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DTPa immunisation for U5 year olds is trending well below 95% coverage: a call to action to reverse the trend though parent engagement

Wednesday 5 November 2025 | 6:30–7:30pm AEDT

Chaired by Dr Rodney Pearce AM

Dr Rodney Pearce AM

GP MedicalHQ Adelaide,
Immunisation Chairman of the Board
Medical Officer of Eastern Health Authority, Adelaide
Past member ATAGI and advice to PBAC

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Welcome and introduction

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We would like to thank Sanofi for sponsoring this event

Presenters

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Dr Rodney Pearce AM

GP MedicalHQ Adelaide,
Immunisation Chairman of the Board
Medical Officer of Eastern Health Authority, Adelaide
Past member ATAGI and advice to PBAC

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Dr Andrew Baird

General Practitioner,
St Kilda Medical Group

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DTPa Immunisation in Australian Children Under 5: Epidemiology, Importance, and Strategies to Reverse Declining Coverage

PART 1

COI Disclosures

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- At times I have received consultation fees from Sanofi, Pfizer, Seqirus, PSA and MSD, taken part as an invited speaker for Sanofi, Advisory board for MSD, and am a Chief Investigator on an investigator-initiated grant investigating RSV complications in children funded by MSD, all outside of this presentation.
- My attendance in this meeting was supported by the Immunisation Coalition

Epidemiology of DTP Diseases

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- Diphtheria: Rare in Australia due to high vaccine coverage; caused by Corynebacterium diphtheriae
- Tetanus: Extremely rare; caused by Clostridium tetani spores in wounds
- Pertussis (Whooping Cough): Most common of the three
  - In Australia most common acute preventable disease
  - Epidemics every 3-4 years
  - Increasing cases among adolescent and adults due to waning immunity
- Children under 5 are most vulnerable, especially infants <6 months

Burden of disease in U5 children

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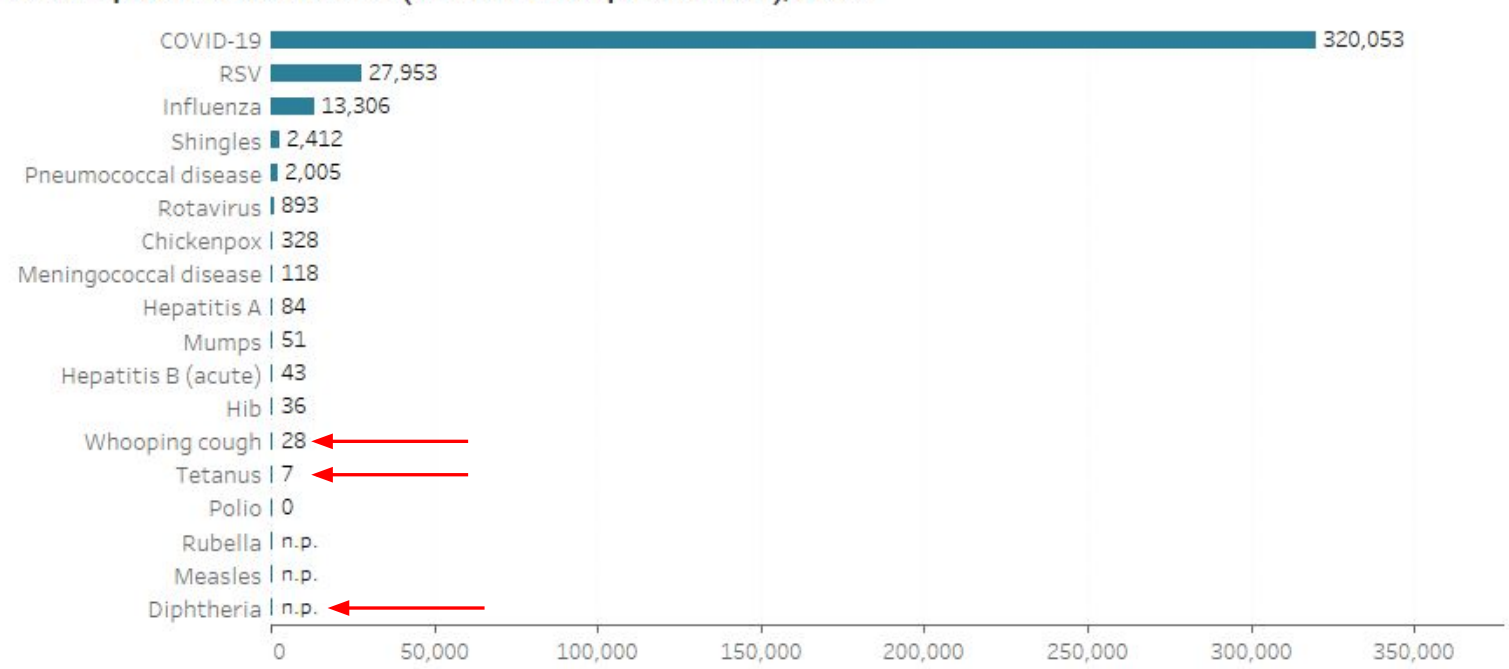
Select measure:
- (●) Number
- ( ) Rate

Select data level:
- ( ) Deaths
- (●) Hospitalisations
- ( ) Notifications

Filter by diseases:
All



n.p. = not publishable because of small numbers, confidentiality or other concerns about the quality of the data
Note: Rate is per 1,000,000 population.
Source: AIHW analysis of National Hospital Morbidity Database.
https://www.aihw.gov.au

- Pertussis hospitalisations highest in infants <6 months
- Complications include pneumonia, seizures, encephalopathy
- Tetanus and diphtheria are rare but potentially fatal if contracted

Prevention of Diphtheria , Pertussis and Tetanus

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- DTPa and dTpa vaccines
- Prevents severe illness and death
- Reduces community transmission
- Protects vulnerable infants too young to be vaccinated
- Very effective in preventing diphtheria and tetanus and about 80% effective against pertussis
  - 71–78% for preventing milder symptoms of pertussis (≥7 days of paroxysmal cough and laboratory confirmation)
  - 84% for preventing typical disease (≥21 days of paroxysmal cough and laboratory confirmation)

DTP vaccine

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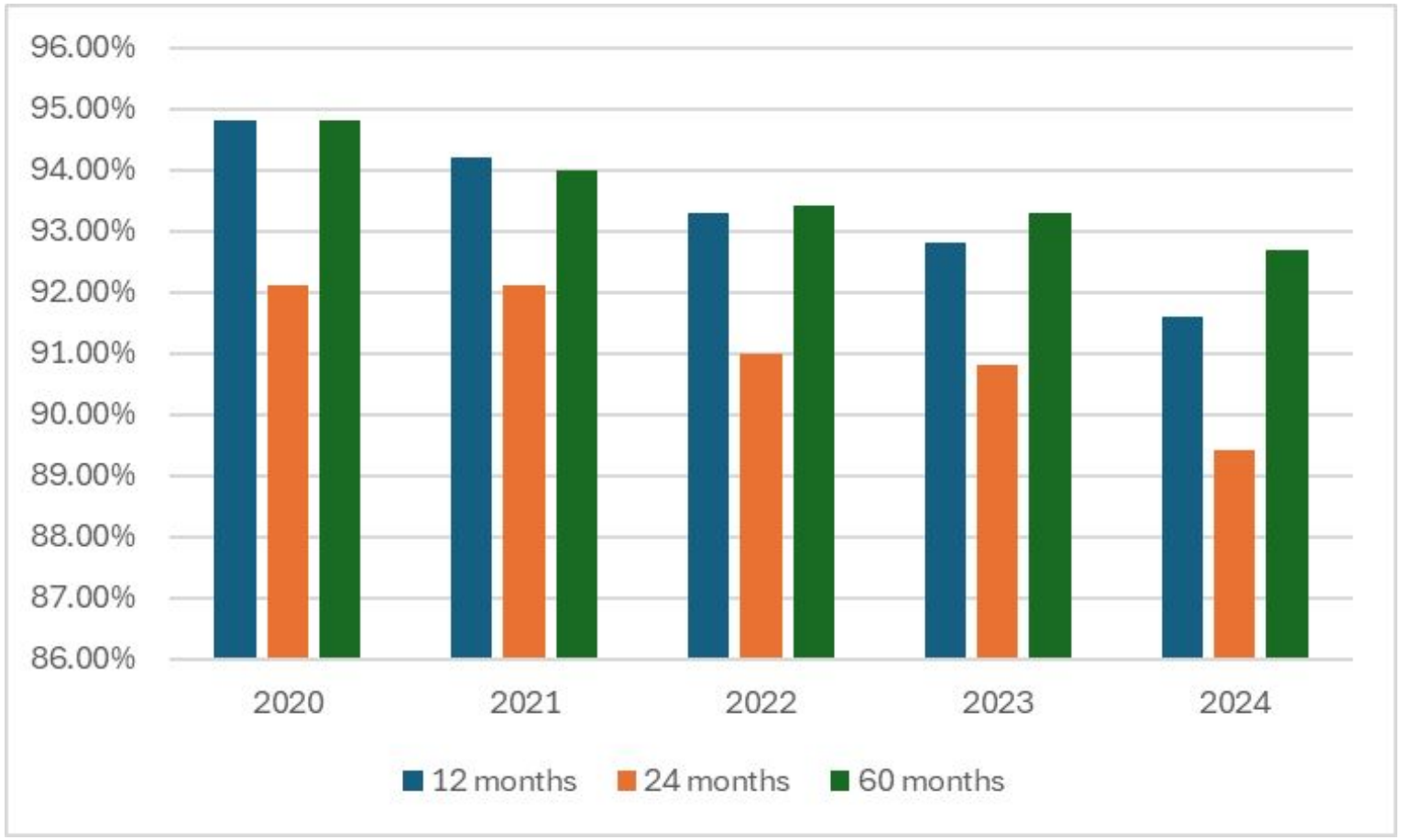
The Australian Immunisation Handbook recommends pertussis vaccination for specific groups including:

- Routine vaccination in infants and children (DTPa: 3 doses, at age 2 , 4 and 6 months with booster at18 months and age 4 years)
- Routine booster vaccination in adolescents at age 11–13 years (dTpa through school-based programs in Year 7)
- Vaccination in adults, including those in special risk groups or in contact with a special risk group, such as:
  - Women in each pregnancy (20–32 weeks' gestation)
  - Women who recently gave birth and were not vaccinated in pregnancy
  - The following adults (vaccination every 10 years)
    - Healthcare workers
    - Early childhood educators and carers
    - People in close contact with infants
    - People at increased risk of pertussis and/or increased risk of complications of pertussis (e.g., elderly, people with diabetes, people with respiratory disorders, others)
  - Refugees and other humanitarian entrants of any age (a free catch-up vaccination is available under the NIP if they did not receive the vaccines in childhood and it is recommended to receive the vaccine)

Fully vaccinated coverage



- Fully vaccinated coverage continue to decrease
- Largest decline at 12 months
- Coverage at 24 months dropped ↓ 90%

https://ncirs.org.au/immunisation-coverage-data-and-reports/annual-immunisation-coverage-report-2024-summary

Declining childhood vaccine coverage

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- Levels of on-time childhood vaccination remain substantially lower than before the pandemic, with vaccines due at older ages more likely to be received late compared to vaccines due at younger ages.

- In 2024, 1 in 3 children received the first dose of measles-mumps-rubella (MMR) vaccine late, while 1 in 5 children received the second dose of a diphtheria-tetanus-pertussis (DTP)-containing vaccine late.

https://ncirs.org.au/immunisation-coverage-data-and-reports/annual-immunisation-coverage-report-2024-summary

