**Is there an association between socioeconomic status and immune response to infant and childhood vaccination in the Netherlands?**

J. van den Boogaard a, b, Nynke Y. Rots a, Fiona van der Klis a, Hester E. de Melker a, Mirjam J. Knol a

a National Institute for Public Health and the Environment (RIVM), Bilthoven, the Netherlands

b European Centre for Disease Prevention and Control (ECDC), Stockholm, Sweden

Published in Vaccine (February 2020): <https://doi.org/10.1016/j.vaccine.2020.01.071>

**ABSTRACT**

Introduction

Socioeconomic status (SES) is a well-known determinant of health, but its relation with vaccine-induced immunity is less documented. We explored the association between SES and immunoglobulin G (IgG) levels against vaccine-preventable diseases in vaccinated children in the Dutch National Immunization Programme.

Methods

Data from a population-wide cross-sectional serosurvey in the Netherlands (2006-2007) were used. We compared geometric mean IgG concentrations/titers (GMC/T ratios) against measles, mumps, rubella, *Haemophilus influenzae* type b (Hib), *Neisseria meningococcus* type C, diphtheria, tetanus, poliovirus types 1,2,3 and pertussis in children of high versus low SES by linear regression analysis. We included 894 children (0-12 years) at one of two timeframes: 1 month to 1 year, or 1-3 years after vaccination. Mother’s educational level and net household income served as binary indicators of SES.

Results

Of 58 possible associations of vaccine-induced antibody responses with educational level and 58 with income, 10 (9%) were statistically significant: 2 favouring (that is, with higher IgG levels at) high educational level (for Hib 1m-1y after vaccination (GMC/T ratio: 2.99, 95%CI: 1.42-6.30) and polio 2 1m-1y after the 9-year booster dose (1.14, 1.01-1.27)) and 8 favouring low income (polio 1, 2 and 3 1m-1y after the 11-month booster (0.74, 0.58-0.94; 0.79, 0.64-0.97; 0.72, 0.55-0.95), polio 3 and pertussis 1-3y after the 11-month booster (0.70, 0.56-0.88; pertussis-prn: 0.60, 0.37-0.98; pertussis-ptx: 0.66, 0.47-0.95), mumps and rubella 1-3y after first vaccination (0.73, 0.55-0.97; 0.70, 0.55-0.90), and rubella 1m-1y after second vaccination (0.83, 0.55-0.90)). After adjustment for multiple testing, none of the differences remained significant. There was no association between SES and proportion of children with protective IgG levels.

Conclusion

In this explorative study, we found no consistent association between SES and immune response to vaccination in the Netherlands and no association with protective IgG levels. Additional studies in other settings should confirm this finding.

**INTRODUCTION**

Socioeconomic status (SES) is a well-known determinant of health [1]. It is a multi-faceted phenomenon that is at least partly captured by parameters such as education, occupational class and income. People with higher educational levels, from higher occupational classes and with higher income tend to have better health outcomes, although true causality is difficult to prove [2].

The association between SES and non-communicable diseases has been studied extensively [3], but less is known about the effect of socioeconomic status on acute infectious diseases, except for its relation with the risk of exposure (e.g. crowding) and with vaccination coverage [4,5]. In a recent study in the Netherlands, some differences in the incidence of self-reported, common infectious disease syndromes (acute upper and lower respiratory tract infections, acute otitis media and urinary tract infections) were found between people from high versus low educational level, but they were not consistently in favour of either high or low educational level [6].

Exposure to stress of various nature early in life has been shown to programme the immune system [7]. Environmental factors, including exposure to pathogens, but also psychological stress, poor nutrition and smoking are thought to affect one’s immune response although it is not known to what extent [8,9]. The effect of SES on immunoglobulin-G (IgG) levels after natural exposure was shown to be pathogen specific and not consistently pointing to one direction in a recent study among adults [10]. To study the effect of SES on immune response independently of its association with exposure, one could compare the immune response to (childhood) vaccination, particularly against diseases that are no longer endemic in the area, between low and high SES groups. Hence, exploring the relation between SES and immune response to vaccination provides additional insights that could help to disentangle the complex interaction between SES and communicable diseases. Moreover, it might be a first step towards optimizing protection against vaccine preventable diseases in future. The aim of this study was to explore the possible association of mother’s educational level and net household income (as proxy indicators of SES) with immune response to vaccination in infants and children vaccinated according to the National Immunization Programme (NIP) in the Netherlands.

**METHODS**

**Study population**

We used data from a population-wide cross-sectional serosurvey (the Pienter2 study) that was conducted in the Netherlands between February 2006 and June 2007. The aim of the Pienter2 study was to establish a national serum bank to monitor antibody levels against vaccine-preventable infectious diseases in the NIP [11]. For sampling in Pienter2, the Netherlands was divided in five regions and participants (0-79 years) were chosen from eight randomly selected municipalities in each region. People who agreed to participate, were asked to complete a questionnaire with questions on their background, immunisation status and health, and to donate a blood sample. For children younger than 14 years, a parent or guardian was asked to fill the questionnaire. In total, 19,781 people were invited to participate in Pienter2 which resulted in 6,348 (32%) completed questionnaires with supplementary blood samples, including an oversampling of non-Western migrants. The study was approved by the Medical Ethics Committee of the foundation of therapeutic evaluation of medicines (METC-STEG) in Almere (The Netherlands) [11].

For our study, only children from Pienter2 who were immunized according to the NIP were included. At the time of the study, the NIP included DTaP-IPV-Hib (Diphtheria, Tetanus, Pertussis, inactivated Poliovirus and *Haemophilus influenza* type b) infant vaccinations at 2, 3, 4 and 11 months (up to 1999 at 3, 4, 5 and 11 months; Hib included since 1993), and childhood booster vaccinations at 4 and 9 years of age for DT-IPV (since 1962). Since 2001, the booster vaccination at 4 years covers pertussis as well. From 2005 onwards, the pertussis component in the DTP-IPV vaccine was changed from whole cell to acellular. The NIP also includes a MMR (measles, mumps, rubella) vaccine at the age of 14 months and 9 years. The MMR vaccine at 14 months is combined with MenC vaccination (since 2002). Vaccination coverage at the age of two years was 94.3% and 94.0% in respectively 2006 and 2007 for DTP-IPV, 95.4% and 95.0% for Hib, 94.8% and 95.6% for MenC and 95.4% and 95.9% for MMR. At the age of 10 years, vaccination coverage for DT-IPV was 93.0% and 92.5% and for MMR 92.9% and 92.5% [12].

