Sexual health services in community pharmacy for women on opioid substitution treatment: a qualitative study

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Disclaimers

None

Abstract

Background. Women on opioid substitution treatment (WOST) are at heightened risk for the sexual transmission of sexually transmitted infections and blood-borne viruses. This study aimed to explore the opportunities to promote their sexual health in community pharmacies in England. **Methods.** Semi-structured interviews were conducted with 20 WOST and 14 community pharmacists (CPs). A focus group was run with three CPs. Participants were recruited in drug services and a service for sex workers (WOST), and in community pharmacies (CP). Data collection took place between October 2016 and September 2017. Data were analysed using Framework Analysis and directed Content Analysis. **Results.** CPs could play a role in promoting sexual health among WOST. Sexual health screening, treatment, and condom supply were suggested as potential ways of delivering pharmacy-based sexual health services. These services should be actively offered to WOST, delivered in a private space and free of cost. We identified several challenges to overcome in order to design and implement sexual health services for WOST in community pharmacies. **Conclusions.** This study highlights the potentially key role CPs can have promoting sexual health and addressing health inequities among WOST. Improvements in pharmacists' training are required in order to address stigma towards WOST, and promote trust and positive rapport. Structural changes are also needed to broaden the services available for this group of women and improve their access to healthcare.

Keywords

Women; Sexual health; Opioid substitution treatment; Qualitative research; Community pharmacy

Introduction

People who use drugs (PWUD) are at high risk of sexually transmitted infections (STIs) and blood-borne viruses (BBVs) – i.e., HIV, Hepatitis B and C – (1-10). Most preventive strategies for PWUD have focused on the prevention of HIV and Hepatitis C, especially among people who inject drugs. These have generally overlooked the prevention of STIs and the sexual transmission of BBVs (11-14). Women are especially vulnerable to STIs and BBVs. This is due to several factors at different social ecological levels (15). Socio-structural factors include gender inequities, gender-based violence, and intersectional stigma. At the individual-level, feelings of love and trust are among barriers for condom use.

Amongst drug-using women, women on opioid substitution treatment (WOST) are an accessible group as they attend social and health services on a regular basis, most notably their community pharmacy where they collect their opioid substitution treatment (OST). In the United Kingdom (UK), WOST often collect OST from community pharmacies on a daily basis. Community pharmacists (CPs) in the UK are highly accessible and key in delivering public health services, with an expanding role in health promotion (16-17). Sexual and reproductive health services for the general population, including STI screening and provision of emergency hormonal contraception, are already available in community pharmacies across the UK. Community pharmacy services for WOST are limited to dispensing OST and harm reduction strategies to prevent BBVs (e.g., needle exchange programs) (18). There is thus an opportunity to explore whether CPs could provide more holistic care to WOST, including sexual health promotion. But, research is needed to design and implement sexual health services that meet the needs of WOST and reach this vulnerable group. Making sexual health services available for WOST alongside their OST presents an opportunity to improve access to healthcare and reduce health inequities for this group of women.

This study explores this opportunity to promote sexual health among WOST in community pharmacy, considering the perspectives of this group of women and CPs. It is part of a larger

project that aims to design a pharmacy-based sexual health service for WOST. This paper addresses three objectives of this project: 1) explore the role of CPs in preventing STIs and BBVs among WOST, 2) characterise key components of a service in community pharmacy to promote sexual health among WOST, and 3) identify potential challenges.

Methods

This qualitative study adopted a pragmatic approach to epistemology and ontology (19-20). Pragmatism was considered to be the most appropriate approach for this study as it offered the flexibility and freedom to choose the methods and procedures that were most relevant for each stage of the study. Research quality was assessed based on the criteria by Yardley (2000, 2015, 2017). Data from this study has already been published (23).

Recruitment Strategy

Recruitment of WOST was opportunistic and venue-based in drug services and a service for sex workers in South West England (Bath, Midsomer Norton and Bristol). Previous studies with hard-to reach populations have used similar recruitment strategies (19). CPs were recruited through community pharmacies in the same localities.

