

# **MAPPING AVAILABILITY OF SEXUAL AND REPRODUCTIVE HEALTH PHARMACEUTICALS IN MELBOURNE'S NORTHERN METROPOLITAN REGION**

**OCTOBER 2022**



**WOMEN'S HEALTH  
IN THE NORTH**  
voice • choice • power

## ACKNOWLEDGEMENT

Women's Health In the North acknowledges Victorian Aboriginal people as the Traditional Owners of the land on which we provide our services – the Wurundjeri Woi Wurrung people of the Kulin nation – and pay our respects to their Elders past and present. We acknowledge the historical trauma and ongoing systemic injustice that continues today, particularly in relation to sexual and reproductive health. As First Peoples, Aboriginal Victorians are best placed to determine a culturally appropriate path to promoting sexual and reproductive health in their communities. WHIN acknowledges that Aboriginal sovereignty was never ceded and expresses hope for justice and reconciliation.

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## ACRONYMS

<b>COVID-19</b>	SARS-CoV-2 virus
<b>ECP</b>	Emergency contraceptive pills
<b>IUD</b>	Intrauterine device
<b>LARC</b>	Long-acting reversible contraceptive
<b>LGA</b>	Local government area
<b>LGBTQIA+</b>	Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual and other persons of diverse genders and sexualities
<b>MTOP</b>	Medical termination of pregnancy
<b>NMR</b>	Northern metropolitan region of Melbourne
<b>STI</b>	Sexually transmissible infection
<b>WHIN</b>	Women's Health In the North



## EXECUTIVE SUMMARY

Access to sexual and reproductive health services in primary care has been consistently highlighted as a priority in improving sexual and reproductive outcomes for women and gender diverse people in Victoria. Despite this, few studies have explored the accessibility of sexual and reproductive health care in a pharmacy setting. The scope of this project was to map the availability of sexual and reproductive health pharmaceuticals in the northern metropolitan region (NMR) of Melbourne, identifying gaps in service provision and reasons for those gaps.

The aims were:

- 1** To identify which areas in the NMR of Melbourne are under-serviced for sexual and reproductive health pharmaceuticals
- 2** To create a baseline for future work and discussion about accessibility to sexual and reproductive health pharmaceuticals in the NMR of Melbourne.

The findings of this project will be used to inform further work in the NMR to improve access to contraception, abortion, and products for the prevention of sexually transmissible infections (STIs).

Sexual and reproductive health pharmaceuticals cover a broad range of products. Within this survey, the questions pertained to the supply of dental dams, emergency contraceptive pills (ECP), the contraceptive implant, intrauterine devices (IUDs), the contraceptive injection, contraceptive pills, and medical termination of pregnancy (MTOP) medication.

198 pharmacies were contacted with 71 responding (35.8% response rate). Long-acting reversible contraception (LARC) such as IUDs, contraceptive implants, and contraceptive injections were available from most pharmacies (68% stocked IUDs; 82% stocked contraceptive implants; 75% stocked contraceptive injections). Almost all respondents stated that their pharmacy stocked ECP (99%). However, of those who stocked ECP, 67% stated that they had restrictions on purchasing the product (n=48). Only 14% of respondents said their pharmacy stocked MTOP medication. Reasons for not supplying MTOP medication included a lack of perceived demand, a lack of staff training, and conscientious objection. One pharmacy reported that they stocked dental dams. Of the pharmacies who responded to the survey, the large majority had a private space to discuss pharmaceutical options (83%).

The results of this survey provide quantitative data about service provision gaps across the NMR in relation to sexual and reproductive health pharmaceuticals. There is a need for future work to expand on this project to generate a larger and more representative sample of pharmacies. In addition, future work ought to explore other factors in accessing sexual and reproductive pharmaceuticals such as cost, and distance needed to travel.

The reproductive rights of women and gender diverse people in the NMR are not only impacted by the limited number of clinics providing sexual and reproductive health services, but also by the lack of availability of sexual and reproductive health pharmaceuticals across the region.

## ABOUT WOMEN'S HEALTH IN THE NORTH

As the regional women's health promotion and advocacy organisation for the northern metropolitan region of Melbourne (NMR), Women's Health In the North (WHIN) seeks to eliminate gender inequalities and improve the health, safety and wellbeing of women and gender diverse people.

WHIN's vision is that women and gender diverse people in the north have voice, choice and power in all aspects of their health, safety and wellbeing.

The principles that form the basis of WHIN's work include: human rights and social justice, feminism, collaborative leadership, intersectionality, inclusivity, and environment and place.

WHIN has prioritised sexual and reproductive health since its establishment in 1992 and acknowledges that sexual and reproductive health is a broad and holistic area of health that has a defining impact on women and gender diverse people throughout their lives.



**FREEDOM,  
RESPECT  
& EQUITY**

**IN SEXUAL HEALTH**

**2022-2026**

For more information about how  
WHIN promotes sexual and  
reproductive health, see our  
regional strategy  
***Freedom, Respect and Equity in  
Sexual Health 2022-2026.***

## BACKGROUND

### ABOUT THE NMR

**The NMR includes the local government areas (LGAs) of Banyule, Darebin, Hume, Merri-bek, Nillumbik, Whittlesea and Yarra.** These LGAs include a vast range of median incomes and population densities. The median weekly income of Hume is \$529 with a population density of 5.3 persons per square kilometre, in stark contrast to Yarra where median weekly income is \$1039 and the population density is 5038.8 persons per square kilometre (WHIN, 2021a; Australian Bureau of Statistics, 2020).

The percentage of the female population aged between 15–50 across each LGA in the NMR ranges from 43.6% in the comparatively older population of Nillumbik to 63.1% in the comparatively younger population of Yarra (Australian Bureau of Statistics, 2020). These demographic characteristics across the NMR are important to note as potential factors that influence the accessibility of sexual and reproductive health services.

### CONTEXT

The Victorian Department of Health and Human Services highlighted the importance of access to sexual and reproductive health services through the inclusion of ‘access to contemporary, safe, and equitable fertility control services’ as an action area in Women’s Sexual and Reproductive Health: Key Priorities 2017–2020 (2017). In particular, the strategy prioritised increasing women’s knowledge of contraception and access to long-acting reversible contraceptives (LARCs) and medical termination of pregnancy (MTOP) in primary care (Victorian Department of Health, 2017). In a 2019 review of Victorian Sexual Health and Service Needs, the Victorian Department of Health outlined ‘availability, accessibility and quality of health services’ as one of four indirect drivers that increase the risk of sexually transmissible infections (STIs). These drivers need to be addressed in order to actualise the Victorian Department of Health’s vision of high quality and inclusive sexual and reproductive health care (2019).

Despite the emphasis on sexual and reproductive health accessibility by the State Government, many Victorians still have difficulty accessing services. The COVID-19 pandemic has changed people’s family planning needs and desires, making access to the appropriate pharmaceuticals even more pressing (Marie Stopes Australia, 2021). Recent reports have indicated that contraceptive and STI prevention products have been less accessible, highlighting shortages of contraception and emergency contraception, condoms, gloves and dental dams (Marie Stopes Australia, 2021). Surveys over the lockdown period in Australia found that even though people were having slightly less sex compared to pre-pandemic levels, sexual and reproductive health service access is increasingly important as rates of casual sex have increased following lockdowns (Coombe et al., 2021). In the NMR, the LGAs Yarra, Merri-bek, and Darebin are reported to have persistently higher rates of STIs compared to the state average rate (Victoria Department of Health, 2019).