DTPa coverage

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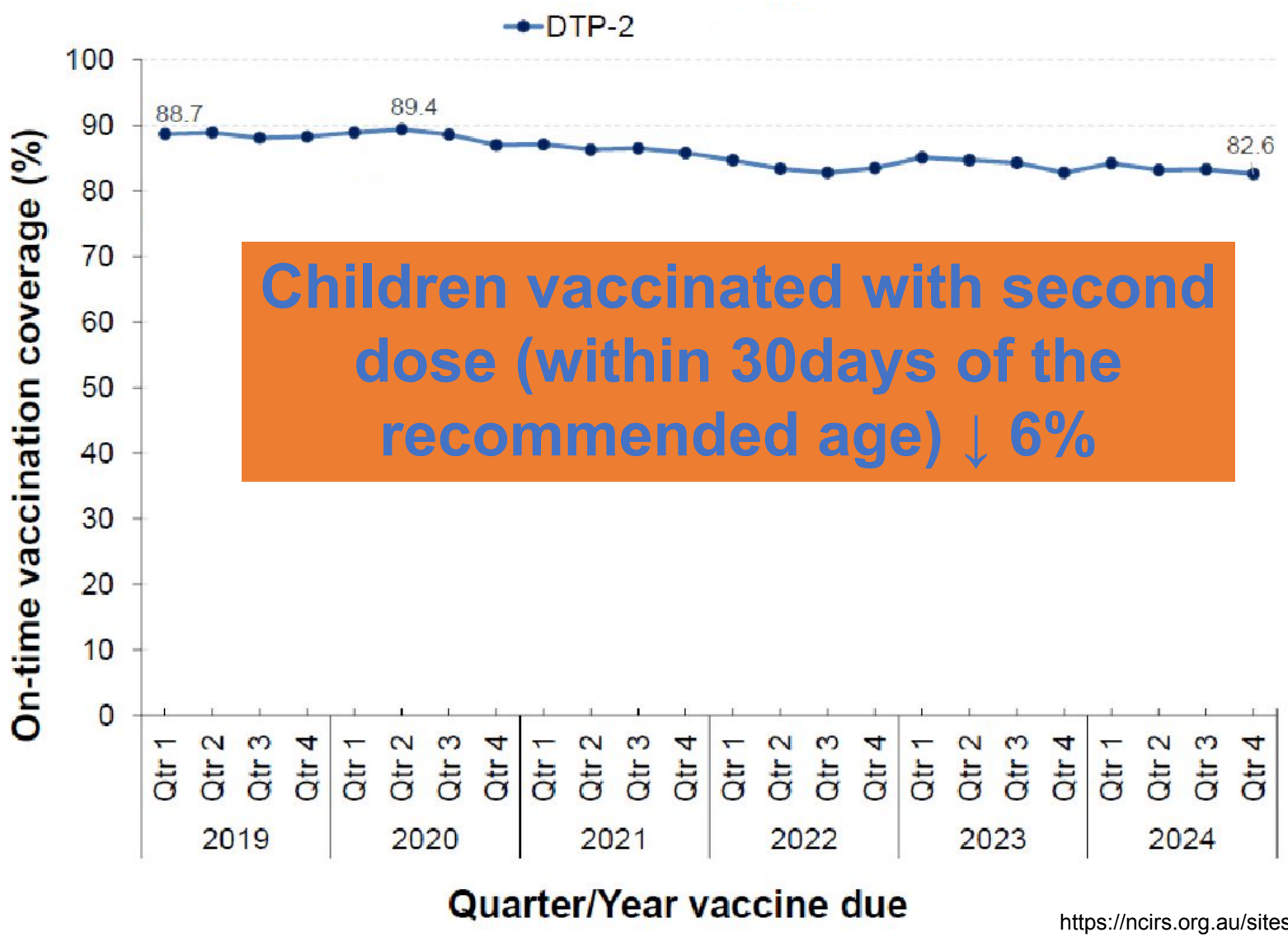
- Coverage of 3rd dose of DTPa in children at 12 months was 93.3% overall in 2023, a 0.6% lower than in 2022 and 92.2% in 2024 , a 1.1% lower than 2023

Vaccine/antigen	Milestone age	Coverage (%)		
		2023	2024	Difference¶
Fully vaccinated*	12 months†	92.8	91.6	-1.2
	24 months‡	90.8	89.4	-1.4
	60 months§	93.3	92.7	-0.6
Diphtheria-tetanus-pertussis	12 months† (dose 3)	93.3	92.2	-1.1
	24 months‡ (dose 4)	91.9	90.7	-1.2
	60 months§ (dose 4 or 5)	93.5	92.9	-0.6

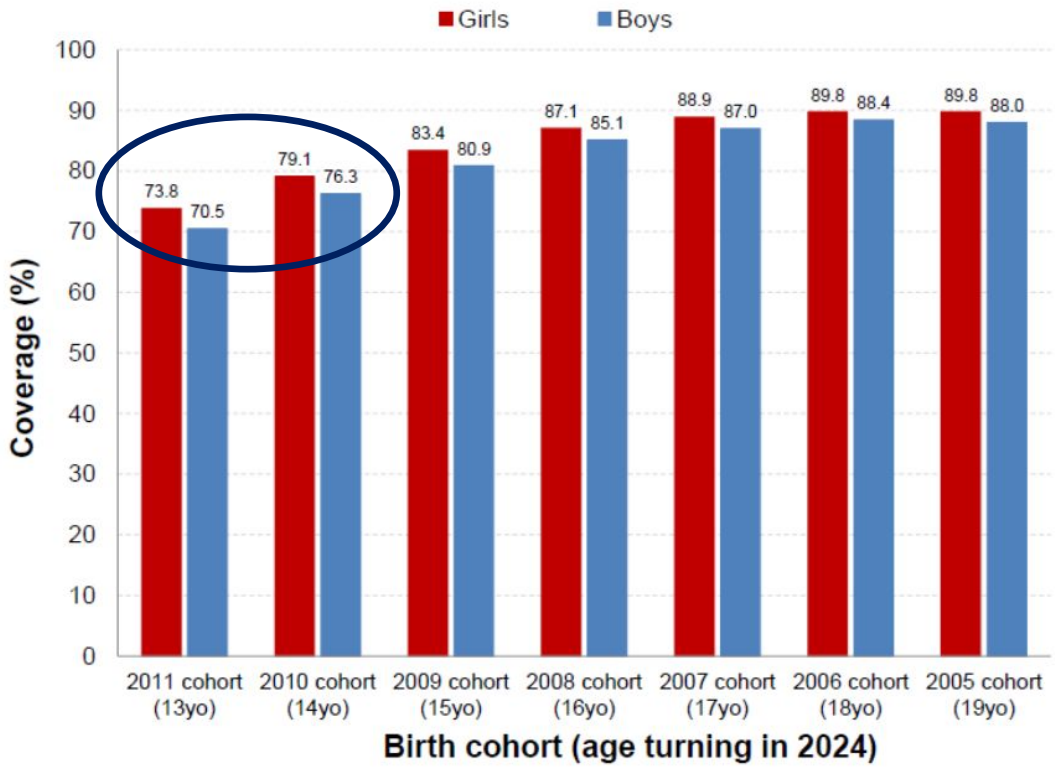
Trends in on-time vaccination coverage for DTPa second dose in children 2019-2024



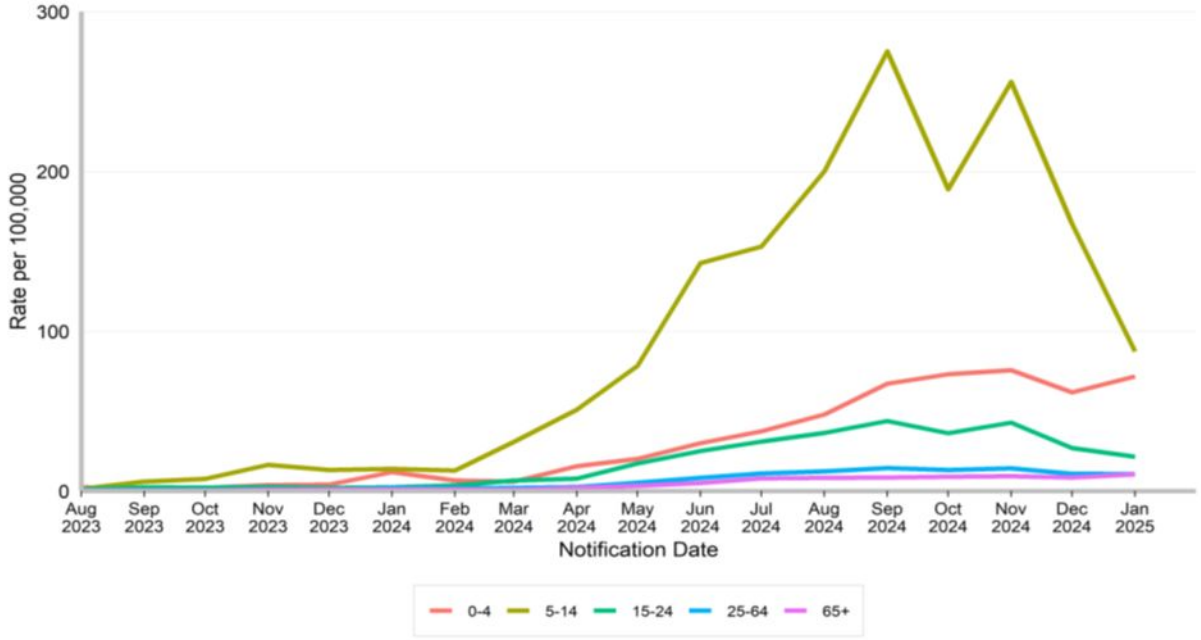
Children vaccinated with second dose (within 30days of the recommended age) ↓ 6%

https://ncirs.org.au/sites/default/files/2025-10/Annual%20Immunisation%20Coverage%20Report%202024.pdf

DTPa vaccination in adolescents



Pertussis notification by month and by age group



NSW Respiratory Surveillance Report – week ending 15 February 2025
https://ncirs.org.au/sites/default/files/2025-10/Annual%20Immunisation%20Coverage%20Report%202024.pdf

Pertussis and waning immunity

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- In highly immunised communities, pertussis can occur in adults and adolescents as a result of waning immunity
- These people are a significant reservoir of infection
- Household contacts and carers are often the source of infection in infants
- Parents are the source in more than 50% of cases
- Siblings are also a significant source of infant infections
- Young infants can also acquire the disease from healthcare workers

…….hence the vaccine recommendations

VACCINES DO NOT save lives VACCINATION DOES

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- **Parental Hesitancy**
  - Concerns about side effects and vaccine safety
  - Influence of misinformation and social media
  - Distrust
- **Access and equity**
  - Remote and rural areas face clinic shortages
  - Difficult appointment scheduling for working families
  - Barriers like transportation, cost, or lack of awareness

- **Cultural and Language Barriers**
  - Different cultural beliefs about illness and treatment
  - Need for multilingual resources and outreach

- **System Pressures**
  - Overstretched healthcare workers
  - Supply issue

Strategies to improve vaccination coverage

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- Improve access
  - Bulk billing
  - After hour delivery of vaccines
- Support provider education and advocacy
  - Funding dedicated tie for vaccination coverage
  - Communication training embedded within professional development
- Support parent/caregiver knowledge and confidence
  - Engaging communities in designing and sharing vaccination messages
  - Proactive reminders

https://www.health.gov.au/resources/publications/national-immunisation-strategy-for-australia-2025-2030?language=en

In conclusion

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- DTP remains critical for child health
- Coverage is below target—action is needed
- HCPs play a vital role in reversing the trend
- Let’s protect every child through timely immunisation

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General Practitioner
St Kilda Medical Group
Melbourne

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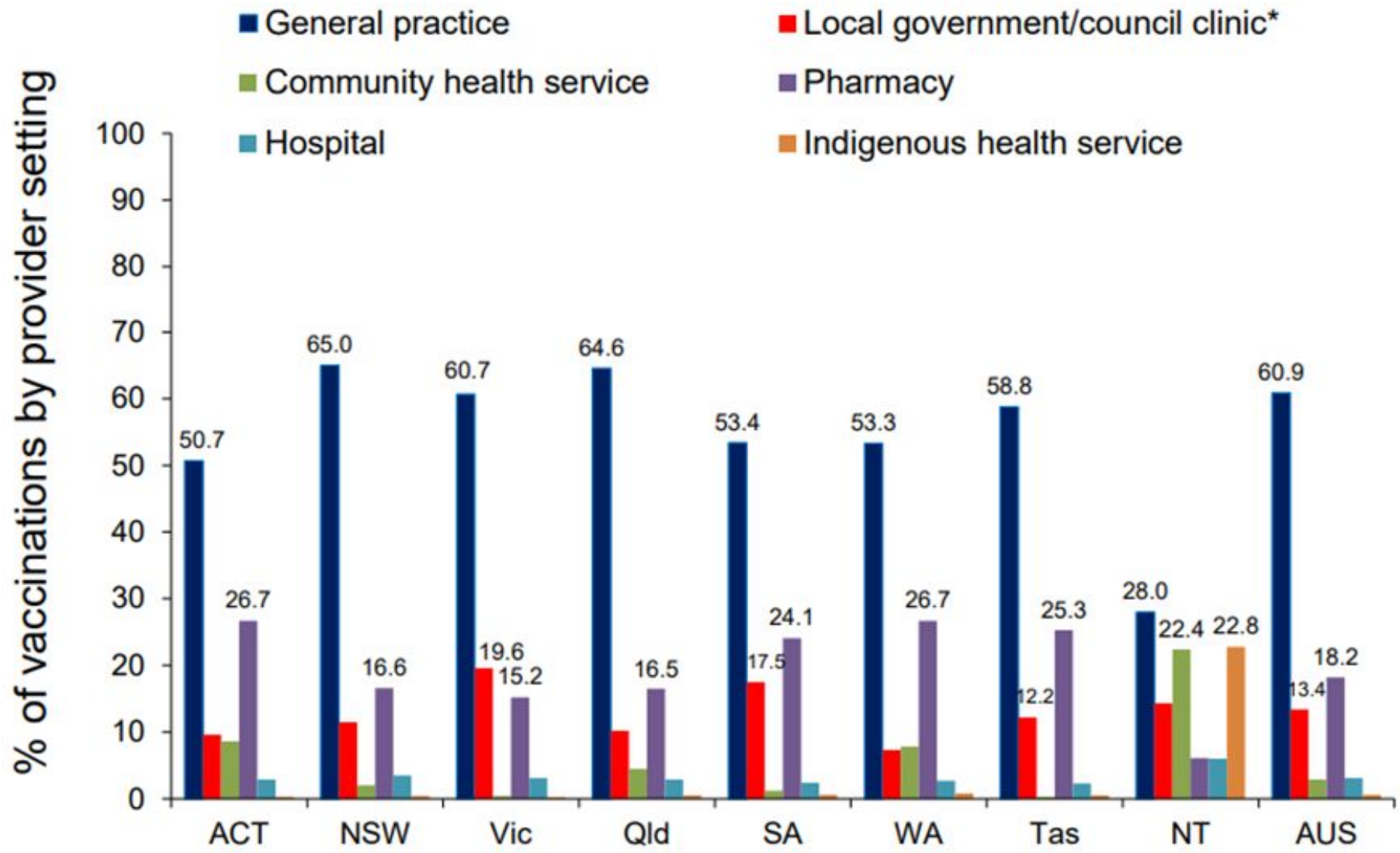
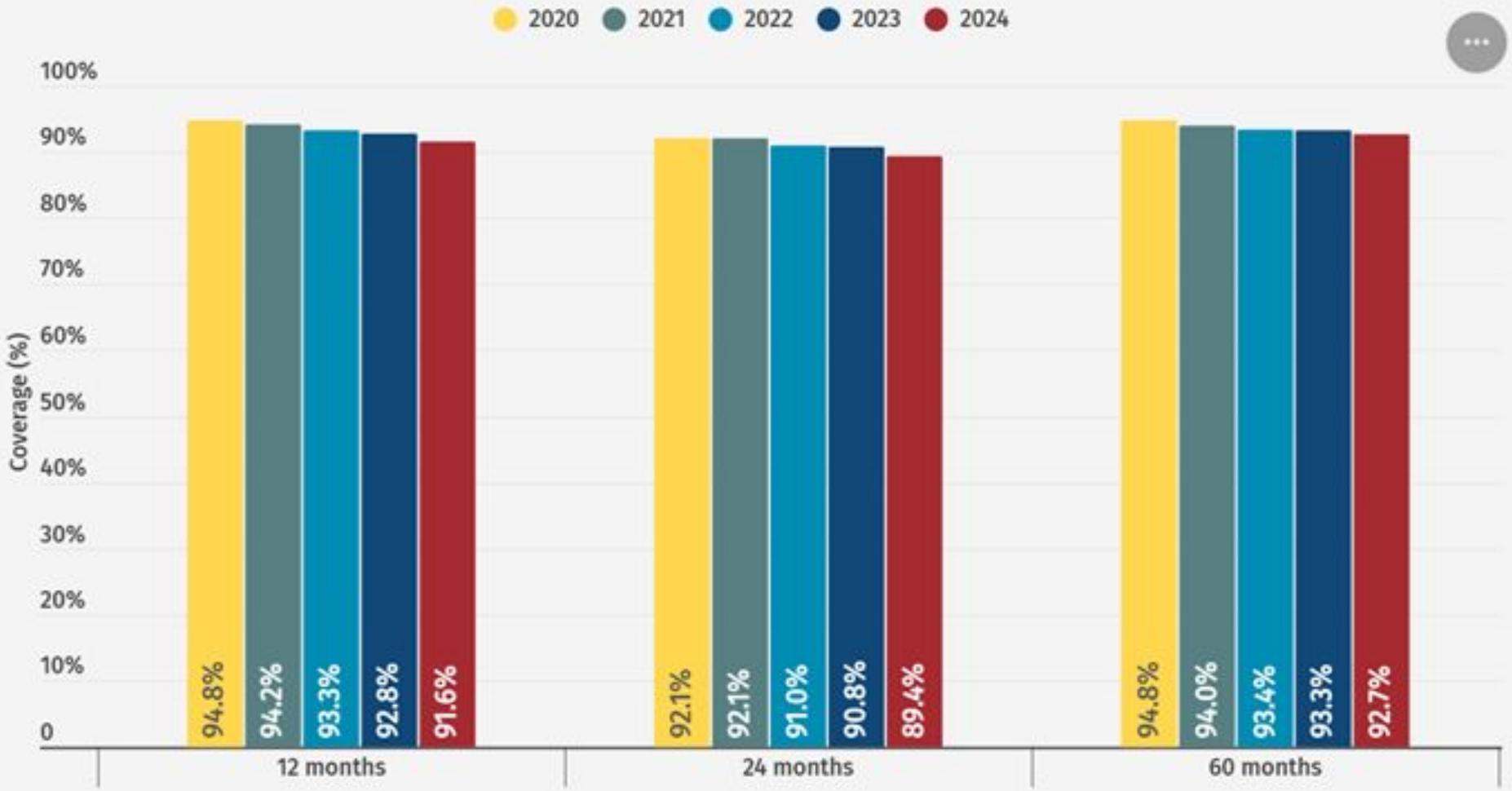
DTPa Immunisation in Australian Children Under 5: Epidemiology, Importance, and Strategies to Reverse Declining Coverage

