RESEARCH ARTICLE

Pooled testing conserves SARS-CoV-2 laboratory resources and improves test turn-around time: experience on the Kenyan Coast [version 1; peer review: 3 approved]

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Abstract

Background. International recommendations for the control of the coronavirus disease 2019 (COVID-19) pandemic emphasize the central role of laboratory testing for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), the etiological agent, at scale. The availability of testing reagents, laboratory equipment and qualified staff are important bottlenecks to achieving this. Elsewhere, pooled testing (i.e. combining multiple samples in the same reaction) has been suggested to increase testing capacities in the pandemic period.

Methods. We discuss our experience with SARS-CoV-2 pooled testing using real-time reverse transcription polymerase chain reaction (RT-PCR) on the Kenyan Coast.

Results. In mid-May, 2020, our RT-PCR testing capacity for SARS-CoV-2 was improved by ~100% as a result of adoption of a six-sample pooled
testing strategy. This was accompanied with a concomitant saving of ~50% of SARS-CoV-2 laboratory test kits at both the RNA extraction and RT-PCR stages. However, pooled testing came with a slight decline of test sensitivity. The RT-PCR cycle threshold value ($\Delta C_t$) was ~1.59 higher for samples tested in pools compared to samples tested singly.

**Conclusions.** Pooled testing is a useful strategy to increase SARS-CoV-2 laboratory testing capacity especially in low-income settings.

**Keywords**
COVID-19, Pooled testing, SARS-CoV-2, Kilifi, Kenya

This article is included in the KEMRI | Wellcome Trust gateway.

This article is included in the Coronavirus (COVID-19) collection.
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Introduction
In Kenya, the first case of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) infection, the etiological agent of coronavirus disease 2019 (COVID-19), was confirmed on the 12th March 2020. Since then the number of confirmed cases has risen steadily, each day, and as of 15th July 2020, a total of 11,252 SARS-CoV-2 positives had been confirmed in the country from 225,495 samples tested, ~5.0% positivity rate overall. Scaling up of testing to enhance early case detection, isolation, treatment and to guide contact tracing has been a cornerstone strategy, worldwide, in managing the COVID-19 pandemic. Between 15th May and 15th July 2020, an average 3,046 laboratory tests were performed daily in Kenya (Figure 1, panel A). Increasing the number of daily tests is a challenge for local laboratory capacity.

Real-time reverse transcription polymerase chain reaction (RT-PCR) is the gold standard method for SARS-CoV-2 diagnosis. The diagnostic process is initiated by viral nucleic acid purification from a suspected patient sample, followed by concurrent target nucleic acid amplification and detection. Soon after 30th January 2020, when COVID-19 was declared a public health emergency of international concern, SARS-CoV-2 diagnostics were recognized as an important bottleneck in the efforts to effectively contain the epidemic. Laboratory testing capacity may be limited by the unavailability of equipment, reagents and qualified staff. As a result, more efficient testing protocols have since been pursued to facilitate the mantra “test, trace, isolate and treat”. One such protocol is pooled testing.

Pooled testing is a diagnostic approach where samples from multiple patients are combined and analyzed in a single test reaction. If the reaction is positive, then individual samples that contributed to that reaction need to be retested singly (Figure 2). Pooled testing was first used during world war II

A. Daily nationwide tests

B. Daily KEMRI-Kilifi tests

Figure 1. Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) laboratory testing in Kenya between 21st March and 15th July 2020. Panel A, the bars show reported daily nationwide tests. Panel B, bars shows the daily tests undertaken at the KEMRI-Kilifi laboratory and when major protocol changes were implemented. In both panels the secondary y-axis shows the daily proportion of tests positive indicated by the dashed line.
to efficiently identify syphilis infected military recruits\(^5\). More recently, this strategy has been applied in blood banks to screen blood products for HIV-1, hepatitis B and C viruses\(^6,10\). Now, again, this strategy is finding application in identifying SARS-CoV-2 infected individuals in the ongoing COVID-19 pandemic\(^7\)–\(^15\).

