Dynamics and control of measles in Portugal: Accessing the impact of anticipating the age for the first dose of MMR from 15 to 12 months of age

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Summary The all-time low incidence of measles in Portugal in the recent years, raises questions regarding whether the disease has been eliminated, the role of recent control measures, and the epidemiological consequences of the rise in the proportion of newborns to vaccinated mothers, as opposed to those born to mothers who acquired immunity by natural infection. We estimate the vaccination coverage against measles in Portugal on a cohort-by-cohort basis, and incorporate this information into an age-structured seasonally-driven mathematical model aimed at reproducing measles dynamics in the past decades. The model reproduces documented trends in disease notifications and the serological profile of the Portuguese population, as estimated by a recent National Serological Survey. We provide evidence that the effective reproduction number ($R_e$) of measles has been driven below 1 in Portugal, and that sustained measles elimination is crucially dependent upon the maintenance of a high (>95%) coverage with the MMR I vaccine in the future. If the vaccination coverage decreases to levels around 90% the anticipation of the first dose of the MMR I from 15 to 12 months of age, will ensure that $R_e$ remains below 1.

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Introduction

Over the past 5 years, the incidence of measles in Portugal has declined to an all-time low. Between 2002 and 2005, a total of 24 suspected cases of measles were notified to the Portuguese authorities [1], corresponding to an annual incidence of <0.6 cases per million individuals. This follows

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a strategy put into place against measles that included a
two-year catch-up vaccination campaign (1998–1999), the
anticipation of the age of the second dose of the measles-
mumps-rubella vaccine (MMR II) from 11–13 to 5–6 years
old (since January 2000), and the maintenance of a high
level of immunization coverage by routine vaccination, as
documented by the National Serologic Survey [2] conducted
in 2001–2002. Portugal thus appears to be on track to fulfill
the 2010 measles elimination target set by WHO [3].

Nevertheless the high transmissibility of measles poses a
significant challenge to any attempt to eliminate it. Recently, measles re-emerged in the European Region of the
WHO, including countries that had already achieved good
levels of measles control [4–8]. Most cases occurred in non-
immunized individuals that either failed vaccination or were
too young to be vaccinated, usually children younger than
15 months of age [4–6]. The building of a susceptible pool
of these infants is of particular concern, as a disproportionate number of measles-associated deaths occur in children
under the age of routine immunization [9,10].

The resurgence of measles in the United States of
America, between 1989 and 1991, provides an outstanding
example. During this epidemic, the epidemiology shifted
dramatically from school-aged to preschool children [11].
Infants below 15 months of age were not yet eligible for
vaccination and, despite comprising only 2% of the general
population, accounted for 24% of the 55,622 cases reported. Sixty percent of measles related deaths occurred
among preschool children [11,12]. Other examples of outbreaks among the very young have been recently reported
in Europe. In a cluster of 580 cases in south London,
between December 2001 and May 2002, 40% were aged
under 12 months [4]. At La Rioja, Spain, where vaccine
coverage was estimated to be 96.3% at 15 months of age,
13 out of the 18 confirmed cases of measles that took
place in 2005–2006, were in children aged under 15 months
[5].

Previous studies have indicated that infants whose mothers
acquired immunity to measles by vaccination, have
increased susceptibility to clinical measles, as compared to
infants born to mothers who have been exposed to the wild
virus [12]. This is in agreement with evidence for a faster
seroprevalence decay of passively acquired maternal antibodies in unvaccinated infants born to vaccinated mothers,
as compared to those whose mothers had measles [13–16].
As the proportion of mothers who have been vaccinated
increases over the years in the current vaccination era, so
do the proportion of children who should respond to the
measles vaccine at younger ages [14]. As a consequence,
in January 1994 the routine age for MMR I vaccination in
the USA was lowered from 15 months to between 12 and
15 months [17]. Recently, concern has also been raised
in Europe regarding this issue [3,5] and, accordingly, the
Portuguese authorities are contemplating to anticipate the
age of MMR I from 15 to 12 months old by the time the
proportion of newborns from vaccinated mothers exceeds
50%.