PART 2

Figure A10. Proportion of all vaccinations given to people of all ages by provider setting and jurisdiction, Australia, 2023



All children



Fully vaccinated coverage

Fully vaccinated coverage for children continued to decrease in 2024 at all three age milestones (12, 24 and 60 months of age).

The largest decrease was at 12 months of age, with coverage dropping by 3.2 percentage points since 2020.

Coverage at 24 months of age dropped below 90% for the first time since 2016.

Coverage at 60 months of age remained higher than at the other age milestones.

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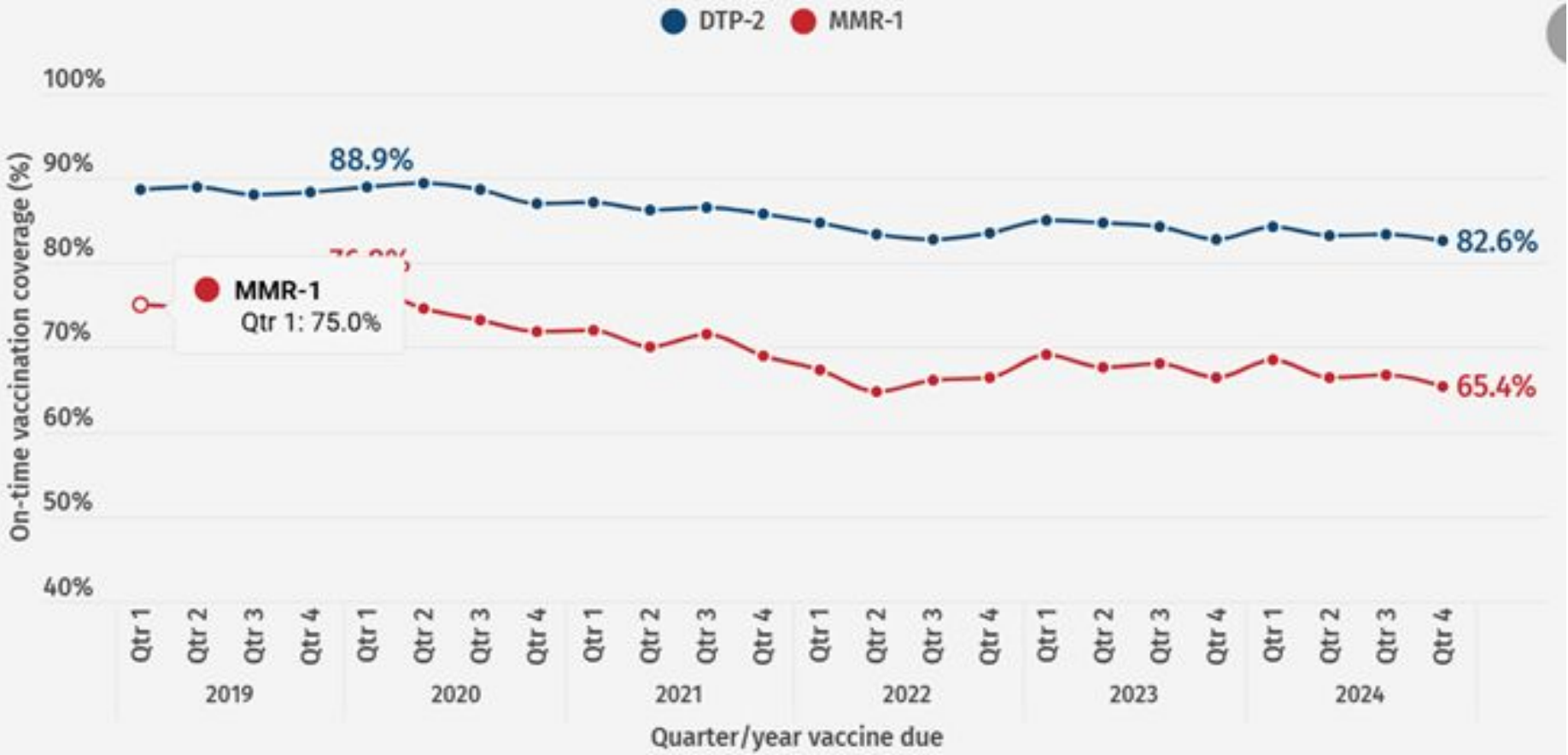
On-time vaccination

Levels of on-time vaccination (i.e. within 30 days of the recommended age) remained lower in young children than before the COVID-19 pandemic.

In the last quarter of 2024, on-time coverage of the second dose of DTP-containing vaccine was 6.3 percentage points lower than in the first quarter of 2020.

On-time coverage of the first dose of MMR vaccine was 11.4 percentage points lower in the last quarter of 2024 than in the first quarter of 2020.