Though the need for sexual and reproductive health care and intervention has been highlighted, few studies have explored the accessibility of sexual and reproductive health care in a pharmacy setting. In 2015, researchers conducted a mystery caller study in Victoria which involved researchers posing as a woman in need of emergency contraceptive pills (ECP) in varying scenarios (Hussainy, Stewart & Pham, 2015). This study highlighted the discrepancies between pharmacies and revealed differing advice based on age and various eligibility criteria, including advanced use and purchase by the intended user (Hussainy, Stewart & Pham, 2015).

Further inconsistencies between pharmacies arise since suppliers are given power in choosing what to stock in their stores. The Pharmaceutical Society of Australia notes in their practice guidelines that pharmacists have the right to decline to supply medicines if they believe it is 'unsafe or inappropriate, even if the prescriber is not in agreement' (Pharmaceutical Society of Australia, 2019). This right also extends to allow pharmacists to act as conscientious objectors, meaning they are able to decline to provide pharmaceuticals to patients based on moral grounds. Conscientious objection is a controversial subject most often discussed in the literature in relation to the rights of medical practitioners to uphold their 'moral integrity' (Magelssen, 2012). Persons seeking sexual and reproductive health pharmaceuticals may face pharmacists who are conscientious objectors, denying sale of certain products, particularly MTOP medication.

This may be especially harmful for persons in regional areas who do not have easy access to alternate pharmacists.

A literature review of pharmacy provision of sexual and reproductive health commodities found that there has been very little documentation multi-nationally around pharmacy distribution of sexual and reproductive health products for adolescents (Gosalves and Hindin, 2017). Despite the lack of clear provisions and guidelines amongst pharmacists, the literature reveals that young people prefer to attend pharmacies for sexual and reproductive health supplies due to ease and anonymity (Gosalves and Hindin, 2017). However, the ease in acquiring these products may be at the cost of appropriate care. A national survey on attitudes and perceptions of pharmacists on emergency contraception found that only 54% believed that it was the pharmacist's role to counsel on STIs (Hussainy et al., 2011). The lack of clear pharmacy provisions and mixed messaging within the pharmacy system in relation to sexual and reproductive health pharmaceuticals may act as a deterrent for people accessing services, especially for those who are already reluctant to seek care.



There are certain population groups who may have additional difficulties in accessing sexual and reproductive health pharmaceuticals and care. LGBTQIA+ persons can find accessing sexual and reproductive health services more daunting unless explicitly made welcome by care providers (Sturgiss et al., 2022). Persons from migrant communities may also experience additional barriers to receiving sexual and reproductive health care due to limited English literacy, despite migrant women expressing they would like increased access to sexual and reproductive health information (Hawkey, Usher & Perz, 2021). Women and gender diverse people in regional areas also have reduced access to sexual and reproductive health pharmaceuticals via pharmacies based on pharmacy trading hours (Downing et al., 2011). These additional barriers, combined with an inconsistent application of pharmacy guidelines across pharmacies reveal the difficulties in accessing sexual and reproductive health pharmaceuticals from primary providers.

## AIMS

This project intended to map the availability of sexual and reproductive health pharmaceuticals in the northern metropolitan region of Melbourne, identifying gaps in service provision and reasons for those gaps.

The aims were:

- 1** To identify which areas in the NMR of Melbourne are under-serviced for sexual and reproductive health pharmaceuticals
- 2** To create a baseline for future work and discussion about accessibility to sexual and reproductive health pharmaceuticals in the NMR of Melbourne.

This report hopes to fill current gaps in the literature around sexual and reproductive health pharmaceutical provision in the pharmacy setting. Whilst previous reports have highlighted the inconsistencies in accessing certain sexual and reproductive health pharmaceuticals such as emergency contraceptive pills, this project seeks to reveal restrictions across a broader range of sexual and reproductive health products including LARCs, dental dams and MTOP medication (Hussainy, Stewart & Pham, 2015).

The aims were achieved through a quantitative report collating the survey responses provided by pharmacies across the NMR. In addition to noting whether pharmacies across the NMR stock certain sexual and reproductive health pharmaceuticals, the survey yields data on restrictions around accessing each sexual and reproductive health pharmaceutical and reasons why pharmacies do not stock each product. These additional questions were intended to create a foundational dataset that can be used in future discussions and research exploring the barriers and enablers to accessing sexual and reproductive health care.

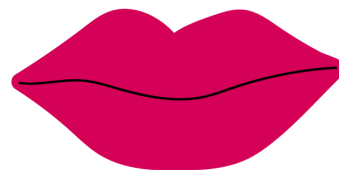
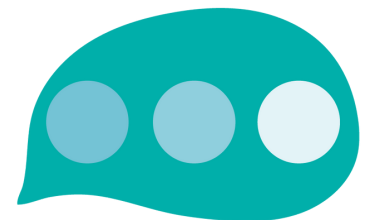


## METHOD

A quantitative survey was developed using the Survey Monkey platform. The survey format and content was modelled from a similar survey conducted by Gippsland Women's Health (2018). The survey consisted of 31 questions. Not all 31 questions needed to be answered depending on the respondent's previous answers. The results from the Gippsland survey informed which answers were included in the multiple-choice answers.

All pharmacies located within the NMR were eligible to participate in the project. Any pharmacies outside of the NMR were excluded from the study as they are outside the scope of WHIN's catchment. A database of NMR pharmacies was developed resulting in 198 pharmacies being contacted to participate in the survey. The initial contact was made by telephone to all pharmacies. Results were collected either over the phone or via a link to the online survey. Pharmacies that did not provide a response were followed up by email.

In order to aid in recruitment and increase legitimacy, WHIN sought approval from the Victorian branch of the Pharmacy Guild of Australia. The Guild approved the research (approval no. 897) and advertised the research via a brief flyer and survey link in their member's newsletter.