Dates of vaccination were copied from the vaccination booklet that participants had to bring to the visit where the blood sample was collected, and checked afterwards in the digital national immunization register. We only included children whose blood sample was taken between 1 month and 1 year (short-term) or between 1 and 3 years (medium-term) after infant vaccination (that is, primary series + booster dose at 11 months of DTP-IPV and Hib; first MMR and MenC at 14 months), or childhood vaccination (that is, booster dose of DT-IPV or DTP-IPV at 4 years; booster dose of DT-IPV at 9 years; second MMR at 9 years). Furthermore, to be included in the study, the age range within which vaccination had to be received, was 10-14 months for the first booster vaccination of DTP-IPV (DTP-IPV4 scheduled at 11 months of age), 13-17 months for MMR1, 42-60 months for the 4-year booster vaccination of DT(P)-IPV, and 96-120 months for the 9-year booster of DT-IPV and MMR2. We excluded infants and children who reported to have been diagnosed with clinical pertussis or mumps.

**Indicators of SES**

We used educational level of the mother and net household income as two separate indicators of SES, since this information was requested in the Pienter2 questionnaire. Children of whom no information was available on one of these indicators, were excluded from analysis with that indicator. To be able to include a sufficient number of children in each stratum, the indicators of SES were used in a binary way: low-intermediate educational level (no education, primary education, junior technical school, or lower general or intermediate vocational secondary education) versus high educational level (higher vocational or higher general secondary education, pre-university or university education), and low-intermediate net household income (≤ € 3,050/month) versus high net household income (> € 3,050/month).

We repeated the analysis with a subset of children who belonged to the “low/intermediate-category” for both educational level of the mother and net household income versus children who belonged to the “high-category” for both SES indicators to compare the extremes in a joint effect of educational level and household income.

**Laboratory analysis**

In the Pienter2 survey, IgG levels were determined by a fluorescent bead-based multiplex immunoassay (MMRV-MIA) using Luminex for simultaneous detection of antibodies against measles, mumps and rubella [13]. Antibodies against MenC and Hib were measured in a similar way, using combined assays [14]. Pentaplex MIA was used to determine IgG levels against pertussis (pertussis toxin (ptx), pertactin (prn) and filamentous hemagglutinin (FHA)), diphtheria, and tetanus [15]. Polio IgG total antibody levels (against poliovirus types 1, 2, and 3) were measured with a standard neutralization test [16]. The IgG concentrations were determined and calibrated to internationally accepted standards, such as the cut-off criteria of the World Health Organization (WHO).

**Data analysis**

We described the study population included after infant and childhood vaccination with descriptive statistics. We calculated geometric mean IgG titers/concentrations (GMC/T; with 95% confidence intervals) for each pathogen at the two timeframes (1 month-1 year and 1-3 years) after infant and childhood vaccination. We used linear regression analyses and calculated GMC/T ratios (GMC/T in the high SES groups divided by GMC/T in the low SES groups) to assess the effect of educational level of the mother, net household income and the combination of both, on logarithmically transformed IgG concentrations for the different pathogens at the two timeframes after vaccination. A GMC/T ratio > 1 “favoured” high educational level or household income (that is, antibody concentrations were higher in the high SES group than the low SES group). Multivariable linear regression was performed to correct for migration background, sex and (exact) age at vaccination. We corrected for multiple testing by applying the Benjamini-Hochberg’s procedure on the p-values for the individual differences in GMC/T between low and high educational level, household income and the combination of both [17].

We compared the proportions of individuals with protective levels of IgG against the different pathogens between children from low-intermediate (hereafter: low) and high household income, and between children with mothers with low-intermediate (low) and high educational level [18-25].

The survey design of Pienter2 with five regions (strata) and 40 municipalities (clusters) was taken into account in all analyses by adding them as random effects, correcting the standard error of the estimates. The analyses were conducted in Stata version SE/15.1 (StataCorp LLC, Texas, USA).

**Validation of results with Pienter1 data**

We repeated the analyses with data from the Pienter1 study, which was conducted between October 1995 and December 1996 and covered data from 8,539 participants (response rate 56%).The Pienter1 study design was similar to Pienter2 and has been described elsewhere [26]. In Pienter1, only data on mother’s educational level (not on household income) was available. At the time of the Pienter1 study, vaccination with DTP-IPV started at 3 months of age (3, 4, 5, and 11 months) and only the whole cell pertussis vaccine was used. MenC vaccination was not yet part of the NIP. Antibody levels against diphtheria and tetanus were determined using toxin binding inhibition assays in Pienter1; antibodies against polio by neutralization tests, and antibodies against measles, mumps, rubella and Hib by ELISAs [27]. For pertussis, only antibodies against pertussis toxin were assessed in Pienter1 by ELISA.

**RESULTS**

**Study population**

For the analyses by educational level, we included between 65 and 113 infants and children in the timeframe 1m-1y after vaccination per pathogen and between 141 and 232 infants and children in the timeframe 1-3y after vaccination per pathogen. For the analyses by net household income, these numbers were 46-101 and 117-191 respectively (Supplementary tables 1 and 2). Data on net household income were missing more often than data on educational level of the mother, which explains the difference in number of infants and children included. The characteristics of the study population are shown in tables 1 and 2. As expected, mother’s educational level and net household income were correlated: infants and children of mothers with a low educational level were more often living in a family with a low net household income than infants and children of mothers with high educational level (table 1), and vice versa (table 2). There were significantly more children born outside the Netherlands in the low income and low educational level groups than in the high income and educational level groups.

