US Government attacked on sexual health policies

In a letter to the Democratic Representatives in the government, the US Government has criticized the information from a government factsheet on HIV and sexually transmitted disease (STD) prevention, indicating that sexual activity is the best way to avoid sexually transmitted infections (STIs) and HIV but added that ‘lax‘ condoms were highly effective when used correctly and consistently’. The revised version says that ‘no protective method is 100% used correctly and consistently’. The Bush administration is also criticised by the American Civil Liberties Union (ACLU) for financially supporting virginity programmes in which youngsters are encouraged to ‘pledge’ to abstain from premarital sex. Abstinence Programs do not teach about contraceptive methods and are sometimes linked with the risk of sexual behaviour and we need to know the effect of vaccination on a population-based cohort. This is of particular importance in the developing countries where such rigorous selection criteria and evaluation of HPV infection are not practical and the impact on cervical cancer, where screening is not an option, needs to be seen. This will require much larger population studies for longer follow-up. In addition, HPV vaccines are known to be highly specific and vaccinating against one subtype may produce less effect on cervical disease as other HPV infections replace the eliminated type.

Effective vaccination against HPV has been anticipated for a number of years now and this has been demonstrated with a significant impact in patients with HPV 16 infection. The completion and final analysis of the trial will be as important as these early results and may produce essential data on the durability of protection offered by such a vaccination regime.

This small study questioned 186 university students on their understanding of the risks of venous thromboembolism (VTE) when taking the combined oral contraceptive (COC). One hundred and forty-five women in this group were taking the pill or had taken it in the past. The women were randomly divided into two groups. One group had the standard information about the COC and the other group had additional information about the risks of VTE following the statement of the Committee on Safety of Medicines (CSM) in 1999, where the previous advice of 1995 was withdrawn. Only about two-thirds of each group could give the correct advice when asked in a questionnaire. The additional information made no difference. The authors are of the opinion that there is very little research done on how to use contraception at first intercourse.

This study was not randomised and it depended on the clinician’s opinion whether the woman was offered Quick Start. In addition, the clinician’s discretion of the provider. How they advised contraception at first intercourse. The women were randomly divided into two groups. One group had the standard information about the COC and the other group had additional information about the risks of VTE following the statement of the Committee on Safety of Medicines (CSM) in 1999, where the previous advice of 1995 was withdrawn. Only about two-thirds of each group could give the correct advice when asked in a questionnaire. The additional information made no difference. The authors are of the opinion that there is very little research done on how to put information across to women regarding the risks of the pill, especially when information becomes sensationalised by unbalanced reporting in the press.

This paper reviews a method of starting the pill at the first visit to the clinic. The authors describe it as the ‘Quick Start’ method. They consider that the traditional way of starting the pill on the first day of the menstrual cycle is to avoid an unexpected pregnancy occurring in the first packet of pills. It is now established that taking hormones in early pregnancy are not harmful to the fetus so it does not matter when the pill is started. The authors have used the Quick Start method of starting the combined oral contraceptive (COC) for several years in their clinics and it is offered to patients at the discretion of the provider. How they advised starting the pill was at the preference of the clinician.

This study was not randomised. Two hundred and fifty women were recruited and 62 (25%) took the first pill at the clinic. The study reviewed the continuation rate of the method after one month. The clinician’s association with continuing the COC was if the partner was aware (odds ratio (OR) 3.9: CI 1.9–8.3), this was followed by Quick Start (OR 2.8: CI 1.1–7.3). There were no differences in bleeding pattern when the Quick Start method was used.

This study was not randomised and it depended on the clinician’s opinion whether the woman was offered Quick Start. In addition, the follow-up time was very short. So is the analysis reflecting the clinicians’ practice rather than the way the pill is started? The authors admit that a randomised trial is needed to see if there is a true effect. Does it as at the level of our own practice? The authors feel that it reduced the amount of counselling needed at the first visit as the women needed less information about how and when the pill was started. No one is forgetting the information. I am sure we all have instances in our own practice where young women have become pregnant after receiving the pills and before starting them. Maybe by getting them to take it at the level of our own practice, would it not be interesting to see when the women want to start the pill rather than when the clinician feels is the best time?


This is of particular importance in the developing countries where such rigorous selection criteria and evaluation of HPV infection are not practical and the impact on cervical cancer, where screening is not an option, needs to be seen. This will require much larger population studies for longer follow-up. In addition, HPV vaccines are known to be highly specific and vaccinating against one subtype may produce less effect on cervical disease as other HPV infections replace the eliminated type.

Effective vaccination against HPV has been anticipated for a number of years now and this has been demonstrated with a significant impact in patients with HPV 16 infection. The completion and final analysis of the trial will be as important as these early results and may produce essential data on the durability of protection offered by such a vaccination regime.

Reviewed by Judy Murty, DRCOG, MFFP
SCMO, Contraceptive and Sexual Health Services, Leeds, UK


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