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Authors' response

We thank Kunte *et al*[1] for a critical reading of our article[2] and expressing their appreciation for our work on the prophylactic use of hydroxychloroquine (HCQ) in healthcare workers (HCWs). The authors[1] found our study design to be suitable and the issues we covered while exploring factors associated with SARS-CoV-2 infection in HCWs appropriate. It also did not escape the notice of the authors of the letter[1] that we had underscored the importance of use of personal protective equipment, as a preventive strategy in conjunction with HCQ.

The lower response rate in our study, as has been pointed out, is a known limitation of a telephone-based survey method. It has been seen that while face-to-face surveys are able to cover wider grounds and attain greater representativeness, telephone surveys may need to approach a larger sample of population to compensate for non-participation. However, telephone-based surveys perform better compared to online, mail, or self-reported data collection methods[3,4]. We tried to maximize the response rates by reaching out to non-responders by calling them over the phone two additional times, preferably at a different time than the previous call. Worth noting was that the response rates (61% in cases and 68% in controls) in our study were higher compared to the rates encountered in other studies that engaged HCWs in India (paediatricians: 57%)[5], Germany (physicians: 56%)[6], France (physicians: 59%)[7] and the USA (internists: 64%)[8].

Our study did not seek to establish the difference in clinical severity of COVID-19 between HCWs taking HCQ prophylaxis and those not taking it. Answering this question would require a differently designed

investigation. We find the authors' proposition of a built-up period of HCQ administration before engaging in clinical care of COVID-19 patients interesting. However, this would need to be based on the data generated through prospective HCQ prophylaxis study. We found associations through case-control investigation, which were indicative of the prophylactic effect of HCQ, and highlighted the need for clinical trials as also suggested by Kunte *et al*[1].

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