

How will mass-vaccination change COVID-19 lockdown requirements in Australia?

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SYDNEY

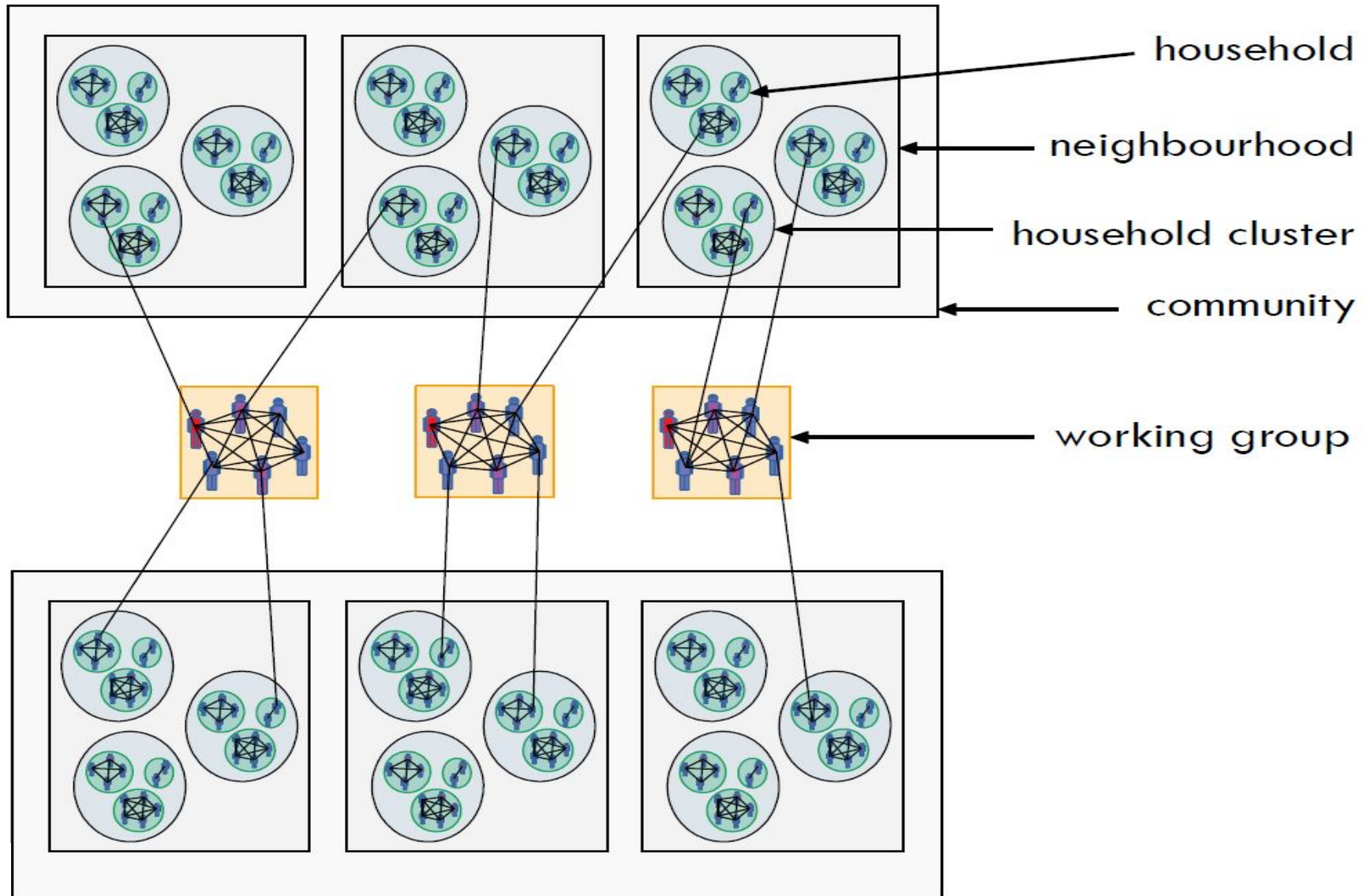
JP Morgan Australia conference
"What will the "New Normal" look like post COVID-19 vaccine rollout?"
June 10, 2021

- Modelling pandemics with large-scale high-resolution agent-based models
 - *demographics*: from census based data to agents
 - *mobility*: travel patterns including long-distance
 - *infection*: disease transmission and natural history models
 - AMTraC-19 – Agent-based Model of Transmission and Control of the COVID-19 pandemic in Australia (about 24M agents)

- COVID-19 pandemic
 - age-dependent epidemiological characteristics, and calibration
 - pandemic trends (peaks, resurgence), and model validation
 - non-pharmaceutical interventions (NPIs): mitigation, suppression, elimination
 - pharmaceutical interventions: vaccination



