

1 Title

2 Predicting the impact of pneumococcal conjugate vaccine programme options in Vietnam: a  
3 dynamic transmission model

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44 **ABSTRACT**

45 Background

46 Catch-up campaigns (CCs) at the introduction of the pneumococcal conjugate vaccines  
47 (PCVs) may accelerate the impact of PCVs. However, limited vaccine supplies may delay  
48 vaccine introduction if additional doses are needed for such campaigns. We studied the  
49 relative impact of introducing PCV13 with and without catch-up campaign, and the  
50 implications of potential introduction delays.

51 Methods

52 We used a dynamic transmission model applied to the population of Nha Trang in Sout  
53 central Vietnam. Four strategies were considered: routine vaccination (RV) only, and RV  
54 alongside catch-up campaigns among <1y olds (CC1), <2y olds (CC2) and <5y olds (CC5). The  
55 model was parameterised with local data on human social contact rates, and was fitted to  
56 local carriage data. Post-PCV predictions were based on best estimates of parameters  
57 governing post-PCV dynamics, including serotype competition, vaccine efficacy and duration  
58 of protection.

59 Results

60 Our model predicts elimination of vaccine-type (VT) carriage across all age groups within 10  
61 years of introduction in all scenarios with near-complete replacement by non-VT. Most of  
62 the benefit of CCs is predicted to occur within the first 3 years after introduction, with the  
63 highest impact in the first year, when IPD incidence is predicted to be 11% (95%CrI 9 – 14%)

64 lower than RV with CC1, 25% (21 – 30 %) lower with CC2 and 38% (32 – 46%) lower with  
65 CC5.

66 However, CCs would only prevent more cases of IPD insofar such campaigns do not delay  
67 introduction by more than 31 (95%CrI 30 – 32) weeks with CC1, 58 (53 – 63) weeks with CC2  
68 and 89 (78 – 101) weeks for CC5.

### 69 Conclusion

70 CCs are predicted to offer a substantial additional reduction in pneumococcal disease  
71 burden over RV alone, if their implementation does not result in much introduction delay.  
72 Those findings are important to help guide vaccine introduction in countries that have not  
73 yet introduced PCV, particularly in Asia.

74

### 75 **KEYWORDS**

76 vaccine, pneumococcal, prediction, catch-up, model, transmission

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84 **Background**

85 Disease due to *Streptococcus pneumoniae* (the pneumococcus) is a leading cause of  
86 morbidity and mortality worldwide, disproportionately so in resource-poor settings [1-3].

87

88 Ten- and 13-valent pneumococcal conjugate vaccines (PCV10 and PCV13), which cover 10  
89 and 13 of 94 known serotypes [4], are steadily being introduced into the routine  
90 immunisation programmes of many low and lower-middle income countries with the  
91 support from Gavi, the Vaccine Alliance [5]. In 2015, 50 out of 73 countries eligible for Gavi  
92 support had introduced the vaccine, and eight additional countries have been approved for  
93 introduction and are expected to introduce PCV within the next two years [5]. In 2012  
94 Pakistan was the first Asian country to routinely introduce PCV, followed by Nepal,  
95 Cambodia and Lao PDR [5]. However, PCV has not been introduced in most of Asia, including  
96 Vietnam. Globally, the number of infants who had had 3-doses of PCV remains low [6].

97

98 The WHO recommends introducing PCV into childhood immunisation programmes  
99 alongside a catch-up campaign (CC) among older children [7], in order to provide direct  
100 protection to age groups at particular risk of pneumococcal disease, as well as to accelerate  
101 the population impact of the vaccine through herd protection [8].

102

103 However, the magnitude of the additional impact of different CCs over RV remains unclear.  
104 Moreover, Gavi has so far not been able to support CCs in eligible countries over concerns  
105 that they would increase vaccine introduction delays, given supply constraints [5].

106

107 The aim of our study was to explore the differential impact on carriage and invasive disease  
108 of catch-up campaigns targeting various age groups, through a dynamic compartmental  
109 model of disease transmission, and also explored the possible impact of delaying vaccine  
110 introduction to allow for CCs to be undertaken.

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## 114 **METHODS**

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116 The model was applied to the population of Nha Trang (~360,000 inhabitants), an urban and  
117 semi-rural area in south-central Vietnam.

118

### 119 **Data**

120

#### 121 *Nasopharyngeal carriage*

122 Two surveys were conducted six month apart among children <5 years randomly drawn  
123 from two communes, with 350 children included in January 2008 [9] and another 350  
124 children in July 2008 [10].

125

126 Samples were processed and cultured as per WHO recommendations [11]. Serotyping was  
127 done by PCR with 29 specific primer pairs which did not differentiate between serotypes 6A  
128 and 6B [9]. Given that both antigens are included in PCV13 but that PCV10 does not include  
129 6A, we decided to implement our model for PCV13.

130

131 The carriage prevalence of VT and NVT among 5-17 year olds and adults ( $\geq 18$  years) was  
132 estimated based on the prevalence and serotype distribution in children  $< 5$  years of age,  
133 using a meta-regression model [12].

134

#### 135 *Social mixing patterns*

136 We derived the age-specific contact patterns from a survey conducted in the same area in  
137 2010. The survey included a random sample of 2002 individuals drawn from the population  
138 census, who completed a diary similar to the one used in the POLYMOD surveys [13], asking  
139 about the frequency and characteristics of social encounters over 24 hours. The  
140 corresponding mixing matrix was derived as in Melegaro et al. [14]. We parameterised our  
141 model based on physical (i.e. skin-to-skin) contacts only, given that *S.pneumoniae* is  
142 generally assumed to be transmitted through close interpersonal contact [15].

143

#### 144 **Model structure**

145

146 We built an age-structured deterministic Susceptible-Infected-Susceptible transmission  
147 model of carriage acquisition and clearance, in which we modelled VT jointly and separately  
148 from NVT, but allowed for co-colonisation, as in previous models [16]. Details about the  
149 model structure and model equations can be found in Supplementary File S1.

150

151 The model comprised of three levels of vaccine-induced immunity; (1) no protection, (2)  
152 partial protection and (3) full protection. The latter refers to the efficacy and duration of  
153 protection conferred after completion of the routine schedule (i.e. 2 infant doses and a  
154 booster at 12 months ('2+1' schedule)) or the completion of a catch-up programme in older

155 children (2 doses in <18 months and 1 dose in  $\geq$ 18 months). Partial protection was gained  
156 from two primary infant doses, or after the first catch-up dose in children aged 12 - 17  
157 months. The difference between full and partial protection lied in the magnitude of vaccine  
158 efficacy against carriage ( $VE_c$ ) and in the duration of protection.

159

160 We applied the model to a population of 81 annual age cohorts (0 to 80 years) divided into  
161 52 weekly age bands of 100 individuals. In the calculation of the force of infection the  
162 population figure was adjusted to represent the actual population, based on census data.

163

#### 164 **Model fitting**

165

166 We fitted the model to pre-vaccination nasopharyngeal prevalence data using a Markov  
167 Chain Monte-Carlo (MCMC) algorithm, and estimating the age-specific probability of  
168 effective transmission in the absence of PCV. For each posterior sample we simulated up to  
169 15 years after vaccine introduction.

170

171 In the calculation of the log-likelihood for carriage, model estimates of VT carriage  
172 prevalence included VT carriers and VT-NVT co-colonization given the higher likelihood of  
173 our PCR assay to detect VT than NVT colonies in case of multiple colonization [9].

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179 **Model parameters and outputs**

180

181 Table 1 displays the value assigned to the parameters governing transmission and  
182 vaccination. Uncertainty around parameters was taken into account by sampling from their  
183 posterior distribution in the MCMC process.

184

185 We obtained the vaccine efficacy against carriage conferring full protection ( $VE_C^F$ ) from a  
186 meta-regression model [17]. We estimated the partial efficacy against carriage ( $VE_C^P$ ) as  
187 0.78 (95% CI 0.64 – 0.92) that of  $VE_C^F$  through a meta-analysis of the relative risk of VT  
188 carriage after full schedules (2+1 or 3+0) compared to partial schedules (2+0), which  
189 included four trials [18-21]. Further details are provided in the Supplementary File S2.

190

191 We assumed an exponential decay function for the waning of  $VE_C^F$ , as in previous models  
192 [16, 22]. We fixed the average duration of protection to 6 years, which best matched the  
193 output of a meta-regression model of waning efficacy [17], and analysed the impact of  
194 shorter (3 years) and longer (20 years) average protection in sensitivity analyses, based on  
195 the uncertainty bounds of the same model [17]. The average duration of protection  
196 following partial vaccination was assumed to be 0.78 (95%CI 0.64 – 0.92) that of a complete  
197 schedule, as for efficacy. Details are provided in the Supplementary File S2.

198

199 In our base case model we set the vaccination coverage of both routine and catch-up  
200 strategies at 90%, in accordance with coverage data from Vietnam [23].

201

202 Carriage estimates were translated into IPD estimates based on the propensity of VT and  
203 NVT serotypes to cause illness as a result of carriage, by age, using estimates from Choi et al.  
204 [24].

205

206 The impact of PCV on IPD was calculated based on VT and NVT disease propensity, as well as  
207 the efficacy against progression to invasive disease as a result of carriage ( $VE_{inv}$ ). The latter  
208 was obtained from a function linking efficacy against IPD ( $VE_{IPD}$ ) with  $VE_C$  and  $VE_{inv}$ , where  
209  $VE_{IPD} = 1 - (1 - VE_C) * (1 - VE_{inv})$  [25].  $VE_{INV}$  was calculated based on estimates of  $VE_{IPD}$  from  
210 Lucero et al. [26] and estimates of  $VE_C$  derived from [17] (Table1), as detailed in the  
211 Supplementary File S2.

212

213 Given limited data on IPD from Nha Trang and Vietnam [27], our main analysis focused on  
214 the proportion reduction in IPD, rather than IPD incidence. However, we illustrated how the  
215 relative IPD change may translate into disease incidence based on a point estimate in <5y  
216 olds of 49 /100,000 as reported for Nha Trang [27]. We did not infer disease impact among  
217  $\geq 5$  year olds.

218

219 To explore the impact of delayed vaccination, we assumed that for each additional week of  
220 delay the incidence of IPD during that time would be at its pre-PCV steady level.

221

222 **Vaccination strategies**

223

224 We explored four different strategies: (i) routine (2+1) vaccination only (RV), and routine  
225 vaccination with a catch-up campaign in (ii) <1y olds (CC1), (iii) <2y olds (CC2), and (iv) <5y  
226 olds (CC5).

