

# Predicting the 2014 Ebola Outbreak in West Africa using Network Analysis

## Milestone Report

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### Abstract

The current Ebola outbreak in West Africa is the worst in history. Most traditional epidemiological models are compartmental models that have a random-mixing assumption. These models calculate the effective reproductive rate of an outbreak. We survey three of these models: the classic SIR (Susceptible, Infectious, Recovered) model and two extensions used in Ebola research.

Network models allow for avoiding the random-mixing assumption inherent in compartmental models. This is done by assigning each individual a finite set of permanent contacts. We review generated contact network models for SARS, including an urban network, a random network, and a scale-free network. We then review a worldwide network model that represents traffic flowing across transportation networks and consider approaches for predicting the extent of an Ebola outbreak.

### I. INTRODUCTION

TODO: Add introduction

### II. RELATED WORK

Related work by (Gomes et al., 2014) attempts to predict the spread of Ebola to different parts of the world based on a model that incorporates both the compartmental approach and the use of world-wide air traffic flows.

In (Meyers et al., 2005), the authors model the spread of the 2002-2003 outbreak of SARS in Hong Kong and Canada using a contact network. A contact network model attempts to characterize every interpersonal contact that can potentially lead to disease transmission in the community, with each person in the community represented as a node and each contact represented as an edge between them.

The majority of research in epidemiological theory is based on the compartmental model, which is not a network model. In order to simply capture the dynamics of disease spread over time, the compartmental model employs a population-wide random mixing assumption, meaning that each individual has a small and equal chance of coming into contact with any other individual in the population. To model the progress of an epidemic in a large population, the individuals in the population are compartmentalized according to the state of the disease. The most widely used such model is the SIR model introduced in (Kermack and McKendrick, 1932):

- **Susceptible (S):** Individuals who have not yet caught the disease from contact with an infectious individual.
- **Infectious (I):** Individuals who have the disease. They have some probability of infecting susceptible people.
- **Recovered (R):** Individuals who have experienced the full infectious period, and are now non-infectious and immune.

The changes among these states over time are represented by a set of differential equations. The basic reproductive number  $R_0$  is defined as the average number of secondary cases generated by a primary case in a pool of mostly susceptible individuals, and is an estimate of epidemic growth at the start of an outbreak if everyone is susceptible.

In (Chowell et al., 2004), the authors model the effect of Ebola outbreaks in 1995 in Congo and in 2000 in Uganda using a compartmental model similar to the SIR model. However, a distinct feature of Ebola is that individuals exposed to the virus who become infectious do so after a mean incubation period. In order to reflect this feature, the SIR model is extended with an additional “Exposed” compartment state. This SEIR model is summarized in Figure 1:



Fig. 1: SEIR model

In (Legrand et al., 2007), the Ebola outbreaks in Congo in 1995 and Uganda in 2000 are also studied. However, a major difference from (Chowell et al., 2004) is that (Legrand et al., 2007) models the spreading of disease in heterogeneous settings.

In order to gain better insight of the epidemic dynamics, the infectious phase is subdivided into three stages: infection in a community setting (I), infection in a hospital setting (H), and infection after death assuming a traditional funeral (F).

This SEIHFR compartmental model is summarized in Figure 2.

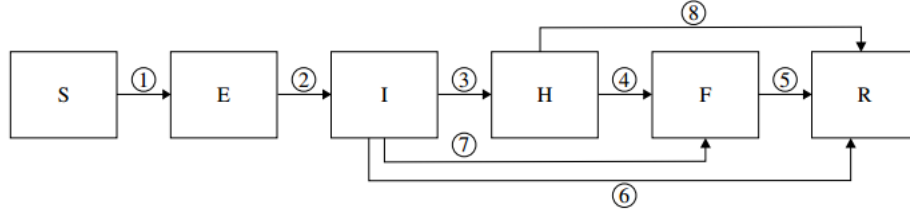


Fig. 2: SEIHFR model

### III. MODELING INTRA-COUNTRY SPREADING BEHAVIOR

#### A. Compartmental approaches

TODO: We used SEIR and something

#### B. Network approaches

TODO: We are looking at modeling via G(n,m) and contact networks

### IV. MODELING WORLDWIDE SPREADING BEHAVIOR

TODO: We are looking at modeling using trade data.

