Primary author and year of publication	Objective/s (to)	Study location	Professional pharmacy service	Category of study design	Target population for pharmacists' SRH service	Study summary
Sexually transmitted and Blood-borne infections (STBBI)						
Brabin et al. (2009)[42]	Assess the uptake of free postal chlamydia screening by women who requested EHC	UK (Manchester)	Chlamydia screening	Quantitative	Women under 25 years requesting emergency contraception	• Based on tracking forms from 33 pharmacies during 1-year study: - 1,348/2,904 (46.4%) women accepted the testing kit - 236/1,341 (17.6%) kits returned and 24 (9.1%) positive • Significant increase in positive tests with age (OR=1.2/year; 95% CI: 1.04-1.44; p=0.015)
Currie et al. (2013)[43]	Determine if a cash reward increased the uptake of chlamydia screening in community pharmacies	Australia (Australian Capital Territory)	Chlamydia screening	Quantitative	Sexually active individuals 16-30 years of age	• 6 pharmacies participated over a 4-week period • 970/979 (99.1%) samples returned; 900/970 (92.8%) appeared to be urine • 671/900 (74.4%) were from unique individuals • 422/671 (62.9%) screened were men • 30 samples from 19 individuals tested positive (positivity rate 2.8%); highest rate (8%) in women 21-25 years • Positivity rate for pharmacy study comparable to overall positivity rate • 11 out of 19 (58%) who tested positive contacted and eight of them treated at sexual health clinic
Gudka et al. (2013)[44]	Develop and measure the effectiveness and acceptability of a pharmacy-based chlamydia screening intervention	Australia (Perth)	Chlamydia screening	Mixed methods	Asymptomatic women ≥18 years requesting emergency contraception	• 20 pharmacies participated in a 6-month study 247/596 (40.4%) women offered testing agreed to participate • 166/247 (67%) were eligible and were provided with a testing kit • 46 (28%) returned a completed test kit of which all were negative • 91/166 (55%) completed telephone interviews • Key findings from consumer focus group (n=5): ensure use of separate consultation

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						area, make available at all times from all pharmacies advertise service, increase venues for returning completed specimen, consider postal returns, give multiple options for obtaining results
Parker et al. (2015)[45]	Describe young participants' experience of, and views about, pharmacy-based chlamydia screening	Australia (Australian Capital Territory)	Chlamydia screening	Mixed methods	Sexually active individuals 16-30 years of age	• 979 chlamydia tests distributed and 945 (96.5%) questionnaires returned • 619 (66%) who participated in study and completed questionnaire were males > 60% of questionnaire respondents felt payment affected decision to have chlamydia test • Semi-structured interviews completed in 18 individuals • Overall, participants highly satisfied with screening service and accessibility was a facilitator • Privacy, confidentiality, and information transfer were cited as barriers
Anderson et al. (2011)[46]	Describe positivity rate by age and gender, profile of users, and determine if the program succeeded in reaching those who are currently being missed in other clinical settings	UK (England and Wales)	Chlamydia screening (and treatment)	Quantitative	Individuals ≥ 16 years of age	• Data from first 2 years of service at major UK pharmacy chain (1000 pharmacies) • 14,378 tests were performed • Positivity rate in males (9.8%) higher than females (6.8%) • Positivity rate highest in age 16-24 group (12.5%) • Out of 1,131 people who tested positive, 533 (47.1%) accessed and paid for treatment at the pharmacy and 133 (25%) partners also accessed treatment
Baraitser et al. (2007)[47]	Assess the feasibility of the program and evaluate uptake and client/ practitioner satisfaction	UK (London)	Chlamydia screening (and treatment)	Mixed methods	Not specified	• Data from a 3-month pilot in 3 pharmacies, 83 tests were taken • 73 (94%) of those tested were women • 8 (9.5%) tests positive; 5/8 (62.5%) treated at pharmacy • 13/ 80 (16%) reported they would not have been tested without the pilot • 64/80 (80%) very satisfied and 11 (14%) were satisfied • All felt very comfortable or comfortable discussing sexual health with pharmacists

