and objective assessment of SSI as a study endpoint. Only through a strict protocol and measures, such as photographic documentation of wounds, can potential assessment bias be minimised. Nevertheless, we agree that SSI is an unresolved multifactorial problem, which cannot be resolved by triclosan-coated sutures alone in either low-risk or high-risk groups of patients.

We declare no competing interests.

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Maximising the effect of combination HIV prevention in Kenya

In Africa, HIV is mainly spread through heterosexual transmission, the majority of individuals infected with HIV are women, and the highest incidence rates are in young women. However, Sarah-Jane Anderson and colleagues (July 19, p 249) recommend that the entire Kenyan HIV prevention budget should be spent only on the protection of men against HIV infection on the basis of their modelling study. They do not recommend any financial resources being spent on the protection of Kenyan women against HIV infection, unless the women are sex workers. Notably, in the general population, around 8% of Kenyan women and 4% of Kenyan men are infected.1 For men, they recommend the financing of voluntary male circumcision programmes (to reduce risk by 60%), behaviour change programmes (to reduce risk by 20%), and pre-exposure prophylaxis (PrEP) (to reduce risk by 75%). Anderson and colleagues also recommend provision of early antiretroviral treatment to men, which will increase survival time. However, their results1 show that it would not be cost effective to finance behaviour change programmes for women or to provide PrEP to women; nor would it be cost effective to provide early antiretroviral treatment to women.

We agree with regard to prioritisation of places in greatest need and we have previously shown that geographic targeting of resources in Africa (prioritising urban centres over rural areas) would be more cost effective in the prevention of HIV infections than a uniform strategy.4 Geographic targeting is beneficial because of the substantial geographic heterogeneity in HIV prevalence throughout Africa.5 However, we strongly disagree with Anderson and colleagues’ sex-biased recommendation for the allocation of prevention resources. Both Kenyan men and women should be provided with protection against HIV.

We declare no competing interests.

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Authors’ reply

We agree with Sally Blower and Brian Coburn that the aim of HIV prevention programmes is to reduce HIV incidence among men and women and that focusing resources on those locations with the greatest intensity of transmission can increase the effect of these programmes.

When limited resources are allocated in a way that maximises their effect, three factors determine where the investments are made.1 First, is the epidemiological context, which was captured in our model through fitting to multiple indicators, including the sex ratio of HIV prevalence. The second determinant is what interventions are available, their efficacy, and their cost. Whereas men can directly benefit from low cost and highly effective circumcision interventions, there is unfortunately no such analogous intervention for women. A number of additional strategies that were not modelled, such as cash transfer to girls and interventions that can prevent intimate partner violence, are promising interventions for women, and could also be considered for inclusion in programmes. The final factor is the budget. With the budget available, the greatest overall effect was not achieved by, for example, provision of all low risk women with pre-exposure prophylaxis (PrEP), but by focusing its use to sex workers in the highest