“Same storm, different boats”: Agent-based Modelling



Population partitions: residential areas and destination zones

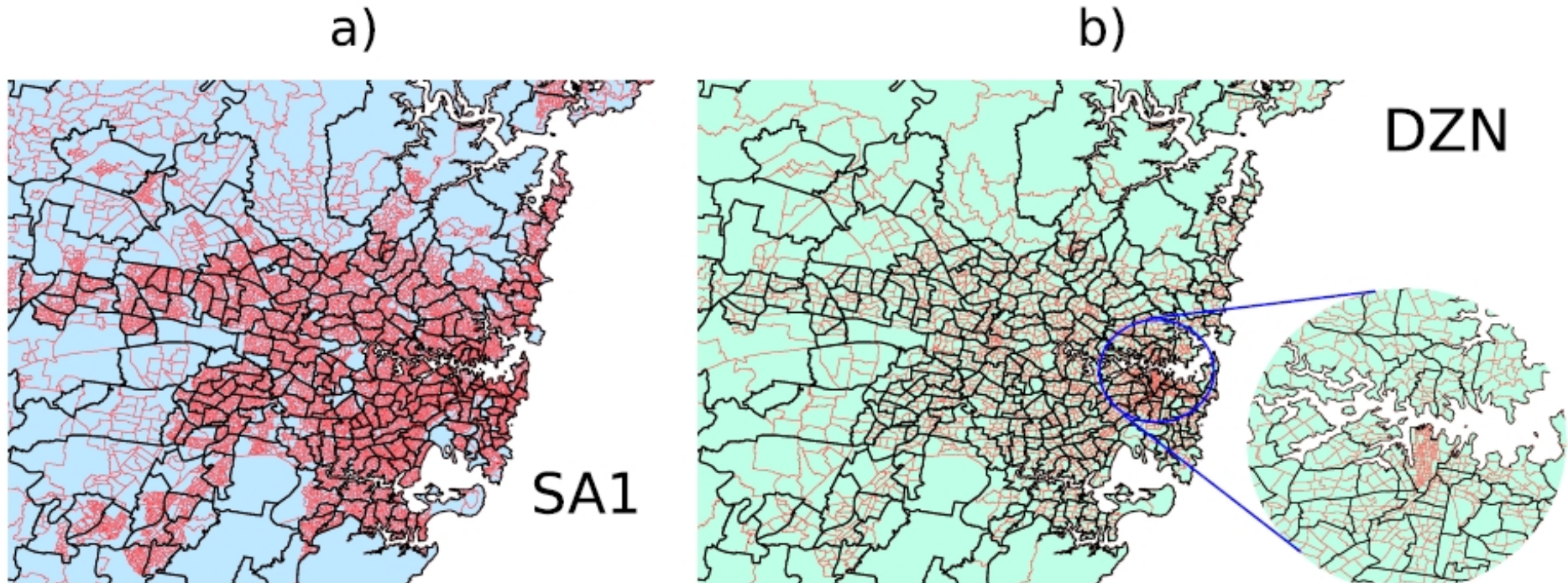


Fig. 1 Maps of the Greater Sydney region illustrating the distribution of population partitions. (a) A map of the Greater Sydney region showing SA2 (black) and SA1 (red) population partitions. (b) A map of the same area showing SA2 (black) and DZN (red) partitions. The inset in (b) zooms in on the Sydney central business district to illustrate the much denser packing of DZN partitions in that area.

Airport code	State	City	Passengers
SYD	NSW	Sydney	40884
MEL	VIC	Melbourne	25859
BNE	QLD	Brisbane	14250
PER	WA	Perth	11449
OOL	QLD	Gold Coast	3022
ADL	SA	Adelaide	2214
CNS	QLD	Cairns	1874
DRW	NT	Darwin	597
TSV	QLD	Townsville	105

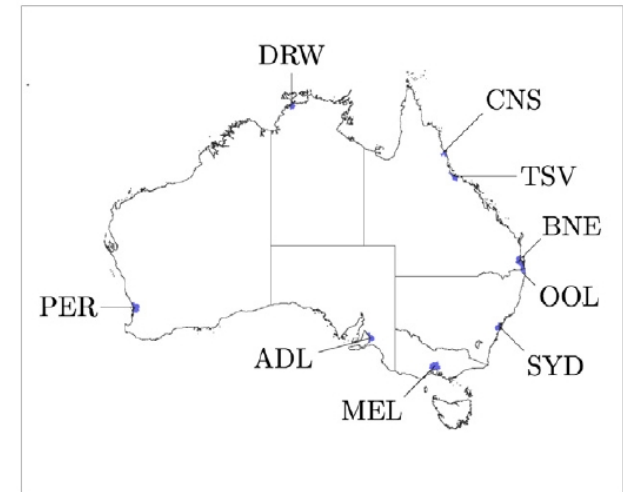


Fig. 3. Daily incoming passengers per Australian international airport obtained from BITRE [30] along with a map detailing the airport locations.