227

228 WHO currently recommends introducing PCV either as a three primary infant dose schedule  
229 (3+0) or as two primary doses with a booster at 12 months of age (2+1 schedule), with the  
230 choice between schedules guided by setting-specific epidemiological characteristics [7]. We  
231 here present the predicted impact of a 2+1 programme, given the relatively low prevalence  
232 of carriage in young children in Nha Trang [27].

233

#### 234 **Sensitivity analyses**

235

236 We also ran the model for coverage levels of 50% and 70% in both routine and catch-up  
237 programmes. We also explored the impact of duration of protection on our model outputs,  
238 based on lower values of 3 years and 20 years, which span across the range of likely values  
239 (Figure S3 in File S2).

240

241

## 242 **RESULTS**

243

244 The carriage prevalence in <5 year olds was 41% (95% CI 38 - 46%) overall, 27% (95%CI 23 -  
245 32%) for VT serotypes and 14% (95%CI 11 - 18%) for NVT serotypes. We estimated the  
246 carriage prevalence of VT in 5 – 17 year olds and in adults to be 14% (95% CrI 10 – 18%) and

247 3% (95%CrI 0 – 7%) respectively, and that of NVT to be 15% (95%CrI 11 – 19%) and 3%  
248 (95%CrI 0 – 7%). Figure 1 shows the model fit to the carriage data.

249

## 250 **Nasopharyngeal carriage**

251

252 Our model predicts elimination of VT serotypes across all age groups within 10 years of PCV  
253 introduction in RV, with near-complete replacement by NVT serotypes, resulting in little or  
254 no change in the overall carriage prevalence (Figure 2A&B), particularly in children >5 years  
255 and in adults. CCs are predicted to reduce VT carriage more quickly through combined  
256 direct and indirect (i.e. herd) effects (Figures 2C and D). In <5 year olds the VT carriage in  
257 children is predicted to decrease by >99% within 6 years and 7 months (95% CI 5y2m - 9  
258 y6m) in RV, 5 years and 11 months (4y6m– 8 y10m) in CC1, 5 years and 1 month (3y9m –  
259 7y10m) in CC2 and 3 yrs (2y2m–4y10m) in CC5. Similar trends are predicted in older  
260 children and adults (Figures 2C and 2D).

261

## 262 **Invasive Pneumococcal Disease (IPD)**

263

264 Our model predicts that the decline of IPD incidence will be proportionally highest among  
265 <2 year olds, falling to about 45% (95%CrI 33% - 57%) of its pre-PCV level and would be  
266 almost halved (57% (48 – 66%)) in children aged 2 – 4 years respectively (Figure 3A and 3B).

267

268 Most of the benefit of CCs over routine vaccination in children <5 years is predicted to occur  
269 within the first three years after PCV introduction, with no noticeable difference at 5 years  
270 (Fig 3C). Our model predicts that the relative risk of IPD after CCs compared to RV would be

271 lowest about 1 year after PCV introduction, with differences between strategies reducing  
272 thereafter until the new equilibrium is reached. Compared to RV, one year after vaccine  
273 introduction the number of cases of IPD is predicted to be 11% (95%CrI 9 – 14%) lower with  
274 CC1, 25% (21-30%) lower with CC2 and 38% (32 – 46%) lower with CC5 (Fig 3C).

275

276 The impact of each strategy on the cumulative proportion of cases averted in the first 3  
277 years post PCV introduction, compared to no vaccination, is illustrated in Figure 3D.

278

279 Based on an average annual incidence risk of 49/100,000 children <5 years before PCV  
280 introduction [27], a routine introduction of PCV would result in a total of 74 cases (95%CrI  
281 62 - 86) per 100,000 children <5 years averted over the first five years of programme  
282 implementation and catch-up campaigns would lead to the prevention of an additional 13  
283 (95%CrI 11 – 16) cases with CC1, 25 (95%CrI 21 – 30) cases with CC2 and 39 (95%CrI 31 – 49)  
284 cases with RV5.

285

286

287

### 288 **Delayed PCV introduction**

289

290 We estimated the relative impact on IPD of catch-up campaigns for increasing delays. Our  
291 results suggest that, compared to RV, more IPD cases would be prevented in children <5  
292 years insofar as PCV introduction is not delayed by more than 31 weeks (95%CI 30 – 32  
293 weeks) for CC1, 58 weeks (53 – 63 weeks) for CC2 and 89 weeks (78 – 101 weeks) for CC5.

294 Vaccination delays would negatively impact <2 year olds more rapidly than 2 – 4 year old  
295 (Figure 4).

296

## 297 **Sensitivity analyses**

298

### 299 *Vaccination coverage*

300 Our model predicts a lengthening of the time to near-elimination of VT serotypes (and  
301 hence, the time to reach the new post-PCV disease equilibrium) as vaccination coverage  
302 decreases but a similar differential impact of catch-up campaigns compared to routine  
303 vaccination. Full details are provided in the Supplementary File S3.

304

### 305 *Duration of protection*

306 A duration of protection of 3 years would increase the time to elimination of VT carriage,  
307 and thus prevent fewer IPD cases overall, while any average duration of protection longer  
308 than 6 years would not change model outcomes. With a duration of 3 years the median  
309 prevalence of VT in <5 year olds is predicted to reach near elimination about 2 years later in  
310 RV and CC1, 1.5 years later with CC2 and about 1 year later with CC5. Similar differences  
311 were predicted for the  $\geq 5$  year olds (Figure S5 in the Supplementary File S3). The relative  
312 impact of one vaccination strategy over another was predicted to be similar than with a  
313 duration of 6 years.

314

## 315 **DISCUSSION**

316

317 We explored the possible impact of introducing PCV13 with and without a catch-up  
318 campaign in Vietnam through a dynamic transmission model. Our results feed into current  
319 debates about introduction strategies, particularly in South-East Asia where pneumococcal  
320 disease burden is high [28], where many countries have not yet introduced PCV [5], and  
321 where epidemiological data to guide decision making remain scarce [28, 29]. Although  
322 Vietnam is Gavi-eligible and is expected to introduce PCV in the coming years, it has not yet  
323 applied [5]. Our results provide estimates about how much catch-up campaigns would  
324 decrease disease burden compared to routine vaccine introduction without a campaign, for  
325 different scenarios. Our study also shows that, although catch-up campaigns would  
326 decrease disease burden more rapidly across age groups, their impact would only be  
327 beneficial insofar as the additional supply and operational constraints of their  
328 implementation does not delay PCV introduction by more than about 6 months to 2 years,  
329 depending on the age cohorts targeted by those campaigns.

330

331 The availability of data on both social mixing patterns – which are central to transmission  
332 models [13, 30] – and carriage in the same population allowed for thorough  
333 parameterisation of a transmission model.

334

335 However, our study has a number of limitations. In the absence of post-PCV data,  
336 predictions were based on the best available estimates of parameters governing vaccine  
337 effects that were observed elsewhere [16, 17, 31], which may not fully capture the local  
338 characteristics. Given that serotypes differ in their pathogenicity, fitness and transmissibility  
339 [32, 33], and that vaccine efficacy and duration of protection differs by serotype [12], our  
340 predictions based on homogeneous characteristics for the group of VT and NVT serotypes

341 may overlook local epidemiological characteristics. This uncertainty was nonetheless  
342 captured to some extent by sampling from the known uncertainty around those parameters  
343 [16]. Moreover, we were not able to assess the impact of PCV on pneumococcal  
344 pneumonia, the burden of which is much higher than that of IPD [34], given the lack of  
345 robust data and the challenges in the aetiological assessment of clinical pneumonia. Results  
346 from ongoing studies in Gavi-eligible countries [35, 36] might help modelling work on the  
347 impact of PCV on pneumonia in the future.

348

349 Our predictions are in line with the experience of PCV7 in Europe and North America [37-  
350 44], as well with post-PCV trends observed in the few studies from low-income settings  
351 [36]. In the region of Kilifi in Kenya, where a catch-up campaign was conducted at PCV  
352 introduction, impact studies have shown a two third reduction in VT carriage prevalence  
353 across all age groups within two years of PCV10 introduction with a catch-up campaign  
354 among children <5 years [43].

355

356 The implementation of PCV in various settings has consistently resulted in little or no  
357 change in overall carriage prevalence, due to replacement effects by NVT serotypes  
358 colonising the space left vacant by VT in the nasopharynx, but a reduction in severe disease  
359 given the lower pathogenicity of the latter, in accordance with our model output. Our  
360 predictions were also robust to estimates of duration of protection of vaccination coverage,  
361 and thus provide useful estimates of the impact of introducing PCV in a semi-urban  
362 Southeast Asian setting.

363



364 While supply issues could also lead to other problems than just delay, such as incomplete  
365 schedules once a programme has started, we here assumed that the planning of vaccine  
366 introduction would be based on vaccine availability, full roll-out capacity and sustainability  
367 at introduction. With supply constraints, and ignoring other supply side, staff and outreach  
368 challenges that could potentially delay the implementation of CCs [5], our study can inform  
369 whether delaying the introduction of the vaccine to allow for CCs would potentially be  
370 beneficial, compared to a routine-only strategy. Moreover, this model also provides a  
371 framework that could feed into economic evaluations to further guide decisions about  
372 vaccine introduction with and without campaigns.

373

374 The generalisability to other settings of the differential impact of CCs needs to be  
375 considered in light of the epidemiological and socio-demographic characteristics of Nha  
376 Trang. In particular, the low prevalence of carriage and an ageing population - with only 5%  
377 of children under the age of five years – impact on the speed with which herd effects are  
378 established. Although similar epidemiological and demographic characteristics are observed  
379 in many other South(east) Asian settings [45, 46], the differential impact of CCs and the  
380 establishment of herd effects in settings with a younger population and a higher carriage  
381 prevalence is likely to differ, and should be addressed with models applied to such settings.

382

383 In conclusion, our study offers insights into the current debate about vaccination strategies  
384 when introducing PCV in South-East Asia. Our model suggests that catch-up campaigns have  
385 the potential to rapidly decrease carriage and disease across age groups, but are only  
386 offering added reduction in disease burden insofar their implementation results in little to  
387 no implementation delay.

388

389 **DECLARATIONS**

390• Ethics approval

391 Ethical approval for the field surveys was granted by the institutional review board of the  
392 London School of Hygiene and Tropical Medicine and the Ethics Commission of National  
393 Institute of Hygiene and Epidemiology, Hanoi and the Nagasaki University.