Aboriginal and Torres Strait Islander children

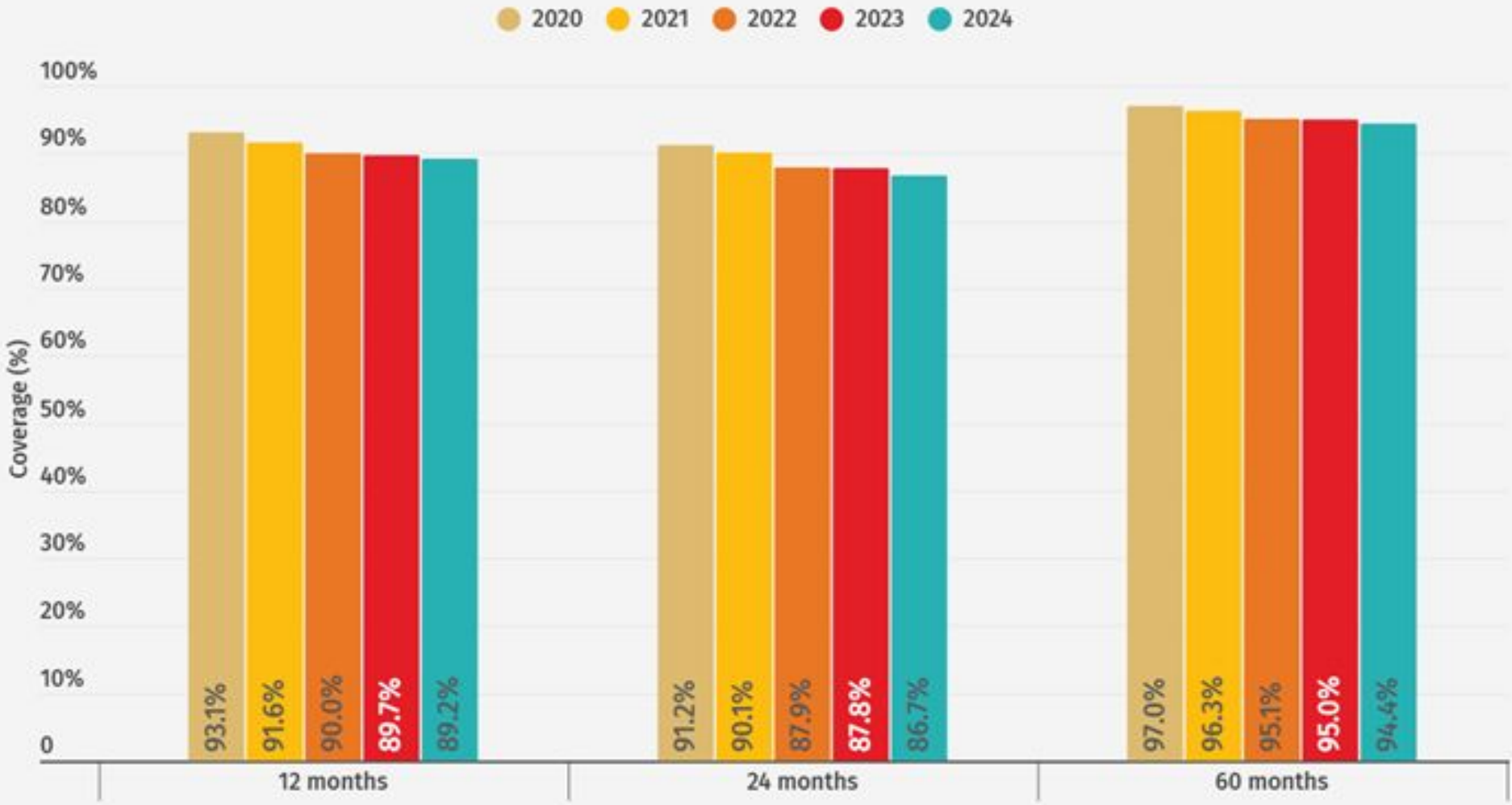
Fully vaccinated coverage

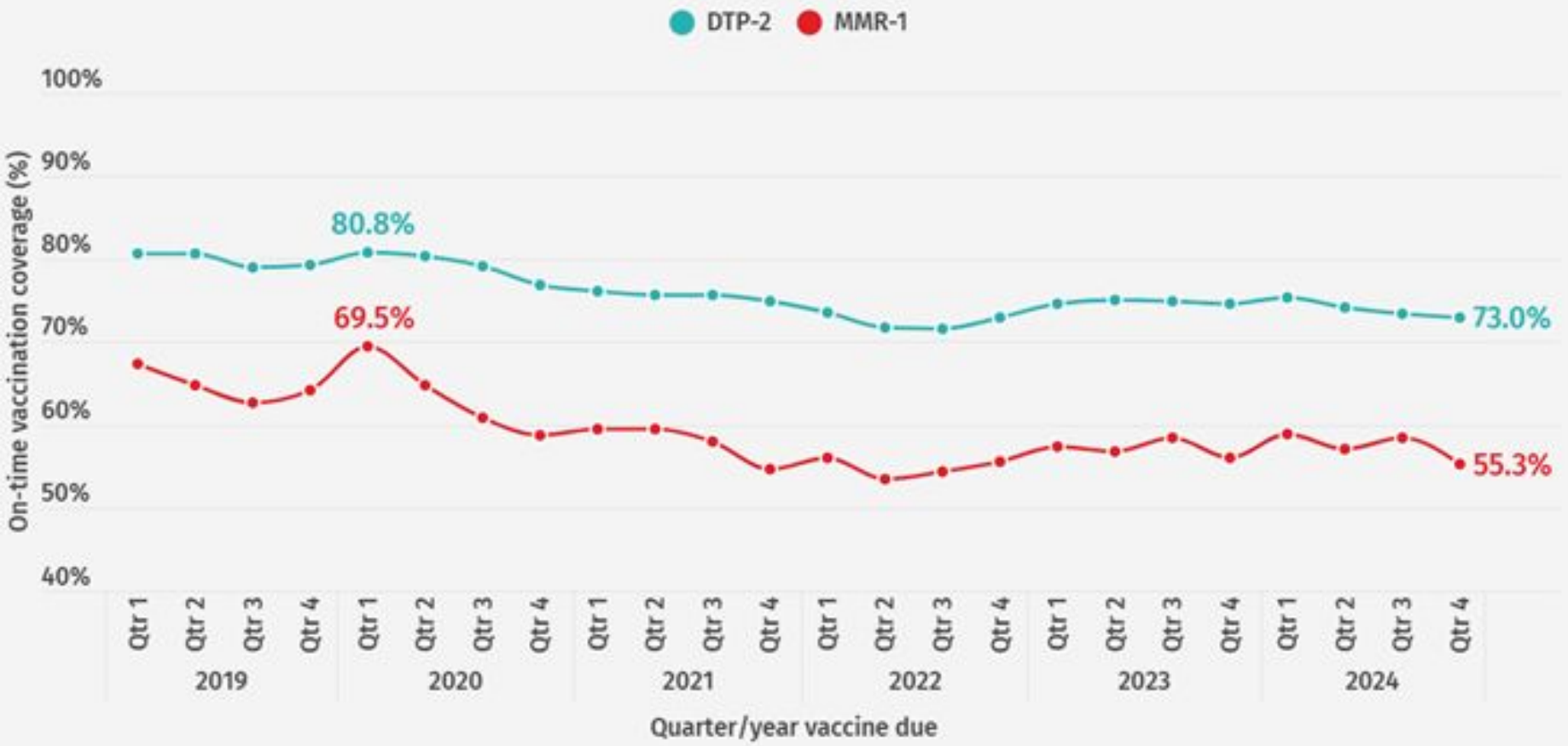
Fully vaccinated coverage for Aboriginal and Torres Strait Islander children continued to decrease in 2024 at all three age milestones (12, 24 and 60 months of age).

The largest decrease was at 24 months of age, with coverage dropping by 4.5 percentage points since 2020.

Coverage at 12 and 24 months of age was below 90%.

Coverage was higher at 60 months of age than at the other age milestones.





On-time vaccination

Levels of on-time vaccination (i.e. within 30 days of the recommended age) remained lower in young Aboriginal and Torres Strait Islander children than before the COVID-19 pandemic.

In the last quarter of 2024, on-time coverage of the second dose of DTP-containing vaccine was 7.8 percentage points lower than in the first quarter of 2020.

On-time coverage of the first dose of MMR vaccine was 14.2 percentage points lower in the last quarter of 2024 than in the first quarter of 2020.

% of children fully immunised at age 5 – annual period to 30 June 2025

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Top five by Statistical Area Level 3 (SA3 - populations are about 30,000 – 130,000)

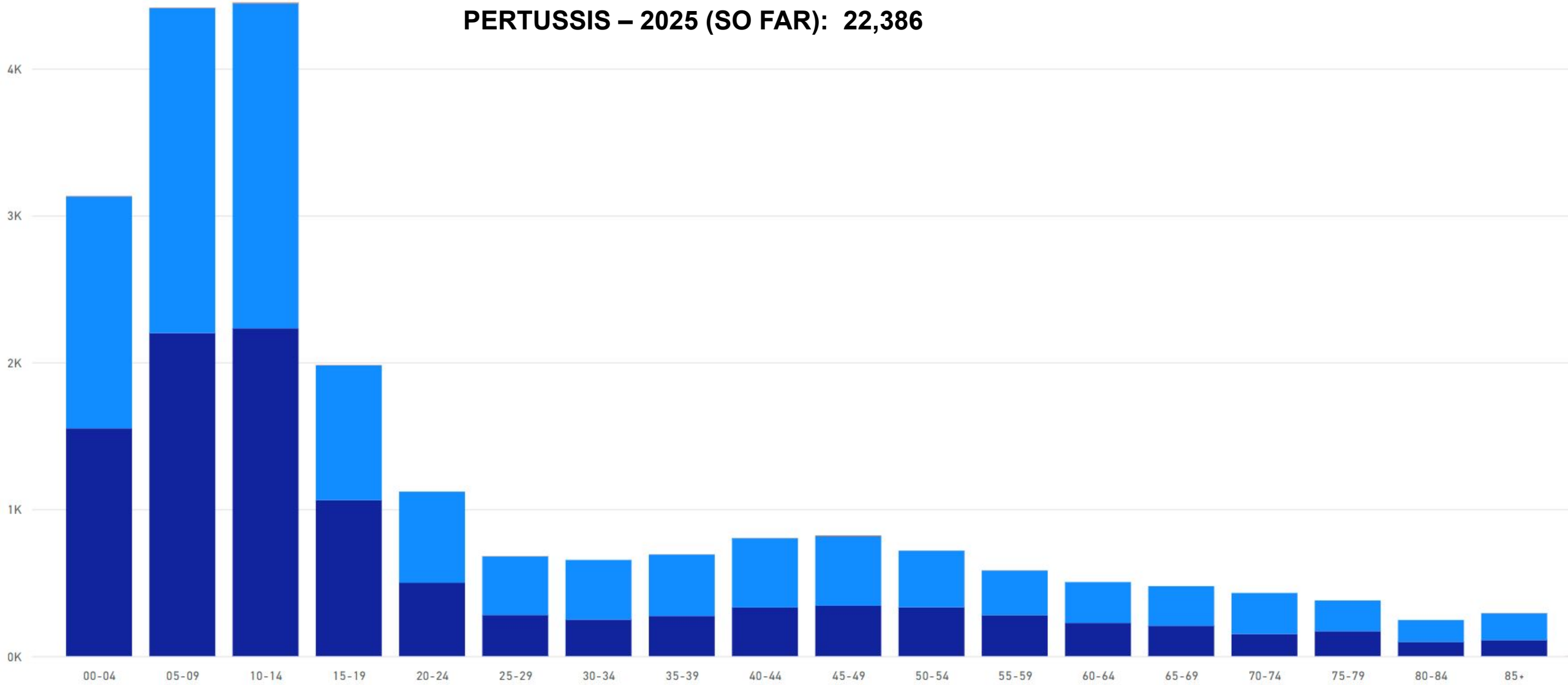
Broken Hill & Far West (NSW)	97.82%
Brighton (TAS)	97.61%
Whitehorse – East (VIC)	97.13%
Bathurst (NSW)	96.78%
Warrnambool (VIC)	96.68%

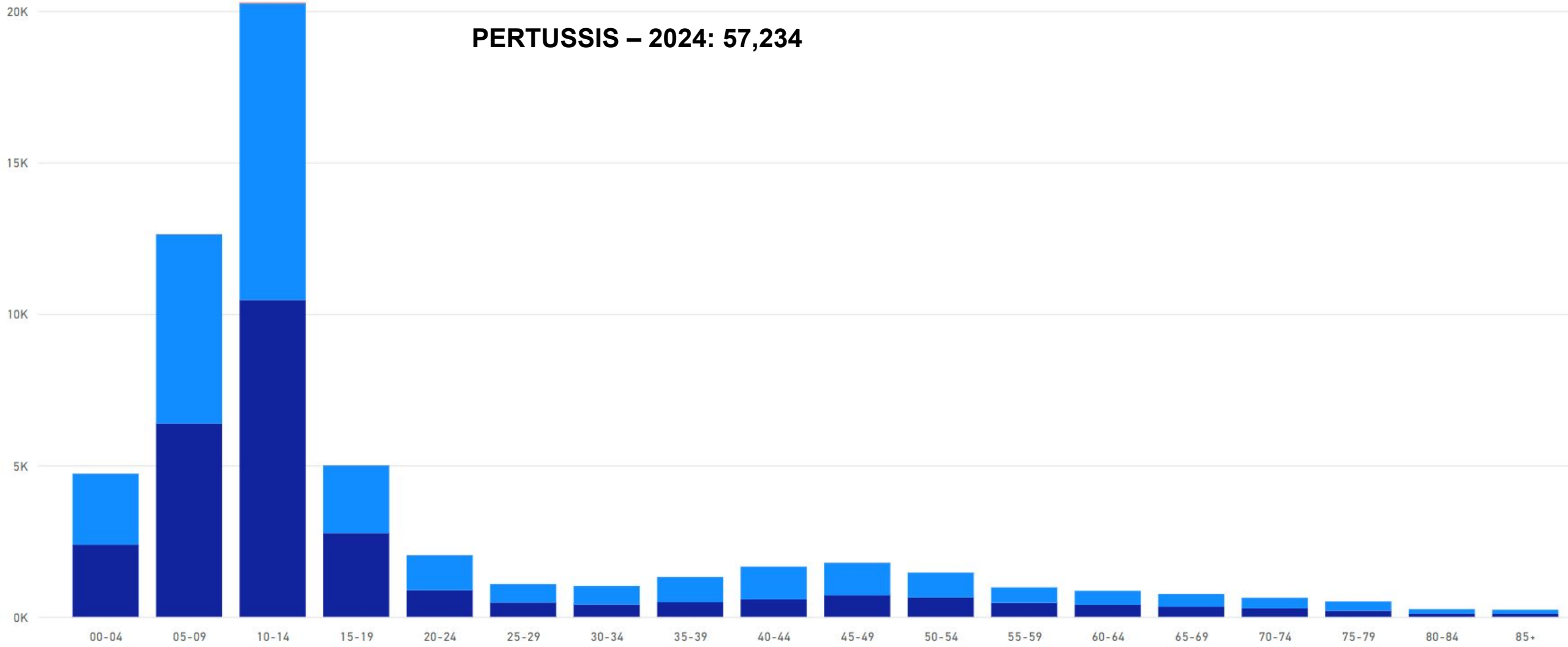
Bottom five by Statistical Area Level 3 (SA3)

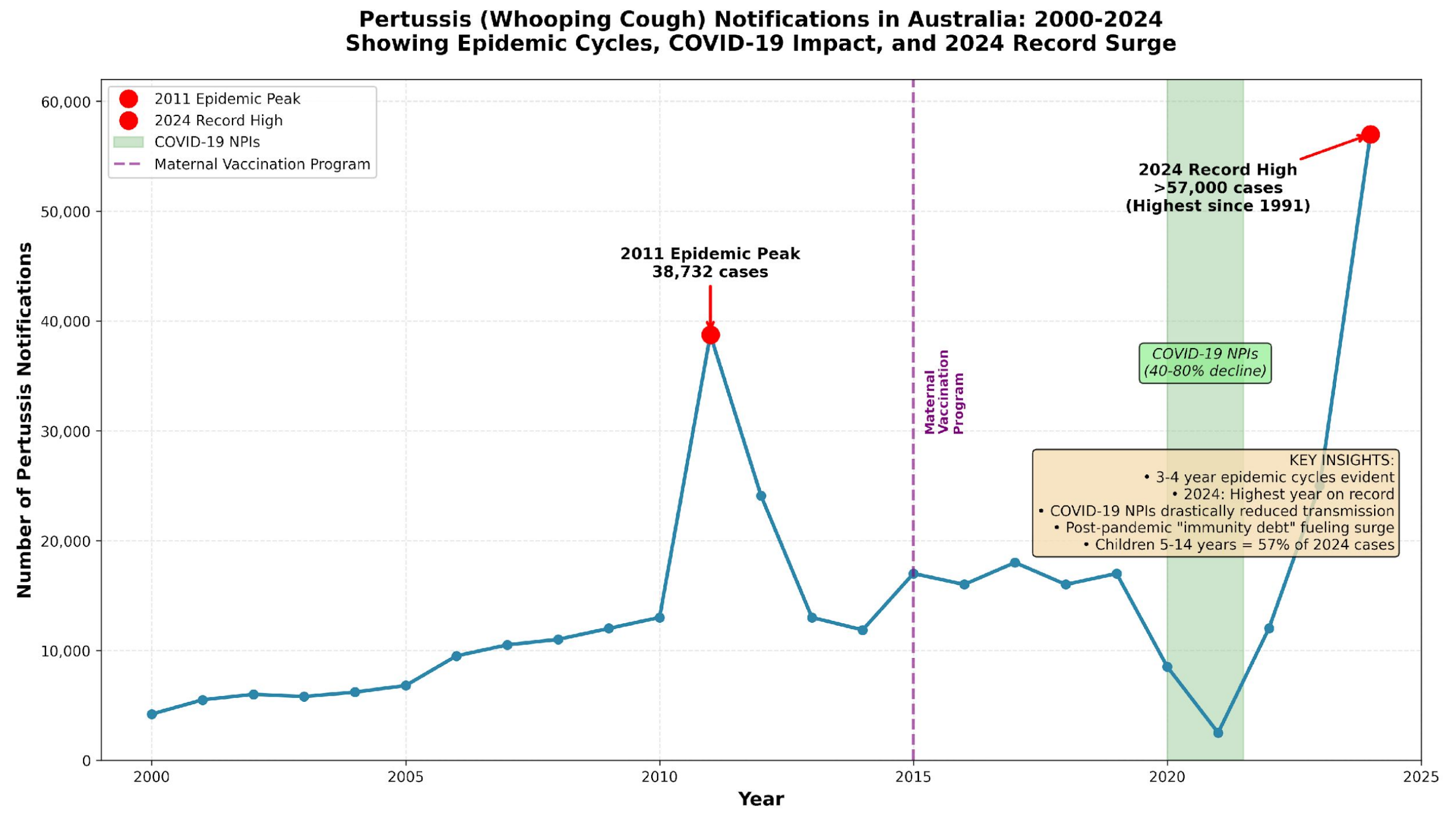
Noosa Hinterland (QLD)	78.60%
Richmond Valley – Coastal (NSW)	80.36%
Gold Coast Hinterland (QLD)	82.38%
Tweed Valley (NSW)	83.90%
Sunshine Coast Hinterland (QLD)	84.96%

