Authors' Reply

To the Editor,

The proportions presented in our paper [1] are not directly based on official data published by the Ministry of Health. The primary aim of our study is to highlight the positivity rate among individuals with high-risk scores. A numerical analysis reveals that, during the studied period, a total of 2,159,903 individuals used the application, and 12,607 positive cases were detected. This indicates that the positivity rate among application users was 5.8 per 1,000. Therefore, there is no 27.8-fold difference between the positivity rate among application users and the general population, as claimed. Moreover, the fact that 12,607 out of 135,277 individuals identified as high-risk tested positive, resulting in a 9.3% positivity rate, underscores the importance of this application in helping individuals, especially those with chronic conditions and at higher risk of severe outcomes, to protect their health during the pandemic.

Our study [1] does not primarily focus on correlating PCR test results with CPA data. Instead, it centers on reducing the transmission risk among the 135,277 individuals identified as high-risk. Given the limited word count of the paper, only the content of the relevant questions was included. For example, risk scores were calculated based on questions related to conditions such as chronic lung disease, diabetes, and hypertension, and users' risk scores were assessed according to these criteria. Although the detailed content of these questions was not extensively covered due to space limitations, the criteria used for risk assessment were summarized.

During the COVID-19 pandemic, as information rapidly evolved and the public was continually exposed to new data, the decline in the use of the application after one month is understandable. The decrease in usage can be attributed to the public gaining more knowledge about the pandemic and the reduced need for existing applications. The detailed analysis and discussion of these usage changes fall outside the scope of this paper.

A total of 1,889,981 individuals from the 10 selected provinces used the application, representing 87.5% of all users. Therefore, these 10 provinces' data were taken into account when calculating usage rates. The lower usage rates in other provinces (13.5%) are statistically insignificant compared to these 10 provinces. As a result, making conclusions based on the smaller statistical subsets of these provinces is not statistically meaningful. Thus, it is not appropriate to consider this as a mathematical or academic error.

The graph presented in Figure 7 [1] illustrates the varying levels of high-risk status by gender and age. The darker color represents females, while the lighter color represents males. The data indicate that the risk disparity between genders increases with age. We acknowledge the critique that this difference should be more explicitly stated and that the graph's explanation could be enhanced.

The evaluation of the highest risk ratio in Gaziantep pertains only to the 10 major provinces and does not imply any specific conclusions about Gaziantep province itself. The paper merely indicates that the risk ratio in Gaziantep was higher compared to other provinces. However, we agree that drawing regional conclusions requires consideration of demographic and other factors. Therefore, our paper only makes statistical observations without delving into demographic-based conclusions.

Finally, our paper [1] does not involve correlating PCR data, and its purpose is to emphasize the general statistical characteristics of the application and its benefits during the pandemic. Additionally, there was no ethical breach in the preparation of this paper, as it does not constitute research directly involving PCR tests. Our objective is to highlight how such applications can empower individuals to protect their health during pandemic periods, particularly through the digitization of health protection measures.

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