Decision-Making in Sexual and Reproductive Health

Pharmacy Consultations

Leading SRH Conversations

Effective, inclusive communication focusing on patient needs and shared decision-making

- **Use open, non-judgemental language:** Avoid assumptions about gender, sexuality, or relationship status. Use terms like "partner(s)" and ask for preferred name and pronouns. The parts and practices model focuses on the body parts a person has, and what they're doing with them, rather than making assumptions.
- **Normalise SRH topics:** Frame SRH as a routine part of health care. Provide resources where appropriate.
- **Be clear and direct:** Use plain language and avoid euphemisms. Patients appreciate clarity when discussing symptoms or concerns.
- **Ensure confidentiality:** Reassure patients that their information is private and protected, especially when discussing sensitive topics.

Cultural Considerations

- **Avoid cultural stereotypes:** Don't assume beliefs or behaviours based on ethnicity or background.
- **Adress language barriers:** Use professional interpreters via TIS National and provide translated resources as needed.

Working with Young People

- Understand decision-making capacity as some may be considered mature minors (Gillick competent) and can legally make informed healthcare decisions. Be aware of jurisdiction-specific requirements.
- **Support autonomous health decisions and provide reassurance about confidentiality.**
- If possible and relevant, offer the option to speak with a pharmacist of a preferred gender or age group.

Providing a Non-Judgemental Service

- **Avoid moralising:** Focus discussions on supporting health outcomes rather than judging personal choices.
- **Listen actively:** Validate concerns and avoid expressions of shock or disapproval.
- **Reflect on internal biases:** Continuously ensure personal attitudes do not influence patient care.
- **Use inclusive resources and signage:** Provide materials that are friendly and welcoming to all patients (e.g. LGBTQIA+).

Pharmacists as SRH Partners

Contraceptive Counselling: Including supplying contraceptives and EC, and in some jurisdictions prescribing selected hormonal contraceptives.

STI Prevention and Support: Gather sexual history to identify signs, symptoms and risk factors for STIs, provide education on STI prevention, and referral to STI testing services.

Health Promotion: Support informed choices through evidence-based education on SRH, menstrual health, fertility and menopause.

Equity of Access: Supporting underserved populations, including rural, remote, and Medicare-ineligible individuals in accessing SRH advice and care.

Referral and Care Coordination: Identify patient needs and connect them with appropriate medical or specialist services, providing follow-up and ongoing support to ensure continuity of care.

Pharmacists Role in STI, HIV PrEP, PEP Management

Ensure treatment aligns with current, evidence-based guidelines including:

- STI Management Guidelines
- PEP Guidelines
- PrEP Guidelines

Provide patient-centred counselling

- Expected side effects and how to manage them
- Importance of treatment adherence and counsel on supporting tools
- Screening for potential drug interactions (including supplements/complementary medicines)
- Management of missed doses
- Counsel on alternative access options if the medication cannot be supplied directly by your service

Consider special circumstances

- Pregnancy and chestfeeding
- Medication allergies and alternative treatment options
- Co-infections with other STIs
- Renal considerations (i.e. medications effect on the kidneys and dosing in the presence of renal dysfunction)
- Hepatitis B status for PEP/PrEP medication

Advise on post-treatment precautions

- Timeframes for abstaining from sexual contact after treatment initiation (varies by infection/treatment)
- Partner notification/treatment, where appropriate
- Importance of follow-up testing if indicated

Referral and Care Coordination

Provider	Services Offered
General Practice	General Practitioner's (GPs) & Nurse Practitioners (NPs). Comprehensive SRH assessment, SRH education, contraception initiation, STI testing, emergency contraception, abortion services, HIV PrEP, HIV management (specialist GP). GPs, and NPs providing LARC and EMA services can be found using AusCAPPS.
State-based SH Services	STI screening and treatment, HIV PEP & PrEP, specialised SRH services (including EC and initiating contraception and medical termination of pregnancy. Local LGBTQ+ organisations may also offer SH services.
Sexual and Reproductive Health Organisations	Contraceptive counselling, LARC insertion, abortion services and education. • ACT: Sexual Health & Family Planning ACT • NSW: Family Planning Australia • NT: Family Planning Welfare Associate of NT • QLD: True Relationships and Reproductive Health • SA: SHINE SA • TAS: Family Planning Tasmania • VIC: Sexual Health Victoria • WA: Sexual Health Quarters
Sexual Assault Services	Crisis support, counselling, medical and forensic care. Locate a service via National Association of Services Against Sexual Violence or Say It Out Loud.
Aboriginal Medical Services (AMS)	Culturally safe SRH care, contraception, STI screening, SRH education, pregnancy support, education, HIV PrEP. Locate a service via Register of Accredited AMS' or NACCHO.
Culturally and Linguistically Diverse (CALD) Services	Contraception, STI screening, SRH education, pregnancy support, education, and tailored support for CALD groups. Locate a service via Child Family Community Australia.
Telehealth Services	Remote SRH consultations, SRH education, contraception advice, abortion care.
MSI Australia	Medical and surgical abortion, contraception counselling and telehealth services.