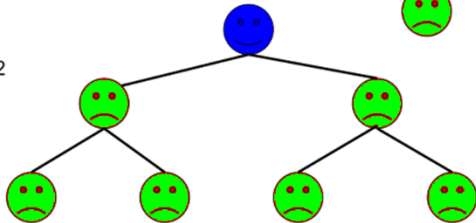


Epidemic modelling: reproductive ratio R_0

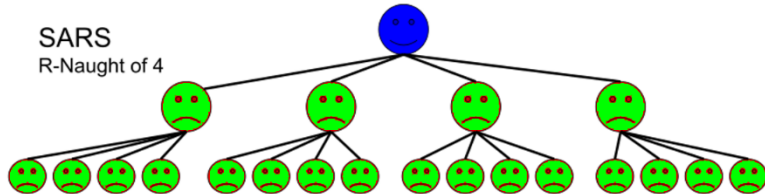
😊 Patient Zero

😞 Infected

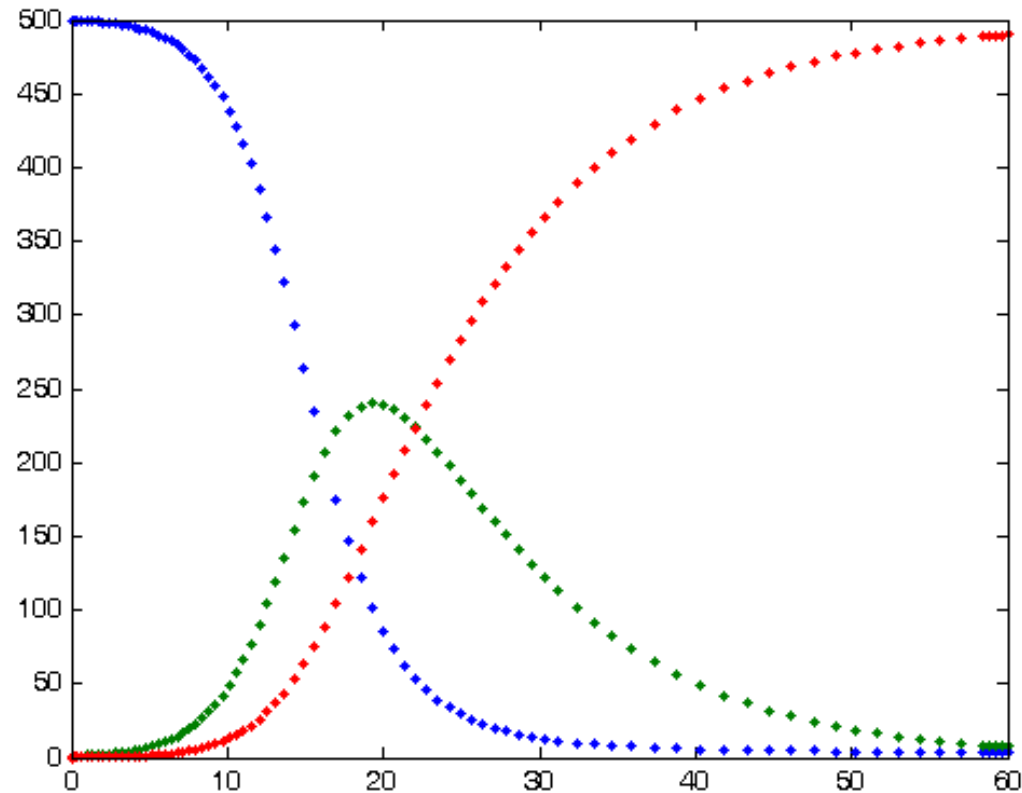
Ebola:
R-Naught of 2



SARS
R-Naught of 4



$$\frac{dI}{dt} = \beta IS - \gamma I, \quad \beta / \gamma = R_0$$



Epidemic modelling: transmission probabilities

Table C2

Daily transmission probabilities $q_{j \rightarrow i}^g$ for different contact groups g , obtained by Eq. (4) where $\beta_{j \rightarrow i}^g$ are reported by [10].

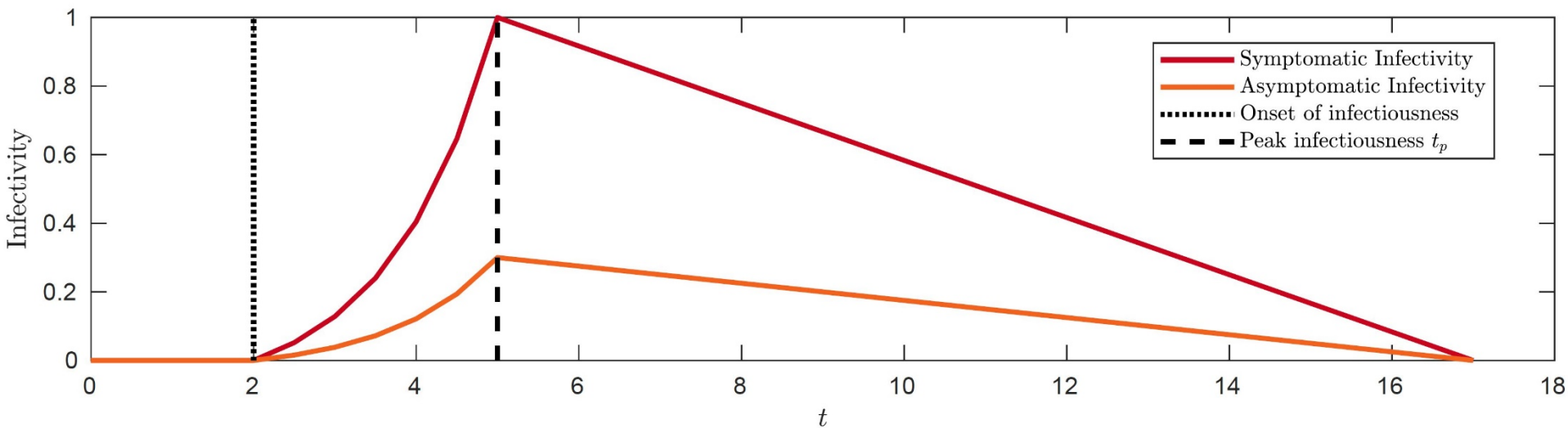
Contact Group g	Infected Individual j	Susceptible Individual i	Transmission Probability $q_{j \rightarrow i}^g$
Household size 2	Any	Child (< 19)	0.0933
	Any	Adult (> 18)	0.0393
Household size 3	Any	Child (< 19)	0.0586
	Any	Adult (> 18)	0.0244
Household size 4	Any	Child (< 19)	0.0417
	Any	Adult (> 18)	0.0173
Household size 5	Any	Child (< 19)	0.0321
	Any	Adult (> 18)	0.0133
Household size 6	Any	Child (< 19)	0.0259
	Any	Adult (> 18)	0.0107
School	Child (< 19)	Child (< 19)	0.000292
Grade	Child (< 19)	Child (< 19)	0.00158
Class	Child (< 19)	Child (< 19)	0.035

$$p_{j \rightarrow i}^g(n) = \kappa f(n - n_j \mid j) q_{j \rightarrow i}^g$$

$$p_i(n) = 1 - \prod_{g \in G_i(n)} \left[\prod_{j \in \mathcal{A}_g \setminus i} (1 - p_{j \rightarrow i}^g(n)) \right]$$

