers often use condoms inconsistently.

According to research the inconsistent use of condoms is in part a result of lack of access, availability and acceptability of condoms amongst young people. For this reason, the “C” card scheme initiative was introduced in many parts of the United Kingdom – including the county of Ceredigion.

Ceredigion “C” card scheme

The Ceredigion Condom Card Scheme – “C” card scheme – is a public health initiative that was introduced in Ceredigion in 2001 when it was initially funded by the Welsh Assembly Government in response to the high levels of STIs amongst young people and teenage conceptions. The scheme was at first run and co-ordinated by a member of the Safe Underage Drink & Drugs Service. However, since 2007 the scheme has been co-ordinated by a member of the Ceredigion Public Health Team.

The aims of the Ceredigion “C” card scheme (as stated in the manual) are:

- to provide free condoms to young people aged 14-25;
- to reduce the incidence of STIs;
- to reduce the incidence of unintended pregnancies.

Whilst the objectives are:

- to increase the availability and accessibility of condoms;
- to increase acceptability and use of condoms;
- to provide verbal and written sexual health information.

The scheme works as follows:

- the young people (who have decided that they need condoms) are given a “C” card and a supply of condoms from an appropriately competent person who has been trained;
- the young person is able to receive more condoms when needed.

At present there are 19 organisations within Ceredigion who deliver the scheme. These organisations include a variety of statutory and voluntary organisations such as secondary schools; colleges; youth centres/drop-ins and student unions. Since the re-launch of the scheme in January
2007 (and up until the end of July 2008) 980 young people have accessed the scheme with approximately 10,000 condoms being distributed.
5. Study Methods

Study Design

This research study utilised qualitative data and adopted a participatory approach of collecting data. According to Meyrick (2002) the way an evaluation is planned and undertaken should be participatory as it has a number of benefits – feeling of ownership; enhances health through skills development and self-esteem; and empowers those involved. A number of “C” card scheme evaluations which have been undertaken by other schemes within England and Wales (Squires 2003; Roberts and Jones 2007) have used both questionnaires and individual interviews to obtain data. However for this particular research insight into people’s opinions, feelings, emotions and experiences were being sought and for this reason the researcher did not believe that questionnaires would be the most appropriate method of data collection as questionnaires are used when what is required is fairly straightforward information. Therefore data was obtained through focus group discussions with a selection of young people who access the “C” card scheme and semi-structured interviews with the distributors.

Sample Selection and size

The purposive sampling method was used for recruiting participant for both the focus group discussions and semi-structured interviews. Purposive sampling is a non-probability sampling technique where the researcher already knows something about the participants and deliberately selects ones because they are seen as ‘instances that are likely to produce the most valuable data’ (Denscombe 2007, p.17). For this particular research those people in the view of the researcher were the young people using the scheme and the distributors.

Recruitment

Organisations that operate the “C” card scheme were invited to involve the young people using the scheme in the evaluation process. A total of seven organisations were invited – those of which were open during the summer months. Six of these agreed and of these four were approached for the final cohort of young people as the researcher perceived this to be a sufficient number of focus group discussions to take place. The individual organisations distributed the letters of invitation to identified interested young people. Although four organisations were approached for the final cohort (of young people) the total number of focus group discussion conducted were three as data saturation, which guided sample size had been reached. A total of twenty (n=20) were involved in the focus group discussions – five females and fifteen males, all aged between 16 and 18 years of age.

In addition all distributors (n=28) which were on the scheme’s database were invited to participate via a letter of invitation. With a stamped addressed envelope included with each letter of invitation for participants to return their responses to the researcher. Of these sixteen took part (two males and fourteen females) (n=16). However, in essence twenty two distributors were invited to participate as six of those listed on the distributor database had either only recently commenced or were still in the process of introducing the scheme and as a result did not feel it
was appropriate to participate. One letter of invitation was returned unopened, whilst five distributors did not wish to take part. Thus, a 73% response rate was achieved which is in close proximity to the ‘generally accepted 75% and above’ (Bowling 1997, p.264) response rate that is deemed good.