Contraception and Early Medical Abortion Care

Contraceptive Methods and Their Use Across Life Stages

REPRODUCTIVE YEARS

Contraception method	IUD (LNG, copper)	Progestogen Implant	DMPA Injection	Combined hormonal contraception (COCP, vaginal ring)	Progestogen-only (POP, mini-pill)
Efficacy†	Extremely effective (99.5% - 99.9%)	Extremely effective (99.95%)	Very effective (96% -99.8%)*	Very effective (93% - 99.5%)*	Very effective (93% - 99.5%)*
User dependency	Low	Low	Low	High	High
Duration	• **Copper IUD:** lasts 5–10 years • **LNG IUD:** lasts 5- 8 years	Lasts 3 years	Lasts 12 weeks	• **COCP:** lasts 24 hours • **Vaginal ring:** lasts 21 days	Lasts 24 hours
Return to fertility after discontinuation	Immediate	Approx. one month after discontinuation	4-6 months but can be up to 12 months	Approx. one month after discontinuation.	Immediate
Discreet	Yes	Yes	Yes	No	No
Impact of Enzyme-Inducing Drugs on Contraception *(Refer to clinical resources for detailed information)*	Contraceptive effectiveness not expected to be affected	Contraceptive effectiveness may be reduced during use of enzyme-inducing drugs and for a period after discontinuation	Contraceptive effectiveness not expected to be affected	Contraceptive effectiveness may be reduced during use of enzyme-inducing drugs and for a period after discontinuation	Contraceptive effectiveness may be reduced during use of enzyme-inducing drugs and for a period after discontinuation
Common side effects	• **Copper IUD:** heavier bleeding, cramping • **LNG IUD:** hormonal side effects‡ may occur	Hormonal side effects‡	Hormonal side effects‡	Hormonal side effects‡ , commonly including nausea and/or bloating	Hormonal side effects‡
Additional benefits	• Long-acting and reversible • **Copper IUD:** suitable for those who do not want to use hormonal contraception • **LNG IUD:** may reduce/stop heavy menstrual bleeding, relieve dysmenorrhoea and improve endometriosis symptoms	• Long-acting and reversible • May reduce/stop menstrual bleeding, relieving dysmenorrhoea in some users	• Longer acting than COCP, vaginal ring, POP • May reduce/stop menstrual bleeding, relieving dysmenorrhoea in some users	• COCP: provides flexible regimen options to suit patient preferences and clinical needs • User-controlled-can be discontinued at any time • Non-contraceptive benefits include improving acne, heavy bleeding, dysmenorrhoea, endometriosis, PCOS, PMS • Reduced risk of uterine & ovarian cancer	• User-controlled; can be discontinued at any time • Can be used in people with contraindications to estrogen
Potential concerns	• Requires pelvic exam & insertion. • Altered bleeding pattern • Small risk of IUD expulsion, uterine perforation and pelvic inflammatory disease	• Requires insertion • Altered bleeding pattern • Small risk of implant migration	• Altered bleeding pattern • Loss of bone mineral density (reversible)	• Risk of Venous Thromboembolism (VTE), ischemic stroke and myocardial infarction • Small increase in the risk of inflammatory bowel disease, cervical and breast cancer • May increase blood pressure • Spotting may occur	• Altered bleeding pattern • Lack of non-contraceptive benefits
Use while chestfeeding	Safe	Safe	Safe	Requires tailored clinical judgement	Safe
Postpartum	Suitable immediately (0-48h) or ≥ postpartum	Suitable immediately	Suitable immediately	Requires tailored clinical judgment	Suitable immediately
Perimenopause *Contraception is required until menopause is confirmed – 12 months of amenorrhoea if aged ≥ 50 years, or 24 months if aged < 50 years. Amenorrhoea is not a reliable indicator of menopause in people using hormonal contraception*	**Copper IUD:** a non-hormonal option • When inserted at ≥ 40 years, it can be retained until menopause **LNG IUD**: improves menstrual control and reduces heavy bleeding or dysmenorrhoea. • When inserted at ≥ 45 years, it can be retained for up to 7 years • Provides endometrial protection when used with MHT	• Suitable in the absence of contraindications • Can cause irregular menstrual bleeding • Cannot be used for endometrial protection when used with MHT	• Not preferred in people > 45 years and not recommended beyond 50 years due to bone density and metabolic concerns	• Oestrogen-based methods are not recommended > 50 years due to cardiovascular risks • May be continued in medically eligible people < 50 years • Assists with cycle regulation and vasomotor symptoms • Review cardiovascular and VTE risk annually	• Suitable for most who cannot use Oestrogen • Can cause irregular bleeding • Amenorrhoea while using POP does not confirm menopause • Does not provide endometrial protection when used with MHT
Menopause *Once menopause is confirmed, contraception is no longer required. Decisions on ongoing hormonal therapies should be guided by menopause management rather than contraception*	**Copper IUD:** Not required after menopause • Remove once menopause confirmed. **LNG-IUD:** Not required for contraception once menopause confirmed • May remain in place for non-contraceptive benefits (e.g. endometrial protection is part of MHT)	• Not required after menopause	• Not recommended after menopause due to adverse effects of bone and lipids	• Not recommended after menopause because of increased cardiovascular risk • Discontinue at menopause and transition to MHT if indicated for symptom management	• Not required after menopause