394•

395• Consent for publication

396•

397• Availability of data and material

398• Other model outputs are available on request. Please contact the corresponding author at  
399 [olivier.lepolain@gmail.com](mailto:olivier.lepolain@gmail.com)

400•

401• Competing interests

402 • OLP: none

403 • WJE: WJE's partner works for GSK, who manufacture PCV10.

404 • KT: none

405 • KA: none

406 • EKM: Kim Mulholland has consulted for GSK on PCV vaccine use and nutritional  
407 strategies to improve vaccine effectiveness.

408 • DG: has served on ad-hoc advisory boards for Pfizer, GlaxoSmithKline and Merck,  
409 and the University College London Institute of Child Health Laboratory receives  
410 contract research funding from Pfizer, GlaxoSmithKline and Merck

411 • YHC: none

412 • DDA: none

413 • LMY: none

414 • SF: none

415•

416• Funding

417 For this work Olivier le Polain was supported by a doctoral research fellowship from the AXA  
418 Research Fund. The baseline pneumococcal carriage and population data in Nha Trang was  
419 obtained from Nha Trang population based cohort study which was supported by Japan  
420 Global Research Network for Infectious Diseases (JGRID).

421• Authors' contributions

422

423• Acknowledgements

424 We would like to thank Dr Ana Maria Henao Restrepo, Dr Hope Johnson and Prof Katherine  
425 L O'Brien for helpful discussions around the study objectives.

426 We are grateful to the participants of this study and their parents as well as to the staff from  
427 Khanh-Hoa Health Service and the medical staff from Khanh Hoa General Hospital for their  
428 support. We also thank the staff from the Japan-Vietnam Friendship Laboratory at National

429 Institute of Hygiene and Epidemiology, Hanoi, and Institute of Tropical Medicine, Nagasaki

430 University.

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432• Authors' information (optional)

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434

435 **LIST OF ABBREVIATIONS**

436 CC: Catch-up campaign

437 CC1: CC in <1 year olds

438 CC2: CC in <2 year olds

439 CC5: CC in <5 year olds

440 IPD: Invasive Pneumococcal Disease

441 MCMC: Markov Chain Monte-Carlo

442 NVT: Non vaccine type

443 PCV: pneumococcal conjugate vaccine

444 PCV7: seven-valent PCV

445 PCV10: 10-valent PCV

446 PCV13, 13-valent PCV

447 RV: Routine vaccination

448  $VE_C^F$ : vaccine efficacy against carriage conferring full protection

449  $VE_C^P$ : vaccine efficacy against carriage conferring partial protection

450 VT: Vaccine Type

451

452

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454

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631 **Tables and Figures**

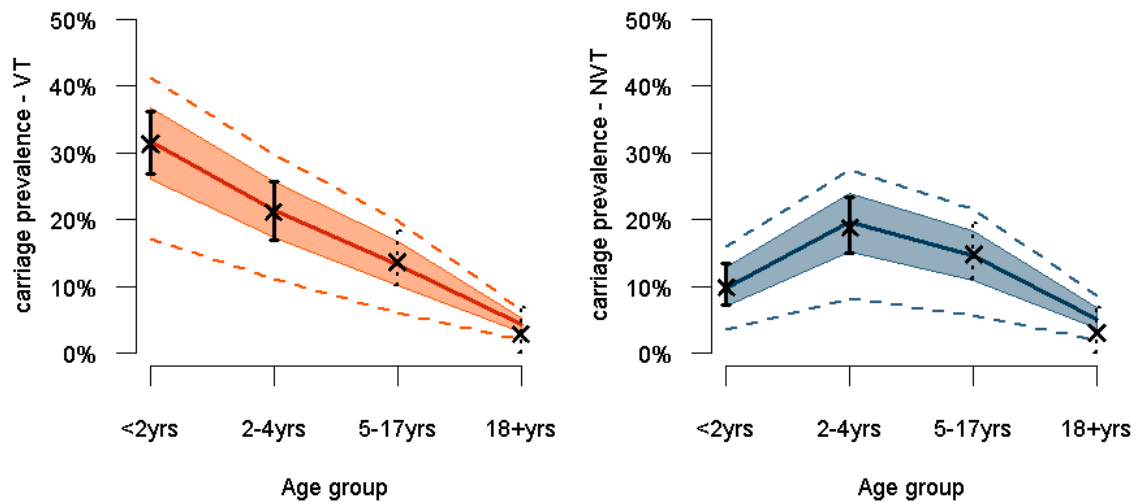
632 **Table 1:** Parameters used in the model

Parameter	Value	Source*
<b>Competition for carriage acquisition (<math>C_N</math> and <math>C_V</math>)<sup>§</sup></b>	0.1 (SD 0.01)	[16, 31]
<b>Duration of carriage (<math>\delta_i</math>)</b>		
0 – 52 months	47.1 days	[47]
12 – 23 months	39.4 days	[47]
24 – 35 months	31.6 days	[47]
36 – 47 months	21.5 days	[47]
48 – 59 months	21.3 days	[47]
5 – 17 years	17.0 days	[22, 48]
18 years and over	18.0 days	[22, 48]
<b>Vaccine efficacy against carriage</b>		
Full protection ( $VE_C^F$ )	62% (95%CrI 52 – 72 %)	[17]
Partial protection ( $VE_C^P$ )	0.78 (95%CI 0.64 – 0.92) * $VE_C^F$	Meta-analysis of [18-21] (Supplementary File S2)
<b>Mean duration of protection against carriage</b>		
In fully protected ( $D_F$ )	6.0 years	[17](Supplementary File S2)
In partially protected ( $D_P$ )	0.78 (95%CI 0.64 – 0.92) * $D_F$	Supplementary File S2
<b>Vaccine efficacy against IPD (<math>VE_{IPD}</math>)</b>	0.80 (95%CrI 0.61 – 0.90)	[49]

633 <sup>§</sup>Where 0.1 means a force of infection which is 10% that of a situation with no competition