Here, we evaluated whether pooled testing is a viable protocol for SARS-CoV-2 diagnosis in our Kenya setting and potentially other low-to-middle income settings across the globe. We first applied the pooled testing strategy in mid-May 2020 when we were receiving >300 SARS-CoV-2 test requests daily but had access only to the low-throughput manual RNA extraction kits (QIAamp Viral RNA Mini Kits). On applying pooled testing, we were able to keep up with the increasing volume of SARS-CoV-2 test requests daily and have henceforth maintained this strategy even with the high-throughput RNA extraction platforms due to the associated resource conservation.

![Figure 2. A schema of how the pooled testing strategy works.](image)

The example illustrates that if an infection is occurring at about 5.6% (i.e. 1/18) then by the pooled testing, a total of 9 tests can identify the infected individual. In Kenya, the current severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) positivity rate is ~5.0% thus pooled testing can conserve 50% of testing kits.

**Methods**

**Study site/location**

This study was undertaken at the Kenya Medical Research Institute (KEMRI)-Wellcome Trust Research Programme (KWTRP) located in Kilifi town, on the Kenyan Coast between 21\(^{st}\) March 2020 and 15\(^{th}\) July 2020. Since the start of the SARS-CoV-2 epidemic in Kenya, in March 2020, KEMRI-Kilifi has been supporting the County Health Department Rapid Response Teams (RRTs) in coastal region of Kenya in SARS-CoV-2 laboratory testing. Respiratory samples collected by the RRTs for testing are received in 2–3 ml of Universal Transport Media or Virus Transport Media. Data on the aggregated Kenya-wide daily SARS-CoV-2 laboratory tests and number of daily positives were compiled from the Kenya Ministry of Health (MoH) website, specifically the periodic COVID-19 situational reports and the daily press releases.

**Ethics and consent**

The work was reviewed internally at KEMRI and considered part of the efforts to promptly develop efficient laboratory protocols for scaling up public health response to the COVID-19 pandemic. As a result, individual patient consent was considered unnecessary for these optimisation experiments. The national daily tally of SARS-CoV-2 tests done and number positive is freely available to the public at the MoH website inclusive of those from KEMRI laboratories.

**Pooled testing protocol**

For an optimal pooled testing protocol, there are three key considerations\(^16\): (i) the diagnostic protocol limit of detection (LoD) to ensure adequate sample volume is included in the
pools, (ii) the diagnostic test sensitivity and specificity and (iii) the prevalence of the infection to guide the optimal pool size (e.g. if infection prevalence reaches 30%, then pooling in groups of 3 would lead to most pools being positive and the need for individual testing, hence no gain in efficiency). In general, pooled testing is most useful when the prevalence of the infection is low (typically <15%)\(^7\).

To select the optimal pool size we used the web-based shiny application from Christopher Bilder available at https://www.chrisbilder.com/shiny/ under Hierarchical testing. Assuming a SARS-CoV-2 prevalence of 4% in our query samples (see later in results section on observed test positivity rate, Figure 1), test sensitivity of 90%, test specificity of 98%,\(^18\) adoption of a two stage pooling algorithm (Figure 2) and a pre-specified preferred pool size range of 3–10, the algorithm calculated the optimal testing configuration was a pool size of n=6 followed by individual testing of samples in positive pools.

**Laboratory procedures**

Our SARS-CoV-2 laboratory testing protocol has been described elsewhere;\(^19\) Briefly, viral RNA purification from the raw samples was extracted using either of three commercial kits from QIAGEN (Manchester, UK); QIAamp Viral RNA Mini Kit (Catalogue # 52906), RNeasy \(^®\) QIAcube \(^®\) HT Kit (Catalogue # 74171) and QIASYMPHONY \(^®\) RNA Kit (Catalogue # 931636). The manufacturer’s instructions were followed for all the three kits. For the individual samples, viral RNA were extracted starting from volume of 140 µl of raw sample while for the pooled samples viral RNA were extracted from a starting volume of ~280 µl (each sample contributing 47 µl) (Figure 2). In both cases the purified RNA were collected in 60 µl of elution buffer.