1) *Preparing data*: TODO: Used public data from the UN and CIA...

### V. TODO: REMOVE BELOW DETAILS OR INCORPORATE INTO METHODS SECTION

#### A. SEIR model details

In the SEIR model, susceptible (S) individuals in contact with the virus enter the exposed (E) state at a rate of  $\beta I/N$ . The exposed (E) individuals undergo an average incubation period of  $1/k$  days before progressing to the infectious (I) state. The exposed state is assumed to be asymptomatic as well as uninfected. Infectious (I) individuals move to the R state, either recovered or dead, at a rate of  $\gamma$ . The parameters are  $\beta$ , the transmission rate per person per day;  $N$ , the total effective population size; and  $I/N$ , the probability that contact is made with an infectious individual.

The following set of differential equations are used to represent this model:

$$\frac{dS}{dt} = \frac{-\beta SI}{N}, \quad \frac{dE}{dt} = \frac{\beta SI}{N} - kE, \quad \frac{dI}{dt} = kE - \gamma I, \quad \frac{dR}{dt} = \gamma I, \quad C = kE$$

Here,  $S$ ,  $E$ ,  $I$ , and  $R$  denote the number of susceptible, exposed, infectious and removed individuals at time  $t$ . In the equations, to simplify our notation, we have omitted the dependency on  $t$ .  $C$  is not an epidemiological state, however it is useful to keep track of the cumulative number of cases from the time of the onset of the outbreak.

In order to model the effect of intervention on the spread of the disease, in the above model, the transmission rate  $\beta$  is modeled as a function of time. At the initial phase of the outbreak, before intervention,  $\beta$  is parameterized by  $\beta_0$ . After intervention, the value of  $\beta$  transitions from  $\beta_0$  to  $\beta_1$ ,  $\beta_0 > \beta_1$  as follows:

$$\beta(t) = \begin{cases} \beta_0 & t < \tau \\ \beta_1 + (\beta_0 - \beta_1) \exp(-q(t - \tau)) & t \geq \tau \end{cases}$$

Where  $\tau$  is the time when interventions begin and  $q$  controls how quickly the rate of transmission changes from  $\beta_0$  to  $\beta_1$ .

The Ebola data for the 1995 Congo and 2000 Uganda outbreaks were represented as  $(t_i, y_i)$ ,  $i = 1, 2, \dots, n$  where  $t_i$  represents  $i$ th reporting time and  $y_i$  the cumulative number of infectious cases from the beginning of the outbreak of to time  $t_i$ . The model parameters  $\Theta = (\beta_0, \beta_1, k, q, \gamma)$  were estimated using a least-square fit by fitting these data to the cumulative number of cases  $C(t, \Theta)$  in Equation ???. The initial condition and appropriate of range of the parameters were taken from Empirical studies, e.g. an incubation period between 1 and 21 days and infectious period between 3.5 and 10.7 days were assumed. Once the parameters are estimated, the basic reproductive number was calculated using the following formula:

$$R_0 = \frac{\beta_0}{\gamma} \quad (1)$$

In addition to calculating  $R_0$ , (Chowell et al., 2004) also proposed an analogous continuous time Markov chain model based on the estimated parameters. The transition rates were defined as follows:

Event	Effect	Transition Rate
Exposure	$(S,E,I,R) \rightarrow (S-1,E+1,I,R)$	$\beta SI/N$
Infection	$(S,E,I,R) \rightarrow (S,E-1,I+1,R)$	$kE$
Removal	$(S,E,I,R) \rightarrow (S,E,I-1,R+1)$	$\gamma I$

The event times  $0 < T_1 < T_2 < \dots$  at which an individual moves from one state to another are modeled as a renewal process with increments distributed exponentially,

$$P(T_k - T_{k-1} > t | T_j, j \leq k-1) = \exp(-t\mu(T_{k-1})) \quad (2)$$

Here,

$$\mu(T_{k-1}) = \frac{1}{\frac{\beta(T_{k-1})S(T_{k-1})I(T_{k-1})}{N} + kE(T_{k-1}) + \gamma I(T_{k-1})}$$

Based on the above stochastic model, (Chowell et al., 2004) provides the results of a Monte Carlo simulation that shows good agreement with the actual data.