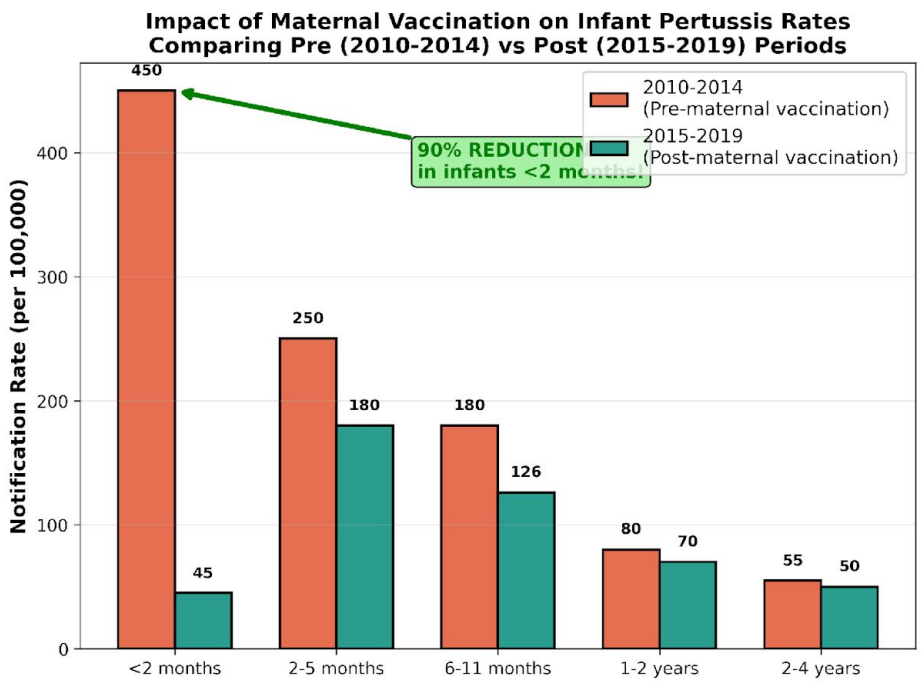
Data from Department of Health, Disability, and Ageing – Childhood immunisation coverage data PHN and SA3
https://www.health.gov.au/resources/collections/childhood-immunisation-coverage-data-phn-and-sa3

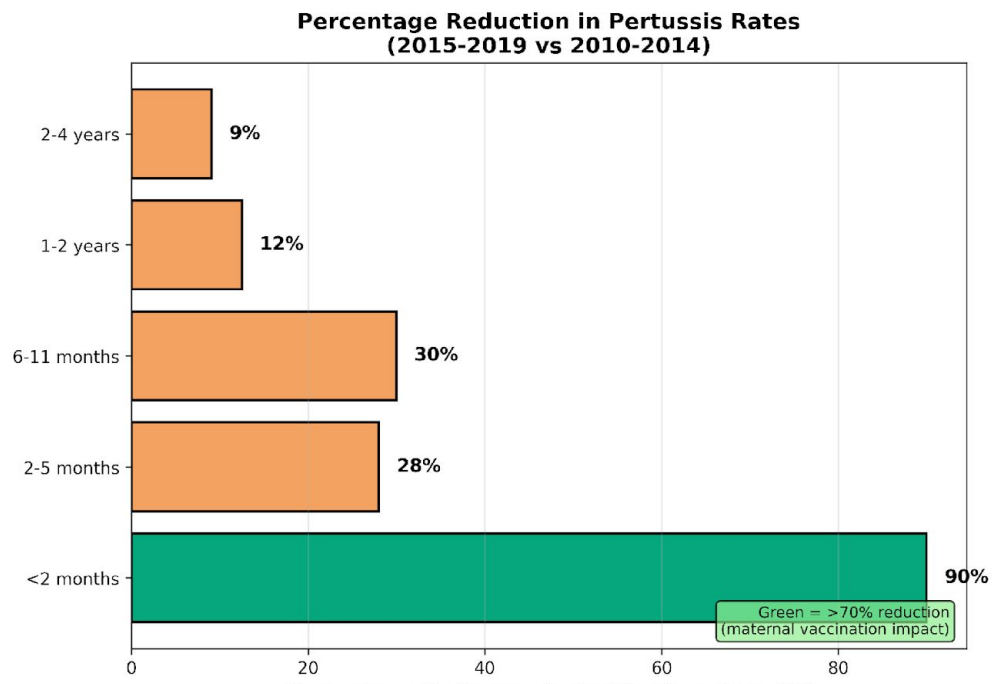
PERTUSSIS – 2025 (SO FAR): 22,386

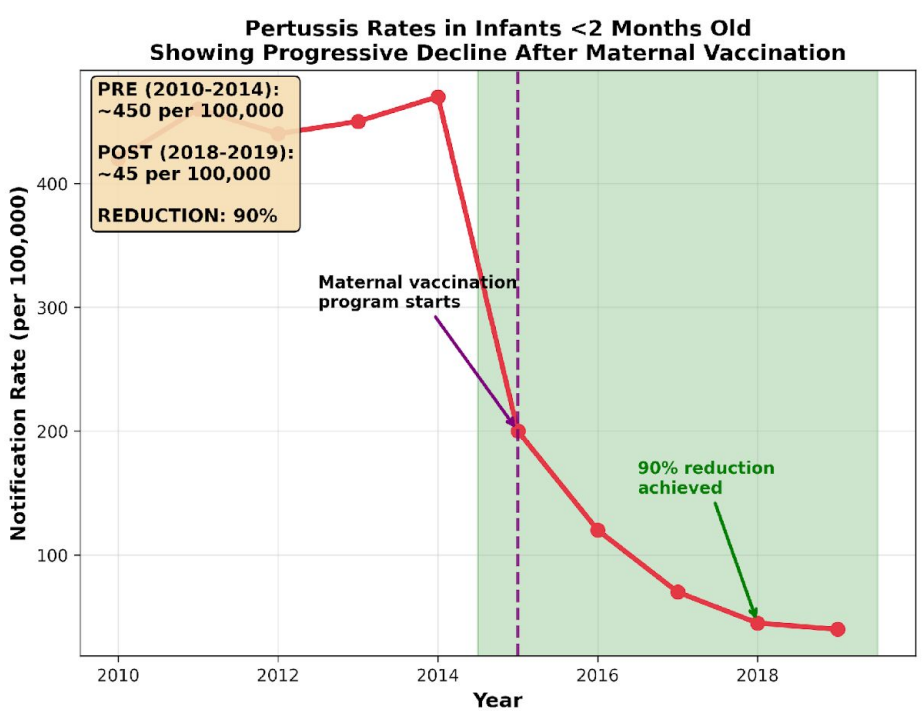


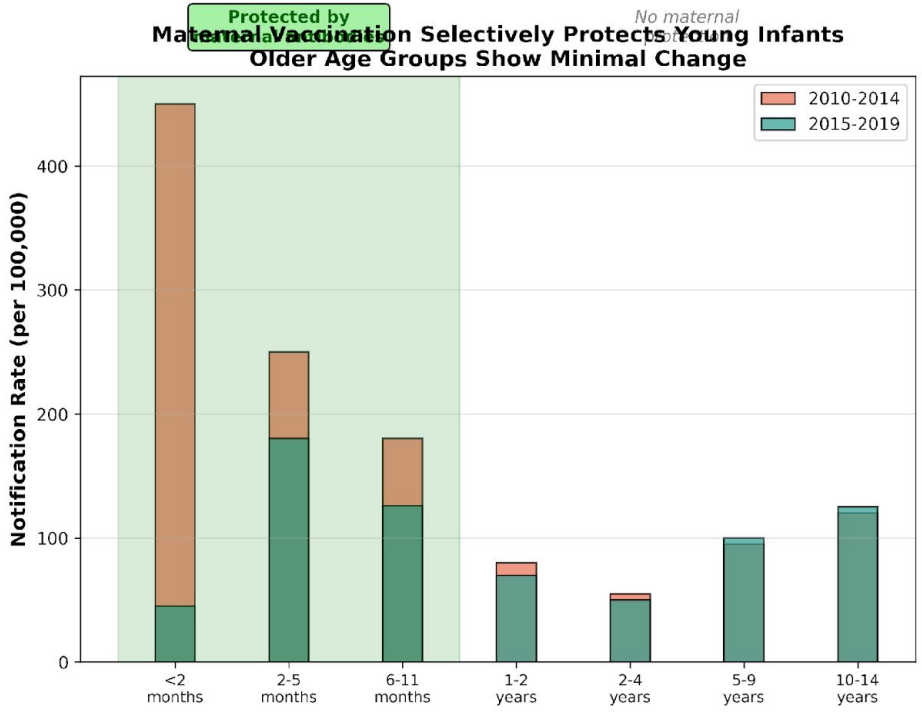

PERTUSSIS – 2024: 57,234
20K
15K
10K
5K
0K
00-04
05-09
10-14
15-19
20-24
25-29
30-34
35-39
40-44
45-49
50-54
55-59
60-64
65-69
70-74
75-79
80-84
85+


Pertussis (Whooping Cough) Notifications in Australia: 2000-2024
Showing Epidemic Cycles, COVID-19 Impact, and 2024 Record Surge
2011 Epidemic Peak
2024 Record High
COVID-19 NPIs
Maternal Vaccination Program
2011 Epidemic Peak
38,732 cases
2024 Record High
>57,000 cases
(Highest since 1991)
COVID-19 NPIs
(40-80% decline)
Maternal Vaccination Program
KEY INSIGHTS:
• 3-4 year epidemic cycles evident
• 2024: Highest year on record
• COVID-19 NPIs drastically reduced transmission
• Post-pandemic "immunity debt" fueling surge
• Children 5-14 years = 57% of 2024 cases
Number of Pertussis Notifications
Year
0
10,000
20,000
30,000
40,000
50,000
60,000
2000
2005
2010
2015
2020
2025


Impact of Maternal Vaccination on Infant Pertussis Rates
Comparing Pre (2010-2014) vs Post (2015-2019) Periods
Notification Rate (per 100,000)
2010-2014
(Pre-maternal vaccination)
2015-2019
(Post-maternal vaccination)
90% REDUCTION
in infants <2 months!
450
45
250
180
180
126
80
70
55
50
<2 months
2-5 months
6-11 months
1-2 years
2-4 years


Percentage Reduction in Pertussis Rates
(2015-2019 vs 2010-2014)
2-4 years
9%
1-2 years
12%
6-11 months
30%
2-5 months
28%
<2 months
90%
Green = >70% reduction
(maternal vaccination impact)
Percentage Reduction in Notification Rate (%)


Pertussis Rates in Infants <2 Months Old
Showing Progressive Decline After Maternal Vaccination
PRE (2010-2014):
~450 per 100,000
POST (2018-2019):
~45 per 100,000
REDUCTION: 90%
Maternal vaccination
program starts
90% reduction
achieved
Notification Rate (per 100,000)
Year


Protected by
No maternal
Maternal Vaccination Selectively Protects Young Infants
Older Age Groups Show Minimal Change
2010-2014
2015-2019
Notification Rate (per 100,000)
<2
months
2-5
months
6-11
months
1-2
years
2-4
years
5-9
years
10-14
years

