



## Sources of Heterogeneity in Contacts

Individual exposure and infection hazard may be heterogeneous for a number reasons:

#### 1. <u>Risk structure</u>

- Determined by behavioural patterns
- Or related to occupation

#### 2. Age-determined contacts

- Childhood diseases
- 3. Seasonality
  - Time-dependent contact rates result in sustained oscillations
  - Harmonic oscillations, harmonic resonance and bifurcations























$$\begin{aligned} & \textbf{Targeting S}_{H} \\ P_{x_{1}}KP_{x_{2}} = \begin{pmatrix} 1 & 0 \\ 0 & 0 \end{pmatrix} \begin{pmatrix} 0.9 & 0.4 \\ 0.4 & 0.7 \end{pmatrix} \begin{pmatrix} 1 & 0 \\ 0 & 1 \end{pmatrix} = \begin{pmatrix} 0.9 & 0.4 \\ 0 & 0 \end{pmatrix} \\ & \textbf{Check:} \quad \rho(K - P_{x_{1}}KP_{x_{2}}) = 0.7 \checkmark \\ & (P_{x_{1}}KP_{x_{2}}) \left(I - K + (P_{x_{1}}KP_{x_{2}})\right)^{-1} \\ & = \begin{pmatrix} 0.9 & 0.4 \\ 0 & 0 \end{pmatrix} \left[ \begin{pmatrix} 1 & 0 \\ 0 & 1 \end{pmatrix} - \begin{pmatrix} 0.9 & 0.4 \\ 0.4 & 0.7 \end{pmatrix} + \begin{pmatrix} 0.9 & 0.4 \\ 0 & 0 \end{pmatrix} \right]^{-1} \\ & = \begin{pmatrix} 1.43 & 1.33 \\ 0 & 0 \end{pmatrix} \\ & \textbf{Hence, T}_{H} = \mathcal{T}_{H \rightarrow H, L \rightarrow H = 1.43} \\ & \textbf{Need to vaccinate } 1 - 1/T_{H} = 1 - 1/1.43 = 0.3 \end{aligned}$$



More Generally					
Target Paths	<b>x</b> 1	<b>X</b> 2	Target Reproduction	Reduction	Vaccination
All	H, L	H, L	$R_0 = 1.21$	0.17	17% H 17% L
H≯H L≯H	Н	H, L	$T_{\rm H} = 1.43$	0.3	30% H 0% L
H≯L L≯L	L	H, L	$T_{\rm H} = 2.30$	0.57	0% H 57% L
H≯H	Н	Н	1.93	0.48	-
L≁L	L	L	Not Defined	-	-
L → H	Н	L	5.33	0.81	-
H≁L	L	Н	5.33	0.81	-









## **Modeling Risk Structure**

- So far, looked at heterogeneity arising in contacts, due to behavioural differences (risk structure)
- Now, we consider changing risk due to age structure, motivated by childhood diseases (ie SIR)
- Initially, assume only two age groups: <u>Low</u> risk (Adults) and <u>High</u> risk (Children)
- Differences from previous model: (i) SIR not SIS, (ii) individuals eventually move from class *C* to class *A* in SIR model









- So far, we have used hypothetical WAIFW matrices
- In reality, we may have data on disease prevalence in C and A classes, but our matrix  $\beta$  has 4 entries we need to estimate!
- Pragmatic assumption has been to simplify WAIFW along intuitive/sensible lines, eg

$$\beta = \left(\begin{array}{cc} \beta_1 & \beta_2 \\ \beta_2 & \beta_2 \end{array}\right)$$

• Often, reasonably obvious what's not a plausible WAIFW matrix

 $egin{aligned} & ext{inlikely} = \left( egin{array}{cc} eta_1 & eta_2 \ eta_2 & eta_1 \end{array} 
ight), \left( egin{array}{cc} eta_1 & 0 \ 0 & eta_1 \end{array} 
ight), \left( egin{array}{cc} eta_1 \ eta_2 \end{array} 
ight), \left( egin{array}{cc} eta_1 \ eta_2 \end{array} 
ight), \end{aligned}$ 

## Application to Childhood Diseases

- Some of earliest discrete age-class (RAS) models developed for measles (Schenzle 1984)
- Make pragmatic assumption: transmission, especially in prevaccine era, primarily driven by school dynamics
- Need four age groups
  - Pre-school (0-4 years)
  - Primary school (5-10 years)
  - Secondary school (11-16 years)
  - Adults (16+)
- We're now faced with old problem of which WAIFW?

# Typical age-specific data

Given *n* age classes, age-specific transmission matrix has  $n^2$  elements ... correcting for reciprocity, we still have n(n-1)/2 term



Often, only have information on age-specific prevalence or serology





