*Discussion.* While the SEIR model adds needed features to the SIR model, it still suffers from the random mixing assumption and only represents a single infectious state.

#### B. SEIHFR model details

Transition ( $i$ )	Effect	Transition Rate ( $\lambda_i$ )
1	$(S,E) \rightarrow (S-1,E+1)$	$(\beta_I SI + \beta_H SH + \beta_F SF)/N$
2	$(E,I) \rightarrow (E-1,I+1)$	$\alpha E$
3	$(I,H) \rightarrow (I-1,H+1)$	$\gamma_h \theta_1 I$
4	$(H,F) \rightarrow (H-1,F+1)$	$\gamma_{dh} \delta_2 H$
5	$(F,R) \rightarrow (F-1,R+1)$	$\gamma_f F$
6	$(I,R) \rightarrow (I-1,R+1)$	$\gamma_i (1 - \theta)(1 - \delta_1) I$
7	$(I,F) \rightarrow (I-1,F+1)$	$\delta_1 (1 - \theta_1) \gamma_d I$
8	$(H,R) \rightarrow (H-1,R+1)$	$\gamma_{ih} (1 - \delta_2) H$

Where the model parameters  $\beta_I$ ,  $\beta_H$ , and  $\beta_F$  are the transmission coefficients in community, hospital and funeral settings respectively,  $\theta_1$  is the fraction of infectious cases hospitalized, and the rest of the parameters are omitted here for brevity.

In order to model the effect of interventions, a two step approach is used:

- Before intervention, population was exposed to the cases in community, hospitalization as well as funeral
- After intervention, no transmission occurred at hospital or funeral, i.e.  $\beta_H = \beta_F = 0$ . The transmission coefficient in the community is decreased by a factor of  $(1 - z)$ .

In the above mentioned model, parameters  $(\beta_I, \beta_H, \beta_F, z)$  were estimated by fitting the model to the morbidity data from the 1995 Congo and 2000 Uganda outbreaks using approximate maximum likelihood. The estimates of other parameters in the above model were drawn from prior work.

Simulations of the stochastic model were performed using Gillespie's first reaction method (Gillespie, 1976). At each iteration of the algorithm, a time  $\tau_i$  is drawn from an exponential distribution with parameter  $\lambda_i$  for each of the transition. Here,  $\lambda_i$  is the transition rate of the transition  $i$ . The next transition  $\mu$  is the transition that has the minimum time to occurrence ( $\tau_\mu$ ). Counts in each compartment are updated accordingly. In addition to the simulation result, (Legrand et al., 2007) also presented the basic reproductive rate as a function of  $(\beta_I, \beta_H, \beta_F, \gamma_h, \gamma_{dh}, \gamma_{ih}, \gamma_d, \theta_1, \delta_1, \delta_2)$ .

*Discussion.* The SEIHFR model comes even closer to modeling the real-life behavior of Ebola, but due to being a compartmental model continues to suffer from the random mixing assumption. Additionally, as more states are added to the compartmental model, complexity increases and ease of characterizing and understanding the model is diminished.

#### C. Discussion: SIR (Chowell et al., 2004; Legrand et al., 2007) vs. networks (Newman, 2002)

(Chowell et al., 2004; Legrand et al., 2007), as described in previous sections, modeled the spread of Ebola using the compartmental modeling procedure. Even though (Legrand et al., 2007) modified the SEIR model to reflect the heterogeneity of infection states, the underlying assumption is still random mixing. A disease like Ebola spreads via networks formed by physical contact among individuals. While an individual may have the same number of contacts per unit time in either a random mixing model or a network contact model, within a static network model the set of contacts is fixed, versus a random-mixing model wherein it is continually changing. A static network model thus captures the permanence of many human relationships.

In (Newman, 2002), the authors extend the concept of the SIR model in network analysis. They provide an exact solution to the SIR model of epidemic disease on networks of various kinds. This is achieved using a combination of mapping to percolation models and using edge probability generating functions.