The researchers sought diversity in participants' discourses by considering different variables. Some of the variables considered for WOST were age, experiences of sex work and homelessness, and type and OST treatment progress. Age, sex, employment status and level of responsibility at work, and type and location of community pharmacies were considered for CPs.

A total of 75 WOST were approached to participate in the study by the PI (LMP). It is unknown the exact number of women who were informed about the study by the services' staff. Even just considering the 75 women directly approached by the PI, nearly ¾ of women declined (73,3%). The number of women who refused to take in the study was however considerably higher. The

PI contacted 94 community pharmacies. Fourteen CPs agreed to the participate (refusal rate 85,1%).

A £10 LovetoShop voucher (multi-retailer gift voucher available in the UK) was offered to all participants.

Data Collection

Thirty-four semi-structured face-to-face interviews were conducted with WOST (N=20) and CPs (N=14) over seven months between October 2016 and April 2017. One focus group with CPs (N=3) was also run on September 21st 2017. Data were collected until saturation was reached. The duration of the interviews was between 25 and 90 minutes. The focus group lasted 60 minutes.

Interview topic guides were developed in collaboration with key informants (e.g., past drug services' users) (see Appendices 1-3). All participants completed a questionnaire on demographics, sexual health and drug use (WOST) and on demographics (CPs) (see Tables 1-3).

Data Analyses

All data collection sessions were audio recorded and transcribed verbatim. The interviews were analysed using Framework Analysis (20) and the focus group using Directed Qualitative Content Analysis (21). Data were primarily analysed by one of the researchers (LMP) with the support and guidance of the rest of team. NVivo software version 10 was used for the analysis. Descriptive statistics of the questionnaire data were undertaken, using SPSS software. Reflexivity was also part of the data analysis process.

Ethical Considerations

This study received ethical approval from the [institution granting ethical approval] on the 17th of August 2016 [reference numbers ethical approvals]. Informed consent was obtained from all participants.

Results

Data from semi-structured interviews and the focus group were merged for both groups of participants and are presented below. See Tables 1-3 for participant characteristics. Main findings are structured by the paper's aims and in two sections: the role of community pharmacists, and potential challenges.

The role of community pharmacists and key components for pharmacy services to promote sexual health

All participants considered it acceptable that community pharmacies offered sexual health services. Both groups recognized that, in principle, community pharmacy was very well placed to provide these services. This was due to frequent contact, pharmacies' opening hours, anonymity, lack of appointments, and (generally) positive rapport between WOST and CPs. However, it appeared that sexual health was rarely discussed. The development of a pharmacy-based sexual health service could then be an opportunity to improve the sexual health and access to care for WOST.

Most CPs believed that, overall, they were well-prepared to deliver sexual health services to WOST and that community pharmacy was an appropriate setting for these services. They considered that with the appropriate training other pharmacy staff (i.e., technicians, dispensers and counter assistants) could be part of providing the service. The role of each professional would depend on the components of the service, and the knowledge and skills required to deliver it.

There were several ideas for developing a sexual health service for WOST in community pharmacy. Suggestions for the components of the service included short consultations, condom supply, sexual health screening and STI/BBV treatment. Working together with other pharmacy staff, and liaising with other health and social care professionals would be essential, according to most participants. They also mentioned how referrals to appropriate professionals would need to be made available when appropriate (e.g., to start anti-retroviral therapy for HIV). This would

not only include referrals for health-related issues but also safeguarding concerns (e.g., gender-based violence). In pharmacies with more resources and capacity, a walk-in sexual health clinic could be organized to exclusively deliver this service.

Potential challenges to overcome

Based on the participants' narratives, we identified several challenges for promoting sexual health among WOST in community pharmacy. These were: 1) intersectional stigma and discrimination; 2) trust and humanity; 3) lack of privacy and time constraints; and 4) financial limitations.

Intersectional stigma and discrimination: beyond drug use

Intersectional stigma refers to a qualitatively unique experience of stigma that results from the overlap of interdependent stigmatized identities (22). In the case of WOST and in relation to a recent paper (23), experiences of intersectional stigma were associated with the female gender, drug use, transactional sex, homelessness and sexual health status. Women's narratives also highlighted how OST (and especially methadone) was stigmatized because of its association with drug use.