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						• Clients valued convenience and speed, non-judgmental approach
Cameron et al. (2010)[48]	Evaluate expedited partner therapy at a pharmacy as an additional choice to treatment at other health facilities	UK (Lothian)	Chlamydia treatment (expedited partner therapy)	Quantitative	Sexual partners of index cases with uncomplicated *c. trachomatis* only	• 90 pharmacies agreed to participate (18-month pilot); 57/90 pharmacies (63%) were used by partners • 231/577 (40%) vouchers issued to chlamydia-positive index patients redeemed at pharmacies • 60/67 index patients completed satisfaction survey • 46 (77%) were very satisfied or quite satisfied with having voucher to pass onto partner
McClure et al. (2016)[49]	Evaluate expedited treatment of index patients through the use of paper 'treatment vouchers' that could be redeemed at community pharmacies	UK (Lothian)	Chlamydia treatment	Quantitative	Individuals ≥ 16 years of age with uncomplicated *C. trachomatis* only	• Over a 12-month period, 300 vouchers issued by sexual and reproductive clinics (15.5% of patients tested positive for chlamydia) • 261 (87%) redeemed by index patients • Median number of days for voucher redemption was 1 day (range 0-126) • 185 (63.6%) of index patients receiving vouchers were females • Voucher issue increased with higher deprivation level of area of residence of index patient
Slutsker et al. (2020)[50]	Examine whether expedited partner therapy prescriptions (vouchers) are filled at community pharmacies when the cost barrier is removed	US (New York, Maryland, California)	Chlamydia treatment (expedited partner therapy)	Quantitative	Patients diagnosed with Chlamydia who would normally receive EPT prescription	• 32 clinical sites participated and distributed 931 vouchers for 28 months • 382 (41%) of issued vouchers were redeemed Vouchers given to patients 18 or younger were less likely to be redeemed than those given to patients older than 18 years (30% vs. 44%, p=0.001) • 196/353 vouchers were redeemed the same day
Havens et al. (2019)[51]	Investigate the acceptability and feasibility of a pharmacist-led HIV screening and PrEP program	US (Nebraska)	HIV PrEP prescribing	Quantitative	HIV-uninfected patients ≥ 19 years of age at high risk of HIV based on risk factors	• 27/60 (45%) individuals started on PrEP chose to continue follow-up through community pharmacy (one participating pharmacy) • 8 out of 27 remained on PrEP at 12 months

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						• PrEP medication adherence was high for those retained in care throughout the study (mean medication possession ratio 93%) • All respondents reported they would recommend the PrEP program • Areas that needed improvement were ease of accessing medication, confusion regarding rectal and pharyngeal STI swab collection, and delayed communication between providers • No participant had seroconverted at the time of publication
Collins et al. (2018)[52]	Describe the HIV testing program and summarize its outcomes	US (Virginia)	HIV screening	Quantitative	Individuals ≥ 18 years of age	• 32 stores involved in testing –3,630 tests completed over 27 months • 58.5% of those tested were male and 46% had never been tested or were unsure if they had been tested • 39.0% were administered during traditional business hours (9 AM to 6 PM, Monday through Friday) and 61.0% were administered outside of traditional business hours (6 PM to 9 AM, Monday through Friday) or on weekends • 30 (0.8%) reactive tests for HIV antibodies • 26 (86.7%) had a positive confirmatory test and 4 (13.3%) were lost to follow-up • 22/26 with confirmed infection linked to care
Crawford et al. (2016)[53]	Evaluate HIV testing uptake patterns when HIV testing is offered as part of a comprehensive chronic disease screening program	US (New York)	HIV screening	Quantitative	Injection drug users ≥ 18 years of age and un- or underinsured customers	• 3 pharmacies offered testing (2 intervention arms and 1 as control) • When adjusted for age and race/ethnicity, testing uptake was not significant different in the comprehensive disease screening arm (n=255), HIV testing (n=193) and video arm, and control arm (n=240) • 36.9% reported at least one form of HIV shame, and 52.8% reported at least one form of HIV blame • In those who reported at least one form of HIV shame or blame, those in video arm were 1.59 (95% CI [1.00,2.53]) times more likely to get tested than control arm after adjusting for age and ethnicity. Those in comprehensive arm were 1.61 (95% CI [1.03,2.49]) times more likely to be tested than control

