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COMMUNITY PHARMACISTS' EXPERIENCES OF PROMOTING THE HEALTH OF YOUNG PEOPLE

Background and hypothesis

'Traditionally', community pharmacists (CP) formulated and dispensed medicines to the public. In "making every contact count" numerous practice frameworks expect CP to go beyond dispensing of medicines and be involved in health promotion and wellbeing of their customers including young people (YP). With presence in places such as the high street, supermarkets/shopping malls and annexed to GP surgeries, CP are key partners in the promotion of health and wellbeing and consequently, ideal for health promotion initiatives aimed at YP, especially those to which the pharmacy may be their only contact with the health system. This requires a 'paradigm shift' of pharmacy into 'youth-friendly' practice.

This study explores the experiences of Suffolk and Cambridgeshire-based CP in promoting the health and wellbeing of YP they have encountered in practice. This is particularly important as pharmacy practices are gradually aligning with public health principles which include a 'population-based' "collective responsibility for health, its protection and disease prevention".

The term 'young people' is a social construct with various definitions depending on geographical and historical settings. As an example, the World Health Organisation defines YP differently to the United Nations (UN). The term is also used synonymously with adolescence. YP (10-24 years old) represent 19% of the UK population compared to 12% for those 70 years old and over.

Health is a fundamental human right, the exercise of which is influenced by the interplay of various factors as indicated in the Dahlgren and Whitehead model of health, such as gender, age, education, housing and food. Health promotion is therefore any process that helps to give people control over the determinants of their health and means to improve it, while 'wellbeing' is a term used broadly to indicate "what makes a good life". Health promotion reduces health inequalities at three preventative levels: primary, secondary and tertiary. In community pharmacy, this manifests in services such as seasonal influenza vaccination, chlamydia screening programmes and medicines use review (MUR) for chronic conditions such as asthma, respectively. Reducing health inequalities has been brought to community pharmacies' forefront activities through the nation-wide adoption of Health Living Pharmacy (HLP) concept and the quality payment system that it represents.

The study was conducted in Cambridgeshire and Suffolk counties that share a border in the East Anglia region of England. The two counties have different demographic and socio-economic challenges. Cambridgeshire has an estimated population of 651,900 compared to 745,300 in Suffolk. YP make up the 19% of the population of Cambridgeshire and 17% of Suffolk. Cambridgeshire is a prosperous county in comparison to Suffolk. Unemployment rate, as an example, is higher in Suffolk than Cambridgeshire 20% and 19%, respectively, making Suffolk a more deprived area in relation to

YP and leading to poorer health outcomes. The recognition of the importance of YP is reflected in the county-wide health strategies and reflects the need for upstream and downstream approaches.

Aims & objectives

This dissertation explored the experiences of Suffolk and Cambridgeshire-based CP in promoting the health and wellbeing of YP (16-24 years old). The study's objectives were to:

- Explore community pharmacists understanding of health promotion and how this influences their health promotion practices
- Explore the practical/experiential reasons for seeing this age group and consequently what are the benefits and challenges of engaging with this age group
- Explore awareness of the policies (local and national) that aids the health promotion of this age group

Method

To conduct this study, ethical approval was gained from the University of Liverpool (Ref: 1540). All participants were given a Participant Information Sheet and a Consent Form to enable them to make informed consent and ultimately the decision to participate or decline. The location of interview was conducive and convenient for both the researcher and the participants. Ethical considerations such as anonymity of participants, data storage/management and professionalism were all considered in conducting this study.

Pharmacists were purposively and conveniently recruited using a snowball sampling method. Pre-registration pharmacists and pharmacists undergoing fitness to practice proceedings were excluded from the study. Pharmacists included were:

- Currently registered and practicing in the UK
- Based in a community setting as opposed to hospital or pharmaceutical industry
- Working in either Cambridgeshire or Suffolk or both

Ten CP (6 females and 4 males), working across Cambridgeshire and Suffolk, were interviewed. Nine participants worked in multiple-chain pharmacies whilst one worked in an independent pharmacy. This resulted in 82 years of experience amongst participants. Six were relief pharmacists (working in different stores depending on the need of their employers), whilst four worked in one single store. Majority of the pharmacists (n=7) worked or had worked in HLP-certified pharmacies.

A semi-structured, individual, face-to-face interview was adopted as it gave the opportunity to "delve deeply" into each pharmacist's experience (the ontology of the study). Interviews were also in line with the interpretivist epistemology used in this study.

Data analysis was conducted using Framework analysis because it is not aligned to any philosophical approach and a pragmatic choice for any type of qualitative data. Framework analysis is also systematic and consists of seven key stages which were followed in the analysis. The stages were:

- Stage 1: Transcription of recorded interview
- Stage 2: Familiarisation with interviews
- Stage 3: Coding of transcripts
- Stage 4: Developing analytical framework
- Stage 5: Applying analytical framework
- Stage 6: Charting data into framework matrix
- Stage 7: Interpreting the data

Results

Based on the interviews, four main themes were developed during the coding stage of data analysis.

