and women, "reducing the incidence of genital warts, cervical intraepithelial neoplasia, and cervical cancer by 97%, 91%, and 91%, respectively". Although the initial expense will be higher, additionally accounting for the prevention of HPV-linked cancers in men (eg, anal, penile, and oropharyngeal cancers) will make this approach cost effective. The eventual eradication, or even a drastic reduction in the rate of HPV infections, will require vaccination of both sexes.

The results of HPV vaccination of people with previous HPV 16 or 18 infection have to be interpreted with caution. Contrary to what Michele Manos suggests, any differences in cervical intraepithelial neoplasia of grade 2 or above (CIN2+) between vaccinated and non-vaccinated women were non-significant, and only 3% of the study population was both HPV 16/18 DNA-positive and seropositive.[2,3]

Antibody-dependent exacerbation of viral infections seems to mainly concern specific RNA viruses, such as feline coronavirus, dengue virus, and feline immunodeficiency virus.[4] Currently, there is little evidence that antibody-dependent exacerbation facilitates HPV infection, particularly since the presently available vaccines against high-risk HPV types seem to neutralise viral particles before cell entry.

Although Manos considers the eradication of HPV infections a "noble goal", the development of HPV vaccines was unnecessarily delayed by doubts about the causal role of HPV infections in cervical cancer.[5] We do not have to wait for more detailed immunological studies before we start planning large-scale interventions, since they will be highly effective public health programmes. Without a strategic vision, global programmes will not be started.

We declare that we have no conflicts of interest.

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Expanding HIV care in Africa: making men matter in Johannesburg

In their Viewpoint (July 25, p 275),[1] Edward Mills and colleagues highlight the need to provide HIV testing and treatment services that are more accessible to men. As they note, men make less use of routine health services than women, partly because such services are often not easily accessible to those who are employed.

In South Africa, we have established services that provide screening, care, and treatment for HIV that target inner-city workers. The Emthonjeni centre is based in central Johannesburg at a large taxi rank used by an estimated 400 000 commuters daily. It provides screening for HIV and tuberculosis, along with blood pressure and glucose checks, and is convenient for commuters and those employed locally. Currently, those found HIV-positive are referred to nearby general practitioners with extended opening hours who provide HIV care and treatment; we plan to extend our services to provide HIV care on site. Taxi drivers are encouraged to be "ambassadors", promoting Emthonjeni services to their passengers. Additionally, Emthonjeni mobile units similarly provide screening to small (<100 employees) inner-city enterprises whose staff rarely have medical insurance.

Between March, 2008, and May, 2009, 14 494 people (57% men) were tested for HIV and received their results, of which 2432 (17%) were positive. 1784 of these are now in HIV care and 1069 have started antiretroviral therapy. We believe that initiatives like ours have potential to promote knowledge of HIV status among men and facilitate earlier access to antiretroviral therapy, thus reducing mortality.

We declare that we have no conflicts of interest.

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The missing ingredient in medicine patent pools

In response to your Editorial (July 25, p 266),[1] we do not find it any more surprising that pharmaceutical companies do not support the UNITAID patent pool, backed by nongovernmental organisations (NGOs), than the fact that NGOs give lukewarm support to GlaxoSmithKline's patent pool over neglected diseases. The pharmaceutical industry and NGOs have been vying for leadership over the issue of access to medicines in competition, rather than in cooperation, with one another.[2]

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There have been some positive outcomes to this competition. Without NGOs rallying public opinion and encouraging countries to issue compulsory licences, industry would probably never have started its current drug donation programmes. Without industry supporting changes at the World Trade Organization that facilitate access in least developing countries, NGOs would not have had a platform for promoting alternative mechanisms such as a prize system and patent pools.

Whatever the successes, however, they have been more on paper than in lives saved. Although it has advanced policy debates, competition has not led to the concrete solutions needed to create, manufacture, and deliver medicines to the world's poor. NGOs and industry need to work together to achieve success.[3]

We support *The Lancet*'s call for government leadership, but would go further. Not only should the government push pharmaceutical companies to license their HIV/AIDS patents to the UNITAID patent pool, the UK should also use its UNITAID board seat to encourage the organisation to invite industry to play a greater part in the design and management of the pool to avoid the perception that only NGOs have a say.

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ERG is a volunteer member of an expert advisory group to UNITAID. JFM has no conflicts of interest.

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Visceral leishmaniasis: time to better use existing resources

Talha Burki's World Report (Aug 1, p 371)[1] highlights the burden of visceral leishmaniasis in east Africa, where the epidemiology of the disease is complex and the case load comparatively low. Burki argues that case management and prevention strategies are deficient or absent, making donors reluctant to invest in their delivery. We disagree.

Effective control strategies exist. Although they could certainly be better, diagnostic tests are sensitive and specific, require limited cold-chain equipment, and are fairly easy to use.[2] A reasonable array of drugs is available to manage most cases effectively. Finally, contrary to Burki's statement that "bednets are not the answer", we believe that this intervention has great potential for prevention of visceral leishmaniasis in east Africa. Bednets are effective in protecting individuals from host-seeking sandfly vectors[3] and have been shown to reduce the incidence of infection or disease in specific settings.[4] The argument that people will not use nets seemingly contradicts the high rates of bednet coverage achieved through malaria control programmes.

A stand-alone control programme for visceral leishmaniasis is unsustainable. Instead, control efforts need to be better integrated into existing health-care delivery,[5] requiring donors to be more flexible about the use of disease-specific funds. Thus, diagnostics and drugs could be requested and supplied through routine commodity supply chains; microscopy and rapid diagnostic testing could be operationalised in health facilities already providing services for malaria or tuberculosis; and many areas coendemic for visceral leishmaniasis and malaria could be prioritised for bednet distribution. These approaches would represent a crucial step towards reducing the burden of visceral leishmaniasis.

We declare that we have no conflicts of interest.

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Department of Error

Peek GJ, Mugford M, Tiruvoipati R, et al, for the CESAR trial collaboration. Efficacy and economic assessment of conventional ventilatory support versus extracorporeal membrane oxygenation for severe adult respiratory failure (CESAR): a multicentre randomised controlled trial. Lancet *2009; **374:** 1351–63*—In this Article (Oct 17), the penultimate sentence of the Findings section of the Summary (p 1351) should have read: "Referral to consideration for treatment by ECMO led to a gain of 0·03 quality-adjusted life-years (QALYs) at 6-month follow-up." The proportion of patients who died at 6 months or less before discharge in the conventional management group in table 3 (p 1354) should have been 45 (50%). In sentence 2 of paragraph 8 of the Results (p 1358), cost-effectiveness estimates were given in GB pounds. The third sentence of the third paragraph of the Discussion (p 1359) should have read "We believe that the lung disease in these patients was slightly less severe than in the three-quarters of patients who did not respond to conventional management and received ECMO, of whom 63% survived."