Inclusion and exclusion criteria

Inclusion:
• Members of the “C” card scheme aged 16-25
• “C” card scheme trained distributors

Exclusion:
• Members and non-members of the “C” card scheme aged below 16 or above 25 – due to ethical implications (legal age of sexual consent) and target age of scheme (14-25yr olds)
• Non-trained “C” card scheme distributors

Ethical approval and legal considerations

Guidance on ethical approval was sought from a member of the Dyfed Powys Local Research Ethics Committee. It was agreed upon that, as this was an evaluation of the Ceredigion “C” card scheme, which essentially is a service evaluation, ethical approval was not required.

Despite ethical approval not being required the researcher adhered to the three underlying ethical principles of research:
1. interest of participants should be protected;
2. researchers should avoid deception or misrepresentation
3. participants should give informed consent

Finally, it should be noted that the researcher has undertaken a Child Protection training course and undergone an enhanced CRB check as part of their professional work.

Focus group discussions

Focus group discussions are ‘unstructured interviews with a small group of people who interact with each other and the group leader’ (Bowling 2002, p. 394). It is carefully planned and is designed to obtain perceptions on a defined area of interest in a permissive, non-threatening way.

Within the domain of health, public health professionals were among the first to embrace focus group interviewing and it’s a method that has been widely used in sexual health research with young people. Rosenthal, Lewis, Succop, et al. (1999) is study to help understand adolescents’ perceptions of the sexual history taking process used focus groups as did Kisker (1985) during her study titled ‘Teenagers talk about sex, pregnancy and contraception’. There is also according to Hyde, Howlett, Brady, et al. (2005) much support in the literature for the view that focus groups are an
appropriate method of choice for health research into sensitive issues of which sexual health is one. Finally, Selwyn and Powell (2006) argue that focus groups provide valuable insights into adolescents' views on sexual health.

Young people orientated focus groups differ slightly to focus group discussions that involve adults and special considerations to these differences are needed when planning a young people orientated focus group discussion.

The focus group discussions were of a mixed gender composition. Special consideration was given to this decision by the researcher. It is recommended that focus group discussions are homogenous and homogeneity with respect to gender is frequently recommended. The reasons for this according to Krueger and Casey (2000) are for analysis purpose and the participants' comfort – the degree to which sharing will be influenced by differences in participants' characteristics. Researchers of previous studies involving focus group discussions and young people have used both single sex and mixed sex focus group discussions. According to Heary and Hennessy (2002) older children and teenagers have an increased interest in the opposite sex which could negatively affect group productivity whilst Peterson-Sweeney (2005) state that school aged boys may be quite resistant to discussing certain topics with same aged girls. Other researchers also state that it may be necessary to have single sex groups in similar age ranges in order for the atmosphere to be permissive and relaxed. However, during Charlesworth and Rodwell’s (1997) study no detrimental effects were noted on communication in the mixed gender groups and in Brown and Pennylegion’s (1997) evaluation into condom availability in public schools again no detrimental effects were noted. Finally, according to Krueger and Casey (2000) after age 14 or 15 youth seem to be better at listening and sharing views and slightly less affected by gender differences.

Based on this evidence mixed gender focus group discussion were conducted as the researcher did not want to reinforce the idea that sex and relationships and in essence the “C” card scheme are not topics that should be discussed openly amongst boys and girls which is quite often the case when Sex and Relationships Education (SRE) is taught in separate sex groups within schools.

The focus group discussions were comprised of between four to eight young people (with an age range of no more than two years between participants) which is a smaller group size compared with adult focus group discussions when between ten and twelve adults take part. Although the risk with smaller groups is that group discussion will resemble parallel interviews as opposed to a dynamic group interaction, larger groups (especially larger groups of young people) may become difficult to control. The young people who took part in the focus group discussions were known to each other – in friendship groups – to 'ensure they felt comfortable to talk amongst each other' (Selwyn and Powell 2006, p. 222).