Maternal Pertussis Vaccination: A Public Health Success Story

BEFORE
2010-2014

~450

per 100,000

Infants <2 months

2015

▼

Maternal vaccination program introduced

AFTER
2018-2019

~45

per 100,000

Infants <2 months

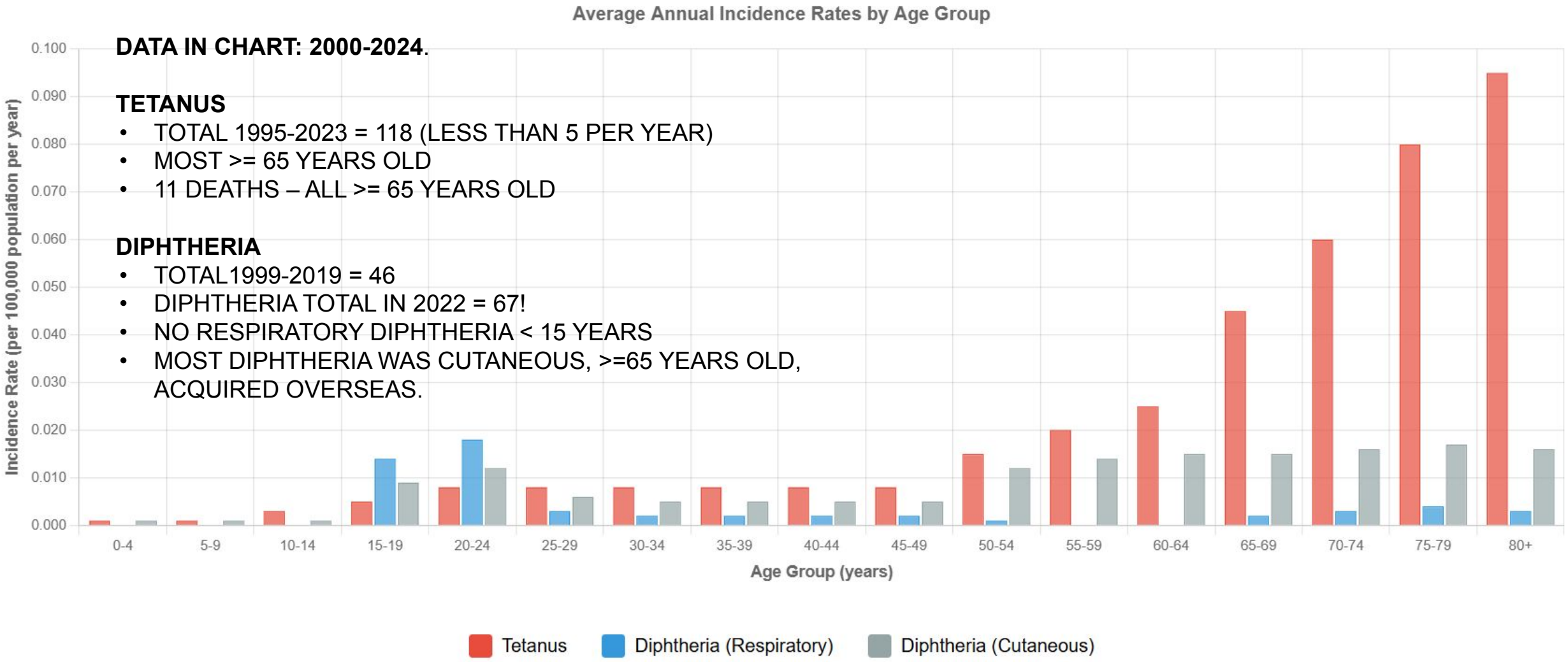
90% REDUCTION

- ✓ Maternal vaccination during pregnancy protects newborns
- ✓ Antibodies cross the placenta before birth
- ✓ Protection lasts until infant can be vaccinated at 6-8 weeks
- ✓ Most effective for infants <2 months (highest risk group)
- ✓ Funded nationally in Australia from July 2018

Source: NNDSS data, Australian vaccine preventable disease epidemiological review series 2013-2018

Source: Australian National Notifiable Diseases Surveillance System (NNDSS), Australian Institute of Health and Welfare (AIHW)

Key Finding: Both tetanus and diphtheria are extremely rare in Australia due to high vaccination coverage. Most cases occur in older adults who may have incomplete vaccination or waning immunity.



DATA IN CHART: 2000-2024.

TETANUS

- TOTAL 1995-2023 = 118 (LESS THAN 5 PER YEAR)
- MOST >= 65 YEARS OLD
- 11 DEATHS – ALL >= 65 YEARS OLD

DIPHTHERIA

- TOTAL1999-2019 = 46
- DIPHTHERIA TOTAL IN 2022 = 67!
- NO RESPIRATORY DIPHTHERIA < 15 YEARS
- MOST DIPHTHERIA WAS CUTANEOUS, >=65 YEARS OLD, ACQUIRED OVERSEAS.

National Vaccination Insights project (Report – October 2025)

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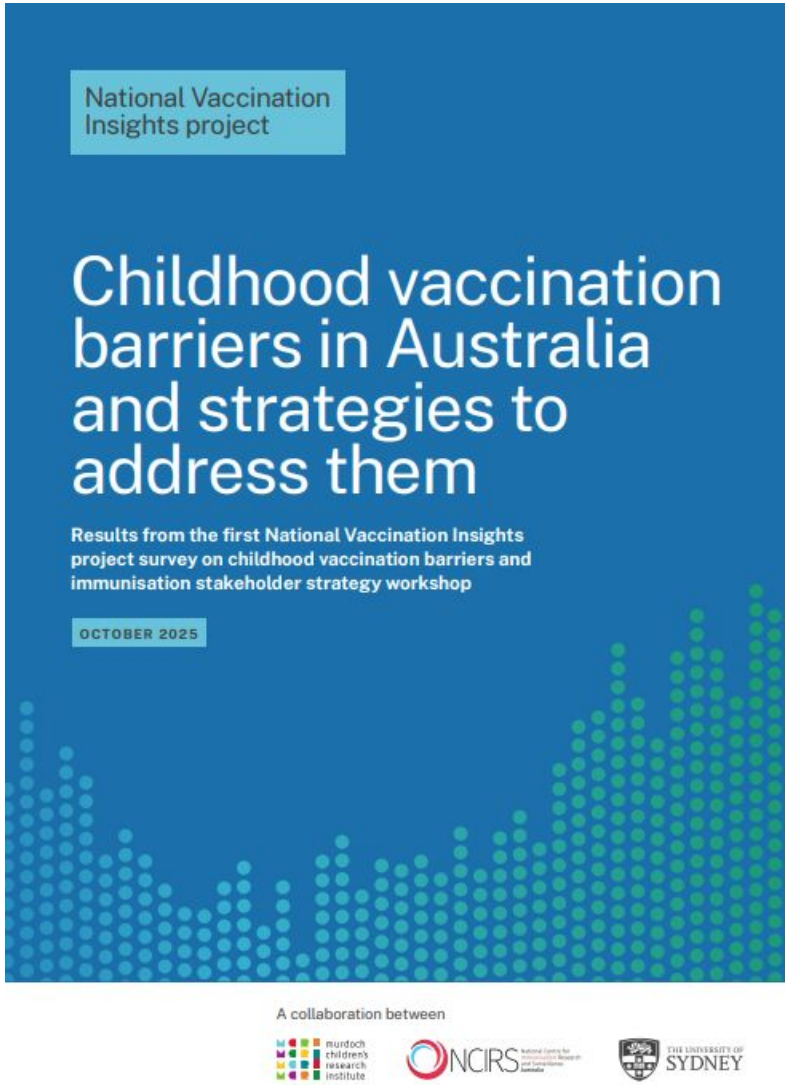
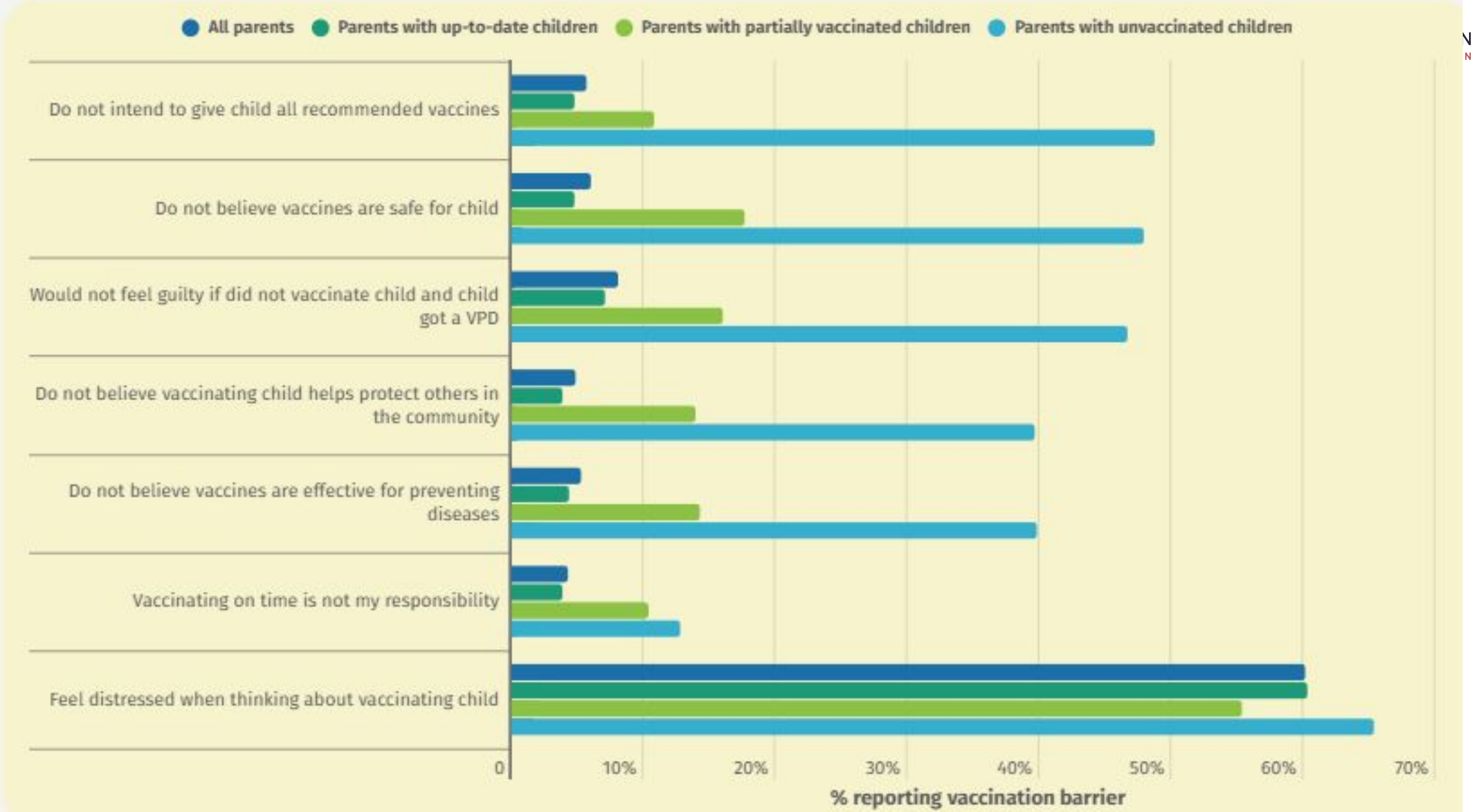
- Vaccine Barriers Assessment Tool (VBAT)
- Behavioural and Social Drivers (BeSD) of Vaccination Tool (World Health Organisation)



Acceptance barriers: thinking-feeling



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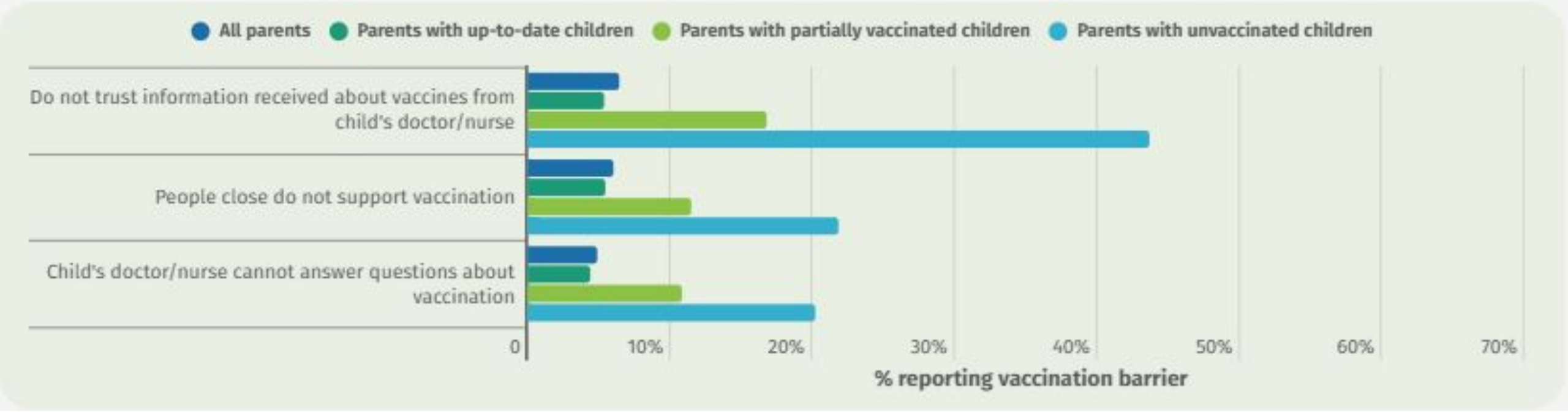
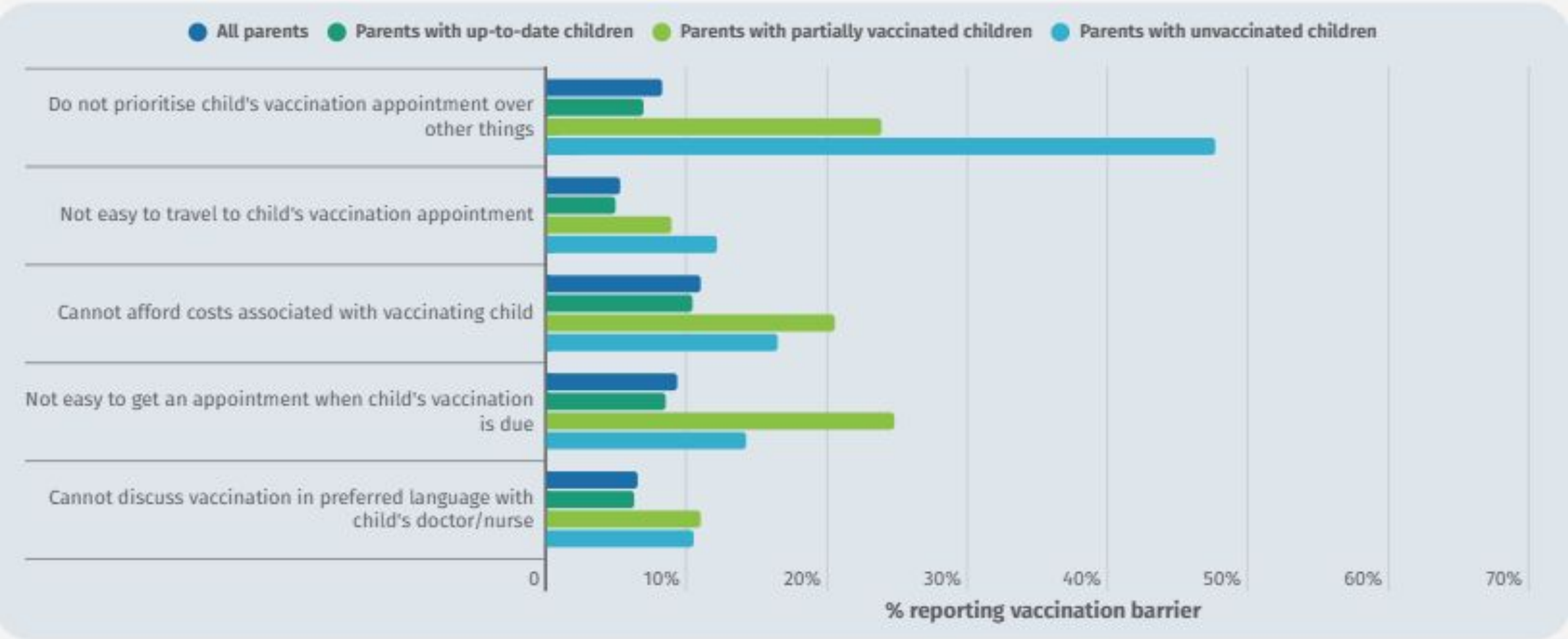
Acceptance barriers: social influence