**Figure 1. Pharmacy sample.**

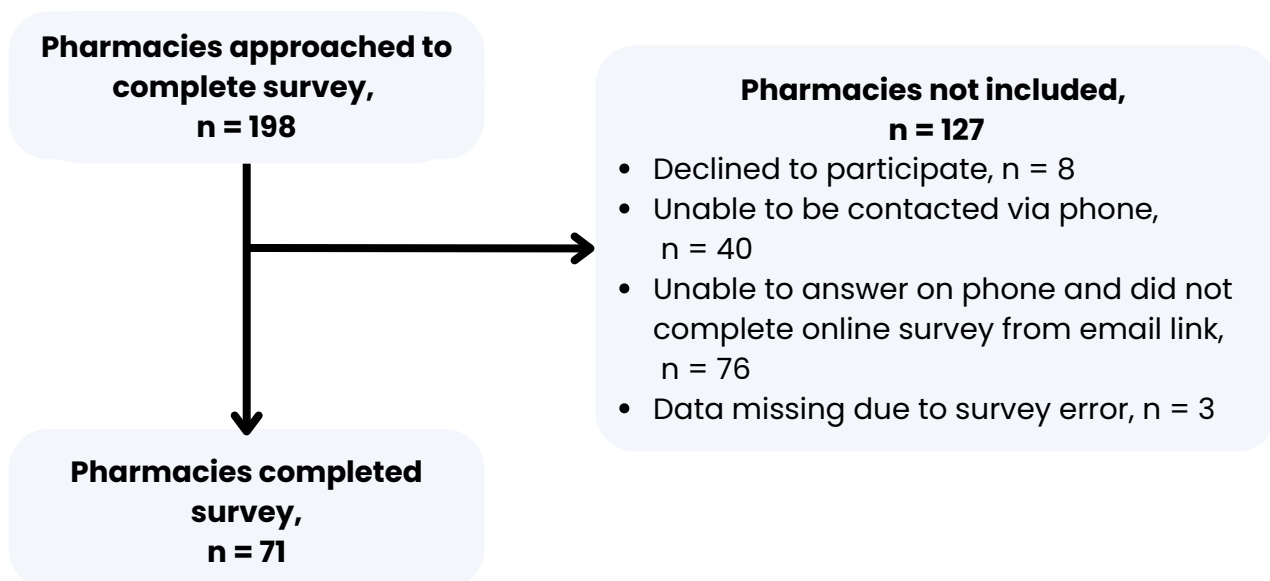


Figure 1 summarises the final sample included in the study (n=71). Of those who declined to complete the survey on the phone, a majority reasoned they were too busy to answer the questions (n=76). These respondents did not respond to the subsequent email sent to their pharmacy contacting the survey link.

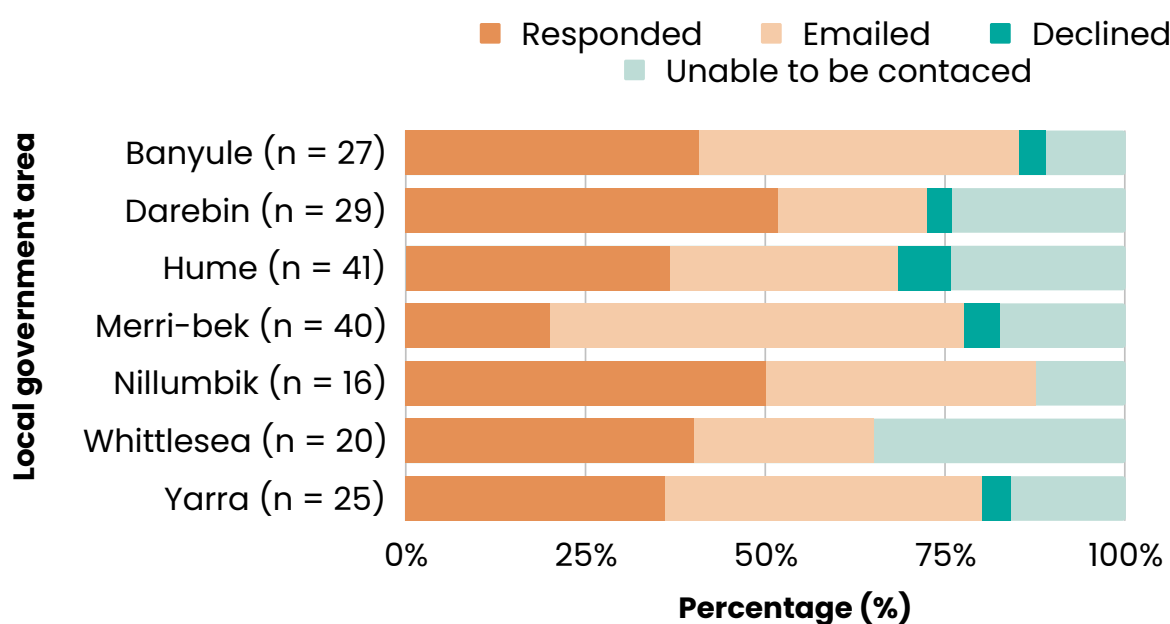
## FINDINGS

### RESULTS FOR THE NMR

#### PARTICIPATION

The response rate of pharmacies from the total sample (n=198) was 35.8% (n=71). Figure 3 outlines the response rate per LGA in the NMR. Response rates ranged from 52% in Darebin to 20% in Merri-bek. The data from three pharmacies were missing due to a technical error with Survey Monkey where the responses were either deleted or not saved. 2 of these pharmacies were located in Moreland and 1 was located in Banyule. Of the pharmacies who declined to answer the survey over the phone (n=76) the majority stated that they were too busy with some explaining that they were held up with conducting vaccinations or were short staffed due to illnesses. A minority of those who would not complete the survey over the phone declined as the person best equipped to respond was unavailable (n=9).

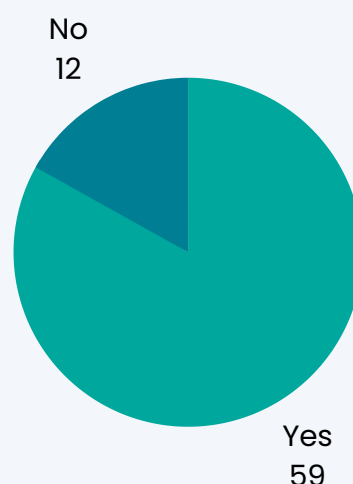
**Figure 2. Pharmacy survey response rates in the NMR.**



#### PRIVACY WITHIN THE PHARMACY FOR CONSULTATION

Of the pharmacies who responded to the survey, the large majority had a private space to discuss pharmaceutical options (83%).

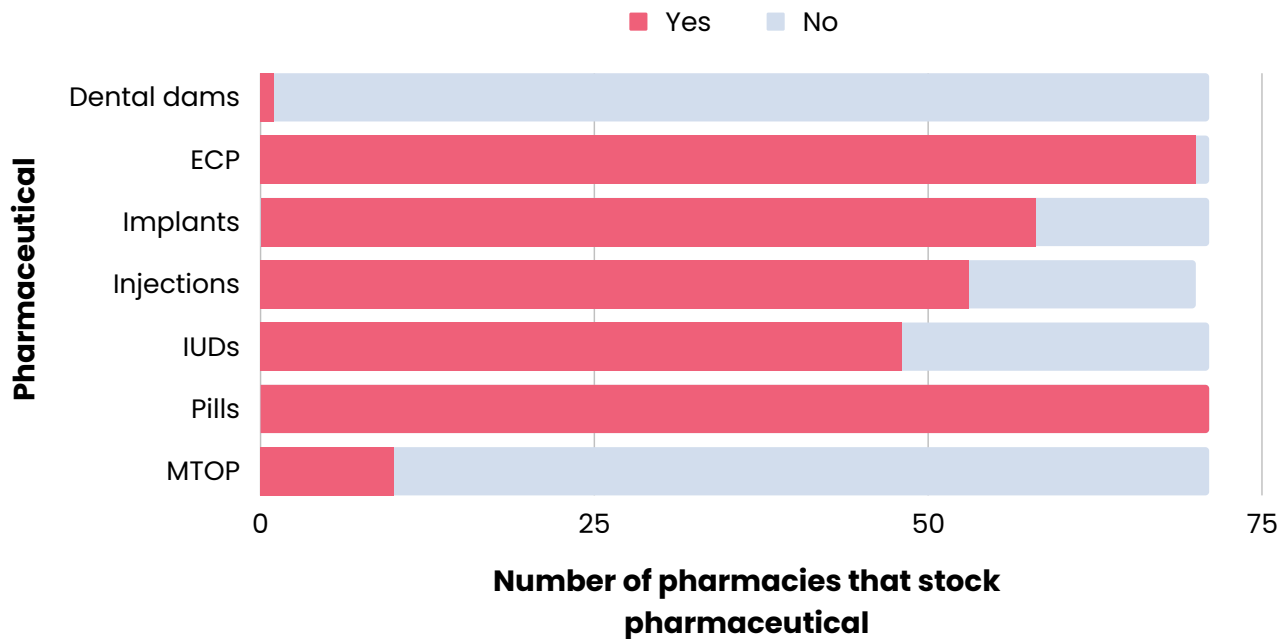
**Figure 3. Number of pharmacies in the NMR who had a private space to discuss pharmacy options.**



