Annual Immunisation Update for Nurses & GPs

13 October 2026

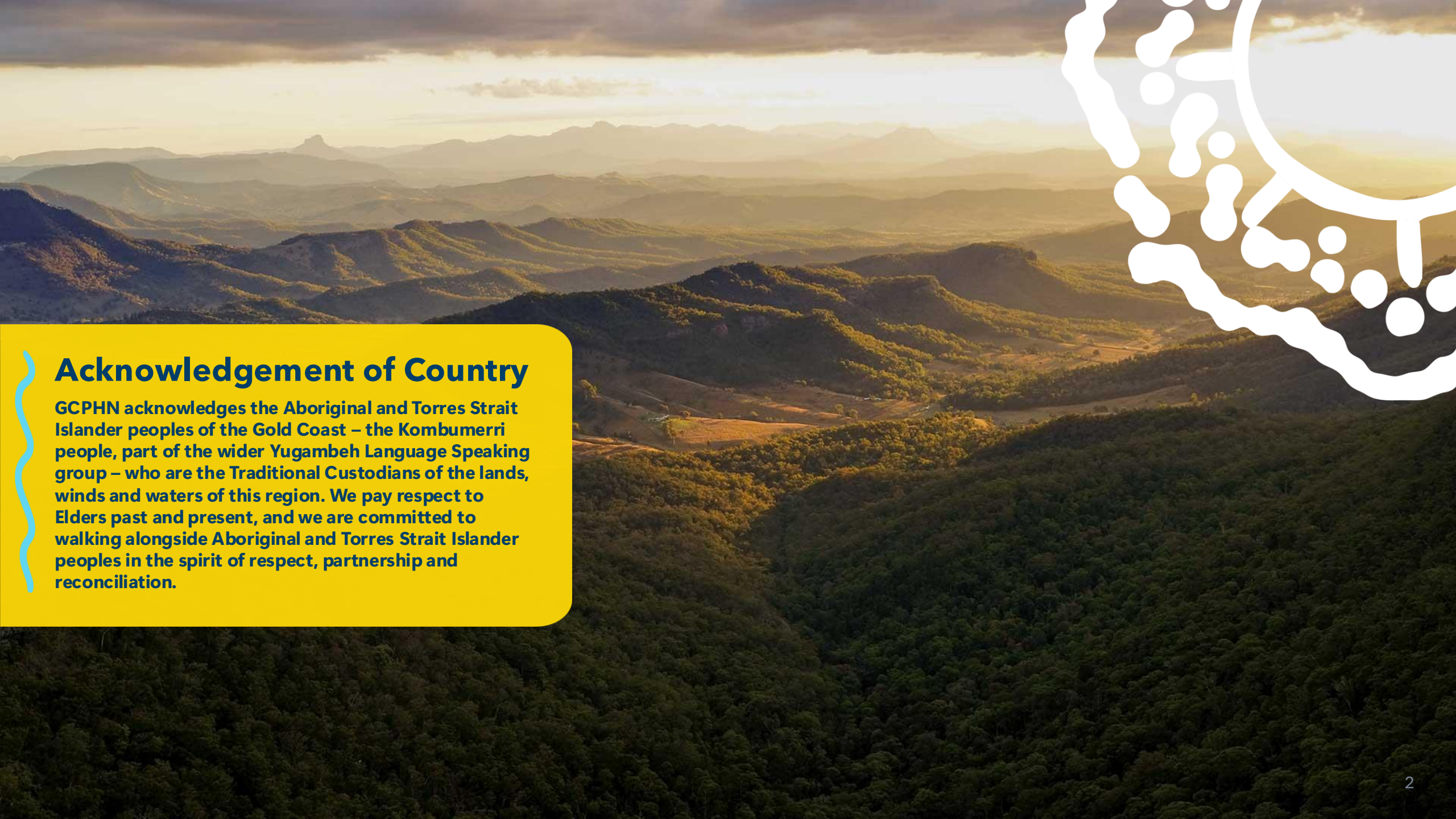
Welcome!

