How relevant is the basic reproductive number computed during the coronavirus disease 2019 (COVID-19) pandemic, especially during lockdowns?

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To the Editor—The basic reproductive number R_0 in epidemiology is defined as the average number of secondary infections that will be likely produced by a primary infected person in a predominantly susceptible population. Mathematically, it is an accurate measure of disease spread.[1] However, the value of R_0 is difficult to estimate from epidemiological data, for example, during the ongoing coronavirus disease 2019 (COVID-19) pandemic. In recent studies on COVID-19, for example,[2–4] computed a time-varying R_0 has been computed, which researchers called R_t. They ascertained that the decline in R_t is due to continued lockdowns and nonpharmaceutical interventions. Although the conclusions in those studies are supported by the data, estimates of R_t raise methodological issues that require further consideration. Here, we convey the essential and technical difficulties in estimating either R_0 or R_t from the data, and we discuss how a model-based R_0 may not adequately capture the actual spread of the disease. Although these limitations are generally unavoidable (even after defining appropriate error structures and statistical modeling), the inappropriate use of this metric, especially in the ongoing COVID-19 pandemic, has important implications for infectious disease mitigation planning.

Suppose that Y_0 is the number of infected people at time t_0 who could generate secondary infections between t_0 and t_1, say, Y_1. However, the testing of all the potential infected individuals during this period need not be complete. Y_1 could generate further secondary infections between t_1 and t_2, say, Y_2, and so on. Again, the testing of the samples through contact tracing need not be complete (Fig. 1). That is, Y_{i+1} at t_{i+1} could be generated by Y_i at t_i for $i = 0, 1, \ldots$. In reality, during most epidemics, and especially for the COVID-19 pandemice, only a fraction of Y_i, say, Y_i' are ever reported (and also diagnosed due to incomplete testing) such that $Y_i' < Y_i$ for all i.[5,6] This partial reporting (including partial diagnosis and partial testing) could also be due to lockdowns and lack of proper knowledge regarding COVID-19 (forced or natural behavior changes in the community, eg, lockdowns and use of masks). The average number of secondary infections generated by Y_i individuals is Y_{i+1}/Y_i. If there is variation in the infected people or a rapid aggregation of infected people, then it is more appropriate that we should use the geometric mean instead of the arithmetic mean approaches to determine expected reproductive numbers. Not only is the former far better suited than the latter to deal both with fluctuations and numbers that are not independent of one another, it also is the only correct mean when using results that are presented as ratios.[7–9]

Suppose that Y_{i+k} is the number of infected people at time t_{i+k} when lockdowns are introduced at k for $k = 0, 1, 2 \ldots$.

Assume that

$$Y_{i+k} < Y_{i+k+1} \text{ for } k = 0, 1, 2, 3, 4. \quad (1)$$

The percentage of growth in the number of infected people during the 4 time intervals (t_{i+k}, t_{i+k+1}) for $k = 0, 1, 2, 3, 4$, are, say, $\gamma_{i+k}\%$ for $k = 0, 1, 2, 3, 4$, respectively. These growth percentages are computed as

$$\gamma_{i+k}\% = \left(\frac{Y_{i+k+1} - Y_{i+k}}{Y_{i+k}} \times 100\right)\% \text{ for } k = 0, 1, 2, 3, 4.$$

The secondary infections caused by an infected individual (Fig. 1) are the people who were not traced by the system. This step assumes that all of the infected people who were identified by the system were either quarantined or were controlled not to spread the virus further. Only a proportion of infected people who were tested and identified during lockdowns was reported, and others were either not diagnosed or not reported. Asymptomatic individuals could be anywhere in the process; that is, they were part of the identified and reported group or were among those who had not been contact traced or diagnosed. The mean (geometric) number of secondary infections would be appropriate because we were considering proportionate secondary infections. Hence, the mean number of secondary infections during $(t_i, t_i + 4)$ is given by