We investigate the current epidemiological situation
of measles in Portugal, focusing on whether recent vaccination strategies created conditions for measles elimin-
ation. We estimate vaccination coverage along cohorts
and input this information into an age-structured PSEIR
(protected-susceptible-exposed-infected-recovered) math-
etical model, where the “protected” category keeps track of newborns from vaccinated, unvaccinated non-
susceptible, and unvaccinated susceptible mothers.

The model is aimed at revealing the most important
aspects of measles dynamics in Portugal in the recent past,
but we also investigate how future scenarios of measles
control are effective at ensuring sustained measles elim-
ination. In particular, we show that, for a narrow region
of vaccination coverage around 90%, the anticipation of
the recommended age for the first dose of the vaccine,
from 15 to 12 months, is crucial to maintain the effective
reproduction number below 1 and thus, preventing measles
outbreaks. For higher levels of vaccination coverage how-
ever, it contributes to hamper the building of a pool of
susceptible children younger than vaccination age, decreas-
ing the likelihood that imported cases result in small clusters
among that age group. We also show that the success in sus-
taining measles elimination is crucially dependent on the
maintenance of a very high vaccination coverage with the
MMR I.

Data and methods

Past-vaccination strategies and vaccine data

Vaccination against measles in Portugal started in 1973, with
a major catch-up campaign aimed at children under 10 years
old. The campaign lasted until 1977 with 650,000 vaccines
being delivered throughout. Routine vaccination started in
1974, with a single-dose at 15 months of age. In 1987, the
monovalent measles vaccine was replaced by the MMR I and,
in late 1990, the second dose (MMR II) was introduced in
the routine calendar for children between 11 and 13 years
old. In 1998, the forecast of an upcoming measles outbreak
from time series analysis [18] prompted health authorities
to conduct a two step catch-up campaign for unvaccinated
children. This second campaign targeted ages 15–59 months
in 1998 and ages 6–18 years old in 1999. In 2000, further
analysis [19] led authorities to anticipate the recommended
age of the MMR II to 5–6 years old.

The number of vaccines delivered every year, has been
published by the Portuguese National Institute of Statistics
[20] with varying age groups over time. Previous attempts
to estimate vaccination coverage in Portugal [21,22], were
based upon the ratio between vaccines given during the
second year of life and estimates of the standing popula-
tion at the same age. By not following cohorts, these
estimates miss the combined impact of campaigns with rou-
tine vaccination and disregarded vaccination with the MMR
II.

In order to estimate vaccination coverage along cohorts,
we have separated vaccines by age, following a procedure
similar to the one by Fine and Clarkson [23]:

1. Vaccines given to age group 0–4 years old:

there is information available on the number of vac-
cines by age. These records show that before 1988, less
than 80% of the vaccines were given between 12 and
24 months of age. After 1989, the percentage given

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at 12–24 months rose above 80%, indicating a tendency to vaccinate closer to the recommended age of 15 months. Whenever necessary, we have thus disaggregated vaccines by age, in years before 1989, following the percentages 2.6%, 65.8%, 18.4%, 7.9% and 5.3% for ages 0, 1, 2, 3, and 4 years old, respectively. In 1989 and later years, we have used the percentages 2.6%, 89.5%, 2.6%, 2.6% and 2.6% for the same ages.

2. Vaccines given to age group 5–10 years:

We have assumed that the majority of children were vaccinated between 5 and 7 years, as they are required to present the vaccination booklet at registration for the first school grade. Vaccines were thus distributed by age, attributing a weight of 2/8 to ages 5, 6, and 7 and 1/8 to ages 8 and 9.

3. Vaccines given to age group 11–16 years old were uniformly distributed by ages. It is assumed that these ages received MMR II, whereas ages 1–10 received MMR I.

There is no information available regarding the break up of the 650,000 vaccines given in the 1973–1977 campaign by year and age, so we have considered three plausible scenarios of vaccine distribution throughout this period which are described in Table 1.