Refer to ASHM's Decision Making in Contraception: Consultation Essentials for further information and consultation considerations.
† Efficacy figures based on data from the Therapeutic Guidelines and The College of Sexual & Reproductive Healthcare
* Efficacy rate variations in non LARC methods reflect difference in typical use and perfect use
‡ Common hormonal side effects include headache, acne, mood changes, weight gain, breast tenderness, and loss of libido

Therapeutic Roles of Hormonal Contraceptives Beyond Contraception

Some hormonal contraceptives are also prescribed to manage a range of medical conditions. Best practice includes confirming the indication, providing person-centred counselling, monitoring treatment response and adverse effects, supporting preventative health and screening, and collaborating with other health professionals when required. Potential therapeutic benefits of hormonal contraceptives include polycystic ovary syndrome (PCOS), endometriosis, primary ovarian insufficiency (POI), and perimenopause.

PCOS:
Used to regulate menstrual cycles, protect the endometrium, and improve androgen-related symptoms (e.g. acne, hirsutism)

Endometriosis:
Used continuously or long-term to suppress ovulation, reduce dysmenorrhoea and pelvic pain, and control menstrual bleeding

POI:
Used as hormone replacement to maintain oestrogen levels, support bone and cardiovascular health, and relieve hypo-oestrogenic symptoms

Perimenopause:
Used to stabilise menstrual cycles, reduce heavy or erratic bleeding, and relieve vasomotor symptoms (e.g. hot flushes, night sweats)

Glossary

ART	Antiretroviral Therapy
COCP	Combined Oral Contraceptive Pill
IUD	Intrauterine Device
LARC	Long-Acting Reversible Contraceptives
LNG	Levonorgestrel
MHT	Menopausal Hormone Therapy
PEP	Post-Exposure Prophylaxis
PrEP	Pre-Exposure Prophylaxis
POP	Progestogen-only Pill
SRH	Sexual and Reproductive Health
STI	Sexually Transmissible Infection
UPSI	Unprotected sexual intercourse

Choosing an Emergency Contraceptive (EC)