Access barriers: practical



Selected strategy	How the strategy would look in practice	How to overcome implementation challenges
Strategies to address access (practical) barriers		
On-site vaccination in community settings	Offer in settings commonly attended (e.g. libraries, playgroups, sporting events) Combine education with vaccination, and offer tailored incentives *'How we can even have events like the healthy food, but also a bit of art, a bit of movement, dancing. We associate the immunisation with being healthy, being strong, being resilient, not like a thing that one must do.'*	More financial support for Aboriginal Community Controlled Health services Better training of community vaccine champions *'Champions or popular sporting players or people like that, people with lower health literacy may be more willing to listen and understand.'*
Strategies to address acceptance (social influence) barriers		
Tailored campaigns to inform/educate the public about vaccination, featuring vaccine champions and advocates	Trusted community champions and relatable 'deadly' cartoon-like characters to share positive vaccination stories	

Selected strategy	How the strategy would look in practice	How to overcome implementation challenges
Strategies to address access (practical) barriers		
Provider performance assessment and feedback	Key performance indicators and financial incentives/payments, including specific Medicare items linked to vaccination at practice level, including for practice nurse administered vaccine	Policies and funding for primary care need to change to enable prioritisation of childhood immunisation Streamline use of Australian Immunisation Register data to inform performance at service level Encourage GPs' sense of ownership of vaccination *'Policy people need to take some responsibility here with provider engagement. Losing providers is in part because we have made it incredibly complicated. I think it starts at a policy level and ends with education.'*
Reminder for next dose/ recall for missed dose	Automated, personalised reminders utilising practice management software or via a system linked directly to AIR, such as Centrelink or Medicare	
Strategies to address acceptance (social influence) barriers		
Dialogue-based interventions, including one-to-one counselling to encourage vaccination	Vaccine education and communication training for healthcare professionals built into provider education *'Vaccination is completely about trust … Gaining that trust again through effective communication is key for us.'*	


1
Improve access to vaccination
2
Support provider education & advocacy
3
Support parent knowledge & confidence
4
Facilitate access to data
To address access barriers
To address acceptance barriers
To address system-level barriers

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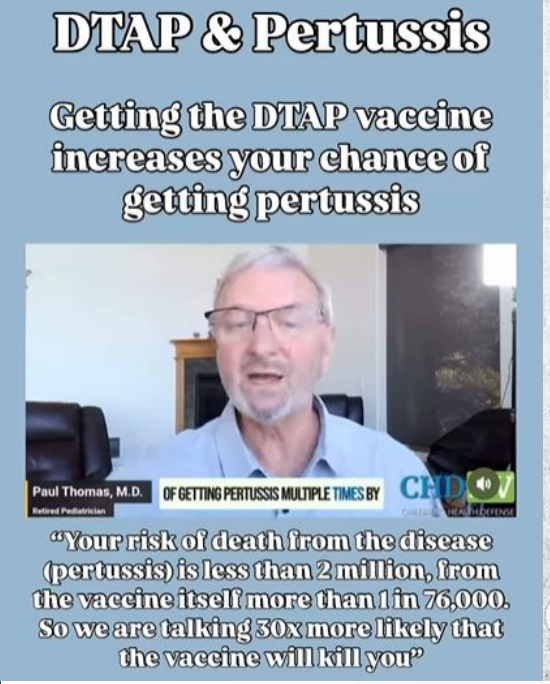
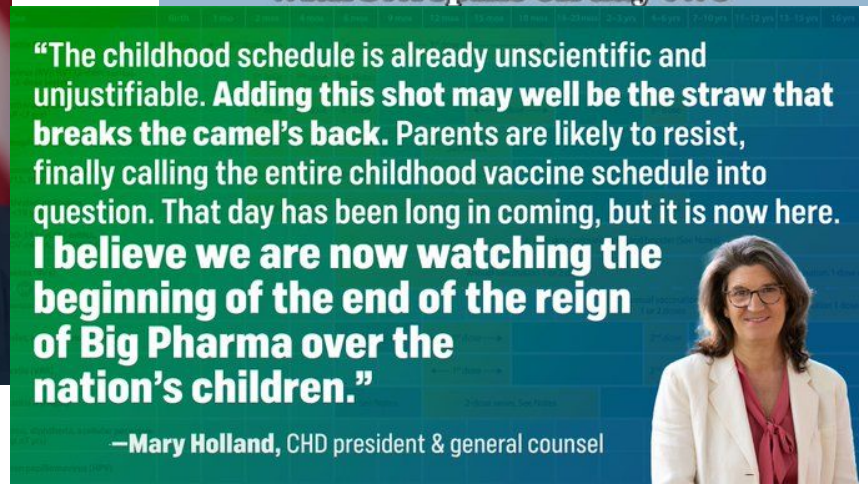
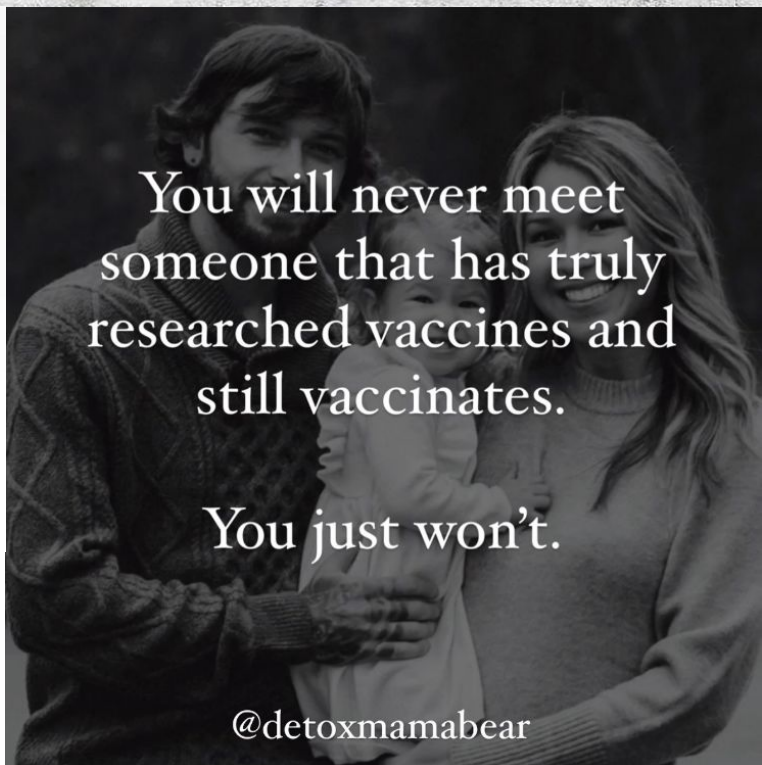
	If Immunisations up to date (UTD)	If Immunisations NOT up to date (UTD)
No Jab, No Pay - National **(1) FTB Part A**	• Full entitlement (varies by income/number of children) • Maximum rate applies if family income < $67,000 per year • Base rate for FTB Part A is $71.26 for each child per fortnight	• Reduced by $34.44 per fortnight per child • Not eligible for FTA Part A Annual Supplement, $938.05
No Jab, No Pay - National **(2) Child Care Subsidy**	• Full entitlement (percentage-based)	• May be suspended/cancelled
No Jab, No Play **– State/Territory based**	• Can enrol in childcare services (e.g., kindergarten, family day care, others) • UTD with vaccinations, confirmed by AIR report. • 16-week ‘support period’ may apply (to get report or to get vaccinated)	• Can’t enrol! • Doesn’t apply to primary and secondary schools • Doesn’t apply in TAS, ACT, and NT

Barriers to immunisation

- Costs – direct and indirect
  - Cost for consultation
  - Costs for travel, time off work
- Access and availability
- Worry about seeing their child in pain
- Worry about safety of vaccines (no causal relationship with SIDS, others)
  - inadequate research, toxic ingredients, Autism, not natural, weakens the immune system
- Worry about efficacy of vaccines (DTPa efficacy for pertussis prevention = 85%[1])







- **SOCIAL MEDIA - FB, IG, X, TIKTOK, YOUTUBE…**
- **ECHO CHAMBERS**
- **CONSPIRACY THEORIES**

Possible solutions?

- **Trusted provider recommendations are the strongest predictor of vaccine acceptance**
- SKAI, relationship-based interventions, stage-of-change, motivational interviewing
- Appropriate for Aboriginal and Torres Strait Islander people, CaLD people
- Start the discussion antenatally – and earlier
- Crucial role of CHNs in childhood immunisation
- More Nurse Immunisers, more Aboriginal Health Practitioners
- Authorised Pharmacist Immunisers (APIs) to give NIP vaccines to children < 5 years old
- Open-access and walk-in availability

Download the free Save The Date To Vaccinate app

Download on the App Store

GET IT ON Google Play

- ‘Stage of change’ and ‘motivational interviewing’
- Trust in the healthcare practitioner
- Different approaches for acceptor, hesitant, selective, or refuser
- Time (all-at-once, versus staged, follow-up, ‘keep the door open’)
- Communication strategies
  - Listen
  - Permission to discuss
  - Elicit and acknowledge concerns

GLOBAL

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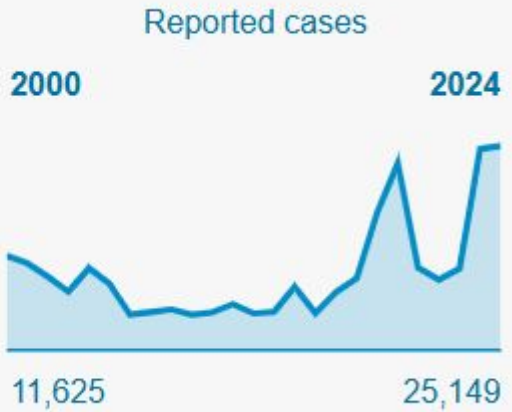
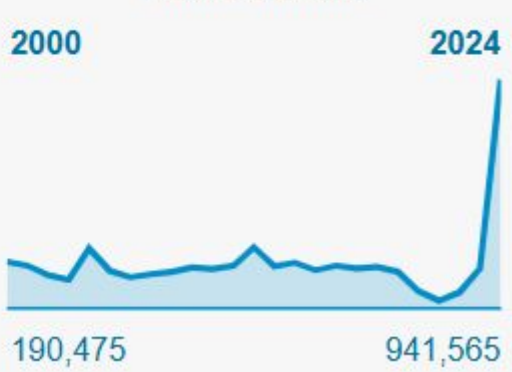
Diphtheria	**25,149**	
Total tetanus	**23,790**	
Pertussis	**941,565**	

Global vaccination coverage trendline

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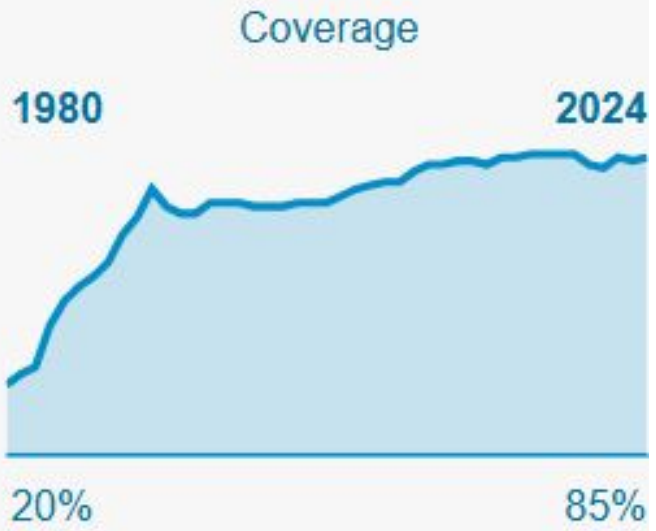
DTP-containing vaccine, 3rd dose

85%



Gavi
The Vaccine Alliance

Gavi, the Vaccine Alliance is a public-private partnership that helps vaccinate more than half the world's children against some of the world's deadliest diseases.