**GMC/T ratios**

In figures 1 and 2, GMC/T ratios with 95% confidence intervals (CI) are presented for high versus low educational level of the mother and net household income respectively. A ratio >1 means that antibody levels are higher in children with high educational level of the mother or with high net household income, i.e. a ratio >1 favours a high level of SES. In the analysis by educational level of the mother (figure 1), the GMC/T ratio (and 95% CI) was >1 for Hib 1m-1y after vaccination (GMC/T ratio 2.99, 95% CI 1.42-6.30) and polio 2 virus 1m-1y after the 9-year booster vaccination (1.14, 1.01-1.27). In the analysis by net household income (figure 2), the GMC/T ratio was <1 for polio 1, 2 and 3 virus 1m-1y after the 11-month booster vaccination (polio 1: 0.74, 0.58-0.94; polio 2: 0.79, 0.64-0.97; polio 3: 0.72, 0.55-0.95) and for polio 3 virus also 1-3y after the 11-month booster vaccination (0.70, 0.56-0.88). In addition, the GMC ratio was <1 for pertussis prn ad ptx 1-3y after the 11-month booster vaccination (prn: 0.60, 0.37-0.98; ptx: 0.66, 0.47-0.95), for mumps 1-3 y after first vaccination (0.73, 0.55-0.97), and for rubella 1-3 y after first vaccination (0.70, 0.55-0.90) and 1m-1y after second vaccination (0.83, 0.55-0.90).

In the analysis by SES (educational level of the mother and net household income combined), the GMC/T ratios of rubella 1-3y after first vaccination and polio 3 virus 1-3y after the 11-month booster vaccination were <1 (rubella: 0.73, 0.55-0.97; polio 3: 0.68, 0.50-0.94; Supplementary figure 1). No other associations were found.

After correcting for sex, migration background and age at vaccination in multivariable linear regression analysis, the differences in GMC/T ratio by educational level remained only significant for Hib, 1m-1y after vaccination(3.88; 1.97-7.66) and polio 2, 1m-1y after the 9-year booster (1.15; 1.02-1.30), and by net household income for polio 1 and 3, 1m-1y after the 11-month booster dose (resp. 0.72; 0.58-0.91 and 0.73; 0.54-0.99) (Supplementary figures 2-7). In the multivariable regression analysis, some other differences became significant. In the analyses by educational level of the mother, the adjusted GMC/T ratio was 1.72 (1.07-2.76) for diphtheria 1m-1y after the 11-month booster vaccination, 1.36 (1.04-1.78) for tetanus and 1.23 (1.00-1.50) for polio 2 virus 1-3y after the 11-month booster vaccination.

After adjustment for multiple testing by applying the Benjamini-Hochberg’s procedure, none of the differences in GMC/T between the high and low SES groups, neither in the univariable analyses nor in the multivariable analyses, were significant.

**Proportions reaching protecting IgG levels**

No differences were observed in proportions of infants and children reaching protective IgG levels with mothers of low versus high educational level, except for IgG levels against rubella. For rubella, 100% of infants of mothers with low educational level and 96% of infants of mothers with high educational levels reached IgG levels above the threshold for protection 1-3y after the first vaccination (p=0.02; table 3). In the analysis by net household income, 67% of infants from low income households and 50% of infants from high income households reached levels of protection against polio 3 virus 1-3 years after infant vaccination (p=0.04). The proportion of children with protective IgG levels against polio 3 is low in all children 1-3y after infant vaccination, but increases thereafter (table 3). This was also shown in previous studies using these data [28]. For the other pathogens, there were no significant differences in proportions of infants and children reaching protective IgG levels at the different timeframes. After adjustment for multiple testing, the differences between the high and low SES groups disappeared.

**Validation of results with Pienter1 data**

The analyses by educational level of the mother were repeated with Pienter1 data on 581 infants aged approximately 0-4 years and 494 children 4-12 years (a total of 1,075 children). None of the differences in IgG levels found between children of mothers from high versus low educational level in the Pienter2 study were also observed in the Pienter1 study. Three differences were found in the Pienter1 study that were not found in Pienter2: the GMC ratios and 95% CI were >1 for polio 1, 2 and 3 virus 1m-1y after the 11-month booster vaccination (resp. 1.43 (1.03-2.01); 1.46 (1.03-2.12); and 1.57 (1.04-2.34)). These differences remained significant after adjusting for age and sex (data not shown), but disappeared after adjustment for multiple testing.

**DISCUSSION**

In this study, we explored the effect of two indicators of SES (educational level and net household income) on immune response to vaccination in infants and children vaccinated according to the Dutch NIP. No consistent patterns were observed that favoured either high or low SES for any of the studied pathogens at either timeframe (1 month to 1 year after vaccination and 1 to 3 years after vaccination). Although a few significant differences in GMC/T were found for some pathogens at some timeframes, these differences were not consistent over timeframes, nor observed after both infant and childhood vaccination. Moreover, repetition of the analyses with data from the Pienter1 serosurvey that was conducted ten years earlier did not show similar differences but rather a few other inconsistent differences. After adjusting for multiple testing, all significant differences disappeared, confirming the irrelevance of the few differences found in the individual comparisons. The proportion of infants and children with protective IgG levels against the different pathogens did not differ significantly between high and low SES, except for slight differences for rubella and polio 3.

Many factors may affect immune response to vaccination. Whereas there is strong evidence about the effect of intrinsic factors (such as age and genetics), comorbidity and vaccine factors on immune response to vaccination, the evidence about the relation with socioeconomic factors such as nutritional status and educational level is ambiguous [9]. Studying associations between SES and health is complicated since several mediators and moderators along the causal pathway should be considered [2]. Studies that explore the association between SES and health outcomes often use educational level, income and occupation as indicators of SES, not in the least because they are measurable and can be addressed in policies. Whereas education may impact health/lifestyle behaviour, it also affects income and occupation [29]. In our study, low educational level was indeed associated with low net household income. Household income and occupation affect healthcare seeking behaviour and lifestyle, but also influence living conditions (e.g. crowding) and the risk of exposure to hazardous factors including pathogens [2, 29]. For example, several studies have shown that low SES (expressed in factors such as sole-parent households, maternal education, car ownership) is associated with increased risk of acquiring pneumococcal, Hib and meningococcal disease in the community [30-32].

In a study in the Netherlands, weak associations were found between SES (educational level and income) and IgG concentrations induced by natural infections with rubella, measles, pneumococcus, Hib and MenC in non-vaccinated adults, although the direction of the association was not consistent (as in our study) [8]. In another study, higher IgG antibody levels against CMV were found in adults >25 years with lower education or income [33]. However, the relative contributions of differences in pathogen exposure versus differences in immune response after natural exposure, were difficult to assess in these studies.

Little is known to what extent SES affects humoral immunity independently of the risk of exposure. By looking at the immune response after vaccination, differences in exposure can be ruled out, at least for vaccine-preventable diseases that are no longer prevalent in the study population (such as rubella, diphtheria and polio in the Netherlands). Our results do not point towards a clinically significant impact of SES on humoral immunity to these vaccine-preventable diseases in Dutch children.