The topic guide questioning strategy was used for this research. Two guides were developed and used interchangeably depending on the responses gained by the young people. The list of topics and issues and they key words and phrases were included in an open question format although the questions themselves did not suggest potential responses.
Prior to administering the topic guide the researcher gave a brief introduction to the focus group discussion’s participants. The introduction aimed to give participants enough information to feel comfortable with the topic, create a permissive atmosphere and remind participants of the aim of the study, why they were selected and the aspect of confidentiality and anonymity. As stated previously, confidentiality of information should be given and ensured to all those who participate in research. However, in a focus group discussion this can prove difficult, as participants may not be aware of such an ethical position. Therefore, the researcher informed the group of this and asked all participants to ensure that everything that was to be discussed during the focus group discussion was to be treated as confidential by the group and what was said by individuals during the discussion ought to remain private and not get disclosed publicly. An icebreaker activity was included in the introduction as according to Krueger and Casey (2000) as much as 10-15 minutes at the beginning of the group might be dedicated to getting acquainted with the group.

The focus group discussions took place at the young people’s place of occupancy – a youth centre, drop-in centre and school with discussions lasting between 30 and 40 minutes. Adult focus groups can last for up to two hours however; young people repeatedly find themselves in environments where change or relocation takes place every 45 to 60 minutes and according to Heary and Hennessy (2002) the majority of focus groups with young people last between 30 and 90 minutes. Refreshments were offered to participants on arrival and once all were present they were seated in a circle to ensure that all had eye contact and everyone accorded equal importance. Name tents were also given to participants as suggested by Krueger and Casey (2000) in order for the researcher to remember names and for participants to follow up on something that someone had said.

The focus group discussions were conducted by the researcher and an assistant with all being tape recorded to facilitate the analysis process.

Finally, as with any research method a pilot study must be conducted preliminary to its administration. According to Krueger (1998) the true pilot test for focus group discussions is the first focus group with participants – “Do the first focus group. If it works, it’s your first group. If it doesn’t, it was a pilot test”. Therefore, the first focus group discussion was the pilot test and in essence the first focus group discussion.

**Semi-structured interviews**

It was decided that one to one semi-structured interviews were going to be used to obtain data from the distributors as structured interviews lend themselves to the collection of quantitative data, as in essence, a structured interview is like ‘a questionnaire which is administered face to face’ (Denscombe 2007, p. 175). Whilst, semi-structured interviews have a clear list of issues to be addressed and questions to be answered and are flexible in terms of the order in which topics are considered and more significantly enables interviewees to ‘raise other relevant issues not covered by the interview schedule’ (Bowling 2004, p. 258).

A list of questions was developed (Appendix 8) for the semi-structured interviews, which underwent a pilot study with the scheme’s administrating assistant. Following the pilot study,
adjustments were made as the researcher felt that the questions were overly structured and as a result constrained the interviewee (Appendix 9). Following the adjustments interviews with the scheme’s distributors were conducted and as with the focus group discussions, prior to administrating the questions the researcher gave a brief introduction to the distributors to remind participants of the aim of the study, why they were selected and the aspect of confidentiality and anonymity.

Interviews were conducted (at a time and place convenient to each individual distributor) by the researcher and lasted between 20 and 30 minutes. As with the focus group discussions all interviews were tape recorded to facilitate the analysis process.

Data Analysis

Data analysis of both the focus group discussions and semi-structured interviews were undertaken manually following the thematic analysis process. All aspects of analysis were undertaken by the researcher and were systematic, verifiable and continuous.

The first stage of analysis involved transcribing the recordings of the focus group discussions and semi-structured interviews (subsequent to each one taking place) using a word processor programme (Microsoft Word). Transcriptions were saved on the hard drive of the computer, on an USB key and a hard copy was printed as according to Denscombe (2007) qualitative data tend to be irreplaceable and it is good practice to make copies of computer files and to photocopy any transcripts. The page template of the transcripts included a wide margin on the right hand side to allow the researcher to add notes and comments next to the relevant text. Double spacing was used between different speakers (specifically for the focus group discussion’s transcripts) and what was said by the researcher was bolded for easy spotting. Complete interviews and focus group discussions were transcribed as although it can be ‘difficult, slow and time consuming complete transcription is usually more rigorous than abridged’ (Litoselliti 2003, p.86). Finally, each transcript was given an individual code which corresponded with the participants’ / focus group discussion’s identification code, first and foremost for the practicality issue of locating original data but also to retain the confidentiality and anonymity of data. Finally, during the transcribing process, any references to individuals and named organisations were removed to again ensure that confidentiality and anonymity was maintained.

