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Health indicators 2026

Snapshot series I: Child & adolescent immunisation

Metro South HHS, to quarter 4, 2025

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Health indicators 2026: Snapshot series I. Childhood immunisation

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An electronic version of this document is available at https://qheps.health.qld.gov.au/msh/cohs/msphu/epidemiology

MSH childhood immunisation at a glance

All children fully immunised rates: quarter 4, 2025

Target = 95% in all age cohorts

- 12 months age cohort – 90.7%
- 24 month age cohort – 89.5%
- 60 month age cohort – 93.1%

Indigenous children fully immunised rates: quarter 4, 2025

Target = 95% in all age cohorts

- 12 months age cohort – 87.3%
- 24 month age cohort – 88.7%
- 60 month age cohort – 91.9%

All children rate trends

12 month age cohort

- Strong trend ⬇ downward since quarter 4 (Q4), 2020
- Quarterly moving average (QMA) currently at lowest point since Q1, 2014

24 month age cohort

- Strong trend ⬇ downward since Q4, 2021
- QMA currently at lowest point since pre-2014

60 month age cohort

- Trending generally ⬇ downward since Q4, 2021
- QMA currently at lowest level since Q3, 2016.

Gains made in all cohorts since at least 2016 have been lost

Indigenous children rate trends

12 month age cohort

- Trend generally ⬇ downward since Q4, 2020 with some stabilisation in 2025
- QMA relatively stable in 2025 at level similar to Q2, 2016

24 month age cohort

- Trend generally ⬇ downwards since Q3, 2021
- QMA currently at lowest point since Q4, 2015

60 month age cohort

- Trend generally ⬇ downward since Q4, 2020 with some stabilisation in 2025
- QMA currently at lowest point since Q2, 2014

Gains made in all cohorts since at least 2016 have been lost

Local variation (All children)

- Proportion of SA2s reaching the 95% target rate in all three cohorts has declined in past 12 months
- At Q4, 2025, lowest rates in 12 month cohort in North Stradbroke Island (77%), Munruben – Park Ridge South (79%) and Cleveland SA2s (81%)
- Lowest rates in 24 month cohort in Southern Moreton Bay Islands (75%), North Stradbroke Island (75%), Kingston (81%) and Cornubia – Carbrook (81%) SA2s
- Lowest rates in 60 month cohort in Woolloongabba (75%), Kangaroo Point (85%) and Loganholme – Tanah Merah (86%) SA2s
- Highest numbers of under-immunised children across cohorts in Boronia Heights – Park Ridge, Yarrabilba, Inala – Richlands and Marsden SA2s. Note: these are not the SA2s with the lowest rates.

Areas of greatest potential gains

- Greatest potential gains are in areas with the highest numbers of under-immunised children.
- These are likely to be in the suburbs in:
  - Central and eastern Logan LGA
  - Central southern Brisbane bordering Logan LGA
  - Beaudesert region
  - Mainland coastal areas within Redland LGA

Factors influencing decreases in childhood immunisation

- Decreases primarily since start of COVID-19 pandemic
- Complex pattern of causes potentially including:
  - Increased vaccine hesitancy
  - Increased vaccine fatigue
  - Decreased vaccine confidence
  - Decreased access to bulk-billing primary care / GP

Adolescent rate trends

- School immunisation program (SIP) rates: trend ⬇ downward since 2021
- 2025 rates in three SIP vaccines (dTpa, HPV, MenACWY) at 60%
- HPV and DTP rates in 15 years cohort: stable in 2025 at 75-80%
- MenACWY rate in 17 years cohort: stable in 2024-25 at 68%

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Health indicators 2026 snapshot series I: Child & adolescent immunisation

Introduction

The Metro South Health (MSH) *Health indicators report series* is a compendium report compiled on an approximately biennial basis that covers a wide range of health indicators and population statistics for the residents of the MSH area. The report is produced as a series of snapshot reports each covering specific indicators/topic areas. The aims of the report series are to examine the current and multi-year trends in various aspects of the health status of people living in the geographical area covered by MSH.

MSH is one of 16 Hospital and Health Services (HHS) in Queensland and serves an estimated population of over 1.2 million people, representing 23 per cent of Queensland's population. The HHS's catchment spans 3,856 square kilometres and covers the area from the Brisbane River in the north to Redland City in the east, south to Logan City and the eastern portion of the Scenic Rim to the border of New South Wales. A detailed profile of the population of MSH can be found in the 2025 Snapshot Series Report I[1].

This sub-report provides an overview of childhood immunisation rates and trends in MSH as at quarter 4, 2025.

Background

Immunisation is a simple and effective way of protecting children from serious diseases. Vaccines work by triggering the immune system to fight against certain diseases. If an immunised person comes in contact with these diseases, their immune system is able to respond more effectively, preventing the disease from developing or greatly reducing its severity and possible complications[2].

The Queensland Childhood Immunisation Program is part of the broader National Immunisation Program (NIP) in Australia. It provides free vaccines to eligible infants, children and adolescents to prevent a range of serious diseases including diphtheria, tetanus, pertussis (whooping cough), measles, mumps, rubella, rotavirus, hepatitis B, respiratory syncytial virus (RSV), pneumococcal disease, meningococcal disease, polio, varicella (chicken pox) and *Haemophilus influenzae* type B[3].

Using data from the Australian Immunisation Register (AIR) and nationally implemented definitions, the immunisation status of children in three birth cohorts (12 to <15 months, 24 to <27 months, 60 to <63 months) is assessed quarterly. Children are assessed as being "fully vaccinated" or "not fully vaccinated" according to the criteria in Table 1.

Note that the Rotavirus vaccine is not included in the definition of 'fully vaccinated' for any age cohort and multiple vaccines are not included in the definition of "fully vaccinated" for the 60 to <63 months cohort. The result of this is that a five-year old child may have missed any or all of Rotavirus, MMR, HIB, Hep B, Men C,

Varicella and Pneumo vaccines, meaning that they are not up to date with the Queensland immunisation schedule, but will still be defined as “fully vaccinated” at 60 months if they have had the age-relevant DTP and polio vaccines.

Table 1: Definitions used nationally to determine whether a child is classified as fully immunised

Age cohort	Vaccine		Vaccine doses required to meet criteria for "fully vaccinated"
12-<15 Months			
	DTP	=	Diphtheria dose 3 + Tetanus dose 3 + Pertussis dose 3
	Polio	=	Polio dose 3
	HIB	=	Haemophilus type B (Pathway B) dose 2
		or	Haemophilus type B (Pathway A) dose 3
	Hep B	=	Hepatitis dose 3
	MMR	=	Not assessed
	Pneumo	=	Pneumococcal dose 2 or 3
	Only those immunisation services a child has received up to 12 months of age are included.		
24-<27 Months			
	DTP	=	Diphtheria dose 4 + Tetanus dose 4 + Pertussis dose 4
	Polio	=	Polio dose 3
	HIB	=	Haemophilus type B (Pathway B) dose 3
		or	Haemophilus type B (Pathway B) dose 4
		or	Haemophilus type B (Pathway A) dose 4
		or	Haemophilus type B (Pathway A) dose 3 given greater than 15 months of age
	Hep B	=	Hepatitis B dose 3
	MMR	=	Measles dose 2 + Mumps dose 2 + Rubella dose 2
	Men C	=	Meningococcal C dose 1
	Varicella	=	Varicella dose 1
	Pneumo	=	Pneumococcal dose 3 or 4
	Only those immunisation services a child has received up to 24 months of age are included.		
60-<63 Months			
	DTP	=	Diphtheria dose 5 + Tetanus dose 5 + Pertussis dose 5
		or	Diphtheria dose 4 + Tetanus dose 4 + Pertussis dose 4 if given after 3.5 years of age
	Polio	=	Polio dose 4
	HIB	=	Not Assessed
	Hep B	=	Not Assessed
	MMR	=	Not Assessed
	Only those immunisation services a child has received up to 60 months of age are included.		

In addition to the vaccines assessed in the three childhood age cohorts, four vaccines currently are offered to adolescents under the school immunisation program (SIP). Human papilloma virus (HPV) and diphtheria/tetanus/ pertussis (dTpa) are offered in year 7 and Meningococcal A+C+W+Y (MenACWY) and Meningococcal B (MenB) in year 10. The vaccines offered under the program, the number of doses offered and the school year levels at which they are offered have varied in past years. As a result time series is available only from 2017 onwards and for dTpa, HPV and MenACWY vaccines.

Adolescents may receive these vaccines from other providers such as their general practitioner, pharmacy or immunisation clinic. Therefore the immunisation rates achieved by the SIP do not represent a population-level immunisation rate. Currently population-level rates are available quarterly from the AIR for 15 and 17 year olds from quarter 2, 2024 onwards.

Child rates: Quarter 4, 2025

Comparison of MSH with Queensland and Australia

At quarter 4, 2025 the all children MSH immunisation rates in all three age cohorts were below the 95% target rate. The MSH rate was slightly higher that the Queensland rate in all three age cohorts, almost identical to the Australian rate for the 12 and 60-month cohorts and slightly higher than the Australian rate for the 24 month cohort.