634

635 **Figure 1:** Pre-PCV carriage estimates across age groups for VT (left panel) and NVT (right  
636 panel), based on survey (plain vertical lines) and meta-regression model (dotted vertical lines)  
637 estimates, and estimates from the corresponding transmission model. **Legend:** Dots  
638 and bars correspond to the point and 95% confidence interval for the carriage estimates  
639 from the survey data (plain dot and plain lines) and the meta-regression model (cross and  
640 dotted lines). The dark red and dark blue plain lines represent the median transmission  
641 model estimate for VT and NVT respectively, the shaded areas the 50% credible interval (CrI)  
642 around the median and the dotted red and blue lines the 95%CrI  
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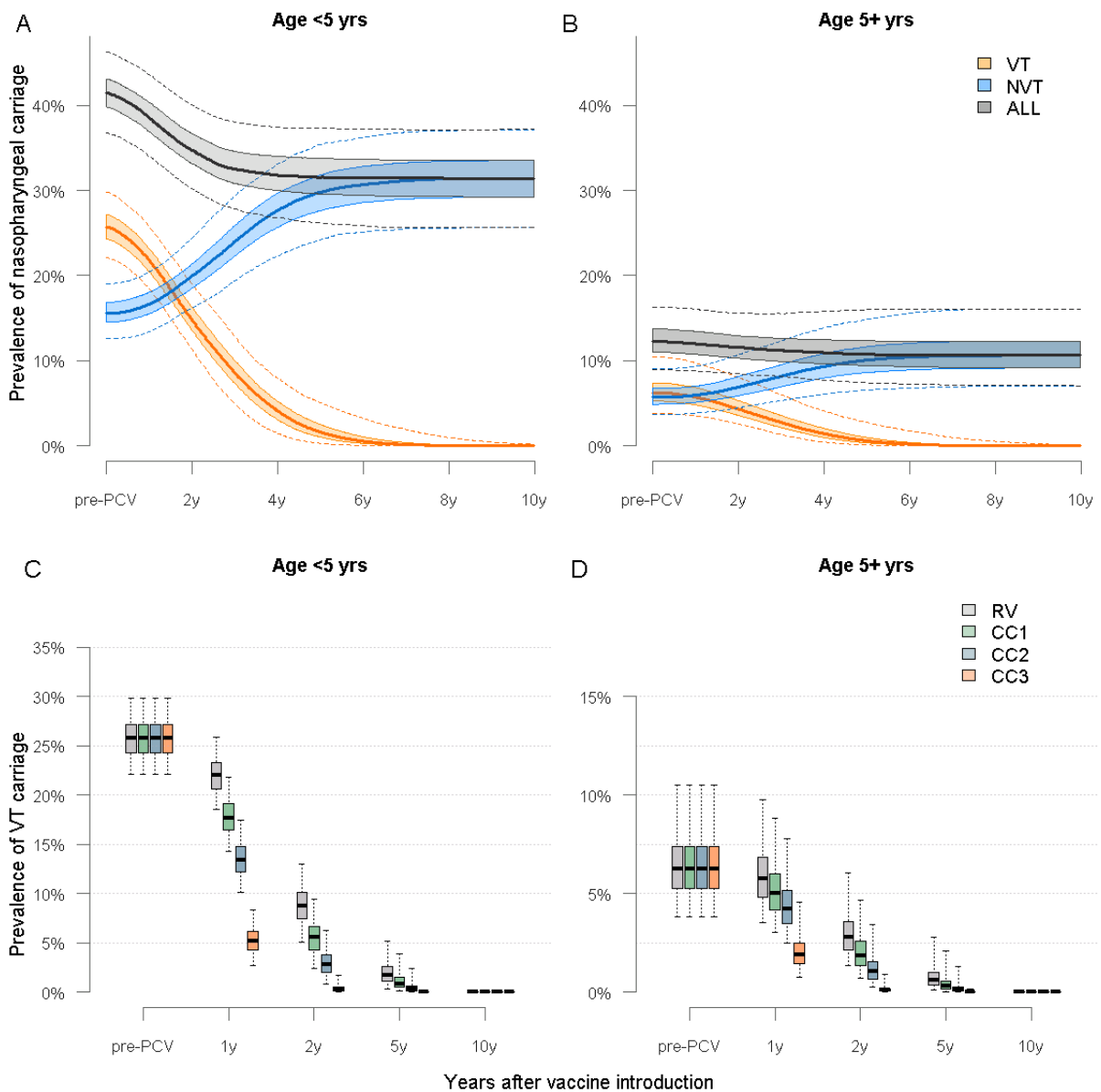
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656 **Figure 2:** Predicted trends in nasopharyngeal carriage following PCV13 introduction in Nha  
657 Trang. **Legend:** A: Predicted trends in VT, NVT and overall carriage in <5 year olds without a  
658 catch-up campaign. B: Predicted trends in VT, NVT, and overall carriage in  $\geq 5$  year olds  
659 without a catch-up campaign. C: Predicted prevalence of VT carriage in <5 year olds for each  
660 vaccination strategy. D: Predicted prevalence of VT carriage in  $\geq 5$  year olds for each  
661 vaccination strategy. In all four panels: plain line= median, shaded areas= 50% credible  
662 intervals and dotted line or whiskers= 95% credible interval  
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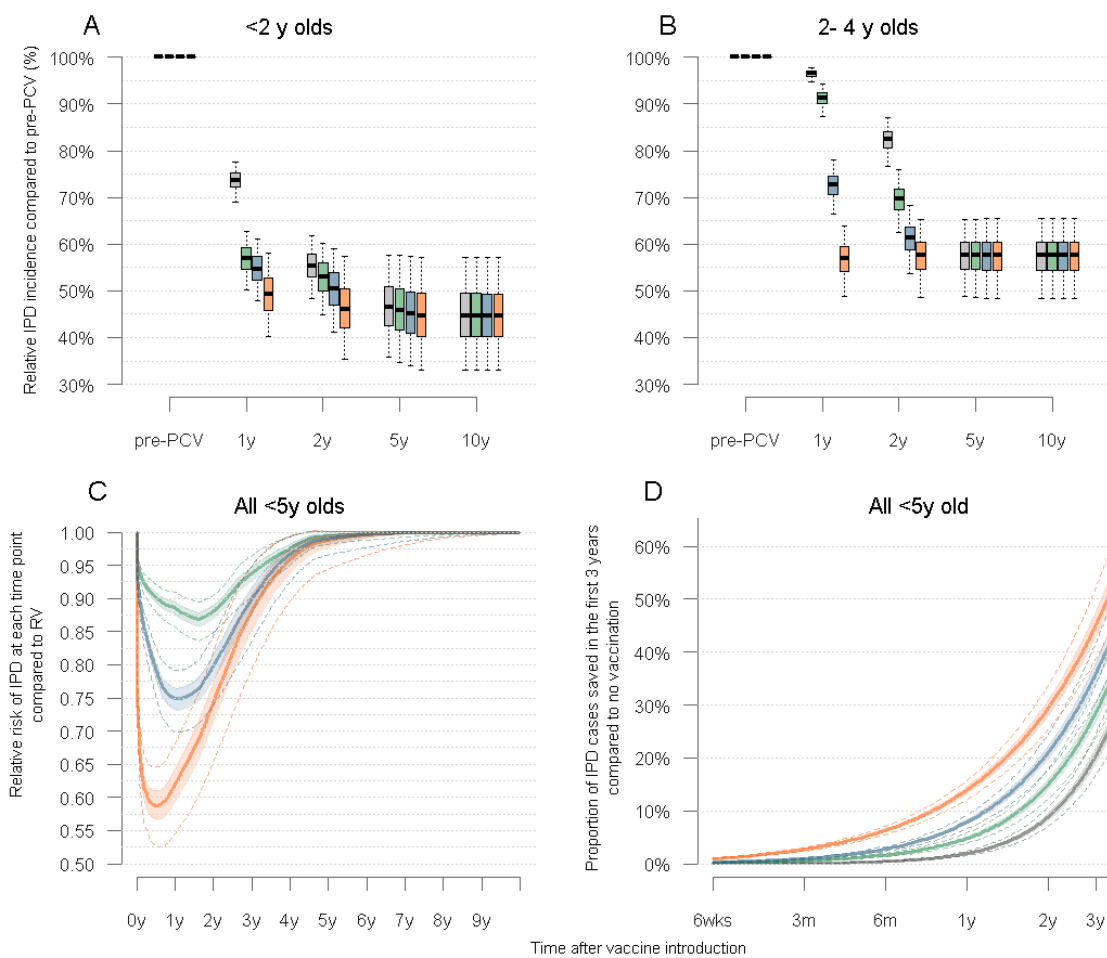
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670 **Figure 3:** Trends in IPD following PCV introduction in children under five years of age in Nha  
671 Trang **Legend:** A: Predicted trends the cumulative annual incidence of IPD in children <2  
672 years for each vaccination strategy considered, at a 90% vaccination coverage B: Predicted  
673 trends the cumulative annual incidence of IPD in children aged 2-4 years for each  
674 vaccination strategy considered, at a 90% vaccination coverage C: Cumulative number of IPD  
675 cases saved for each catch up strategy compared to RV, in children <5 years of age. D:  
676 Overall cumulative number of cases saved for each vaccination strategy, compared to no  
677 vaccination, in the first 3 years post PCV introduction. In all four panels: plain line= median,  
678 shaded areas= 50% credible intervals and dotted line or whiskers= 95% credible interval  
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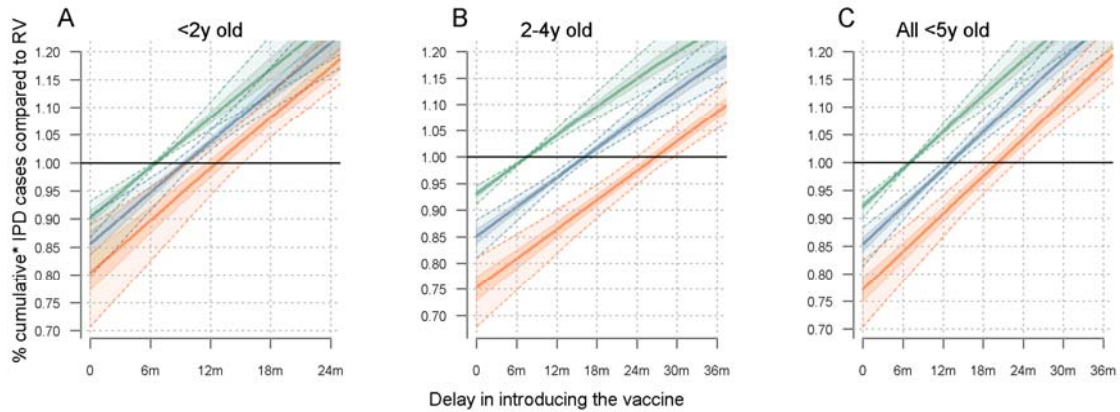
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687 **Figure 4:** Impact of delayed PCV introduction with a catch-up campaign on VT carriage  
688 (panel A) and on IPD cases saved (panel B) in children under five years of age. **Legend:** A: <2  
689 year olds. B: 2 – 4 year olds C: <5 years olds. The middle plain trend line corresponds to the  
690 median estimate (Green=CC1, Blue=CC2, Red=CC5), the dark shaded areas the 50% CrI and  
691 the light shaded areas the 95%CrI. The plain horizontal line at 1.00 represents the point  
692 below which interventions will be more favourable than a timely RV.



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708 **Supplementary File S1: Model structure**

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710 We built a realistic age-structured deterministic Susceptible-Infected-Susceptible (SIS)  
711 transmission model of carriage acquisition and clearance, similar to Choi et al. [16].

712 The model considers all VT serotypes jointly and separately from the group of NVT  
713 serotypes, but allows for VT-NVT co-colonization, thus resulting in four compartments of  
714 carriage states, namely susceptible, VT carriers, NVT carriers and VT-NVT co-colonized as in  
715 Choi et al. [16]. In this model movements from the susceptible to the VT or NVT  
716 compartments are determined by age-specific forces of infection for VT ( $\lambda_{Vi}$ ) and NVT ( $\lambda_{Ni}$ )  
717 respectively, and co-colonization is determined by competition parameters ( $C_N$  and  $C_V$ ),  
718 which represent the degree with which prior colonization reduces the likelihood of co-  
719 colonization. Age-specific recovery rates ( $r_i$ ) determine the speed with which individuals  
720 revert back from the co-colonized to either VT or NVT compartments, and from colonization  
721 to susceptible compartments, assuming no natural immunity to carriage.

722

723 The model comprised of three levels of vaccine-induced immunity; (1) no protection, (2)  
724 partial protection and (3) full protection (Figure S1). The latter means the efficacy and  
725 duration of protection conferred after completion of the infant schedule (i.e. 2 infant doses  
726 and a booster at 12 months ('2+1' schedule)) or the completion of a catch-up programme in  
727 older children (2 doses in <18 months and 1 dose in  $\geq 18$  months). Partial protection was  
728 gained from two primary infant doses, or after the first catch-up dose in children aged 12 -  
729 17 months. The difference between full and partial protection lied in the magnitude of  
730 vaccine efficacy against carriage ( $VE_C$ ) and in the duration of protection.

731

732 We applied the model to a population of 81 annual age cohorts (0 to 80 years) divided into  
733 52 weekly age bands of 100 individuals. In the calculation of the force of infection the  
734 population figure was adjusted to represent the actual population, based on census data.

735

736 We inferred the impact on IPD based posterior estimates of carriage at each time step,  
737 case:carrier ratios for VT and NVT by age group [16], the vaccine efficacy against  
738 invasiveness and the vaccination coverage of each weekly age cohort at each time step.

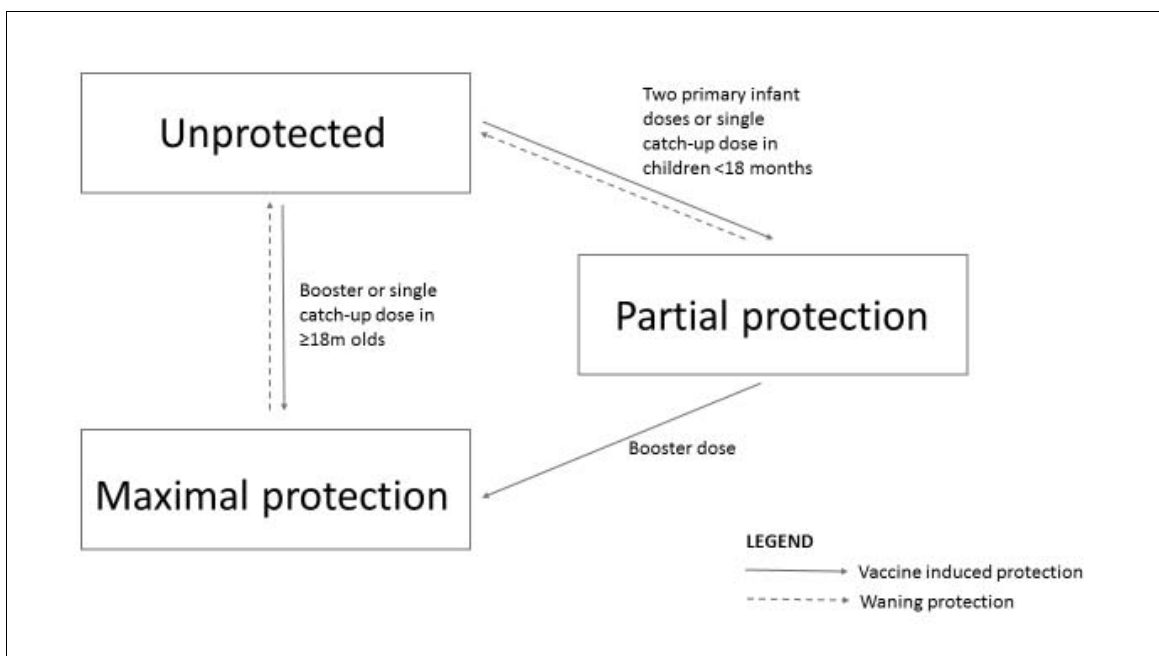
739 Details about parameters of vaccine efficacy are provided in the Supplementary File S2.