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Darin et al. (2015)[54]	Evaluate the acceptability and feasibility of pharmacist-provided rapid testing for HIV	US (Michigan)	HIV screening	Quantitative	Individuals ≥ 18 years of age	• 69 HIV tests performed at 2 pharmacies over 17-month period • 1 (1.5%) reactive test – immediately referred for confirmatory testing • HIV testing service required a median time of 30 minutes • 59.5% of those tested were females, and 46.4% were black • 42% reported this was their first HIV test • Participants reported positive perceptions about the testing experience • 27.5% responded they were willing to pay for HIV test, and 63.7% said that they might pay pending on the cost
Fernandez-Balbuena et al. (2015)[55]	Assess the feasibility and the main outcomes of three programs for HIV screening	Spain (Basque Country, Castilla y León, Catalonia)	HIV screening	Quantitative	Individuals ≥ 16 years of age	• 24,151 people got tested at 110 pharmacies in different regions of Spain (Basque Country, Catalonia, Castilla y Leon), over a 2-4-year period • 226 reactive tests overall • Pharmacy-testing program contributed to 8.7%, 10.3%, and 12.7% of all the new HIV diagnoses in the three regions during the time period of testing
Weidle et al. (2014)[56]	Test the feasibility of offering rapid, point-of-care HIV testing at community pharmacies and retail clinics	US	HIV screening	Quantitative	Not specified	• Over a 2-year period, 21 sites including 18 community pharmacies offered testing • 1,540 total HIV tests were performed and 24 (1.6%) resulted in reactive test • 16/24 reactive tests outcome of confirmatory testing unknown to site staff • 5/8 reactive tests were false-positive on confirmatory testing, 2 were previously diagnosed with HIV, and one confirmed as new HIV case • The median amount of time required for pretest counseling/consent, waiting for test results, and posttest counseling was 4, 23, and 3 minutes, respectively

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Kelly et al. (2020)[57]	Develop and assess the implementation of a novel pharmacy-based HIV testing model in two Canadian provinces	Canada (Alberta and Newfoundland)	HIV screening	Mixed methods	Individuals ≥ 18 years of age who had active healthcare number	• 4 pharmacies participated, during 6-month study Of 123 tests, 1 was reactive and confirmed as new HIV diagnosis • Participants were primarily male (75.6%) and most common risk behavior was MSM (47.1%) 27.3% reported this was their first HIV test • Participants were very satisfied with the program; 99% agreed HIV POCT should be routinely offered in pharmacies and 78% were willing to pay for the service • Participants liked the accessibility of the pharmacy and convenience of POCT as well as the anonymity of the pharmacy • The main concern reported was related to the pipette used for blood collection
Calo et al. (2019)[58]	Evaluate the implementation of HPV vaccination services in community pharmacies	US (North Carolina, Michigan, Iowa, Kentucky, and Oregon)	HPV vaccination	Quantitative	Adolescents and young adults (no age specified)	• Open enrollment at 15 pharmacy sites in 5 states for combined 12 months • 13 HPV vaccine doses administered in adolescents and 3 doses to young adults • Engagement barriers included low demand from parents and pharmacy staff engagement • Feasibility, adoption, sustainability impacted by lack of 3rd party reimbursement, care coordination, and public awareness of pharmacists' training • Parents who got HPV vaccine for their children in participating pharmacies found the service highly acceptable • Participating pharmacists were knowledgeable about vaccines in general not just HPV vaccine, had the training to immunize adolescents, and were able to report vaccines administered to state immunization registries • Protocols and procedures were not well integrated into pharmacy workflow
Doucette et al. (2019)[59]	Assess the feasibility of a coordinated model of HPV vaccine delivery between a clinic and a community pharmacy	US (Iowa)	HPV vaccination	Quantitative	Not specified	• 51 patients referred to a single pharmacy to receive 2nd and 3rd doses of vaccine • 23 out of 51 patients received a total of 25 vaccinations • 18 (78.3%) were female

