Predictive model of COVID-19 incidence and socioeconomic description of municipalities in Brazilian

Extended Title (or sort abstract):

The present study aims to describe the demographic and socioeconomic characteristics of cities with cases of COVID-19 in Brazil, as well as to determine a predictive model for the number of cases. We analyzed data from 614 cities where 68,8% of the Brazilian population live. Our model predicts, if the conditions are maintained, 819,397 (693,455 to 945,338) cases, till June 23, 2020.

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ABSTRACT:

Coronaviruses are enveloped viruses which can cause respiratory, gastrointestinal, hepatic, and neurological diseases. On December 2019 a new coronavirus highly contagious named severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) emerged in China causing a potentially lethal human respiratory infection named COVID-19, associated with fever and cough, which can progress to a stage of pneumonia and dyspnea in more severe cases. Previous study has shown that social distance measures alone may not be sufficient to prevent COVID-19 spread and its overall impact is of great concern. The present study aims to describe the demographic and socioeconomic characteristics of 614 cities with cases of COVID-19, as well as to determine a predictive model for the number of cases. Was analyzed data from cities with at least 1 case of COVID-19 until May 23, 2020. It was observed that cities with cases are present in all Brazilian states, reaching 35% of the municipalities in the highest state incidence. In these cities live more than 68,8% of the Brazilian population and the stratification of the age groups of the inhabitants and the average of women and men, does not show a variation in relationship with the COVID-19 incidence (confirmed cases/100k inhabitants). The demographic density, the MHDI and the per capita income of the municipalities with cases of COVID-19, does not show a variation in relationship with the incidence. In addition, if conditions are maintained, our model predicts 819,397 (693,455 to 945,338) up to June 23, 2020.

Keywords: COVID-19, COVID-19 in Brazil, Exploratory data analysis, ARIMA, computational model.

INTRODUCTION:

Pandemic is any epidemic disease widely distributed geographically and that affects different regions simultaneously. Over the years, humanity has been facing and going through moments like this, where health and science are put to the test and need to present answers. The Spanish flu ravaged the whole world, and is often confused with several other diseases, such as cholera, dengue, and typhus (GOULART, 2005). At the end of the pandemic, the total number of deaths was around 50 million people. In 2009 there was the emergence and declaration of the Influenza A (H1N1) pandemic by the World Health Organization (WHO). In this case, it was observed that, at first, transmission remained focused in Mexico for at least one month. Since migratory events and population movement caused the virus to spread to other countries, where transmission was started again (LIPSITCH et al., 2011). In official World Health Organization records, the H1N1 pandemic fatally killed 18,500 people around the world.

On March 11, 2020, after a declaration by the World Health Organization, the world population returned to live under the nickname of fear of a new pandemic, this time caused by the coronavirus. Coronaviruses are enveloped viruses that are part of a large family of single-stranded RNA viruses with a positive polarity genome and can cause respiratory, gastrointestinal, hepatic, and neurological diseases. These can infect many animal species, including birds, cows, pigs, and humans, causing acute and chronic diseases (Chang et al., 2012; Weiss, 2011). It is known that most infections caused by [coronaviridae](https://pt.wikipedia.org/wiki/Coronaviridae) virus in humans induce a mild form of the disease, where the patient usually has flu-like symptoms. However, after the discovery of Severe Acute Respiratory Syndrome (SARS), a greater contagion capacity and lethality potential of this viral family was evidenced (Weiss et al., 2011). The etiological agent of SARS, SARS-CoV, was identified in mid-2003, after an outbreak of the disease in November 2002, in Guangdong Province, China, where 8,700 cases were confirmed with 774 deaths (Contini et al., 2020). The so-called new coronavirus, initially referred to as 2019-nCoV, was first described when a group of patients reported symptoms of pneumonia of unknown cause in Wuhan City, Hubei Province, China, in December 2019 (ZHU, 2020).