Following transcribing, the next task for the researcher was to become familiar with the data by reading and re-reading the transcripts. This was done in conjunction with reading the researcher’s separate diary of feelings and interpretations that was kept during the course of conducting the research to allow more in-depth consideration to the circumstances surrounding the data collection and to events that might have influenced what was said during the interviews and focus group discussions. The rationale for this stage in qualitative data analysis is that, ‘having become thoroughly familiar with the data, the researcher is in a position to identify appropriate codes and themes’ (Denscombe 2007, p.291) -which was the next stage of analysis undertaken.

The coding process which used the unit of individual words involved the careful, line by line reading of the text to identify as many codes as possible. Codes were then grouped together to
create categories, which the researcher perceived to have a common property as they related to a particular theme. This approach was adopted for both the focus group discussions and semi-structured interviews with themes constantly being compared and contrasted with the researcher asking the questions of ‘How are they similar?’ and ‘How are they different?’ Following this process which was revisited on more than one occasion as the codes, categories and themes get developed and refined, selected quotations (both negative and positive as researchers must seek to detect and interpret items of data that appear to contradict or challenge the themes derived from the majority) were pasted onto a word processor document to evidence the emergence of themes. The analysis process then moved on to examining how the themes interconnected.
6. Findings and Results

Study participants

As stated previously the total number of focus group discussions conducted was three. Two were conducted in a youth setting (youth club and drop-in) and one in a school. A total of twenty young people (n=20) were involved – five females and fifteen males – all aged between 16 and 18 years of age.

In addition, sixteen distributors participated in the semi-structured interviews – fourteen females and two males. The distributors consisted of two school nurses, two community nurses, four youth workers, four student advice and guidance officers and two shelter accommodation workers.

Themes and sub-themes identified

The researcher identified a number of themes during the analysis process. Not all were relevant to the research question of ‘Has the Ceredigion “C” card scheme been successful in delivering its objectives?’ and therefore have been omitted from this particular research study. However, these themes (cards, school holidays and monitoring forms) will be used to inform the future running of the scheme at a future date.

Having excluded some themes, a total of four remained with additional sub-themes being identified under each. The researcher did not preempt two of the themes that emerged whilst the other two were prior themes which the researcher had anticipated would emerge as a result of the use of the topic guide during the focus group discussions and the list of questions during the semi-structured interviews.

The surprise themes identified were:

- **barriers to accessing local sexual health services and condoms** (embarrassment; cost; transport; family planning clinics);

- **aspects of the Ceredigion “C” card scheme reducing barriers to accessing condoms** (free condoms; confidentiality; location; familiarity; communication; empowerment)

Whilst the prior themes were:

- **sexual health information**;

- **sexual activity**.
7. Discussion

Barriers to accessing local sexual health services and condoms

Barriers according to Richards (2006) make it difficult to access services and even deter some young people from seeking help. Both the young people and distributors referred to physical and psychological barriers to accessing local sexual health services and condoms. These included embarrassment; cost; transport and family planning clinics (location and hours/days of opening).

Previous research conducted by Gibbons (2007) and Newman (2002) suggested that embarrassment is a barrier for young people wanting to access local sexual health services and condoms. This is evident in this particular research.

According to Gibbons (2007) young people are often too embarrassed to buy condoms as was illustrated during this evaluation. Whilst, Newman (2002) stated that young people who live in smaller towns and rural villages are faced with additional embarrassment of people knowing them. Within the smaller towns and villages of Ceredigion; for example those situated away from the two largest towns of Aberystwyth and Cardigan, it seems that ‘everybody knows everyone’s business’. This can according to the distributors deter young people from utilising local sexual health services such as the family planning clinics and from buying condoms; consequently limiting and decreasing the accessibility of condoms.