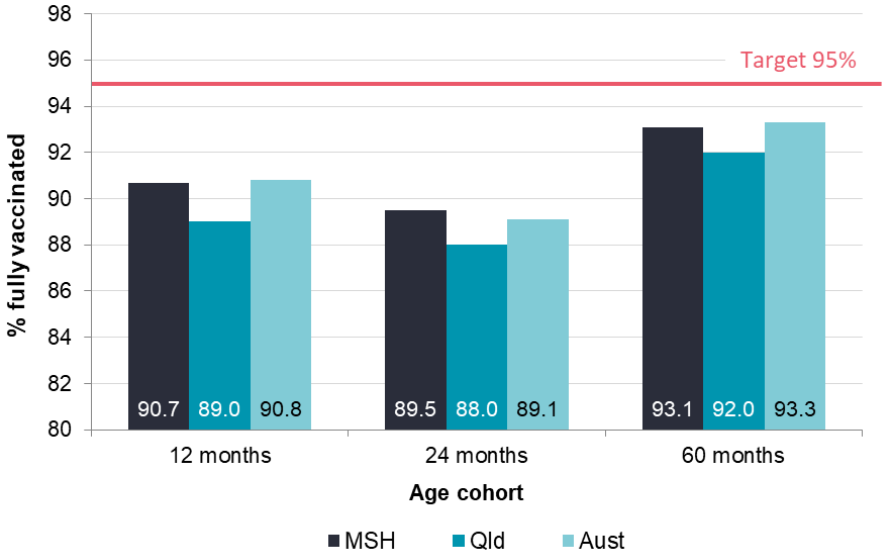

Figure 1: Percentage of All Children in three age cohorts fully immunised, MSH, Queensland and Australia, quarter 4, 2025

Rates in Indigenous children were lower than in all children in all three age cohorts. For Indigenous children the MSH rates in both the 12 and 60 month cohorts were lower than the Queensland and Australian rates, while in the 24 month cohort the MSH rate was highest of the three.

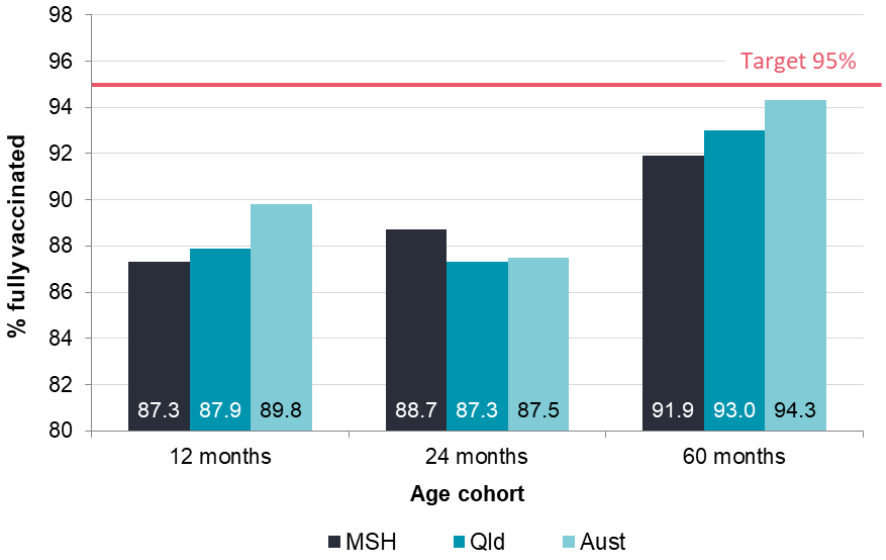

Figure 2: Percentage of Indigenous Children in three age cohorts fully immunised, MSH, Queensland and Australia, quarter 4, 2025

Summary of rate changes: quarter 4, 2024 to quarter 4, 2025

Within each cohort, immunisation rates vary slightly from quarter to quarter owing to differences in the make-up of the cohort each quarter. These minor variations do not necessarily indicate any longer-term trends. To adjust for these variations, quarterly moving average (QMA) rates are calculated over the four most recent quarters for each age cohort. These QMAs provide a more accurate picture of the underlying rate in each cohort. Both raw quarterly rates and QMAs are presented in this and some subsequent sections.

Tables 2 and 3 detail the raw quarter 4 rates for all and Indigenous children for MSH and Queensland, along with the MSH QMA as at quarter 4, 2025 and a description of the change in rate since quarter 4 of 2024.

Table 2: All Children quarter 4 2025 immunisation rates (MSH and Qld) and quarter 4 QMA (MSH) and change since quarter 4, 2024

Age cohort	Rate description	Rate (%)	Description of change since Q4 2024
12-<15 months	MSH quarter 4, 2025	90.7	Decrease of 1.6 percentage points
	Qld quarter 4, 2025	89.0	Decrease of 1.7 percentage points
	MSH quarter 4 2025 QMA	91.3	Decrease of 1.2 percentage points
24-<27 months	MSH quarter 4, 2025	89.5	Decrease of 1.2 percentage points
	Qld quarter 4, 2025	88.0	Decrease of 1.5 percentage points
	MSH quarter 4 2025 QMA	89.5	Decrease of 1.2 percentage points
60-<63 months	MSH quarter 4, 2025	93.1	Decrease of 0.1 percentage points
	Qld quarter 4, 2025	92.0	Decrease of 0.4 percentage points
	MSH quarter 4 2025 QMA	92.4	Decrease of 0.6 percentage points

Table 3: Indigenous Children quarter 4 2025 immunisation rates (MSH and Qld) and quarter 4 QMA (MSH) and change since quarter 4, 2024

Age cohort	Rate description	Rate (%)	Description of change since Q4 2024
12-<15 months	MSH quarter 4, 2025	87.3	Decrease of 2.8 percentage points
	Qld quarter 4, 2025	87.9	Decrease of 1.1 percentage points
	MSH quarter 4 2025 QMA	88.6	Decrease of 0.9 percentage points
24-<27 months	MSH quarter 4, 2025	88.7	Increase of 0.7 percentage points
	Qld quarter 4, 2025	87.3	Decrease of 1.3 percentage points
	MSH quarter 4 2025 QMA	86.8	Decrease of 1.3 percentage points
60-<63 months	MSH quarter 4, 2025	91.9	Increase of 0.2 percentage points
	Qld quarter 4, 2025	93.0	Decrease of 1.2 percentage points
	MSH quarter 4 2025 QMA	92.3	Decrease of 0.6 percentage points

Number needed to immunise (NNI)

The metric 'number needed to immunise' (NNI) is defined as the number of children in a particular age group cohort who would need to be vaccinated in order to achieve a particular immunisation rate in that cohort.

For example, NNI95 for Metro South Health (MSH) one-year olds is the number of additional one year old children in MSH per quarter who would need to become fully immunised in order for the immunisation rate in that cohort to reach 95% (Table 4).

Table 4: NNI95 and NNI100 for All Children and Indigenous Children, MSH and Queensland for each of the three age cohorts, quarter 4, 2025.

Area	Age cohort	Group	Rate "Fully vaccinated" (%)	Number in cohort	NNI95	NNI100
MSH	12-<15 months	All children	90.7	3,501	151	326
Queensland	12-<15 months	All children	89.0	14,096	846	1,551
MSH	24-<27 months	All children	89.5	3,653	201	384
Queensland	24-<27 months	All children	88.0	14,854	1,040	1,782
MSH	60-<63 months	All children	93.1	4,071	77	281
Queensland	60-<63 months	All children	92.0	16,043	481	1,283
MSH	12-<15 months	Indigenous children	87.3	212	16	27
Queensland	12-<15 months	Indigenous children	87.9	1,294	92	157
MSH	24-<27 months	Indigenous children	88.7	300	19	34
Queensland	24-<27 months	Indigenous children	87.3	1,670	129	212
MSH	60-<63 months	Indigenous children	91.9	248	8	20
Queensland	60-<63 months	Indigenous children	93.0	1,682	34	118

All children

- To reach the 95% "fully vaccinated" target across all cohorts combined in MSH would have required an additional 429 children to be "fully vaccinated" out of a combined cohort of 11,225 children. This was a 31% increase from the 328 required in quarter 4, 2024.
- To reach 100% "fully vaccinated" (i.e. all children immunised) across all cohorts combined would have required an additional 990 children to be "fully vaccinated" out of a combined cohort of 11,225 children. This was a 12% increase from the 890 required one year previously.

Indigenous children

- To reach the 95% "fully vaccinated" target across all Indigenous cohorts combined would have required an additional 43 children to be "fully vaccinated" out of a combined cohort of 760 children. This was a slight increase from the 40 required in quarter 4, 2024.
- To reach 100% "fully vaccinated" across all Indigenous cohorts combined would have required an additional 81 children to be "fully vaccinated" out of a combined cohort of 760. This was a small increase from the 78 required in quarter 4, 2024.

Child rates: Trends 2014 to 2025

All children: 12-<15 month cohort

The rate of full immunisation of children in the 12 month age cohort showed a strong upward trend from the start of 2014 to the end of 2017. The rate reached or exceeded the 95% target on six occasions between quarter 3, 2017 and quarter 3, 2021 but the target was not sustained for more than three successive quarters. Throughout much of 2018 to 2020 the rate remained relatively stable at between 94% and 95% but it trended downwards following a peak of 95.3% in quarter 3, 2020 (Figure 3). In quarter 4, 2025 the rate was the lowest recorded since pre-2014.