RT-PCR was undertaken using primer/probes from the following four protocols, the details of which we described elsewhere;\(^11\); (i) the Berlin (Charité)\(^20\) (targeting E i.e. envelope gene, N i.e. nucleocapsid gene or RdRp i.e. RNA-dependent RNA-polymerase gene), (ii) European Virus Archive – GLOBAL (EVA-g) (targeting E or RdRp genes), (iii) Da An Gene Co. detection Kit (targeting N or ORF1ab) and Beijing Genomic Institute (BGI) RT-PCR kit (targeting ORF1ab). For the first two protocols only primer/probe mixes from the original protocol were used, as for the other RT-PCR components we used alternative RT-PCR reagents while the latter two are commercial kits that come with all RT-PCR components pre-mixed ready for native RT-PCR reagents while the latter two are commercial kits.

| Sample pool # | Original Ct | Pool Ct | Individual Ct |
|---------------|-------------|--------|---------------|
| 1 (Pool 1)    | 20.65       | 21.88  | 19.63         |
| 2 (Pool 2)    | 24.78       | 25.60  | 23.18         |
| 3 (Pool 3)    | 27.17       | 30.28  | 27.17         |
| 4 (Pool 4)    | 29.63       | 34.18  | 30.86         |
| 5 (Pool 5)    | 33.36       | Negative | 35.18        |
| 6 (Pool 6)    | 36.24       | Negative | Negative      |

*Table shows the Ct values obtained when the samples were tested the first time individually (Original Ct), when pooled testing was applied (Pool Ct) and when retested individually again (Individual Ct).
rate among tested samples during this period, and the anticipated increase in the following weeks, we inferred that an n=6 pool size was the optimal at that time point. Note that with similar assumptions of RT-PCR sensitivity and specificity parameters stated in the methods section, for SARS-CoV-2 positivity rates of: 5-7%; 8-15%; and 16-20% a pool size of: n=5, n=4 and n=3 would be recommended, respectively.

The pooled testing strategy allowed us to screen 471 samples on the first day (14th May 2020) of deployment up from 264 the previous day, a 78% increase. Importantly the pooled testing protocol was using QIAamp manual Extraction Mini Kit for viral RNA purification a switch from the high-throughput QIAcube® HT Kit that we had deployed since 18th April 2020 (Figure 1, panel B).

Test sensitivity dynamics in pooled testing
The pools that included a strongly positive sample with a Ct value <33.0 also gave a positive result in the pools, while the pools including previously weakly positive samples that had a Ct value above 33.0 gave a negative result in the pools Table 1. On repeat testing the previously positive individually, all confirmed positive results except one sample with the previous highest Ct value. This observation is consistent with previous literature on the lack of reproducibility of weak RT-PCR positives especially those close to the test LoD.

Example pooled testing result in KEMRI-Kilifi laboratory
To further evaluate the benefit of pooled testing, we examined test results from 1500 samples tested in our laboratory between in the first week of June 2020. The testing started with creation of 250 pools (i.e. of 6 samples in each pool), 75 (30.0%) of which gave a positive result. The 75 positive pools were then expanded to 450 individual tests. From these, one or more positive samples were identified in 65 pools, a total of 112 positives (i.e. 7.5% of the original 1500 samples) (Figure 3, panel A).

On comparison of the Ct value differences (∆Ct) in the pooled testing and individual sample testing (considering the strongest positive sample only where there were multiple positives in a pool), there was on average a 1.59 Ct value increase for the samples during pooled testing versus the same samples tested singly. Expanded pools tested negative for all 6 individual assays in 13.3% of instances (95% CI: 6.6-23.1%), despite initially testing positive. The Ct values for expanded pools testing negative for all 6 individual tests ranged 19.73 to 37.83 with median 30.45 (IQR: 26.1-35.66). For the pools where 1 or more positives

Figure 3. Summary results from the analysis of the 1500 samples analyzed at KEMRI-Kilifi using the pooled testing strategy. Panel A, shows the number of positives from the created pools. Panel B, comparison of Ct values from pooled tests versus individual sample tests.
were identified the Ct values ranged 16.97 to 37.81 with median 30.43 (IQR: 25.68-32.90). False-positive results during pooled testing may arise as technical artifacts of degraded probe, primer/probe cross-reaction with non-SARS-CoV-2 sequences in some samples or technical cross-contamination/mislabelling during sample processing.  