## SEXUAL AND REPRODUCTIVE HEALTH PHARMACEUTICALS STOCKED BY NMR PARTICIPATION

Figure 4 provides an overview of the sexual and reproductive health pharmaceuticals available in the NMR as reported by survey respondents. The numerical values for each of these are outlined in Table 1. These data will be explored in further detail by product category.

**Figure 4. Sexual and reproductive health pharmaceuticals stocked by pharmacy respondents in the NMR.**



**Table 1. Sexual and reproductive health pharmaceuticals stocked by pharmacy respondents in the NMR.**

Pharmaceutical	Stocked	Not stocked
Dental dams	1	70
ECP	70	1
Implants	58	13
Injections	53	17
IUDs	48	23
Pills	71	0
MTOP	10	61

## DENTAL DAMS

Only one pharmacy in the NMR reported that they stocked dental dams (n=1). The single respondent who did report that their pharmacy stocked dental dams seemed slightly unsure of their answer. The primary reason respondents gave was due to no perceived demand for the product (n=21). Other reasons included only having a small pharmacy, respondent unsure or pharmacist unfamiliar with products stocked on the pharmacy floor, or a belief that their customer base do not require the product with one respondent stating that 'they don't serve that clientele'. A significant number of respondents stated that they had never heard of dental dams or were unfamiliar with the product (n=37).



## CONTRACEPTIVE PILLS

All pharmacies that completed the survey stated that they stocked contraceptive pills (n=71). Other than requiring a prescription, only 6 pharmacies had additional restrictions to purchasing contraceptive pills. Restrictions included: sale only allowed after consultation with patient (n=4), sale only allowed after considering patients' medical conditions (n=3), and considerations based on time from last intercourse (n=1).

## LONG-ACTING REVERSIBLE CONTRACEPTIVES

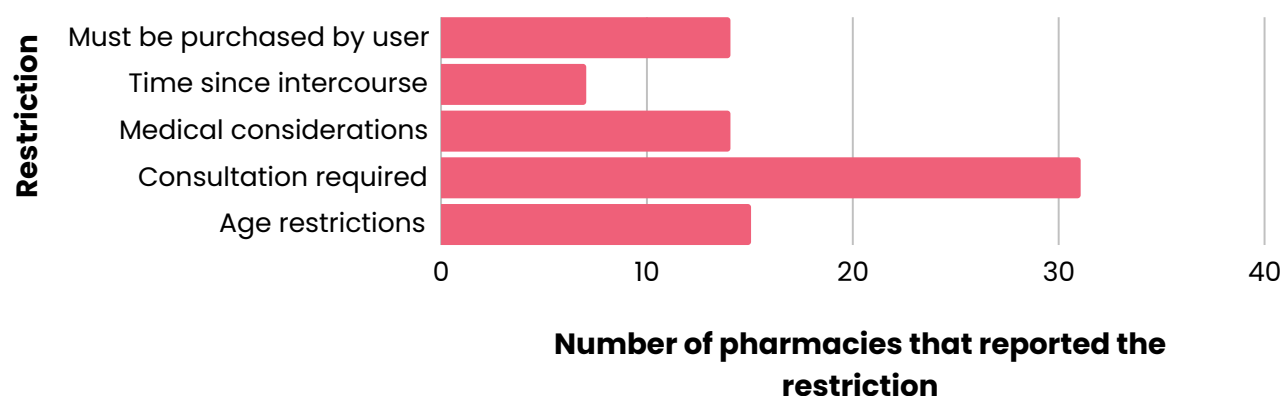
Pharmacies were asked about three different long-acting reversible contraceptives (LARCs): contraceptive injections (i.e. Depo-Provera), contraceptive implants (i.e. Implanon), and intrauterine devices (IUDs). 75% of pharmacies who responded stocked contraceptive injections (n=53), 82% stocked contraceptive implants (n=58) and 68% stocked IUDs (n=48). Of those who stocked LARCs, no pharmacies reported having additional restrictions in purchasing the product beyond requiring a prescription. Of those who stocked IUDs, the majority of pharmacies stocked Mirena (n=44), followed by Kyleena (n=10), and copper IUDs (n=8). Some pharmacies stocked more than one type of IUD. Of those who did not stock one or more of the LARCs listed, the most common reason was a perceived lack of demand for the product. Multiple pharmacists stated a short expiry window and low turnover as a reason for not stocking the Mirena IUD. The shelf life for Mirena, the amount of time the product can remain unopened prior to insertion, is 3 years from manufacture date (Health Direct, n.d).

## EMERGENCY CONTRACEPTIVE PILLS

Almost all respondents stated that their pharmacy stocked emergency contraceptive pills (ECP) (n=70, 99%). Of those who stocked ECP, 67% stated that they had restrictions on purchasing the product (n=48). Restrictions are displayed in Figure 5 below. Categories of restrictions are not mutually exclusive with some pharmacies noting multiple restrictions.



**Figure 5. Restrictions in accessing ECP.**



The most common restriction was that pharmacists required a consultation with the person purchasing ECP (n=31). There were inconsistencies across the pharmacies who responded on whether ECP could only be purchased by the person who intends to use it. 14 pharmacies stated the product must be purchased by the end user, though other pharmacists commented verbally that someone could purchase the product on behalf of the user, with one pharmacist noting that there is no requirement of discussion 'if the guy comes in'.

