Birth year, immune history and differences in risk from seasonal influenza A/H1N1 and A/H3N2

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# Abstract

\cmt{KG: Rough outline. Would appreciate your input on the core message.}

\begin{itemize}

\item Two subtypes of influenza A virus currently circulate in humans.

\item Subtype H1N1 has disproportionate impacts in children and young people, whereas subtype H3N2 is more widely distributed across age groups.

\item Subtype H3N2 causes the majority of cases in persons over age 65, and the majority of influenza related deaths.

\item Differences in the age distribution and mortality impact of H1N1 and H3N2 may be linked to childhood imprinting, as older cohorts would have been exposed to H1N1 viruses in childhood, whereas younger cohorts are more likely to have had childhood exposures to H3N2. But few existing studies have analyzed differences in subtype-specific age distribution with respect to single year of age, and to date, no study has analyzed the association between single year of birth (a proxy for childhood imprinting history), and subtype-specific risk.

\item Here, we analyzed seasonal surveillance data collected between ### and ### across ## countries.

\item The data confirmed previous observations that H1N1 primarily impacts younger people, while H3N2 disproportionately impacts older people.

\item We fitted several competing models to the data, and model comparison supported the hypothesis that childhood imprinting to a particular HA or NA subtype shapes birth year-specific risk from H1N1 and H3N2. Model comparison showed little support for heterosubtypic protection at the HA group level.

\end{itemize}

# Introduction

Childhood exposures to influenza leave an immunological imprint, which has reverberating, lifelong impacts on the quality and specificity of immune responses against influenza viruses encountered later in life. Foundational work on this phenomenon, also known as original antigenic sin [CITE] and antigenic seniority [CITE], showed that individuals of all ages maintain the highest serological titers against influenza strains encountered in childhood and not necessarily against contemporary strains of the same subtype. [STATEMENT ABOUT SIN]

In contrast to potential negative impacts from antigenic sin, a recent wave of studies has highlighted the potential for childhood imprinting to provide lifelong immunological benefits. For decades, most emerging influenza viruses were considered too antigenically novel to face any pre-existing immunity as they emerged into humans. But we now know childhood immune imprinting can provide broad, heterologous (cross-subtype) protection against novel, emerging avian [CITE] or pandemic [CITE] strains.

This new wave of studies has also highlighted imprinting’s ability to shape multiple layers of influenza immune memory, both broad and narrow. Influenza’s immunodominant epitopes, the primary targets of most antibody responses, show considerable structural diversity and drift antigenically over time. As a result, most seasonal influenza immunity provides only narrow, ephemeral protection. Until recently, broader, cross-subtype (heterologous) responses were considered rare or anomalous, and so research on immune imprinting focused exclusively on narrow, within-subtype (homologous) responses [CITE].

More recently, the 2009 H1N1 pandemic, and subsequent efforts to develop a universal influenza vaccine drew attention to antibody responses that provide broader, heterologous protection [XITE CITE CITE]. Broadly protective antibodies that target conserved epitopes on the HA stalk have been particularly well studied. These stalk-specific antibodies typically provide cross protection at the HA group-level, i.e. across all subtypes in phylogenetic group 1, or group 2 of the HA tree. Recently, we showed that childhood imprinting strongly shapes the population-level impacts of these broadly protective responses. Cohorts who imprinted in childhood to a group 1 seasonal strain now show strong, lifelong protection against novel, avian influenza viruses from the same HA group. Likewise, group 2-imprinted cohorts show preferential, lifelong protection against emerging group 2 viruses.

Similar imprinting effects may also shape how protection against specific seasonal influenza subtypes is distributed across birth cohorts. Since 1977, two distinct subtypes of influenza A, H1N1 and H3N2, have circulated seasonally in humans, and these subtypes show consistent differences in age distribution. H3N2 causes the vast majority of cases in older adults, while H1N1 causes a greater proportion of cases in younger cohorts [CITE CITE CITE]. These differences in age distribution are qualitatively consistent with childhood imprinting patterns, in that older cohorts were almost certainly exposed to historical variants of H1N1 in childhood, and may now be preferentially protected against modern, seasonal H1N1 by virtue of their childhood imprinting [CITE CITE CITE]. Likewise, younger cohorts have the highest probabilities of childhood imprinting to H3N2, which is consistent with greater incidence of the opposite seasonal subtype, H1N1.

However, it remains unclear whether these ostensible cohort effects arise due to immune memory imprinted at the narrow, within-subtype level, or at the broader group level. The well-established impacts of narrow, within-subtype seasonal influenza immunity intuitively suggest that narrow, subtype-level imprinting may also drive seasonal influenza cohort effects. If HA subtype-level imprinting is the key driver, then childhood imprinting to H1, or to H3 might provide preferential lifelong protection against seasonal variants of the same HA subtype. Similarly, childhood imprinting might act strongly at the NA subtype level, providing lifelong protection specific to N1 or to N2 (Fig. ##).

Alternatively, broad, HA group-level imprinting might drive seasonal influenza cohort effects. Although the antibodies involved in group-level protection usually play a minimal role in immunity against familiar, seasonal influenza viruses [CITE], these antibodies can rise in frequency and play a strong role in immunity if the host lacks immune memory of variable immunodominant epitopes [CITE]. Thus, in theory, HA group-level immune memory may serve as a second line of defense against drifted seasonal strains, called in as backup to target conserved epitopes when narrow, first-line antibodies are unable to recognize their drifted, variable targets. If HA group-level imprinting strongly shapes seasonal influenza cohort effects, then cohorts imprinted to H1 or H2 (both group 1) should be protected against modern, seasonal H1N1, while only cohorts imprinted to H3 (group 2) would be protected against modern, seasonal H3N2 (Fig. ##).

In addition to cohort effects from childhood imprinting, differences in H1N1 and H3N2’s rates of antigenic drift may also contribute to differences in subtype-specific age distribution. Subtype H1N1 drifts more slowly than H3N2, and as a result, H3N2 may be more able to cause infections in older, immunologically experienced cohorts, whereas H1N1 may be relatively restricted to incidence in immunologically naïve children [CITE].

Using two large data sets on seasonal influenza incidence, which together represent ## cases observed across ## years of circulation in ## countries, we tested whether observed differences in age distribution of H1N1 and H3N2 cases are primarily driven by cohort effects from childhood imprinting, or by other factors. We compared age distributions of infection caused by H1N1 and H3N2, and confirmed that subtype-specific differences in risk are consistent across time, and space. To test whether HA group-level imprinting, HA subtype-level imprinting, NA subtype-level imprinting or no effect of imprinting was most consistent with observed patterns, we developed a suite of models, fitted models to data using maximum likelihood, and performed model selection using AIC. Additionally, to test whether differences in H1N1 and H3N2’s rates of antigenic advance could be a dominant driver of observed subtype-specific differences in age distribution, we analyzed the relationships between the magnitude of antigenic advance, and the shape of age-specific risk in specific influenza seasons.

# Results

## Expected impacts from imprinting

### Reconstructed imprinting patterns

We reconstructed birth year-specific childhood imprinting patterns, as described previously \cite{Gostic2016b}. **Figure 1A** shows one representative reconstruction for Peru during the 2016 Southern Hemisphere (SH) influenza season. Reconstructions for other countries differ only in the underlying data used to inform the fraction of cases caused by H1N1 or H3N2 in recent decades.

Imprinting patterns mirror the timeline of influenza circulation in humans, in which pandemic years mark the transitions between eras of subtype-specific circulation. Older cohorts born between pandemics in 1918 and 1957 all imprinted to H1N1 as children. Middle-aged cohorts born between pandemics in 1957 and 1968 imprinted to H2N2. Ever since its emergence in 1968, H3N2 has dominated seasonal circulation in humans, and caused the majority of imprinting in younger cohorts. However, H1N1 has also caused some seasonal circulation since 1977, and thus a fraction of post-1977 cohorts are imprinted to H1N1 (**Fig.1A**).

### Expected age distributions under alternate imprinting models

We considered three models for the breadth of imprinting: HA group-level protection, HA subtype-level protection and NA subtype-level protection. All tested models assumed imprinting to past variants of H1N1 would provide lifelong protection against modern, seasonal H1N1. Similarly, all models assumed imprinting to past variants of H3N2 would provide lifelong protection against modern, seasonal H3N2. Only the imprinting protection status of H2N2-imprinted cohorts differed between models (Fig. 1B). The HA group-level imprinting model assumed, H2N2 imprinted cohorts would be protected against modern H1N1 viruses, as H2 an H1 are in the same HA group. The HA subtype-level model assumed H2N2 imprinted cohorts would not be protected against either modern, seasonal subtype. Finally, the NA group-level model assumed H2N2 imprinted cohorts would be protected against modern H3N2, due to the shared N2 subtype (Fig. ##B).

The intrinsic correlation between age and birth year is a key challenge for any analysis of imprinting effects on seasonal influenza epidemiology. To tease apart age-specific risk factors from birth year-specific imprinting effects, we noted that age-specific risk factors are largely subtype-independent. Specifically, age-specific risk, or probabilities of case ascertainment could be influenced by medical factors like age-specific vaccine coverage, age-specific risk of severe disease, and immunosenescence, or by behavioral factors like age-assorted social mixing, and age-specific healthcare seeking behavior. But all these factors should have similar impacts on any influenza subtype.

Thus, we fit a single step function to characterize the shape of age-specific risk of any confirmed influenza infection. Then, we modeled residual, subtype-specific differences in risk between H1N1 and H3N2 as a function of birth year (i.e. as a function of imprinting status). Finally, each model generated an expected age distribution of H1N1 or H3N2 incidence (Fig. ##G-I) using a linear combination of age-specific risk (Fig. ##C) and birth year-specific risk, given one of three tested imprinting hypotheses (Fig. ##D-F).

All models predicted greater impacts from H3N2 in older cohorts, and greater impacts from H1N1 in younger cohorts. Collinearities between the predictions of different imprinting models (Fig. 1G-I) were inevitable, given the limited diversity of influenza circulation in humans over the past century. However, differences in the shape of predicted risk in middle-aged, H2N2 imprinted cohorts provided leverage to differentiate between imprinting at the HA subtype, HA group or NA subtype level.