Please take a seat, enjoy networking and dinner.

phn GOLD COAST

An Australian Government Initiative

Shaping healthier lives



Acknowledgement of Country

GCPHN acknowledges the Aboriginal and Torres Strait Islander peoples of the Gold Coast – the Kombumerri people, part of the wider Yugambeh Language Speaking group – who are the Traditional Custodians of the lands, winds and waters of this region. We pay respect to Elders past and present, and we are committed to walking alongside Aboriginal and Torres Strait Islander peoples in the spirit of respect, partnership and reconciliation.

Housekeeping

- Please switch mobile phones to silent
- Toilets are located across the foyer
- Exits are located at the rear of the room
- QR codes are located on the table to participate tonight

WIFI password: mercureconf

Agenda

6:00 pm	**Arrival, Dinner, Networking**	
6:30 pm	**Welcome**	**Bec Norris** Immunisation Project Officer Gold Coast Primary Health Network
6:35 pm	**Disease trends, NIP Changes and Public Health Updates**	**Linda Menton** Acting Clinical Nurse Consultant Gold Cost Public Health Unit
6:55 pm	**Improving 12-month Vaccination Rates in General Practice**	**Emily Welch** 2026 Nurse Immunisation Scholarship Recipient
7:05 pm	**Nurse Immunisation Innovators Q&A session**	**Bo Young - Labrador Park Medical** **Emily Welch – Doctors @ Helensvale**
7:15 pm	**Communication Techniques and Empowering Parents to Navigate Misinformation Online**	**Dr Ketaki Sharma** Consultant Paediatrician
7:35 pm	**Update on 2026 FluMist Implementation, State-wide and Innovations in Vaccine Delivery**	**Laurelle Nelson** Clinical Nurse Consultant Queensland Health Immunisation Program

How to participate this evening

Scan to participate

Submit a question

Upcoming Events and Training

Register for training

Integrated GP Placement

Host a student

GCPHN Nurse Facebook Group

Join today

How did you find tonight's event?

Complete on closing

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What's your biggest immunisation challenge right now?



Join at menti.com 7399 7828

What's your biggest immunisation success this year?

Had a little family the other day with an 18 month old. Vaccines were delayed due to sickness but discussion with the nurse informed them on the benefits of staying protected. Family was grateful

Working with and importing hesitate t to vaccinate their children (even if it is one at a time)

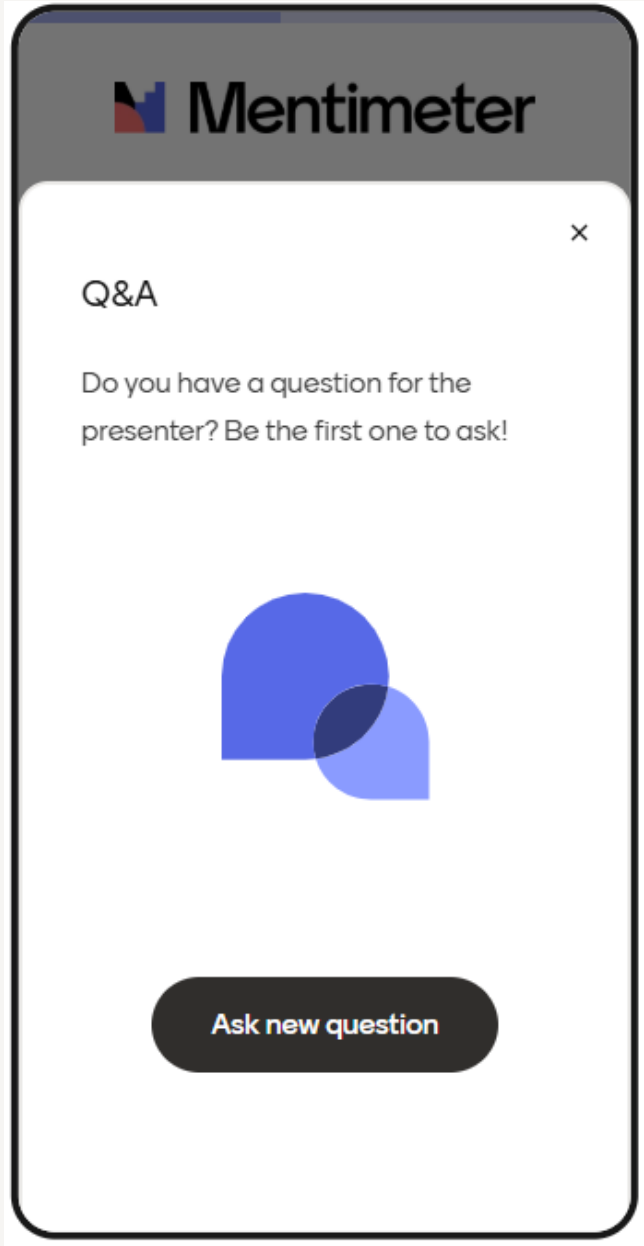
Increased the number of patients with an up to date Shingles vaccine