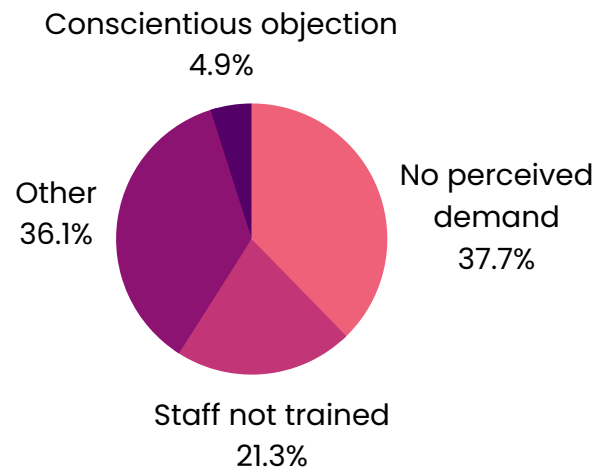
Pharmacies were also inconsistent with their age requirements; however, an exact age cut-off was not asked of participants. Of those who reported any type of age restriction or additional consideration, some respondents noted additional considerations for those under 16 wanting ECP to determine if sexual assault was a factor (n=2). Other respondents noted that they refer persons under 16 to a general practitioner for a referral prior to allowing sale (n=2). One pharmacy reported requiring parental approval prior to sale to a person under 16. Several respondents who noted that their pharmacy does place restrictions on accessing ECP were vague in their responses with comments such as: 'follow[ing] schedule 3 requirements,' having 'lots of requirements' and completing a written form.

## MEDICAL TERMINATION OF PREGNANCY

Only 14% of respondents said their pharmacy stocked medical termination of pregnancy medication (n= 10). Figure 6 shows the varying reasons why MTOP medication was not stocked in their pharmacy.

The most common reason for not stocking MTOP medication according to respondents was lack of perceived demand (n=23), followed by a lack of staff training (n=13), with three respondents stating that they are conscientious objectors. Other (n= 22) reasons included: respondent unsure why product not stocked (n=3), pharmacist refers clients to nearby providers who stock the product (n=3), low number of prescribing doctors in the area (n=2), or perceptions by the respondent that those decide the product orders do not support the product (n=2).

**Figure 6. Pharmacy respondents in the NMR: reasons for not stocking MTOP medication.**

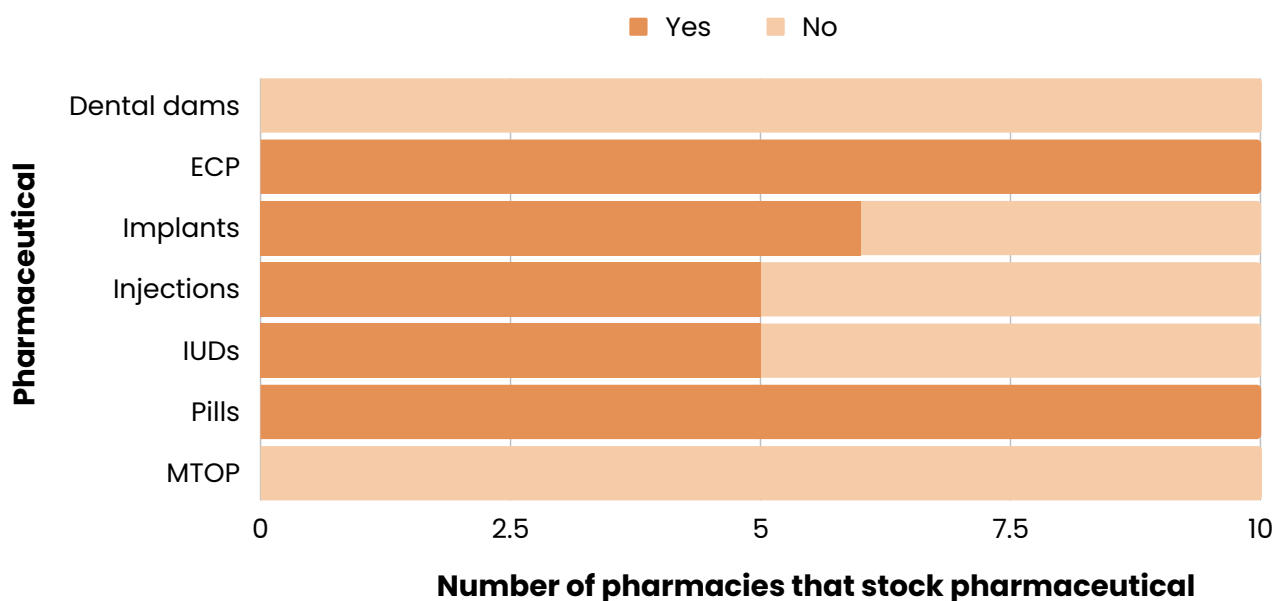


## RESULTS BY LOCAL GOVERNMENT AREA

### BANYULE

The response rate for Banyule was 41% (n=10). No pharmacies stocked MTOP medication or dental dams. All pharmacies stocked contraceptive pills and emergency contraceptive pills. Only half of pharmacies stocked contraceptive injections and IUDs, with slightly more than half stocking contraceptive implants.

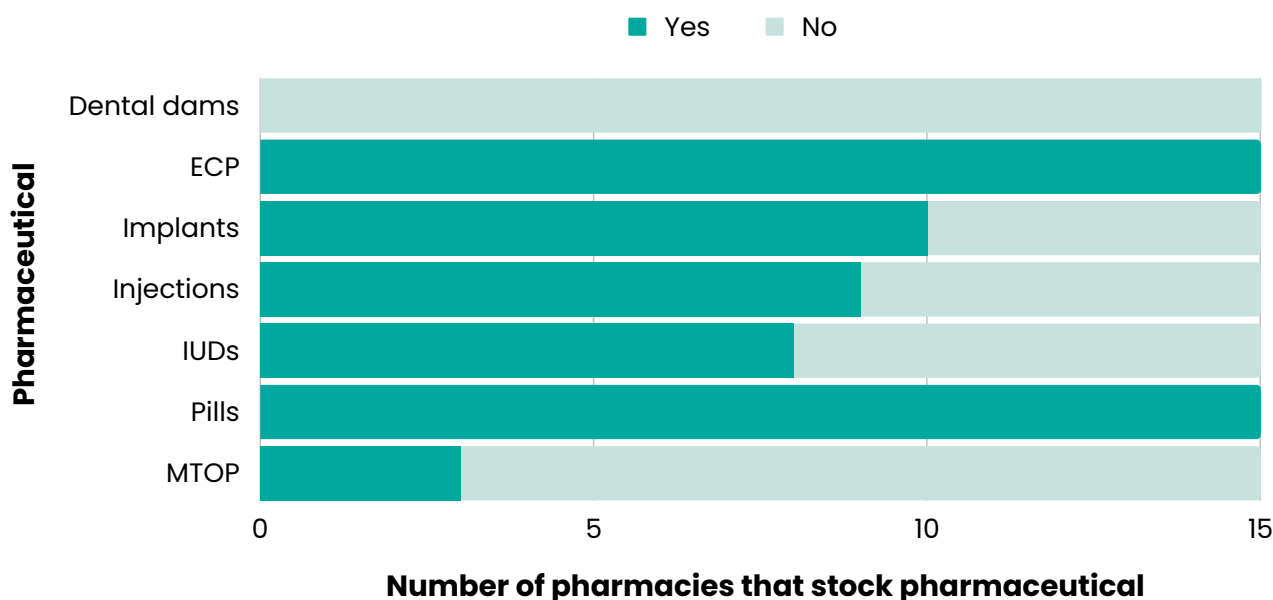
**Figure 7. Sexual and reproductive health pharmaceuticals stocked by pharmacy respondents in the City of Banyule.**



## DAREBIN

The response rate for Darebin was 52% (n=15). No pharmacies stocked dental dams. All pharmacies stocked contraceptive pills and ECP. A large majority of pharmacies stocked contraceptive implants, with a smaller majority stocking contraceptive injections and IUDs. Only 20% of pharmacies in Darebin stocked MTOP medication.