>1.2bn

children vaccinated through routine programmes, 2000–2024 – more than 72 million in 2024 alone

The vaccine goal

63%

The 57 Gavi-supported countries increased breadth of protection with vaccines in the Gavi portfolio to 63%, up 8 percentage points from 2023.

- **58** Gavi-supported vaccine introductions and preventive campaigns took place in 2024 – in addition to 50 outbreak response vaccination campaigns supported by Gavi.
- **32m** >32.6 million girls fully immunised against HPV with Gavi support in 2024 alone – more than the previous ten years combined.
- **17** 17 countries accessed cholera, meningococcal and yellow fever vaccines through Gavi-supported emergency stockpiles a total of 44 times in 2024.

>2.1bn

vaccinations through preventive vaccination campaigns, 2000–2024

>20.6m

future deaths averted, 2000–2024 (including 1.7m in 2024 alone – the most lives saved in a single year). In addition, >2.7m deaths were averted by COVAX across participating AMC low- and middle-income countries.

The equity goal

82%

In 2024, Gavi-supported countries increased DTP3 coverage to 82% (compared to the 85% global average).

- **72m** >72m children were reached with Gavi-supported routine vaccines in 2024 – more than in any year previously.
- **48** 48 countries have installed more than 64,000 cold chain equipment (CCE) units procured by UNICEF Supply Division through Gavi's CCEOP – nearly 2,700 in 2024 alone.
- **87%** Average coverage of DTP3 in 26 low-income countries supported by Gavi is not yet back to pre-pandemic levels (i.e. 75% in 2019) – while lower middle-income countries exceeded 2019 coverage by 1 pp, reaching 87% in 2024.

The sustainability goal

US$ 1.9bn by end 2024

In the face of fiscal challenges, climate change, conflict and instability, most Gavi-supported countries maintained or increased domestic resources for co-financing of Gavi-supported vaccines in 2024, bringing to US$ 1.9 billion their total contribution since the introduction of the co-financing policy in 2008.

- **255m** US$ 255m was contributed by countries towards the co-financing of Gavi-supported vaccines in 2024 – the highest amount yet and a testament to country ownership and the long-term financial sustainability of Gavi-supported vaccines.
- **55** 55 vaccine programmes originally introduced with Gavi funding are self-financed by countries as of 2023, up from 40 in 2018.
- **100%** 100% of countries fully met their 2024 co-financing obligation – except six waivers for humanitarian crises.

The healthy markets goal

20

Through Gavi's market shaping efforts, the number of manufacturers supplying prequalified Gavi-supported vaccines reached 20 in 2024 (with nearly half based in low- and middle income countries) – compared with 5 in 2001.

- **10** 10 markets for vaccines and immunisation products exhibited acceptable levels of healthy market dynamics in 2024, meeting the target for the year.
- **12** 12 innovative products were within the pipeline of commercial-scale manufacturers in 2024, continuing to exceed the Alliance target of 8 by 2025 well ahead of schedule.
- **500k** 500,000 mpox vaccine doses secured within a month of the WHO emergency declaration.

695[1]

vaccine introductions and preventive vaccination campaigns, 2000–2024

1 Excluding COVID-19 vaccination. Routine introductions and preventive vaccination campaigns relate to Gavi-supported vaccines against 18 infectious diseases, as of 2023. In the Gavi 1.0 and 2.0 strategic periods, introductions were completed for hepB mono and tetra-DTP-hepB that are not counted here.

>US$ 1.9bn

in co-financing contributions from Gavi-supported countries since 2008 – and a high of US$ 255m in 2024 alone

US$ 54 for US$ 1 spent

A study covering 73 Gavi-supported countries shows that, for every US$ 1 spent on immunisation in the 2021–2030 period, US$ 21 are saved in health care costs, lost wages and lost productivity due to illness and death. When considering the value people place on lives saved by vaccines – which is likely to include the value of costs averted plus the broader societal value of lives saved and people living longer and healthier lives – the return on investment is estimated to be US$ 54 per US$ 1 spent.

Kim S.Y., Watts E., Constenla D., Brenzel L., Patenaude B.N. Return On Investment From Immunization Against 10 Pathogens In 94 Low- And Middle-Income Countries, 2011–30. Health Affairs, 2020

>US$ 280bn

in economic benefits generated in the countries we support, 2000–2024

- **14.3m** 14.3 million children in Gavi-supported countries are under-immunised – they have not received all three doses of the essential childhood vaccine containing diphtheria, tetanus and pertussis (DTP). Of this group, 70% are 'zero-dose' children – they have not received even a single dose of DTP-containing vaccine. In Gavi-supported countries in 2024, there were 10.2 million zero-dose children – down from 10.7 million in 2023.
- **54%** 54% of children under 12 months in Gavi-supported countries in 2024 received the last recommended dose of each of the 11 antigens currently recommended by WHO for all infants worldwide by their first birthday, up from 49% in 2023.
- **^** Gavi-supported countries continue to have higher coverage of vaccines against pneumococcus, rotavirus and *Haemophilus influenzae* type b (Hib) than the rest of the world.

Learn more at www.gavi.org and VaccinesWork, our digital platform covering news, features and explainers from every corner of global health and immunisation.

Scan the QR code to view our **annual report**

AVAILABLE AT GAVI.ORG/PROGRESS-REPORT

Global childhood vaccination coverage > 95%

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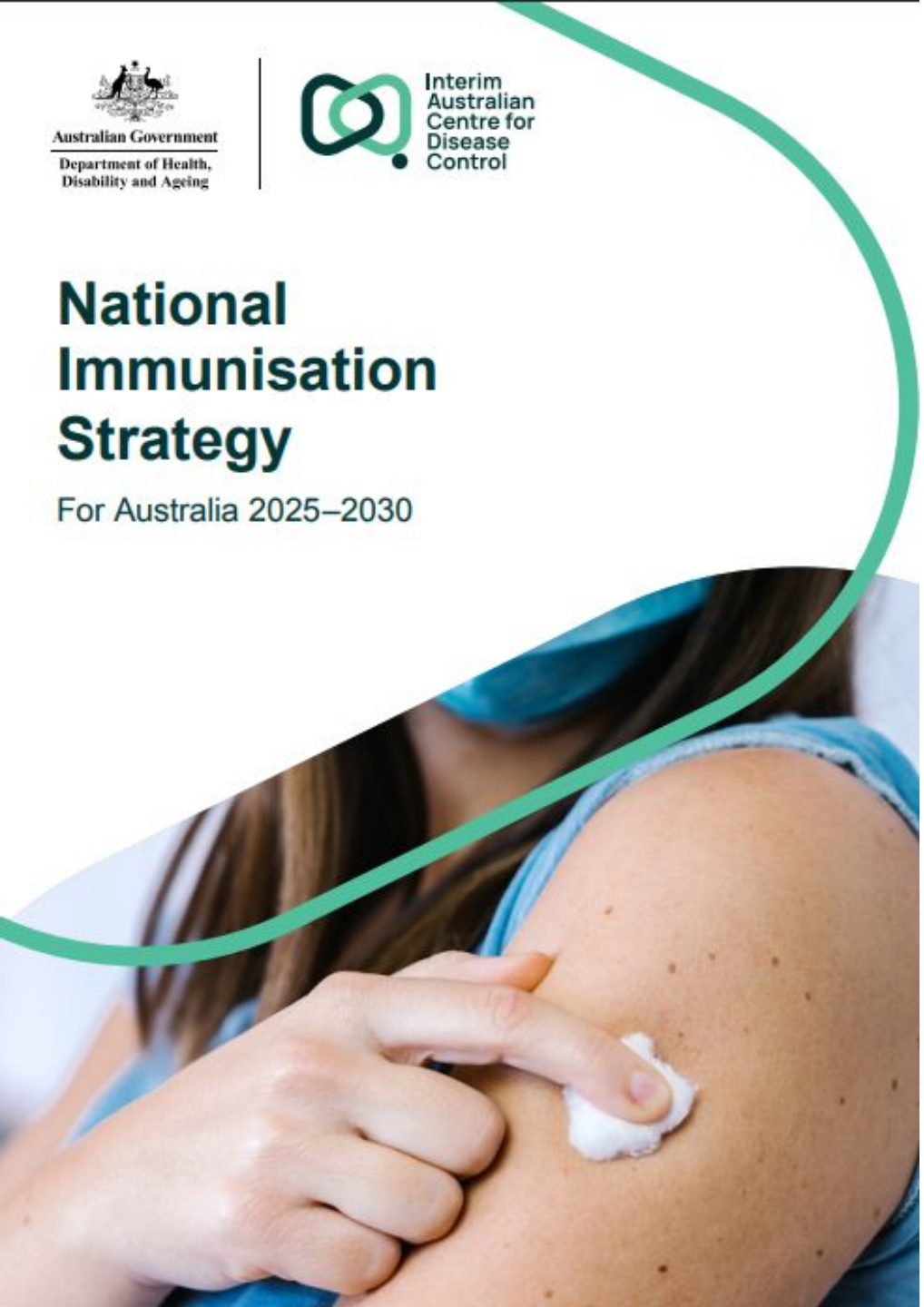
- Countries
  - China
  - Singapore
  - 25 of 53 WHO European Region countries
- Features and strategies
  - Political commitment
  - Infrastructure – access and delivery
  - Systems for monitoring and targeting

Global childhood vaccination coverage has improved > 3 percentage points 2023-2024

- Countries
  - Mali
  - Democratic Republic of the Congo
  - Rwanda
  - Ethiopia
  - India (total population approx. 1.5 billion people; children under 5 approx. 115 million)
- Features and strategies
  - Political commitment (Mission Indradhanush in India (Hindi for ‘rainbow’, Indra’s bow, Indra is the Hindu god of thunder and lightning))
  - Infrastructure – access and delivery, free



- The National Immunisation Strategy 2025-30, targets 95% coverage through six priorities:
  - improving equitable access,
  - building trust,
  - enhancing data use,
  - strengthening workforce,
  - harnessing technology, and
  - implementing governance reform

Do you CARE about data? National Immunisation Strategy

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- Use data more effectively to target immunisation strategies and monitor performance
- Improve the completeness, timeliness and transparency of AIR data
- Work towards a whole of life, interactive, real-time dashboard of coverage data (VaxView)
- Expand data linkage capacity, analysis and reporting for better monitoring of vaccine program coverage, effectiveness, safety and impact
- Integrate and report timely surveillance data on diseases, vaccine coverage, safety, and social and behavioural insights
- Strengthen vaccine safety surveillance

Vaccine Administration Errors in Australia - 2022 Data (NCIRS)

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- 678 reports of vaccine administration errors (not far off 2 per day)
- Don’t tell anyone! It could undermine their confidence in vaccination…
- Wrong
  - Recipient (wrong person, or contraindications to vaccine)
  - Product
  - Dose
  - Site
  - Age

Vaccine surveillance systems in Australia

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- Australian Immunisation Register (AIR)
  - https://www.servicesaustralia.gov.au/australian-immunisation-register (for Australians to access AIR)
- Database of Adverse Event Notifications (DAEN) – Therapeutic Goods Administration
  - https://www.tga.gov.au/safety/adverse-events/database-adverse-event-notifications-daen
- AusVaxSafety (NCIRS collaboration) – data from online post-vaccination surveys. The link is for data to 30 September 2025 for the 4-year-old schedule point (DTPa-IPV)
  - https://ausvaxsafety.org.au/national-immunisation-program-schedule-vaccines/4-years-schedule-point
- Paediatric Active Enhanced Disease Surveillance (PAEDS) – tertiary hospital based monitoring for infectious diseases including vaccine-preventable diseases (VPDs)

Other topics…

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- Influenza – high incidence and low vaccination rates in 2025
- Where’s the AI in immunisation?

Other topics…

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- Influenza – high incidence and low vaccination rates in 2025
- Where’s the AI in immunisation?
- Here it is…

Other topics…

IMMUNISATION COALITION

- Influenza – high incidence and low vaccination rates in 2025
- Where's the AI in immunisation?
- Here it is…

ImmunIsAtIon

Summary

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- Childhood vaccination coverage in Australia is dangerously low… and trending lower.
- Similar trends globally – with some exceptions (India, some African countries).
- Increased risk of VPDs and ‘knock on’ effects for communities and health services.
- Reasons for decline in coverage… multiple and complex, hesitancy > refusal.
  - Infrastructure, systems, access, costs
  - Sociocultural, misinformation
- Getting to > 95% coverage – how?
  - Trusted provider recommendations, SKAI approaches, culturally appropriate.

References

- National Centre for Immunisation Research and Surveillance Australia,
  - ncirs.org.au
- Immunization dashboard, World Health Organisation,
  - https://immunizationdata.who.int/
- Sharing Knowledge About Immunisation, Empowering Immunisation Conversations,
  - https://skai.org.au/healthcare-professionals
- National Notifiable Diseases Surveillance System (NNDSS) data visualisation tool,
  - https://www.health.gov.au/resources/apps-and-tools/national-notifiable-diseases-surveillance-system-nnds

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Questions

immunisationcoalition.org.au

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Thank you to our speakers and the audience for engagement and questions.

There will be a very short **Evaluation Form** coming after the event closes.
We look forward to planning an even better event next year.

Subscribe to the **Immunisation Coalition Newsletter** for Educational events and vaccination information

Good evening and stay safe.

immunisationcoalition.org.au

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DTPa immunisation for U5 year olds is trending well below 95% coverage: a call to action to reverse the trend though parent engagement

Thank you for attending!