Transmissibility  $T$  of a disease is defined as the average probability that an infectious individual will transmit the disease to a susceptible individual with whom they have contact. The epidemic threshold  $T_c$  is the minimum transmissibility required for an outbreak to become a large-scale epidemic. The authors provide the relation between the basic reproductive number  $R_0$  of an SIR network and the transmissibility  $T$  as follows:

$$R_0 = T \frac{\langle k^2 \rangle}{\langle k \rangle - 1}$$

In addition, (Newman, 2002) also provide the value of epidemic threshold  $T_c$ . In an uncorrelated network, it is given by:

$$T_c = \frac{\langle k \rangle}{\langle k^2 \rangle - \langle k \rangle}$$

Here,  $\langle k \rangle$  and  $\langle k^2 \rangle$  are the mean degree and mean square degree of the network. Parameters for Poisson and power law networks are chosen such that all three networks share the same epidemic threshold. The authors predict average size of the outbreak  $\langle s \rangle$  and the probability of an epidemic  $S$ .

The results in (Newman, 2002) allow us to compare more directly the relationships between random mixing models and network models under certain assumptions. This may prove handy in validating our models.

#### D. Contact Networks for Epidemiology (Meyers et al., 2005)

In our search for existing literature on the use of contact networks to model the spread of Ebola, we haven't come across any previous work that precisely does this, possibly due to the lack of detailed data in the locations historically affected by the disease. In (Meyers et al., 2005), the authors model the spread of the 2002-2003 outbreak of SARS in Hong Kong and Canada using a network model. A contact network model attempts to characterize every interpersonal contact that can potentially lead to disease transmission in the community. Each person in the community is represented as a node in the network and each contact between two people is represented as an edge connecting them. In (Meyers et al., 2005), the authors presented three different contact network models for SARS:

- **Urban Network:** A plausible urban-setting contact network was generated using simulation based on Vancouver data. Households were randomly chosen and their members given ages, schools, occupations, hospital beds as patients, and caregivers according to statistics from public data. This model offers a high degree of realism, but is complex.
- **Random Network:** A random network with Poisson degree distribution in which individuals connect to other independently and uniformly at random.
- **Scale-free Network:** There may be individuals in the network called "superspreaders" with unusually large numbers of contacts or "supershedders" who are unusually effective at excreting the virus into the environment they share with others. Neither the urban nor the random networks contains a significant number of superspreaders. To incorporate the effects of superspreaders in disease transmission, (Meyers et al., 2005) also studies a network with truncated power law degree distribution. This type of network has a heavy tail of superspreaders. These individuals, despite being few in number, have a profound effect on the outbreak patterns.

*Discussion.* (Meyers et al., 2005) extended the result from (Newman, 2002) to calculate the fate of an outbreak based on its initial condition, the probability that a patient zero with degree  $k$  will start an epidemic, and the probability that an outbreak of size  $N$  will start an epidemic. However, (Newman, 2002) did not capture the temporal progression of the epidemic, instead providing an overall number and distribution of the infected individuals. The authors predicted the probability  $S$  that an outbreak with  $R_0 > 1$  will lead to an epidemic for their three networks.  $S$  is often significantly less than 1 and can be different for two networks with the same  $R_0$ . Outbreaks are consistently less likely to reach epidemic proportions in power law networks than in the others.  $R_0$  is a valuable epidemiological quantity, however it has its limit since  $R_0$  is a function of both the transmissibility of a disease and the contact patterns that underlie the transmission. Therefore, measuring  $R_0$  in a location where contact rates are unusually high will lead to an estimate that is not appropriate for the larger community. Estimating  $T$  instead of  $R_0$  may give us a way out of this difficulty.

#### E. Report assessing the international spreading risk of Ebola (Gomes et al., 2014)

A recent study (Gomes et al., 2014) gathered data from the Disease Outbreaks News of the WHO and used what they call the Global Epidemic and Mobility Model to predict the spread of the current (2014) Ebola outbreak. In this model, the world is divided into geographical regions defining a subpopulation network, modeling connections among subpopulations representing traffic flows due to transportation infrastructure.