740

741 The model equations are provided in Text S1 below.

742

743 **Figure S1:** The three groups of vaccine protection states defined in the model and  
744 movement between groups



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748 **Text S1:** Model equations

$$\frac{dS_i(t)}{dt} = r_{Vi} * V_i(t) + r_{Ni} * N_i(t) - (\lambda_{Vi}(t) + \lambda_{Ni}(t)) * (\gamma_{i(\text{inf})} + \gamma_{i(\text{catch-up})}) * S_i(t) + \omega_p * Sp_i(t) + \omega_f * Sf_i(t)$$

$$\frac{dV_i(t)}{dt} = \lambda_{Vi}(t) * S_i(t) + r_{Ni} * B_i(t) - (C_N * \lambda_{Ni}(t) + r_{Vi}) * V_i(t) - \gamma_{i(\text{inf})} + \gamma_{i(\text{catch-up})} * V_i(t) + \omega_p * Vp_i(t) + \omega_f * Vf_i(t)$$

$$\frac{dN_i(t)}{dt} = \lambda_{Ni}(t) * S_i(t) + r_{Vi} * B_i(t) - (C_V * \lambda_{Vi}(t) + r_{Ni}) * N_i(t) - \gamma_{i(\text{inf})} + \gamma_{i(\text{catch-up})} * N_i(t) + \omega_p * Np_i(t) + \omega_f * Nf_i(t)$$

$$\frac{dB_i(t)}{dt} = (C_V * \lambda_{Vi}(t) * N_i(t) + C_N * \lambda_{Ni}(t) * V_i(t) - (r_{Ni} + r_{Vi}) * B_i(t) - (\gamma_{i(\text{inf})} + \gamma_{i(\text{catch-up})}) * B_i(t) + \omega_p * Bp_i(t) + \omega_f * Bf_i(t)$$

$$\frac{dSp_i(t)}{dt} = r_{Vi} * Vp_i(t) + r_{Ni} * Np_i(t) - ((1 - VE_{pc}) * \lambda_{Vi}(t) + \lambda_{Ni}(t) + \gamma_{i(\text{booster})} + \omega_p) * Sp_i(t) + \gamma_{i(\text{inf})} * S_i(t)$$

$$\frac{dVp_i(t)}{dt} = (1 - VE_{pc}) * \lambda_{Vi}(t) * Sp_i(t) + r_{Ni} * Bp_i(t) - (C_N * \lambda_{Ni}(t) + \gamma_{i(\text{booster})} + \omega_p) * Vp_i(t) + \gamma_{i(\text{inf})} * V_i(t)$$

$$\frac{dNp_i(t)}{dt} = \lambda_{Ni}(t) * Sp_i(t) + r_{Vi} * Bp_i(t) - (C_V * (1 - VE_{pc}) * \lambda_{Ni}(t) + \gamma_{i(\text{booster})} + \omega_p) * Np_i(t) + \gamma_{i(\text{inf})} * N_i(t)$$

$$\frac{dBp_i(t)}{dt} = (C_V * (1 - VE_{pc}) * \lambda_{Vi}(t) * Np_i(t) + C_N * \lambda_{Ni}(t) * Vp_i(t) - (r_{Ni} + r_{Vi} + \gamma_{i(\text{booster})} + \omega_p) * Bp_i(t) + \gamma_{i(\text{inf})} * B_i(t)$$

$$\frac{dSf_i(t)}{dt} = r_{Vi} * Vf_i(t) + r_{Ni} * Nf_i(t) - ((1 - VE_{fc}) * \lambda_{Vi}(t) + \lambda_{Ni}(t) + \omega_f) * Sf_i(t) + \gamma_{i(\text{booster})} * Sp_i(t) + \gamma_{i(\text{catch-up})} * Sp_i(t)$$

749

$$\frac{dVf_i(t)}{dt} = (1 - VE_{fc}) * \lambda_{Vi}(t) * Sf_i(t) + r_{Ni} * Bf_i(t) - (C_N * \lambda_{Ni}(t) + \omega_f) * Vf_i(t) + \gamma_{i(\text{booster})} * Vp_i(t) + \gamma_{i(\text{catch-up})} * Vp_i(t)$$

$$\frac{dNf_i(t)}{dt} = \lambda_{Ni}(t) * Sf_i(t) + r_{Vi} * Bf_i(t) - (C_V * (1 - VE_{fc}) * \lambda_{Ni}(t) + \omega_f) * Nf_i(t) + \gamma_{i(\text{booster})} * Np_i(t) + \gamma_{i(\text{catch-up})} * Np_i(t)$$

$$\frac{dBf_i(t)}{dt} = (C_V * (1 - VE_{fc}) * \lambda_{Vi}(t) * Nf_i(t) + C_N * \lambda_{Ni}(t) * Vf_i(t) - (r_{Ni} + r_{Vi} + \omega_f) * Bf_i(t) + \gamma_{i(\text{booster})} * Bp_i(t) + \gamma_{i(\text{catch-up})} * Bp_i(t)$$

750

751  $i$  represent the weekly age groups.  $\gamma$  is the vaccination coverage for infant doses (inf), the

752 booster dose (boost) and the catch-up dose (catch-up).  $VE_{fc}$  and  $VE_{pc}$  is the vaccine efficacy

753 against carriage acquisition after full and partial vaccination respectively.  $\omega_p$  and  $\omega_f$

754 represent the rate of waning immunity after partial and full vaccination.

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## 760 **Supplementary File S2: Vaccine efficacy and duration of protection**

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### 762 **Vaccine efficacy against carriage**

763

#### 764 *Full vaccination*

765 We obtained the vaccine efficacy against carriage after full protection ( $VE_C^F$ ) and its  
766 uncertainty from a Bayesian meta-regression model based on estimates from 22  
767 intervention studies. The details have been published elsewhere [17]. The model of vaccine  
768 efficacy was run for as many iterations as in our transmission model, so that we could  
769 sample one estimate of  $VE_C^F$  at each iteration of the post-vaccination simulations.

770

#### 771 *Partial vaccination*

772 A systematic review of the impact of pneumococcal conjugate vaccines on carriage [50]  
773 provided information on intervention studies with 2 primary-dose arms where compared  
774 with either 2+1 schedules or 3+0 schedules.

775

776 We included individual randomized controlled trials providing nasopharyngeal carriage  
777 estimates within 3 – 20 months after a 2-dose infant schedule (2+0 arm) and after a  
778 complete schedule (either 3+0 or 2+1 arm). We excluded studies providing carriage  
779 estimates within 3 months after vaccination to account for the delay in producing an  
780 immune response, and time to carriage clearance under the assumption that existing  
781 carriage at the time of vaccination is not affected by PCV [17].

782

783 We extracted data on the number of carriers of VT and total number of individuals swabbed  
 784 in each study arm before and after vaccination. We then computed the relative risk of VT  
 785 carriage among fully vaccinated compared to partially vaccinated children. The pooled  
 786 estimates were obtained through a random effects meta-regression model.

787

788 We pooled estimates from four studies, including trials in Fiji [19], Israel[18], The Gambia  
 789 [51] and The Netherlands [20], providing together eight different survey points, into a  
 790 simple random effects meta-analysis, not taking into account within-study dependence  
 791 given the limited number of data points per study. The details of the studies are provided  
 792 in Table S1 below.

793

794 **Table S1:** Studies included in the meta-analysis

Study	Country	Schedule	Age (months)	Time since last dose (months)	Carriers /total	Relative Risk (95%I)
Dagan (2012)[18]*	Israel	3+0	9.5m	3.5m	58/327	0.83 (0.57 – 1.20)
Dagan (2012)[18]*	Israel	2+0	9.5m	3.5m	36/169	ref
Ota (2011)[51]	Gambia	3+0	11m	7m	20/200	0.59 (0.36 – 1.00)
Ota (2011)[51]	Gambia	2+0	11m	8m	33/198	ref
Ota (2011)[51]	Gambia	3+0	15m	11m	24/193	0.80 (0.49 – 1.32)
Ota (2011)[51]	Gambia	2+0	15m	12m	30/196	ref
Russell (2010)[19]	Fiji	3+0	6m	3m	13/127	0.95 (0.47 – 1.89)
Russell (2010)[19]	Fiji	2+0	6m	3m	16/148	ref
Russell (2010)[19]	Fiji	3+0	9m	6m	4/122	0.32 (0.11 – 0.93)
Russell (2010)[19]	Fiji	2+0	9m	6m	15/146	ref
Russell (2010)[19]	Fiji	3+0	12m	9m	8/114	1.25 (0.49 – 3.23)
Russell (2010)[19]	Fiji	2+0	12m	9m	9/143	ref
van Gils (2009)[20]	Netherlands	2+1	18m	7m	51/329	0.64 (0.47 – 0.88)
van Gils (2009)[20]	Netherlands	2+0	18m	14m	79/327	ref
van Gils (2009)[20]	Netherlands	2+1	24m	13m	47/333	0.96 (0.66 -1.39)
van Gils (2009)[20]	Netherlands	2+0	24m	20m	49/332	ref

795 \*In this study pooled results were provided for samples taken at 7 months and 12 months of age,  
 796 and we therefore considered the age and time since the last dose as the average between the two