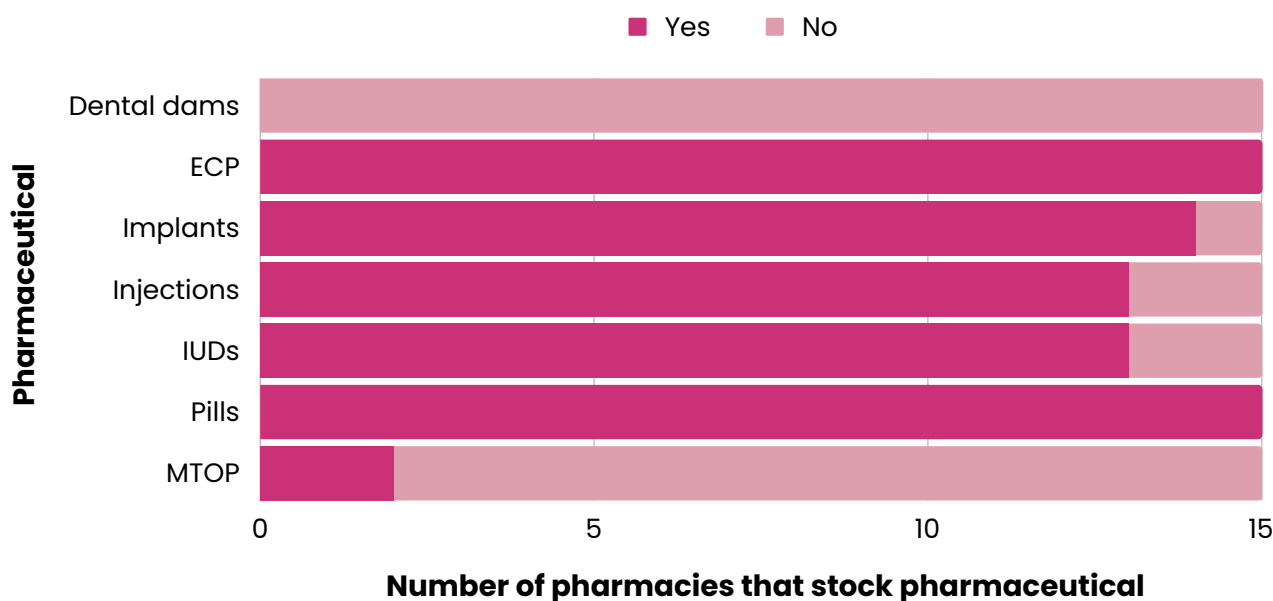
**Figure 8. Sexual and reproductive health pharmaceuticals stocked by pharmacy respondents in the City of Darebin.**



## HUME

The response rate for Hume was 37% (n= 41). All pharmacies stocked contraceptive pills and ECP, but no pharmacies stocked dental dams. Of respondents, only two stated they stocked MTOP medication.

**Figure 9. Sexual and reproductive health pharmaceuticals stocked by pharmacy respondents in the City of Hume.**

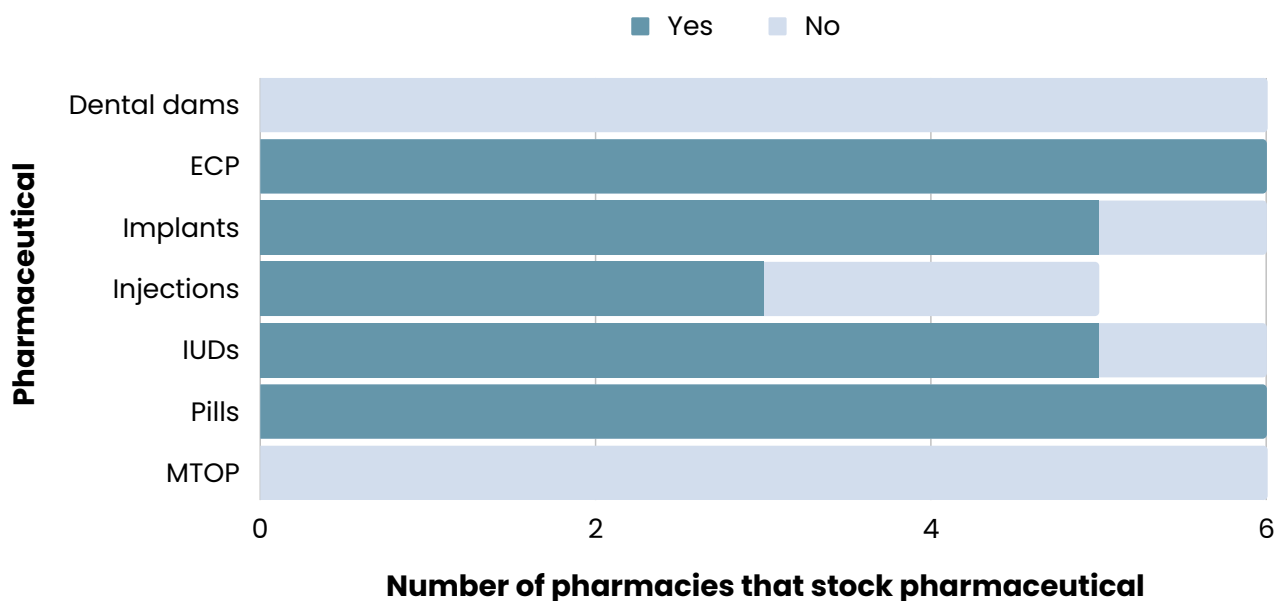




### MERRI-BEK

The response rate for Merri-bek was 20% (n=6). No responding pharmacies stocked MTOP medication or dental dams. All pharmacies stocked contraceptive pills and ECP. A large majority of pharmacies stocked contraceptive implants and IUDs and a small majority stocked contraceptive injections. One pharmacy did not report on contraceptive injections.