Women's narratives indicated a relationship between experiencing stigma and a lack of access and engagement with healthcare services. They expressed how they had, at some point, felt stigmatized and discriminated against in community pharmacies. This was either by CPs, other pharmacy staff or other pharmacy clients. Facing situations of stigmatization and discrimination left WOST feeling ashamed, helpless and reluctant to access services in community pharmacy.

It was relatively common that CPs dichotomized clients into "not normal" (WOST) and "normal" (any other pharmacy clients). CPs sometimes seemed to be unaware of their own stigmatizing attitudes towards OST clients. Other times participants were aware of their own attitudes and tried to amend them explicitly (*"well I should not say normal"*). Some CPs referred to OST clients using stigmatizing and dehumanizing terms such as: "these people",

"addicts", "blue scripts" – OST clients have a blue script rather than green in the UK –, or "drunks". Also, a few CPs viewed PWUD as "a public health and public safety issue" for the general population. Working on BBV prevention with OST clients was even perceived as a risk for pharmacists to contract HIV. This displays the idea of PWUD as carriers of disease (and especially HIV), which is another example of stigmatizing views and attitudes that some pharmacists may hold. Some CPs recognized that the stigma towards PWUD was a barrier for health promotion and engaging WOST in health services.

We identified differences in how CPs viewed drug use and OST. Some stigmatizing attitudes towards PWUD (and thus OST clients)appeared to be associated with the experiences and socially-constructed meanings of drug use of CPs..

Trust and humanity: building positive rapport and good communication

Except for one participant, all WOST felt comfortable in their current community pharmacy and with the rapport and interactions that they had with their CPs. Some participants explained the positive role that their CPs had had in their progression towards recovery from drug use. Women felt that some CPs cared for them as they had helped them in the past with their OST and other personal matters. Building a relationship of trust was important for WOST to feel comfortable in their community pharmacy and to be willing to engage in pharmacy services.

At the same time, WOST perceived that pharmacists and other professionals had a limited understanding and misconceptions about their life experiences and the context of drug use. There seemed to be a gap in the realities of WOST and CPs that was difficult to bridge, as pharmacists appeared to view drug use as an individual-level phenomena. This maintained and strengthened feelings of isolation and helplessness among WOST, and could hinder good communication and building trust and positive rapport between WOST and CPs.

CPs thought most interactions with WOST as being positive, which diverges from WOST's experiences of intersectional stigma. Some emphasized the importance of having a positive rapport with WOST and called for a humane treatment of WOST. Working with WOST was

however seen as challenging. CPs experienced it as rewarding when WOST progressed in their treatment, but as frustrating when they were either not progressing or relapsing back to drug use. Involvement of OST clients in thefts or arguments damaged the rapport and hindered good communication and understanding between clients and pharmacists. It was explained that these incidents could sometimes make CPs resentful and could create an environment of distrust. When such incidents were repeated, CPs suspended the OST and transferred clients to another community pharmacy. They were perceived to be a barrier to engage WOST in pharmacy services, and limited CPs willingness to deliver services to WOST.

Lack of privacy and time constraints: providing a space and time to share

Even though all community pharmacies had a private consultation room, time constraints were significant barriers for having private consultations. This lack of privacy in pharmacy seemed to exacerbate experiences of stigma and discrimination. Women felt ashamed to be identified as a PWUD when they were picking up their medication in community pharmacy, especially if by someone they knew.

Time constraints were identified as main barriers to deliver health promotion services in community pharmacy. WOST also mentioned that they were less likely to express health-related concerns and engage in services with CPs having short time for consultations. According to CPs, delivering additional services (e.g., a new sexual health service) within current resources would be highly restricted by time and workload pressures.

Financial limitations: community pharmacy as a business

CPs explained that public health services were commissioned, usually directly by the NHS or through Clinical Commissioning Groups[1] or local authorities. Several CPs highlighted that community pharmacies are businesses and that the services they provide need to translate into

[1] Clinically-led statutory NHS bodies responsible for the planning and commissioning of health care services for their local area.

financial gains. Some CPs feared losing clients if they had a high volume of OST clients, therefore losing pharmacy income.