Our study had several strengths. First, we were able to use data from a national serosurvey in a representative sample of the Dutch population, including detailed and verified information on dates of vaccination for each included child [11]. Moreover; we were able to include children at two different timeframes after vaccination (1 month to 1 year, and 1-3 years). This allowed us to look at possible differences in the short versus medium-long term effects after vaccination. In addition, we were able to validate our results by repeating the analysis with data from the previous national serosurvey (10 years earlier) [26, 27].

The study also had some limitations. As proxies for SES, only mother’s educational level and net household income were available from the Pienter2 study. Data on possible mediators and moderators between these indicators and immune response to vaccination, such as nutritional status, smoking and alcohol use, was not collected in the Pienter2 study. Hence, even if we had found a clear association between education/income and immune response, we would not have been able to interpret this in terms of causality; additional studies with another design would be needed for this.

Not for all children in the Pienter2 study, data was available on net household income. This resulted in smaller groups for the analysis by income and larger confidence intervals. Since people with a low income may be less eager to report on their income than people with higher incomes, the low income group may have been an underrepresentation of reality (selection bias). Due to small numbers in each group, we were not able to include more than two categories for education and net household income (low-intermediate versus high). By using two instead of several categories for educational level and income, we were not able to compare the highest versus the lowest levels of SES only, meaning that we might have missed differences only apparent when comparing the extremes. We compensated for this by also comparing GMC/T ratios in the low educational level *plus* low income group versus the high educational level *plus* high income group. However, in countries with relatively small differences in SES, such as the Netherlands, differences in immune response may be more difficult to detect.

Every child was sampled only once in this cross-sectional study, meaning that every child was included in only one timeframe after vaccination. Thus, the two timeframes (1m-1y and 1-3y) could not be compared directly as data in the two timeframes were from two different groups of children. On the other hand, within each timeframe the data were correlated (IgG levels against different pathogens measured in each sample). The latter implies that an outlier in IgG level against one pathogen would likely be an outlier in IgG levels against other pathogens as well if a general factor such as SES would be the cause of this. We did not verify this at the individual level.

Also, we aimed to look at immune response to vaccination only, interference with natural exposure to pathogens that are still circulating in the Netherlands (such as *Bordetella pertussis*, measles and mumps virus) could not be ruled out completely. Individuals who self-reported to have been diagnosed with clinical pertussis or mumps (resp. n=3 and n=0) were excluded from analysis, but we could not take into account possible natural boostering of immunity. In a previous study with Pienter2 data, an association was found between self-reported coughing > 2 weeks in the previous 12 months and higher pertussis ptx IgG levels [34]. Although we had access to this information, we decided not to exclude children of whom parents reported coughing > 2 weeks, since that would have meant that we had to exclude about 25% of our study population. However, there was no difference in the numbers of infants and children with > 2 weeks coughing between high and low SES.

Finally, we only considered the effect of SES on humoral immune response (IgG levels) to vaccination, which is still the most conventional response to investigate. However, vaccine response can also be quantified by looking at cellular and cytokine responses, and responses of the innate immune system [9]. Future studies should take this complex interplay of the different parts of the immune system into account.

In conclusion, this explorative study did not provide evidence for an association between SES and immune response to infant and childhood vaccination in the first three years after infant and childhood vaccination. Additional studies in other settings with data collected specifically for this purpose should confirm this. Moreover, it would be interesting to look at the longer term protection after vaccination in relation to SES.

**ACKNOWLEDGEMENTS/FUNDING**

We gratefully acknowledge the help of Liesbeth Mollema, epidemiologist at RIVM, for her help with accessing and interpreting Pienter1 and Pienter2 data.

This study was funded by the Dutch Ministry of Health.

**CONFLICTS OF INTEREST**

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

**CONTRIBUTORS**

JvdB, NR and MK designed the study and analysed the data. JvdB prepared the manuscript. All authors critically revised the manuscript. All authors approved the final article.

**REFERENCES**

[1] Marmot M, Allen J, Bell R, Bloomer E, Goldblatt P. WHO European review of social determinants of health and the health divide. Lancet 2012;380:1011─29.

[2] Mackenbach J, De Jong JP. Health inequalities, an interdisciplinary exploration of socioeconomic position, health and causality. Discussion paper. Koninklijke Nederlandse Akamedie van Wetenschappen (KNAW). Amsterdam, November 2018.

[3] Sommer I, Griebler U, Mahlknecht P, Thaler K, Bouskill K, Gartlehner G, Mendis S. Socioeconomic inequalities in non-communicable diseases and their risk factors: an overview of systematic reviews. BMC Public Health 2015;15:914. DOI: 10.1186/s12889-015-2227-y.

[4] De Cantuária Tauil M, Sayuri Sato AP, Waldman EA. Factors associated with incomplete or delayed vaccination across countries: a systematic review. Vaccine 2016;34:2635­─43.

[5] Jain A, Van hoek AJ, Boccia D, Thomas SL. Lower vaccine uptake amongst older individuals living alone: a systematic review and meta-analysis of social determinants of vaccine uptake. Vaccine 2017;25:2315─28.

[6] De Gier B, Houben-van Herten M, Uiters E, Hahné S. Educational differences in acute infectious diseases in the Netherlands: results from a nationwide health survey. 2019; Submitted for publication.

[7] Lockwood KG, John-Henderson NA, Marsland AL. Early life socioeconomic status associates with interleukin-6 responses to acute laboratory stress in adulthood. Physiology and Behavior 2018;188:212─20.

[8] Van Loveren H, Van Amsterdam JGC, Vandebriel RJ, Kimman TG, Rümke HC, Steerenberg PS, Vos JG. Vaccine-induced antibody responsed as parameters of the inluence of endogenous and environmental factors. Environ health Perspect 2001;109:757─64.

[9] Zimmerman P, Curtis P. Factors that influence the immune response to vaccination. Clinical Microbiology Reviews 2019;32:e00084-18.

[10] Hoes J, Boef AGC, Knol MJ, De Melker HE, Mollema L, Van der Klis FRM, Rots NY, Van Baarle D. Socioeconomic status is associated with antibody levels against vaccine preventable diseases in the Netherlands. Frontiers in Public Health 2018;6:209.

