

masculinity and the fear of knowing their HIV status contribute to men's reluctance to undergo testing [7]. In addition, men reported feeling that primary health centers, which are generally staffed by female nurses, were not welcoming [7].

Among HIV testing interventions conducted in LMICs in sub-Saharan Africa, most interventions tried to reach men through women [8]. That approach must be changed to address HIV-related stigma among men. Evidence-based strategies were developed to increase HIV testing and decrease HIV-related stigma in other key populations (Table 1). Those strategies need to be adapted for South African men. Three main strategies need to be implemented: (1) "men-oriented" clinical health services, (2) widely offered and available HIV testing, and (3) home-based, HIV self-testing kits distributed in venues that men frequent. Targeted community-level education campaigns are also needed for men.

Although HIV testing and treatment has increased among South Africans, men are being left behind with the current HIV testing approach, similar to the situation in other LMICs. We hope that our proposed evidence-based strategies can be adapted for men and reduce HIV-related stigma. Better engagement and increased HIV testing among men is needed to reach the UNAIDS 90-90-90 targets and end the HIV epidemic.

Notes

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Table 1. Evidence-Based Strategies Implemented in Key Populations and Other Epidemics That Could Be Adapted to Increase Human Immunodeficiency Virus Testing Among Men in Low- and Middle-Income Counties

Problem	Solutions
Men do not feel welcome at primary care centers	Create "men-oriented" primary care centers that offer free HIV and sexually transmitted infections services staffed by men for men [9].
Stigma connected to HIV testing	Normalize HIV testing: require that HIV testing is made available and offered to newly married couples, government document and license applicants, prisoners, new employees, those opening bank accounts, those receiving a cellular phone SIM card, those entering military service, those entering government work, those entering government training programs, and those entering educational institutions [10, 11].
HIV testing is primarily conducted in government facilities	Distribute home-based HIV self-tests kits in venues that men frequent (eg, shebeens, churches, bars, clubs, sports facilities) [12, 13].

Abbreviations: HIV, human immunodeficiency virus; SIM, subscriber identity module.

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Noah Kojima¹ and Jeffrey D. Klausner^{1,2}

¹David Geffen School of Medicine and ²Fielding School of Public Health, University of California, Los Angeles

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Correspondence: N. Kojima, David Geffen School of Medicine, University of California, Los Angeles, 10833 Le Conte Ave, Los Angeles, CA 90095 (nkojima@ucla.edu).

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Reply to Kojima and Klausner

TO THE EDITOR—We have noted and agree with the insight provided by Kojima and Klausner that more successful human immunodeficiency virus type 1 (HIV-1) testing of men and engagement in care

of those who are HIV-positive are critical to controlling the epidemic, especially in high-burden low- and middle-income countries (LMICs) [1]. Our recent review focused on viral suppression, that is, achieving the last “90” in the World Health Organization goal of 90-90-90 in LMICs, and was not intended to specifically address the challenges of testing or linkage to care [2]. We did describe strategies for improving testing and linkage to care for populations at especially high risk for nonsuppression due to social vulnerability or lack of attention. Testing and treatment initiation are critical steps toward achieving epidemic control, but sustained viral suppression is a lifelong challenge with many barriers. Accordingly, we focused on the most pressing gaps in viral suppression among vulnerable subpopulations, including adult males.

In addition to men who have sex with men (MSM) and prisoners, we included the general population category in our paper (in which heterosexual, nonincarcerated men are included) [2]. Certainly, the recommendations made by Kojima and Klausner to improve testing among men in LMICs will help achieve the “expanded and consistent access to HIV testing” we recommended for the general population in Table 1 of our review [2]. Unfortunately, population-based, gender-disaggregated reports on 90-90-90 outcomes are not currently widely available in LMICs, but efforts are being made to address this gap. As more data emerge, we expect detailed intra- and cross-country comparisons of 90-90-90 outcomes for men (MSM and heterosexual), women (pregnant/breastfeeding and nonpregnant), and other key subpopulations.

Notes

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Jean B. Nachega,^{1,2,3} Nadia A. Sam-Agudu,^{4,5,6}
Lynne M. Mofenson,⁷ Mauro Schechter,⁸
John W. Mellors⁹

¹Departments of Epidemiology, Infectious Diseases and Microbiology, University of Pittsburgh Graduate School of Public Health, Pennsylvania; ²Departments of Epidemiology and International Health, Johns Hopkins Bloomberg School of Public Health, Baltimore, Maryland; ³Faculty of Medicine and Health Sciences, Department of Medicine and Centre for Infectious Diseases, Stellenbosch University, Cape Town, South Africa; ⁴Institute of Human Virology, University of Maryland School of Medicine, Baltimore; ⁵International Research Center of Excellence, Institute of Human Virology Nigeria, Abuja; ⁶Department of Paediatrics, University of Cape Coast School of Medical Sciences, Ghana; ⁷Elizabeth Glaser Pediatric AIDS Foundation, Washington, D.C.; ⁸Projeto Praça Onze, Universidade Federal do Rio de Janeiro, Brazil; and ⁹Division of Infectious Diseases, University of Pittsburgh School of Medicine, Pennsylvania

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Correspondence: J. B. Nachega, Department of Epidemiology, University of Pittsburgh Graduate School of Public Health, 130 DeSoto St, 503 Parran Hall, Pittsburgh, PA 15261 (jbn16@pitt.edu).

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Regulations Regarding Operating Room Head Attire Appear Discordant With Literature

TO THE EDITOR—We enjoyed reading the article entitled “Naked Surgeons? The Debate About What to Wear in the Operating Room” and would like to seek opinions from Bartek et al regarding some regulatory facts pertinent to the discussion specific to head attire. The existing rule regarding operating room (OR) attire in general in the United States is published

in the Federal Register (42 CFR § 482.51) (b), which verbatim states that “Surgical services must be consistent with needs and resources. Policies governing surgical care must be designed to assure the achievement and maintenance of high standards of medical practice and patient care” [1]. Medicare is the largest payer of health-care services in the United States. Current Medicare interpretation and implementation of this rule includes restrictions on type and source of operating room head attire and what anatomical structures such a cap should cover. Specific items that are contentious yet specifically outlined by the Association of periOperative Registered Nurses include: (1) Required covering of the nape of the neck and ears for all personnel in the OR, and (2) requiring the use of disposable bouffant caps as opposed to allowing “surgeon” style caps or laundered cloth caps. Because data evaluating surgical head attire has been produced as a result of a multidisciplinary effort on behalf of the stakeholders to which this rule pertains, such findings should be included in any discussion of acceptable guidelines; such a process normally involves stakeholder input [2–5].

There is substantial medical literature which was produced around the same time Bartek et al’s manuscript was published; these articles evaluate outcomes based on practice, some of which include:

1. 20 National Surgical Quality Improvement Program and Texas Alliance for Surgical Quality-affiliated hospitals were evaluated for surgical site infections (SSIs) and their association with various infection control practices; surgical attire was one that had no benefit toward prevention of SSIs [6].
2. Disposable bouffant hats had greater permeability, penetration, and greater microbial shed when compared with disposable skull caps. When compared with cloth skull caps, disposable bouffant caps demonstrated greater permeability, particulate contamination, and passive microbial shed [7].