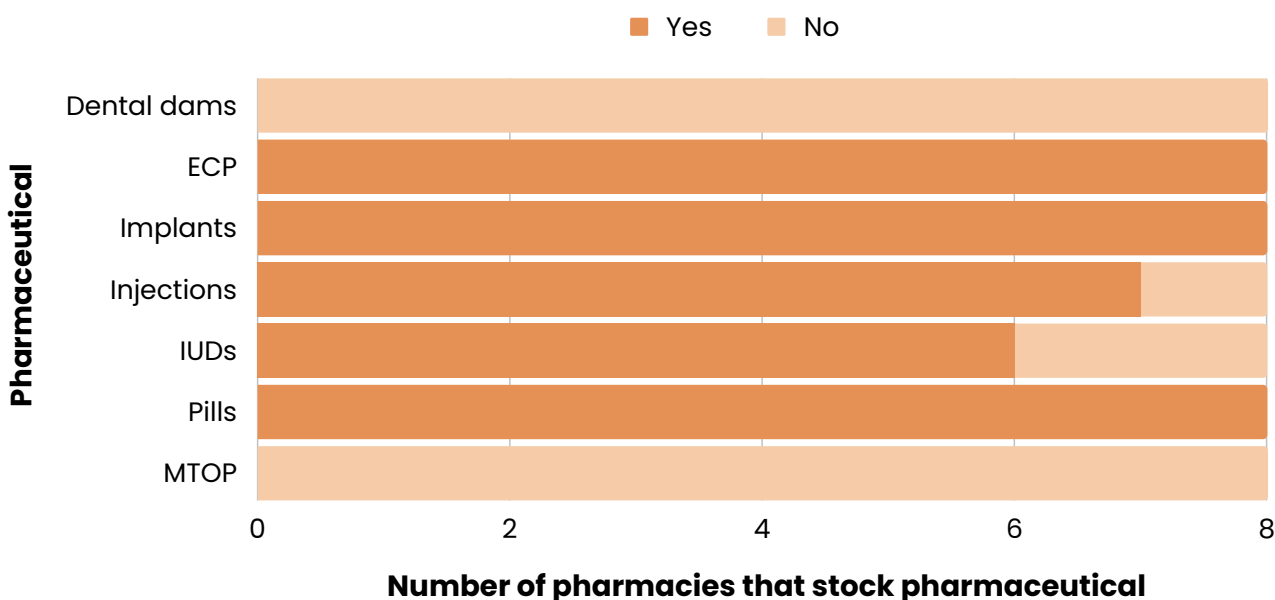
**Figure 10. Sexual and reproductive health pharmaceuticals stocked by pharmacy respondents in the City of Merri-bek.**



### NILLUMBIK

The response rate for Nillumbik was 50% (n=8). No respondents said they stocked MTOP medication or dental dams. However, all pharmacies stocked ECP, implants and contraceptive pills. A majority of pharmacies stocked contraceptive injections and IUDs.

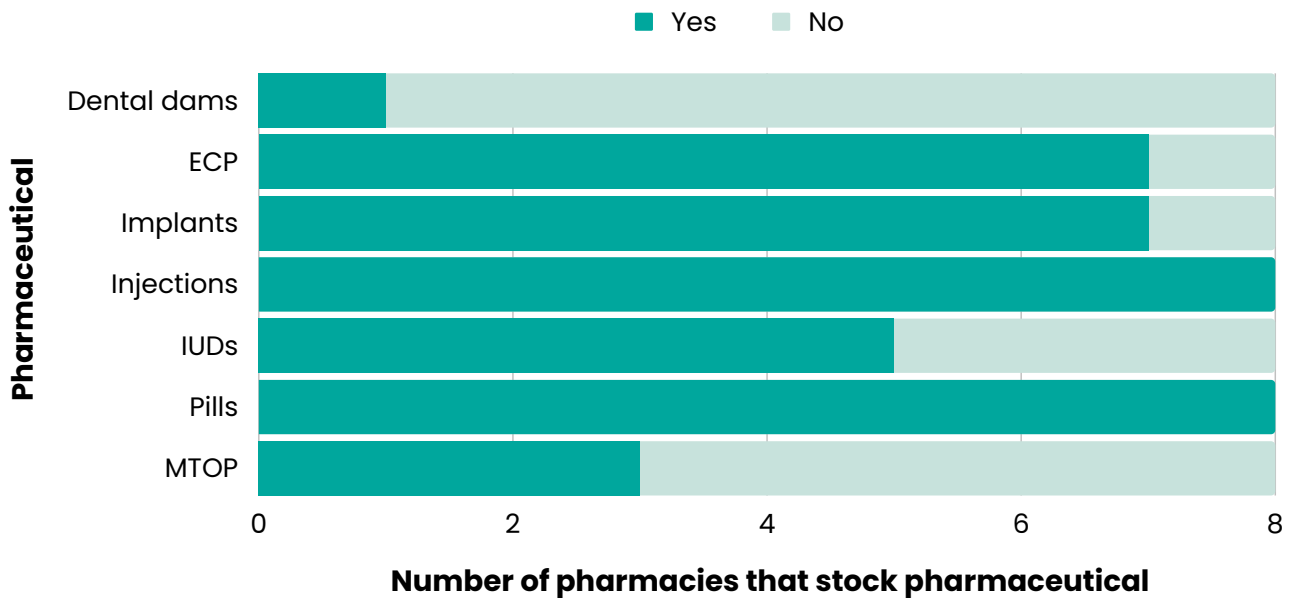
**Figure 11. Sexual and reproductive health pharmaceuticals stocked by pharmacy respondents in the City of Nillumbik.**



## WHITTLESEA

The response rate for Whittlesea was 40% (n=8). A majority of pharmacies stocked LARCs, but less than half stocked MTOP medication. All but one pharmacy stocked ECP and only one pharmacy stocked dental dams.

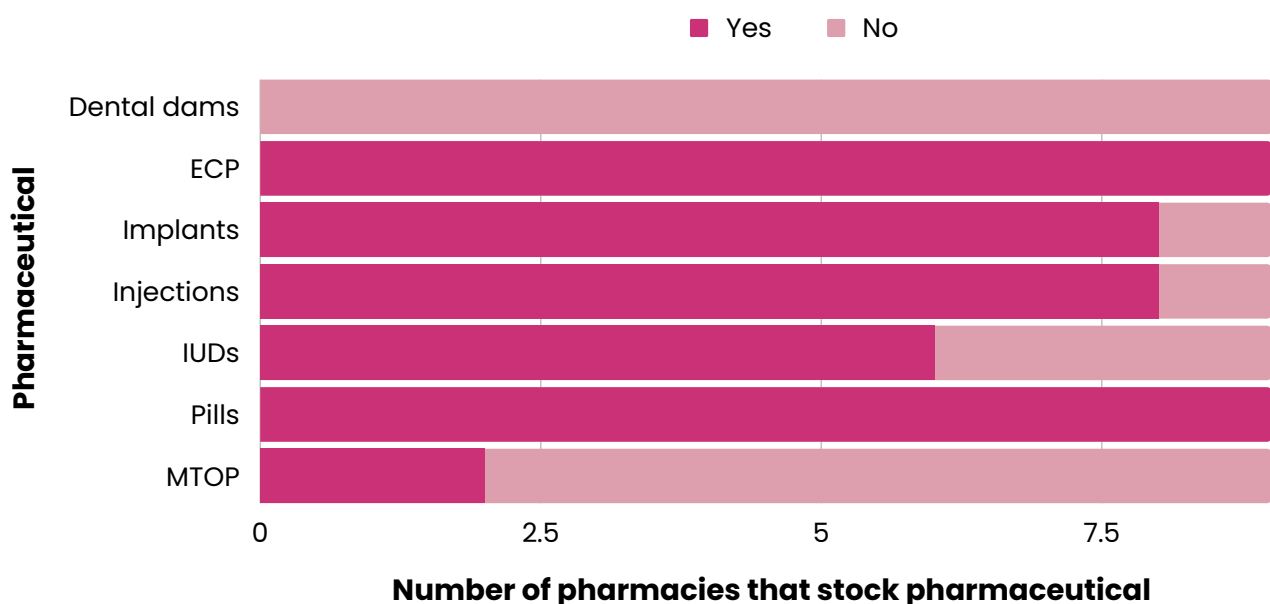
**Figure 12. Sexual and reproductive health pharmaceuticals stocked by pharmacy respondents in the City of Whittlesea.**



## YARRA

The response rate for Yarra was 36% (n=9). No pharmacies stocked dental dams. All pharmacies stocked contraceptive pills and ECP. A large majority of pharmacies stocked contraceptive implants, injections, and IUDs. Less than a third of pharmacies stocked MTOP medication.