### Table 1

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Vaccine distribution</th>
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<tbody>
<tr>
<td>1</td>
<td>2/7</td>
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<td>2</td>
<td>5/15</td>
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<tr>
<td>3</td>
<td>4/8</td>
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Vaccination coverage

Vaccination coverage with the MMR I is the cumulative proportion of vaccinated individuals along each cohort, estimated as follows,

\[
VC = \frac{\sum_{i=0}^{10} (\frac{v_i}{N_0} - \frac{v_i}{N_0})d_i}{N_0 - \sum_{i=0}^{10} d_i}
\]

For each cohort, the number of vaccines, \(v_i\), given to children in yearly age groups \(i = 0, 1, 2, \ldots, 10\), was added up to give the total number of vaccines at age \(i\). As the cohort ages, its initial number of individuals, \(N_0\), diminishes because of deaths, \(d_i\). We denote the number of children alive at age \(j\) by \(N_j = N_0 - \sum_{i=0}^{j} d_i\). A proportion of deaths \(\frac{v_i}{N_0}d_i\), is subtracted from those who were vaccinated, assuming that the likelihood of dying is independent of the vaccination status. To estimate the vaccination coverage with the MMR II, Eq. (1) was adapted to ages between 11 and 16 years old.

### Epidemiological model

#### Basic structure

The transmission dynamics of measles was modelled by a deterministic SEIR (susceptible, exposed, infectious, recovered) age-structured model [24,25], where the protected compartment has been split into two, one for newborns to vaccinated mothers and another for newborns to mothers who became immune by contact with the wild virus; newborns to susceptible mothers enter directly into the susceptible compartment. Individuals are classified into cohorts, where each cohort consists of children born at the beginning of the school year (starting 1st of October). The age of all children is incremented by one year at the end of the school year (30th September). The mean number of births per year, life expectancy and the fertility function used in the model (Table 2), were estimated from Portuguese data [26,27]. Epidemiological parameters (Table 2), were drawn from the literature [28]. Markowitz et al. [14] demonstrated that 98% of children born from vaccinated mothers had a serological response to measles vaccine at 12 months of age, compared with 83–90% of children born from naturally immune mothers. Assuming an exponential decay of antibodies, these percentages can be accounted by, respectively, a maternal mean antibody duration of, approximately 3 and 6 months.

The model keeps track of daily changes between epidemiological compartments within each cohort, due to disease transmission, disease recovery, and vaccination. The latter was input based on our estimates of vaccination coverage along cohorts, following the methodology described above, and attempting the three campaign scenarios in Table 1. Mathematically, the model is represented by a set of ordinary differential equations (Appendix A), one for each compartment.

#### Transmission rates

The model incorporated age-dependent force of infection and seasonality driven by the school calendar. The contact patterns of four age groups (0–4, 5–10, 11–20, >20) are described by the ‘‘Who Acquires Infection From Whom’’ (WAIFW) matrix [28] presented in the Appendix A. These age groups roughly correspond to the main school grades in Portugal: preschool (0–4 years old), primary school (5–10 years old), secondary school (11–20 years old), and adults. The structure of the matrix embodies the opinion that the main route of transmission for measles is within the school playground or classroom. There is a unique coefficient, \(b(2)\), describing the presumed high transmission among susceptible and infectious individuals of age group 5–10 and other coefficients, \(b(1)\) and \(b(3)\), for contacts among individuals less than 20 years old while the older age group is described as likely to acquire infection from a wider range of age groups. This structure was used in Schenzle [24] and in Anderson and May [28] to model measles notification data in England and Wales before the introduction of mass vaccination. Following previous authors [24,25,28], we have assumed that the contact rate within the 5–10 age group depended upon the school calendar. Transmission attained a maximum in school days and a minimum in weekends and holidays. We have also assumed that the contact rate in the

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5—10 years old group was always equal or greater than that in the 0—4 years old group. In Portugal, notification reports of measles started in 1987, 14 years after the beginning of mass vaccination, rendering the direct estimation of the force of infection from notifications unfeasible. To circumvent this problem, we have initially approximated the transmission rates by numerical values derived from estimates of the basic reproduction numbers used to characterize the transmission dynamics of measles in England and Wales (case 1 in Table 3) [24].