[11] Van der Klis FRM, Berbers GAM, De Melker HE, Coutinho RA. Second national serum bank for population-based seroprevalence studies in the Netherlands. The Netherlands Journal of Medicine 2009;67:301─8.

[12] Van Lier EA, Oomen PJ, Oostenbrug MWM, Zwakhals SLN, Drijfhout IH, De Hoogh PAAM, De Melker HE. Vaccinatiegraad Rijksvaccinationprogramma Nederland. Jaarverslag 2006-2008. RIVM rapport 210021007. 2008. RIVM, Bilthoven, The Netherlands. Available from: <https://www.rivm.nl/bibliotheek/rapporten/210021007.pdf> (accessed 15 August 2019).

[13] Smits GP, Van Gageldonk PG, Schouls LM, Van der Klis FR, Berbers GA. Development of a bead-based multiplex immunoassay for simultaneous quantitative detection of IgG serum antibodies against measles, mumps, rubella and varicella-zoster virus. Clinical and Vaccine Immunology 2012;19:396─400.

[14] De Voer RM, Schepp RM, Versteegh FG, Van der Klis FR, Berbers GA. Simultaneous detection of Haemophilus influenzae type b polysaccharide-specific antibodies in a fluorescent-bead-based multiplex immunoassay. Clinical and Vaccine Immunology 2009;16:433─6.

[15] Van Gageldonk PG, Van Schaijk FG, Van der Klis FR, Berbers GA. Development and validation of a multiplex immunoassay for the simultaneous determination of serum antibodies to Bordetella pertussis, diphtheria and tetanus. Journal of immunological methods 2008;335:79─89.

[16] Van der Maas N, Mollema L, Berbers G, Van Rooijen D, Van der Avoort H, Conyn-Van Spaendonck M, et al. Immunity against poliomyelitis in the Netherlands, assessed in 2006 to 2007: the importance of completing a vaccination series. Editorial team Editorial advisors 2014:43.

[17] Benjamini Y, Hochberg Y. Controlling the false discovery rate: a practical and powerful approach to multiple testing. J. R. Statist. Soc. 1995;57:289-300.

[18] Mollema L, Smits G, Berbers G, Van der Klis F, Van Binnendijk R, De Melker H, et al. High risk of a large measles outbreak despite 30 years of measles vaccination in The Netherlands. Epidemiology and Infection 2014;142:1100─8.

[19] Smits G, Mollema L, Hahné S, De Melker H, Tcherniaeva I, Van der Klis F, et al. Seroprevalence of rubella antibodies in The Netherlands after 32 years of high vaccination coverage. Vaccine 2014;32:1890─5.

[20] Smits G, Mollema L, Hahné S, De Melker H, Tcherniaeva I, Waaijenborg S, et al. Seroprevalence of mumps in the Netherlands: dynamics over a decade with high vaccination coverage and recent outbreaks. PloS ONE 2013;8:e58234.

[21] Swart E, Van Gageldonk P, De Melker H, Van der Klis F, Berbers G, Mollema L. Long-term protection against diphtheria in the Netherlands after 50 years of vaccination: results from a seroepidemiological study. PloS ONE 2016;11:e0148605.

[22] Steens A, Mollema L, Berbers G, Van Gageldonk P, Van der Klis F, De Melker H. High tetanus antitoxin antibody concentrations in the Netherlands: a seroepidemiological study. Vaccine 2010;28:7803─9.

[23] De Voer RM, Mollema L, Schepp RM, De Greeff SC, Van Gageldonk PG, De Melker HE, et al. Immunity against Neisseria meningitidis seorgroup C in the Dutch population before and after introduction of the meningococcal c conjugate vaccine. PloS ONE 2010;5:e12144.

[24] De Melker H, Van den Hof S, Berbers G, Conyn-van Spaendonck M. Evaluation of the national immunisation programme in the Netherlands: immunity to diphtheria, tetanus, poliomyelitis, measles, mumps, rubella and Haemophilus influenazae type b. Vaccine 2003;21:716─20.

[25] Whelan J, Hahné S, Berbers G.A.M., Van der Klis F, Wijnands Y, Boot H. Immunogenicity of a hexavalent vaccine co-administered with 7-valent pneumococcal conjugate vaccine. Findings from the National Immunization Programme in the Netherlands. Human Vaccines & Immunotherapeutics 2012;8:743─8.

[26] De Melker H, Conyn-van Spaendonck M. Immunosurveillance and the evaluation of national immunization programmes: a population-based approach. Epidemiol Infect 1998;121:637─43.

[27] De Melker H, Van den Hof S, Berbers G, Conyn-van Spaendonck M. Evaluation of the national immunisation programme in the Netherlands: immunity to diphtheria, tetanus, poliomyelitis, measles, mumps, rubella and *Haemophilus influenzae* type b. Vaccine 2003;21:716─20.

[28] Hoes J, Knol MJ, Mollema L, Buisman A, De Melker HE, Van der Klis FRM. Comparison of antibody response between boys and girls after infant and childhood vaccinations in the Netherlands. Vaccine 2019;37:4504─10

[29] Adler NE, Newman K. Socioeconomic disparities in health: pathways and policies. Health Affairs 2002;21:60─76. DOI: 1377/hlthaff.21.2.60.

[30] McVernon J, Andrews N, Slack M, Moxon R, Ramsay M. Host and environmental factors associated with Hib in England, 1998-2002. Arch Dis Childhood 2008;93:670─5. DOI: 10.1136/adc.2006.097501.

[31] Loeb MB. Use of a broader determinants of health model for community-acquired pneumonia in seniors. Clinical Infectious Diseases 2004;38:1293─7.

[32] Kriz P, Bobak M, Kriz B. Parental smoking, socioeconomic factors, and risk of invasive meningococcal disease in children: a population based casecontrol study. Arch Dis Childhood 2000;83:117─21. DOI: 10.1136/adc.8.

[33] Dowd JB, Aiello A. Socioeconomic differentials in immune response in the US. Epidemiology 2009;20:902─8. DOI: 10.1016/j.socscimed.2008.12.010.

[34] De Greeff SC, De Melker HE, Van Gageldonk PG, Schellekens JF, Van der Klis FR, Mollema L, Mooi FR, Berbers GA. Seroprevalence of pertussis in The Netherlands: evidence for increased circulation of Bordetella pertussis. PLoS ONE 2010;5(12):e14183. DOI: 10.1371/journal.pone.0014183.