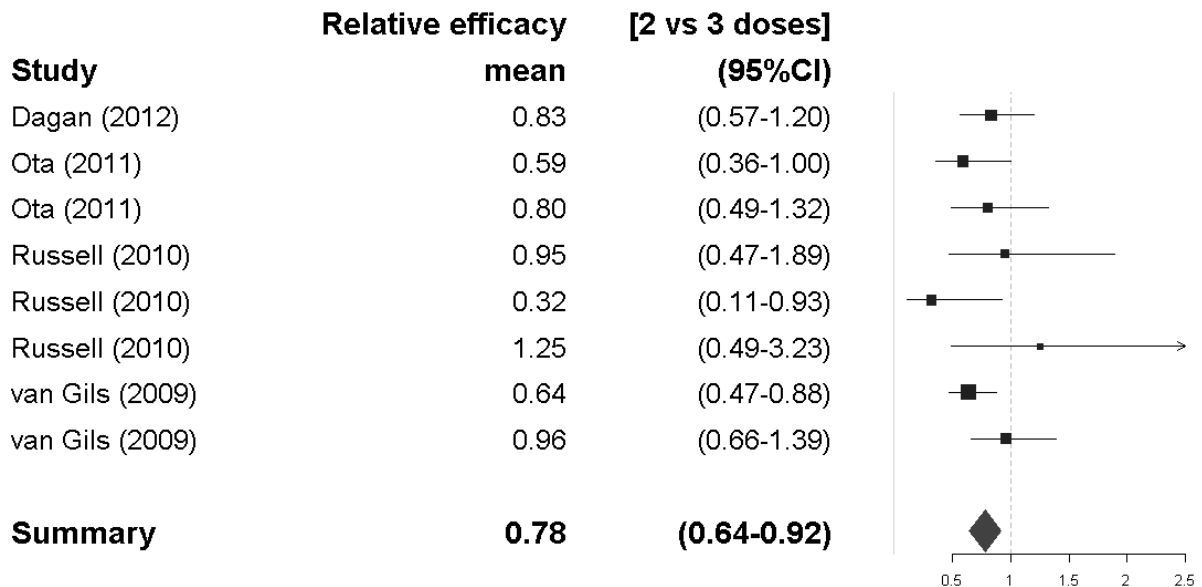
797 The pooled relative risk of carriage among children with a full schedule was 78% (95%CI 64  
 798 – 92%) that of a partial schedule (Figure S2), with no evidence of heterogeneity ( $I^2=3\%$ ).

799

800 At each iteration of the MCMC, we sampled a value from the relative risk 78% (95%CI 64 –  
 801 92%) multiplied by a value of the full vaccine efficacy against carriage acquisition ( $VE_C^F$ ), to  
 802 obtain a measure of the partial efficacy ( $VE_C^P$ ).

803

804 **Figure S2:** Forest plot of the relative risk of VT carriage of 3 primary doses (2+1 or 3+0), for  
 805 four different individual randomized controlled trials (RCTs), at eight different time points  
 806 [18-20, 51].



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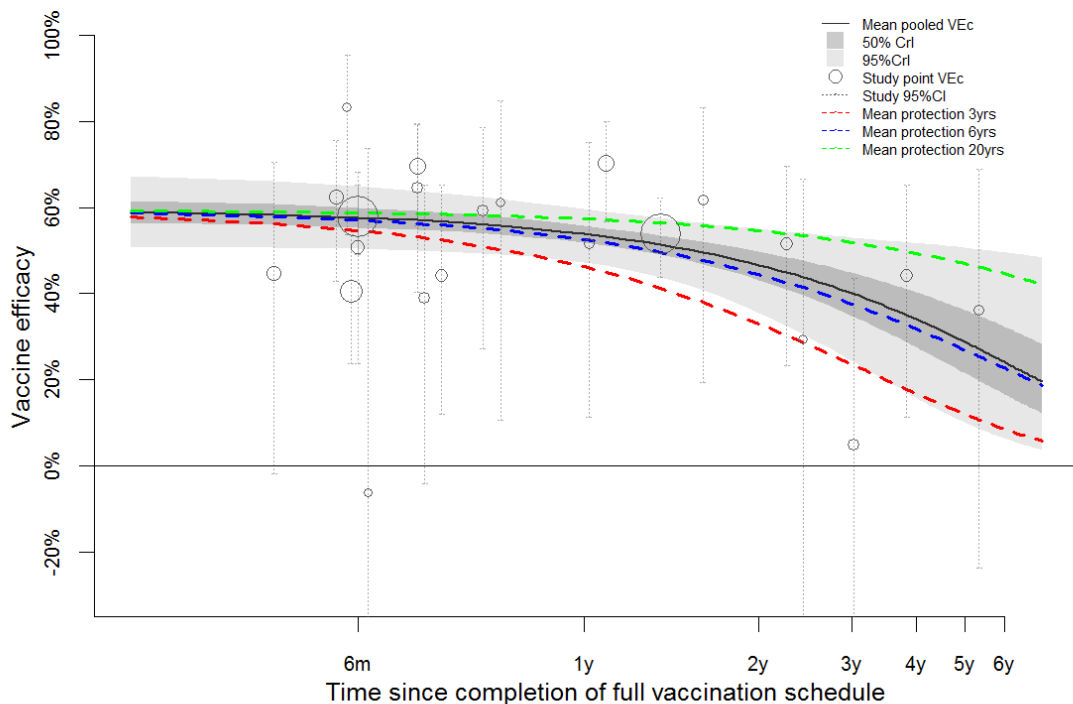
812 **Duration of protection**

813

814 The duration of protection against carriage acquisition was obtained from le Polain et al  
815 [17]. The median estimate of a model of waning efficacy, using an asymptomatic function,  
816 closely matched that of an exponential decay with a mean duration of protection of 6 years  
817 (Figure S3). Hence, this estimate was taken as the average duration of protection in the  
818 main model. For sensitivity analyses, we considered mean durations of 3 years and 20 years  
819 as the lower and higher values, as shown in Figure S3.

820

821 **Figure S3:** Duration of protection of PCV against carriage acquisition



822

823 **Legend** : Each circle represents the mean vaccine efficacy estimate for each study included  
824 in the analysis – see [17]. The size of the circle is proportional to the study size. The whiskers  
825 on either side of each circle represent the 95%CrI around the point estimate. The dark grey

826 area corresponds to the 50% CrI around the main model estimate of vaccine efficacy and its  
827 waning (plain black line), and the lighter grey area to the 95% CrI. The blue, red and green  
828 dotted lines show the waning with an exponential decay function for a mean duration of  
829 protection of 6 years, 3 years and 20 years respectively. Figure adapted from le Polain de  
830 Waroux et al. [17], with permission from PIDJ

831

832 In the absence of estimates on the duration of protection of partial vaccination, we assumed  
833 that the duration of protection of a partial vaccination was 0.78 (0.64 – 0.92) that of a full  
834 vaccination, as for  $VE_C$

835

### 836 **Vaccine efficacy against Invasive Pneumococcal Disease**

837

838 The vaccine efficacy against invasive pneumococcal disease ( $VE_{IPD}$ ) can be expressed as a  
839 function of the vaccine efficacy against carriage acquisition ( $VE_C$ ) and the efficacy against  
840 progression to disease as a result of carriage, which we here term the vaccine efficacy  
841 against invasiveness ( $VE_{inv}$ ) [25], where  $VE_{IPD} = 1 - (1-VE_C)(1-VE_{inv})$ .

842

843 Based on estimates from a large systematic review by Lucero et al. [26], we assumed  $VE_{IPD}$   
844 to be 80% (95%CI 58 – 90%) and generated a binomial distribution that closely matched  
845 those estimates . Hence, we calculated  $VE_{inv}$  based on the distribution of  $VE_{IPD}$  and that of  
846  $VE_C$  and obtained a value of  $VE_{inv}$  at each iteration in our MCMC process.

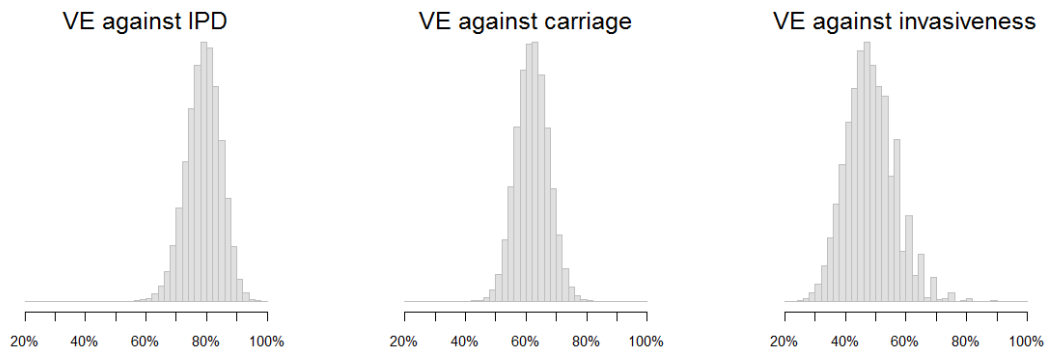
847

848 The mean  $VE_{inv}$  was 80% (95%CrI 67 – 90%), the mean  $VE_C$  was 62% (95%CrI 52 – 73%) and  
849 mean  $VE_{inv}$  was 48% (95%CrI 34 – 65%). The distributions are shown in Figure S4 below.

850

851

852 **Figure S4:** Estimates of vaccine efficacy



853

854 **Legend:** density plot of the vaccine efficacy against IPD (left panel), carriage (medium panel)  
855 and invasiveness (right panel). The x axis displays the vaccine efficacy.

856

857

858 In the model, was assumed no waning of  $VE_{inv}$ , and that  $VE_{inv}$  would be conferred after 2  
859 primary doses, or any catch-up dose. Although there is evidence that  $VE_C$  after partial  
860 vaccination differs from that after complete vaccination (see earlier), evidence that the  
861 efficacy against progression to invasiveness differs between two and three primary doses is  
862 scarce.

863

864 Although it is likely that  $VE_{inv}$  wanes over time, we did not consider waning in the main  
865 model, given that most of the direct impact of PCV on IPD occurs in the first few years of  
866 life, before establishment of the herd immunity effect (see results), and given the lack of  
867 estimates of waning of  $VE_{inv}$ .

868

869

870

871

872

873 **Supplementary File S3: Sensitivity analysis (coverage and duration of vaccine protection)**

874

875 **Vaccination coverage**

876

877 We explored model outputs with lower vaccination coverage in both cohort and catch-up  
878 immunization. Our model predicted a lengthening of the time to near-elimination of VT  
879 serotypes (and hence, the time reach the new post-PCV disease equilibrium) as vaccination  
880 coverage lowers but a similar differential impact of catch-up campaigns compared to  
881 routine vaccination.

882

883 Figure S4 compares predictions of trends in VT carriage for all four strategies and  
884 vaccination coverage levels of 90%, 70% and 50%.

