The impact of vaccination on the epidemiology of infectious diseases

Roy Anderson

Faculty of Medicine,
Imperial College London

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• Changing world.
• Basic epidemiological principles.
• Criteria for eradication.
• Heterogeneities.
• Impact of mass vaccination on epidemiological pattern.
• Influenza A.
• H1N1 – lessons learnt.
• Conclusions.
Human evolution

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World population growth by continent: past and predicted
Record of increasing travel over four male generations of the same family.

(A) Great-grandfather. (B) Grandfather. (C) Father. (D) Son. Each map shows in a simplified manner the individual’s ‘life-time tracks’ in a widening spatial context, with the linear scale increasing by a factor of 10 between each generation (Bradley, 1994 Geog. Ann. 76:91-104).
Air traffic flow – world picture - 2009
Re-assortment of bird and human influenza viruses

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<td>Asia</td>
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<td>Latin America</td>
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<tr>
<td>Japan</td>
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<tr>
<td>North America</td>
<td>2</td>
<td>2</td>
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</tbody>
</table>
Surveillance - spatial dynamics of influenza A in France

French sentinel system for influenza case reporting.

Very rapid spread seen over a period of 4 reporting weeks.

http://www.b3e.jussieu.fr/sentiweb/en/sommaire.html
Daniel Bernoulli - 1700 to 1782

D. Bernoulli (1760) used a simple mathematical model to evaluate the effectiveness of variolation to protect against smallpox.

Daniel Bernoulli was one of a number of early mathematicians who turned their skills to probability problems raised by gamblers - perhaps at the card tables in Monte Carlo (e.g. C. Huyghens 1657).
Stochasticity & persistence

Disease extinction likely by chance when number of infectives falls to very low numbers.

- so extinction more frequent as population size decreases and cycle amplitudes increase.
Critical community size

*Minimum population size at which measles fadeouts (proportion of weeks with no cases) become rare.*
Seasonality in transmission of measles – school holidays

![Graph showing incidence of measles over weeks, with RCGP and model lines, and confidence bars.](image)
HIV-1 prevalence in Nairobi, Kenya 1981-1999 – stratified by risk group
Basic principles in Infectious Disease Epidemiology

- The key determinant of incidence and prevalence of infection is the basic reproductive number $R_0$. 

- $R_0$ measures the average number of secondary cases generated by one primary case in a susceptible population.

- Many factors determine its magnitude, including those that influence the typical course of infection in the patient and those that determine transmission between people.
Basic Reproductive number, $R_0$

Chains of transmission between hosts

- $R_0$: Basic reproduction number
  - average no. of secondary cases generated by 1 primary case in a susceptible population

- $R_t$: Effective reproduction number
  - number of infections caused by each new case occurring at time, $t$

- The key determinant of incidence and prevalence of infection is the basic reproductive number $R_0$.
- Many factors determine its magnitude, including those that influence the typical course of infection in the patient and those that determine transmission between people.
The epidemic curve

- Establishment
- Exponential growth
- Endemicity

Random (stochastic) effects

Equilibrium, or recurrent epidemics

Exhaustion of susceptibles
Typical course of infection within the host

Estimation of average latent & infectious periods plus distributions
The typical course of infection

**SARS CoV**

- Percentage of samples positive
- Days post onset of clinical symptoms
- Nasopharyngeal aspirate blue
- Stool dark red
- Urine light yellow

**Influenza A**

- Viral load
- Symptom score
- Days post viral inoculation

Experimental human influenza A/Texas/36/91 (H1N1) intranasal inoculation 10^5 dose

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Transmission - directly transmitted viral and bacterial respiratory tract infections

For a directly transmitted viral infection that induces long lasting immunity post recovery $R_0$ is given by; $R_0 = \beta XD$

Where $\beta$ is the probability of transmission on contact between infected and susceptible individuals, $X$ is susceptible population density (influenced by the net birth rate and vaccine coverage) and $D$ is the average duration of infectiousness.
Basic principles in Infectious Disease Epidemiology

- The magnitude of $R_o$ varies according to location and population - it is strongly influenced by birth rate, population density and behavioural factors.

- The magnitude of $R_o$ can be ascertained by cross sectional serological surveys.
What is Herd Immunity?

• The impact of the fraction immune in the community on the per capita rate of transmission of an infectious agent.

• The level of herd immunity can be measured by reference to the magnitude of reduction in the value of $R_0$. 
How can the degree of herd immunity and the magnitude of $R_0$ be assessed?