Financial constraints were not identified by WOST as they may not have been aware of the business and financial side of community pharmacy.

Discussion

Community pharmacists have been identified to have a key role in promoting health (16-18). Our findings suggest that there are opportunities for CPs to get involved in delivering sexual health services for WOST. There were several suggestions for the components of a pharmacy-based sexual health service: having short consultations, condom supply, sexual health screening, and STI/BBV treatment. Proactively advertising and providing these services in private would be key to engage WOST. Working with other professionals, including other pharmacy staff, would be necessary. Specific training for all pharmacy staff would be fundamental, especially to equip pharmacists with the necessary skills to initiate a discussion on sexual health and be able to deal with sensitive topics. Drug services' staff and GPs may need to be involved in engaging WOST in the service, and communicate effectively with CPs to provide holistic, quality and person-centred care.

There are important barriers at the social and structural level that need to be considered and addressed. These seemed somehow to challenge the positive views towards having pharmacy-based sexual health services for WOST. Abandoning individual-level approaches and taking a social ecological perspective to address these challenges at other levels (i.e., social and structural) is then essential (24).

Even though most interactions between WOST and CPs were deemed to be positive, women still felt stigmatized and discriminated by pharmacy staff (including CPs) and other clients. This is an important barrier to accessing pharmacy services, especially for vulnerable and marginalized populations such as WOST. We suspect that experiences of stigma and discrimination may have been under-reported by women. Despite the efforts of providing a safe

space for WOST to share their experiences, data collection took place mostly within drug services that they attend on a regular basis. There is the possibility that some participants may have felt cautious to share their experiences of community pharmacy. Stigmatizing attitudes seemed to be embedded within most CPs, and some were unaware of their own attitudes towards WOST. As health professionals, most pharmacists were mindful of the need to deliver non-judgmental and patient-centred consultations. However, this was not always applied in practice. The way some pharmacists talked about WOST showed how ingrained stigma towards PWUD is (23, 25-28). The fact that CPs may not even be aware of their own stigmatizing attitudes may increase the complexity of stigma reduction strategies for community pharmacy. Also, CPs taking part in this study could potentially hold less negative views on OST clients, compared to other pharmacists who were not interested in participating. However, we did not interview other pharmacy staff (e.g., counter assistants) and these other professionals also interact daily with WOST. Future research could explore their views and attitudes towards WOST in order to provide a more holistic picture of stigma and discrimination in community pharmacy. Strategies to reduce stigma in community pharmacy should be a priority to deliver health services to WOST effectively. These could include training programs for pharmacy staff, patient-centred approaches for health services (that are applied in practice), new and/or improved policies considering and addressing stigma, rights-based policy approaches (29).

The “blame culture” towards PWUD prevails. Drug use is commonly attributed to individual factors (e.g., personality) rather than socio-structural factors (e.g., poverty). It would be expected that health professionals working with PWUD (e.g., pharmacists working with WOST) would be familiar with the multidimensionality and complexity of drug use. Interestingly, this was not what we encountered in our research. A few pharmacists still viewed drug use and healthcare from a reductionist and biomedical perspective, which calls for a review of pharmacists’ training (30). These misconceptions about the realities of WOST may limit their access to healthcare and contribute to maintaining health inequities among this group. It is then essential to consider stigma and discrimination as main barriers to health and access to

healthcare. But it is also vital to take social ecological perspectives to public health. This will allow us to address social-structural determinants of health, to improve health, protect the human and health rights of WOST, and reduce social and health inequities.

Trust is key to delivering of pharmacy services (31-32), particularly among vulnerable and marginalized populations such as WOST. Our findings suggested that building a trusting relationship would enhance access to sexual health services among WOST. Building positive rapport would encourage women to express their concerns and overcome reluctance to discuss their sexual health. It may also have a significant role in promoting effective communication, and reducing perceived and enacted stigma. It is also essential that human and health rights are protected by treating WOST humanely, and reducing stigma and discrimination (33-36).