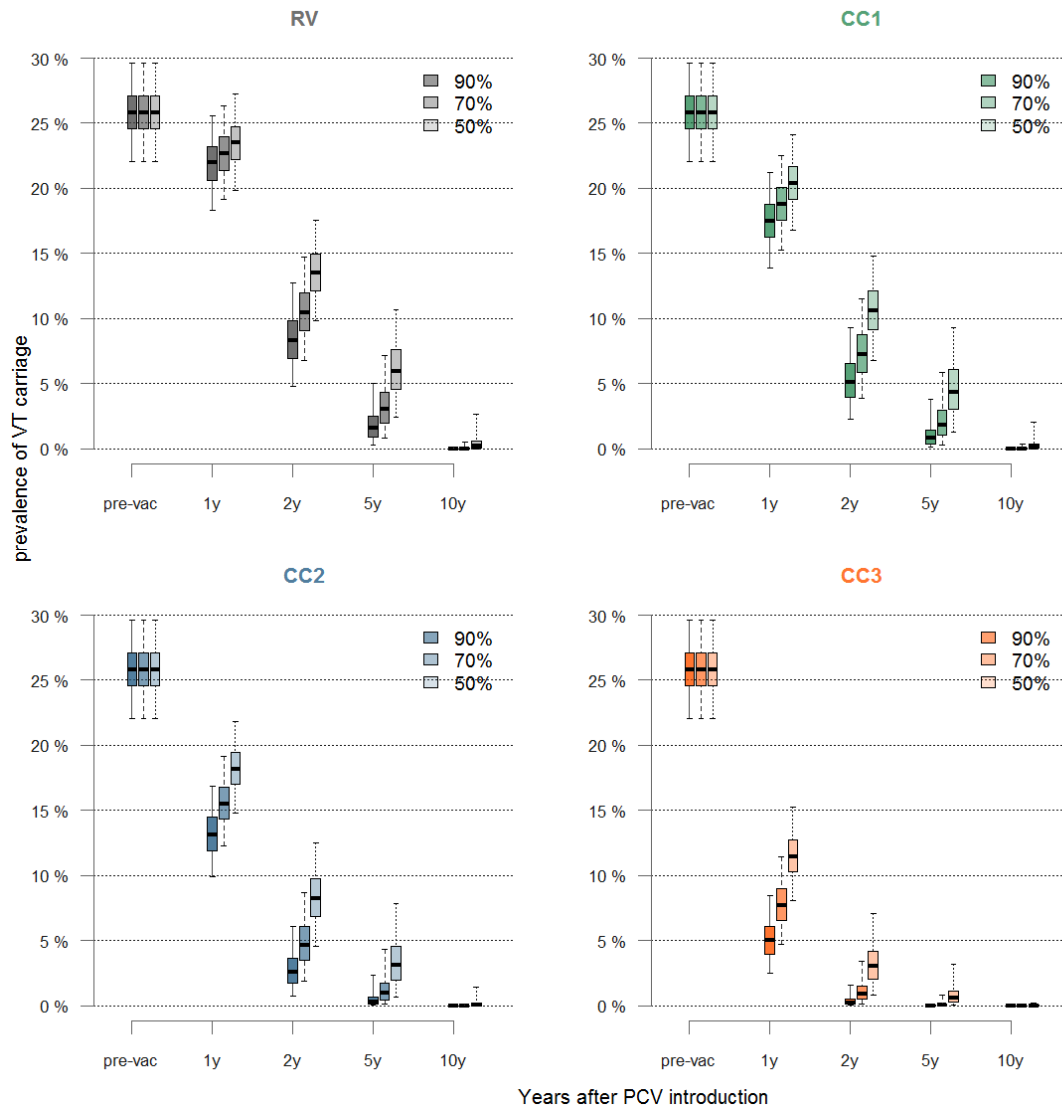
885

886 **Duration of protection**

887

888 A duration of protection of 3 years would increase the time to elimination of VT carriage,  
889 and thus prevent fewer IPD cases overall, while any average duration of protection longer  
890 than 6 years would not change model outcomes. With a duration of 3 years the median  
891 prevalence of VT in <5 year olds is predicted to reach near elimination about 2 years later in  
892 RV and CC1, 1.5 years later with CC2 and about 1 year later with CC5. Similar differences  
893 were predicted for the  $\geq 5$  year olds (Figure S5). The relative impact of one vaccination  
894 strategy over another was predicted to be similar than with a duration of 6 years.

895 **Figure S4:** Impact of vaccination coverage on VT carriage for each strategy considered, and  
896 comparing 90%, 70% and 50% homogeneous coverage for each of the four strategies, in  
897 children aged 0 – 59 months



898

899 **Legend:** In all four panels: plain horizontal line= median, boxes= 50% credible intervals and  
900 whiskers= 95% credible interval, for each of the three levels of vaccination coverage (90%,  
901 70%, 50%) and for all four vaccination strategies.

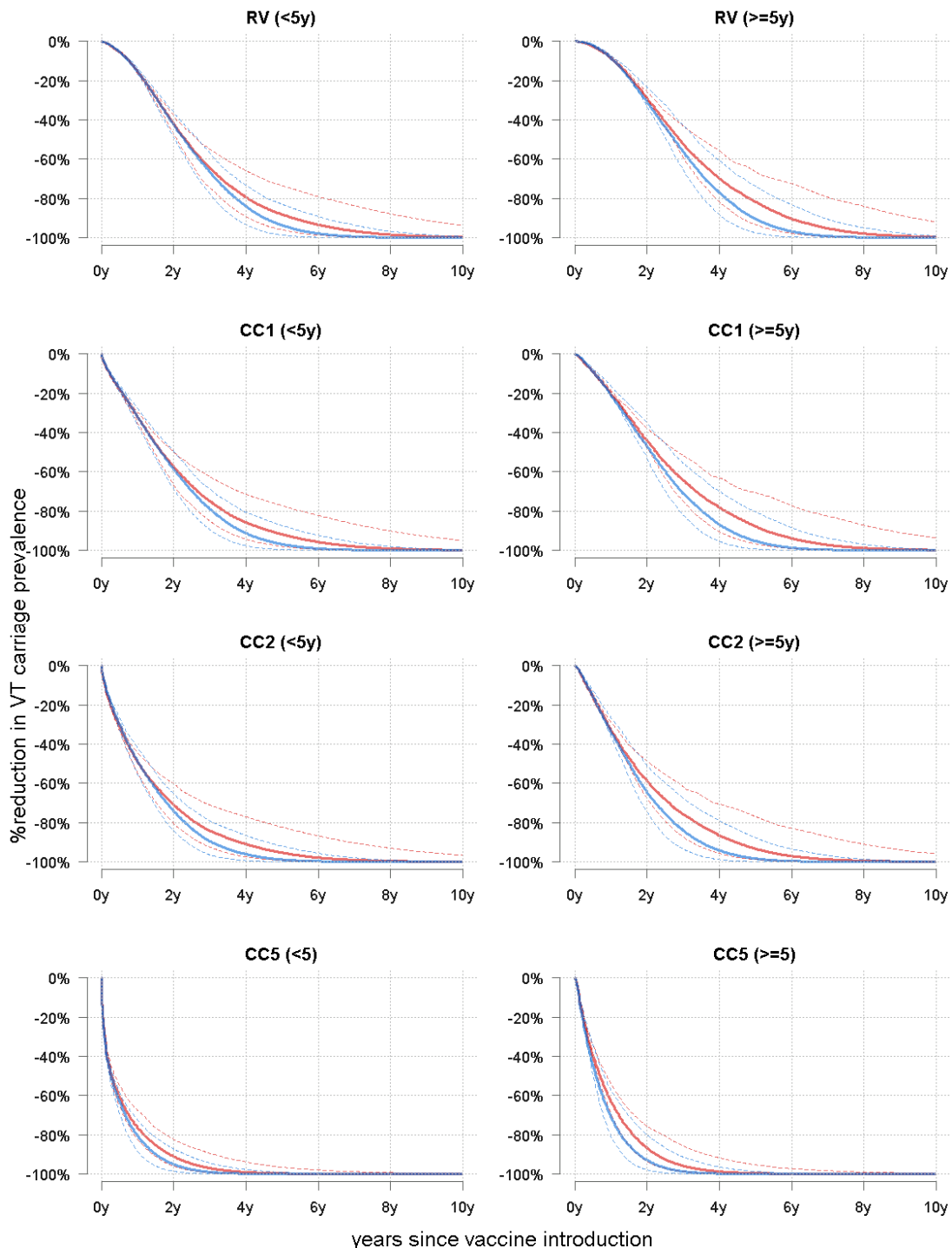
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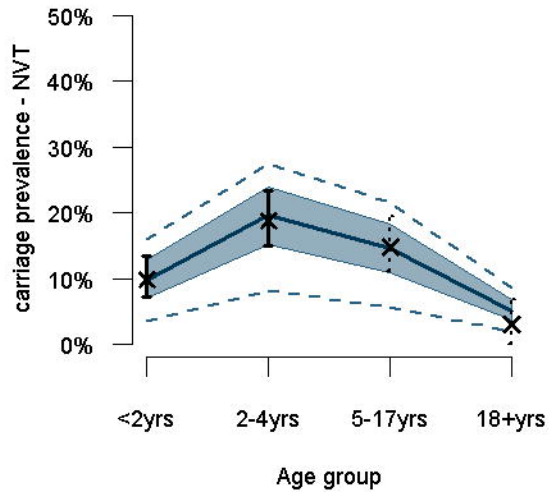
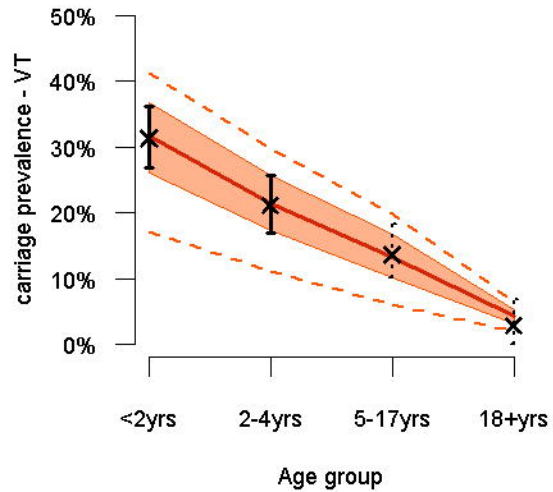