Improving overall immunisation coverage and follow up, with better tracking of residence and vaccination status

Having 30 minutes for appointments so parents have time to chat and feel heard about their concerns

Increasing uptake of fly vaccines given

Successfully doing catch-ups for patients from different countries



For each presenter, you can submit questions.

This is what it will look like on your phone



Give students insight and experience into how general practice, community and hospital care can work together through an integrated clinical placement. GCPHN is inviting GPs and general practices to host students in a child and women's health-focused placement.

Why participate?

- → Help shape the next generation of healthcare professionals
- → Share your expertise in caring for children, women and families
- → Give students a deeper understanding of primary care, including prevention, early intervention and continuity of care
- → Help students understand how health services work together to deliver coordinated care
- → Choose from set placement dates
- → Access dedicated support and teaching resources

Upcoming Events and Training

OCT 29 IV Cannulation and Iron Infusion

OCT 30 RACH and Community Aged Care Nurses Wound Management

OCT 31 Endocrinology Update

NOV 26 Blood Collection Perform Venous Blood

Upcoming Programs

OCT 29 APNA Cultiv-8 Program

Design and plan your nurse-led clinic tailored to the needs of your practice community. Eight funded spots to join an 8-week program in 2027.

OCT 31 2027 Nurse Immunisation Scholarship

Become an Authorised Nurse Immuniser with a fully funded scholarship to complete the Immunisation Course for Health Professionals by the Benchmarque Group (HESA accredited).

To register your interest, please see the back table of GCPHN resources

Apply Now!
Quality Improvement Activity

Expression of Interest are now open for two activities commencing in 2027.

Optimising Bowel and Cervical Cancer Screening QI Activity

- Activity runs January 2027 – May 2027

PHASES with Primary Sense QI Activity

- Activity runs January 2027 – June 2027

Disease trends, NIP Changes and Public Health Updates

Presented by Linda Menton

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Immunisation Update for General Practice

Linda Menton
Clinical Nurse Immuniser, Public Health









As Nurses you are the heart of healthcare and the front line of protection and prevention in our communities. Your role in immunisation not only prevents disease – it saves lives, empowers families and builds healthier futures for generations.

Thank you for your dedication, commitment and vital role you play every day

Overview

- Public Health and immunisation
- Immunisation coverage update
- Disease trends
- NIP changes
- Frequent Q’s