Like (Legrand et al., 2007), they use the SEIHFR compartmental disease model and compare it with the more traditional SEIR model, while simulating an ensemble of possible epidemic evolutions for observables such as newly-generated cases,

Guinea				Sierra Leon			
Incidence Dependent Parameters		Value	Comments	Value		Comments	
Initial Case $t_0$	December 2, 2013		one person fell ill	April 23, 2014		one person fell ill	
$S_0$		0	-	0		-	
$E_0$		0	-	0		-	
$I_0$		1	-	1		-	
$R_0$		0	-	0		-	
$C_0$		1	-	1		-	
Intervention time	March 2, 2014		Gov. of Guinea informed WHO	June 12, 2014		Country declared emergency	
$\tau$		110	-	50		-	
Estimated Parameters		Value	95% CI	Comments	Value	95% CI	Comments
Incubation Time $1/k$		6.3	-	based on previous works	6.3	-	based on previous works
Infection Time $1/\gamma$		5.4957	[5.43, 5.545]	-	6.36	[6.324, 6.396]	-
$\beta_0$		0.2407	[0.2374, 0.244]	-	0.357	[0.3525, 0.3613]	-
$\beta_1$		0.2084	[0.2033, 0.2135]	-	0.2012	[0.1994, 0.2028]	-
$q$		32	[0.1, 100]	-	34	[1.9, 110]	-
Fatality Rate		0.67	-	-	0.38	-	-
$R_0$		1.323	[1.295, 1.341]	-	2.27	[2.243, 2.298]	-
$R_1$		1.145	-	-	1.28	-	-

Liberia				West Africa			
Incidence Dependent Parameters		Value	Comments	Value		Comments	
Initial Case $t_0$	March 31, 2014		official confirmation two infected	December 2, 2013		one person fell ill in Guinea	
$S_0$		0	-	0		-	
$E_0$		0	-	0		-	
$I_0$		2	-	1		-	
$R_0$		0	-	0		-	
$C_0$		2	-	1		-	
Intervention time	July 30, 2014		School shutdown	March 2, 2014		Gov. of Guinea informed WHO	
$\tau$		120	-	110		-	
Estimated Parameters		Value	95% CI	Comments	Value	95% CI	Comments
Incubation Time $1/k$		6.3	-	based on previous works	6.3	-	based on previous works
Infection Time $1/\gamma$		10.7	[8.9, 10.7]	-	6.8	-	-
$\beta_0$		0.169	[0.168, 0.191]	-	0.2	-	-
$\beta_1$		0.0001	[0.0001, 0.1]	-	0	-	-
$q$		0.0085	[0.0072-0.0264]	-	0	-	-
Fatality Rate		0.67	-	-	-	-	-
$R_0$		1.808	-	-	1.36	-	-
$R_1$		0.001	-	-	-	-	-

time of arrival of infection, and the number of traveling disease carriers. The parameter  $\theta_1$  is computed so that  $\theta\%$  of infectious cases are hospitalized.

The expression for the basic reproductive number  $R_0 = R_I + R_H + R_F$  where  $R_I$  is a term that accounts for transmissions in the community,  $R_H$  accounts for transmissions in the hospital, and  $R_F$  accounts for infections due to dead individuals. Parameters were fit using latin hypercube sampling of the parameter space defined by the vector  $P = (R_I, R_H, R_F)$ .

To make predictions, the authors ran Monte Carlo simulations exploring the value of  $R_0$  while relying on results reported in (Legrand et al., 2007) and elsewhere for the rest of the model parameters.

*Discussion.* The approach used in (Legrand et al., 2007) appears to be the state of the art in epidemic prediction for situations where the available data is very limited. Unfortunately, as previously discussed, the SEIHR model has a random mixing assumption that does not reflect reality over large areas. It may be possible to use small world networks or other generated networks to model locality more effectively based on population density and geographical information.

## VI. PROJECT PROPOSAL

### A. Data set

The data set we plan to use (Rivers, 2014) is an aggregation of Ebola outbreak data from multiple sources, including the WHO, the Liberia Ministry of Health, and the Sierra Leone Ministry of Health. The data set consists of time series totals for suspected infected, confirmed infected, and dead on an almost-daily basis across several countries, and counties within countries. To model a world-wide contact network, we will be using information from additional sources, such as the CIA factbook or World Trade Organization (WTO) economic trade data between countries.