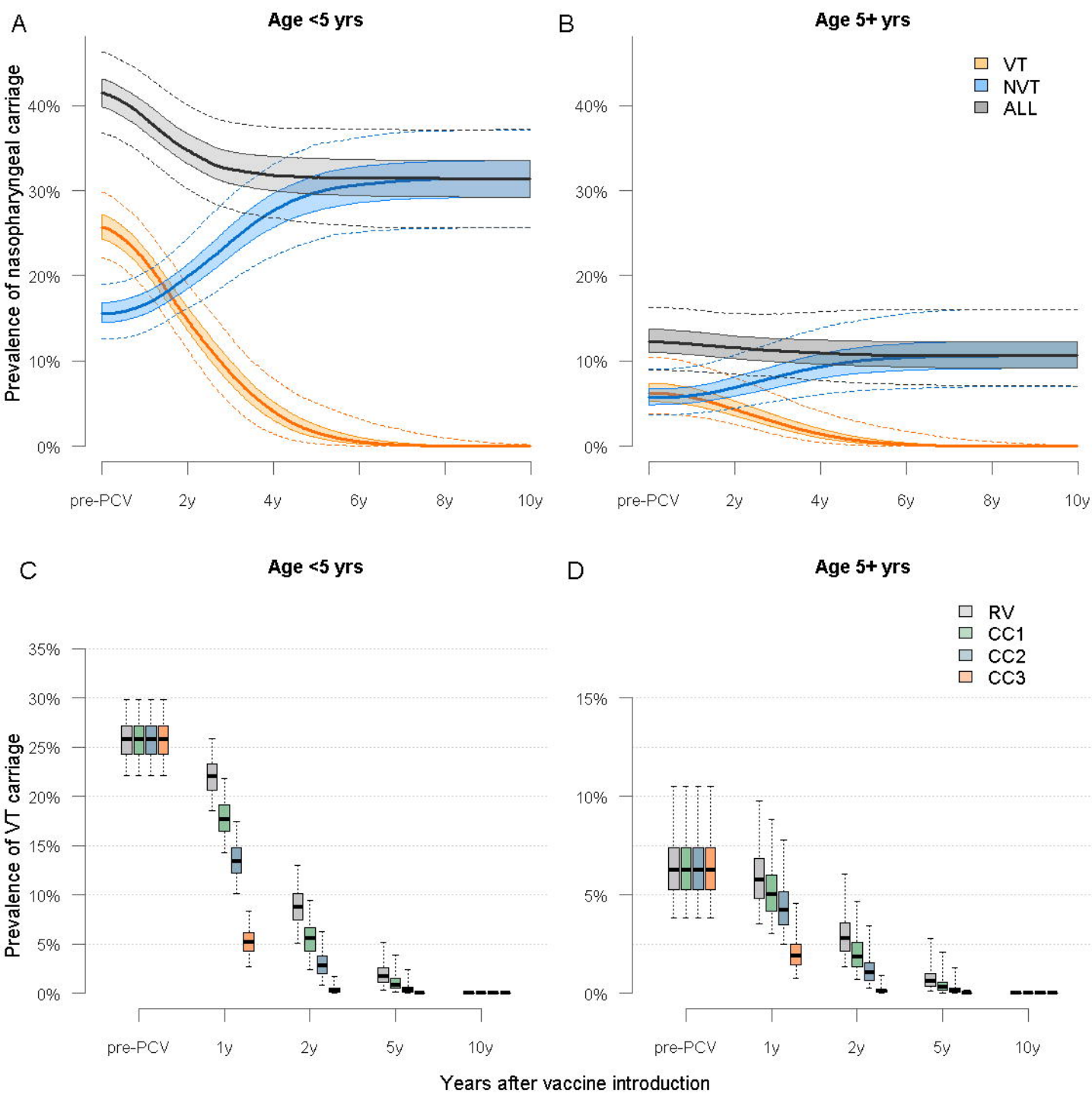
905 **Figure S5:** Comparing model estimates with an average duration of protection of 6 years  
906 (blue) and of 3 years (red) for each of the vaccination scenarios considered and by age  
907 group

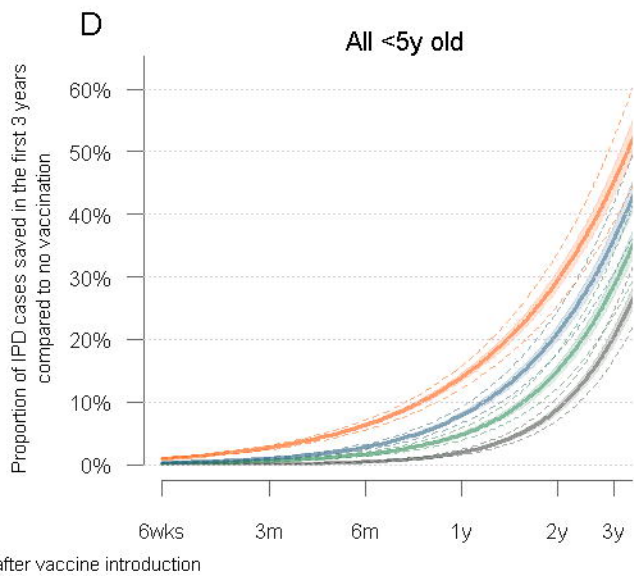
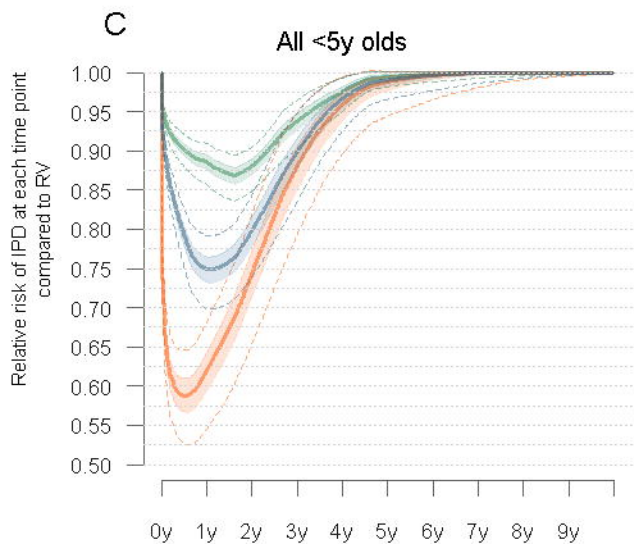
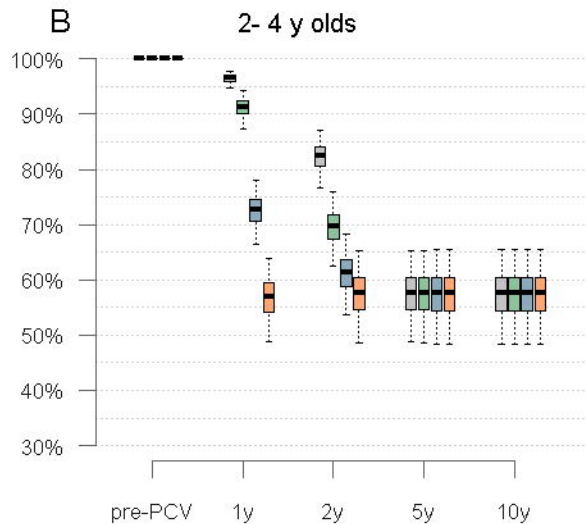
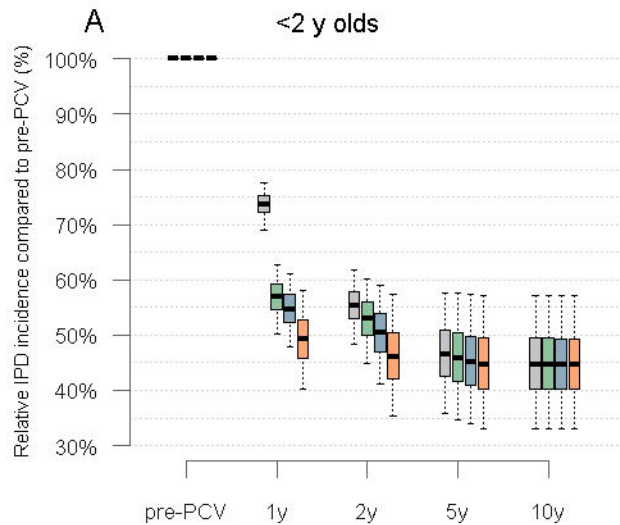


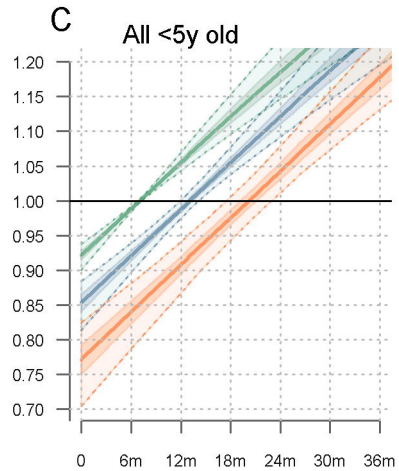
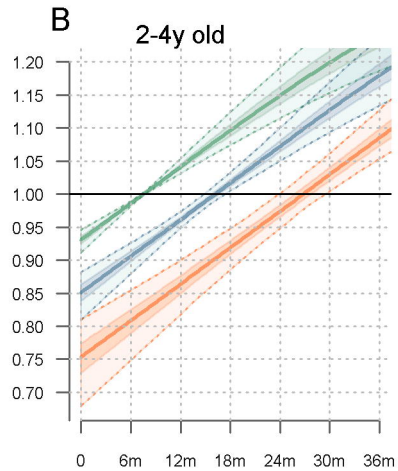
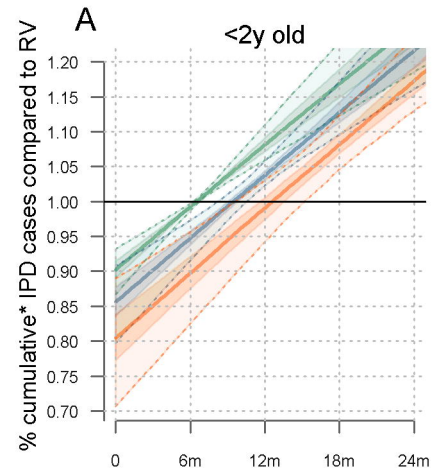
908

909 **Legend:** Percentage reduction in VT carriage in children <5 years (left) and  $\geq 5$  years old. In  
910 blue is are estimates of the main model (average duration of protection of 6 years) and in  
911 red are estimates considering a mean duration of protection of 3 years. The plain lines  
912 represent the median and the dotted lines the 95% credible interval









Delay in introducing the vaccine

\*in the 5 years post PCV introduction