On February 11, 2020, after phylogenetic and pathophysiological analyses, the 2019-nCoV was named SARS-CoV-2 due to its similarity to SARS-CoV, as announced by the Coronavirus Study Group (CSG) of the International Virus Taxonomy Committee, according to the 2015 World Health Organization nomenclature guidelines (Gorbalenya et al., 2020). The pathology caused by SARS-COV-2 infection was named COVID-19, characterized by a flu-like condition associated with fever and cough, which can progress to a stage of pneumonia and dyspnea in more severe cases (CHAN et al., 2020). The incubation period of the disease varies from 2 to 14 days and, in approximately 80% of cases, infected individuals remain asymptomatic. However, unlike influenza infection, these patients are competent for viral transmission (Contini et al., 2020). In addition, according to Contini (2020), its mechanism of contagion is direct, that is, through contact with infected people. Other studies show that SARS-CoV-2 can survive in the air for more than 3 hours and on surfaces such as plastics and metals for up to 3 days (Van Doremalen et al., 2020). Currently, there are no vaccines to fight the disease, reinforcing the need for prophylactic measures, the main ones being: the correct hygiene of the hands, environments and surfaces and social distance.

Previous study has shown that social distance and other prophylactic measures alone may not be sufficient to prevent the spread of COVID-19 and its overall impact is of great concern (Sohrabi et al., 2020). It is also noteworthy that additional research is needed to help define the exact rates and mechanisms of transmission from person-to-person, as well as the knowledge of additional factors that can guide containment actions.

The internal and external logistic and transitory movements, as well as several other socioeconomic factors, can contribute not only to the understanding of virus spread, but also to assist in surveillance measures and competent decision-making to regional health systems, where such analysis can (and should) work to reduce the exponential curve growth of positive cases. Different approaches are being used to better understand the transmission dynamics of SARS-CoV-2, to apply pandemic prevention and control measures. In this context, the present study aims to verify the association of demographic and socioeconomic characteristics with COVID-19 incidence and lethality rate, as well as to adjust predictive models for the number of the disease’s cases , thus, expanding the possibilities of decision-making at the micro and macroregional levels.

MATERIALS AND METHODS:

In the present work, the concept of Ecological Study was used, this method of epidemiological study helps us to generate hypothesis about possible relations between socioeconomic characteristics of the Brazilian municipalities and the COVID-19 incidence and fatality rate. Considering the 614 cities present in a database fed daily, which had confirmation of the SARS-Cov-2, in addition, we seek to understand the territorial area, demographic density, average age among inhabitants, gender, socioeconomic data and MHDI (Municipal Human Development Index) through a database collected for the same municipalities.

For the exploratory data analysis (EDA) and the predictive model adjustment the Python programming language was used, which allows the use of several libraries, specific for this purpose. Along with the Python language, it was necessary to import different packages and libraries, the most used ones being: Pandas, Numpy and Scipy, with the function of organizing and structuring the data. For statistical calculations, Statsmodels, were imported to analyze the Time Series and the autoregressive integrated moving average (ARIMA) model for the forecasts. The purpose of these method is to make the model fit the data as well as possible. Matplotlib and Seaborn, used to generate two-dimensional (2D) graphics. The project can be accessed through the github page, <https://github.com/gfsilveira/covid>. The analyzed database has 614 municipalities (11.02% of the cities in Brazil) of the 26 states of the federation, plus the Federal District.

The records of COVID-19 cases at the municipal level were obtained through a set of daily information from the Health Departments of the Federative Units compiled by Álvaro Justen and his collaborators until May 23, 2020, available at https://brasil.io/dataset/covid19/caso. Demographic and socioeconomic characteristics publicly available at the municipal level, such as population density, Municipal Human Development Index (MHDI), total area in km² and per capita income were obtained from the Brazilian Institute of Geography and Statistics (IBGE) from the demographic census conducted in 2010. data on the average age between inhabitants and gender were obtained from the 2015 census.