The age-specific basic reproduction number, \( R_{0,i} \), is defined as the average number of secondary infections (in all age classes) generated by one primary case in the \( i \)th age class, when the population is wholly susceptible [28]. With this definition,

\[
R_{0,i} = \sum_{j=1}^{N_0} \beta_{ji} (a_j - a_{j-1})
\]

where \( N_0 \) is the number of newborns, \( \nu \) is recovery rate from the infectious state, and the \( a_j \) are bounds on discrete age classes. The transmission coefficients \( \beta_{ij} \) are the elements of the WAIFW matrix, and represent the probability per unit time of an effective contact of individuals in age group \( i \) with individuals in age group \( j \). Eq. (2) can be simplified by limiting the number of distinct elements in the WAIFW matrix, namely, by setting it symmetric, such that \( \beta_{ji} = \beta_{ij} \) and assuming equal contact rates among selected age groups [24,28].

Assuming that the pattern of \( R_0 \) variation with age has not been too different across European countries [31], we have adopted the \( R_{0,k} \) values 4.5, 9.0, 3.5, and 3.0, respectively, for preschool children, primary school children, adolescents, and adults, which have been used in Schenzle [24] for England and Wales. We have then calculated four corresponding numerical values for the transmission parameters, \( \beta_{ik} \), that satisfy that baseline \( R_{0,k} \) vector. Furthermore, we have considered nine additional plausible \( R_{0,k} \) sets (Table 3) that are slight modifications of the baseline vector, gathering a total of ten possible \( R_{0,k} \) sets that were used to access the sensitivity of model results.

The model was run for each \( R_{0,k} \) set until reaching equilibrium. Those sets yielding sustained 2—3-year epidemic cycles, typical of measles in absence of mass vaccination [32], were then selected. The vaccination campaign was allowed to start both in epidemic and non-epidemic years.

### Model validation

The model was validated by several criteria. First, transmission parameters were selected to yield sustained incidence oscillations with an inter-epidemic period of 2—3 years. Second, measles incidence simulated by the model was compared with case-notifications available in Portugal for the period 1987—1997; attention was particularly directed to (i) the model’s ability to reproduce three epidemic peaks known to have occurred in 1984—1985, 1988—1989, and 1993—1994, and (ii) the ability to reproduce the five-fold increase observed in case-notifications, between pre-epidemic and epidemic peaks. Third, the distribution of seropositives by age predicted by the model in 2001 was compared with the results of the National Serologic Survey conducted in Portugal for 2001—2002. Fourth, seasonality coefficients (mean deviation between monthly incidence and overall mean) predicted by the model were compared with case-notification seasonality. Finally, we have compared the incidence by age in epidemic years predicted by the model with notifications by age in the 1988—1989 and 1993—1994 epidemics. The selection of epidemic years for comparison is meant to avoid the noise associated with under-reporting and false positives, both known to be more pervasive in inter-epidemic periods [33].

### Effective reproduction number

The effective reproduction number, \( R_e \), is defined as the actual mean number of secondary cases produced by a typical infectious individual in the population. If measles is in endemic equilibrium, one expects \( R_e \approx 1 \), as each case produces on average one other case, whereas if the infection is driven to elimination, one expects \( R_e \) to be consistently below 1. Mathematically, \( R_e \) is the largest eigenvalue of the following matrix [34,35]:

\[
\text{Diag}(S)G
\]
where \( \text{Diag}(S) \) is a matrix with the proportion of susceptible per age group in the main diagonal and \( G = [g_{ij}] \) is the so-called next generation matrix. The elements \( g_{ij} \) can be decomposed as

\[
g_{ij} = \frac{\beta_{ij}}{u}
\]

where \( u \) is the instantaneous rate of recovery from infectiousness, \( 1/u \) is the average duration of the infectious period (with type I mortality), and \( \beta_{ij} \) is the transmission coefficient. In the simulations, \( R_e \) was computed on a daily basis, by building the \((4 \times 4)\) matrix in Eq. (3) and extracting its largest eigenvalue.