### B. Project Progress

- 1) **Estimating model parameters and basic reproduction number for 2014 Ebola data using a random mixing model:**
- 1) **Estimating model parameters and basic reproduction number for 2014 Ebola data using a random mixing model:**  
In the first phase of the project, we are planning to use the SEIR model proposed in (Chowell et al., 2004) as a baseline model, and estimate the model parameters  $\beta_0, \beta_1, k, q, \gamma$  and basic reproduction number  $R_0$  to fit the data obtained from current Ebola outbreak. Once the parameters are obtained, we are planning to use these parameters to perform prediction

of the epidemic assuming a fully mixed model. To benchmark our prediction, we are planning to use the prediction performed by the CDC (Meltzer et al., 2014). We are interested in observing how different parameters in the model affect the spread of the disease. To this end, we are planning to vary critical parameter values, such as mean incubation period and transmission rate, in order to observe their effects on disease growth.

As an extension to the above approach to find more accurate parameters for the compartmental model described above we ran a simulation using mcmc approach and time series data for the various infected regions. Initial values and the range of the parameters were based on the existing literature. The simulation is currently running and we expect better values for the parameters of the model based on the data for the current outbreak.

- 2) **From random mixing model to contact network:** (Meyers et al., 2005; Newman, 2002) extended the basic SIR model to network analysis. Whether this model is readily applicable to the modified (SEIR, SEIHFR) compartmental models used previously in Ebola research (Chowell et al., 2004; Legrand et al., 2007) is not immediately clear. In the second phase of our project, we will model contact networks using the basic reproductive number and other parameters obtained in phase 1. We will then estimate the propagation of disease on generated contact networks by assuming an initial number of infected nodes. Since in a contact network based model each node can propagate the disease to only its immediate neighbors, the spread of disease will be different than our first phase of analysis.

We have county-level data points for Liberia and are planning to use that granularity in different ways. One approach is to model individuals as nodes in a small-world network, and since the individuals within a particular county are more likely to have contact with each other, we may use a different probability of adding long-range links within a county than between counties. The number of edges between different counties can be dependent on features taken from public data such as the underlying transportation networks, distance between counties, or amount of trade between the regions. Within each county, we also plan to simulate disease-spread behavior using different types of generated contact networks, including random graphs, small world networks, and scale-free networks.

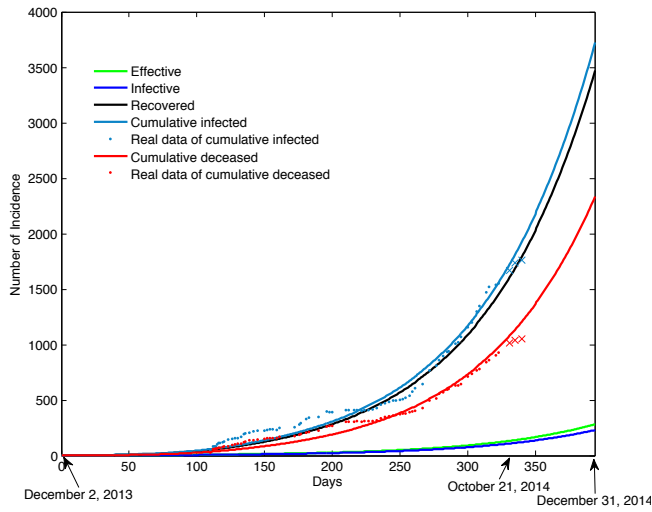
The growth curve of the Ebola virus has been very different in different countries (Rivers, 2014). When using a compartmental model for analysis, we will use different values of  $R_0$  to fit these trends. When modeling as a contact network, we can start by calculating a single value of transmissibility  $T$  and model contact networks for Liberia or Guinea differently using different average degrees of nodes. We can also try using different types of network models for different places and observe the effect of these different assumptions on the spread of the disease.