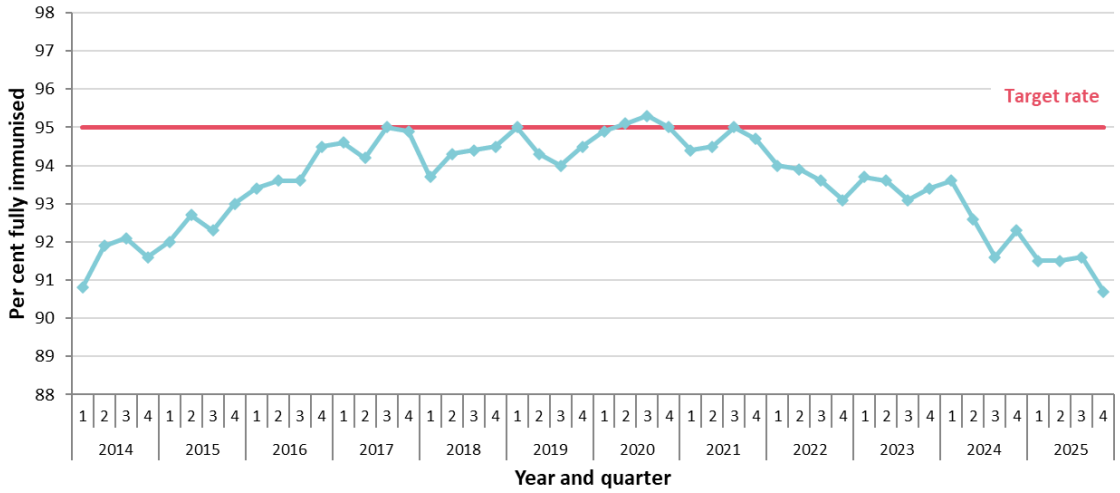

Figure 3: Percentage of All children aged 12 to <15 months (12 month cohort) fully immunised, MSH, quarter 1, 2014 to quarter 4, 2025

The QMA for the 12 month cohort shows that the fully immunised rate has steadily declined since quarter 4, 2020 (Figure 4). In quarter 4, 2025 it was at the lowest point recorded since quarter 1, 2014.

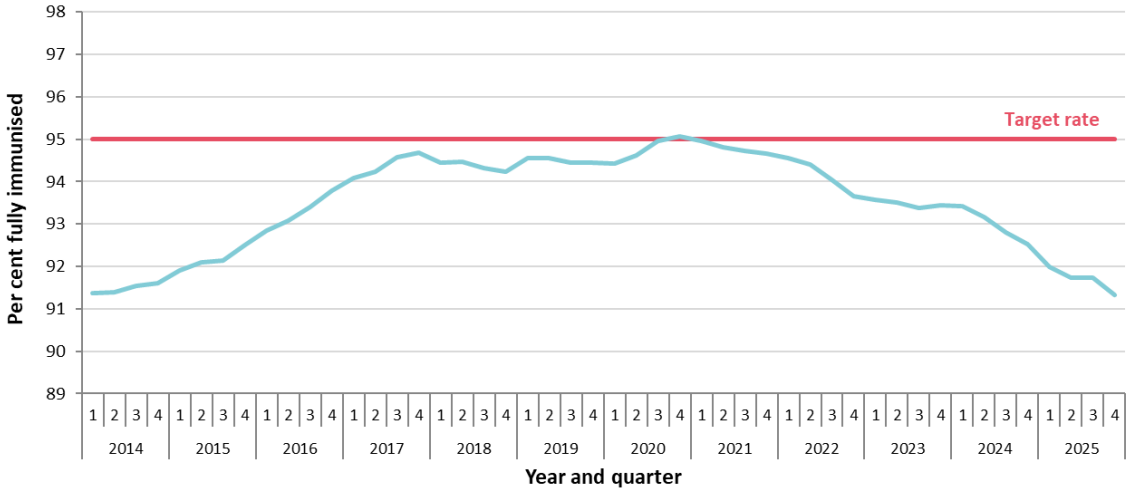

Figure 4: Quarterly moving average of percentage of All children aged 12 to <15 months (12 month cohort) fully immunised, MSH, quarter 1, 2014 to quarter 4, 2025

All children, 24-<27 month cohort:

Immunisation rates in the 24 month cohort were consistently substantially lower than in the younger cohort. The rate was highly variable from 2014 to 2018, at least partly owing to a number of additional vaccines added to the definition of "fully vaccinated". Through 2020 to 2021 the rate generally increased, peaking at 93.9% in quarter 3, 2021. However following that peak, rates moved strongly downwards (Figure 5). In quarter 3, 2025, the rate below 89%, the lowest level recorded since pre-2014. This was followed by a slight rebound in quarter 4, 2025 which did not alter the overall downward trend (Figure 5).

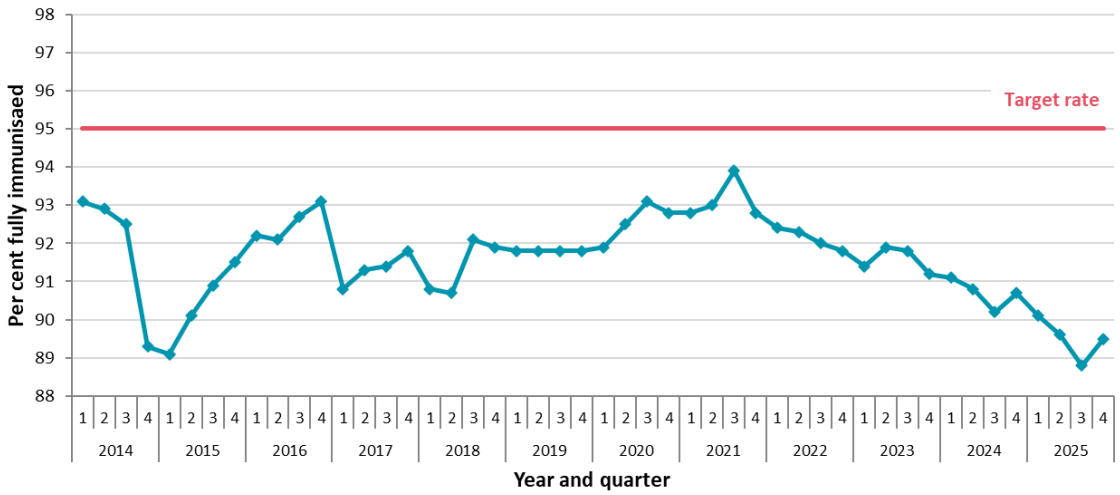

Figure 5: Percentage of All children aged 24 to <27 months (24 month cohort) fully immunised, MSH, quarter 1, 2014 to quarter 4, 2025

The QMA for the 24 month cohort shows the relatively steady increase in rates that occurred between 2018 and 2021, mirrored by the steady decline through 2022 to 2025 (Figure 6). In quarter 4, 2025 the QMA was at the lowest point recorded since pre-2014.

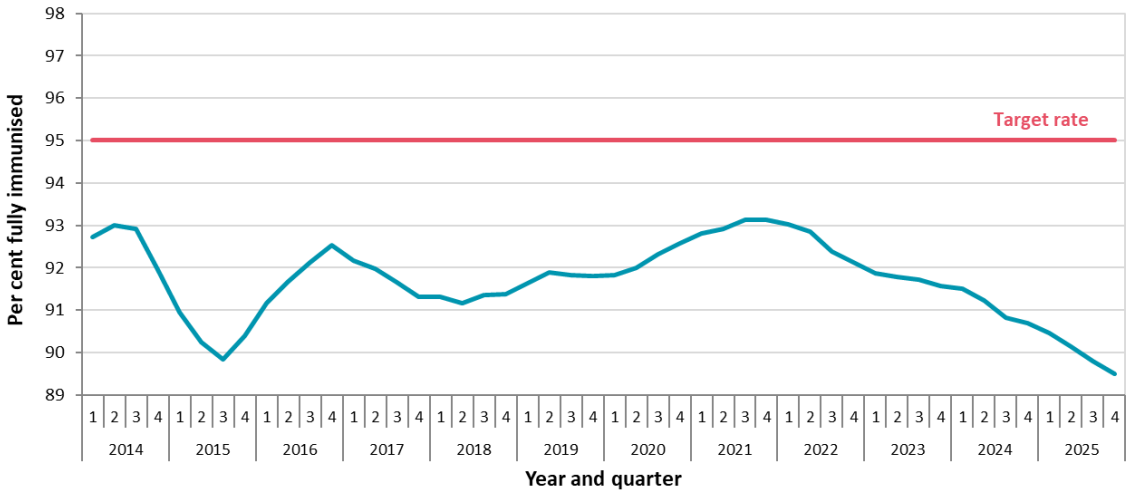

Figure 6: Quarterly moving average of percentage of All children aged 24 to <27 months (24 month cohort) fully immunised, MSH, quarter 1, 2014 to quarter 4, 2025

All children: 60-<63 month cohort

From 2014 onwards, immunisation rates in the 60 month cohort were almost always slightly lower than in the 12 month cohort but higher than the 24 month cohort. The rate in the 60 months group trended upwards between 2014 and 2018, reaching the 95% target in two quarters in 2018-2019; however this level was not reached again after quarter 2, 2019. Following a period of stability at over 94% from 2019 to 2021, a general decrease occurred with the rate recorded in quarter 3, 2025 (91.8%) the lowest achieved since quarter 4, 2014 (Figure 5).