- Cross-sectional and longitudinal serological surveys.
- Serum and saliva (viral infections).
- Activated T cells (bacteria and protozoa)?
- Quantitative assays.
Scientific methods in the study of herd immunity

• **Immunological and Disease Surveillance** methods provide the empirical base for analysis and interpretation.

• **Mathematical & statistical** methods play an important role in the analysis of infectious disease transmission and control.

• They help to define both what needs to be measured, and how best to measure define epidemiological quantities.
Age-specific serology

Used to calculate the average age at infection, $A$, the average duration of maternal antibody protection, $M$, and the degree of herd immunity.
### Average age, \( A \), at infection prior to immunisation

<table>
<thead>
<tr>
<th>Infection</th>
<th>Average age at infection, ( A )</th>
<th>Location/time period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measles virus</td>
<td>5-6 years 2-3 years</td>
<td>USA 1955-58 Bangkok, Thailand 1967</td>
</tr>
<tr>
<td>Rubella virus</td>
<td>9-10 years</td>
<td>Sweden 1965</td>
</tr>
<tr>
<td>Varicella virus</td>
<td>6-8 years</td>
<td>USA 1921-28</td>
</tr>
<tr>
<td>Polio virus</td>
<td>12-17 years</td>
<td>USA 1920-60</td>
</tr>
<tr>
<td>Mumps virus</td>
<td>7-8 years</td>
<td>England &amp; Wales 1975</td>
</tr>
<tr>
<td>Smallpox virus</td>
<td>10-15 years</td>
<td>Bangladesh 1940</td>
</tr>
</tbody>
</table>
The calculation of the magnitude of $R_o$

A series of simple relationships exist between key epidemiological, demographic and vaccination programme related parameters.

The magnitude of $R_o$ and the average at infection prior to mass vaccination, $A$, plus life expectancy in the population are related as follows

$$R_o \approx \frac{(L - A)}{(A - M)}$$

Here, $M$ is the average duration of maternal antibody protection (6 months) and $L$ is life expectancy.
## Estimates of the basic reproductive number, $R_0$

<table>
<thead>
<tr>
<th>Infection</th>
<th>Location</th>
<th>Time period</th>
<th>$R_0$</th>
</tr>
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<tbody>
<tr>
<td>Measles</td>
<td>England</td>
<td>1947-50</td>
<td>13-15</td>
</tr>
<tr>
<td></td>
<td>Canada</td>
<td>1912-13</td>
<td>11-13</td>
</tr>
<tr>
<td>Varicella</td>
<td>USA</td>
<td>1943</td>
<td>7-8</td>
</tr>
<tr>
<td>Mumps</td>
<td>Netherlands</td>
<td>1970-80</td>
<td>11-14</td>
</tr>
<tr>
<td>Rubella</td>
<td>West Germany</td>
<td>1970-79</td>
<td>6-7</td>
</tr>
<tr>
<td>Polio</td>
<td>USA</td>
<td>1955</td>
<td>5-6</td>
</tr>
<tr>
<td>HIV-1</td>
<td>Nairobi, Kenya</td>
<td>1981-85</td>
<td>11-12</td>
</tr>
<tr>
<td></td>
<td>(sex workers)</td>
<td></td>
<td></td>
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<tr>
<td>Smallpox</td>
<td>Bangladesh</td>
<td>1940</td>
<td>4-6</td>
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<tr>
<td>Influenza A</td>
<td>England</td>
<td>2010</td>
<td>1-1.5</td>
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<tr>
<td>(H1N1)</td>
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</table>
Estimation of $R_0$ from past influenza A epidemics

[Graphs showing the estimation of $R_0$ over time for different influenza A epidemics.]
SARS - distribution of $R_0$

**Super spreading Events (person, place & setting)**

**Rapid SARS Virus Spread in Flats 7 and 8, Block E, Amoy Garden, Hong Kong.**

1st March 2003 –

292 people infected by one index case
The generation of secondary cases with vaccination

<table>
<thead>
<tr>
<th>Generation</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
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<td>0</td>
<td>0</td>
<td>0</td>
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<td>inf</td>
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<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Number Infected</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>$R$</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1.5</td>
<td>1.33</td>
<td>1.25</td>
<td>0.2</td>
</tr>
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</table>

Vaccinated individuals
Basic principles in Infectious Disease Epidemiology

The magnitude of $p_c$, the fraction of each birth cohort that must be immunised to block transmission is given by the following simple expression:

$$p_c \approx \frac{L - A}{L - b} / \epsilon$$

The parameter $b$ is the average age at first vaccination, $L$ is life expectancy (related to the net birth rate), and $A$ is the average age at infection prior to mass immunisation. Vaccine efficacy $= \epsilon$, ranging from 0-1.
Vaccine efficacy