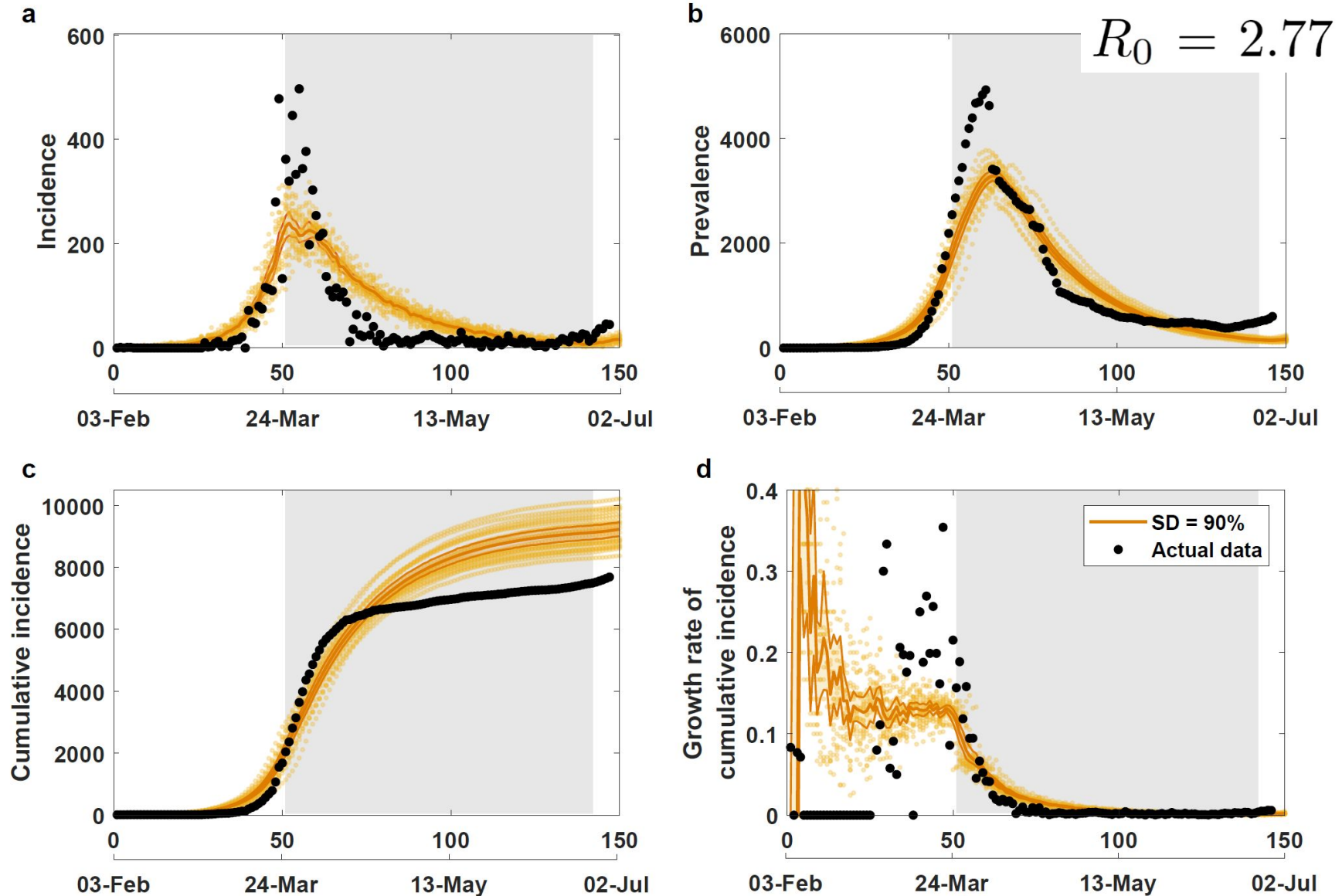
global scalar
 $\beta / \gamma = R_0$

Epidemic modelling: natural history of the disease (our 2020 model: AMTraC-19 version 6.1)