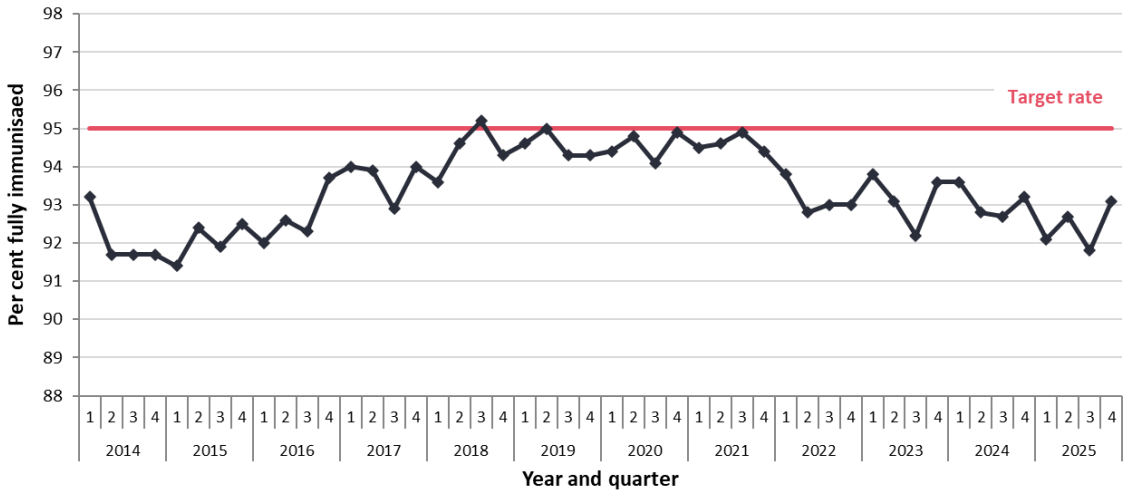

Figure 7: Percentage of All children aged 60 to <63 months (60 month cohort) fully immunised, MSH, quarter 1, 2014 to quarter 4, 2025

The QMA for the 60 month cohort illustrates the steady upward trend in rates between 2015 and 2019, followed by a period of stability lasting until the end of 2021. The rate decreased during late 2021 and 2022, stabilised in 2023-2024 and trended lower again through 2025 (Figure 8). The QMA in quarter 4, 2025 was identical to that in quarter 3, 2016.

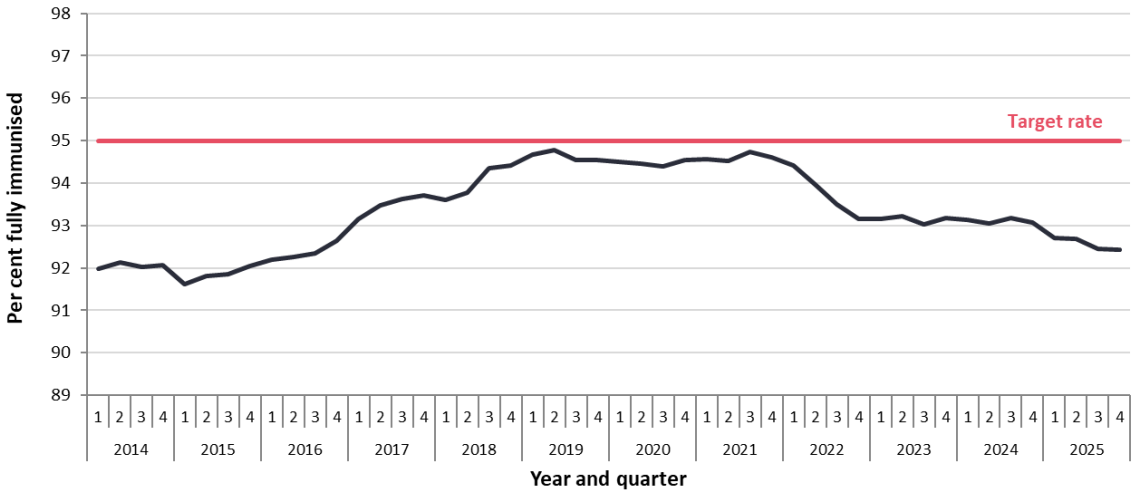

Figure 8: Quarterly moving average of percentage of All children aged 60 to <63 months (60 month cohort) fully immunised, MSH, quarter 1, 2014 to quarter 4, 2025

Indigenous children: 12-<15 month cohort

Between-quarter volatility in immunisation rates in the three Indigenous children cohorts is commonly recorded. This is largely the result of the small and variable cohort sizes in this population. Recently, from 2023 to 2024 each cohort has represented an average of around 230 to 270 children in Metro South. As a result, small between-quarter changes in either reported cohort size and/or reported numbers being immunised can cause relatively major changes in reported immunisation rates. Owing to this volatility, overall trends are the most reliable and important information rather than quarter-to-quarter variability.

Immunisation rates in Indigenous children in the 12 month cohort peaked at 96.3% in quarter 2, 2020. However since that time they have trended downwards. The rate in quarter 1, 2025 (91.0%) was the lowest recorded since quarter 2, 2015 (Figure 9).

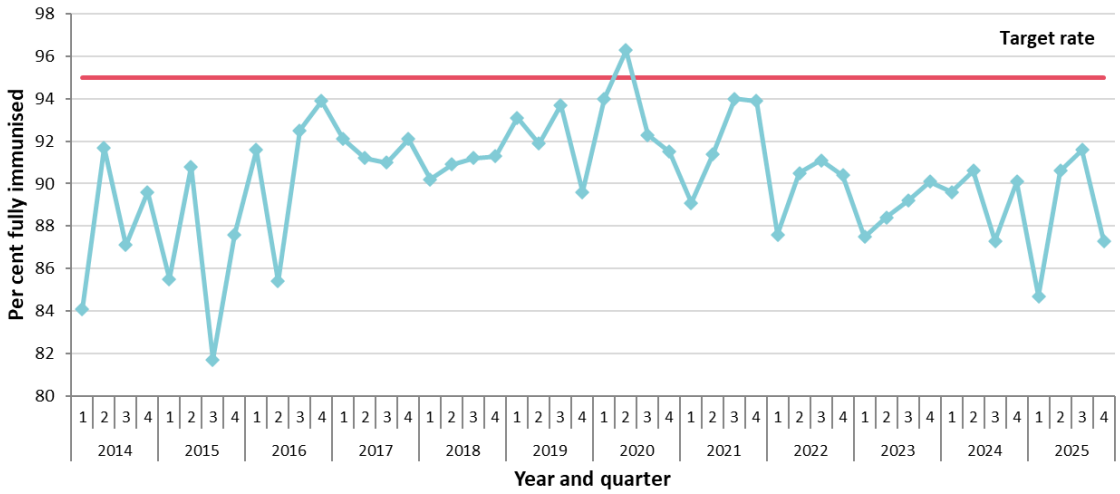

Figure 9: Percentage of Indigenous children aged 12 to <15 months (12 month cohort) fully immunised, MSH, quarter 1, 2014 to quarter 4, 2025

The QMA for the 12 month Indigenous cohort shows the increasing rate trend from 2014 to quarter 4, 2020. From 2021 onwards the rate trended fairly consistently downwards (Figure 8) with a relative steadying occurring in 2025 with the rate reaching the lowest level recorded since quarter 2, 2016.

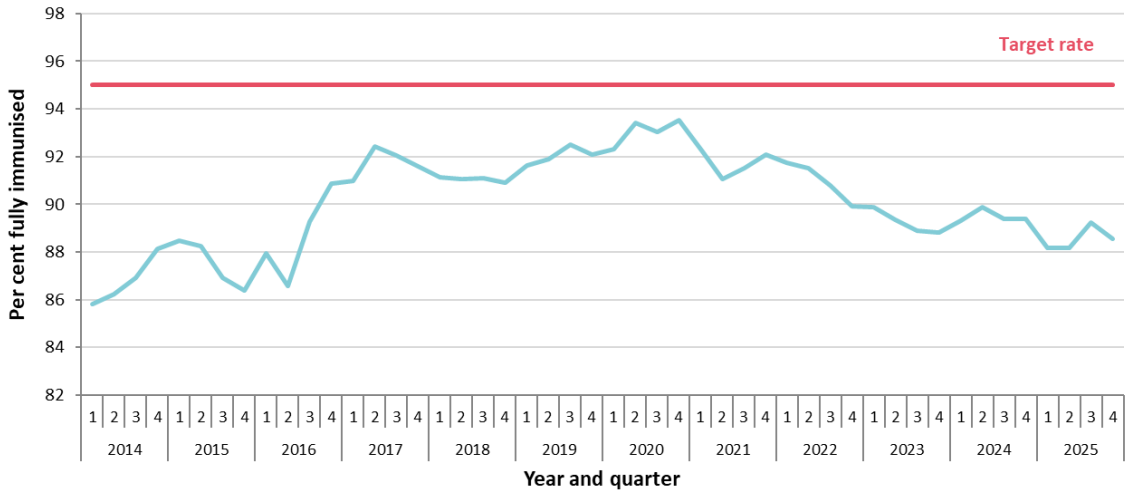

Figure 10: Quarterly moving average of percentage of Indigenous children aged 12 to <15 months (12 month cohort) fully immunised, MSH, quarter 1, 2014 to quarter 4, 2025

Indigenous children: 24-<27 month cohort

Historically, immunisation rates in the Indigenous children 24 month cohort have had higher levels of variability than the 60 month cohort and lower levels than in the younger cohort. Following a major drop to quarter 1, 2015 caused by a change in the definition of “fully immunised”, rates generally increased to a peak of 94.5% in quarter 2, 2021 (Figure 11). Since that time rates have fallen with the quarter 3, 2025 rate (83.3%) the lowest recorded since quarter 1, 2015. The extreme variability in the cohort indicates why concerns should generally only be raised either if a rate remains at a particularly low level for two or more successive quarters or when negative trends are established.