**TABLE 1.** Characteristics of all infants and children included in timeframes 1m-1y (n=358) and 1-3y (n=536) after vaccination according to NIP by educational level of mother

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | | **Infants (approximately 0-4 years)** | | | | | **Children (approximately 4-12 years)** | | | | |
| **Low educational level** | | **High educational level** | |  | **Low educational level** | | **High educational level** | |  |
| **N** | **%** | **n** | **%** | **p-value** | **n** | **%** | **n** | **%** | **p-value** |
| **Total** | | | 190 | 53% | 168 | 47% | - | 327 | 61% | 209 | 39% | - |
| **Male sex** | | | 92 | 48% | 89 | 53% | 0.27 | 157 | 48% | 103 | 49% | 0.81 |
| **Born in the Netherlands** | | | 176 | 93% | 157 | 93% | 0.90 | 269 | 82% | 189 | 90% | 0.002 |
| **Migration background** | **Indigenous Dutch** | | 123 | 65% | 135 | 80% | 0.002 | 199 | 61% | 162 | 78% | 0.004 |
| **1st generation other western** | | 0 | 0% | 1 | 0.6% | 1 | 0.3% | 1 | 0.5% |
| **2nd generation other western** | | 4 | 2% | 11 | 7% | 12 | 4% | 14 | 7% |
| **1st generation Moroccan or Turkish** | | 2 | 1% | 1 | 0.6% | 20 | 6% | 2 | 1% |
| **2nd generation Moroccan or Turkish** | | 28 | 15% | 1 | 0.6% | 26 | 8% | 1 | 0.5% |
| **1st generation Surinam or Aruban or Dutch Antillean** | | 4 | 2% | 2 | 1% | 16 | 5% | 8 | 4% |
| **2nd generation Surinam or Aruban or Dutch Antillean** | | 16 | 8% | 6 | 4% | 23 | 7% | 8 | 4% |
| **1st generation other non-western** | | 2 | 1% | 3 | 2% | 14 | 4% | 8 | 4% |
| **2nd generation other non-western** | | 11 | 6% | 8 | 5% | 16 | 5% | 5 | 2% |
| **Urbanization** | | **Very high** | 35 | 18% | 31 | 18% | 0.97 | 58 | 18% | 38 | 18% | 0.96 |
| **High** | 58 | 31% | 54 | 32% | 117 | 36% | 71 | 34% |
| **Moderate** | 35 | 18% | 28 | 17% | 65 | 20% | 45 | 22% |
| **Low** | 62 | 33% | 55 | 33% | 87 | 27% | 55 | 26% |
| **Net household income** | | **High** | 17 | 9% | 73 | 43% | <0.001 | 29 | 9% | 78 | 37% | <0.001 |
| **Low** | 128 | 67% | 71 | 42% | 228 | 70% | 101 | 48% |
| **Unknown** | 45 | 24% | 24 | 14% | 70 | 21% | 30 | 14% |
| **Median age (months) at vaccination (5th-95th percentile)** | | **DTP-IPV 11 m** | 11 (10-13) | | 11 (10-13) | | 0.25 | n.a. | | n.a. | | - |
| **DTP-IPV 4 y** | n.a. | | n.a. | | - | 46 (44-51) | | 46 (44-54) | | 0.11 |
| **DT-IPV 9 y** | n.a. | | n.a. | | - | 107 (99-116) | | 107 (99-114) | | 0.98 |
| **MMR1** | 14 (12-16) | | 14 (13-16) | | 0.63 | n.a. | | n.a. | | - |
| **MMR2** | n.a. | | n.a. | | - | 107 (100-116) | | 107 (100-114) | | 0.96 |
| **MenC** | 14 (14-16) | | 14 (14-16) | | 0.58 | n.a. | | n.a. | | - |
| **Hib** | 11 (10-13) | | 11 (10-13) | | 0.059 | n.a. | | n.a. | | - |

**TABLE 2.** Characteristics of all infants and children included in timeframes 1m-1y (n=294) and 1-3y (n=438) after vaccination according to NIP by net household income

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | | **Infants (approximately 0-4 years)** | | | | | **Children (approximately 4-12 years)** | | | | |
| **Low household income** | | **High household income** | |  | **Low household income** | | **High household income** | |  |
| **N** | **%** | **n** | **%** | **p-value** | **n** | **%** | **n** | **%** | **p-value** |
| **Total** | | | 203 | 69% | 91 | 31% | - | 331 | 75% | 107 | 24% | - |
| **Male sex** | | | 102 | 50% | 48 | 53% | 0.67 | 155 | 47% | 55 | 51% | 0.47 |
| **Born in the Netherlands** | | | 183 | 91% | 86 | 95% | 0.42 | 269 | 81% | 100 | 93% | 0.004 |
| **Migration background** | **Indigenous Dutch** | | 122 | 60% | 80 | 88% | 0.02 | 192 | 58% | 93 | 87% | 0.007 |
| **1st generation other western** | | 0 | 0% | 1 | 1% | 1 | 0.3% | 1 | 0.9% |
| **2nd generation other western** | | 10 | 5% | 7 | 8% | 16 | 5% | 6 | 6% |
| **1st generation Moroccan or Turkish** | | 3 | 1% | 0 | 0% | 18 | 5% | 0 | 0% |
| **2nd generation Moroccan or Turkish** | | 26 | 13% | 0 | 0% | 23 | 7% | 0 | 0% |
| **1st generation Surinam or Aruban or Dutch Antillean** | | 6 | 3% | 0 | 0% | 18 | 5% | 3 | 3% |
| **2nd generation Surinam or Aruban or Dutch Antillean** | | 18 | 9% | 2 | 2% | 25 | 8% | 2 | 2% |
| **1st generation other non-western** | | 6 | 3% | 0 | 0% | 18 | 5% | 2 | 2% |
| **2nd generation other non-western** | | 12 | 6% | 1 | 1% | 20 | 6% | 0 | 0% |
| **Urbanization** | | **Very high** | 42 | 21% | 18 | 20% | 0.51 | 63 | 19% | 21 | 20% | 0.75 |
| **High** | 56 | 28% | 35 | 38% | 112 | 34% | 43 | 40% |
| **Moderate** | 39 | 19% | 13 | 14% | 68 | 21% | 22 | 21% |
| **Low** | 66 | 33% | 91 | 31% | 88 | 27% | 21 | 20% |
| **Educational level mother** | | **High** | 128 | 63% | 17 | 19% | <0.001 | 101 | 31% | 78 | 73% | <0.001 |
| **Low** | 71 | 35% | 73 | 80% | 228 | 69% | 29 | 27% |
| **Unknown** | 4 | 2% | 1 | 1% | 2 | 1% | 0 | 0% |
| **Median age (months) at vaccination (5th-95th percentile)** | | **DTP-IPV 11 m** | 11 (10-13) | | 11 (10-13) | | 0.39 | n.a. | | n.a. | | - |
| **DTP-IPV 4 y** | n.a. | | n.a. | | - | 46 (44-52) | | 46 (44-50) | | 0.55 |
| **DT-IPV 9 y** | n.a. | | n.a. | | - | 107 (99-114) | | 107 (100-114) | | 0.89 |
| **MMR1** | 14 (14-16) | | 14 (13-16) | | 0.81 | n.a. | | n.a. | | - |
| **MMR2** | n.a. | | n.a. | | - | 107 (100-115) | | 107 (100-114) | | 0.39 |
| **MenC** | 14 (14-16) | | 14 (14-16) | | 0.89 | n.a. | | n.a. | | - |
| **Hib** | 11 (10-13) | | 11 (10-13) | | 0.17 | n.a. | | n.a. | | - |