Other barriers to providing sexual health services alongside OST were the pragmatic considerations of lack of privacy and time. The lack of time may have a negative impact on effective communication and limit the proactive promotion and provision of sexual health services. This could restrict the access to healthcare and thus be another factor that maintains health inequities for WOST. We therefore need to be careful that appropriate time and spaces are provided for delivering sexual health services. This may have implications on the funding needed for sexual health services, to ensure that community pharmacies have the necessary resources to implement these services. This links with another of the challenges identified: the need for funding. Commissioning sexual health services would be essential for implementing the services as community pharmacies cannot fund these services themselves.

Limitations

One of the main limitations is that this research did not include other women using drugs, and only included women who were already accessing health services. It is possible that incorporating the views of women who are not accessing services could have provided a broader insight on how to develop health services. Another limitation was that participants may had underreported some of their negative experiences and views. For instance, it may be that CPs

could have portrayed themselves more positively in their interactions with WOST. Likewise, CPs who decided to take part in the study were probably those who already held more positive views, experiences and relationships with WOST. Despite these limitations we also believe this study had several strengths, such as the comprehensive exploration of participants' experiences by using qualitative research methodologies.

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Conflict of interests

The authors declare no conflict of interest.

Key points

- There are important opportunities to expand available public health services in community pharmacy to promote sexual health among WOST.
- There are opportunities to improve how pharmacy services are being delivered.
- Barriers need to be considered when developing and implementing public health services in community pharmacy.
- Policies need to be improved to protect the health of WOST and other drug-using populations.
- Improving access to healthcare services and protecting human and health rights of WOST should be at the core of public health services

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Tables

Table 1

Characteristics of women on opioid substitution treatment taking part in the interviews

Participant characteristics (N=20)	n (%)
Age	*M*=39.50 (*SD*=9.65)
Ethnicity	
English/Welsh/Scottish/Northern Irish/British	18 (90)
White European	1 (5)
Black African	1 (5)
Primary language	
English	20 (100)
Education	
No academic qualifications	8 (40)
0 Level/Scottish Higher or equivalent (NVQ/SVQ Level 2)	7 (35)
A Level/Scottish Higher or equivalent (NVQ/SVQ Level 3)	3 (15)
First degree	2 (10)
Homelessness	
Current	3 (15)
Lifetime	3 (15)
Employment status	
Unemployed	16 (80)
Annual income (N=19)	
£ 0-4,999	9 (45)
£ 5,000-9,999	7 (35)
£ 10,000-14,999	3 (15)
Current drug use	
Tobacco	20 (100)
Heroin	18 (90)
Alcohol	17 (85)
Methadone (prescribed and non-prescribed)	17 (85)

Crack cocaine	15 (75)
Cannabis	15 (75)
Benzodiacepines	15 (75)
Codeine	13 (65)
Opioid substitution treatment	
Methadone	17 (70)
Buprenorphine	5 (25)
Suboxone	1 (5)
Sexual partners	
Men only	14 (70)
Women and men	5 (25)
Women only	1 (5)
Transactional sex (lifetime)	8 (40)
Sexual abuse (N=19)	17 (89.5)
Sexual health	
STI/BBV preventive methods	
No sex	11 (55)
None	5 (25)
Male condom use	4 (20)
STI/BBV screening (at least once) (N=18)	17 (94.4)
STI/BBV diagnoses	
Hepatitis C	7 (35)
Chlamydia	4 (20)
Genital warts	2 (10)
Pubic lice	2 (10)
Scabies	2 (10)
Gonorrhoea	1 (5)

Human Papillomavirus 1 (5)

Table 2

.Community pharmacists' characteristics.