A data structure containing different age groups between 0 and over 80 years old from the IBGE 2015 census database was used. To compare the COVID-19 incidence rate, age of people resident in Brazilian municipalities was separated into groups of children (0 to 9 years), teenager (10 to 19 years), yang adults (20 to 29 years), adults (30 to 64 years) and elderly (65+ years). Declared gender data was also considered, comparing the incidence rate of COVID-19 among men and women residents. In addition to data from the population, the number of cities with COVID-19 cases within each state was analyzed and the percentage of Brazilian municipalities / states of confirmed cases was calculated by May 23, 2020.

Data from the IBGE 2010 and 2015 demographic census database was compared with data from municipalities with COVID-19 cases and deaths rate. The Demographic Density (hab/km²), Municipal Human Development Index (MHDI), socioeconomic data (per capita income), the different age groups, men and women, each analyzed with cases confirmed /100k and deaths/population ratio.

For the development of the predictive model, we used the ARIMA model proposed by Box & Jenkins (1970), which consists of proposing and adjusting stationary or non-stationary linear models to an observed time series. The autoregressive indicates that the variable of time series is regressed on its own lagged values. The I (for "integrated") indicates that the data values have been replaced with the difference between n+1 and n values, performed more than once. Moving average is a calculation of data points by creating a series of averages of different subsets of full data. In the moving average the regression error is a linear combination of various times in the past and error terms whose values occurred contemporaneously. The construction of the model was based on the daily epidemiological data from COVID-19. To determine which predictive model to use, autocorrelation function (FAC) and partial autocorrelation function (FACP) was analyzed, to determine the ARIMA p, d, q parameters. The d = 2 was defined because, with only a second order of differentiation, we have the stationary series. In the second order of the PACF with lag 2, it is already below significance. We thus define p = 1. The same occurs in the ACF in the second order, where lag 2 is below significance. Then, it was tested, by the minor Akaike Information Criteria (AIC), four ARIMA models, (0.2.0), (1.2.0), (0.2.1), (1.2.1). With these new data, the ARIMA parameters (1,2,1) showed the best adjustments. In order to analyze the adjustment of the ARIMA model parameters, was used the Augmented Dickey-Fuller (ADF) test (Figure 01).

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| **Figure 01. ACF and PACF plots for model parameters determination.** (A-C) Original series, (D-F) 1st order differencing and (G-I) 2nd order differencing. (A, D and G) time series, (B, E and H) auto-correlation function, and (C, F and I) partial auto-correlation function. With this was determined a model ARIMA(p=1, d=2, q=1). (J) Adjustment of forecast and data that have been observed. |

RESULTS:

1. 68,8% of the Brazilian population lives in cities with confirmed cases of COVID-19

Since COVID-19 is a pathology caused by SARS-Cov-2 that is transmitted directly from human to human, in the present work we seek to observe the characteristics of the affected cities. The analyzed database has 614 municipalities (11.02% of the 5,570 cities in Brazil) from the 26 states of the federation, plus the Federal District, which until May 23, 2020 had at least 1 confirmed infection, totaling 321,780 (0.15% of the Brazilian population) cases of COVID-19, 20,817 deaths. Until the last analyzed date, we observed an incidence rate of 174,715.09 and a mortality rate of 114.5 (100k inhabitants). The data analyzed in this work is updated daily, from Feb 25, 2020 to May 23, 2020. The first 100 confirmed cases were reached on March 13. The first 100 confirmed cases were reached on March 14, after one week, on March 21, 1000 cases, on April 4, 10,000, and 100,000 on May 3. In the first 30 days, from February 25 to March 25, there were 1 to 2565 cases, from March 26 to April 24, 2987 to 54209 (18.14x), and from April 25 to May 23, 59506 to 321780 (5,41x). COVID-19 cases are reported in all states, where up to 35% of the municipalities have reports (Figure 02).