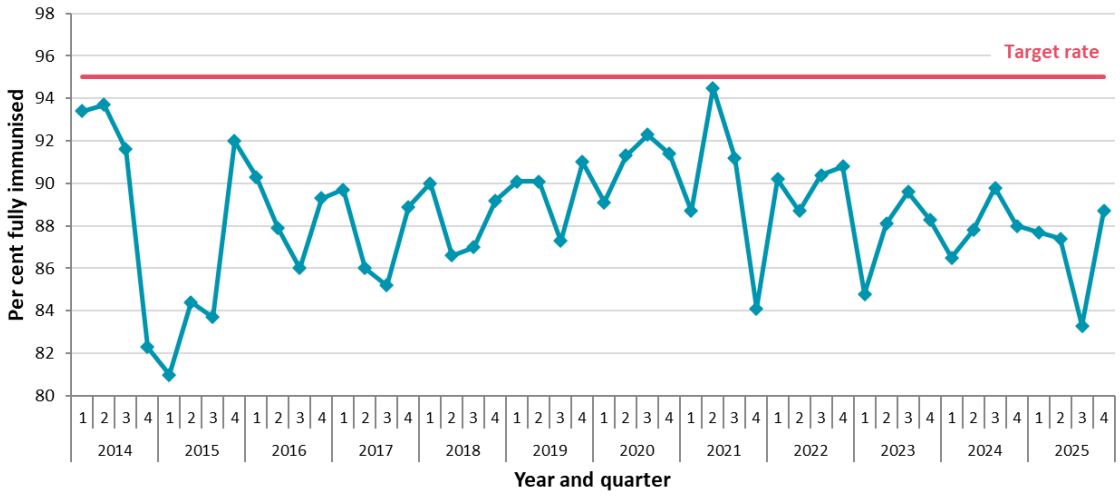

Figure 11: Percentage of Indigenous children aged 24 to <27 months (24 month cohort) fully immunised, MSH, quarter 1, 2014 to quarter 4, 2025

The QMA for the 24 month Indigenous cohort illustrates the gradual increase in rates which occurred from 2018 to 2021. After quarter 3, 2021 the general trend was downward although unusual stability was recorded throughout 2024 and early 2025 (Figure 12).

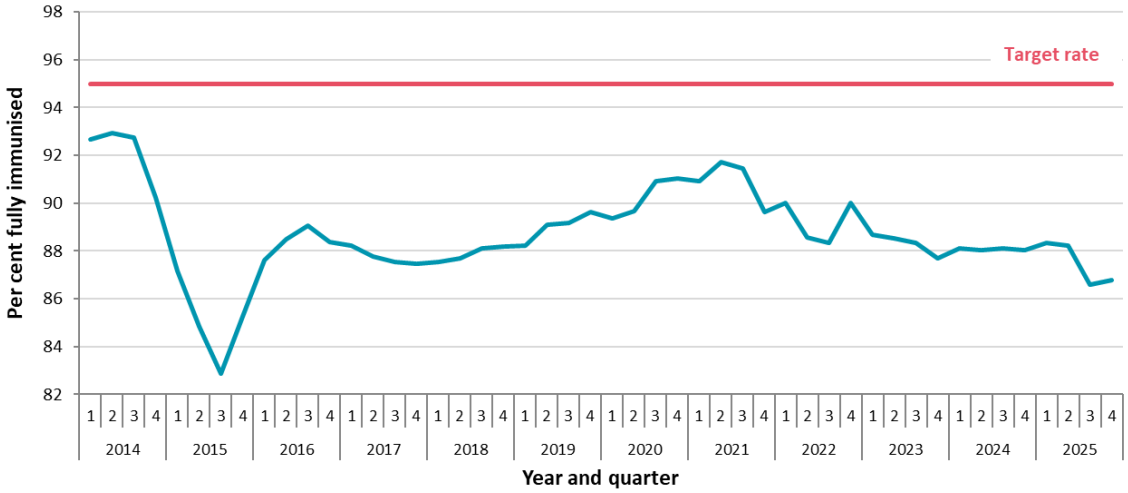

Figure 12: Quarterly moving average of percentage of Indigenous children aged 24 to <27 months (24 month cohort) fully immunised, MSH, quarter 1, 2014 to quarter 4, 2025

Indigenous children: 60-<63 month cohort

Indigenous child immunisation rates in the 60 month cohort were consistently higher and more stable than those in the 12 and 24 month cohorts. The cohort rate was consistently at or above the 95% target rate from quarter 1, 2017 to quarter 3, 2021, peaking at 97.8% in quarter 2, 2019 (Figure 13). Despite being above 95% ,the rate started trending down from the end of 2020 onwards (Figure 13). The rate in quarter 1, 2025 (91.0%) was the lowest recorded since quarter 2, 2015 (90.3%).

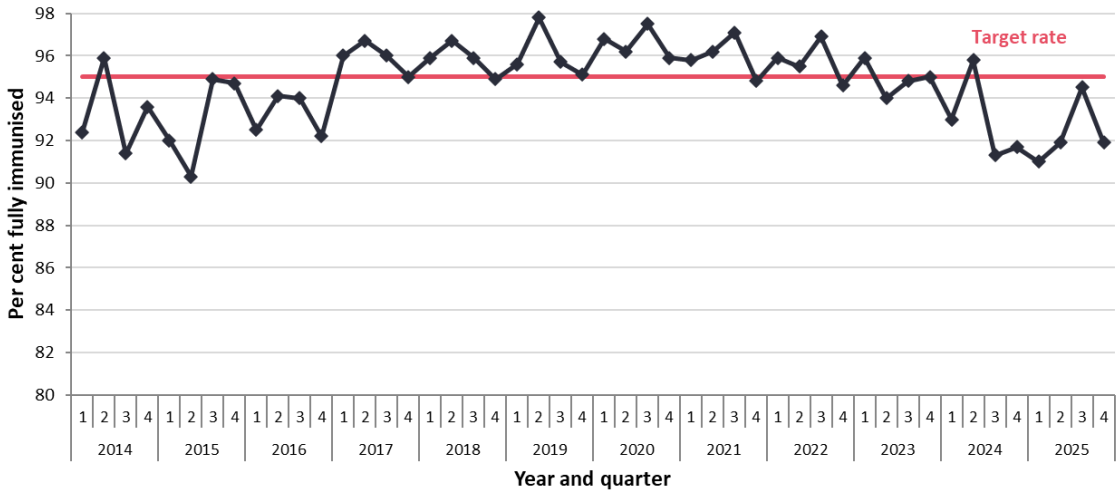

Figure 13: Percentage of Indigenous children aged 60 to <63 months (60 month cohort) fully immunised, MSH, quarter 1, 2014 to quarter 4, 2025

The QMA for the 60 month Indigenous cohort shows the fully immunised rate increased from below 92% at the start of 2014, to almost 96% in quarter 4, 2017. After that time, the rate remained around 96%, well above the All children rate, for almost five years. However, following a peak of 96.6% in quarter 4, 2020, the rate trended gradually downward, dropping below the target rate of 95% from quarter 3, 2023 onwards (Figure 14). The observed downward trend is concerning in the context of the downward trends in the younger cohorts and because the rate of decline increased in more recent quarters.

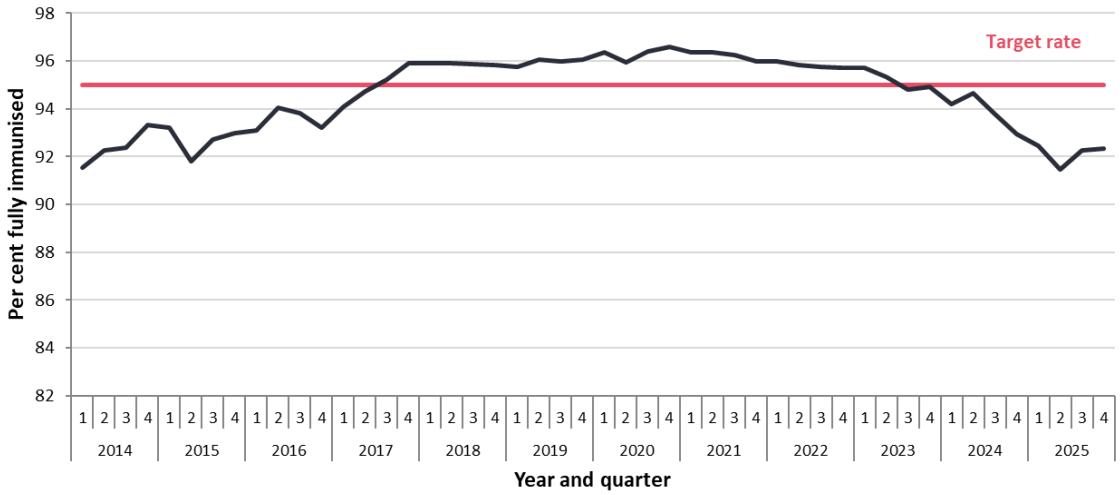

Figure 14: Quarterly moving average of percentage of Indigenous children aged 60 to <63 months (60 month cohort) fully immunised, MSH, quarter 1, 2014 to quarter 4, 2025

Child rates: Local variation in immunisation – All children

Under the Australian Statistical Geography Standard (ASGS) 2021 classification, MSH is subdivided into 116 statistical area level 2s (SA2s) which broadly represent suburbs or groupings of suburbs[1].

The four-quarterly moving average rates, as at quarter 4, 2025, were mapped at the statistical area level 2 (SA2) level for each of the three age cohorts. In the greater Brisbane area SA2 boundaries map well to the boundaries of individual or pairs of suburbs and therefore they can be used as a proxy for suburbs.

Using the number of children in the cohort and the quarterly moving average immunisation rate, the number of children who were not fully immunised was imputed at the SA2 level. These counts were also mapped by SA2. Some comparisons with the four-quarterly moving average rates as at quarter 4, 2024 were undertaken.