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Hohmeier et al. (2016)[60]	Describe and report on the impact of a multimodal series of pharmacist-led educational interventions on HPV vaccination rates	US (Tennessee)	HPV educational intervention	Quantitative	Individuals of 9-26 years of age filling acne or birth control prescriptions	• Data collected from one pharmacy over an 8-week period. There was a total of 21 questionnaire respondents • 10 out of 21 participants targeted for counselling on HPV vaccine were vaccinated at the pharmacy • Most common reasons for not receiving vaccine were cost (n=6) and insurance coverage (n=5) • Patient awareness and obtaining vaccine most often reported to be as a result of pharmacist recommendation (n=10 and n=6, respectively) • Patients more likely to choose the pharmacy as vaccination site due to no appointment necessary (n=8) and convenience hours (n=4) • Cost (n=6) and insurance coverage (n=5) were the most common reasons for the ones not receiving the vaccine
Jiménez-Quiñones et al. (2017)[61]	Observe whether local HPV vaccination rates are improved by a patient and physician education program	Puerto Rico (Lares)	HPV educational intervention	Quantitative	Individuals between 18-26 years of age	• 79 of the 200 patients were candidates to receive the HPV vaccine were reached by phone to invite them to an HPV related educational session • 24/79 reported being previously vaccinated for HPV • 4/79 patients received HPV vaccination during the study period
Navarrete et al. (2014)[62]	Describe the development and implementation of an HPV vaccine patient assistance program for university students	US (Texas)	HPV vaccination	Quantitative	Students ≥ 19 years of age	• Over 2-year period, 167 vaccine doses administered at community pharmacy located in a university setting • 89 individuals received approval from a vaccine patient assistance program • 81% (n=72) of all patients approved by the program were women • 79.8% students (n=71) received their second dose and 48.3% (n=43) completed the series • 46 individuals did not complete HPV series

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Buchanan et al. (2020)[63]	Describe the cost-effectiveness of a community pharmacy testing service in a population of people at risk of HCV	UK (Isle of Wight)	HCV screening	Quantitative	Clients with known risks factors for HCV	• 186 tests conducted over 24 months by 20 pharmacies • Majority of tests performed in males (53%) and most common disclosed risk factor was injection drug use (37%) • 13 (7%) were positive for HCV RNA; 10 of these had a history of current or former injection drug use • 12/13 attended point-of-diagnosis appointment with a specialist at the community pharmacy • 6/13 individuals were treated and achieved sustained virologic response
Buchanan et al. (2016)[64]	Reduce the burden of undiagnosed HCV and link new diagnoses directly to specialist care	UK (Isle of Wight)	HCV, HBV, HIV, and Syphilis screening	Quantitative	Clients attending for needle exchange and opiate substitution therapy	• 22 pharmacies participated over a 9-month period (5 did not complete any tests) • 88 tests were performed • Primary risk factor disclosed for undergoing testing was injection drug use (39%) • 16 (18%) presented for testing due to publicity campaign and the rest recruited by the pharmacists • 7% of patients tested were positive for HCV (similar to 9% who tested HCV positive at island recovery integrated service during same time period) • HCV positive patients attended point-of-diagnosis consultation with testing pharmacist and hepatology specialist
Dong et al. (2017)[65]	Describe the first community pharmacy-based hepatitis C antibody (HCV-Ab) point-of-care (POC) screening program and its outcomes	US (California)	HCV screening	Mixed methods	Not specified	• 83 tests were performed in a 3-month pilot at 1 pharmacy • Person-to-person outreach on street was most effective approach to encourage testing • 80% denied previous HCV testing • Most common self-identified HCV risk factors was birth cohort (65%) • 1/83 had positive HCV Ab (no information on confirmatory testing and linkage to care)