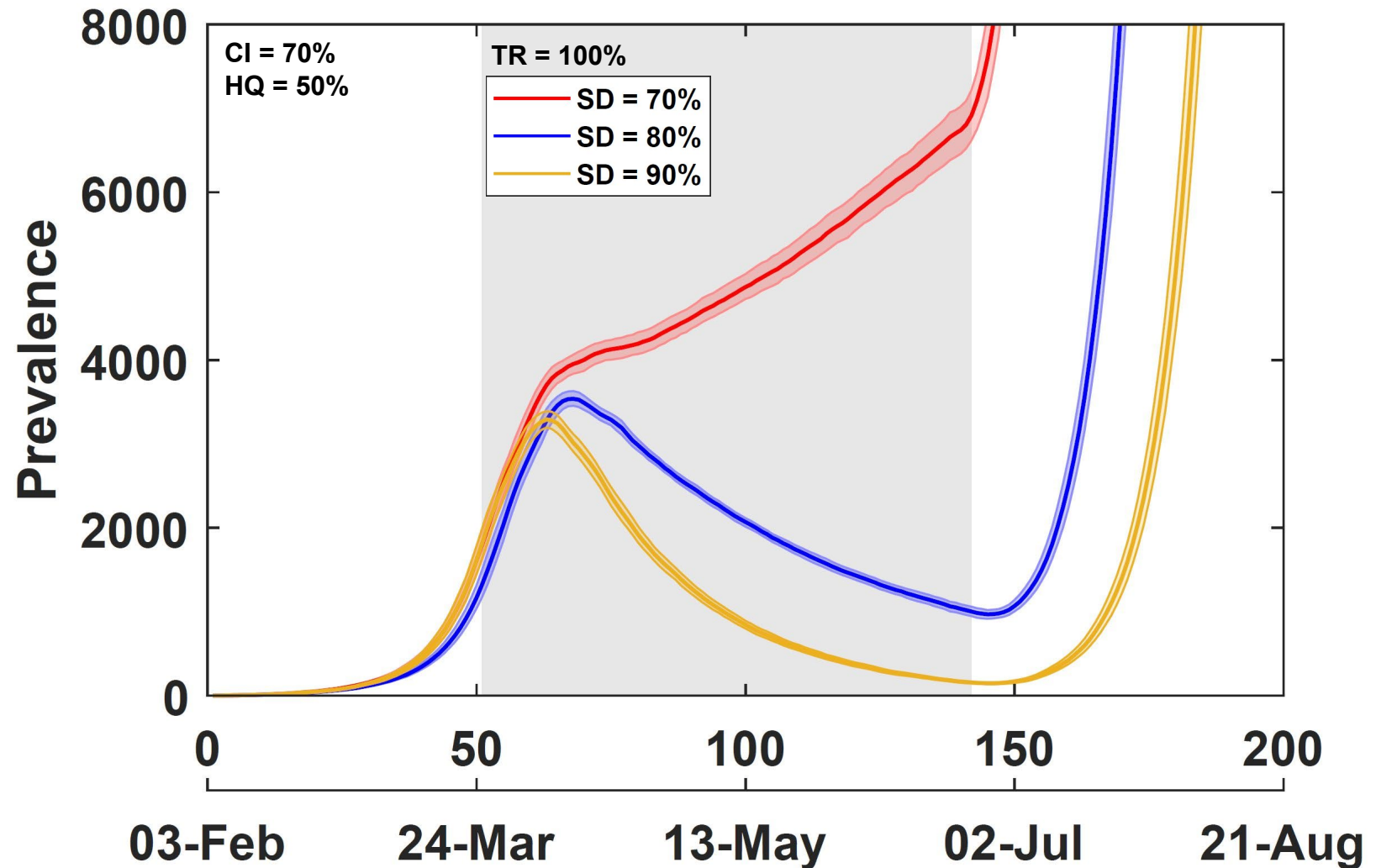


AMTraC-19 validation (version 6.1)





2020 model: a tipping point in social distancing





Media coverage (April 2020)

THE LATEST

COVID-19 IMPACT OF SELF DISTANCING



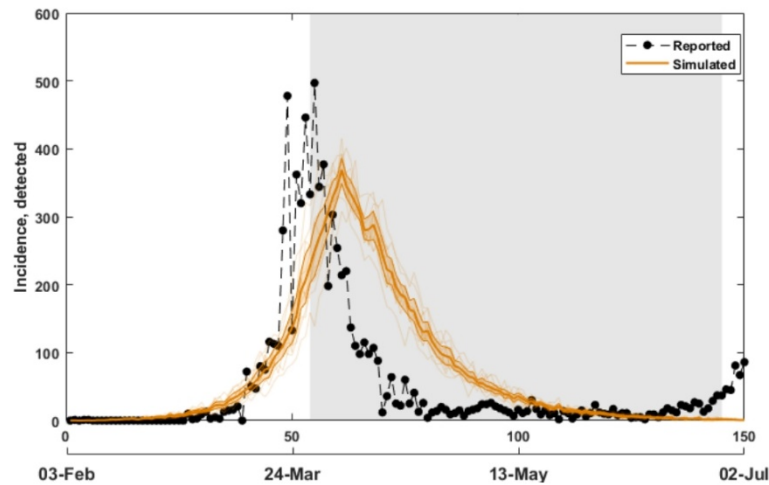
Epidemic modelling: natural history of the disease (our 2021 model: AMTraC-19 version 7.6)

- infectious incubation period is log-normally distributed with mean 5.5 days
- infectious asymptomatic or symptomatic period, following incubation, lasts between 7 and 14 days (uniformly distributed with mean 10.5 days)
- differentiation between:
 - “asymptomatic infectivity” (factor of 0.5) and
 - “pre-symptomatic infectivity” (factor of 1.0)
- detection probabilities:
 - symptomatic (detection per day is 0.23)
 - pre-symptomatic and asymptomatic (detection per day is 0.01)



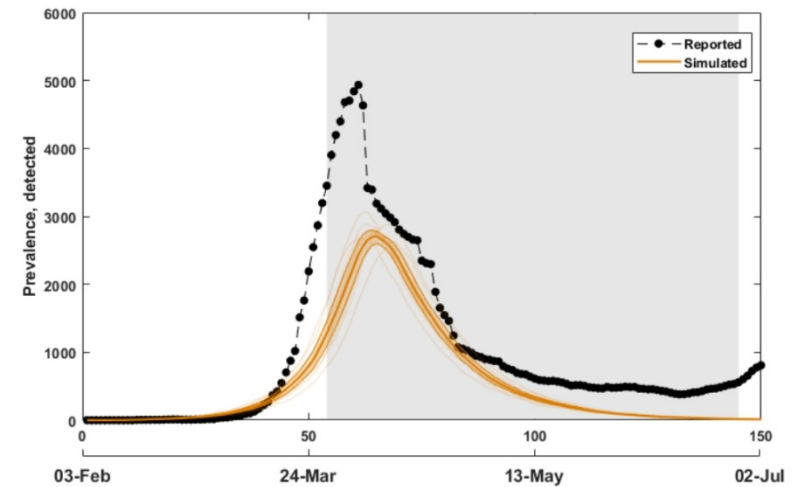
AMTraC-19 validation (version 7.6): 1st wave

a)

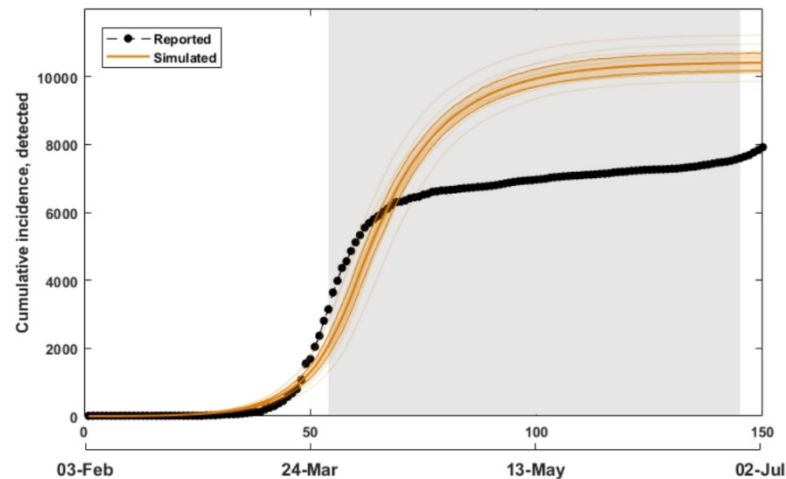


b)