Resources conserved in pooled testing

Overall, in the above example, to get results for 1500 samples we performed 700 tests (RNA extraction and RT-PCR). We estimated that in our laboratory, it costed ~ $6 United States Dollars (USD) per SARS-CoV-2 test. Thus, by undertaking only 46.7% of the tests to identify the positives, using the pooled testing protocol we spent ~ 4200 USD to test the 1500 samples down from ~9000 USD if all samples are tested singly thus saving ~4800 USD. Although two assays were required, because of the overall reduction in numbers of assays, the turnaround time was faster and fewer staff were required to handle the laboratory tests when using the pooled testing approach.

Conclusions

Pooled testing can yield significant savings of test kits resources while effectively identifying infected SARS-CoV-2 individuals in the population rapidly. This protocol is especially relevant in low-to-middle income settings as testing resources are mostly dependent on limited purchased imports or donations. The strategy further increases test specificity (positives are mostly dependent on limited purchased imports or donations) limiting false positives. However, due to sample dilution, there is a risk of missing weak positives during the first step of pooled testing. Although overall the sample handling time was reduced, it was difficult to “fast track” individual assays that were declared urgent by clinicians or public health officers where the initial pooled test is positive. As the COVID-19 pandemic evolves, the pool size used by a testing laboratory should be kept under constant review and adjusted if there are changes in the prevalence of the infection in the target population or test accuracy characteristics.

Data availability

Underlying data

Replication Data for: Pooled testing conserves SARS-CoV-2 laboratory resources and improves turn-around time: experience at KEMRI-Wellcome Trust Programme, Kenya.  

https://doi.org/10.7910/DVN/I4XUC5

This project contains the following underlying data:

- CAgoti_SARSCoV2_Lab_Experience_Codebook.pdf (Codebook for datasets)
- CAgoti_SARSCoV2_Lab_Experience_Readme.txt (Data description and usage instructions)
- datafiles.zip (Analysis datasets)
- scripts.zip (Analysis scripts)

Data are available under the terms of the Creative Commons Attribution 4.0 International license (CC-BY 4.0).

Acknowledgments

We are thankful to the members of the Ministry of Health Rapid Response Teams in coastal Kenya counties who collected the patient samples. We grateful to the European Virus Archive Global for kindly providing us the SARS-CoV-2 primers and probes used in our COVID-19 testing. This manuscript was submitted for publication with the permission of the Director KEMRI.

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Agoti et al. provide a timely and important report on the implementation of pooled SARS-CoV-2 PCR testing on the Kenyan Coast. The manuscript describes the epidemiological context and pooling strategy concisely and clearly. The authors find that pooling drastically increases testing throughput and saves on number of test kits used. Given the hesitancy of many settings to implement pooled testing for fears of logistical challenges and reduced sensitivity, this is an important success story that should be useful to many low-and-middle income settings (and indeed high-income settings!). I really enjoyed reading this paper!

1. The title and results suggest that pooling reduced the test turnaround time. However, I can see no results to support this claim (other than the final, qualitative results sentence). This is a key (potential) benefit of pooling, so please could you provide these results?

2. It would be useful to provide some context on why these tests were carried out. Presumably all of these samples were from a clinical setting, where the considerations for sensitivity (and specificity) may be different than e.g. surveillance or routine screening of HCWs.