**Control scenarios**

We have examined the likely contribution of the 1998—1999 catch-up campaign to the elimination of indigenous measles in Portugal, and simulated realistic scenarios of measles control, in order to determine which are likely to sustain measles elimination. In particular, we have explored the ongoing vaccination coverage with the MMR I, either at 90% or 95%, assuming that individuals effectively immunized by vaccination stay lifelong immune. Vaccination coverage with the MMR II was simulated at 10% and 70% of those that remained susceptible. We have also examined how important it is to anticipate the recommended age of the MMR I from 15 to 12 months of age. Vaccine efficacy is assumed to be of 95%.

**Results**

**Vaccination coverage**

The number of vaccines against measles given in Portugal increased over the years, since vaccination begun in 1973 (Fig. 1), with peak uptakes observed shortly after 1985, 1989, and 1994, probably a reaction to the epidemic outbreaks that took place in those years. The number of MMR II doses decreased since its introduction (Fig. 1). Nevertheless, as the effort to accurately target the recommended 11—13 year olders improved, estimates of MMR II coverage at 12 years old increased from about 20% in the 1979 cohort to above 40% in subsequent cohorts (Fig. 2). It has not been possible to determine what percentage of those that received the MMR II were already immune by either vaccination or infection.

In the years following the introduction of mass vaccination, the number of vaccines was much smaller than the number of newborns, but this ratio changed around 1989 (Fig. 1). Accordingly, at 2 years of age the vaccination coverage of the 1975 cohort was around 20%, but coverage gradually increased in subsequent cohorts, reaching 80% in the 1989 cohort and remaining above this value thereafter. Children in cohorts born before 1987 were vaccinated at ages older than recommended and consequently, at 7 years of age, the cumulative coverage of these cohorts almost doubled the cumulative coverage at 2 years of age (Fig. 2). Vaccination coverage with the MMR II, as accessed at 12 years of age, remained at low levels, varying between 20% and 60% between 1991 and 2000 (cohorts 1979—1988). An unknown proportion of individuals were already immune by the time they took the MMR II, so the additional coverage of susceptibles brought about by the MMR II should be yet lower.

**Incidence and model validation**

The simulation results were very sensitive to the set of basic reproduction numbers adopted. Only the set number 7 (Table 3), when combined with scenario 1 of the vaccination campaign (Table 1), produced incidence patterns resembling measles epidemiology between 1987 and 1998 (Fig. 3). There is a good match between simulated incidence and notifica-
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Figure 5  Evolution between 1967 and 2000 of the proportion of immune individuals since birth to 15 years old (simulate by the model).

MMR I remains at 15 months or is anticipated to 12 months of age (Fig. 7) unless vaccination coverage is near 90%.

The ratio between newborns to vaccinated mothers versus newborns to naturally immune mothers has been rising steeply since the late 1980s (Fig. 8). We estimate that by 2011 it should hit 50%, an estimate that is little sensitive to assumptions concerning vaccination coverage with MMR I so long as it remains within realistic limits (more than 90–98%).

Given the shorter duration of passive immunity in newborns to vaccinated mothers, more infants less than 15 months old will experience a larger period during which the titer of maternal antibodies falls below a protective level. At 10 months of age, for example, the prevalence of susceptible children is expected to increase from 87% to 93% and 96%, respectively in the cohorts of 1998, 2010, and 2028.

If vaccination coverage decreases to levels around 90%, anticipation of the age from 15 to 12 months of age should decrease \( R_e \) below 1 and avoid outbreaks. For higher levels of vaccination coverage, if indigenous measles remains absent,

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the system will reach a state where every newborn child will be born either to a vaccinated or to a susceptible mother. In such a limit situation, the anticipation of the age of MMR I from 15 to 12 months of age should decrease the number of susceptible infants per day in about 25% (assuming Type I mortality and average duration of passive immunity of 3 months). We have found that this is not an important determinant for sustained measles elimination in Portugal, but it would reduce the likelihood of infants being involved in localized outbreaks triggered by imported cases of measles.