**TABLE 3.** Comparison of proportions of infants and children with protective IgG levels by educational level of mother and net household income

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  | **Educational level of mother** | | | | | **Net household income** | | | | | |
| **Low educational level** | | **High educational level** | |  | **Low household income** | | **High household income** | |  | |
| **Pathogen** | **Threshold for protection 17-24** | **Vaccination** | **n/N** | **%** | **n/N** | **%** | **p-value** | **n/N** | **%** | **n/N** | **%** | **p-value** |
| Measles | ≥0.2 IU/ml | BMR1, 1m-1y | 42/43 | 98% | 41/41 | 100% | 0.31 | 38/39 | 97% | 27/27 | 100% | 0.42 |
|  |  | BMR1, 1-3y | 126/126 | 100% | 102/103 | 100% | 0.28 | 135/135 | 100% | 54/54 | 100% | - |
|  |  | BMR2, 1m-1y | 62/62 | 100% | 25/25 | 100% | - | 56/56 | 100% | 13/13 | 100% | - |
|  |  | BMR2, 1-3 y | 86/86 | 100% | 68/69 | 99% | 0.25 | 88/88 | 100% | 30/30 | 100% | - |
| Mumps | ≥45 RU/ml | BMR1, 1m-1y | 40/43 | 93% | 36/41 | 88% | 0.42 | 37/39 | 95% | 24/27 | 89% | 0.36 |
|  |  | BMR1, 1-3y | 112/126 | 89% | 88/103 | 85% | 0.48 | 121/135 | 90% | 46/54 | 85% | 0.24 |
|  |  | BMR2, 1m-1y | 60/62 | 97% | 25/25 | 100% | 0.37 | 55/56 | 98% | 12/13 | 92% | 0.26 |
|  |  | BMR2, 1-3 y | 84/86 | 98% | 68/69 | 99% | 0.71 | 86/88 | 98% | 30/30 | 100% | 0.39 |
| Rubella | ≥10 IU/ml | BMR1, 1m-1y | 43/43 | 100% | 41/41 | 100% | - | 39/39 | 100% | 27/27 | 100% | - |
|  |  | BMR1, 1-3y | 126/126 | 100% | 99/103 | 96% | 0.02 | 134/135 | 99% | 53/54 | 98% | 0.49 |
|  |  | BMR2, 1m-1y | 61/62 | 98% | 25/25 | 100% | 0.54 | 55/56 | 98% | 13/13 | 100% | 0.53 |
|  |  | BMR2, 1-3 y | 85/86 | 99% | 67/69 | 97% | 0.45 | 87/88 | 99% | 29/30 | 97% | 0.41 |
| Diphtheria | ≥0.01 IU/ml | DTP-IPV 11 m, 1m-1y | 38/40 | 95% | 48/48 | 100% | 0.09 | 43/45 | 96% | 28/28 | 100% | 0.19 |
|  |  | DTP-IPV 11 m, 1-3y | 108/119 | 91% | 78/88 | 89% | 0.61 | 108/122 | 89% | 39/44 | 89% | 0.98 |
|  |  | DTP-IPV 4 y, 1m-1y | 70/70 | 100% | 43/43 | 100% | - | 75/75 | 100% | 26/26 | 100% | - |
|  |  | DTP-IPV 4 y, 1-3y | 95/96 | 99% | 66/67 | 99% | 0.79 | 98/98 | 100% | 35/36 | 97% | 0.13 |
|  |  | DT-IPV 9 y, 1m-1y | 53/53 | 100% | 24/24 | 100% | - | 48/48 | 100% | 12/12 | 100% | - |
|  |  | DT-IPV 9 y, 1-3y | 83/83 | 100% | 68/68 | 100% | - | 87/87 | 100% | 30/30 | 100% | - |
| Tetanus | ≥0.01 IU/ml | DTP-IPV 11 m, 1m-1y | 40/40 | 100% | 48/48 | 100% | - | 45/45 | 100% | 28/28 | 100% | - |
|  |  | DTP-IPV 11 m, 1-3y | 119/119 | 100% | 88/88 | 100% | - | 122/122 | 100% | 44/44 | 100% | - |
|  |  | DTP-IPV 4 y, 1m-1y | 69/69 | 100% | 43/43 | 100% | - | 75/75 | 100% | 26/26 | 100% | - |
|  |  | DTP-IPV 4 y, 1-3y | 95/95 | 100% | 67/67 | 100% | - | 98/98 | 100% | 35/35 | 100% | - |
|  |  | DT-IPV 9 y, 1m-1y | 53/53 | 100% | 24/24 | 100% | - | 48/48 | 100% | 12/12 | 100% | - |
|  |  | DT-IPV 9 y, 1-3y | 83/83 | 100% | 68/68 | 100% | - | 87/87 | 100% | 30/30 | 100% | - |
| Polio 1 | Log2≥3 | DTP-IPV 11 m, 1m-1y | 39/40 | 98% | 47/48 | 98% | 0.90 | 44/45 | 98% | 27/28 | 96% | 0.73 |
|  |  | DTP-IPV 11 m, 1-3y | 107/119 | 90% | 82/88 | 93% | 0.50 | 113/122 | 93% | 39/44 | 89% | 0.35 |
|  |  | DTP-IPV 4 y, 1m-1y | 70/70 | 100% | 43/43 | 100% | - | 75/75 | 100% | 26/26 | 100% | - |
|  |  | DTP-IPV 4 y, 1-3y | 94/96 | 98% | 66/67 | 99% | 0.78 | 95/98 | 97% | 36/36 | 100% | 0.37 |
|  |  | DT-IPV 9 y, 1m-1y | 53/53 | 100% | 24/24 | 100% | - | 48/48 | 100% | 12/12 | 100% | - |
|  |  | DT-IPV 9 y, 1-3y | 82/83 | 99% | 69/69 | 100% | 0.36 | 87/87 | 100% | 30/30 | 100% | - |
| Polio 2 | Log2≥3 | DTP-IPV 11 m, 1m-1y | 40/40 | 100% | 47/48 | 98% | 0.36 | 45/45 | 100% | 27/28 | 96% | 0.21 |
|  |  | DTP-IPV 11 m, 1-3y | 101/119 | 85% | 80/88 | 91% | 0.26 | 106/122 | 87% | 39/44 | 89% | 0.72 |
|  |  | DTP-IPV 4 y, 1m-1y | 70/70 | 100% | 42/43 | 98% | 0.16 | 75/75 | 100% | 25/26 | 96% | 0.06 |
|  |  | DTP-IPV 4 y, 1-3y | 95/96 | 99% | 67/67 | 100% | 0.42 | 98/98 | 100% | 35/36 | 97% | 0.13 |
|  |  | DT-IPV 9 y, 1m-1y | 53/53 | 100% | 24/24 | 100% | - | 48/48 | 100% | 12/12 | 100% | - |
|  |  | DT-IPV 9 y, 1-3y | 82/83 | 99% | 69/69 | 100% | 0.36 | 87/87 | 100% | 30/30 | 100% | - |
| Polio 3 | Log2≥3 | DTP-IPV 11 m, 1m-1y | 38/40 | 95% | 44/48 | 92% | 0.56 | 44/45 | 98% | 24/28 | 86% | 0.06 |
|  |  | DTP-IPV 11 m, 1-3y | 77/119 | 65% | 49/88 | 56% | 0.27 | 82/122 | 67% | 22/44 | 50% | 0.04 |
|  |  | DTP-IPV 4 y, 1m-1y | 64/70 | 91% | 35/43 | 81% | 0.19 | 67/75 | 89% | 22/26 | 85% | 0.51 |
|  |  | DTP-IPV 4 y, 1-3y | 78/96 | 81% | 52/67 | 78% | 0.57 | 79/98 | 81% | 28/36 | 78% | 0.75 |
|  |  | DT-IPV 9 y, 1m-1y | 53/53 | 100% | 23/24 | 96% | 0.16 | 48/48 | 100% | 12/12 | 100% | - |
|  |  | DT-IPV 9 y, 1-3y | 79/83 | 95% | 67/69 | 97% | 0.57 | 85/87 | 98% | 28/30 | 93% | 0.28 |
| Pertussis-prn | ≥25 EU/ml | DTP-IPV 11 m, 1m-1y | 24/29 | 83% | 30/36 | 83% | 0.95 | 31/35 | 89% | 13/18 | 72% | 0.15 |
|  |  | DTP-IPV 11 m, 1-3y | 15/110 | 14% | 14/85 | 16% | 0.60 | 19/112 | 17% | 5/42 | 12% | 0.43 |
|  |  | DTP-IPV 4 y, 1m-1y | 42/69 | 61% | 31/45 | 69% | 0.35 | 44/74 | 59% | 19/25 | 76% | 0.05 |
|  |  | DTP-IPV 4 y, 1-3y | 43/88 | 49% | 29/53 | 55% | 0.55 | 47/86 | 55% | 14/31 | 45% | 0.51 |
| Hib | ≥0.15 µg/ml | Hib 1m-1y | 34/39 | 87% | 46/48 | 96% | 0.19 | 40/45 | 89% | 27/28 | 96% | 0.27 |
|  |  | Hib 1-3y | 96/116 | 83% | 84/93 | 90% | 0.13 | 100/117 | 85% | 43/49 | 88% | 0.72 |
| MenC | ≥2 µg/ml | MenC 1m-1y | 23/43 | 53% | 22/42 | 52% | 0.91 | 24/41 | 59% | 14/26 | 54% | 0.66 |
|  |  | MenC 1-3y | 18/130 | 14% | 11/102 | 11% | 0.45 | 20/135 | 15% | 4/56 | 7% | 0.14 |