Theme 1: Perceived use of pharmacies

This theme related to the general experiences of the everyday health-related use of pharmacy by YP that brought them in contact with the pharmacists. Participants reported a general lack of presence of YP in the pharmacy leading to a limited number of opportunities to engage in the health promotion. Young females were also noted by participants to be the predominant users of the pharmacy. Reasons given by the participants related to access and were influenced by factors such as the location of the pharmacy and the types of pharmacy services being offered. As an example, pharmacists based near colleges saw more YP and those who offered emergency hormonal contraception invariably saw more females.

Theme 2: Health and health promotion

The theme related to participants' understanding of the term health promotion and when the opportunity came up, the method or tools adopted for health promotion.

Most of the definitions of health promotion given by participants implied giving lifestyle advice and education to improve public health. Where patients were on medication, health promotion was about ensuring adherence to medication, a process that may involve behaviour change. Participants acknowledged the difficulty of health promotion of YP due to the perception of this age group being relatively healthy.

Participants adopted several approaches to health promotion but, these were broadly related to medicines, education or empowerment through education.

Theme 3: Enablers and challenges to health promotion

Parents, in contradictory terms, were both 'enablers' and a 'hindrance' to health promotion. Participants reported parents' presence in lieu of their "adolescent" child created a barrier. On the other hand, parents were valuable in encouraging medication adherence, as an example.

Participants felt YP in the upper limit of the age range were more comfortable to approach the pharmacist to discuss their health needs. In addition, the young pharmacist who participated felt being close in age to their target audience was an advantage and adopted a peer approach to health promotion. Participants felt the need to go out beyond the scope of their regular settings (outreach) and be present where YP frequented, such as schools and universities.

Theme 4: Support to enable health promotion

Participants indicated the need for resources such as adequate support staff to enable their health promotion of YP. Pharmacists also recognised the need for additional targeted training on young people's health, a requirement the Centre for Pharmacy Postgraduate Education could help address. Participants also wanted to see national policies and campaigns aimed at YP which pharmacists can support.

Discussions and conclusion

This study showed the complex nature of promoting the health of YP within pharmacy practice. There were tensions in the ways participants spoke about their experiences which was marked by contradictions at times. This indicated that promoting the health of YP in pharmacy settings was not straightforward. For example, there were opposing views about how YP used the pharmacy. Some pharmacists reported that their encounters with YP were less frequent leading them to perceive them as "hard-to-reach". Contrary to this, others reported regular encounters with YP. However, exploring this further, it emerged that the location of the pharmacy was a key determinant for this observed difference. Pharmacist working in the University city reported seeing more YP compared to those in the rural settings.

Parents as gatekeepers were construed as 'facilitators' and 'inhibitors'. When parents/guardians presented at the pharmacy on behalf of their children (YP), this resulted in a missed opportunity for pharmacists to interact face-to-face with some YP. In such cases, some participants did not have the confidence in the information being relayed precisely to the intended young person. Contrary to this, the parental intervention was recognised as a mechanism to encourage, for example, medication adherence in YP. It should be noted that despite the advantage of face-to-face interaction in dealing with YP pharmacists should be aware of other mechanisms for health promotion within their role such as the use of leaflets and online, both of which were mentioned as tools for health promotion. This therefore means, a parent's presence should not prevent or hinder the health promotion of YP.

In this study, more females used pharmacies than their male counterparts, irrespective of the location. This noted gender difference in the use of pharmacies, reflects findings from another UK-based study. This observation is further compounded by the view that seeking help amongst young men negates the socially constructed notion of masculinity. The gender bias is in part also not helped by the types of public health services offered through community pharmacies. The main reason given by participants for seeing YP was for the supply of EHC which requires the female to be present, unless in exceptional circumstances, consequently, a gender bias will be observed.

The pharmacists in this study believed an effective health promotion for this age group requires a more pro-active stance in which pharmacists will have to seize every opportunity to build a rapport and interact with YP. The use of 'outreach' was also implied by participants. The young pharmacists who took part in this study recommended a peer approach with YP as they were also within the age group. This reconfiguration of the relationship between the pharmacist and the patient has been shown to achieve positive outcomes and paramount in achieving a patient-centred care.

Pharmacists were aware that well-documented barriers such as confidentiality needed to be addressed, consequently, participants mentioned the use of consultation rooms because from their experiences, once confidentiality concerns were addressed, YP talked openly about their health concerns.

The definitions of health promotion given by the participants broadly reflected the methods adopted by the pharmacists which were mainly aligned to biomedical model, through the supply of medication, or the educational model using verbal and textual materials. These methods may be indicative of broader issues such as the pharmacists' time due to increasing workload and therefore inability to build rapport with YP. Hence, participants mentioned the use of support staff such as accuracy checking technicians to allow pharmacists to spend more time with YP.

This study shows the complex nature of health promotion of YP. However, with organisational and political support, pharmacists as the most accessible healthcare professionals are in a prime position to shift the focus to make every contact count and to drive the YP agenda. A focus on YP now, will establish the profession within public health in the future as there is still misgivings of the public health role of CP. Pharmacists should endeavour to interact with YP and not take their perception of 'being healthy' at face value as an opportunistic interaction could reveal the need for intervention.

This study emphasises the need for health promotion interventions for this age group to be undertaken with respect to the social determinants of health and a life course approach. It adds to the current body of knowledge relating to community pharmacy and YP's health.