3. “... by combining a previously identified positive sample ... we replicated this 6 times”. This phrasing suggests the same positive sample was diluted 6 different times. Please rephrase to make clear that these were 6 distinct samples across a range of Ct values. Also, were these re-tested samples subjected to an additional freeze-thaw cycle which might degrade RNA?

4. Section “Example pooled testing result in KEMRI-Kilifi laboratory”: “... in our laboratory between in the first week of June 2020”. Typo here (remove between). Also, “The testing started with creation of...”, missing “the”.

5. It would be interesting to discuss where some of the Ct values actually increased from the pooled to individual testing. This could help give an idea of how much testing variation...
there is in addition to reduced sensitivity through dilution or may simply be due to the
presence of both low and high Ct samples in the pool.

6. For the 13.3% of positive pools which had no individually positive samples, was there any
retesting or were they assumed false positives? It seems unlikely that all of these pools were
false positives (indeed most were likely false negative individual tests). Also, bringing this up
here seems a bit at odds with the discussion sentence “The strategy further increases test
specificity...”.

7. I think it may be useful to discuss some of the practical lessons learned here. For example,
was it easy for staff to adapt their workflow to implement pooling rather than individual
testing? How much longer did it take to test a batch using pooling vs. individual testing? I’m
sure there are many laboratories around the world that would be interested to hear about
the more qualitative lessons learned here.

8. The conclusions are a bit brief. For example, I think readers would like to hear more about
the difficulty in fast tracking individual assays. As suggested above, context regarding
where and why samples were tested is important, as speed and accuracy requirements may
depend on why a test is carried out.

9. As suggested by another reviewer, it would be interesting to see if the number of validation
tests required tracked changing % positive.

Is the work clearly and accurately presented and does it cite the current literature?
Yes

Is the study design appropriate and is the work technically sound?
Yes

Are sufficient details of methods and analysis provided to allow replication by others?
Yes

If applicable, is the statistical analysis and its interpretation appropriate?
Yes

Are all the source data underlying the results available to ensure full reproducibility?
Yes

Are the conclusions drawn adequately supported by the results?
Yes

Competing Interests: No competing interests were disclosed.

Reviewer Expertise: Epidemiological modeling. I have focused on strategies to improve and
harness PCR testing during the COVID-19 pandemic (including pooling).

I confirm that I have read this submission and believe that I have an appropriate level of
The manuscripts is generally well written. Agoti et al. describe their experience with SARS-CoV-2 pooled testing in KIMRI-Kilifi. The authors point out that the rational of pooled testing is to conserve resources and had calculated pooling size according to prevalence rate. However, several following points in the manuscript should be improved/ clarified.

1. The authors should clarify whether 6- samples-pooled testing were conducted until 16 Jul. 2020. Based on Figure 1, the percentage of positives seems to have sporadic increase from 21 May until 18 June, which may lead to increase of prevalence.

2. Figure 2B show some pooled CT values are lower than individual Ct values and vise versa. This does not support fully the statement of “RT-PCR cycle threshold value was -1.59 higher for samples tested in pools compared to samples tested singly’. The authors should clarify why some pooled CT values are lower than individual Ct values. Were these the effect of several positives in one-pool?

3. Were the pooling being done randomly or by cluster or stratified?

Is the work clearly and accurately presented and does it cite the current literature?
Yes

Is the study design appropriate and is the work technically sound?
Yes

Are sufficient details of methods and analysis provided to allow replication by others?
Yes

If applicable, is the statistical analysis and its interpretation appropriate?
Yes

Are all the source data underlying the results available to ensure full reproducibility?
Partly

Are the conclusions drawn adequately supported by the results?
Yes

**Competing Interests:** No competing interests were disclosed.

**Reviewer Expertise:** Virology, COVID-19 pooling.

I confirm that I have read this submission and believe that I have an appropriate level of expertise to confirm that it is of an acceptable scientific standard.