**Figure 1. Expected age distributions of infection, given each tested imprinting effect. (A)** Reconstructed, birth year-specific probabilities of imprinting. **(B**) Expected imprinting protection against H1N1 or H3N2 under the three tested models. (**C**) Cartoon of age-specific risk curve. The shape of this curve is purely hypothetical, but each tested model fitted a similar step function to data. (**D**-**F)** Effects of imprinting under each of three tested models. Plots show H1N1 and H3N2 risk, based on the estimated fraction of each cohort unprotected by their childhood imprinting (see panel A). (**G-I)** A linear combination of age-specific risk (column 1), and birth year-specific risk given imprinting (column 2) gave the expected age distribution of H1N1 or H3N2 cases under each imprinting model. Note: In all panels except B and C, reconstructed imprinting probabilities are specific to Peru, 2016, but provide a representative example of reconstructions from other countries and years.

## Data

We analyzed two, large epidemiological data sets. First, the Arizona State Department of Health Services (AZDHS) provided a data set of 18,812 influenza cases, each confirmed to subtype via PCR, or a combination of ##, as defined by AZDHS protocols [CITE]. Cases were observed from the 1993-1994 to the 2014-2015 northern hemisphere influenza seasons. Confirmed influenza cases were reported to a statewide surveillance database by the Arizona State Public Health Laboratory, and by participating commercial labs. Data from Arizona included only patient birth year, subtype and season in which each confirmed influenza case was observed. Denominator data on the age distribution of all tested cases were not available.

The second data set was provided by the INSIGHT outpatient study, and included 11,575 tested cases (1,998 PCR positive for H1N1 and 2,080 PCR positive for H3N2). Adult patients (18+) were enrolled after reporting to a participating medical provider with influenza like illness (ILI). Patients were enrolled from 17 countries, between the 2009-2010 Northern Hemisphere (NH) influenza season, and the 2016-2017 NH season. INSIGHT data included some details that were not available in the Arizona surveillance data set, including relevant medical history, (influenza vaccination in the previous year, antiviral treatment used, underlying conditions present), and denominator data on the age distribution of cases that tested negative for influenza. These data enabled us to include additional risk factors in our analyses of INSIGHT data, that could not be tested in the Arizona data set.

## Expected impacts from differences in rate of antigenic advance

## Observed age distributions of infection

We compared age distributions of confirmed H1N1 and H3N2 cases from within each data set overall, and for individual countries and seasons in which H1N1 and H3N2 cocirculated (≥50 confirmed cases of each subtype) (**Fig. 2-3**). INSIGHT data only included adults ages 18+, whereas AZDHS data included cases of all ages. To facilitate comparison between data sets, we excluded children under age 18 from **Fig. 2**. Supplementary Figures S1-S7 show plots specific to countries or seasons in which few cases were observed, in which only one subtype circulated, plots that include data from children age 0-17, and plots showing alternate smoothing parameters.

Age distributions of infection in both AZDHS and INSIGHT data were qualitatively consistent with the expected population-level impacts of imprinting, in that H3N2 consistently caused most cases observed in older cohorts, while H1N1 caused more cases in younger cohorts (Fig. 2). However, signals of subtype-specific differences in age distribution were weaker in the INSIGHT data than in the Arizona data, and also showed greater fluctuations across seasons and countries. Despite differences in the strength and consistency of the signal in each data set, observed patterns never contradicted the expected effects of imprinting. Whenever subtype-specific differences in age distribution were observed, older cohorts always showed greater H3N2 incidence, while younger cohorts always showed greater H1N1 incidence.



**Figure 2. Observed age distributions, Arizona, 1993-2015**. Points show fraction of confirmed H1N1 or H3N2 cases observed in each single year of age (18-90). Lines show a smoothing spline fit to observed distributions. **(A)** All confirmed cases. (**B-G**) Season-specific age distributions.

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**Figure 3. Observed age distributions, INSIGHT outpatient data, 2009-2017**. Panels follow the same format as in Fig. 1. **(A)** All confirmed cases. (**B-F**) Season-specific age distributions. (**G-L**) Country-specific age distributions.

## Model Selection

To assess statistical support for seasonal influenza cohort effects driven by the three tested levels of childhood imprinting, we fitted a suite of models to each data set using maximum likelihood, and then performed model selection using AIC. Technical details and a link to all relevant code are provided in the Methods.

### Models fit to AZDHS Data

We fitted a set of four models to the AZDHS data set. The simplest model contained only age-specific risk (A), and more complex models added effects from imprinting at the HA subtype level (AS), at the HA group level (AG), or at the NA subtype level (AN). The age-specific risk curve took the form of a step function, in which relative risk was fixed to 1 in age bin 0-4, and one free parameter was fit to relative risk in each of the following 12 age bins: {5-10, 11-17, 18-24, 25-31, 32-38, 39-45, 46-52, 53-59, 60-66, 67-73, 74-80, 81. Within models that contained imprinting effects, additional free parameters estimated the relative risk of confirmed H1N1 or H3N2 infection given imprinting protection.

Fitted age-specific risk curves took similar forms in all models, with the risk of severe infection highest in young children, and then decreasing over time. Parameter estimates consistently indicated that childhood imprinting protection against H1N1 was stronger than protection against H3N2. Figure 4 shows parameter estimates, and fitted age-specific or birth year-specific risk patterns from the best model, which included imprinting at the NA subtype level. Table S3 lists parameter estimates from all models fitted to Arizona Data.

The best model included imprinting protection at the NA subtype level. The second best model included imprinting protection at the HA subtype-level (ΔAIC=21.65). Model comparison showed effectively no statistical support for model that included imprinting protection at the broad, HA group-level, or the model containing no effect of imprinting (ΔAIC>400, Fig. 4).

Visual assessment of model fits (Fig. 4##-##) confirmed that models containing imprinting effects at the narrow, NA or HA subtype levels provided the best fits to data. Predictions from the two best models were highly collinear, except their predictions among H2N2-imprinted cohorts (birth years 1957-1968). The model containing broad, HA group-level performed badly among H2N2 imprinted cohorts, predicting too few H1N1 cases and too many H3N2 cases. The model containing no imprinting effects did not allow H1N1 and H3N2 age distributions to take different shapes, and so this model dramatically overestimated the number of H1N1 cases in older cohorts, and the number of H3N2 cases in younger cohorts.

### Models fit to INSIGHT data

When fitting to the INSIGHT data, which contained additional medical details, the suite of tested models included three additional risk factors: vaccination (V), antiviral treatment (T), and presence of underlying conditions (U). Factors T and U each added one free parameter, which respectively characterized the relative risk of any influenza infection, given antiviral treatment or given the presence of underlying conditions. We assumed vaccination might have slightly different effects on H1N1 risk and H3N2 risk, so factor V added two free parameters which characterized the relative risk of H1N1 or of H3N2 infection, given vaccination against influenza. We tested all possible combinations of V, T, and U, in addition to age-specific risk (A) and each of the three imprinting hypotheses (S, N and G), for a total of ## tested models.

Additionally, the INSIGHT study collected denominator data on the age distribution of cases that tested negative for influenza. Thus, in all models fitted to INSIGHT data, we input the age distribution of all tested cases from each country and influenza season as the null, expected age distribution. Because these denominator data were not available in the AZDHS dataset, the age-specific risk curves fit to the INSIGHT and AZDHS data have different interpretations. The age-specific risk curve fitted to AZDHS data represented all facets of the infection and case observation process, including the age-specific risk of developing influenza-like illness and seeking medical treatment, and the age-specific rate of testing positive for influenza. On the other hand, INSIGHT denominator data allowed us to characterize empirically the age-specific risk of developing influenza and seeking treatment. As a result, the fitted age-specific risk curve only represents residual, age-specific differences in the rate of testing positive for influenza, and the age-specific risk curve fitted to INSIGHT data shows much less variation between age groups than the curve fitted to AZDHS data (compare Fig. 4A to Fig. 5A).

Confidence intervals around the age-specific risk parameters fit to INSIGHT data always overlapped 1, which indicates no significant age-specific differences in the fraction of positive influenza tests (Fig. ##, Table ##). The estimated relative risk of confirmed influenza given antiviral treatment was greater than 1 in all fitted models, which most likely reflects the fact that antivirals are often prescribed in reaction to a confirmed infection. The relative risk associated with vaccination consistently took values less than one, indicating some level of vaccine-induced protection, although confidence intervals around these parameter estimates often overlapped the null value of one, indicating that estimated reductions in risk from vaccination were not always significant. Parameter estimates from the best model suggested that vaccination provided slightly stronger protection against H1N1 than against H3N2. The relative risk of confirmed influenza given underlying conditions was never significantly different from the null value of one. Overall, risk parameters fitted to the INSIGHT data took values closer to 1 and had wider confidence intervals than risk parameters fitted to the Arizona data, which is consistent with the fact that the INSIGHT data contained fewer confirmed cases and showed smaller differences in age distribution between subtypes than the AZDHS data.

In general, model selection on INSIGHT data did not strongly support any single best model. ## of the top models received almost equivalent statistical support, with ΔAIC<2 (Table 2). Most of the best models contained effects of antiviral treatment (T), vaccination (V), and imprinting at the NA subtype-level (N), or HA subtype-level (S). No model with ΔAIC<4 contained HA imprinting at the broad, HA group level.

Akaike weights can be interpreted as the proportional support for a given model, out of all models tested. The total Akaike weight for models including imprinting at the NA subtype level was 0.44, for models including imprinting at the HA subtype-level was 0.36, for models including imprinting at the broad, HA group level was ##, and for models containing no imprinting was ##. Although no single model fit to INSIGHT data was definitively preferred in terms of AIC, results aligned qualitatively with the results of model selection on AZDHS data, in that models containing NA subtype-level imprinting or HA subtype-level imprinting received the most support, whereas models containing broad, HA group-level imprinting or no imprinting at all were less preferred.