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| **Figure 02. All Brazilian states have confirmed cases of COVID-19.** Distribution of confirmed cases of COVID-19 by state. Percentage of cities with at least 1 case of positive infection. |

In the cities that present cases of COVID-19, was analyzed the age of the residents, declared gender, area (km²), demographic density (hab/km²), Municipal Human Development Index (MHDI) and per capita income. In the analysis of age, Brazilian municipalities have a relative homogeneity in the distribution range every 5 years of life, up to 35 years, when there is a gradual reduction in the numbers (Figure 2A). The population of inhabitants in Brazil in 2018 (last available data) was 210147125 inhabitants. The cities where cases of COVID-19 were observed has 144,573,522, representing 68,8% of the Brazilian population and, as expect, the distribution of age groups is the same as the general distribution in Brazil (Figure 2B). It is possible to observe that there is no difference between the age distribution in the total Brazilian municipalities (Figure 3A) and in the affected municipalities (Figure 3B). In the present study, the age ranges of the population in the affected cities were grouped (Figure 2C), in order to obtain seniors patients over 65 and adults (who represent a greater likelihood of comorbidity) between 30 and 64 years, with a higher risk, and children aged 0 to 9, teenagers aged 10 to 19 and young adults aged 20 to 29, with lower risk. The percentages of each age group (Figure 2D) will be used for the analysis in relation of COVID-19 incidence. The quartiles of number of habitants in each age distributions in the affected cities do not show a relationship with the incidence of the disease. Municipalities with a greater or lesser number of inhabitants do not indicate a greater or lesser incidence (Figure 3E-I).

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| **Figure 03. Age distribution in cities with cases of COVID-19.** (A) Number of inhabitants by age group (5 years) in Brazil. (B) Number of inhabitants by age group in cities with cases of COVID-19. Stratification of age groups by age in the municipalities studied, represented by number of inhabitants, absolute (C) and percentage for each city (D). Distribution of quartiles of number of habitants per age groups of (E) young adults, (F) adults, (G) seniors, (H) children, and (I) teenagers, in relation to the COVID-19 incidence, in the affected cities. |

Another demographic information analyzed was the declared gender of the inhabitants. In Brazil, the percentage of distribution is 51.7% for women and 48.3% for men. As expected by the size of the population of inhabitants in the affected municipalities, we observed a similar distribution, with 50.29% (4,618,650) women and 49.71% (4,581,800) men (Figure 4). Additionally, the quartiles of number of habitants in each age distributions in the affected cities do not show a relationship with the incidence of the disease. Municipalities with a greater or lesser number of woman (Figure 4D) or man (Figure 4C) inhabitants do not indicate a greater or lesser incidence.

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| **Figure 04. Declared gender of inhabitants in cities with cases of COVID-19.** (A) Number and (B) percentage of men and women living in cities that present cases of COVID-19. Distribution of quartiles of number of habitants (C) male and (D) female, in relation to the COVID-19 incidence, in the affected cities. |

Since SARS-Cov-2 are transmitted from person-to-person, we describe characteristics of the displacement and agglomeration of people, such as area (km²) and demographic density (hab / km²) in the municipalities. In cities with COVID-19 reports, we observed that the demographic density (hab/km²) for different quantiles, (Figure 5A) 0.39 to 44.75; (Figure 5B) 44.75 to 138.87; (Figure 5C) 138.87 to 567.62; (Figure 5D) 567.62 to 13024.56, obeys the relationship between number of inhabitants (population) and area (km²). The cities analyzed, therefore, are more densely populated than the national average, which is 23.8 hab/km².

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| **Figure 05. The demographic density in cities with cases of COVID-19.** Number of inhabitants (Population) by area (km²) resulting in demographic density (hab / km²) in four quantiles, (A) 0.39 to 44.75; (B) 44.75 to 138.87; (C) 138.87 to 567.62; (D) 567.62 to 13024.56. |

The Municipal Human Development Index (MHDI) is related to healthy and long life (measured by life expectancy); education/access to knowledge (calculated using the average schooling of adults and the expected years of schooling for children of school age); and income/standard of living (measured by Gross Domestic Income per capita). The global Brazilian HDI for 2013 was 0.744, the 79th position in the world ranking among the 187 countries and territories recognized by the United Nations. In the Global HDI for HDR 2014, the three dimensions have the same weight and the human development ranges are fixed, being: Low Human Development - less than 0.550; Average - 0.550 and 0.699; High - 0.700 and 0.799; and Very High - above 0.800. The per capita income, number of minimum wages [R$ 975.00] per month per capita for formal workers, in Brazil was 1.48 (R$ 1,443.10) for 2017 (last year measured). In this context, the MHDI was compared to per capita income, for the different population ranges, in cities with cases of COVID-19 (Figure 06).