Author Response 28 Oct 2020

Arnold Wasike Lambisia, Kenya Medical Research Institute-Wellcome Trust Research Programme, Centre for Geographic Medicine Research, Kilifi, Kenya

1. **The authors should clarify whether 6- samples-pooled testing were conducted until 16 Jul. 2020. Based on Figure 1, the percentage of positives seems to have sporadic increase from 21 May until 18 June, which may lead to increase of prevalence.**

   Our response: Yes, the n=6 pool size was maintained from 14\textsuperscript{th} May to 31 July 2020 as the high positivity rate spikes during this period were short-lived rather than sustained.

   1. **Figure 2B show some pooled CT values are lower than individual Ct values and vice versa. This does not support fully the statement of “RT-PCR cycle threshold value was -1.59 higher for samples tested in pools compared to samples tested singly’. The authors should clarify why some pooled CT values are lower than individual Ct values. Were these the effect of several positives in one-pool?**

   Our response: The reviewer is correct in their interpretation i.e. such was observed in pools with more than one positive. In the result section, we did point this out: “On comparison of the Ct value differences (\(\Delta\text{Ct}\)) in the pooled testing and individual sample testing (considering the strongest positive sample only where there were multiple positives in a pool), there was on average a 1.59 Ct value increase for the samples during pooled testing versus the same samples tested singly. (Note: The reviewer is referring to figure 3B rather than 2B which is relevant to the question)

   1. **Were the pooling being done randomly or by cluster or stratified?**

   Our response: Same question was raised by reviewer #1 above (question #3), so same answer. We have updated this information into the revised version of the manuscript

   **Competing Interests:** No competing interests were disclosed.
Agoti et al. share their experience with SARS-CoV-2 pooled testing using real-time reverse transcription polymerase chain reaction (RT-PCR) on the Kenyan Coast. The authors evaluated the viability of pooled testing approach for SARS-CoV-2 diagnosis in low-to-middle income settings such as Kenya. To achieve this, the authors utilized a total of 1500 respiratory samples collected in the coastal region of Kenya during the first week of June 2020. A total of 250 pools (each comprising 6 samples) were subjected to RT-PCR, followed by individual testing of samples in positive pools. By employing this strategy, only 700 tests (including RNA extraction and RT-PCR) were conducted to get results for the 1500 samples, translating into a cost reduction of 4,800 USD. Although data analysis reveals increased test specificity, the strategy has an associated risk of reduced sensitivity which might result in false negatives.

The study has been well conducted and the manuscript well written. The findings of this study are timely in light of the global COVID-19 pandemic that has created an urgent demand for accurate rapid diagnostic strategies to allow for prompt clinical and well-tuned public health interventions. The pandemic has resulted in unprecedented demand on the RT-PCR testing capacity of all countries. Demand for testing has been coupled with a global shortage of commercial kits, reagents, consumables, disruptions in the global transport networks, and exacerbated by international competition for testing resources. Accordingly, even many high-income countries have inadequate RT-PCR testing capacity to effectively suppress ongoing transmission, and most low and middle-income countries (LMICs) are unlikely to be able to establish adequate RT-PCR capacity in the immediate future. Thus, the pooled testing strategy for SARS-CoV-2 offers an attractive solution in molecular testing especially for LMICs.

However, minor revisions are required to accept the manuscript for indexing:

1. The authors described the specificity and sensitivity of the pooled testing strategy for SARS-CoV-2 in general terms. Please provide calculated figures for these measures of test reliability.

2. The authors note in their conclusion that, “due to sample dilution, there is a risk of missing weak positives during the first step of pooled testing.” It will be useful for the authors to explain the implication of such reduced sensitivity and if there are any mitigation measures that can be employed to help improve the reliability of the test.

3. Was there any method to the pooling of samples? Was it random or non-random?
4. Were the samples from symptomatic or asymptomatic patients?

5. What is the effect of viral loads on pool size and test performance?

6. Please correct a few typographical errors especially under the section, “Example pooled testing result in KEMRI-Kilifi laboratory.”