\section\*{Discussion}

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%% DRAFT SUMMARY

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We analyzed two large, epidemiological data sets on influenza A to assess whether suspected impacts from childhood imprinting consistently shape birth year specific risk from H1N1 and H3N2 influenza. First, we reconstructed birth year-specific imprinting histories for all birth years from 1918 to the present, and then developed three antigen-specific hypotheses to describe expected patterns if childhood imprinting to conserved HA epitopes, variable HA epitopes, or to NA was the dominant driver of birth year-specific risk (Fig. \ref{fig1}). Then, we compared differences in the age distribution of risk from H1N1 and H3N2 across influenza seasons from 2007 to 2016, and found that H3N2 consistently caused more cases than H1N1 in older cohorts, while H1N1 consistently had the highest impacts in younger cohorts. In general, these differences between subtype-specific age distributions were qualitatively consistent with population-level imprinting protection (Fig. \ref{fig1}), although the magnitude and shape of differences between H1N1 and H3N2 distributions varied somewhat across time and space (\ref{fig2}-\ref{fig3}). Finally, we fit a suite of models to data using maximum likelihood, and performed model comparison to test which candidate imprinting hypothesis, if any, was most consistent with observed differences in risk from H1N1 or H3N2. Model comparison on both INSIGHT and Arizona data sets showed the greatest support for imprinting effects at the HA subtype level, or NA imprinting.

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%% Differences between AZ, INSIGHT

%% \* age-specific sampling

%% \* recommendations

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Overall, subtype-specific differences in age distribution were much less pronounced in the INSIGHT data than in the Arizona data. Given that differences in vaccination rate [CITE], population density [CITE], latitude [Cite], and connectivity [CITE] are known to modulate the intensity and seasonality of influenza A, observed differences between INSIGHT study data and Arizona data may reflect true differences in the distribution of subtype-specific impacts between Arizona, and the various countries in which INSIGHT data was collected. However, study-specific differences may also be due, at least partially, to study-specific or geographical differences in case ascertainment. The INSIGHT study did not enroll children, and enrolled adult populations contained relatively few subjects under the age of 25, or over the age of 70 (Fig. S\ref{figS8}). The relative dearth of cases at the extremes of age in the INSIGHT study may have dampened the signal of subtype-specific differences in risk; patterns of imprinting protection are much more distinct among the youngest and oldest cohorts (Fig. \ref{fig1}A,D-F), which were poorly sampled in the INSIGHT study, than among well-sampled middle aged adults. The age distribution of tested cases was not known in the Arizona data, but given the large numbers of confirmed cases in children, teens and the elderly (Fig \ref{figS8}), it is obvious that the extremes of age were comparatively well-sampled.

cmt{I'm considering adding a supplementary figure here, where we down-sample the Arizona data using sampled age distributions from the INSIGHT study. I'm curious to see whether a subset of cases from Arizona that largely excludes children and older adults erodes the signal of subtype-specific differences in age distribution. But I also already have tons of supplementary figures. Is this worth pursuing or should I leave it?}

%% Ideal data

The potential for age-specific sampling biases to erode or magnify the signal of imprinting effects in a given data set highlights some limitations of existing epidemiological data for analysis of birth year-specific imprinting patterns. The ideal comparison of H1N1 and H3N2's age distributions across multiple countries and multiple influenza seasons would be informed by an extremely large data set, in which all ages were sampled evenly, or proportionally to their demographic representation. Furthermore, a sufficient number of cases would be observed in each sampled season and location to precisely characterize a distribution across 90-100 single years of age, or birth years. Ideally, several hundred or more cases of each subtype would be observed in each sampled country and season, and data would be available continuously for several decades of influenza circulation. Long-term data collection is necessary to track subtype-specific circulation over time, as H1N1 and H3N2 do not circulate strongly each and every year. Long-term data collection also provides the ability to track individual birth years over time, thus eroding the correlation between birth year and age. In reality, sampling for influenza is usually somewhat opportunistic, uneven across age groups, and the total size or surveillance data sets changes over time. Although large surveillance data sets often span several decades, the total number of recorded cases has increased dramatically over the past decade, and sample sizes from the 2009 pandemic are often prohibitively small. Pandemic years or seasons in which influenza circulation has a particularly high burden tend to be relatively heavily sampled.

%% Recommended changes to data sharing

The INSIGHT data set analyzed here is remarkable in its size, geographic coverage, and in its inclusion of medical history and denominator data. However, as a focused clinical study, even the INSIGHT data set is smaller than ideal for population-level immuno-epidemiological inference. Seasonal surveillance data are of a more appropriate scale, and already collected regularly by most state or national public health agencies, but existing reporting and data sharing practices limit the utility of seasonal surveillance data for immuno-epidemiological inference. One major challenge is that when influenza surveillance data are shared publicly, age is often reported in 5-year bins, or broad categories, whereas single year of age, or birth year, is necessary to study cohort effects. Furthermore, the absence of denominator data on the age distribution of all tested subjects in many surveillance data sets poses a serious challenge for statistical inference. The expense and difficulty of maintaining large, public databases should not be taken for granted, and those responsible for collecting and curating high-quality data deserve more professional credit for their work. But if influenza surveillance data were more systematically shared with single year of age, and age-specific denominators, it could represent a turning point in the ability to leverage, massive, existing, seasonal surveillance data sets for basic science research linking influenza's immunology and virology with its epidemiology. As we enter the era of big data, a widespread data sharing initiative for influenza surveillance data would also lay the groundwork for a decades-long repository, in which specific birth cohorts could be tracked over time as they grew older, and in which the epidemiological impacts of relatively rare events (e.g. antigenic cluster transitions) could be systematically studied.

cmt{I PROBABLY NEED TO TONE THIS DOWN, BUT WANTED TO SEE WHAT YOU GUYS THINK.}

%% Interpretation of INSIGHT fits

cmt{I NEED TO WORK ON TRANSITION}

Comparison of models fit to INSIGHT data showed nearly equal statistical support for five tested models that all had $\Delta AIC < 4$. The spread of $\Delta AIC$ values among all tested models was also much narrower among models fit to INSIGHT data than among models fit to Arizona data. This is unsurprising given that the signal of imprinting effects was weaker overall in the INSIGHT data than in the Arizona data (Fig. \ref{fig2}-\ref{fig3}). The simplest model fit to INSIGHT data (A), whose fit was based solely on the observed age distribution of all tested cases, and on the fitted age-specific risk curve, provided a fairly good fit to observed data, and additional effects from patient medical history or imprinting improved on this simplest fit only marginally (Fig. \ref{fig5} G-H). Because the fitted data set was large (4,078 confirmed influenza A cases), these small improvements in fit translated to statistically meaningful differences in model likelihood, and in AIC.

%% Interpretation of AZ fits

Among models fit to the Arizona data, the spread of $\Delta AIC$ values was much wider, and visually, competing models showed much more dramatic differences in goodness of fit (Fig. \ref{fig4}). The best model fit to Arizona data, AN, would normally be interpreted as having definitive statistical support. Based on widely used rules of thumb for the interpretation of $\Delta AIC$ values, the second best model (AS, $\Delta AIC=21.65$), would normally be ruled out as inferior, and we should conclude that childhood imprinting to NA is a much better predictor of subtype-specific seasonal influenza risk than HA subtype-level imprinting. However, the only qualitative difference between the predictions of model AN (best) and model AS (second best), is the protection status of H2N2 imprinted cohorts against seasonal H3N2 (fits in Fig. \ref{fig4} E-F, consistent with differences between hypotheses in Fig. \ref{fig1} B). Visually, neither model AN nor AS is a precise fit to the observed data in the H2N2-imprinted region where their predictions differ (Fig. \ref{fig4} E-F), and so we hesitate to assert that NA-specific childhood imprinting is a much better predictor of seasonal influenza risk than HA subtype-specific imprinting. Rather, fits to the AZ data set show that models including either NA-level or HA subtype-level childhood imprinting provide better fits to data than models assuming HA group-level imprinting (AG), or no imprinting effects. However, none of the tested models provided a perfect fit to the Arizona data in all birth cohorts, indicating that models considering only the impacts of childhood imprinting to one antigen, HA or NA, are probably insufficient to precisely capture observed epidemiological patterns. Some combination of effects from HA imprinting, NA imprinting, and from imprinting to internal proteins most likely drives birth year-specific risk.

%% Complexity/colinnearity issues

We considered testing more complex models that would have incorporated a mixture of imprinting effects, but ultimately decided that, given extensive collinearities between the predictions of even the simple models tested here, the data were unlikely to support a more complex analysis. Deeper insights into the relative contributions of HA and NA to seasonal imprinting patterns are needed, but given the limited diversity of influenza circulation in humans over the past century, epidemilogical data can support a limited scope of inference. Deeper insights will most likely need to come from immunological data. The recent NIH initiative to fund large cohort studies [CITE], and technological advances in the sequencing of B and T cell repertoires [CITE].

%% HA and NA subtype-level protection is best

Model comparison on both data sets independently provided the strongest support for effects from childhood imprinting to NA, or subtype-level protection from imprinting to HA. These results are consistent with decades of research on seasonal influenza immunity, in which titers against HA and NA have always been considered the strongest correlates of protection, and in which narrow, homosubtypic immunity has been considered the norm against seasonal influenza.

%% Potential immunological explanation

Still, it is somewhat surprising given the known influence of antigenic drift, that signatures of homosubtypic imprinting protection persist across an entire human lifetime. On average, antigenic clusters persist for only 3.3 years [SMITH 2004]. Circulating H1N1 and H3N2 viruses drift by 0.62 and 1.01 antigenic units per year, respectively [cite Bedford eLife paper], which roughly correponds to a two-fold drop in titer for every 1.61, or 0.99 years of antigenic evolution between viruses. Cross-protective titers between viruses sampled 15 or more years apart are consistently too low to measure [Bedford, elife], indicating that cross-protection should be weak or absent. Thus, it is somewhat puzzling that influenza immunity primed in childhood provides any meaningful protection after adolescence, let alone throughout adulthood and into old age.