$$R_0 = 2.75$$

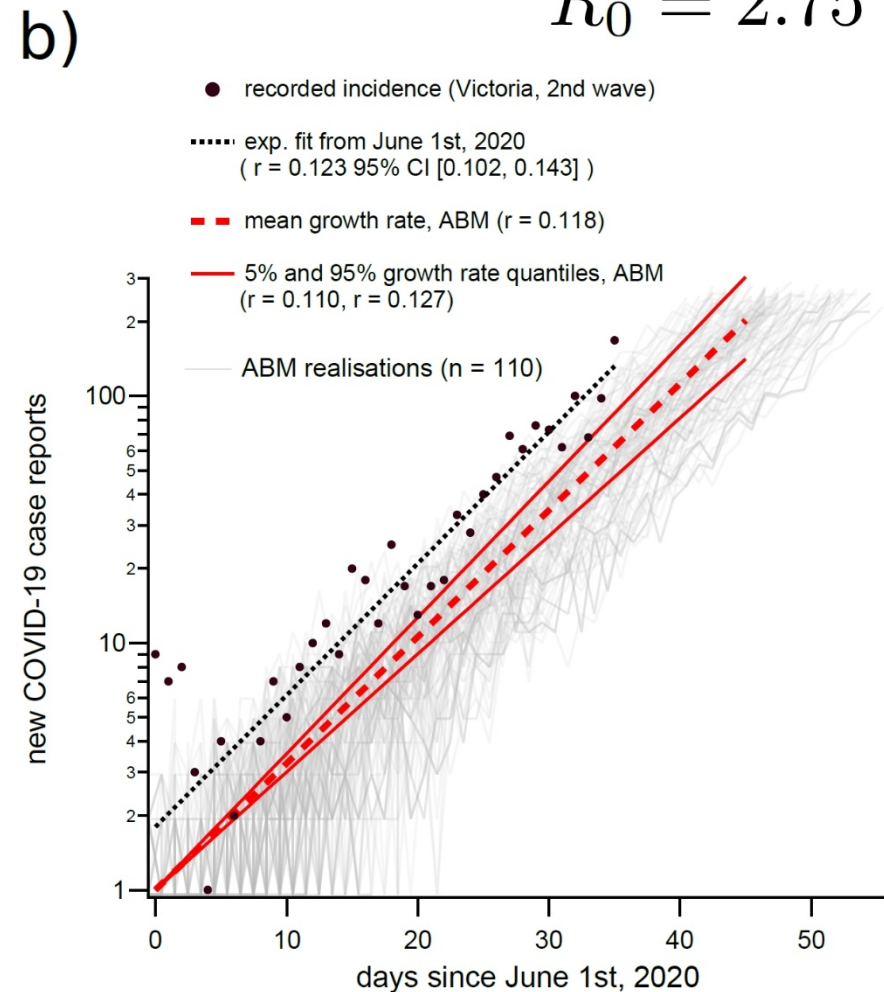
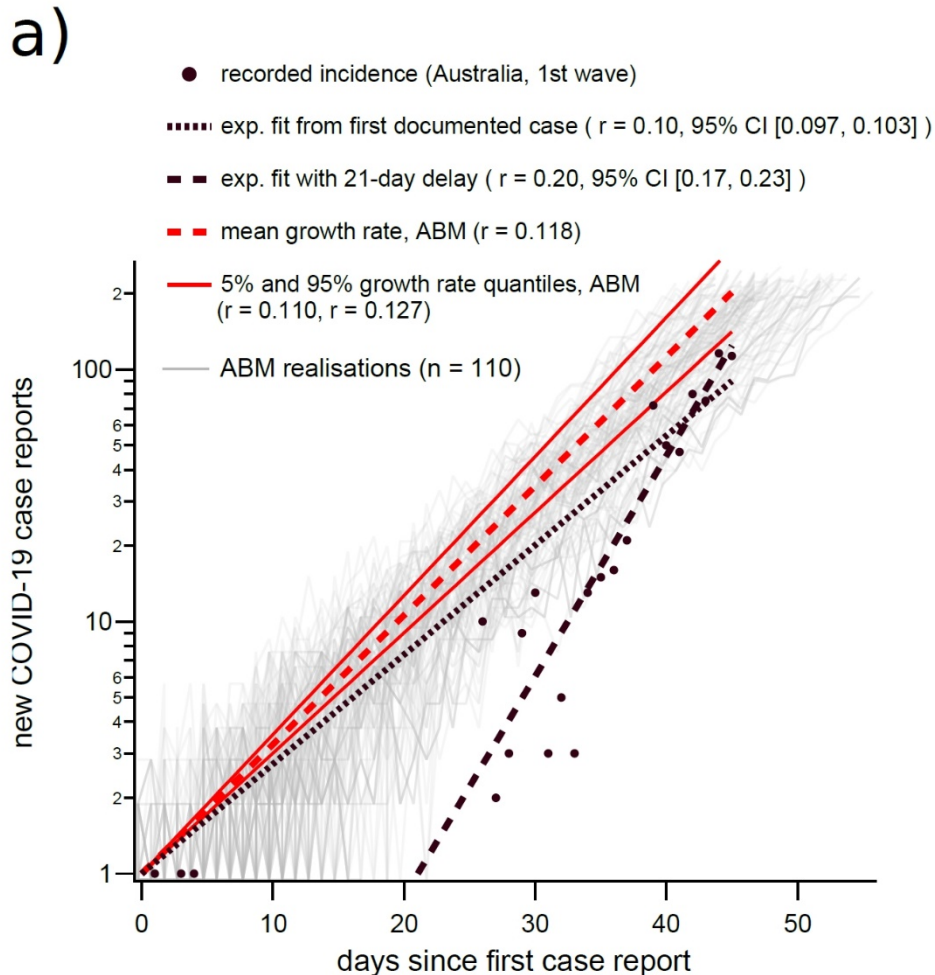


c)



AMTraC-19 validation (v7.6): 1st and 2nd waves

$$R_0 = 2.75$$



C. Zachreson, S. L. Chang, O. M. Cliff, M. Prokopenko, How will mass-vaccination change COVID-19 lockdown requirements in Australia? *arXiv:2103.07061*, 2021.