All children: 12-<15 month cohort

Eighteen per cent (21/114) of MSH SA2s recorded the 95% target rate in the 12 month cohort. This was lower than the 28% recorded at the QMA to quarter 4, 2024 and was a very substantial decrease from the 56% recorded at quarter 1 of 2022. The majority of SA2s which recorded the 95% rate were in the Brisbane local government area (LGA) (19/21), with one in Logan LGA (Loganlea) and one in Redland LGA (Thorneside) recording the target.

Exactly half of the MSH SA2s (57/114) had rates in the range 90 to <95%. These were spread across the three major LGAs. A further quarter of the SA2s (28/114) had rates in the rage 85 to <90%. These were in Brisbane and Logan LGAs along with Beaudesert SA2 in Scenic Rim LGA (Figure 15).

In 2024 only four SA2s in MSH had rates for this cohort below 85%, with the lowest being 82.9% in Southern Moreton Bay Islands SA2. In 2025 this had risen to seven SA2s, with two of these having a rate lower than 80%: North Stradbroke Island (77.3%), Munruben – Park Ridge South (79.2%), Cleveland (80.7%), Southern Moreton Bay Islands (81.8%), Woolloongabba (81.9%), Mount Warren Park (83.0%), Logan Village (84.7%) and Wellington Point (84.9%) (Figure 15).

The areas with the lowest rates tended to cluster in bayside and Brisbane River-adjacent areas, the central to south-eastern part of Logan LGA, and areas adjacent to the south-east freeway (Figure 15).

A high immunisation rate does not necessarily translate into a small number of children who are not fully immunised. For example, the SA2 of Chambers Flat – Logan Reserve had a rate of 91.1% but was the SA2 with the fourth highest number of children not fully immunised (31) in this cohort because of its large population of young children. The SA2 with the highest number of non-fully immunised children in this cohort was Boronia Heights – Park Ridge (47 children) with a moderate immunisation rate of 90.2%. High numbers were also found in Yarrabilba, Inala – Richlands, Woodridge and Marsden SA2s, largely in Logan LGA

(Figure 16). Yarrabilba SA2 coupled high numbers of under-immunised children (46) with a low immunisation rate (85.4%).

The overall MSH 12 month cohort QMA immunisation rate decreased by 1.2 percentage points from quarter 4 2024 to quarter 4, 2025. At the SA2 level, a decrease in rate was recorded in 57% of SA2s (65/114) over this period with an average reduction per SA2 of 4.2 percentage points. Over the same period a further 46 SA2s (40%) recorded an increase in immunisation rate with an average increase per SA2 of 3.2 percentage points. Rates in the remaining three SA2s were stable (varied by less than 0.15 percentage points) over the period.

A comparison of Figure 15 and Figure 17 illustrates the overall reduction in immunisation rates in this cohort over the past 12 month period. In 2024 (Figure 17) there was a far greater area within MSH with rates at or above 90% (green shades) while in 2025 (Figure 15) the area with rates below 90% (yellow to red shades) had expanded substantially.

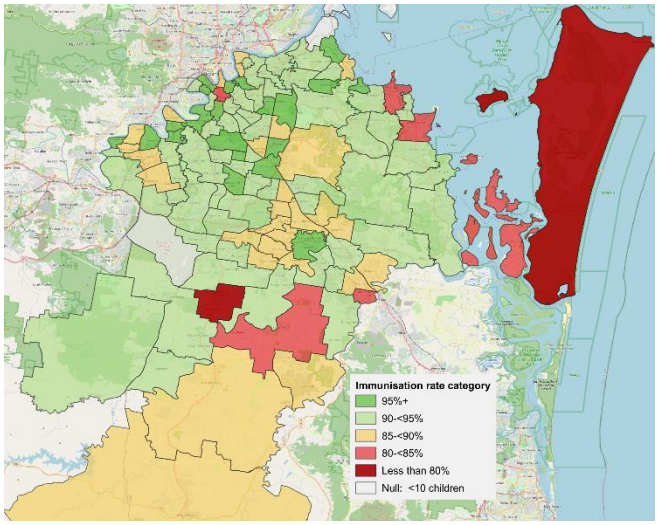

Figure 15: Quarterly moving average immunisation rates (Q1 to Q4-2025), 12 month cohort, by SA2

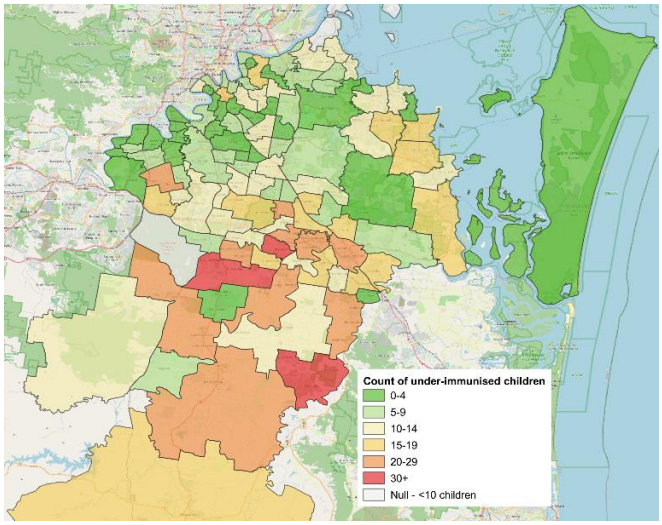

Figure 16: Quarterly moving average number of children not fully immunised (Q1 to Q4-2025), 12 month cohort, by SA2

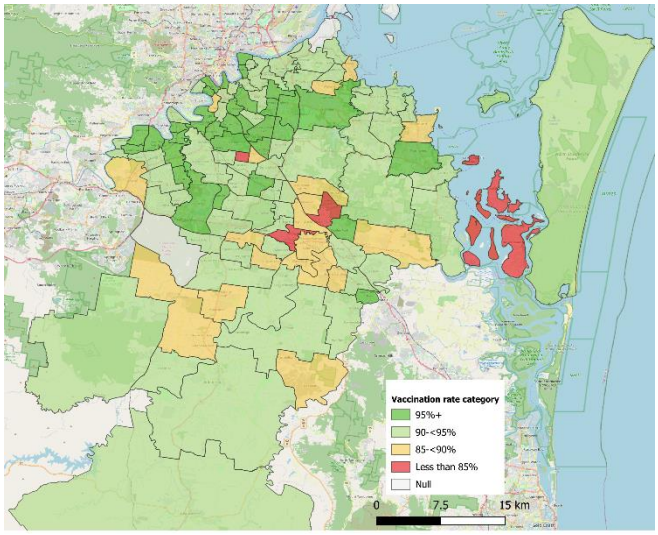

Figure 17: Quarterly moving average immunisation rates (Q1 to Q4-2024), 12 month cohort, by SA2

All children: 24-<27 month cohort

Immunisation rates were generally lower in the 24 month cohort than the 12 and 60 month cohorts. This is reflected in fewer SA2s (8/114 or 7% of the total) recording the 95% target rate in this cohort. This was lower than the 11% recorded at the QMA to quarter 4, 2024. The majority (7/8) of the SA2s which recorded the 95% rate in the most recent quarter were in the Brisbane LGA (Salisbury – Nathan, Kangaroo Point, Oxley, Moorooka, Jindalee – Mount Ommaney, Coorparoo, Yeronga), with only Mount Warren Park in Logan LGA and nil SA2s in Redland LGA (Figure 18).

Approaching half (45%) of SA2s (51/114) had rates in the range of 90 to <95%, lower than the 56% in this range at quarter 4, 2024. Three quarters of these SA2s (39/51) were in Brisbane LGA with the remaining 25% split between Logan and Redland LGAs.

Fifteen SA2s in this cohort had a rate below 85% with two from Redland LGA of these lower than 80%: Southern Moreton Bay Islands (74.5%) and North Stradbroke Island (75.0%). Most of the SA2s with a rate in the 80 to <85% range (9/13) were in Logan LGA but the SA2s of Beaudesert (Scenic Rim LGA; 83.1%), Cleveland (Redland LGA; 84.0%), Woolloongabba and Robertson (Brisbane LGA; 81.4% & 81.5%) SA2s were also in this range (Figure 18).

An additional 40 SA2s had rates between 85 and <90%. These were spread between Brisbane (18/40), Logan (17/40) and Redland (5/40) LGAs (Figure 18).

The areas with the lowest rates in the 24 months cohort tended to cluster in the northern to central part of Logan LGA around the south-east freeway along with the Moreton Bay islands and Beaudesert (Figure 18).

The SA2s with the highest numbers of under-immunised children in the 24 month cohort were primarily in Logan LGA. Boronia Heights – Park Ridge had the highest number (52), followed by Kingston (43) and Yarrabilba (40). Inala – Richlands (36), Calamvale – Stretton (32) and Beaudesert (32) outside of Logan also had high numbers (Figure 19). All SA2s with high (30+) numbers of under-immunised children also had cohort immunisation rates below 90%.

The overall MSH 24 month cohort QMA immunisation rate decreased by 1.2 percentage points from quarter 4 2024 to quarter 4, 2025. At the SA2 level, a decrease in rate was recorded in 65% of SA2s (74/114) over this period with an average reduction per SA2 of 4.2 percentage points. Over the same period 38 SA2s (33%) recorded an increase in immunisation rate with an average increase per SA2 of 2.9 percentage points. Rates in the remaining two SA2s were stable (varied by less than 0.15 percentage points) over the period.