- 3) **Possibility of Ebola becoming a world-wide epidemic:** In (Gomes et al., 2014), the authors use airport network data to predict the spread of Ebola to different parts of the world. In the third phase of our project, we plan to use a similar approach to predict the spread of the epidemic over a wider region of the world. To this end, we will make use of estimated parameters and insight gained from phases 1 and 2 of our project. We will evaluate our predictions by predicting current numbers based on prior data points. In order for the disease to spread, we need to consider the underlying contact networks between different regions of the world. In order to model such a contact network, we can make use of public data such as transportation networks, trade routes, and levels of trade between countries and regions. Since some traditional river-based funeral practices may increase the chance of spreading the disease, we can also make use of river flow data.

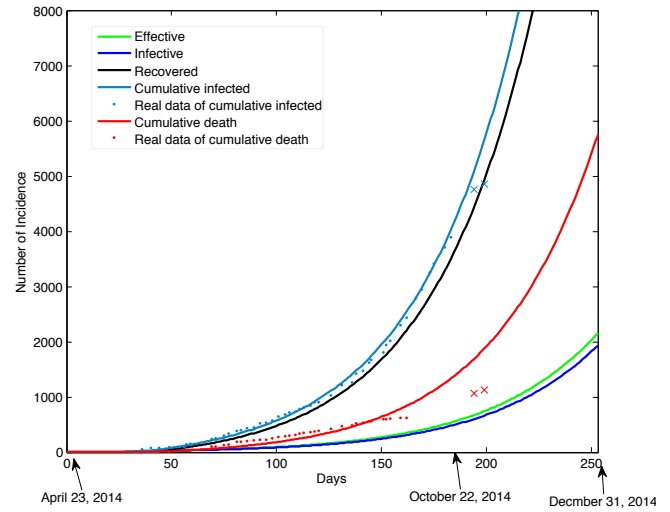
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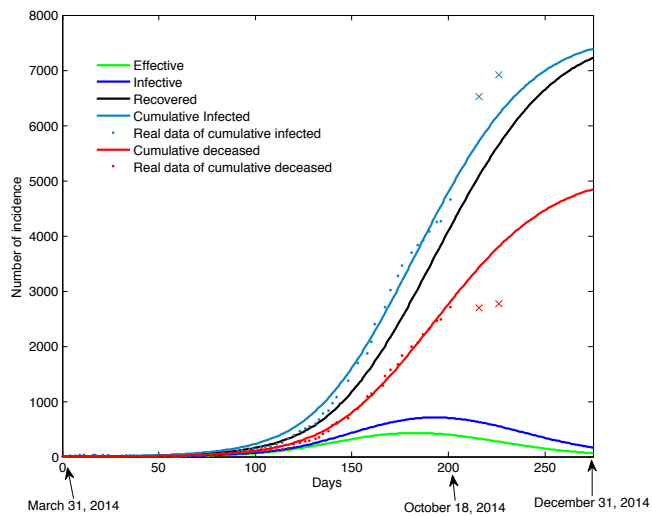




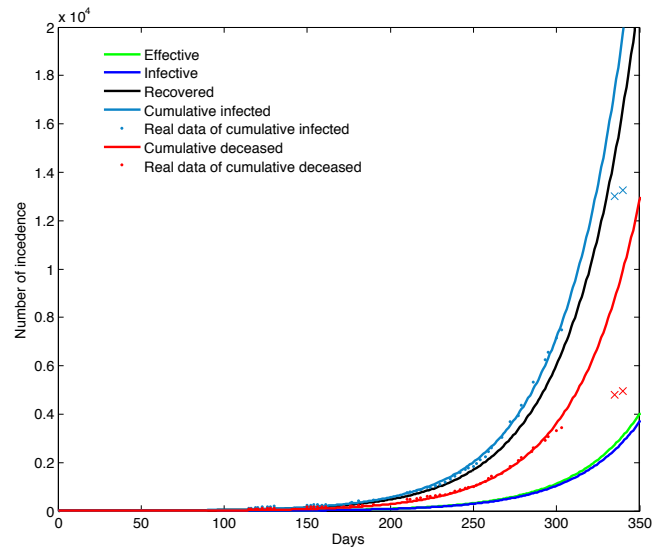
(a) Guinea



(b) Sierra Leon



(c) Liberia



(d) West Africa

Fig. 3: Main figure caption