Method	Key considerations
Copper IUD *Effective up to 120 hours after UPSI (efficacy is consistent across this period)*	• Highest efficacy EC while also providing an ongoing contraception • Efficacy unaffected by body weight or medicines • Requires insertion by trained provider • Higher upfront cost
Ulipristal acetate (UPA) 30mg *Effective up to 120 hours after UPSI (efficacy relatively consistent across this period)*	• If the dose is vomited within 3 hours of taking the tablet, another dose is required • More effective than LNG-EC • Efficacy may be reduced if BMI > 30 or weight > 85kg • Efficacy reduced by progestogen (excluding LNG IUD) used 7 days before or 5 days after UPA • Avoid hormonal contraception for 5 days after UPA • Use caution in patients with severe asthma treated with oral glucocorticoids, and in those who have used a CYP3A4 inducer or griseofulvin within the past 4 weeks • Not recommended for repeated use within the same cycle • UPA and LNG may impair each other's effects. After using LNG EC, wait ≥ 7 days before using UPA • UPA passes into milk; risk to infant low (limited data). Contact a pregnancy medicine information service for patient-specific advice
Levonorgestrel (LNG) 1.5mg *Effective up to 72 hours after UPSI, with some evidence for effectiveness up to 96 hours after UPSI (efficacy decreases as time since UPSI increases)*	• If the dose is vomited within 2 hours of taking the tablet, another dose is required • Safe during chestfeeding • Efficacy may be reduced if BMI > 30 or weight > 85kg • Possible drug interactions with griseofulvin or CYP3A4 inducers used within the past 4 weeks • UPA and LNG may impair each other's effects. After using UPA EC, wait ≥ 5 days before using LNG EC

Early Medical Abortion (EMA)

Pharmacists can dispense mifepristone and misoprostol combination tablets (e.g. MS-2 Step) without special registration, improving timely, accessible EMA – particularly groundbreaking for underserved populations.

Best Practice EMA Consultation

- Use a private consultation room or arrange telehealth.
- Explain medication use: dosing, timing, and common side effects.
- Screen for potential interactions with concomitant medication and supplements.
- Recommend a trusted support person during MS-2 Step administration and suggect comfort measures; rest, analgesics, antiemetics.
- Avoid tampons, bath, swimming, and sexual intercourse for 7 days post-treatment. Advise on what to do if patient vomits any doses.
- Outline red flags for urgent care including heavy bleeding, severe pain, signs of infection.
- Reinforce that bleeding does not confirm expulsion. Prescriber follow up at 2-3 weeks is essential.
- Encourage return for support and discussion of ongoing contraception.
- Provide written and online resources for the patient and support person.

EMA Resources & Support

- MS-2 Step program
- WHV Early Medical Abortion online course
- Pharmacists' Support Service (PSS): 1300 244 910, 8 am–11 pm daily, offers debriefing for challenging encounters
- Join the AusCAPPS Network for expert clinician and peer support, education, and resources on EMA and LARC.

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Common STIs

STI	Symptoms	Mistaken for
Chlamydia • Organism: Chlamydia trachomatis • Most reported STI in Australia, especially among people under 30 • **First-line recommended treatment is doxycycline** • Treatment duration depends on infections site(s) (genital/pharyngeal vs anorectal)	• Often asymptomatic • Dysuria • Penile urethral discharge • Vaginal discharge • Pelvic/testicular pain • Dyspareunia • Postcoital bleeding	• Urinary tract infection • Bacterial vaginosis • Thrush • Other STIs (e.g. gonorrhoea, trichomoniasis)
Gonorrhoea • Organism: Neisseria gonorrhoeae • Most commonly diagnosed in men who have sex with men, young (heterosexual) Aboriginal and Torres Strait Islander people living in remote and very remote areas, and travelers returning from high prevalence areas overseas. • **First line recommended treatment is ceftriaxone plus azithromycin** • Treatment dose will vary by infection site. • Emerging resistance in urban Australia may compromise the effectiveness of first-line treatments	• Penile urethral discharge • Dysuria • Vaginal discharge • Dyspareunia with cervicitis • Conjunctivitis • Anorectal symptoms (e.g. discharge, irritation, painful defecation, disturbed bowel function)	• Urinary tract infection • Prostatitis • Bacterial vaginosis • Thrush • Other STIs (e.g. chlamydia, trichomoniasis)
Syphilis • Organism: Treponema pallidum • Known as the "great imitator" – symptoms can mimic many other conditions • Infections increasing in major cities and among women of reproductive age, with ongoing outbreaks in remote Aboriginal and Torres Strait Islander communities • **First-line treatment is intramuscular injections of benzathine benzylpenicillin** • Treatment regimen depends on infection stage (e.g. early, late latent, tertiary)	• Asymptomatic in ~ 50% of infections • Painless ulcer (chancre) • Rash • Neurological symptoms in late stages	• Herpes • Non-infectious skin conditions • Other systemic illnesses
HIV • Organism: Human Immunodeficiency Virus • Untreated HIV causes chronic immune deficiency which can progress to AIDS (average ~10 years post infection) • PLHIV should start ART ASAP after diagnosis (regardless of immune status) – treatment is lifelong • Daily ART with sustained undetectable viral load prevents sexual transmission (U=U) and supports near-normal life expectancy	**Acute infection:** Symptomatic in ~70% • Fever, rash, lymphadenopathy, pharyngitis, myalgia, diarrhoea (seroconversion illness ~2 weeks post-exposure) **Asymptomatic phase:** • May last for years without symptoms **Immune deficiency:** • Symptoms due to low CD4 count; oral thrush, chronic diarrhoea, weight loss, skin infections, herpes zoster	Mistaken for many conditions. E.g. • Other STIs (e.g. syphilis, gonorrhoea, chlamydia) • Other viral infections (e.g. COVID-19, CMV, influenza, viral hepatitis) • Tuberculosis • Lymphoma and other cancers • Chronic fatigue syndrome • Rheumatoid arthritis
Bacterial Vaginosis • Transmission is associated with sexual activity • **First line treatment is metronidazole (oral or intravaginal)** • High recurrence rates (up to 80%); partner treatment now recommended • Polymicrobial vaginal dysbiosis (not a single organism)	• Malodorous vaginal discharge • Thin white or greyish homogenous vaginal discharge • Commonly asymptomatic	• Candidiasis • Trichomoniasis • Normal physiological discharge • Other causes of vaginal discharge (e.g. cervicitis, foreign body, hormonal changes)

