patients had low Haemophilus IgG, 79% of patients had low Pneumococcal IgG, and 1% of patients had low Tetanus IgG.

37/48 patients had low FAA; 29 of these patients were recommended to receive booster vaccines. 9/15 of parents reported reduction of RTI post booster vaccine. 10/12 of patients had their FAA documented to have returned to normal.

**Conclusions** 60% of patients with low FAA had reduced RTI post booster vaccine. FAA should not be done in children less than 13 months of age as the booster dose is due at 12–13 months and a low level may not necessarily change management. FAA is a useful tool for investigating children with recurrent RTI.

**Methods** A questionnaire was administered that addressed gender, age, number of household members, monthly family income, history of jaundice and immunization, number of rooms in the house, education level of the parents, day-care/school attendance, and type of water supply. The socioeconomic status score of each child was determined by summing the scores for monthly family income, education level of the parents, number of rooms in the house and number of people living in the house. Blood samples were collected and analyzed for anti-HAV IgG.

**Results** Significant associations between anti-HAV seropositivity and socioeconomic status, age under 6 years old and attending daycare, a history of jaundice and monthly family income were found (p<0.001, p=0.003, p<0.001, p=0.04, respectively). Only the association between the history of jaundice and anti-HAV seropositivity remained significant in the multivariate analysis, with an adjusted Odds ratio of 13.1 (range: 2.9–59.5; p=0.001).

**Conclusions** Our findings showed an inverse correlation between HAV seropositivity and socioeconomic status. A high in-house population and paternal education level were not a significant factor increasing the risk of anti-HAV positivity. However, as the maternal education level increased, less HAV positivity was recorded.