Conclusions

The vaccination coverage in Portugal increased consistently since 1974, as the number of vaccines given over time increased and the yearly number of newborns decreased (Fig. 1). Vaccination coverage per cohort, evaluated at 2 years of age, was estimated to rise from about 20% in 1974 to current levels at about 95% (Fig. 2). The peak vaccine uptakes observed shortly after 1985, 1989, and 1994 (Fig. 1), probably in reaction to the epidemic outbreaks that took place those years, are also a likely consequence of the new vaccination schemes introduced in 1987 (monovalent vaccine was substituted by the MMR) and 1990 (the two-dose scheme began).

The age-structured seasonally-forced model presented here, has the capability to reconstruct the epidemiological patterns of measles incidence in Portugal during the most recent decades, given the appropriate set of basic reproduction numbers and plausible assumptions about how vaccination was distributed over ages and time. The model reproduces the pre-vaccination 3-year inter-epidemic period, which had previously been reported from time series analysis of deaths by measles [32], as well as the major outbreaks that took place in 1984–1985, 1988–1989, and 1993–1994. As expected, the absolute number of cases over time, predicted by the model, is much larger than the number of measles notifications reported to authorities in Portugal. Indeed, the model suggests that notifications underestimate the number of cases by a factor of seven. This figure is coincident with the conclusion by Fleming et al. [36] that chickenpox incidence is seven times higher than the number of notifications reported by the Portuguese sentinel surveillance network.

The distribution of seropositives by age (>2 years old) produced by the model is in good agreement with results of the NSS based on blood samples collected in 2002 (Fig. 4B). Both show that the most prominent pool of susceptibles is in the 1978–1982 cohorts (20–24 years of age in 2002), with an estimate of 10% and 14% susceptibles, respectively, in the model and in the NSS. Cohorts from 1974, the year that correspond to the introduction of vaccination, until 1983 were shown to have low vaccination coverages (Fig. 1) which allied to smaller outbreaks (Fig. 3) cause this increase in susceptibility. Nonetheless, during the years from 1974 to 1977, there was supplementary vaccination due to the catch-up campaign held between 1973 to 1977, making this cohorts less susceptible than the 1978 to 1982 ones.

The model indicates that the 1998–1999 catch-up campaign, put into place by health authorities to avoid an outbreak projected for 1999–2000, created conditions to bring the effective reproduction number of measles to values continuously below 1. The simulations thus support the claim that the reduced notification of suspected cases of measles in Portugal since 2002, and the absence of laboratory confirmed cases, is a consequence of the interruption of indigenous measles transmission in Portugal since the late 1990s.

Outbreaks linked to imported cases are likely to continue to occur as long as measles remains endemic in parts of the world. Importations to well immunized countries will affect susceptible infants and previously vaccinated individuals whose immunity may not be complete. The capacity to keep imported cases from triggering endemic disease resurgence, is very much dependent on our ability to maintain a very high level of vaccination coverage (>95%) with the MMR I. This conclusion remains valid, irrespective of whether the vaccine is given at 12 or 15 months, and is little sensitive to changes in realistic levels of vaccination coverage with the MMR II. It is also in agreement with previous theoretical results on how crucial it is to keep high levels of first-dose coverage in two-dose vaccination schemes against childhood diseases [19].

The anticipation of the age of the MMR I has a significant impact on global transmission levels for a narrow band of vaccination coverage around 90%. Below this level of vaccination $R_0$ will be above 1 irrespective of whether the age for MMR I is anticipated or not. Also if the level of vaccination coverage is above this band the reproduction number is always below 1. This result differs from other authors [37] who considered the contact rate in the first age group (0–4 years old) the lowest one. In our case this is the second highest contact rate, which is in accordance with the high rates of attendance of very young infants (from 4 months old) to daycare centers in Portugal.

In conclusion, Portugal is expected to remain free of endemic measles transmission if the present social and demographic conditions are maintained and levels of vaccination coverage with the MMR I remain above 95%, together with timeliness in the application of the recommended schedule. The greatest threat to measles elimination in countries like Portugal is reduced compliance with vaccination in face of a false sense of security created by absence of publicized outbreaks over the years. The longer the community goes without circulating measles virus, the more strict public health officials must be in handling imported cases and fighting the tendency to lower defences against what might become perceived as a disease of the past to the eyes of health workers and the general public.