Is the work clearly and accurately presented and does it cite the current literature?
Yes

Is the study design appropriate and is the work technically sound?
Yes

Are sufficient details of methods and analysis provided to allow replication by others?
Yes

If applicable, is the statistical analysis and its interpretation appropriate?
Yes

Are all the source data underlying the results available to ensure full reproducibility?
Yes

Are the conclusions drawn adequately supported by the results?
Yes

Competing Interests: No competing interests were disclosed.

Reviewer Expertise: Infectious diseases, point-of-care diagnostics development, clinical medicine

We confirm that we have read this submission and believe that we have an appropriate level of expertise to confirm that it is of an acceptable scientific standard.

Author Response 19 Oct 2020
Arnold Wasike Lambisia, Kenya Medical Research Institute-Wellcome Trust Research Programme, Centre for Geographic Medicine Research, Kilifi, Kenya

We thank the handling editor and the peer reviewer for the very important comments and suggestions received. We have revised the manuscript in light of this feedback. Below we provide a point-by-point response to the queries raised by the reviewer.

1. The authors described the specificity and sensitivity of the pooled testing strategy for SARS-CoV-2 in general terms. Please provide calculated figures for these measures of test reliability.
We restrained from calculating pooled testing protocol sensitivity and specificity since that required having results on a minimum number of samples (after sample size calculation) processed in parallel with a gold standard method which we did not have or include in our study. Plans are underway for analyzing a set of samples in our laboratory with the pooled testing protocol and the standard individual testing to provide data on the sensitivity and specificity of the protocol and this will be presented in our follow up analysis.

1. The authors note in their conclusion that, “due to sample dilution, there is a risk of missing weak positives during the first step of pooled testing.” It will be useful for the authors to explain the implication of such reduced sensitivity and if there are any mitigation measures that can be employed to help improve the reliability of the test.

The significance of missing weak positive cases depends on the reason for testing. For example if it is to identify who is positive so as to put them into isolation to slow down or stop spread, then there is not much loss as weak positives are less likely to contribute to onward transmission. However if the aim is identify how many people have been infected to calculate particular epidemiological parameters e.g. infection prevalence, then there is a danger of their underestimation. Strategies that can improve the sensitivity of the pooled testing protocol include (i) increasing the sample volume during nucleic acid extraction (but this has to be balanced with other extraction kit reagents e.g. the lysis buffer) (ii) using high performance nucleic acid extraction kits and (iii) loading a higher volume of extracted nucleic acid from the pooled samples into the RT-PCR reaction. We have included this discussion into the revised manuscript.

1. Was there any method to the pooling of samples? Was it random or non-random?

Samples collected from a known infected individuals (as per our previous test on the same individual) to check if they were still virus positive and samples from deceased individuals to investigate if they died of COVID-19 were always processed singly. All other samples were processed using the pooled testing protocol. The sample pools were assigned randomly following the consecutive order in which the samples were delivered in the laboratory by the Rapid Response Teams (RRTs). This information has been clarified in the revised manuscript.

1. Were the samples from symptomatic or asymptomatic patients?
The clinical records indicated that these samples were from both asymptomatic individuals (n=1009, 72.1%) and symptomatic individuals (n=54, 3.6%). For 364 samples (24.3%), information on the symptom status of the sampled individuals was unavailable. We have added this information into the revised manuscript.

1. What is the effect of viral loads on pool size and test performance?
When the viral load in a sample is low, a large pool size may lead to a false negative. However, it is not possible to know about the patient viral load before testing. Thus, the pool size has to be optimized as described in the paper and elsewhere (considering assay limit of detection, sensitivity, specificity and infection prevalence) to make both economic and clinical purpose sense.
1. Please correct a few typographical errors especially under the section, “Example pooled testing result in KEMRI-Kilifi laboratory.” These have been corrected.

We thank the handling editor and the peer reviewer for the very important comments and suggestions received. We have revised the manuscript in light of this feedback. We have clarified the symptom status of the individuals we tested, the pooled testing protocol inclusion and exclusion criteria and the implications of the sensitivity of pooled testing protocol on application of the arising results. Below we provide a point-by-point response to the queries raised by the reviewer.

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