This element of embarrassment and ‘everyone knowing everyone’s business’ could be linked to the traditional culture of Ceredigion and indeed Britain of not talking openly and honestly about sex and in particular contraception. As stated by Weyman (2007) sex is widely portrayed in British culture on television soap dramas, and in papers and magazines. However, the number of people in society that openly discuss these aspects (sex and contraception) is few and far between. As a result of this lack of open discussion and indeed positive discussion, it could be believed that society disapprove of sex and see it as a ‘naughty’, ‘bad’ or ‘wrong’ activity to partake in. Therefore, young people who want to access local sexual health services and condoms may be too embarrassed due to the fact that they are then known to be sexually active and may feel that they are being disapproved of by members of society and may even experience judgmental attitudes as a result of ‘local culture and beliefs’ (Craig and Stanley 2005, p.179).

In addition, the cost of condoms was identified by both the young people and researcher as a barrier and a prohibitive factor to accessing condoms. Research conducted by Cohen, Scribner, Bedimo and Farley (1999); Richards (2006) and Gibbons (2007) amongst others have also concluded that cost is a barrier to accessing condoms, which in turn limits both its accessibility and availability. However, how much of a barrier is cost and embarrassment? As when asked by the researcher whether or not they would access and use condoms if the scheme did not exist the young people stated yes. Therefore, one would assume that the young people would access condoms free of charge at the local sexual health services or buy condoms in a shop, despite the perceived barriers of embarrassment and cost. Nevertheless, one explanation for this differing and
somewhat contradicting finding could be down to the bravado of the young people. The young people who participated in the focus group discussions may not want to divulge information to the researcher (who may be seen as an authoritative figure) which may suggest that they wouldn’t access and use condoms.

As well as cost and embarrassment, transport was identified (by distributors only) as a barrier to accessing local sexual health services and condoms. Young people are particular reliant on transport (public transport specifically), and 'as they progress to adulthood, their needs typically become greater and more complicated' (National Youth Association 2007, p.1). This ‘need’ include wanting to access local sexual health services and condoms which can be situated up to 18 miles from where they live. According to the Department of Health (2004) study titled Living on the Edge: sexual behaviour and young parenthood in rural and seaside areas, transport problems make services particularly inaccessible and in rural areas distance can be a problem in relation to getting to local sexual health services ‘especially if young people are unable to drive or rely on public transport’ (Richards 2006, p.25).

Transport and its barrier to accessibility is one that has already been identified within Ceredigion (although not exclusively to young people and accessing local sexual health services and condoms). The Ceredigion Health, Social Care and Wellbeing strategy and action plan (2005-2008) described numerous accessibility issues and gave high priority to tackling the geographical access problems residents of Ceredigion are faced with. Along with this, the Welsh Index of Multiple Deprivation (WIMP) (2005) found that 45% of the super outputs areas of Ceredigion are in the most deprived 10% in Wales for the domain ‘access to services’. This poses many challenges for people in particular those living in rural areas of the county and those dependant on public transport (i.e. young people).

Also linked to the barrier of transport and as highlighted by one of the distributors is the barrier of cost. According to the National Youth Association (2007) the cost of transport excludes many young people from full access to a number of facilities and services of which local sexual health services are one.

As a result of the barrier of transport – its access and cost – young people often rely on the ‘taxi’ service of their parents or guardian. However, as stated by the Department of Health (2003) and Richards (2006) obtaining lifts from parents can deter young people from getting help if they have to say where they are going. This in turn compromises young people’s ability to approach services. Nonetheless, this was not an aspect identified by neither the young people nor distributors during this particular research.

(*super output areas = geographic hierarchy for England and Wales with base units used for the reporting of Census data)
The final barrier to accessing local sexual health services and condoms that were identified, which limits the accessibility and availability of condoms in particular is the family planning clinic (namely their location and opening hours/days). There are four family planning clinics in Ceredigion. These are located in the two largest towns of Aberystwyth and Cardigan, the seaside town of Aberaeron and the market town of Lampeter. For some young people (as stated previously) the locations of these services are up to 18 miles from where they live and are therefore inaccessible due to the barrier of transport, which was illustrated during the findings. By contrast, some of the distributors (namely those who were based in the towns where the family planning clinics are located) perceive that the locations are convenient for some young people.

This perception relates to Craig and Stanley’s (2005) research that those rural areas more closely connected in a dynamic and geographical way to the seaside areas (for example Aberystwyth, Cardigan and Aberaeron) are more accessible for young people compared to the remote and often rural areas linked to small market towns (for example, Lampeter).