HIV Prevention: PrEP vs PEP

HIV Pre-Exposure Prophylaxis (PrEP)	HIV Post-Exposure Prophylaxis (PEP)

• PrEP is the use of ART by HIV-negative individuals to prevent HIV infection.
• Refer to PrEP Guidelines
	• PEP is a 1-month course of ART taken by HIV-negative individuals after a potential exposure to HIV. Types of PEP:
	  ▫ Non-occupational PEP (nPEP): used after potential HIV exposure in non-work-related settings (e.g. condomless sex, sexual assault, sharing injecting equipment)
	  ▫ Occupational PEP (oPEP): used after potential HIV exposure in workplace settings (e.g. needle stick injuries in healthcare workers, mucosal exposures to blood or body fluids)
	• Refer to PEP Guidelines

Medications used
Daily PrEP:
• Tenofovir disoproxil fumarate + Emtricitabine – 300mg/200mg once daily
• Different salts of tenofovir disoproxil (fumarate, maleate, phosphate) co-formulated with emtricitabine are considered bioequivalent and interchangeable for PrEP use in Australia
• For HIV prevention, PrEP reaches protective levels:
  ▫ after 7 days of daily dosing for receptive anal sex
  ▫ after 21 days for receptive vaginal sex
On-Demand PrEP (2-1-1 method):
• Appropriate for cisgender men not on oestradiol-based hormones not requiring HBV treatment
• 2 tablets 2–24 hours before sex, then 1 tablet 24 hours later, and another 48 hours after first dose
	• 2-drug PEP is suitable for lower-risk exposures, while 3-drug PEP is recommended for higher-risk exposures (e.g. known HIV-positive source with detectable viral load)
	• PEP regimens:
	  ▫ Standard 2 drug regimen: tenofovir disoproxil 300 mg + emtricitabine 200 mg
	  ▫ Third drug options: dolutegravir 50mg or raltegravir 600mg HD tablets
	  ▫ These regimens are recommended by national guidelines, but drug availability may vary by service or location, depending on prescriber preference, supply, and local protocols

Who is eligible Patients with recent or anticipated HIV risk, including: • Condomless sex with partners of unknown or positive HIV status • Recent STI diagnosis • Shared injecting equipment	Patients with recent potential exposure to HIV. Potential considerations for nPEP initiation: • Exposure occurred within the past 72 hours • Exposure type meets PEP criteria (e.g. condomless sex, needlestick injury, sexual assault) • Risk assessment confirms a significant potential for HIV transmission • No known contraindications to PEP initiation (e.g. allergy to PEP components)
Access • Any prescriber, including GPs and nurse practitioners, can prescribe PrEP • Any pharmacy can dispense PrEP with a valid prescription • PBS-subsidised for Medicare card holders • Medicare-ineligible clients can access PrEP via private prescription or self-importation	• PEP is available in all Australian states and territories, though specific services and access pathways may vary by location. For more information, visit: Get PEP • PEP is not PBS-subsidised – access may be free or involve a small co-payment depending on the service provider and setting

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