Vaccine efficacy and herd immunity (...textbook)

Vaccine efficacy: $VE = 1 - \text{risk}$

where **risk** is relative risk for developing a **condition** in vaccinated people compared to unvaccinated people

Herd immunity threshold:

$$\frac{1 - 1/R_0}{VE}$$

$R_0 = 2.75$ and $VE = 0.9$:

$$\frac{1 - 1/2.75}{0.9} = 0.707$$

$R_0 = 5.5$ and $VE = 0.8$:

$$\frac{1 - 1/5.5}{0.8} = 1.023$$

Modelling vaccination rollout (our 2021 model: AMTraC-19 version 7.6)

- Efficacy for susceptibility (**VEs**): impacts immunity in those susceptible to the virus (reduces the probability of becoming infected if exposed)
- Efficacy for disease (**VEd**): impacts the expression of illness in those who are vaccinated and subsequently become infected (reduces the probability of expressing symptoms if infected)
- Efficacy for infectiousness (**VEi**): impacts the potential for vaccinated individuals to transmit the virus if infected (reduces the force of infection produced by infected individuals who are vaccinated)

$$VE = VEd + VEs - VEs \times VEd$$

$$VEi = \sim 0.5$$

for example:

$$0.91 = 0.7 + 0.7 - 0.7 \times 0.7$$

$$0.92 = 0.8 + 0.6 - 0.8 \times 0.6$$

$$0.75 = 0.5 + 0.5 - 0.5 \times 0.5$$

$$0.65 = 0.5 + 0.3 - 0.5 \times 0.3$$

Will there be herd immunity?

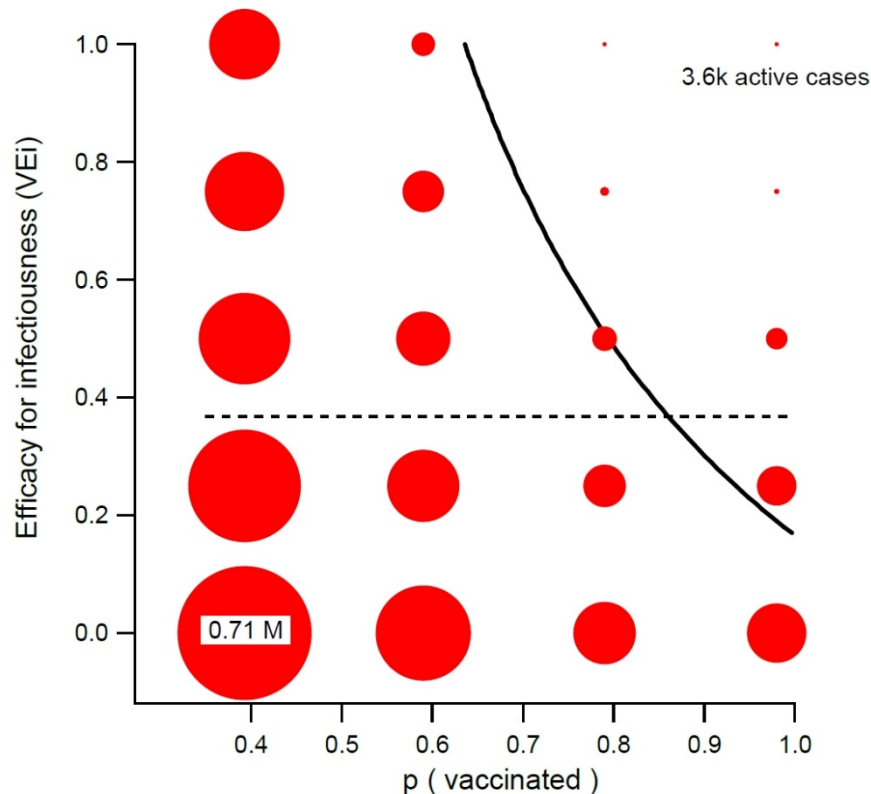
VE = 0.6

General vaccine
with targeted interventions

• average peak prevalence
(n = 10 ABM simulations)

herd immunity threshold (hom. approximation)
—●— VEd = 0.368, VEs = 0.368

upper bound on plausible VEi range
--- VEi = 0.368



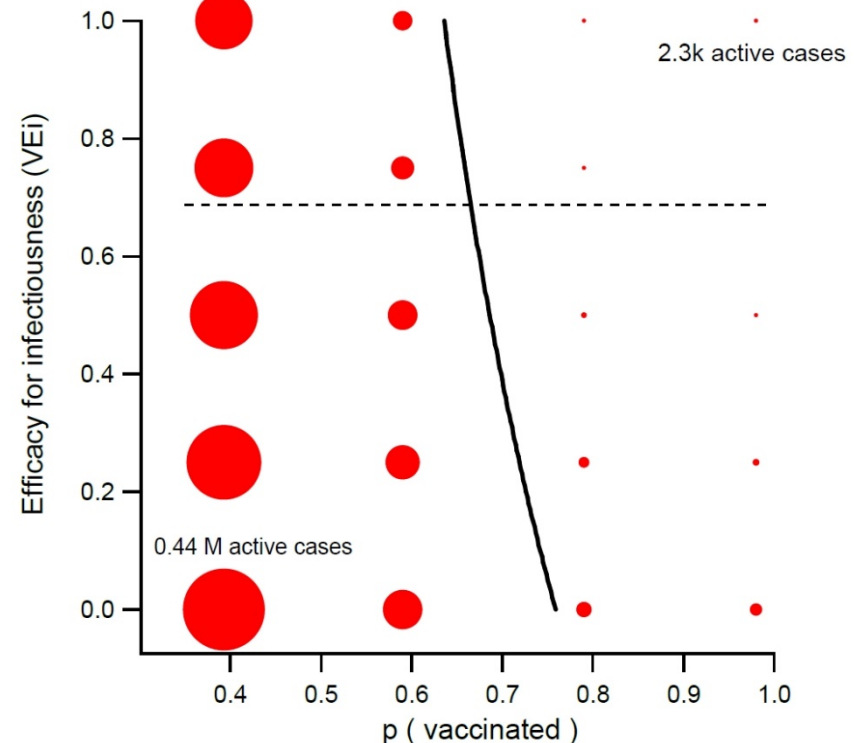
VE = 0.9

Priority vaccine
with targeted interventions

• average peak prevalence
(n = 10 ABM simulations)

herd immunity threshold (hom. approximation)
—●— VEd = 0.684, VEs = 0.684

upper bound on plausible VEi range
--- VEi = 0.684



Feasible rollout scenarios

scenario	targeted NPIs	priority immunisations	general immunisations
no intervention	nil	nil	nil
targeted NPIs only	TR, CI, HQ*	nil	nil
priority vaccine (5M)	”	5×10^6	nil
general vaccine (11.5M)	”	nil	11.5×10^6
priority vaccine (10M)	”	10^7	nil
priority 10M, general 2.5M	”	10^7	2.5×10^6
priority 10M, general 6.1M	”	10^7	6.1×10^6
priority 10M, general 10.7M	”	10^7	10.7×10^6