(Christensen & Bottiger, 1991; Clarkson & Fine, 1987; Ramsey et al., 1994)

**MEASLES** 90%-95%

**MUMPS** 72%-88%

**RUBELLA** 95%-98%
Mass vaccination

Fraction that must be vaccinated to block transmission (A=5 years)

Vaccine efficacy changes with age due to presence of maternal antibodies

Maximum vaccine efficacy $Q$

- $Q=1.0$
- $Q=0.98$
- $Q=0.97$
Age at vaccination - good and bad patterns

**Good pattern** - clustered around the optimal age

**Poor pattern** - spread to the right side of the optimal age
Percentage of children who had completed the primary course of measles or MMR vaccine at two years of age, Great Britain, 1980 - 2000

[Source: Department of Health, Statistics Division]

Adverse publicity in February 1998 created by a publication suggesting link between MMR, autism plus inflammatory bowel disease.
Predictions based on mathematical models of transmission and the impact of mass vaccination

1) Increase in average age at infection
2) Increase in the inter-epidemic period
3) Toughs in susceptibility in the herd immunity profile
4) Changes in the age distribution of infection and serious disease
5) Non-linear relationship between the incidence of infection and disease and vaccine uptake
Average age of infection - the impact of vaccination

Average age at infection set at 5 years.

Average age of vaccination set at 2 years.
Vaccination - and the age distribution of infection

Measles - Gweru City, Zimbabwe
Vaccination since 1971

Proportion of cases in age class

Age group (months)
0-11, 12-23, 24-35, 36-47, 48-59, 60-71, 72-83, 84-95, 96-107, 108-119, 120+

pre-vacc 1975 1979-82 1984-5 1987-8
Impact of vaccination on serology
Herd immunity profile - across age classes and through time
(Anderson and May, 1982; Science 215:1053-60).

Measles - serology post the introduction of a cohort based vaccination programme
Age stratified & longitudinal serology for Rubella antibodies. Finland 1979-91

(Ukkonen et al, 1995)
Mass vaccination can increase the incidence of serious disease if the likelihood rises with age per case of infection (Anderson & May, 1983; *J. Hygiene* 90:259-325)

The case of rubella and congenital rubella syndrome
Demography - age specific birth rates in the UK 1981 & 1996: Rubella immunization
Percentage gain from the **indirect** effects of herd immunity

Critical vaccination coverage to block transmission, $p_c$
Model design for individual based stochastic simulations

- High performance, object-oriented code. Intended to be scaleable to allow 000s of model simulations of 60 million population to be performed.
- Computationally intensive (>5GB memory use for 60 million).
- Three levels of population structure:
  - Flexible modelling of disease biology (arbitrary distributions, number of disease stages), and interventions (ring vaccination, mass vaccination, quarantine, anti-viral treatment, movement constraints).
Spatial kernels – mobile phone data – frequency versus – distanced moved per defined time unit

Number of people

Distance metres

- Sum over daily legs
- Legs
- Daily Extent

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Data needs: detailed population data: *Landscan* (Oakridge Natl. Lab.)

Need both population data (density, age, household) and mixing/travel data.

Population density – based on satellite imagery
Individual-based stochastic simulation model with three scales of mixing – extensive sensitivity analysis and analysis of past influenza epidemics.
Simulating global spread – Influenza A

(Ferguson et al, 2009)
H1N1 in England during the 2009-10 seasons – compared with previous years

Week ending 28 February 2010: **9.0 consultations per 100,000 population**

* Level reduced by availability of NPFS for 2009/2010 period but not earlier periods

Source: RCGP to 28 February 2010
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R for Mexico in April-May

(Fraser et al, 2009 Nature)

- $R=1.5$ (95% Cr.I.:1.2-1.9) from confirmed case epi curve.
- $R=1.4$ (95% Cr.I.:1.1-1.9) from spatial back-calculation.
- $R=1.2$ (95% Cr.I.:1.1-1.9) from sequence analysis.
England and Wales – RCGP consultation rates for Total Respiratory Disease (TRD), Acute Bronchitis (AB) & Influenza like illness (ILI)
Blocking transmission by mass vaccination

Protective vaccine – critical proportion to be immunized, \( p_c \), to block transmission as a function of \( R_0 \) and the duration of protection, \( V \) (efficacy, \( \varepsilon = 1 \)).

\[
p_c = \left[ 1 - 1 / R_0 \right] / \varepsilon
\]