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Appendix A. Model description

We have used an age-structured model with six epidemiologic compartments: maternally protected newborns, split
Dynamics and control of measles in Portugal

Initial conditions are defined every year as:

\[ P_0 = n_0 - \left( \sum_i f_i S_i + \sum_i f_i V_i \right) \]
\[ M_0 = \sum_i f_i V_i \]
\[ S_0 = \sum_i f_i S_i \]

Also,

\[ E_0(0) = I_0(0) = R_0(0) = V_0(0) = 0 \quad \text{and} \quad P_i(0) = M_i(0) = S_i(0) = E_i(0) = I_i(0) = R_i(0) = V_i(0) = 0 \]

After running the differential equations for 365 days, the initial values are update as:

\[ P_i(t) = P_i(365) \]
\[ M_i(t) = M_i(365) \]
\[ S_i(t) = S_i(365) \]
\[ E_i(t) = E_i(365) \]
\[ I_i(t) = I_i(365) \]
\[ R_i(t) = R_i(365) \]
\[ V_i(t) = V_i(365) \]

Here \( m \) and \( p \) are the rates of loss of protection by maternal antibodies in newborns, respectively, vaccinated and naturally immunized mothers. Individuals leave the susceptible compartment either by vaccination at rate \( \psi_i \), that depends on age \( a \) and time \( t \), or by infection at a rate defined by the force of infection \( \lambda(a, t) \). Once infected, individuals become latent and then infectious at rate \( \sigma_i \), recovering from infectiousness at rate \( \omega_i \). Individuals who become immune, either by vaccination or natural infection, are assumed to stay immune lifelong. Numerical values for the parameters are listed in Table 2.

The force of infection is defined by the function,

\[ \lambda(a, t) = \sum_{a=1}^{4} b(a) l(a, t) \quad \text{(A.1)} \]

where \( b(a) \) is the age-related transmission rate (number of contacts per unit time). \( l(a, t) \) is the number of infectious individuals in age group \( a \) at time \( t \). Age groups are defined as 0–4, 5–10, 11–20 and more than 20 years. The force of infection depends on the WAIFW (Who Acquires the Infection From Whom) matrix, a way of representing assumptions about how individuals mix among ages [24,28]. We have used a WAIFW matrix that conveys the common opinion that the main route of transmission takes place in primary schools (5–10 years old children). The structure of the WAIFW matrix was defined as in Schenzle [24] and Anderson and May [28],

\[
\begin{pmatrix}
  b(1) & b(2) & b(3) & b(4) \\
  b(1) & b(2) & b(3) & b(4) \\
  b(2) & b(3) & b(3) & b(4) \\
  b(4) & b(4) & b(4) & b(4)
\end{pmatrix}
\]

There is a unique coefficient \( b(2) \) describing the transmission among susceptible and infectious in age group 2 and there are two other coefficients, \( b(1) \) and \( b(3) \), for the contacts among individuals aged less than 21 years; whereas adults are described as being likely to acquire infection from a wider range of age groups. We further use a symmetry relation, indicating that individuals in age group \( j \) make contact with individuals in age group \( i \) at the same rate as individuals...
in the latter group make contact with those in the former. Transmission in the 5–10 age group, \( b(2) \), takes a minimum value (equal to \( b(1) \)) every Sunday, during Christmas holidays (23rd of December to January the 7th), Easter holidays (11th to 25th of April) and during the summer holidays (14th of July to the 7th of October). The set of values used for the WAIFW matrix elements are in Table 3.

The adopted structure fits the pattern found by Del Valle et al. [7] when studying contact patterns that determine the transmission of air born diseases.

To compute the number of newborns through time as a function of women's age, we have used the fertility function \( f_i \), estimated for Portugal in 1994 [26], defined as the average number of children per women at age \( i \).

We assumed that all individuals die as they reach the age of 75 years (type I mortality).

References


[34] Mossong J, Muller CP. Modelling measles re-emergence as a result of waning of immunity in vaccinated populations. Vaccine 2003;21(31):4597–603.