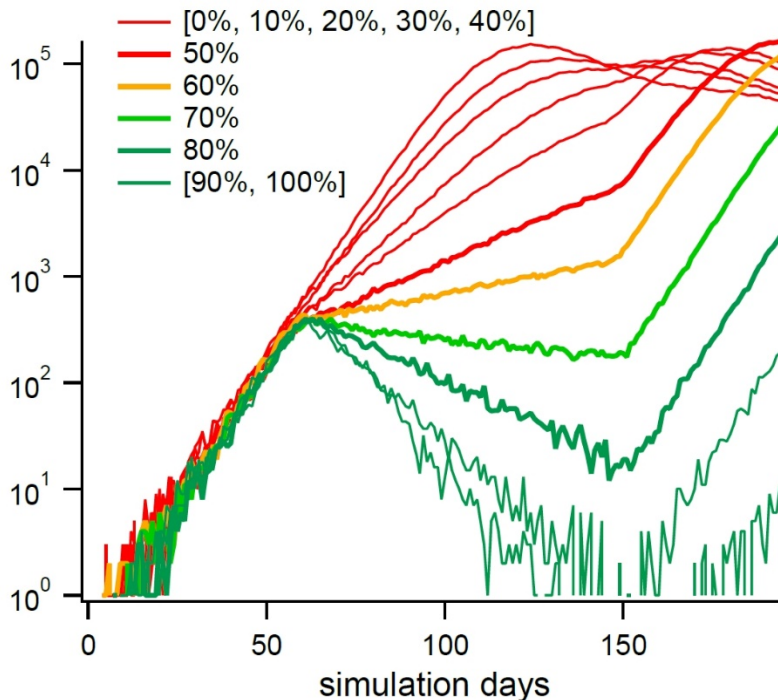


How much social distancing will be required?

a)

Case-targeted NPIs only

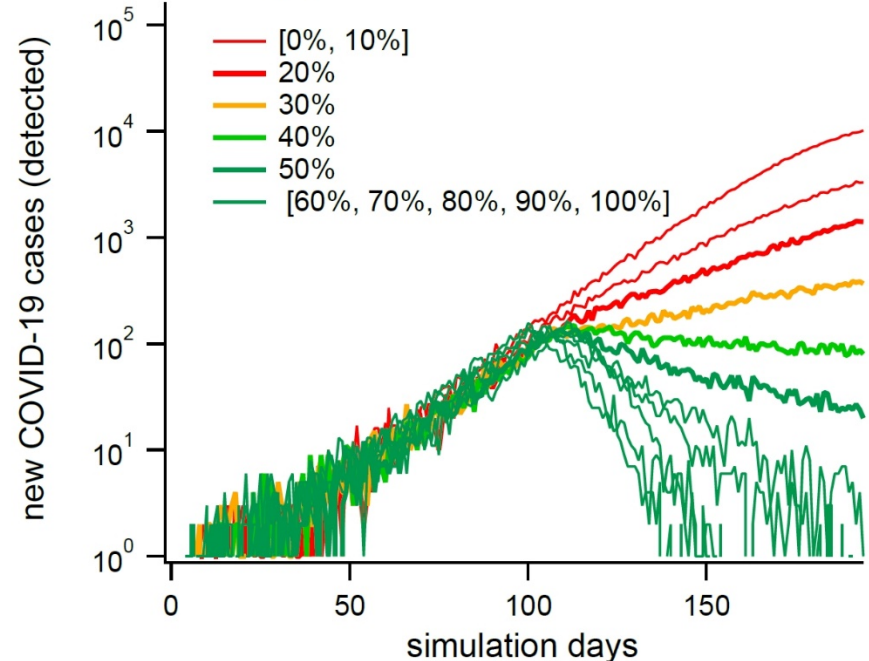
% of population in lockdown



b)

Priority: 10M, General: 10.7M
(with case-targeted NPIs)

% of population in lockdown



- targeted interventions (CI, HQ) would continue to be required in near future
- a hybrid rollout (using both priority and general vaccine), even with 80-90% of coverage, will not reach herd immunity:
 - partial restrictions will be needed during outbreaks (~40% SD: working from home, reduced contacts, school closures, ...);
 - otherwise, rapid sizeable outbreaks with thousands of new cases per day are likely
- border closures (TR) would be required until at least 70% of the population is vaccinated with a **high-efficacy** vaccine ($VE > 0.9$), assuming $R_0 < 3$
- mass-vaccination with current vaccines needs to be completed before the booster(s) for new variants become available, and before the first vaccinated cohorts lose immunity
- if efficacy remains high ($VE > 0.9$) against new variants ($R_0 > 5$), then vaccinating **90% of the population** would be required before returning to “new normal” (small isolated outbreaks)
- potential risks:
 - convergence to a super-bug (say, $R_0 > 10$)
 - increased symptoms in children
 - immune escape (e.g., efficacy of AZ is 10.4% against the variant found in S. Africa)
 - lasting immunity gets shorter than 9-12 months
- potential solutions:
 - wide-spread adoption of mRNA vaccines and boosters (e.g., Pfizer, Moderna)
 - new anti-viral drugs and treatments (beyond Regeneron “antibody cocktail”)

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