A comparison of Figure 18 and Figure 20 illustrates the overall reduction in immunisation rates in this cohort over the past 12 month period. In 2024 there was a greater area, especially within Brisbane LGA with rates at or above 90% (green shades) while in 2025 the area with rates below 90% (yellow to red shades) has expanded particularly in the north of Logan LGA and adjacent south of Brisbane LGA and inner areas along the Brisbane River .

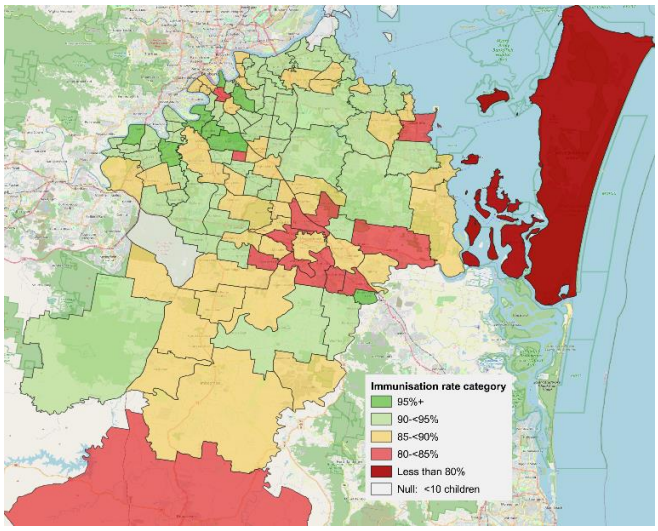

Figure 18: Quarterly moving average immunisation rates (Q1 to Q4-2025), 24 month cohort, by SA2

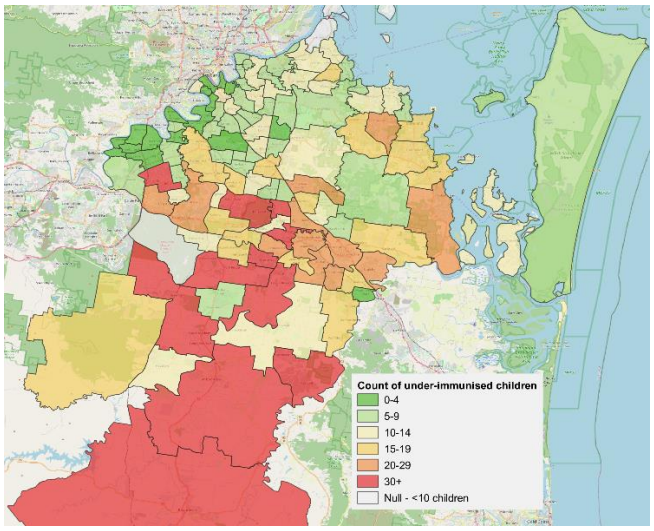

Figure 19: Quarterly moving average number of children not fully immunised (Q1 to Q4-2025), 24 month cohort, by SA2

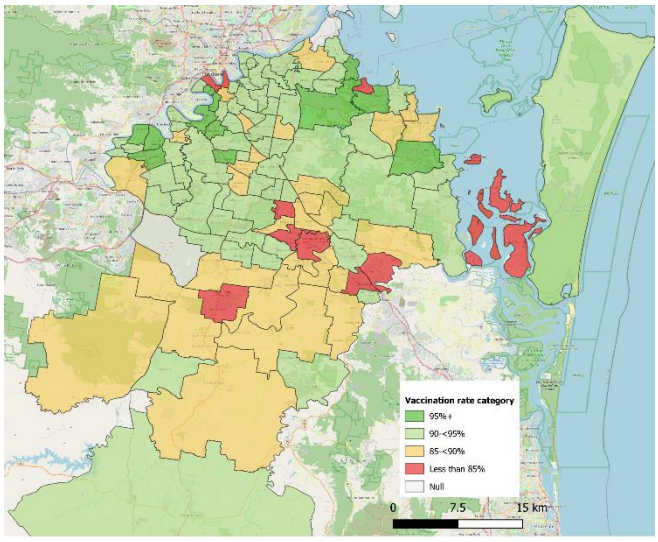

Figure 20: Quarterly moving average immunisation rates (Q1 to Q4-2024), 24 month cohort, by SA2

All children: 60-<63 month cohort

Just over one quarter (31/114) of MSH SA2s recorded the 95% target rate in the 60 month cohort. This was lower than the percentage recorded at the QMA to quarter 4, 2024. The majority of the SA2s which recorded the 95% rate were in Brisbane LGA (26/31: 84%). Two SA2s in Redland LGA (Thorneside and Sheldon – Mt Cotton) and three SA2s in Logan LGA (Mount Warren Park, Flagstone West – New Beith, Cornubia – Carbrook) also reached the target (Figure 21).

The worst performing SA2 in this cohort with a rate of 75.0% was Woolloongabba. All other SA2s had rates over 85.0%.

Nineteen SA2s had rates between 85% and <90%. More than half (11/19) of these were in Logan LGA, mostly in its north and eastern areas. Cleveland SA2 (86.8%) had the lowest rate in Redland LGA while the areas of Brisbane LGA with lowest rates were mostly clustered in the inner areas by the Brisbane River (Figure 21).

The SA2 with the highest number of children in this cohort who were not fully immunised was Marsden (40 children). Boronia Heights – Park Ridge and Yarrabilba SA2s also each had more than 30 under-immunised children Ten additional SA2s had 20 or more under-immunised children in this cohort. All of these except Inala – Richlands SA2 were in Logan LGA (Figure 22). Just over half (51%) of MSH SA2s had fewer than ten children in this cohort who were not fully immunised.

The overall MSH 60 month cohort immunisation rate decreased by 0.6 percentage points from quarter 4, 2024 to quarter 4, 2025. At the SA2 level, a decrease in rate was recorded in 50% of SA2s (57/114) over this period with an average reduction per SA2 of 3.5 percentage points. Over the same period a further 54 SA2s (47%) recorded an increase in immunisation rate with an average increase per SA2 of 3.2 percentage points. Rates in the remaining three SA2s were stable (varied by less than 0.15 percentage points) over the period.

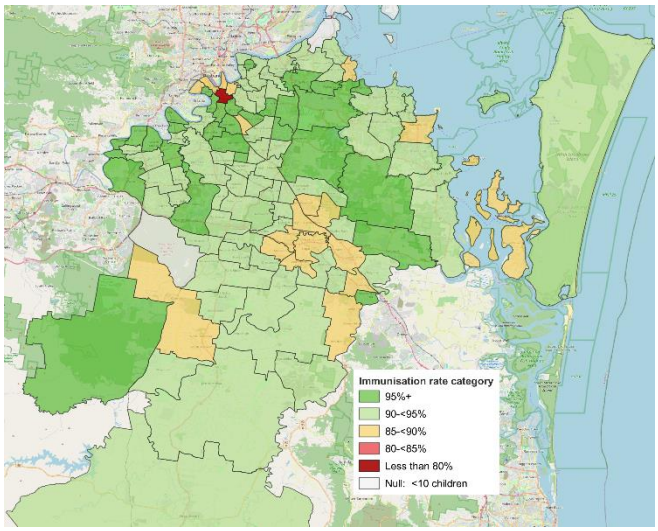

Figure 21: Quarterly moving average immunisation rates (Q1 to Q4-2025), 60 month cohort, by SA2

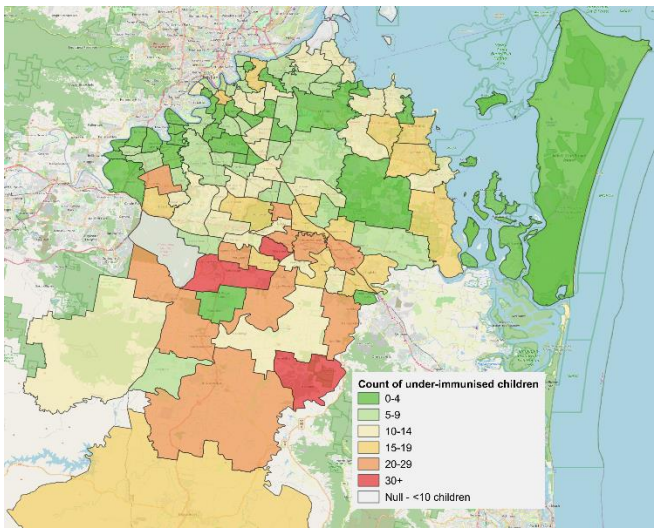

Figure 22: Quarterly moving average number of children not fully immunised (Q1 to Q4-2025), 60 month cohort, by SA2

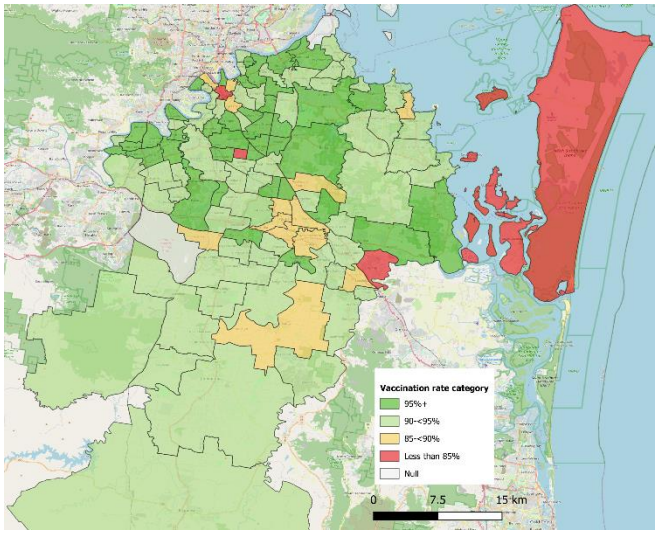

Figure 23: Quarterly moving average immunisation rates (Q1 to Q4-2024), 60 month cohort, by SA2

A comparison of Figure 21 and Figure 23 illustrates the relatively small reduction in areas with 95% immunisation rates in this cohort and small increase in areas with rates in the 85-+<90% range over the past 12 month period. In 2024 there was a greater area with rates below 90% (red shades) but most of these

areas have small populations of young children these improvements represent very small actual numbers of additional children being immunised.