$$\sqrt[4]{\prod_{k=0}^{3}(1 + \gamma_{i+k}\%)}. \quad (2)$$

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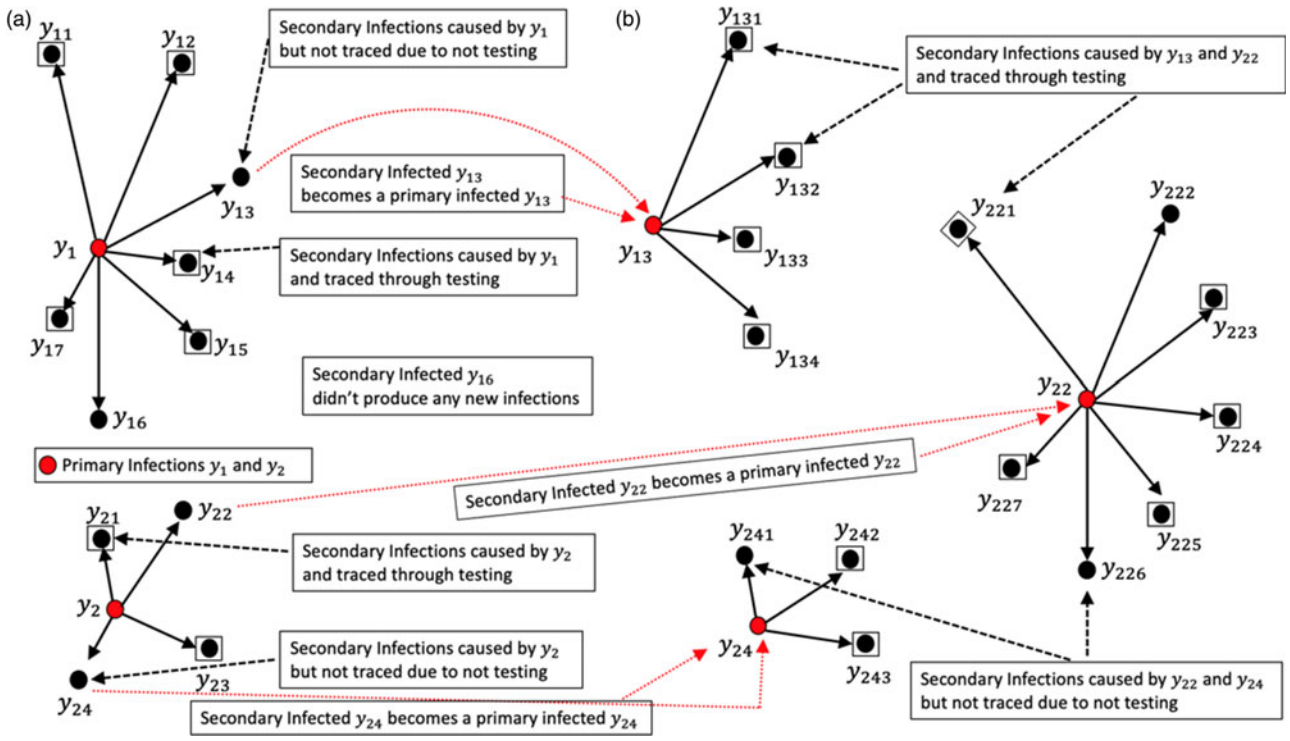

Fig. 1. Demonstration of average number of secondary infections observed through tracing and diagnosing. In **(a)**, let y_1 and y_2 be the two primary COVID-19 infected, where the individual y_1 had generated 7 secondary infections out of which 5 were traced and diagnosed. The individual y_2 had generated 4 secondary infections out of which 2 were traced and diagnosed. The observed arithmetic average secondary infected by $\{y_1 y_2\}$ in (a) was $\frac{5+2}{2} = 3.5$, but the true average by them was $\frac{7+4}{2} = 5.5$. In **(b)**, the third secondary infection in **(a)**, say, y_{13} becomes a primary infected that generates 4 secondary infections out of which all were traced and diagnosed. In **(b)**, the second secondary infection in **(a)**, say, y_{22} becomes a primary infected that generates 7 secondary infections out of which only 5 were traced and diagnosed. Finally, in **(b)**, the fourth secondary infection in **(a)**, say, y_{24} by primary infected y_2 becomes a primary infected that generates 3 secondary infections out of which only 2 were traced and diagnosed. The observed arithmetic average secondary infections by $\{y_{13} y_{22} y_{24}\}$ was $\frac{4+5+2}{3} = 3.67$, but if every COVID-19 patient was diagnosed, then the true average secondary infections by them was $\frac{4+7+3}{3} = 4.67$. Note that the total traced and tested could be many fold more than the actual positive cases found. Suppose 22 secondary infections generated during the third generation, then the mean number of secondary infections (geometric) obtained during three generations of spread is $\sqrt[3]{3.61} = 1.53$.