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Radley et al. (2017)[66]	Compare uptake of dried blood spot testing (DBST) for HCV infection between community pharmacies and established services	UK (Scotland)	HCV screening (DBST also screened for HBV and HIV but this was not reported)	Mixed methods (quasi-experimental)	Patients in receipt of opioid substitution therapy (OST) not tested for HCV within 12 months	• 6 pharmacies provided OST for approximately 363 patients • 43 tests were performed in a 1-year period • 43/143 patients in receipt of opioid substitution therapy with no record of testing accepted DBST • 12/43 reactive tests • Significant difference in uptake between community pharmacies and established services (30% vs 13%, respectively) • Participants reported that pharmacies were a good place to be tested and valued the service and they are seen as part of the local community
Radley et al. (2020)[67]	Evaluate whether a pharmacist-led care pathway compared with conventional care could increase HCV testing, treatment uptake and completion, and cure rates	UK (Scotland)	HCV screening (DBST also screened for HBV and HIV but this was not reported)	Quantitative - cluster-randomized trial	Patients who had received opioid substitution therapy (OST) for approximately 3 months, and were HCV PCR positive, were infected with HCV genotype 1 or 3, and were willing to have a pharmacist supervise their antiviral drug administration	• 55 participating pharmacies included 2,718 patients receiving OST (1,365 in the pharmacist-led care group and 1,353 in the conventional care group) • More patients in the pharmacist-led care group versus the conventional care group: - Met the primary endpoint of SVR12 in the pharmacist-led care group (98 [7%] of 1365) than in the conventional care group (43 [3%] of 1,353; odds ratio 2·375, 95% CI 1·555–3·628, p<0·0001). - Agreed to dry blood spot testing (245 [18%] of 1,365 vs 145 [11%] of 1,353, 2.292, 0.968–5.427, p=0.059) - Initiated treatment (112 [8%] of 1,365 vs 61 [4%] of 1,353, 1·889, 1.276–2.789, p=0.0015) - Completed treatment (108 [8%] of 1,365 vs 58 [4%] of 1,353, 1.928, 1.321–2.813, p=0.0007). No serious adverse events were recorded

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Contraception						
Anderson et al. (2019)[68]	Describe early utilization of pharmacist prescription of contraception	US (Oregon)	Hormonal contraception prescribing	Quantitative	Patients obtaining a new prescription for oral and transdermal methods and who had continuous Medicaid coverage	• Retrospective analysis of claims data from the first 2 years following a policy change • 162 pharmacists prescribed contraception resulting in 1,313 fill claims • 367/3,614 (10%) patients received their prescription from a pharmacist • Average of 61 prescriptions per month filled by pharmacists as the prescriber five months after implementation • The most common method of contraception prescribed was the combined OC (90.5%) • The majority of patients who were prescribed contraception by pharmacists (73.8%) had no history of contraceptive prescriptions in the preceding 30 days
Gardner et al. (2008)[69]	Describe implementation of a collaborative drug therapy protocol for safe use of hormonal contraceptives prescribed by community pharmacists	US (Seattle)	Hormonal contraception prescribing	Mixed methods	Women between 18-44 years of age in need of contraception	• 26 pharmacists participated over an 18-month period • 195/214 (91%) women recruited into the study were prescribed hormonal contraceptives by pharmacists • Most women (87%) were experienced users of hormonal contraceptives • More than 80% of women paid for the pharmacist's services out of pocket • After 12 months, 70% of women responding to an interview reported continuing use of hormonal contraceptives • Women were satisfied with the experience
Lu et al. (2019)[70]	Describe hormonal contraception services provided by pharmacists and characterize patient populations utilizing the service	US (California and Oregon)	Hormonal contraception prescribing	Quantitative	Women, and women ≥ 18 years of age or younger with previous contraceptive use (in California and Oregon, respectively)	• 381 pharmacists from a pharmacy chain provided hormonal contraception (HC) services in 391 locations during a 7-month period • 2,117 visits during the study period, and 1,970 (93%) received hormonal contraception from a pharmacist • 91% of women were previous HC users • HC prescribed included pill (95.7%), vaginal ring (2.6%), transdermal patch (1.6%), and injectable depot (0.1%)