**Figure 13. Sexual and reproductive health pharmaceuticals stocked by pharmacy respondents in the City of Yarra.**



## DISCUSSION

There were several limitations in conducting this project. The most notable challenge was recruiting a sufficient number of pharmacies to participate in the survey. Though the majority of pharmacies within the NMR were able to be contacted, roughly a third went on to complete the survey. Pharmacies' reasons for not completing were often reported as being short-staffed, busy conducting vaccinations or otherwise occupied with clients. Since the majority of pharmacies were contacted between June and July 2022, these difficulties were enhanced with the onset of the flu season and the rising COVID-19 case numbers causing staff shortages across Victoria.

Two key strategies were implemented to address these challenges. First, the original script when conducting phone calls was truncated and slightly rephrased to emphasise the survey's brevity, and to make the initial invitation sound more conversational. This included always trying to use the respondent's name when possible. Additionally, framing of the project was reworded as a project mapping the products stocked by pharmacists across the NMR as mentioning sexual and reproductive health pharmaceuticals at the beginning of the conversation seemed to deter some potential respondents. The perceived lack of interest from pharmacists following the mention of sexual and reproductive health further demonstrates the need to highlight its importance in the pharmacy sector. Second, WHIN approached the Victorian branch of the Pharmacy Guild of Australia to increase exposure of the study. After receiving approval from The Guild, the project and survey link was advertised in their internal newsletter. Though there was no method of confirming if this increased response numbers, it is likely to have increased credibility of the project which may have persuaded more pharmacies to respond.

Though the response rate for the survey was relatively low, the data we were able to extract is a valuable start in being able to explore the accessibility of sexual and reproductive health pharmaceuticals in the NMR of Melbourne. The LGAs within the NMR vary significantly in population density. It was predicted that inner city LGAs with a high population density may have a lower response rate compared to those in the outer regions. It was presumed that a higher population density would equate to busier pharmacies in that area. However, response rates were not found to have a strong correlation with population density, with both Hume and Yarra having response rates of 36%. Merri-bek was a notable outlier with only a 20% response rate, due in part to two surveys being lost due to technical errors. It is possible that the availability of sexual and reproductive health pharmaceuticals may be underrepresented given the lack of data in densely populated Merri-bek which may be more likely to stock a wide range of products.

No data was collected on the size of the pharmacies interviewed. It may be the case that smaller pharmacies who were less busy were more likely to answer the phone yet less likely to have certain products in stock compared to their larger counterparts. Despite these limitations, the results of this study provide a valuable overview of the SRH products stocked within each LGA in the NMR.

Of those who did respond, there were several notable trends in the data collected. All but one pharmacy stocked ECP. While this result is encouraging, the varying responses from pharmacists on restrictions to access ECP may be cause of concern. Since the surveys were conducted verbally and the listed responses were not read aloud, it is possible that some respondents misinterpreted the question or did not provide comprehensive answers due to time pressures in their venue. Pharmacists' responses varied between respondents with some referring vaguely to pharmacy guidelines and others contradicting previous respondents, citing age restrictions and whether sale can only be made to the intended user. Discrepancies between pharmacies restrictions on ECP access are consistent with other Victorian studies (Hussainy, Stewart & Pham, 2015). These findings are also consistent with a national study that showed that though pharmacists followed a written protocol when dispensing ECP, 13 different protocols were identified (Hussainy et al., 2011). There were very few restrictions placed on prescription sexual and reproductive health medications. This may be because the pharmacist assumes the prescribing doctor has completed the appropriate assessment and upheld their duty of care, absolving the pharmacist of any additional checks.

The almost complete absence of dental dams in pharmacies is discouraging. This may be explained in part by the lack of emphasis placed on safer sexual practices between women who have sex with women and other persons engaging in anal or vaginal oral sex due to the misconception that these practices are low risk of STI transmission (ASHRA, 2021).

Other pharmacies reported that they have ageing populations who do not require sexual and reproductive health pharmaceuticals. This assumption is arguably tied to ageist notions that older adults are not sexual beings and ignores the increasing rates of STIs amongst older persons (Bourchier et al., 2020). This assessment may also be biased given that older persons may attend pharmacies more frequently to access other medications and care, artificially influencing pharmacists' perception of the area's demographic profile. There was also a low number of pharmacies who reported that they stocked MTOP medication. Whilst most claimed this was due to lack of training and low demand, there were several pharmacies who noted that they or their pharmacy decision makers were conscientious objectors. Interestingly, there was a brief period during the project following the overturning of Roe v Wade in the United States where respondents seemed more eager to explain that they were not opposed to stocking the medication. The lack of products reported by many pharmacies highlights the need for a greater emphasis in the health sector on the importance of sexual and reproductive health as an area integral to overall health and wellbeing.



## CONCLUSION

This project highlights the need for improved access to sexual and reproductive health pharmaceuticals in the NMR. Whilst some products, such as emergency contraceptive pills, were widely available, the availability of other products was severely lacking, such as dental dams.

In acquiring this knowledge, WHIN will be able to better understand the barriers women and gender diverse people face when looking to acquire sexual and reproductive health pharmaceuticals in the NMR. Whilst this project sought to map the availability of sexual and reproductive health pharmaceuticals across the NMR, there is a need for future work to expand on this project to generate a larger and more representative sample of pharmacies. In addition, future work ought to explore other factors in accessing sexual and reproductive pharmaceuticals such as cost and distance needed to travel. A qualitative study exploring pharmacists' attitudes towards SRH pharmaceuticals and reasons for stocking products would enhance the findings of this study. Whilst the quantitative survey outlined some reasons why products were or were not stocked, a comprehensive explanation from pharmacists was beyond the scope of the study.

As the COVID-19 pandemic continues, Victorians are being asked to seek care from primary providers to ease pressures on hospitals. As a result, accessibility and care from pharmacies and pharmacists is increasingly important.

For some women and gender diverse persons, acquiring sexual and reproductive health pharmaceuticals may be a daunting task. For those who may already be hesitant or uncomfortable purchasing sexual and reproductive health pharmaceuticals, any additional hurdles such as having to go to multiple pharmacies to try to locate their desired product or waiting until the next day may be a harmful deterrent. More work ought to be done in order to ensure that persons are able to acquire adequate care and resources from their local pharmacy.

## RECOMMENDATIONS

Recommendations for future work to promote sexual and reproductive health pharmaceutical access include:

- Training pharmacists to build their capacity and confidence in discussing sexual and reproductive health with clients, and providing appropriate, timely care to persons seeking support
- Improving consistency and transparency of pharmacy guidelines on sexual and reproductive health service provision
- Establishing clearer referral pathways for pharmacists to refer clients to another provider if they are unable to provide adequate care.

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