Similarly, the trend in eq. (1) continues for $k = 0, 1, \ldots n$, then the mean number of secondary infections during the lockdown period $(t_i, t_i + n)$ is given by

$$\sqrt[n]{\prod_{k=0}^{n-1}(1 + \gamma_{i+k}\%)}. \tag{3}$$

This point applies to several studies in which the reporting over time of the study is not constant. Even if the testing numbers and testing patterns are constant over a period, the proportion of underreported cases may not be constant. Thus, the estimation of R_0 is likely to be highly variable in any given situation. For the practical purposes of computing R_0 or R_t we usually have data on $Y_i^{'}$, the number tested.

When the ratios Y_{i+k+1} / Y_{i+k} for $k = 0, 1, \ldots n$ are considered, then the geometric mean of these growth rates would be

$$\sqrt[n]{\prod_{k=0}^{n} \frac{Y_{i+k+1}}{Y_{i+k}}} = \sqrt[n]{\frac{Y_{i+n+1}}{Y_i}}. \tag{4}$$

However, $\widehat{R}_0$ or $\widehat{R}_t$, (the estimated basic and time-varying reproductive numbers at the start or ongoing through an epidemic, respectively) may not be at all close to R_0 or R_t even if the Y_i values are generated from a mathematical model for a period $i > 0$ that uses data on susceptible, exposed, infected, and recovered in which the underlying epidemiological processes are time varying. This factor will introduce bias to estimates of model-based basic reproductive rates and time-varying reproductive rates. Some other limitations in various studies arise due to computing R_t after lockdowns were relaxed. Possibly, heterogeneity exists in the data that could have masked R_t measures due to the computation of subnational and regional parameters in several COVID-19–affected countries.

The lesson here is that mathematical models must be used with care. They must be fitted to the data, and their accuracy must be carefully monitored and quantified.[10] Any alternative course of action could lead to wrong interpretation and mismanagement of the disease with disastrous consequences.

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Prevention and management of coronavirus disease 2019 (COVID-19) in prison: Feedback from an experience in a French remand center

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To the Editor—The prisons are at high risk of coronavirus disease 2019 (COVID-19) epidemics because they concentrate a disadvantaged population within a significantly small proximity (Fig. 1).[1,2] Faced with the spread of severe acute respiratory coronavirus virus 2 (SARS-CoV-2), French prison authorities and international learned societies have issued recommendations to organize prison health care units.[3–6] These structures located within the prisons were created in France in 1994 and operate thanks to the university hospital center. We reorganized the prison in Brest, France, to respond to the COVID-19 pandemic.

First, we implemented the following measures: any detained person arriving in prison must disinfect their hands with alcohol-based hand sanitizer (ABHS), must wear a surgical mask, must take his temperature, and must declare any clinical signs. We also implemented numerous additional measures. Detainees are isolated in a cell for 14 days before joining the detention quarters. Supervisors and detainees routinely wear surgical masks during close physical contact. Walks are authorized in compliance with social distancing measures: wearing a surgical mask, respecting the distances between inmates, disinfecting the hands with ABHS.

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At the end of the confinement, personal linen is placed in water-soluble bags collected by the supervisors. The laundry is washed at 60°C for 30 minutes in a dedicated machine. After 3 hours of ventilation, the cell is disinfected with bleach diluted with 0.5% active chlorine. The prisoner is then relocated in his neighborhood of origin.

Prisoners suspected of COVID-19 are screened in the health unit by nasopharyngeal swab. The prisoner and their codetainees are confined to their cells pending the results. If the test is positive for COVID-19, the prisoner remains confined for 14 days. He is allowed to go for a walk alone, equipped with a surgical mask. He must not have direct contact with other prisoners. Inmates who have shared the same cell are also confined alone for 14 days.

All medical, paramedical, and penitentiary personnel must wear surgical masks in the care unit. Prisoners with signs suggestive of COVID-19 are isolated from other patients in a specific room for screening. The consultation rooms are disinfected after each passage of inmates and are ventilated for 3 hours in the event of suspicion of COVID-19.

The management of COVID-19 in prison must include systematic screening of new arrivals and suspected persons, cohorting and social distancing, work stoppage for professionals contaminated, and training of professionals and inmates regarding hygiene precautions.[7] During the first epidemic wave, the French penitentiary authorities suspended visits to prisoners. Thanks to these

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