Nevertheless, despite this somewhat contradictory perception of the locations of the family planning clinics, access to such services is hindered further according to the distributors due to the ‘high visibility’ of some of the locations due to the fact that the services share their premises with other specialties. This finding mirrors other research and relates to the barrier of embarrassment and ‘everyone knowing everyone's business’. During Craig and Stanley’s (2005) research young people considered that their ‘high visibility’ constituted a barrier to using local sexual health services and accessing condoms.

The final aspect of the family planning clinics, which was identified during the analysis as a barrier to access, was the hours and days of opening. This finding supports other research that has suggested that ‘inappropriate opening times for example, during school hours’ (Reeves, Whitaker, Parsonage, Robinson, Swale and Bayley, 2006 p.377) are ‘problematic’ (Craig and Stanley 2005, p.177) for young people.

As illustrated and discussed, young people within Ceredigion are faced with barriers to accessing local sexual health services and condoms. These in turn limit the accessibility, availability, acceptability and the use of condoms. However, it should be noted that the majority of the barriers discussed were ones that were identified by the distributors only. This raises the question of whether it’s the distributors themselves that perceive these as barriers or the young people.
Aspects of the Ceredigion “C” card scheme that reduces the barriers to accessing condoms

In addition to the barriers, aspects of the Ceredigion “C” card scheme that reduce barriers to accessing condoms were described by the young people and distributors and identified by the researcher. The aspects referred to include free condoms, confidentiality, location, familiarity, communication and empowerment.

Providing young people with free condoms, which the Ceredigion “C” card scheme does, overcomes and removes the barrier of cost to accessing condoms. This aspect of the scheme was highlighted by the young people during the research and is an aspect that increases the accessibility and availability of condoms.

In addition to increasing their accessibility research suggests that their use is also increased. During their research Fortenberry, Tu, Harezlak, et al. (2002) concluded that distribution of free condoms would result in more young people using them, while DiClemente (1991) stated that young people are more likely to use condoms if the condoms are to be of little or no cost. Both the young people and distributors stated that the use of condoms is more likely due to the scheme. However, as stated by Fortenberry, Tu, Harezlak, et al. (2002) young teenagers often use condoms inconsistently. The distributors acknowledged this inconsistent use.

Hatherall, Stone, Ingham, et al. (2007) identified the following reasons for inconsistent use of condoms amongst young people:

- they were with a regular partner;
- they were using another form of contraception;
- they felt that condoms were difficult to use consistently with a well known partner;
- they did not have a definite desire to have sex or use a condom.

Whilst other research found that condoms were used inconsistently as young people perceived wearing a condom as ‘decreasing penile sensation’ (Flood 2003, p.35) and ‘did not know how to use a condom’ (Nelson 2006, p.1712), however, neither of the above was found to be the reasons during this particular research. It was alcohol and drugs that were identified.

The element of being too drunk was identified by Nelson (2006) with both alcohol and drugs being identified and highlighted recently by the Independent Advisory Group on Sexual Health and HIV. According to the Independent Advisory Group (2007) alcohol and drug misuse are related to risky sexual behaviour (with lack of condom use being classed as a risky sexual behaviour). During their report Sex, Drugs, Alcohol and Young People it was stated that ‘the greater the level of alcohol consumed, the greater the chance of unprotected sex, particularly in adolescence’ (Independent Advisory Group on Sexual Health and HIV 2007, p.13). Research also shows that there is a strong correlation between sexually transmitted infections and type of drug used.
The second aspect of the “C” card scheme, which was referred to, was confidentiality. Previous research (Craig and Stanley 2005; Brook 1998; and Newman 2002) has suggested that doubts about confidentiality, especially in rural areas such as Ceredigion, constituted as a barrier to accessing local sexual health services and condoms. Nevertheless, this research study did not identify lack of confidentiality as a barrier. Instead the confidentiality that the “C” card scheme (although not unconditional) offers young people was identified (by both the young people and distributors) as an aspect which overcame barriers to accessing condoms and ensured young people’s anonymity, thus increasing accessibility. As stated by Thomas, Murray and Rogstad (2006) if confidentiality is lost young people may not seek advice and utilise sexual health services.

