

1 **Comment for Session 1 of RSS Meeting on R_0**

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7 **Main**

8 I congratulate: Parag, Thompson, and Donnelly; Jewell and Lewnard; and Coffeng
9 and de Vlas on their papers which highlight both the benefits and potential pitfalls
10 associated with statistics such as the doubling time T_d and the basic reproductive
11 number R_0 during the COVID-19 pandemic. As is appropriate for a
12 methodological meeting, these papers focus on the choice of statistics themselves
13 rather than the specific data sets on which estimates are based. In this brief
14 comment, I would like to also highlight opportunities for innovative study design
15 and mention specifically the value of accurate measures of infection prevalence.

16 During a pandemic, when the value of epidemiological information is much higher
17 than at other times, there is an opportunity to gather novel population data which
18 would otherwise be deemed too expensive. In the UK, there are a number of
19 examples of community surveys, including the Office for National Statistics
20 Coronavirus Infection Survey [Pouwels et al., 2021], Virus Watch
21 [Hayward et al., 2020] and the REal-time Assessment of Community Transmission
22 (REACT) [Riley et al., 2020]. REACT is a program of studies separated into
23 REACT-1 [Riley et al., 2021] that collects self-administered nose and throat swabs
24 [Riley et al., 2021] and REACT-2 that collects self-administered lateral-flow
25 antibody tests [Ward et al., 2021].

26 Incidence and growth-rate estimates based on routine surveillance are subject to
27 changes in the propensity of individuals to seek tests and in the ability of the

28 system to supply those test [Omori et al., 2020]. Community surveys can help to
29 overcome these issues. For example, in recruiting participants randomly from
30 those registered for healthcare in England, the REACT-1 design attempts to reduce
31 the impact of temporal variation when making growth rate estimates
32 [Riley et al., 2021].

33 In addition to growth rates, population surveys of infection provide estimates of
34 prevalence at national and regional scales that can be easily understood as
35 measures of individual risk: measured swab-positivity is easily translated into odds
36 of people in a community being infected. While doubling times and reproduction
37 numbers are valuable as indicators of future changes in risk, it could be argued that
38 their prominence in official UK government communications in the UK has led to
39 their value in assessing current levels of risk being misunderstood.

40 **References**

41 [Hayward et al., 2020] Hayward, A., Fragaszy, E., Kovar, J., Nguyen, V., Beale,
42 S., Byrne, T., Aryee, A., Hardelid, P., Wijlaars, L., Erica Fong, W. L., Geismar,
43 C., Patel, P., Shrotri, M., Navaratnam, A. M. D., Nastouli, E., Spyer, M.,
44 Killingley, B., Cox, I., Lampos, V., McKendry, R. A., Liu, Y., Cheng, T.,
45 Johnson, A. M., Michie, S., Gibbs, J., Gilson, R., Rodger, A., and Aldridge,
46 R. W. (2020). Risk factors, symptom reporting, healthcare-seeking behaviour
47 and adherence to public health guidance: protocol for virus watch, a prospective
48 community cohort study.

49 [Omori et al., 2020] Omori, R., Mizumoto, K., and Chowell, G. (2020). Changes
50 in testing rates could mask the novel coronavirus disease (COVID-19) growth
51 rate. *Int. J. Infect. Dis.*, 94:116–118.

52 [Pouwels et al., 2021] Pouwels, K. B., House, T., Pritchard, E., Robotham, J. V.,

53 Birrell, P. J., Gelman, A., Vihta, K.-D., Bowers, N., Boreham, I., Thomas, H.,
54 Lewis, J., Bell, I., Bell, J. I., Newton, J. N., Farrar, J., Diamond, I., Benton, P.,
55 Walker, A. S., and COVID-19 Infection Survey Team (2021). Community
56 prevalence of SARS-CoV-2 in england from april to november, 2020: results
57 from the ONS coronavirus infection survey. *Lancet Public Health*,
58 6(1):e30–e38.

59 [Riley et al., 2021] Riley, S., Ainslie, K. E. C., Eales, O., Walters, C. E., Wang, H.,
60 Atchison, C., Fronterre, C., Diggle, P. J., Ashby, D., Donnelly, C. A., Cooke, G.,
61 Barclay, W., Ward, H., Darzi, A., and Elliott, P. (2021). Resurgence of
62 SARS-CoV-2: Detection by community viral surveillance. *Science*,
63 372(6545):990–995.

64 [Riley et al., 2020] Riley, S., Atchison, C., Ashby, D., Donnelly, C. A., Barclay,
65 W., Cooke, G., Ward, H., Darzi, A., Elliott, P., and REACT study group (2020).
66 REal-time assessment of community transmission (REACT) of SARS-CoV-2
67 virus: Study protocol.

68 [Ward et al., 2021] Ward, H., Atchison, C., Whitaker, M., Ainslie, K. E. C., Elliott,
69 J., Okell, L., Redd, R., Ashby, D., Donnelly, C. A., Barclay, W., Darzi, A.,
70 Cooke, G., Riley, S., and Elliott, P. (2021). SARS-CoV-2 antibody prevalence in
71 england following the first peak of the pandemic. *Nat. Commun.*, 12(1):905.