Vaccine efficacy = \( \varepsilon \), ranging from 0-1
For influenza A …… if \( R_0 = 1.6 \) then \( p_c = 37.5\% \).
Seroprevalence following the second wave of pandemic 2009 H1N1 influenza

Serology for H1N1 in an English School in September 2009 after the first wave

(Miller et al, Lancet January 21st 2010)
Mortality in the UK by age group
H1N1 - 2009

Age group (years)

England & Wales 2009

USA 2009
Mean time between exports with differing degrees of travel restrictions

(Hollingsworth, Ferguson & Anderson, 2006)

Stochastic effects
Incidence as a function of time for four realizations of a stochastic simulation of an influenza epidemic. Incidence is highly variable during the early stages of any epidemic, here ranging between 10 and 120 cases per day by day 20. Incidence increases during the course of an epidemic and the interval between exports will decrease rapidly.
Lessons learnt – H1N1

• Estimation of morbidity and mortality rates early in the epidemic.
• Serology as soon as possible – essential for estimation of case fatality (stratified by age and risk factors).
• Identify co-morbidities/risk factors as quickly as possible – first 500 cases.
• On the bases of $R_0$ and case fatality estimates – define policy objectives.
• Electronic capture of data and display real time.
• Logistics of antiviral delivery and policy of use.
• Policy on vaccine delivery to at risk groups.
• Vaccine uptake – reasons for refusal.
Conclusions

• Eradication difficult when $R_0$ large and population density plus net birth rate high.
• Heterogeneity in population density and vaccine coverage important.
• Carrier state important as are reservoir hosts (if involved).
• Mathematical & computational methods permit analytical & simulation studies of potential impact of different strategies.
• Cost benefit studies need to take account of indirect effects of mass vaccination on transmission.
• Vaccine coverage must be maintained at high levels to avoid the immigration of infectives stimulating epidemics in susceptible pockets.
• Multi- strain systems – more research required – will new strains replace those targeted by a multi-valent vaccine?
The End
HIV-1 vaccines

• At present, there are many ongoing HIV-1 vaccine trials and several pending for 2006, involving different vaccines (of which some are DNA-based, some use recombinant viral vectors, 4 are protein subunits and 3 are lipopeptide-based).

• Most are in Phase I, with VaxGen’s two trials (in North America and Thailand) the only Phase III studies completed. Both Phase III trials were completed in 2003, with efficacy data revealing no difference in infection in treated and untreated arms.

• The majority use clade B strains, but a few candidates (especially among the newer ones in the pipeline) are based on clades A, C, D and E (http://www.iavi.org).
Eradication criterion – protective vaccines

\[ p_c > \frac{\left[1 - 1/R_0\right]\left[1 + L/V\right]}{\varepsilon} \]

\( p_c \) is the critical fraction of each cohort immunised, \( R_0 \) is the basic reproductive number, \( L \) is life expectancy, \( V \) is the duration of vaccine protection and \( \varepsilon \) is vaccine efficacy.
Imperfect vaccines

• Vaccinated individuals acquire infection but show slower progression to AIDS.
• Slower progression is linked to lower viral loads – especially in the primary HIV-1 infection phase.
• Lower viral load is linked to lowered infectiousness to susceptible sexual partners.
• Vaccination may be linked to increased risk behaviours.
Eradication criterion – imperfect vaccines

\[ p_c > \frac{\left[ 1 - 1 / R_0 \right][1 + L / V]}{\varepsilon\left[ 1 - R_{0v} / R_0 \right]} \]

\( p_c \) is the critical fraction of each cohort immunised, \( R_0 \) is the basic reproductive number for unvaccinateds, \( R_{0v} \) is the reproductive numbers for vaccinateds, L is life expectancy, V is the duration of vaccine protection and \( \varepsilon \) is vaccine efficacy.
Illustrative schematic diagram, in two dimensions, of a multidimensional parameter space denoting the six possible equilibrium states that can exist for different epidemiological and vaccine property related parameter combinations (Anderson & Hanson, 2005, JID).

- No vaccination & endemic persistence of HIV-1 infection (Ro>1, p=0)
- No persistence of HIV-1 infection (Ro<1)
- Vaccination & eradication of HIV-1 infection (y_v*<0)
- Vaccination & good outcome of increased HIV-1 infection but increased population size (y_v*>y*, N_v*>N*)
- Vaccination & good outcome of decreased HIV-1 infection & increased population size (y_v*<y*, N_v*>N*)
- Vaccination & perverse outcome of increased HIV-1 infection & decreased population size (y_v*>y*, N_v*<N*)

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