**FIGURE 1.** GMC/T ratios: high versus low educational level of mother, with 95% confidence intervals

**FIGURE 2.** GMC ratios: high versus intermediate/low net household income, with 95% confidence intervals

**SUPPLEMENTARY TABLE 1.** Number of infants and children included by educational level of mother

**SUPPLEMENTARY TABLE 2.** Number of infants and children included by net household income

**SUPPLEMENTARY FIGURE 1.** GMC/T ratios: high versus low SES total (net household income and educational level combined), with 95% confidence intervals

**SUPPLEMENTARY FIGURE 2.** GMC/T ratios: high versus low educationalof mother with 95% confidence intervals, unadjusted (red square) and adjusted (blue circle), MMR

**SUPPLEMENTARY FIGURE 3.** GMC/T ratios: high versus low educationalof mother with 95% confidence intervals, unadjusted (red squares) and adjusted (red circles), Hib and MenC

**SUPPLEMENTARY FIGURE 4.** GMC/T ratios: high versus low educationalof mother with 95% confidence intervals, unadjusted (red squares) and adjusted (blue circles), DTP-IPV

**SUPPLEMENTARY FIGURE 5.** GMC/T ratios: high versus low net household income with 95% confidence intervals, unadjusted (red squares) and adjusted (blue circles), MMR

**SUPPLEMENTARY FIGURE 6.** GMC/T ratios: high versus intermediate/low net household income with 95% confidence intervals, unadjusted (red squares) and adjusted (blue circles), Hib and MenC

**SUPPLEMENTARY FIGURE 7.** GMC/T ratios: high versus intermediate/low net household income with 95% confidence intervals, unadjusted (red squares) and adjusted (blue circles), DTP-IPV