Contraceptive use among women attending an open access genitourinary medicine department. Trewinnd K, Foley E. Int J STD AIDS 2009; 20: 573–574

In this short audit report, Trewinnd and Foley looked at contraception use in women attending a walk-in genitourinary medicine (GUM) clinic at the South Hants Hospital in Southampton, UK. It is known that abortion rates in the UK are rising, especially in the under-20s, and that this is occurring despite an increase in the use of contraception. They wanted to assess contraception use among women attending a GUM department.

They carried out a simple review of the last 26 months of all patients attending the clinic. Of the 152 women who completed the questionnaire, which appears to be a low proportion of the total number of patients attending, 36% were not using any reliable method of contraception. Potential reasons for this were given, and 50% of those surveyed wanted advice, and would accept the contraception that many women were willing to ask for further.

Due to patients’ perception of health care provision for the wider sexual health population. They put this down to over-reporting of contraceptive use in the GUM setting. In their discussion the authors reported use of condoms (which were considered unreliable) and had a poor uptake of long-acting reversible contraceptives (LARCs). Many women attending GUM clinics for sexually transmitted infection (STI) screening do so for the needs for those attending GUM clinics.


This paper reports a multi-centre, placebo-controlled, trial undertaken in Thailand with a community-based sample of 16 402 men and women aged 18–31 years. Analysis of study data found that a combination of ALVAC and AIDSVAX for vaccine regimen provided some protective effect against HIV infection. However, among individual groups who contracted HIV infection, there was a marginally smaller number of infections (i.e. fewer) than expected, for the full ITT analysis. This exclusion/modification is well described and eminently reasonable. Infection rates overall were 0.28%/year in the placebo group and 0.16%/year for vaccine (VE estimate (31.2%) was marginally better than that for full ITT analysis. This is because by chance the excluded ‘no hope’ participants had been under-vaccinated and possibly missed two doses – to 2. Despite the marginally smaller number of infections for the modified ITT analysis (by 7), the higher VE found meant a p value of 0.04 for the hypothesis of non-inferiority to placebo, whereas no difference was found at the conventional 5% threshold. However, while this VE might be statistically different from zero, it is almost as imprecisely estimated as for the full analysis, with true population VE having 95% CI of 1% to 51%. The paper also reported VE estimates by subgroups based on key characteristics (e.g. age, risk group), but clearly these subgroup estimates would be even less reliably estimated than the overall VE!

The discussion of the paper focuses on mechanisms for vaccine effect and immune responses presented in the data, with strong contradiction within the results (under current immunological theory) between the VE effect found, and the fact that among those testing positive for HIV after 24 weeks there was no difference between vaccine and placebo participants in viral load in the 6 weeks after infection. While there is mention of ‘lack of power’, there was no reflection as to why the study turned out to be underpowered. Part of the explanation would appear to be a lower than expected infection rate in the placebo group (0.28% vs 0.34% used in sample size calculation), but the main reason is the low VE found – 31% (or 26%), rather than the 50% used in the sample size calculation. This lack of power exacerbates a fundamental uncertainty that pertains in all trial reports, namely that we do not know for sure that the true population effect is at least as good as the point estimate from the sample (VE = 31%). The CIs reported remind us that the true effect might also be lower than the point estimate, and in this study, ‘lower’ might mean as low as 14%.

Nir is there reflection on the public health potential of a vaccine with an efficacy of around 30%. If a minimum of 50% VE was used for sample size calculation, this would mean that anything lower, in particular 31%, is deemed clinically unimportant. However, the likelihood is that the 50% minimum threshold for VE was used to ensure the study was feasible at all (i.e. did not require excessive sample size and/or time to result). It would have been helpful to have discussion of this and, given the uncertainty in the estimate, reflection on whether this might be a minimally useful effect for public health.

A pragmatic view must be that in the absence of any better vaccine being available, the ability to adopt such a vaccine may be important, and even if the VE is not as high as planned, it would seem that the vaccine could provide an important contribution to vaccination and policy formulation.

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