Child rates: Conclusion

All children

- In Q4-2025 rates in all three age cohorts below 95% target rate and broadly similar to rates in Queensland and Australia.
- QMA rates in all three age cohorts decreased over past 12 months.
- All children four-quarterly moving average rates:
  - 12 month cohort: trending down since Q4-2020; in Q4-2025 at lowest point since Q1-2014.
  - 24 month cohort: trending down since Q4-2021; in Q4-2025 at lowest point since pre-2014
  - 60 month cohort: trending down since Q4-2021; in Q4-2025 at lowest point since Q3-2016.
  - All gains made in all cohorts since at least 2016 have been lost
- To reach the 95% fully immunised target across the three MSH all children age cohorts combined would have required an additional 429 children to be fully immunised out of a combined cohort of 11,225.

Indigenous children

- In Q4-2025 rates in all three age cohorts below 92% and lower than rates in Queensland and Australia in 12 and 60 month cohorts.
- QMA rates in all three cohorts decreased over past 12 months.
- Indigenous children four-quarterly moving average rates:
  - 12 month cohort: generally trending down since Q4-2020; some steadying of rates in 2025; in Q4-2025 at a level comparable with Q2-2016
  - 24 month cohort: generally trending down since Q3-2021 however stable from Q1-2024 to Q2-2025; in Q4-2025 at lowest point since Q4-2015
  - 60 month cohort: trending down since Q4-2020; currently at lowest level since Q2-2014
  - All gains made in all cohorts since at least 2016 have been lost
- To reach the 95% fully immunised target across the three Indigenous children cohorts combined an additional 43 children out of a combined cohort of 760 children would have to be fully immunised.

Local-level variation

- At the local level, a high immunisation rate does not always translate to a low number of under-immunised children, owing to variations in population density and structure.
- Across all three cohorts combined, the SA2s with the lowest overall immunisation rates were Woolloongabba and North Stradbroke Island, both with rates below 80%.
- Across all three cohorts combined, the SA2s with the highest numbers of non-fully immunised children were Boronia Heights – Park Ridge (135 children), Yarrabilba (119 children), Inala - Richlands (100 children) and Marsden (98 children).

- Areas with the highest numbers of under-immunised children (rather than areas with the lowest rates) are potentially where the greatest gains can be made through increased resourcing.
- On this basis, the greatest gains will likely be found in the suburbs of central and eastern Logan LGA, the Beaudesert region, central south Brisbane bordering Logan LGA and mainland coastal areas within Redland LGA.

Adolescent rates: School immunisation program

In 2017 the SIP achieved immunisation rates just below 75% of year 7 students for both dTpa and HPV vaccines (Figure 24). The rate for MenACWY in year 10 students was much lower at 56% in 2017 (the first year this vaccine was included in the SIP) but it rose in subsequent years, reaching a peak of 75% in 2020. From 2021 onwards (during and post-pandemic) the SIP immunisation rates in all three vaccines fell sharply, with all three at or just below 60% by 2025 (Figure 24).

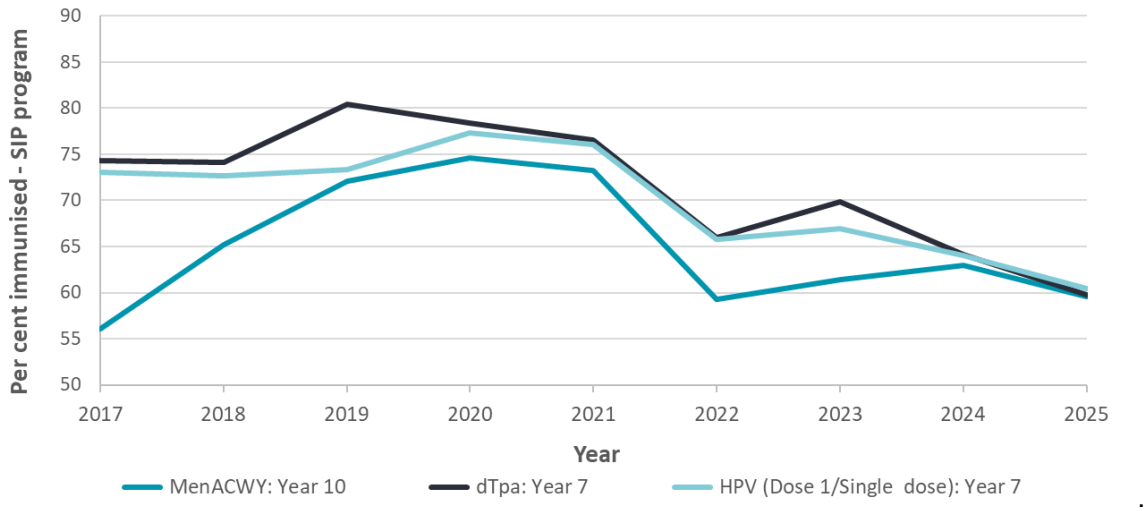

Figure 24: Immunisation rates achieved via school immunisation program (SIP), three vaccines, year 7 and year 10 students in MSH schools, 2017 to 2025

Adolescent rates: Age cohort data from AIR

At time of publication of this report, accessibility to HHS-level quarterly data for adolescent age cohorts was still developing. Data was available for statistical area 3s (SA3s) for quarter 2, 2024 to quarter 4, 2025 only. Approximate quarterly rates for MSH were able to be calculated by combining data from the 20 SA3s contained within the MSH area, noting that two of these SA3s are also partly within Metro North HHS boundaries.

The rates for both HPV and DTP in the 15 years cohort decreased throughout 2024 from around 83% to about 77%. Both then remained relatively stable throughout 2025 at between 75% and 80% (Figure 25). In the 17 years age cohort the rate of MenACWY immunisation remained fairly stable at approximately 68% (Figure 25).

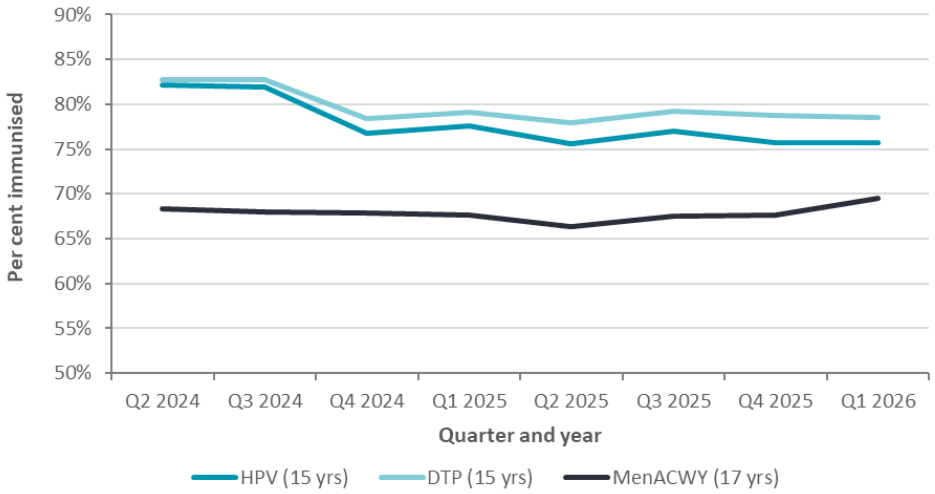

Figure 25: Immunisation for three vaccines, in 15 and 17 years age cohorts, MSH, quarter 2, 2024 to quarter 4, 2025

The differences observed between the rates achieved via the SIP program and those recorded across the entire relevant age cohort indicate the approximate proportion of the vaccine being delivered via other routes including GP clinics, pharmacies and community immunisation clinics. For both HPV and DTP the data suggest that at least 15% of 15 year olds are receiving vaccines outside of the SIP program while only about 8% of 17 year olds are receiving MenACWY vaccine from these other sources.

Factors potentially influencing immunisation rates

- The decreases observed in immunisation rates across all child and adolescent age cohorts have primarily occurred since the start of the COVID-19 pandemic. Temporary factors related to COVID-19 (such as decreased GP access) likely contributed to the immediate decline. However rates continued to decrease as the pandemic receded continuing broadly throughout 2025.
- GP bulk-billing rates for both adults and children peaked in April 2020, early in the pandemic and then declined, with the steepest decline occurring throughout 2022 and 2023[4]. Changes in access to bulk-billed services is a further factor which may contribute to observed reductions in immunisation rates.
- The highest numbers of under-immunised children are consistently found in areas within Logan LGA. The Logan City Council operates a free immunisation program, meaning GP access is unnecessary to access childhood immunisation in this LGA. This points towards a complex interplay of factors beyond access alone.
- The pandemic increased concerns regarding vaccine safety and effectiveness in sections within the community. This has resulted in increased vaccine hesitancy and vaccine fatigue and decreased vaccine confidence.
- Vaccine uptake is shaped by interconnected factors. High coverage rates can only be achieved when both demand (willingness and motivation to immunise) and supply (convenient, available services) are effectively addressed.

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