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Authors' reply

This online publication has been corrected. The corrected version first appeared at thelancet.com on April 11, 2016

Robert Grant and David Glidden present interesting data from the iPrEx trial.[1] By contrast with their findings, the PROUD study[2] did not show a major reduction over time in risky sexual behaviour. The figure shows the number of different partners with whom participants reported receptive anal sex without a condom in the 90 days before visits at enrolment, and at 12 months and 24 months. In both the immediate and deferred PrEP groups, about 80% of participants reported one or more partners at 12 months and at 24 months (not necessarily the same individuals). Thus for most men it was appropriate to continue prescribing PrEP, suggesting that subpopulations might exist who need the drug for a longer time than suggested by the iPrEx data. We note the iPrEx analysis is limited to seroconverters who, by definition, were at especially high risk of HIV infection; the PROUD analysis[2] excludes men who stopped attending clinic and who might have been at lower risk. These factors could partly account for the difference between the findings of these two analyses.

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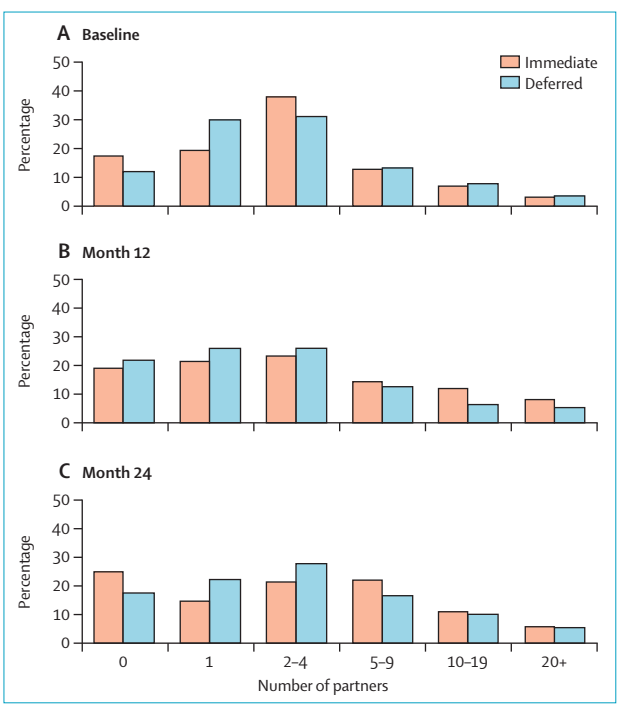

Figure: **Number of partners with whom participants reported receptive anal sex without a condom in previous 90 days**
Based on 515 values at baseline, 406 values at 12 months, and 244 values at 24 months. Further data will become available at 24 months with continued follow-up.

Nonetheless, we agree with Grant's and Glidden's key point about individual variation in the risk of acquiring HIV infection, including periods of no or low risk. In view of this, we were surprised that they did not mention the IPERGAY study,[3] which reported that intermittent PrEP (two tablets before sex and a further two tablets after sex) was highly effective. This is arguably a more logical and cost-effective approach than daily dosing for individuals who "[pass] through HIV risk moments" rather than being at continuous substantial risk. PrEP guidelines for the men who have sex with men population at risk of HIV are not uniform at present: US guidelines recommend daily dosing only,[4] whereas the European AIDS Clinical Society recommend either daily or intermittent dosing.[5] Further evaluation is needed to determine the optimum way to promote and deliver PrEP in different populations, taking account of the wide range of behaviours and the need to tailor regimens to individual circumstances.

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Refusal to provide health care to people with HIV in France

Refusals to provide care to people with HIV have been reported in the USA,[1] the UK,[2] and elsewhere in Europe,[3] but their frequency remains poorly documented. In 2015, the French parliament examined a law that includes an article on non-discrimination in access to health care and the possibility of doing tests to determine the extent and nature of the discrimination. During the legislative debates, AIDES did a situation testing survey[4] to ascertain the frequency and nature of refusals to provide dental and gynaecological care to people with HIV.

The situation testing survey was done by telephone in 440 dental and 116 gynaecology offices randomly selected in 20 French cities, chosen on the basis of their HIV incidence and medical density for these two specialties. The replies to two callers requesting an appointment for the same reason (scaling or a vaginal smear), both with the same sociodemographic characteristics and the same health insurance status, differing only in their HIV serological status, were compared. Negative responses were categorised as outright refusals (explicit refusals to grant an appointment), disguised refusals (arguments aimed at discouraging the caller from making an appointment), and discriminatory remarks with no refusal to provide care.