



Large-scale meta-population patch models of

infectious diseases on Cray machines

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Health Protection Agency A non-departmental public body

Health Protection Agency

- Centre for Infections
- Centre for Emergency Preparedness and Response
- Centre for Radiation, Chemical and Environmental Hazards
- Local and Regional Services

Microbial Risk Assessment -

(Part of the Emergency Response Division)

Emerging and re-emerging disease threats: Contingency planning Predictive modelling Training exercises Emergency response.

Bioterrrorism, Pandemic Influenza, Legionella, Zoonotic Diseases.

Fostering international collaborations: *EU* (Two projects INFTRANS, MODELREL), *G8* (Conferences and publications), WHO, European CDC, links to US modelling groups via MIDAS





Overview

- Infectious disease threats
- Metapopulation models
 - Parameterisation for the UK
 - Parallel implementation
- Performance analysis
- Further work



Infectious diseases

Time

A diseased individual passes through

- Incubating period
- Symptomatic period, possibly with a prodrome

An infectious disease also has

- Latent period
- Infectious period
- > Basic reproduction number, R_0

Time of infection		
Incubating	Symptomatic	
Latent	Infectious	



Disease transmission





Pandemic influenza

Three pandemics during 20th Century (1918, 1957, 1968) 20 million deaths worldwide in 1918-19



Modelling for future pandemic, assuming

- 2 day latent, 1 day asymptomatic infectious, 1.5 day symptomatic infectious periods
- ➢ Basic reproduction number in the range 1.4-2.2
- 25% of UK population show clinical infection with 0.37% case fatality rate
- Excess deaths in the UK of *c.* 50,000



Smallpox

- Eradicated in the wild globally in 1979
- Stockpiles retained in Atlanta, US and Novosibirsk, Russia
- Decreasing immunity in the population
- > 12 day latent, 2.5 day prodromal, 8.6 day infectious periods
- ➢ 30% case fatality rate
- Basic reproduction number of 5
- Potential to be used in bioterrorism



SIR compartmental model



Mass action dynamics (Kermack and McKendrick (1927)) $\frac{dS}{dt} = -\beta \frac{S}{N}I \qquad \frac{dI}{dt} = \beta \frac{S}{N}I - \frac{I}{\tau_1} \qquad \frac{dR}{dt} = \frac{I}{\tau_1}$

Also can use stochastic transitions



Increasing compartments

Include more disease states than in SIR >Latent/exposed >Prodromal >Asymptomatic infectious >Dead

Introduce stage age (pseudo-individual)





Meta-population models





Parameterisation

Describe the UK by administrative regions ≻Electoral wards(10608) ≻Districts (426)

2001 Census for ≻Populations ≻Travel to work

Alternatively, "health geographies"

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426 "districts"

Source: 2001 Census, Output Area Boundaries. Crown copyright 2003. Crown copyright material is reproduced with the permission of the Controller of HMSO



Patch dynamics



Night time population

Subpopulations

Contribution to force of infection on other patches

Total number of subpatches in the model $O(n^2)$ for n patches 80000 (districts), 1.5 million (wards)



Parallelisation

Single patch on process





Parallelisation

Local accumulation



Patch 2

Two patches of a four patch system held on one process



Spatial spread



Spread of disease away from seed in London



Implementation

Palu – XT3

- 1664 dual-core processors
- ➤ 1 GiB memory per core
- SeaStar interconnect

Iluvatar – Linux cluster

- ≻ 88 dual-core processors
- ➤ 2 GiB memory per core
- Gigabit Ethernet interconnect

Consider

Simple and pseudo-individual models

- Pandemic influenza and smallpox
- ≻10608 and 426 patches



Scalability - Pseudo-individual

Scaling for 10608 patches, pandemic influenza and smallpox





Scalability - Simple



Process count



Conclusions and further work

Scaling at large problem sizes is good on both machines
 Palu offers good scaling to large process counts
 Problem size increases when consider Europe or the world
 Scaling for smaller problems has possibilities for response

Dynamic load balancing will improve scaling
 Model complexity can be increased



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