One possible explanation for the evident longevity of protection from childhood imprinting is that imprinting to a particular HA or NA subtype builds strong memory to epitopes that are relatively conserved at the subtype level, and drift more slowly than the epitopes that react in hemagglutination inhibition assays.

Another possible explanation is that the exact B cell clones developed during the first childhood influenza exposure are not necessarily identical to the clones deployed against strains encountered later in life. Memory B cells maintain some phenotypic plasticity, and through somatic hypermutation, have some capacity to tailor their binding affinity to match newly encountered antigens. Thus, childhood imprinting may provide preferential, lifelong protection against a particular HA or NA subtype by filling a child's B cell repertoire with clones that will serve in the future, not as final products, but as raw prototypes that can be rapidly and effectively tailored to recognize drifted influenza strains of the same subtype, but less effectively tailored to recognize more distantly related, heterosubtypic strains. A third possibility is that childhood imprinting depends strongly on a combination of B and T cell memory. The protective effects of T cells is not measured in the HI or neutralization assays used to build antigenic maps and characterize antigenic drift, and so these studies may systematically underestimate the functional strength of cross-immunity between drifted strains of the same subtype.

%% Group-level

Neither the INSIGHT nor the Arizona data set supported a strong role of HA group-level imprinting. Previously, we showed that childhood imprinting at the HA group level (presumably driven by memory of conserved HA epitopes) is a surprisingly strong predictor of birth year-specific risk from two emerging, avian influenza A subtypes, H5N1 and H7N9. Conserved HA epitopes are known to play a particularly strong role in the immune responses against novel influenza subtypes like avian H5 and H7 [CITE]. On the other hand, more variable HA epitopes are known to be immunodominant upon exposure to a more familiar, seasonal HA subtype [CITE]. Thus, it is not surprising that HA group-level imprinting appears to play a strong role against novel, emerging influenza viruses, whereas subtype-level imprinting plays a dominant role against established, seasonal variants.

%% Epidemiological interpretation

The vast majority of influenza-related deaths occur in adults over age ##, and H3N2 causes an estimated ## times as many deaths in these cohorts than H1N1. This study suggests that the low number of H1N1-related deaths in elderly cohorts is at least partially explained by the fact that childhood imprinting appears to reduce the incidence of clinically attended H1N1 disease in high-risk elderly age groups. H2N2 imprinted cohorts (born c. 1950-1968) will eventually replace the H1N1-imprinted cohorts currently at the highest risk of influenza-related mortality. Results from this study suggest that in the future, elderly H2N2 imprinted cohorts will not be preferentially protected against H1N1 from their childhood imprinting, and so epidemiologists may expect the mortality burden of H1N1 to increase in the future. H2N2-imprinted cohorts may instead enjoy some protection against H3N2 given childhood imprinting to the same NA subtype, or based on HA subtype-level imprinting, may not be protected against either circulating seasonal subtype. In the latter case, the overall mortality impact of influenza A may increase in the future.

NEED SOME SORT OF PUNCHY CONCLUSION...TO WRITE AFTER WE DISCUSS AND SETTLE ON A CORE MESSAGE.

\section\*{Materials and Methods}

\subsection\*{Data and exclusion criteria}

\subsubsection\*{Arizona Data}

The Arizona data set contained the variables birth year, subtype and season for 18,813 cases confirmed in the state of Arizona. AZDHS staff removed identifying details from the data, and only variables of interest to our study were shared. Birth year was extracted from each patient's reported date of birth, except in the 1993-1994, and 1994-1995 seasons, where birth year was approximated as (year of observation)-(age at time of observation). Birth year was necessary to estimate probabilities of imprinting protection for each patient. We calculated patient age as (year observed - birth year), where year observed was set to the second year of the influenza season associated with any case (e.g. 2014 for a case observed in the 2013-2014 season). We excluded one case whose birth year was not available, and ultimately analyzed 18,812 cases.

AZDHS staff classified cases into seasons using the standard definition, with the Northern Hemisphere (NH) season beginning in week 40, and ending in week 39 of the following calendar year (roughly Oct-Sept). Note that in the Arizona data, most H1N1 cases from the 2009 H1N1 pandemic were confirmed and reported during the 2009-2010 season, although some cases from early pandemic waves were reported during the 2008-2009 season. The relatively low number of pandemic H1N1 cases reported during the 2008-2009 season was due to lower case incidence early in the pandemic, and to limited testing capacity during the first pandemic wave. %% See pdf in raw\_data folder

\subsubsection\*{INSIGHT Data}

The INSIGHT outpatient data contained 11,679 total cases, and the variables: age, date of enrollment, antiviral treatment used (Y/N), presence of any underlying conditions (Y/N), influenza subtype (H1N1, H3N2, B or negative), and country. The data also contained variables for influenza vaccination in the past 6 months, or influenza vaccination in the past 12 months. We combined these data into a single binary variable, which classified subjects as vaccinated if they reported recent influenza vaccination at either timescale.

We used patient age and date of study enrollment to impute year of birth. Birth year can be approximated as (observation year)-(age), but this approximation is slightly biased, and biased in different ways for cases observed during the NH and SH influenza seasons. Cases observed earlier in the year (e.g. in January) are more likely to have a birthday that has not yet passed in the current calendar year, whereas cases observed later in the year (e.g. in December) are most likely to have already had a birthday pass in the current calendar year. Thus, the time of year at which a case is observed impacts how birth year should be estimated. Using logic laid out in Fig \ref{figS9}, we used the following three formulas to obtain three possible birth years for cases observed in the NH influenza season: (current year)-(age)-1, (current year)-(age)-, and (current year)-(age)-+1. We then took a weighted average of the three relevant, birth year-specific imprinting protection probabilities, using weights 0.0625, 0.875 and 0.0625, respectively. Meanwhile, for cases observed in a SH season, only two birth years were possible. Here, we used the formulas: (current year)-(age)-1, and (current year)-(age) to calculate both possible birth years, with each receiving a probabilistic weight of 0.5 (Fig \ref{figS9}). Table \ref{tabS1} shows

We excluded 7 subjects whose ages did not fall in the focal age range (18-90). We excluded 94 subjects for whom season, age, vaccination status, antiviral treatment use or presence of underlying conditions was unknown. We also excluded 3 cases of co-infection with multiple subtypes. After excluding 104 cases in total, we ultimately analyzed a data set of 11,575 tested cases, including 1,998 confirmed H1N1 cases and 2,080 confirmed H3N2 cases. Cases were confirmed in 16 countries (Argentina, Australia, Austria, Belgium, Chile, Denmark, Estonia, Germany, Greece, Japan, Peru, Poland, Spain, Thailand, UK, and USA), and our study analyzed cases observed during 16 influenza seasons, starting with the 2009-2010 Northern Hemisphere season (which included the second wave of the 2009 H1N1 pandemic), and ending with the 2016-2017 Northern Hemisphere season. To facilitate comparison between data sets, we defined INSIGHT cases enrolled in Oct-May as part of the Northern Hemisphere (NH) influenza season, and cases enrolled in June-Sept as part of the Southern Hemisphere (SH) season. October 1 roughly aligns with the week 40 NH season start date used in the Arizona data set. Table \ref{tabS2} shows confirmed case counts from each country and season.

\subsection\*{Splines}

In Figures \ref{fig2}-\ref{fig3}, smoothing splines were fit to aid visual interpretation of noisy data. We fit splines using the command \textit{smooth.spline(x = AGE, y = FRACTIONS, spar = 0.8)} in R version 3.5.0. Variables \textit{AGE}, and \textit{FRACTIONS} were vectors whose entries represented single years of age, and the fraction of cases observed in the corresponding age group. The smoothing parameter 0.8 was chosen to provide a visually smooth fit. Alternative smoothing parameter choices (0.6 & 1.0) are shown in Figs. \ref{figS3}, \ref{figS6} \& \ref{figS7}. Observed differences in H1N1 and H3N2 age distribution were insensitive to our choice of smoothing parameter; although the overall shape of fitted splines changed with different smoothing parameter choices, differences between the splines fit to H1N1 data and the splines fit to H3N2 data usually remained qualitatively consistent within a given season or country.

\subsection\*{Reconstruction of imprinting patterns}

Using methods described previously [CITE], we estimated the probability that an individual born in a given year would have first been exposed in childhood to an H1N1, H2N2 or H3N2 influenza A virus. For birth years of ages 0-12 in the year of case observation, reconstructions included the probability that an individual remained naive to influenza A, and had not yet imprinted. We repeated reconstructions for all birth years, and for all countries and years of case observation relevant to the data. Code to perform reconstructions is available at in the Supplementary Materials.

We calculated probabilities of birth year-specific protection for each of the three tested imprinting hypotheses using the rules defined in Table \ref{tab1}, where $p\_{HxNx}$ gives the estimated probability of imprinting to subtype \textit{HxNx} for a given birth year.

\begin{table}[!ht]

\begin{adjustwidth}{0in}{0in} % comment out/remove adjustwidth environment if table fits in text column.

\centering

\caption{{\bf Estimated probabilities of imprinting protection}, where $p\_{HxNy}$ gives the probability of having imprinted to subtype $HxNy$ in childhood.}

\begin{tabular}{l|l|l}

\hline

\textbf{Imprinting hypothesis} & \textbf{Challenge} & \textbf{p(protected)} \\

\hline

HA subtype-level protection & H1N1 & $p\_{H1N1}$ \\

& H3N2 & $p\_{H3N2}$ \\

\hline

NA subtype-level protection & H1N1 & $p\_{H1N1}$ \\

& H3N2 & $p\_{H3N2}+p\_{H2N2}$$ \\

\hline

HA group-level protection & H1N1 & $p\_{H1N1}+p\_{H2N2}$ \\

& H3N2 & $p\_{H3N2}$ \\

\end{tabular}

\label{tab1}

\end{adjustwidth}

\end{table}

\subsection\*{Model formulation}

Information on individual case medical histories was available in the INSIGHT data set, and so we were able to model age-specific impacts from vaccination prior to the influenza season of interest (V), of underlying symptoms (U) and of antiviral treatment (T) explicitly when fitting to these data. However, when fitting to the Arizona dataset, these patient details were not reported, and so tested models only included age-specific risk (A), and birth year-specific risk from imprinting, which could provide protection at the HA subtype (S), HA group (G), or NA subtype (N) level.