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Rodriguez et al. (2020)[71]	Describe reasons for and experiences with obtaining contraception from pharmacists	US (California, Colorado, Hawaii, and Oregon)	Hormonal contraception prescribing	Quantitative	Women aged 18-50 years presenting for hormonal contraception at community and university pharmacies	• Planned secondary analysis from prospective cohort study • 426 women presenting for hormonal contraception (n=150 pharmacist prescribers) • Most common reasons received contraception from a pharmacist was because no appointment required (25%), their prescription had lapsed (24%), and location was convenient (24%) • Women who received contraception through a pharmacy were more likely to report they would use the same provider again versus women who used clinic-based prescriptions (100% vs 95.3%, p=0.007), as well as were more likely to refer a friend (9.0% vs 93.5%, p=0.04)
Rodriguez et al. (2020)[72]	Compare the amount of hormonal contraceptive supply dispensed between pharmacists and clinic-based prescriptions	US (California, Colorado, Hawaii, and Oregon)	Hormonal contraception prescribing	Quantitative	Women aged 18-50 years who received at least 1 month of hormonal contraception from a clinician or pharmacist	• Data collected over 9-month period in 2019. 139 pharmacies participated (California, 46; Colorado, 14; Hawaii, 10; and Oregon, 69) • 144/410 women obtained contraception from a pharmacist • Pharmacists were significantly more likely to prescribe a 6-month or greater supply of contraceptives than clinicians (6.9% vs 1.5%, p<0.001) • Pharmacists were as likely as clinicians to prescribe a progestin-only method to women with a potential contraindication to estrogen (n=60 women; 8 [20.0%] vs 6 [30.0%], p=0.52)
Gibbs & Harvey (2020)[73]	Assess the impact of a policy that allows pharmacist prescribing of the pill and patch on contraceptive receipt for Medicaid-insured women	US (Oregon)	Hormonal contraception prescribing	Quantitative	Women aged 15-44 years enrolled in Medicaid filling new prescriptions for contraceptives	• 2 years Medicaid data was used to compare before and after the policy implementation (2015-2017) • No significant effects of the policy change on receipt of all contraceptive services or on receipt of the pill or patch • In the first 2 years after policy implementation, greater than 98% of prescriptions filled for the pill and patch were prescribed by a non-pharmacist provider

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Heller et al. (2017)[74]	Examine the feasibility and acceptability of users receiving the subcutaneous form of the contraception injection from pharmacists	UK (Scotland)	Contraceptive injection administration	Mixed methods	Women between 15-45 years who had been using the contraceptive injection for at least six months	• 11 pharmacies participated over a 25-month period in pilot • Global unavailability of the product during the study adversely affected recruitment and retention • 50/78 women approached for study participation were recruited • 48 injections out of a possible 150 were administered at the pharmacy • 26 (54%) participants chose not to continue with the study after one or two injections • 22 women completed an exit questionnaire (44% of participants, 92% had experienced the intervention) • Participants reported mixed experiences, with some welcoming the intervention but others experiencing difficulty with pharmacist availability
Monastersky Maderas & Landau (2007)[75]	Explore the potential of pharmacist-administered contraceptive injections and feasibility and acceptability among patients	US (California)	Contraceptive injection administration	Mixed methods	Women using injectable contraceptive	• Over a 2-year period, 26 community pharmacies offered injectable contraceptive administration as a demonstration program • 69 women received 143 depot medroxyprogesterone injections • 60% of participants had their injections paid for by state-funded health insurance programs • Approximately 50% of users would be willing to pay a set fee (up to $10) for the pharmacist injection service • One half of the women used the service more than one time
Picardo and Ferrari (2010)[76]	Assess the feasibility of administering subcutaneous hormonal contraceptive in a pharmacy setting and assess patient satisfaction.	US (North Carolina)	Contraceptive injection administration	Quantitative - Randomized controlled trial	English-speaking women ≥ 18 years of age	• Women randomized to receive second and third dose at one clinic or one community pharmacy located in a shopping mall • 50 participants, 25 in each group (pharmacy or clinic) • Most women found the pharmacy setting convenient (70%), private (100%), the providers respectful (100%) and were satisfied with DMPA-SC and the pharmacy as a clinical site (≥89%). • Continuation rates and patient satisfaction with