The Ceredigion “C” card scheme is mainly located within youth and school settings. According to Swann, Bowe, McCormick, et al. (2003) good evidence has been found for the effectiveness of contraceptive services based within these settings. This is evident within this research, as the locations of the “C” card scheme were referred to by the young people and distributors as informal and convenient as these were places which young people frequent on a regular basis. And as stated by the Independent Advisory Group on Sexual Health and HIV (2007) condoms should be accessible and available in the places that young people frequent in their everyday lives. A further aspect of the location of the “C” card scheme that is advantageous to young people and reduces the barriers to accessing condoms is the fact that the locations ‘provide a further ‘cover’ for young people concerned about exploring sexual health issues’ (Craig and Stanley 2005, p. 180). Since young people access youth settings and schools on a regular basis, for a number of reasons and ‘not purely to obtain condoms’ (Lyttle and Currie 2004, p.452). Thus the location of the scheme increases the accessibility and availability of condoms.

Other research (DoH 2004) has stated that young people frequently described sexual health professionals within sexual health services as judgmental and stigmatising. This was not identified during this research. In fact it was the familiarity and non-judgmental attitudes of the distributors of the “C” card scheme that was identified as an aspect that increased the acceptability of condoms. This mirrors other research. According to Newman (2002) youth workers (of whom many are distributors) are in a good position to offer young people informal, non-judgmental and individual support on sensitive issues such as sexuality because of the voluntary nature of the relationship they hold with the young people (i.e. not parents or teachers). And although other distributors are not youth workers per se (for example school nurses) elements of their work include those of a youth worker i.e. being young people friendly. Kirton and Tanner (2004) stated that having young people friendly staff is important to young people and will improve their (condoms) acceptability.

According to the National Children’s Bureau (2004) communication is a key issue for young people, and they want all service providers to be good at talking and listening. In addition to receiving condoms, young people who are members of the scheme are encouraged to talk about their feelings and thoughts in relation to their sexual health and relationships with the distributor. This aspect (that was identified during this particular research) of encouraging the young people to talk increases and develops young people’s communication skills around sexual health and relationships. This according to previous research (Wang 2002; DiClemente 1991; Tulloch,
McCaul, Miltenberger and Smyth (2004) increases the likelihood of a condom being used consistently, as those with ‘good communication skills are able to negotiate condom use with a partner’ (Welsh Assembly Government 2004, p.7). In addition, developing and increasing young people’s communication skills will hopefully result in these young people being able to communicate openly in the future with their children about sex and relationships. According to Kakoullis (2005) research suggest that young people who are able to communicate with their parents about sex and relationships before they are sexually active are more likely to use contraception at first intercourse. Whilst research also suggests that there is a greater chance that young people will carry and use condoms if they communicate with their parents about sex and the use of condoms. Furthermore, increasing and developing young people’s communication skills will in turn improve their health literacy which according to Kickbusch, Maag and Saan (2005) is the ability to make informed health decisions in the context of everyday life. Thus increasing young people’s communication skills increases both the use and acceptability of condoms.

The final aspect of the ‘C’ card scheme that was identified was its ability to empower the young people who access the scheme ‘to take more control over their health’ (Ewles and Simnett 2003, p.50). The empowerment of girls was highlighted specifically by the distributors. According to previous research (Sixsmith, Griffiths, Hughes, et al. 2006) young women’s control over the use of condoms may be enhanced should their accessibility be improved.

Aspects of the Ceredigion “C” card scheme have been illustrated and discussed that reduce the barriers to accessing condoms thus increasing the accessibility, availability, acceptability and use of condoms. However, an increase in the use of condoms is not definite due to external factors such as alcohol and drugs.

Sexual health information

The Ceredigion “C” card scheme provides both verbal and written sexual health information to those young people accessing the scheme, with the aim of increasing their sexual health knowledge. Yet, it was found during this research study that in the view of the distributors gaps exist in young people’s sexual health knowledge. This finding reflects that of Hatherall, Stone, Ingham, et al. (2007) when they identified that although young people’s knowledge of sexual health and contraception was generally good, significant gaps in their knowledge existed. However, young people who participated in the research perceived that they received enough sexual health information. This reflects the findings of Richards (2006) that young people consider themselves to be well informed about issues relating to sexual health. Nevertheless, this could be as a result of young people’s bravado (as referred to earlier). As on one hand, they feel that they receive enough sexual health information and on the other, high rates of STIs and teenage conceptions suggest that young people are not putting their knowledge into practice.