We assumed underlying symptoms (U) and antiviral treatment (T) would have similar impacts on H1N1 and H3N2’s age distributions and therefore fit a single curve to describe these impacts on both H1N1 and H3N2, however, we fit distinct impacts of vaccination (V), and of imprinting protection (I) for each subtype. Below, the abbreviation I will be used to represent any of the three possible imprinting hypotheses, G, S or N.

For each unique country and season in which cases were observed, define $p$ as a vector whose entries, $p\_a$ represent the expected case age distribution for a given subtype, i.e., the expected probability that a randomly drawn H1N1 or H3N2 case was observed in an individual of age a. Then, use a linear model to define $p$, as follows:

\begin{equation}

p = null\*A\*T\*U\*\mathbbm{1}\_{H1N1}(V\_{H1N1}\*I\_{H1N1})\*\mathbbm{1}\_{H3N2}(V\_{H3N2}\*I\_{H3N2})

\end{equation}

Note $\mathbbm{1}\_{H1N1}$ is an indicator function that takes value 1 if $p$ describes the expected age distribution of H1N1 cases, and 0 otherwise. %Thus, $\mathbbm{1}\_{H1N1}$ and $\mathbbm{1}\_{H3N2}$ ensure that subtype-specific risk factors are only included in relevant subtype-specific predictions, whereas subtype-independent factors are always included, regardless of the focal subtype.

\subsubsection\*{Null}

When fitting to INSIGHT data, the null expected age distribution was proportional to the total number of subjects enrolled in the study, regardless of their influenza test outcome. Crucially, this null prediction ensured that the predicted number of cases was only greater than 0 in countries, seasons and ages where one or more subjects was enrolled. This null distribution was particularly important when fitting to the INSIGHT data, where the number of confirmed cases was often low, and where the age distribution of cases in a given country and season was not always fully populated (Table \ref{tabS2}).

AZDHS only collects surveillance data on confirmed influenza cases, and not on the age distribution of ILI cases that tested negative for influenza. Thus, we were unable to include a null distribution in models fitted to data from Arizona. Crucially, this technical difference in model formulation leads to a different interpretation of free parameters fitted to the Arizona and INSIGHT data sets, as noted above.

%When fitting to Arizona data, where no denominator data was available, the fitted age-specific risk curve describes a combination of the age-specific probability of developing ILI and seeking medical treatment, and of testing positive (i.e. the age distribution of all positive tests). On the other hand, when fitting to the INSIGHT data, the null distribution controls for the age-specific probability of developing ILI and seeking medical treatment, while and all other factors describe only the relative risk that an administered test is positive (i.e. the age-specific test positive rate). The age-specific rate of positive tests (INSIGHT fits) is much less variable across age groups than the age distribution of all positive tests (AZ fits), which is why the age-specific risk curve fitted to the AZ data (Fig. \ref{fig4} A), shows a much wider range of relative risk estimates than the age-specific risk curve fitted to the INSIGHT data (Fig. \ref{fig5} A).

\subsubsection\*{Age-specific risk}

Define age-specific risk, ($A$), as a step function, with each step representing the expected fraction of cases of a given subtype observed in each of $Z$ age bins. Fit $Z-1$ free parameters, $r\_z$ to describe relative risk in each age bin, except one arbitrarily chosen reference bin, in which relative risk is fixed to 1. Below, $\mathbbm{1}\_z$ are indicator functions that take value 1 if a given vector entry belongs in age bin \textit{z}, and 0 otherwise. To obtain the predicted fraction of cases observed in each single year of age, we normalized risk distribution given by equation 2 so that predicted risk across all age groups summed to 1.

\begin{equation}

A = norm(\mathbbm{1}\_{1}+\mathbbm{1}\_{2}r\_2...\mathbbm{1}\_{z-1}r\_{z-1}+\mathbbm{1}\_{z}r\_z)

\end{equation}

\subsubsection\*{Antiviral treatment}

Within a given country and season, $f\_T$ is a vector whose entries describe the fraction of tested cases of a given age that received antiviral treatment. Free parameter $r\_T$ defines the relative risk of a positive test, given antiviral treatment. Then, define risk factor \textit{T} as:

\begin{equation}

T = f\_Tr\_T+(1-f\_T)

\end{equation}

\subsubsection\*{Underlying conditions}

The underlying conditions risk factor takes the same form as factor \textit{T}:

\begin{equation}

U = f\_Ur\_U+(1-f\_U)

\end{equation}

\subsubsection\*{Vaccination and Imprinting}

Factors describing risk from vaccination (\textit{V}) and imprinting (\textit{I}) took forms similar to risk factors \textit{T} and \textit{U} (equations 3 and 4), but with subtype-specific impacts. An indicator function defined whether a given prediction vector described risk of confirmed H1N1 or H3N2 infection:

\begin{equation}

V\_{HxNy} = \mathbbm{1}\_{HxNy}(f\_V\*r\_V+(1-f\_V))

\end{equation}

Below, $f\_I$ describes the probability that an individual of a given age, and observed during a particular influenza season, is protected from the subtype of interest by their childhood imprinting.

\begin{equation}

I\_{HxNy} = \mathbbm{1}\_{HxNy}(f\_I\*r\_I+(1-f\_I))

\end{equation}

\subsection\*{Model fitting and model comparison}

We simultaneously estimated all free parameter values using maximum likelihood estimation (MLE). We calculated likelihood profiles for each fitted free parameter, and defined profile confidence intervals based on the range of fixed parameter values for which the profile likelihood exceeded a minimum threshold. The threshold was defined using the method of likelihood ratios, in which Wilks's Theorem states that $-2\ln(\frac{L\_{profile}}{L\_{full}}) \sim \chi ^2$. Then, the threshold is given by the value of $L\_{profile}$ for which the left-hand side of the above inequality is equal to the 95th quartile of a $\chi ^2$ distribution with one degree of freedom. All models fit to a given data set were compared using AIC.

\subsection\*{Code and data availability}

Code to perform all analyses and construct all plots is available \#\#HERE\#\#. Data from AZ AVAILABILITY? Data from the INSIGHT study are available by application, pending approval from the study's scientific review committee (LINK). Because we are not free to share the INSIGHT data, the posted code contains an INSIGHT data file with scrambled column entries.

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%%%%%%%%%%%%%%%%%%%%%%%%%%%%%%

%% Supporting information

%%%%%%%%%%%%%%%%%%%%%%%%%%%%%%

\section\*{Supporting Information}

%These commands reset the figure counter and add "S" to the figure caption (e.g. "Figure S1"). This is in case you want to add actual figures and not just captions.

\setcounter{figure}{0}

\setcounter{table}{0}

\renewcommand{\thefigure}{S\arabic{figure}}

\renewcommand{\thetable}{S\arabic{table}}

\subsection\*{Figures}

%% -----------------------

%% Figure S1

\begin{figure}[ht]

\includegraphics[width=\textwidth]{age-dists-by-season-ARIZONA-ages0-90.pdf}

\caption{\color{Gray} \textbf{AZ age distributions, including children ages 0-17.} Alternate version of Fig. \ref{fig2} showing observed age distributions with children ages 0-17 included. Children ages 0-17 were not enrolled in the INSIGHT study, and so children ages 0-17 were excluded from main text Fig. \ref{fig2}, in order to facilitate comparison between the Arizona and INSIGHT data sets.}

\label{figS1} % \label works only AFTER \caption within figure environment

\end{figure}

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%% -----------------------

%% Figure S2

\begin{figure}[ht]

\includegraphics[width=\textwidth]{age-dists-ARIZONA-all-seasons.pdf}

\caption{\color{Gray} \textbf{AZ age distributions, all seasons.} Alternate versions of Fig. \ref{fig2} showing observed age distributions from all influenza seasons. Observed case fractions (points) were only plotted if 10 or more cases of a given subtype were confirmed, to avoid extreme stretching of the y axis. Smoothing splines were only plotted if 50 or more cases of a given subtype were observed, as fits to fewer data points would not have been meaningful.}

\label{figS2} % \label works only AFTER \caption within figure environment

\end{figure}

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%% Figure S3

\begin{figure}[ht]

\includegraphics[width=\textwidth]{age-dists-by-season-ARIZONA-hilowsmoothpar.pdf}

\caption{\color{Gray} \textbf{Alternate smoothing parameters, AZ age distributions.} Alternate versions of Fig. \ref{fig2} B-G, with smoothing parameters chosen to fit smoothing splines that are less (\textbf{A-F}), or more (\textbf{G-L}) smooth than the splines shown in the main text.}

\label{figS3} % \label works only AFTER \caption within figure environment

\end{figure}

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%% Figure S4

\begin{figure}[ht]

\includegraphics[width=\textwidth]{age-dists-INSIGHT-all-countries.pdf}

\caption{\color{Gray} \textbf{INSIGHT age distributions, all countries.} Observed age distributions from all countries in which one or more confirmed cases of either subtype was observed, (as opposed to Fig. \ref{fig3}, in which only countries reporting $>=$ 50 cases of both subtypes were shown). Smoothing splines were only plotted if 50 or more cases of a give subtype were observed, as fits to fewer data points would not have been meaningful.}

\label{figS4} % \label works only AFTER \caption within figure environment

\end{figure}

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%% Figure S5

\begin{figure}[ht]

\includegraphics[width=\textwidth]{age-dists-INSIGHT-all-seasons.pdf}

\caption{\color{Gray} \textbf{INSIGHT age distributions, all seasons.} Alternate versions of Fig. \ref{fig3} showing observed age distributions from all seasons in which one or more confirmed cases were observed. Smoothing splines were only plotted if 50 or more cases of a give subtype were observed.}

