

Times, and/or Symbol in 8-12 point. Figure quality can be checked by zooming in to a larger size; the figure will not reproduce well in the published article if the text or graphic is pixelated or broken when enlarged. Note that PDF, .jpeg and .doc files are not acceptable for figure reproduction.

5. Complete contact information for an alternate corresponding author in the event that the corresponding author is unavailable.
6. All sources of funding and conflict of interest information must be listed in the Notes section of the manuscript, at the end of the main text. If no author has a potential conflict of interest or funding source, a statement to this effect must be included.
7. If any change is made to the author listing, such as a reordering of authors or an addition of an author, an agreement form signed by all authors must be submitted to the editorial office before the revision can be processed.
8. Any supplementary data will be published online only. Note that this material is not typeset or copy edited. It is the author's responsibility to ensure the submitted material is proof ready with no errors or changes needed. Supplemental data files must be separate from the main manuscript. Do not include any supplemental data legends in the main file.
9. A highlighted version of the revision with all changes marked. A final, clean version should also be uploaded for production usage.

Kind regards,

5.1.2e

Reviewer #1:

This is a well written manuscript that aims to measure the effectiveness of PH measures. The authors conducted a seroprevalence survey and used a statistical model to find associations between the odds of seroprevalence and various behaviors and demographic characteristics. The manuscript contains helpful background on the COVID-19 pandemic in the Netherlands for readers who may be unfamiliar with the Netherlands. Although the manuscript provides interesting results, these are not discussed at length, and in general, there are details missing throughout.

Introduction

- Can the authors provide some examples regarding the reduction in group sizes? Also, can they please comment on the use of PPE (i.e. - masks) in the general population?
- The authors state that serosurveys for SARS-CoV-2 "provide an unbiased indicator of cumulative infection". This could be interpreted as an overly optimistic statement, since there is bias in every study, and we know that SARS-CoV-2 antibody levels decline over time, meaning that it is (unlike for traditional vaccine-preventable diseases) seroprevalence studies are an imperfect method for estimating burden of disease.
- Was the PIENTER study created prior to the pandemic?
- There may be an error in lines 42 and 43 regarding which age-groups needed to adhere to distancing guidelines.

Methods

- There are a lot of important details missing from this section.
- What was the sampling frame for the random selection of participants? Was it geography/address based? Random digit dialing? What ages were the participants? Was the study aiming to recruit a certain number of individuals in each age-band and region? Please specify.
- The temporality is not clear - were participants invited in April and enrolled in June?
- Was the finger prick blood sample collected on a filter paper, or in a container? As there are many other groups performing these studies, details would be of interest.
- More details are required about the assay, despite having included a reference.
- Were sample size calculations performed? If so, why not?
- What data source was used to ascertain the distribution of the Dutch population in order to allow weighting the samples?
- Could the authors define the meaning of "testing models without religion"?

Results

- The characteristics of the study cohort, compared to non-responders should be included as the first table in the main text (not in the supplement). The non-response rate should be written in the first paragraph.
- It is difficult to believe that there was no difference in seroprevalence between sexes and ethnic backgrounds. Is it perhaps more accurate to say that the differences were not statistically significant?
- Please show sensitivity analyses.

Discussion

- What is the significant of your finding that half of the respondents had two or more close contacts, and that individuals attended indoor meetings? Was this surprising? How does this compare to the public health rules at the time?
- The conclusion in the first paragraph of the discussion, stating that the data justify a policy of allowing close contact between teachers in primary school pupils is a bit overconfident. It would be a good idea to dial it back a bit.
- Could you please comment on the surprising finding that individuals in urban settings had a lower odds of seropositivity than those in low density settings? Also, the finding that low educated individuals had a lower odds than "middle" educated level was surprising.

Other comments

The enclosed supplement, while very interesting, is not appropriate to include in a journal manuscript in its current form. Usually, supplemental data are provided as stand-alone tables and figures, rather than in the form of a thesis.

Reviewer #2:

Vos et al report a broad data set focusing on the associations between population characteristics and contacts and seroprevalence of antibodies against SARS-CoV-2 in an attempt to identify factors associated with an increased likelihood of contracting the virus. As governments around the globe try to weigh the effectiveness of lockdown measures, this is a very important area of research. In their paper they draw four main conclusions:

- * physical distancing is effective
- * indoor group size reductions are effective
- * young adults play a significant role in viral spread
- * primary school-age children do not play a significant role in viral spread

Major comments to the authors

1. With regards to the first conclusion: physical distancing is effective. It is unclear exactly what their basis is for this conclusion as the authors did not find a clear association between number of contacts and risk of SARS-CoV-2 seroprevalence. This requires clarification.
2. The statement 'young adults play a significant role in viral spread' is somewhat premature and should be toned down. Seroprevalence is not the same as viral spread, and higher seroprevalence could also reflect other factors, such as an increased likelihood to have a strong antibody response to infection. The observation might also be confounded by for instance an increased likelihood to have jobs that do not allow for social distancing.
3. The authors note the low response rate as a possible limiting factor in the study that might have introduced selection bias as responders might be more likely to be those who adhere to social distancing measures. Could the authors comment on other potential selection biases, such as that responders might more likely be health care workers, persons who had been previously diagnosed with COVID-19 or persons with close contacts who had been diagnosed with COVID-19?

In compliance with data protection regulations, you may request that we remove your personal registration details at any time. (Use the following URL: <https://www.editorialmanager.com/cid/login.asp?a=r>). Please contact the publication office if you have any questions.