In addition to bravado, the perception of the young people who participated in the focus group discussions i.e. that they are well informed about issues relating to sexual health, could be as a result of the organisations to which they belong. In addition to delivering the “C” card scheme, these organisations actively promote the sexual health of young people. Therefore, young people who access these organisations (and held the view that they are well informed) may
well be receiving enough sexual health information. However, this may illustrate the variation of sexual health knowledge amongst young people within Ceredigion. This variation was also evident during the Hatherall, Stone, Ingham, et al. (2007) study with significant variations in the level of sexual health information and knowledge between different study sites being identified.

**Sexual activity**

Results of research conducted by Kirby (2002) concluded that having condoms freely available for young people does not increase sexual activity. According to Kakoullis (2005) evidence from Switzerland suggests that a public education campaign promoting condom use can be effective without increasing the proportion of teenagers who are sexually active. In addition condom distribution schemes for teenagers in the US have shown an increase in condom use but they did not increase sexual activity of teenagers. These findings were evident during this research with all distributors and the majority of young people stating that schemes such as the “C” card schemes do not encourage sexual activity amongst young people. However, two young people did perceive the “C” card scheme as encouraging sexual activity. Though this perception is not evidenced by other research it should not be disregarded.
8. Recommendations

It has become evident during this evaluation and research that young people within Ceredigion are faced with barriers to accessing local sexual health services and condoms. Aspects of the Ceredigion “C” card scheme overcome these; thus increasing the accessibility, availability, acceptability and use of condoms. It also became clear that the scheme is highly regarded by both the young people and distributors. Therefore, the researcher recommends that the Ceredigion “C” card scheme continues and is extended to other organisations and young people. This would include ongoing evaluation extended to incorporate quantitative data and health economic evaluation.

However, there are aspects which have arisen which would benefit from further research. Therefore, the second recommendation would be that further research is conducted with young people specifically to investigate:

- what they perceive to be barriers to accessing local sexual health services and condoms;
- reasons for the inconsistent use of condoms;
- the sexual health knowledge of young people;
- whether or not schemes such as the “C” card scheme encourages young people to become sexually active.
9. Research limitations

Certain limitations surrounding the research were identified during its implementation. These include:

- focus group discussions and semi structured interviews were conducted during the months of July, August and the beginning of September – Majority of this time was during the summer holidays which limited the number of young people and distributors that took part.

- young people and distributors which participated were those who were willing and eager to do so which may serve to bias the sample in ways that are not readily evident;

- mixed focus group discussions were predominately made up of male participants which hindered the amount of participation on the part of the females at certain times;

- researcher bias to some extend due to the fact that the researcher is also the Ceredigion “C” card scheme co-ordinator.
10. Conclusion

Within the limitations of the research it can be concluded that the Ceredigion “C” card scheme has been successful in delivering its objectives. With the objectives being whether or not the Ceredigion “C” card scheme has increased the accessibility, availability, acceptability and use of condoms amongst young people along with providing verbal and written sexual health information.

Although young people within Ceredigion are faced with barriers to accessing local sexual health services and condoms, aspects of the “C” card scheme overcome the barriers. In addition, it can be concluded that gaps in young people’s sexual health knowledge exists and on the basis of this research there is inconclusive evidence on whether or not schemes such as the “C” card scheme encourages young people to have sex.

As a result of the findings the researcher has recommended that the Ceredigion “C” card scheme continues to be delivered and is extended to more organisations and young people, with ongoing evaluation extended to incorporate quantitative data and health economic evaluation. It has also been recommended that further research is conducted with young people specifically to investigate:

- what they perceive to be barriers to accessing local sexual health services and condoms;
- reasons for the inconsistent use of condoms;
- the sexual health knowledge of young people;
- whether or not schemes such as the “C” card scheme encourages young people to become sexually active.
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