\label{figS5} % \label works only AFTER \caption within figure environment

\end{figure}

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%% Figure S6

\begin{figure}[ht]

\includegraphics[width=\textwidth]{age-dists-INSIGHT-hiSmoothPar.pdf}

\caption{\color{Gray} \textbf{INSIGHT age distributions, increased smoothness.} Alternate versions of Fig. \ref{fig3}, except with a higher smoothing parameter value (greater smoothness) used to fit smoothing splines.}

\label{figS6} % \label works only AFTER \caption within figure environment

\end{figure}

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%% Figure S7

\begin{figure}[ht]

\includegraphics[width=\textwidth]{age-dists-INSIGHT-lowSmoothPar.pdf}

\caption{\color{Gray} \textbf{INSIGHT age distributions, increased smoothness.} Alternate versions of Fig. \ref{fig3}, except with a lower smoothing parameter value (less smoothness) used to fit smoothing splines.}

\label{figS7} % \label works only AFTER \caption within figure environment

\end{figure}

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%% Figure S8

\begin{figure}[ht]

\includegraphics[width=\textwidth]{all-tested-cases.pdf}

\caption{\color{Gray} \textbf{Age distributions of all tested and confirmed cases.} \textbf{A}, Counts and \textbf{B}, frequencies from the Arizona and INSIGHT data. Note that data on the age distribution of all tested cases was not available in the Arizona data. The Arizona data contains comparatively more confirmed cases at the extremes of age.}

\label{figS8} % \label works only AFTER \caption within figure environment

\end{figure}

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%% Figure S9

\begin{figure}[ht]

\includegraphics[width=\textwidth]{FigS8-birth-yr-est-table.pdf}

\caption{\color{Gray} \textbf{Rationale for birth year estimation, INSIGHT data.} \textbf{A}, This worked example illustrates that the month of case observation determines potential birth dates, and cases observed earlier in the year have a higher probability of a birthday falling in the previous year. Because NH season cases are observed late in year y0, or early in year y1, an individual of age 0, observed during the NH 2000-2001 season would most likely have been born in 2000, with low probabilities of birth in 1999 or in 2001. However, an individual of age 0 observed in the SH season has an equal probability of birth in 2000 or 2001. \textbf{B}, the patterns shown in \textbf{A}, were generalized to develop a scheme to calculate the weighted average birth year for individuals of any age, whose cases were observed in a NH season spanning years y0-y1, or in a SH season during year y1.}

\label{figS9} % \label works only AFTER \caption within figure environment

\end{figure}

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# Tables

Table S1. Confirmed case counts from AZDHS data, by season.

|  |  |  |
| --- | --- | --- |
| **Season** | **H1N1** | **H3N2** |
| 1993-1994 | 101 | 0 |
| 1994-1995 | 38 | 12 |
| 2002-2003 | 8 | 71 |
| 2003-2004 | 71 | 0 |
| 2004-2005 | 131 | 0 |
| 2005-2006 | 321 | 1 |
| 2006-2007 | 28 | 212 |
| 2007-2008 | 244 | 196 |
| 2009 pandemic\* | 384 | 6261 |
| 2010-2011 | 1204 | 472 |
| 2011-2012 | 348 | 595 |
| 2012-2013 | 1578 | 80 |
| 2013-2014 | 151 | 1475 |
| 2014-2015 | 2109 | 5 |

\*The 2009 pandemic spanned the ’08-’09 and ’09-’10 seasons.

Table S2. Confirmed case counts from INSIGHT data.

Country & H1N1 & H3N2 & Country & H1N1 & H3N2 & Country & H1N1 & H3N2 & Country & H1N1 & H3N2 & Country & H1N1 & H3N2 \\

\hline

NH '09-'10 & & & NH '12-'13 & & & NH '15-'16 & & & SH '11 & & & SH '14 & & \\

\hline

Austria & 9 & 0 & Argentina & 1 & 0 & Belgium & 91 & 3 & Argentina & 6 & 238 & Argentina & 1 & 303 \\

Belgium & 15 & 0 & Belgium & 88 & 6 & Denmark & 7 & 2 & Australia & 2 & 3 & Australia & 0 & 1 \\

Denmark & 17 & 0 & Denmark & 0 & 5 & Estonia & 17 & 1 & Chile & 17 & 2 & Belgium & 0 & 1 \\

Estonia & 7 & 0 & Estonia & 8 & 7 & Germany & 7 & 0 & & & & Peru & 3 & 21 \\

Germany & 23 & 0 & Germany & 6 & 6 & Greece & 52 & 0 & & & & Poland & 2 & 0 \\

Greece & 91 & 0 & Peru & 0 & 21 & Peru & 6 & 1 & & & & Thailand & 30 & 23 \\

Poland & 16 & 0 & Poland & 3 & 1 & Poland & 34 & 0 & & & & & & \\

Spain & 14 & 0 & Spain & 2 & 1 & Spain & 10 & 2 & & & & & & \\

Thailand & 4 & 0 & Thailand & 1 & 1 & Thailand & 17 & 69 & & & & & & \\

USA & 121 & 0 & UK & 1 & 1 & UK & 6 & 1 & & & & & & \\

& & & USA & 5 & 56 & USA & 24 & 1 & & & & & & \\

\hline

NH '10-'11 & & & NH '13-'14 & & & NH '16-'17 & & & SH '12 & & & SH '15 & & \\

\hline

Australia & 1 & 0 & Belgium & 26 & 43 & Belgium & 0 & 7 & Argentina & 20 & 34 & Argentina & 23 & 267 \\

Belgium & 5 & 0 & Denmark & 9 & 1 & Denmark & 0 & 2 & Australia & 0 & 6 & Australia & 0 & 2 \\

Denmark & 5 & 0 & Estonia & 8 & 1 & Estonia & 0 & 4 & Peru & 3 & 7 & Peru & 0 & 21 \\

Estonia & 29 & 0 & Germany & 3 & 4 & Peru & 0 & 1 & Thailand & 1 & 0 & Thailand & 13 & 95 \\

Germany & 12 & 0 & Japan & 2 & 0 & Poland & 0 & 6 & USA & 0 & 2 & UK & 0 & 1 \\

Greece & 14 & 0 & Poland & 1 & 26 & Thailand & 13 & 32 & & & & & & \\

Poland & 10 & 0 & Spain & 10 & 2 & USA & 0 & 8 & & & & & & \\

Thailand & 11 & 10 & Thailand & 111 & 61 & & & & & & & & & \\

UK & 1 & 0 & USA & 48 & 2 & & & & & & & & & \\

USA & 5 & 3 & & & & & & & & & & & & \\

& & & & & & & & & & & & & & \\

& & & & & & & & & & & & & & \\

\hline

NH '11-'12 & & & NH '14-'15 & & & SH '10 & & & SH '13 & & & SH '16 & & \\

\hline

Belgium & 0 & 103 & Belgium & 22 & 116 & Australia & 21 & 1 & Argentina & 207 & 52 & Argentina & 400 & 0 \\

Denmark & 0 & 2 & Denmark & 6 & 11 & Thailand & 101 & 26 & Australia & 2 & 0 & Australia & 1 & 3 \\

Estonia & 0 & 6 & Estonia & 1 & 9 & & & & Chile & 1 & 2 & Belgium & 1 & 0 \\

Germany & 0 & 1 & Germany & 1 & 15 & & & & Peru & 36 & 2 & Peru & 3 & 2 \\

Peru & 0 & 3 & Greece & 0 & 6 & & & & Thailand & 2 & 39 & Spain & 1 & 0 \\

Spain & 0 & 4 & Japan & 0 & 10 & & & & & & & Thailand & 25 & 85 \\

USA & 1 & 4 & Peru & 1 & 0 & & & & & & & USA & 1 & 0 \\

& & & Poland & 7 & 17 & & & & & & & & & \\

& & & Spain & 0 & 3 & & & & & & & & & \\

& & & Thailand & 9 & 79 & & & & & & & & & \\

& & & UK & 0 & 3 & & & & & & & & & \\

& & & USA & 0 & 51 & & & & & & & &. &. \\

\end{tabular}\vspace{1in}

\label{tabS2}

\end{sidewaystable}

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%% Table S3

\begin{table}[!ht]

\small

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\caption{{\bf Paramter estimates from fits to Arizona Data}. Values represent maximum likelihood estimates of relative risk, given membership in each risk group. 95\% profile CIs are given in parentheses.}

\begin{tabular}{l|l|l|l|l}

\hline

\hline

& \textbf{A} & \textbf{AN} & \textbf{AS} & \textbf{AG} \\

\hline

\hline

$\Delta AIC$ & 0 & 21.65 & 449.7 & 1131.95\\

\hline

H1N1 imp. prot. & & 0.28 (0.24-0.33) & 0.25 (0.22-0.3) & 0.63 (0.57-0.7) \\

H3N2 imp. prot. & & 0.59 (0.53-0.67) & 0.62 (0.56-0.71) & 0.44 (0.39-0.5) \\

Ages 5-10 & 0.87 (0.82-0.92) & 0.81 (0.77-0.86) & 0.8 (0.76-0.86) & 0.88 (0.84-0.94) \\

Ages 11-17 & 0.59 (0.56-0.63) & 0.56 (0.53-0.6) & 0.55 (0.52-0.6) & 0.62 (0.58-0.67) \\

Ages 18-24 & 0.49 (0.46-0.53) & 0.48 (0.46-0.52) & 0.47 (0.44-0.52) & 0.53 (0.5-0.57) \\

Ages 25-31 & 0.42 (0.39-0.45) & 0.42 (0.4-0.46) & 0.41 (0.39-0.45) & 0.44 (0.42-0.48) \\

Ages 32-38 & 0.28 (0.26-0.31) & 0.25 (0.24-0.28) & 0.25 (0.23-0.28) & 0.29 (0.26-0.32) \\

Ages 39-45 & 0.25 (0.24-0.28) & 0.21 (0.2-0.24) & 0.20 (0.19-0.23) & 0.27 (0.25-0.3) \\