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| **Figure 06. The Municipal Human Development Index (MHDI) and per capita income in cities with cases of COVID-19.** MHDI and income (number of minimum wages [R$ 975.00] per month for formal workers) in cities with cases of COVID-19. |

The results show that for both MHDI and per capita income, most cities with positive cases for COVID-19 are above the national average. With these data set, was analyzed the quartiles of demographic density (Figure 07A), MHDI (Figure 07B) and income (Figure 07C) in relationship with incidence of COVID-19. The socioeconomic index does not show a relationship with the incidence of the disease.

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| **Figure 07. The relationship between the socioeconomic indices and COVID-19 incidence.** Cities with cases of COVID-19 / 100,000 inhabitants in relationship to (A) demographic density (hab / km²), (B) MHDI, and (C) per capita income. |

Once described some of the characteristics of the cities that present cases of COVID-19, using the time series of confirmed cases, we seek to determine a model for predicting the infection.

1. Until June 23, 2020, the evolution model allows predicting 819,397 (693,455 to 945,338) confirmed cases.

The results presented suggest that municipal characteristics should be considered regarding the current epidemiological condition. However, due to the current level of infection in the cities analyzed, the scarcity of data does not allow the development of a robust predictive model for cases confirmed at the municipal level. Seeking to understand the condition of the infection at the national level, we analyzed the time series of accumulated data for confirmed. There was a clear upward trend in the number of cases (data not show). In order to suggest a prediction for evolution of COVID-19 cases in Brazil, we use computational modeling in the time series. The best adjusted model for the forecast was ARIMA(1,2,1) using the last 30 days, where we reached the forecast of 819,397 (693,455 to 945,338), up to June 23, 2020, with 95% confidence (Figure 8).

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| **Figure 09. Average estimate of 819,397 confirmed cases in 30 days**. ARIMA model of forecast of confirmed cases until June 23, 2020. Confirmed cases (blue), forecast (orange), model fit analysis (green) and forecast interval with 95% confidence (gray). Up to the end date, between 693,455 and 945,338 cases are expected. |

CONCLUSION:

Together, the analyzed data from 614 cities with at least 1 case of COVID-19 until May 23, 2020 shows that the 68,8% of population live in cities with contagious risk. Average age group of the inhabitants remains the same as the average age group of the Brazilian population, with the most populous cities of Brazil then included. The average of women and men in the cities studied also agrees with the national average. The demographic density, the MHDI and the per capita income of the municipalities with cases of COVID-19 are above the national average. However, there seems to be no relationship between the indexes analyzed and the incidence of COVID-19 in these cities, suggesting that other factors may influence this progression and, our model predicts 819,397 (693,455 to 945,338), up to June 23, 2020.

DISCUSSION:

In this work, we studied the recent occurrence of severe acute respiratory syndrome, a respiratory disease caused by coronavirus SARS-Cov-2, originated in the city of Wuhan, China and the correlation of transmission and death rates, through confirmed cases, with Brazilian demographic and socioeconomic data. Having knowledge of the demographic distribution of the population and socioeconomic situation becomes significant when it is aimed to compare transmission and death rates across the country.

Brazil currently has 5,570 municipalities distributed disproportionately over a total area of 8,511,000 km² that has 26 states (IBGE, 2019). As previously described, in the results section, municipalities with a population larger than 295,955 inhabitants showed a positive correlation between the size of the population and the number of confirmed cases of the disease. However, of this total of municipalities, only 95 have a population of over 295,955 inhabitants, including all state capitals and the Federal District. As a percentage, these 95 municipalities represent 1.71% of the country's total cities, with the majority of Brazilian cities, 94.22% (5,245 municipalities), having a population less than or equal to 100,000 inhabitants (IBGE, 2019).