Semi-structured interviews		Focus group	
Sample (	**n (%)**	**Sample Characteristics (N=3)**	**n (%)**
Age	*M*=36 (*SD*=9.46)	**Age**	*M*=35.67 (*SD*=13.32)
Sex		**Sex**	
Female	7 (50)	Female	2 (66.7)
Male	7 (50)	Male	1 (33.3)
Ethnicity		**Ethnicity**	
English/Welsh/Scottish/N	5 (35.7)	English/Welsh/Scottish/N	2 (66.7)
orthern Irish/British	4 (28.6)	orthern Irish/British	1 (33.3)
White European	1 (7.1)	Indian	
White non-European	1 (7.1)		
Indian	2 (14.3)		
Chinese	1 (7.1)		
Other			
Primary language		**Primary language**	
English	7 (50)	English	3 (100)
Non-English	7 (50)		
Education		**Education**	
First degree	7 (50)	First degree	3 (100)
Postgraduate certificate of	1 (7.1)		

	education (PGCE)	5 (35.7)	
	Other postgraduate qualification (including professional)	1 (7.1)	
	Doctorate		
Employment status		**Employment status**	
	Work ≥ 16 hours /week	9 (64.3)	Work ≥ 16 hours /week	3 (100)
	Work < 16 hours/week	1 (7.1)	
	Self-employed	4 (28.6)	
Job title		**Job title**	
	Superintendent pharmacist	2 (14.3)	Superintendent pharmacist	1 (33.3)
	Pharmacy manager	6 (42.9)	Pharmacy manager	1 (33.3)
	Responsible pharmacist	3 (21.4)	Other	1 (33.3)
	Pharmacist	1 (7.1)		
	Independent prescribing pharmacist	2 (14.3)		
Time being a pharmacist (in months)		*M*=145.64 (*SD*=124.69) (12.14 years)	**Time being a pharmacist (in months)**	*M*=144.67 (*SD*=166.21) (12.05 years)
Responsible for OST		14 (100)	**Responsible for OST**	3 (100)
Time being a pharmacist responsible for opioid		*M*=71.69 (*SD*=69.68	**Time being a pharmacist responsible for opioid**	*M*=24 (*SD*=16.97

substitution treatment (in months) (n=13)	) (5.97 years)	**substitution treatment (in months) (n=2)**	) (2 years)

Table 3. Participants' verbatims

The role of community pharmacists and key components for pharmacy services to promote sexual health	*"I think it would be more helpful cause it's somewhere that they would be going to go and pick up their prescriptions and so it [sexual health service] would be there." (Emmeline, 35 years old; WOST).* *"If it was a sort of health assessment that*

	would be easier to do with your daily methadone pick-ups because you could, have multiple attempts to sell them the idea." (Matthew, 51 years old; CP; focus group).
Potential challenges to overcome Intersectional stigma and discrimination: beyond drug use	*"It sort of it's like everyone knows about methadone and I think that it… if I went with that I would think that I would be judged more." (Marion, 37 years old; WOST).* *"[I was] just treated badly because you know, I was on methadone prescription, so… you know, it takes, it kind of makes you want not to engage with any of them." (Lily, 36 years old; WOST).* *"I think one barrier that you probably won't be able to overcome easily is the negative judgmental attitudes towards OST." (Olivia, 27 years old; CP; focus group).* *"When I came here [UK] it was a bit awkward. Because I couldn´t understand how the government can give to those people [OST clients] drugs [OST]." (Susan, 35 years old; CP; interview).*
Trust and humanity: building positive rapport and good communication	*"He'd [CP] sometimes ask if there are any problems, especially when I went through that stuff [intimate partner violence] when he [ex-*

	partner] beat me up and that, cause he [CP] was seeing me every day so he [CP] was obviously seeing things (...).” (Sylvia, 27 years old; WOST). *“I’m firm with them and I threaten them and I say […] I will ring up and cancel the script and you can go elsewhere and that” (Martha, 57 years old; CP; interview)*
Lack of privacy and time constraints: providing a space and time to share	*“It’s kind of quite embarrassing, you know, because you don’t really want people to know that you’ve been a drug addict you know”. (Lily, 36 years old; WOST).* *“(...) but you haven’t really got the time to sit in the consulting room with them and then you face a pile of prescriptions to come back to, that is unfortunately how it is” (Martha, 57 years old; CP; interview).*
Financial limitations: community pharmacy as a business	*“Even though we want to help them, we can’t offer them anything free unless we are commissioned by the commissioning body” (Peter, 25 years old; CP; interview).*