Ages 46-52 & 0.27 (0.24-0.3) & 0.23 (0.21-0.26) & 0.20 (0.18-0.22) & 0.30 (0.28-0.33) \\

Ages 53-59 & 0.22 (0.2-0.24) & 0.24 (0.22-0.28) & 0.22 (0.2-0.24) & 0.24 (0.22-0.26) \\

Ages 60-66 & 0.16 (0.15-0.18) & 0.23 (0.2-0.26) & 0.23 (0.21-0.26) & 0.17 (0.16-0.2) \\

Ages 67-73 & 0.14 (0.13-0.16) & 0.20 (0.18-0.24) & 0.21 (0.19-0.24) & 0.15 (0.14-0.18) \\

Ages 74-80 & 0.13 (0.12-0.16) & 0.19 (0.18-0.22) & 0.20 (0.18-0.24) & 0.14 (0.13-0.17) \\

Ages 81+ & 0.09 (0.08-0.1) & 0.12 (0.11-0.14) & 0.13 (0.12-0.15) & 0.09 (0.08-0.1)

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%% Table S4

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\caption{{\bf Paramter estimates from fits to INSIGHT Data (1/2)}. Values represent maximum likelihood estimates of relative risk, given membership in each risk group. 95\% profile CIs are given in parentheses.}

\begin{tabular}{l|l| l| l| l| l| l| l| l| l}

\hline

\hline

Model & \textbf{ATVN} & \textbf{ATVS} & \textbf{ATUVN} & \textbf{ATV} & \textbf{ATUVS} & \textbf{ATUV} & \textbf{ATVG} & \textbf{ATUVG} & \textbf{AVN} \\

\hline

\hline

$\Delta AIC$ & 0 & 0.45 & 1.95 & 2.09 & 2.4 & 4.01 & 4.65 & 6.57 & 8.99 \\

\hline

Ant. Vir. Trt. & 1.36 (1.14-1.62) & 1.36 (1.14-1.62) & 1.36 (1.14-1.62) & 1.36 (1.14-1.62) & 1.36 (1.14-1.62) & 1.36 (1.14-1.62) & 1.36 (1.14-1.62) & 1.36 (1.14-1.62) & \\

Und. Conds. & & & 0.98 (0.85-1.14) & & 0.98 (0.85-1.14) & 0.98 (0.85-1.14) & & 0.98 (0.85-1.14) & \\

Vaccin. H1N1 & 0.64 (0.48-0.83) & 0.64 (0.48-0.84) & 0.64 (0.48-0.83) & 0.62 (0.47-0.81) & 0.64 (0.48-0.84) & 0.62 (0.47-0.81) & 0.63 (0.48-0.82) & 0.63 (0.48-0.83) & 0.65 (0.49-0.84) \\

Vaccin. H3N2 & 0.85 (0.67-1.06) & 0.84 (0.67-1.06) & 0.85 (0.68-1.07) & 0.86 (0.69-1.08) & 0.85 (0.67-1.06) & 0.87 (0.69-1.08) & 0.85 (0.67-1.06) & 0.85 (0.67-1.07) & 0.85 (0.68-1.07) \\

Impr. H1N1 & 0.84 (0.62-1.12) & 0.78 (0.61-1.00) & 0.84 (0.62-1.12) & & 0.78 (0.61-1.00) & & 0.98 (0.79-1.24) & 0.98 (0.79-1.23) & 0.83 (0.62-1.12) \\

Impr. H3N2 & 0.90 (0.69-1.19) & 0.96 (0.81-1.16) & 0.89 (0.69-1.19) & & 0.96 (0.81-1.16) & & 0.92 (0.77-1.16) & 0.92 (0.77-1.16) & 0.90 (0.70-1.20) \\

Ages 18-24 & 0.97 (0.86-1.10) & 0.97 (0.86-1.09) & 0.97 (0.86-1.10) & 0.97 (0.86-1.09) & 0.97 (0.86-1.09) & 0.97 (0.86-1.09) & 0.97 (0.86-1.10) & 0.97 (0.86-1.10) & 0.97 (0.86-1.09) \\

Ages 25-31 & 1.04 (0.94-1.16) & 1.05 (0.94-1.17) & 1.04 (0.94-1.16) & 1.04 (0.94-1.16) & 1.04 (0.94-1.17) & 1.04 (0.94-1.16) & 1.04 (0.94-1.16) & 1.03 (0.94-1.16) & 1.04 (0.94-1.17) \\

Ages 39-45 & 0.99 (0.87-1.13) & 0.97 (0.86-1.09) & 0.99 (0.87-1.13) & 0.99 (0.89-1.11) & 0.97 (0.86-1.09) & 0.99 (0.89-1.11) & 1.00 (0.89-1.13) & 1.00 (0.89-1.13) & 1.00 (0.88-1.14) \\

Ages 46-52 & 0.95 (0.83-1.09) & 0.92 (0.81-1.04) & 0.95 (0.83-1.10) & 0.95 (0.85-1.07) & 0.92 (0.81-1.04) & 0.95 (0.85-1.08) & 0.94 (0.83-1.08) & 0.94 (0.83-1.09) & 0.95 (0.83-1.09) \\

Ages 53-59 & 0.95 (0.83-1.08) & 0.92 (0.81-1.06) & 0.95 (0.83-1.09) & 0.95 (0.83-1.08) & 0.93 (0.81-1.07) & 0.95 (0.84-1.08) & 0.93 (0.80-1.11) & 0.93 (0.80-1.12) & 0.95 (0.84-1.09) \\

Ages 60-66 & 0.96 (0.79-1.18) & 0.99 (0.82-1.19) & 0.96 (0.79-1.18) & 0.95 (0.82-1.11) & 0.99 (0.82-1.19) & 0.96 (0.82-1.12) & 0.93 (0.78-1.14) & 0.93 (0.78-1.15) & 0.97 (0.80-1.19) \\

Ages 67-73 & 1.01 (0.78-1.31) & 1.06 (0.84-1.33) & 1.02 (0.78-1.32) & 1.01 (0.82-1.23) & 1.07 (0.84-1.34) & 1.02 (0.83-1.25) & 0.98 (0.79-1.25) & 0.99 (0.79-1.26) & 1.02 (0.79-1.32) \\

Ages 74-80 & 1.00 (0.71-1.41) & 1.05 (0.76-1.44) & 1.01 (0.71-1.43) & 1.00 (0.74-1.33) & 1.06 (0.77-1.45) & 1.01 (0.74-1.35) & 0.97 (0.70-1.34) & 0.98 (0.71-1.36) & 1.04 (0.73-1.47) \\

Ages 81-90 & 0.90 (0.55-1.45) & 0.95 (0.58-1.48) & 0.91 (0.55-1.46) & 0.90 (0.56-1.38) & 0.96 (0.58-1.50) & 0.91 (0.56-1.40) & 0.88 (0.54-1.38) & 0.88 (0.54-1.39) & 0.96 (0.58-1.53) \\

\hline

\hline

Model & \textbf{AVS} & \textbf{ATN} & \textbf{ATS} & \textbf{AV} & \textbf{AUVN} & \textbf{AUVS} & \textbf{ATUN} & \textbf{ATUS} & \textbf{AUV} \\

\hline \hline

$\Delta AIC$ & 9.37 & 10.35 & 10.55 & 10.84 & 10.98 & 11.37 & 12.06 & 12.27 & 12.82 \\

\hline

Ant. Vir. Trt. & & 1.34 (1.12-1.60) & 1.34 (1.12-1.60) & & & & 1.35 (1.12-1.61) & 1.35 (1.12-1.60) & \\

Und. Cond. & & & & & 0.99 (0.86-1.15) & 0.99 (0.86-1.15) & 0.96 (0.83-1.11) & 0.96 (0.83-1.11) & 0.99 (0.86-1.15) \\

Vaccin. H1N1 & 0.65 (0.49-0.85) & & & 0.63 (0.47-0.81) & 0.65 (0.49-0.84) & 0.65 (0.49-0.85) & & & 0.63 (0.47-0.82) \\

Vaccin. H3N2 & 0.85 (0.67-1.06) & & & 0.87 (0.69-1.08) & 0.85 (0.68-1.07) & 0.85 (0.67-1.06) & & & 0.87 (0.69-1.09) \\

Impr. H1N1 & 0.78 (0.61-1.00) & 0.81 (0.59-1.09) & 0.76 (0.59-0.97) & & 0.83 (0.62-1.12) & 0.78 (0.61-1.00) & 0.81 (0.59-1.09) & 0.76 (0.59-0.97) & \\

Impr. H3N2 & 0.96 (0.81-1.16) & 0.89 (0.69-1.19) & 0.94 (0.79-1.13) & & 0.90 (0.70-1.20) & 0.96 (0.81-1.16) & 0.89 (0.69-1.19) & 0.94 (0.79-1.13) & \\

Ages 18-24 & 0.96 (0.86-1.09) & 1.00 (0.89-1.13) & 1.00 (0.89-1.12) & 0.97 (0.86-1.09) & 0.97 (0.86-1.09) & 0.96 (0.86-1.09) & 0.99 (0.89-1.12) & 0.99 (0.89-1.12) & 0.96 (0.86-1.09) \\

Ages 25-31 & 1.05 (0.94-1.17) & 1.06 (0.95-1.18) & 1.06 (0.96-1.19) & 1.04 (0.94-1.16) & 1.04 (0.94-1.17) & 1.05 (0.94-1.17) & 1.06 (0.95-1.18) & 1.06 (0.96-1.18) & 1.04 (0.94-1.16) \\

Ages 39-45 & 0.98 (0.88-1.10) & 0.98 (0.86-1.11) & 0.96 (0.86-1.09) & 1.00 (0.90-1.12) & 1.00 (0.88-1.14) & 0.98 (0.88-1.11) & 0.98 (0.86-1.12) & 0.97 (0.86-1.09) & 1.00 (0.90-1.12) \\