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						• The contraceptive method and the pharmacy setting were comparable to those who attended a family planning clinic
Mantzourani et al. (2019)[77]	Describe long-term trends in the use of community pharmacist-based EC services and insight into changing patterns of EC use over time.	UK (Wales)	Emergency contraception provision	Quantitative	Women ≥ 13 years of age	• Evaluated the National Health Service funded community pharmacy EC service over a 5-year period • 181,359 consultations were recorded (authors unable to track repeat EC service users) • No data on the number of pharmacists in Wales, or the number of pharmacies • More than a quarter of the consultations were conducted on a Monday (25.8%) • More than two-thirds of requests made through the EC service took place within 24 hours of UPSI (67.5%) • Almost half (47.9%) of requests were because no contraception had been used • Levonorgestrel was supplied in 96.7% of the consultations • Further sexual health and contraception counselling was provided in 79.2% and referral to another agency in 31.3% of EC consultations
Turnbull et al. (2020)[78]	Report on young women's experiences of accessing ECPs from pharmacies and sexual health clinics	UK (London)	Emergency contraception provision	Qualitative	Women aged 16–25 years, English speaking, and self-reporting at least one pregnancy scare or ECP use	• 21 participants were recruited from a young person's sexual health clinic (10), five pharmacies (6) and by snowballing (5) • Key advantages reported were ease and speed of access and convenience • Disadvantages included less personal service, not enough attention to information needs and to prevention of need for recurrence of EC, and unsupportive attitudes of pharmacy staff • Suggested improvements included increasing privacy, providing more advice on contraception, having a more empathetic approach and signposting follow-up services

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Michie et al. (2014)[79]	Determine the feasibility of pharmacy- based interventions to increase the uptake of effective contraception after EC	UK (Scotland)	Hormonal contraception provision or referral	Quantitative - cluster-randomized trial	Women ≥ 16 years of age	• Data collected from 11 pharmacies over 8-month • Pharmacies were randomized into standard care, 1-month progestogen-only pills (POP) provision, or rapid access (invitation to present the empty EC packet to a family planning clinic (FPC) for contraceptive advice) • 168 women were recruited, and 102 women (61%) were contacted 6–8 weeks later to determine contraceptive use: - 90% women used the pills provided in the POP arm - 32% women attended the FPC in the rapid access arm • The proportion of women using effective contraception at follow-up was significantly greater in both POP [56% (22/39), p=0.001] and rapid access [52% (13/25), p=0.006] groups compared to standard care [16% (5/31)]
Pregnancy						
Di Pietro et al. (2017)[80]	Describe the development and implementation of pre-conception care services with the use of TMR in three areas: 1) medications that may cause fetal harm, 2) folic acid, 3) immunizations	US (Ohio)	Counselling and education on pregnancy related topics	Quantitative	Female between 15-45 years of age members of the Medicaid plan	• 1,149 pharmacists from 818 different pharmacies completed at least 1 TMR in a 19-week period post implementation • 6,602 TMRs were acted on (33% of all TMR opportunities) with a 65% success rate • Needs patient education on (successful TMR): - Folic Acid supplement: 1,775 (65%) - Immunization (MMR/hep B): 971 (69%) - Category D/X medication use: 1,520 (62%)
Truong et al. (2019)[81]	Test the feasibility of a pharmacist consultation in early pregnancy and inform the design of a definitive trial	Norway	Education on pregnancy related topics	Quantitative - randomized control trial	Women ≥ 18 years of age in early pregnancy	• Over a 3-month period, 6 pharmacies participated • The median gestational age of participants at recruitment was 9 weeks • 28/35 participants had experienced at least one pregnancy-related ailment • The median duration of the interventions (n=11) was 15 minutes and seemed feasible

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						• Treatment of nausea and vomiting (10/11) and general information about medications (8/11) were frequently discussed • The women reported high satisfaction with the consultation (8/11)
Sexual dysfunction						
Morales et al. (2013)[82]	Assess pharmacists' ability to detect erectile dysfunction and encourage patients to seek medical evaluation	Spain and Greece	Screening, education and referral for erectile dysfunction	Quantitative	Men ≥ 18 years of age if history or medications indicated that they had a risk factor for ED and/or if they had consulted with a pharmacist about ED or ED treatments	• 25 pharmacists from Spain and 29 from Greece participated in the pilot • Among the 451 men (Spain=196 and Greece=255), 90% had a risk factor (usually hypertension, hypercholesterolemia, or diabetes) • The first health care professional approached by patients was a pharmacist (50%) • 348 (77%) men had a Sexual Health Inventory for Men score ≤21 • Less than one-third of men contacted for follow-up had visited their physician, despite pharmacist encouragement