Therefore, based on the results of this article, it is possible to note that the transmission of the disease is more likely to impact in less than 2% of Brazilian municipalities. However, it is essential to reinforce that these 95 cities, together, are home to 83,951,535 inhabitants, which represents 40% of the total population of Brazil, which currently has a demographic density of 205.5 million people (IBGE, 2018). Thus, neglecting the recommendations of the World Health Organization about isolation and social conduct, in a time of pandemic, will be an attack on public health in Brazil.

When analyzing the data in relation to the states of the Federation, it is noted that it follows the same line obtained in relation to the municipalities, with the state of São Paulo being the most populous in the country and in turn the state with the highest number of confirmed cases of COVID -19, 11,043 cases to date, according to the Ministry of Health (2019). Through data studies described in this article, it is also possible to observe, through a more refined analysis, that the new measures of conduct and social isolation employed in the country have been the main form of controlling the pandemic. It is important to note that the actual numbers of cases and deaths from the disease may be different from the official data, taking into account the impact that the delay in notifications has on the estimates and also the fact notifications depend on hospitalization. (FIOCRUZ, 2020).

When we take into account the data obtained, it is possible to say that yes, social isolation is a valid measure to be applied in municipalities that have a resident population larger than 295,000 inhabitants and that in these municipalities, the more intensified the measure, flatter the transmission curve become, thus enabling hospitals and health units to have greater control under the demand of patients who inspire specialized care.

However, it is important to mention that it is not possible to conclude the real importance of social isolation in municipalities with a population below the aforementioned number, however, according to the results, there is a negative correlation between demographic density and the number of cases in these cities, which, in theory, would indicate a lack of connection between these aspects.

According to Hellewell et al. (2012), in a study carried out to evaluate measures to contain the transmission of the disease, social isolation is insufficient to control the outbreak, requiring new interventions to achieve control of the transmission of the disease. However, isolation can contribute to reducing the overall size of an outbreak over a longer period of time (Hellewell et al., 2012). Taking this into account, it becomes possible to assess the importance of measures of social isolation, even for the municipalities with a small population, demonstrating the great importance of such measures, but which should be intensified in the most populous cities and not neglected in the cities with less than 295,000 inhabitants. Therefore, it is interesting to evaluate the average traffic of the Brazilian population mainly in the forms of essential workers, as truck drives, with the supply of basic needs items, primarily carried out in Brazil, through land transportation, often on long distance journeys, between the capitals and other municipalities of the federation, with an average, during the month of march, of 1000 trucks arriving at the Supply Center of the Federal District every Monday and Thursday (CEASA, 2020).

It would be interesting, as a future perspective, to deepen the studies in order to develop a system of equations that would indicate the existence or not of a proportional factor of relationship between population vs the lethality rate, trying to correlate how many times the lethality of a more populous cities are larger than that of the less populous. In order to show that as you double or triple the number of inhabitants in a city, lethality does not necessarily double or triple, indicating that there is no linearity in the cases.

Therefore, the information reported in this study, allows us to highlight that cities with a higher number of inhabitants, who choose not to comply with social isolation, have a higher risk and probability of infection. However, it is essential to show that contamination by the SARS-Cov-2 is not due to the simple fact of living in a more or less populous city, and that there are different regional characteristics, both geographic and socioeconomic that can influence dispersion, not only for SARS-CoV-2 virus, but for many other pathogens (Mogi and Spijker, 2020; Dowd et al., 2020).

Thus, it is worth emphasizing once again that social isolation has proven to be an efficient measure to control contamination in the most populous cities, which shows that such an approach should indeed not just be stimulated but also amplified, as an option to contain the pandemic, together with other protective measures such as masks and gloves, following the recommendation of use by the World Health Organization, in order to avoid hospital demand above the service capacity, since the saturation of the hospital network, is already being reported by some states, which also will have an impact over the data and the rate of reported cases as well as on lethality rate (FIOCRUZ, 2020).

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