Ages 46-52 & 0.92 (0.81-1.04) & 0.93 (0.82-1.08) & 0.90 (0.80-1.02) & 0.95 (0.85-1.07) & 0.95 (0.83-1.09) & 0.92 (0.81-1.04) & 0.94 (0.82-1.08) & 0.91 (0.81-1.03) & 0.95 (0.85-1.08) \\

Ages 53-59 & 0.93 (0.81-1.07) & 0.93 (0.82-1.06) & 0.90 (0.79-1.04) & 0.95 (0.84-1.08) & 0.95 (0.84-1.09) & 0.93 (0.81-1.08) & 0.94 (0.82-1.07) & 0.91 (0.79-1.05) & 0.96 (0.84-1.09) \\

Ages 60-66 & 1.00 (0.83-1.20) & 0.93 (0.77-1.14) & 0.95 (0.80-1.15) & 0.96 (0.82-1.12) & 0.97 (0.79-1.19) & 1.00 (0.83-1.20) & 0.94 (0.77-1.16) & 0.96 (0.80-1.16) & 0.96 (0.82-1.13) \\

Ages 67-73 & 1.07 (0.85-1.34) & 0.97 (0.75-1.26) & 1.01 (0.81-1.27) & 1.02 (0.83-1.24) & 1.02 (0.79-1.33) & 1.07 (0.85-1.35) & 0.98 (0.76-1.28) & 1.02 (0.81-1.29) & 1.02 (0.83-1.25) \\

Ages 74-80 & 1.09 (0.79-1.49) & 0.97 (0.69-1.36) & 1.01 (0.73-1.38) & 1.04 (0.77-1.38) & 1.05 (0.73-1.48) & 1.09 (0.79-1.50) & 0.98 (0.69-1.39) & 1.02 (0.74-1.41) & 1.04 (0.77-1.40) \\

Ages 81-90 & 1.01 (0.61-1.56) & 0.87 (0.52-1.38) & 0.90 (0.55-1.40) & 0.95 (0.59-1.46) & 0.96 (0.58-1.54) & 1.01 (0.61-1.57) & 0.88 (0.53-1.41) & 0.91 (0.56-1.43) & 0.95 (0.59-1.47) \\

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\caption{{\bf Paramter estimates from fits to INSIGHT Data (2/2)}. Values represent maximum likelihood estimates of relative risk, given membership in each risk group. 95\% profile CIs are given in parentheses.}

\begin{tabular}{l|l| l| l| l| l| l| l| l| l}

\hline \hline

Model & AVG & AT & AUVG & ATG & ATU & ATUG & AN & AS & AUN \\

\hline \hline

$\Delta AIC$ & 13.55 & 14.19 & 15.54 & 15.57 & 15.81 & 17.2 & 18.48 & 18.66 & 20.33 \\

\hline

Ant. Vir. Trtmt & & 1.34 (1.12-1.59) & & 1.35 (1.12-1.60) & 1.34 (1.12-1.60) & 1.35 (1.12-1.61) & & & \\

Und. Conds. & & & 0.99 (0.86-1.15) & & 0.96 (0.83-1.11) & 0.96 (0.83-1.11) & & & 0.97 (0.84-1.12) \\

Vaccin. H1N1 & 0.64 (0.48-0.83) & & 0.64 (0.48-0.83) & & & & & & \\

Vaccin. H3N2 & 0.85 (0.68-1.07) & & 0.85 (0.68-1.07) & & & & & & \\

Impr. H1N1 & 1.00 (0.80-1.25) & & 1.00 (0.80-1.25) & 0.95 (0.77-1.20) & & 0.95 (0.77-1.20) & 0.80 (0.59-1.08) & 0.76 (0.59-0.97) & 0.81 (0.59-1.09) \\

Impr. H3N2 & 0.91 (0.77-1.15) & & 0.91 (0.77-1.15) & 0.91 (0.75-1.14) & & 0.91 (0.75-1.15) & 0.90 (0.70-1.20) & 0.95 (0.80-1.14) & 0.90 (0.70-1.20) \\

Ages 18-24 & 0.97 (0.86-1.09) & 1.00 (0.89-1.12) & 0.97 (0.86-1.09) & 1.00 (0.90-1.13) & 0.99 (0.89-1.12) & 0.99 (0.89-1.12) & 1.00 (0.89-1.12) & 0.99 (0.89-1.12) & 0.99 (0.89-1.12) \\

Ages 25-31 & 1.04 (0.94-1.16) & 1.05 (0.95-1.18) & 1.03 (0.94-1.16) & 1.05 (0.95-1.18) & 1.05 (0.95-1.17) & 1.05 (0.95-1.17) & 1.06 (0.95-1.18) & 1.06 (0.96-1.19) & 1.06 (0.95-1.18) \\

Ages 39-45 & 1.01 (0.91-1.14) & 0.98 (0.89-1.10) & 1.01 (0.91-1.14) & 0.99 (0.89-1.12) & 0.99 (0.89-1.11) & 1.00 (0.89-1.12) & 0.99 (0.87-1.12) & 0.97 (0.87-1.10) & 0.99 (0.87-1.13) \\

Ages 46-52 & 0.94 (0.83-1.08) & 0.94 (0.84-1.06) & 0.94 (0.83-1.08) & 0.93 (0.82-1.08) & 0.95 (0.84-1.07) & 0.94 (0.82-1.08) & 0.93 (0.82-1.08) & 0.90 (0.81-1.02) & 0.94 (0.82-1.08) \\

Ages 53-59 & 0.92 (0.81-1.11) & 0.93 (0.82-1.06) & 0.92 (0.80-1.11) & 0.91 (0.78-1.10) & 0.94 (0.82-1.07) & 0.92 (0.78-1.11) & 0.94 (0.82-1.07) & 0.91 (0.80-1.05) & 0.94 (0.82-1.08) \\

Ages 60-66 & 0.93 (0.79-1.14) & 0.92 (0.79-1.07) & 0.93 (0.79-1.15) & 0.90 (0.74-1.10) & 0.93 (0.80-1.09) & 0.91 (0.75-1.12) & 0.94 (0.77-1.16) & 0.96 (0.81-1.16) & 0.95 (0.78-1.17) \\

Ages 67-73 & 0.98 (0.80-1.25) & 0.96 (0.79-1.17) & 0.98 (0.79-1.26) & 0.94 (0.74-1.20) & 0.97 (0.80-1.19) & 0.95 (0.75-1.22) & 0.98 (0.76-1.27) & 1.02 (0.81-1.28) & 0.99 (0.77-1.29) \\

Ages 74-80 & 1.00 (0.73-1.38) & 0.96 (0.70-1.27) & 1.00 (0.73-1.40) & 0.94 (0.68-1.29) & 0.97 (0.71-1.30) & 0.95 (0.68-1.32) & 1.01 (0.71-1.42) & 1.05 (0.76-1.43) & 1.02 (0.71-1.44) \\

Ages 81-90 & 0.92 (0.56-1.44) & 0.85 (0.53-1.29) & 0.92 (0.56-1.45) & 0.83 (0.51-1.30) & 0.86 (0.53-1.32) & 0.84 (0.51-1.33) & 0.92 (0.55-1.46) & 0.95 (0.58-1.48) & 0.93 (0.56-1.48) \\

\hline \hline

Model & AUS & A & AG & AU & AUG & & & & \\

\hline \hline

$\Delta AIC$ & 20.51 & 21.99 & 23.69 & 23.77 & 25.48 & & & & \\

\hline

Ant. Vir. Trtmt & & & & & & & & & \\

Und. Conds. & 0.97 (0.84-1.12) & & & 0.97 (0.84-1.12) & 0.97 (0.84-1.12) & & & & \\

Vaccin. H1N1 & & & & & & & & & \\

Vaccin. H3N2 & & & & & & & & & \\

Impr. H1N1 & 0.76 (0.59-0.97) & & 0.97 (0.78-1.23) & & 0.97 (0.78-1.22) & & & & \\

Impr. H3N2 & 0.95 (0.80-1.14) & & 0.90 (0.75-1.14) & & 0.90 (0.75-1.14) & & & & \\

Ages 18-24 & 0.99 (0.88-1.12) & 0.99 (0.89-1.12) & 1.00 (0.89-1.12) & 0.99 (0.89-1.12) & 0.99 (0.89-1.12) & & & & \\

Ages 25-31 & 1.06 (0.96-1.18) & 1.05 (0.95-1.18) & 1.05 (0.95-1.18) & 1.05 (0.95-1.17) & 1.05 (0.95-1.17) & & & & \\

Ages 39-45 & 0.97 (0.87-1.10) & 0.99 (0.90-1.11) & 1.01 (0.90-1.14) & 1.00 (0.90-1.12) & 1.01 (0.90-1.14) & & & & \\

Ages 46-52 & 0.91 (0.81-1.03) & 0.94 (0.84-1.06) & 0.93 (0.82-1.07) & 0.95 (0.84-1.07) & 0.94 (0.82-1.08) & & & & \\

Ages 53-59 & 0.91 (0.80-1.06) & 0.94 (0.82-1.06) & 0.91 (0.79-1.10) & 0.94 (0.83-1.07) & 0.92 (0.79-1.11) & & & & \\

Ages 60-66 & 0.97 (0.81-1.17) & 0.93 (0.80-1.08) & 0.90 (0.75-1.11) & 0.93 (0.80-1.10) & 0.91 (0.76-1.12) & & & & \\

Ages 67-73 & 1.03 (0.81-1.30) & 0.97 (0.80-1.18) & 0.94 (0.75-1.20) & 0.98 (0.80-1.20) & 0.95 (0.76-1.22) & & & & \\

Ages 74-80 & 1.06 (0.76-1.45) & 0.99 (0.73-1.32) & 0.96 (0.69-1.32) & 1.00 (0.73-1.34) & 0.97 (0.70-1.35) & & & & \\

Ages 81-90 & 0.96 (0.58-1.50) & 0.89 (0.56-1.36) & 0.87 (0.53-1.36) & 0.91 (0.56-1.39) & 0.88 (0.54-1.39) & & & &

\end{tabular}\vspace\*{2in}

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