Public Health and Immunisation

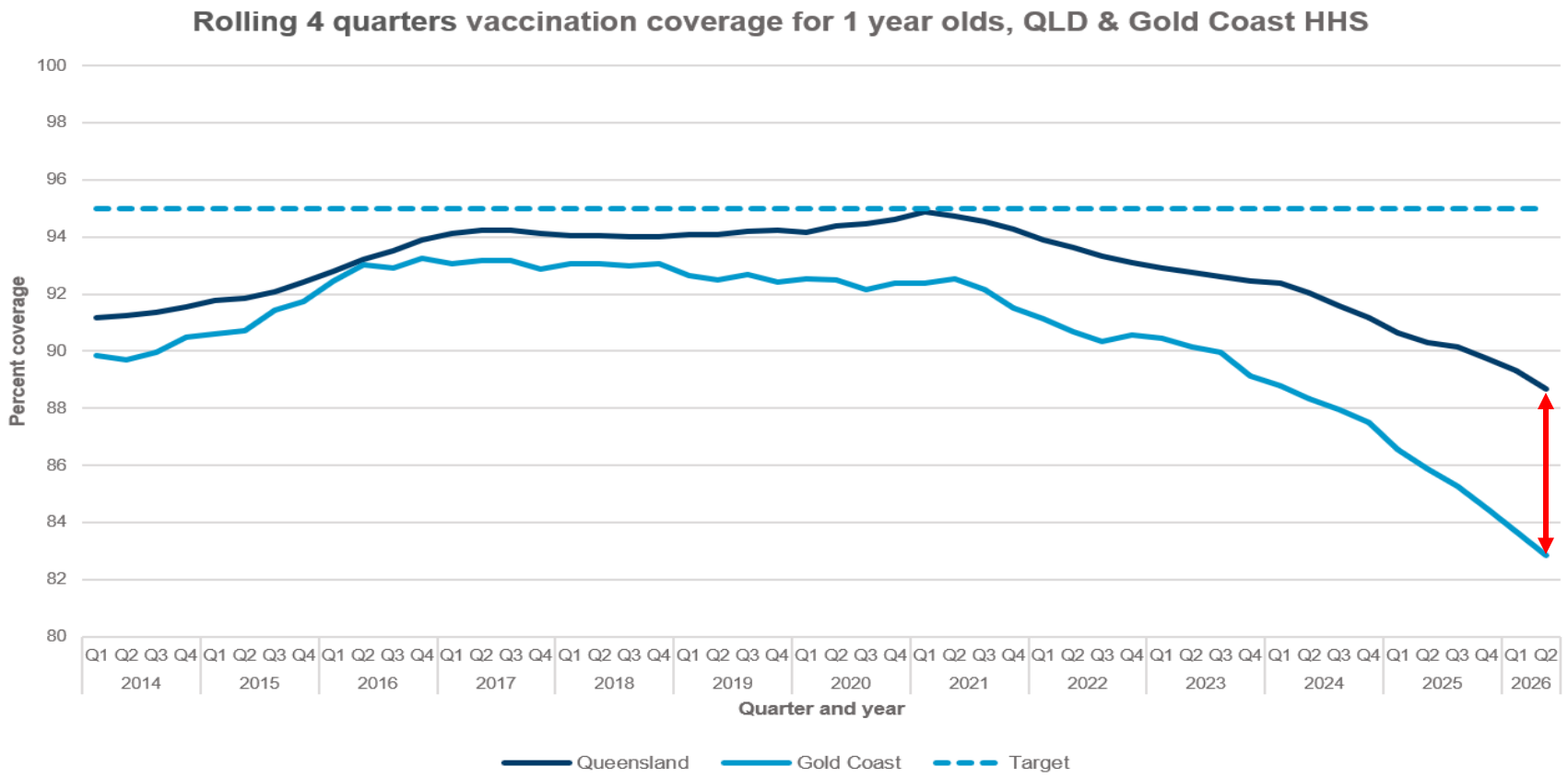


- Immunisation services:
  - School Immunisation Program: 59 schools (Y7 & Y10)
  - Community immunisation clinics (incl. pop-up clinics)
- Advice and support to vaccine service providers
  - Immunisation and schedule queries
  - Catch-ups
  - Adverse events following immunisation (AEFIs)
  - Vaccine administration errors (VAEs)
  - Cold chain breaches
- Research, QI activities, data quality, advocacy, education



Immunisation coverage update

Childhood immunisation: 1 year

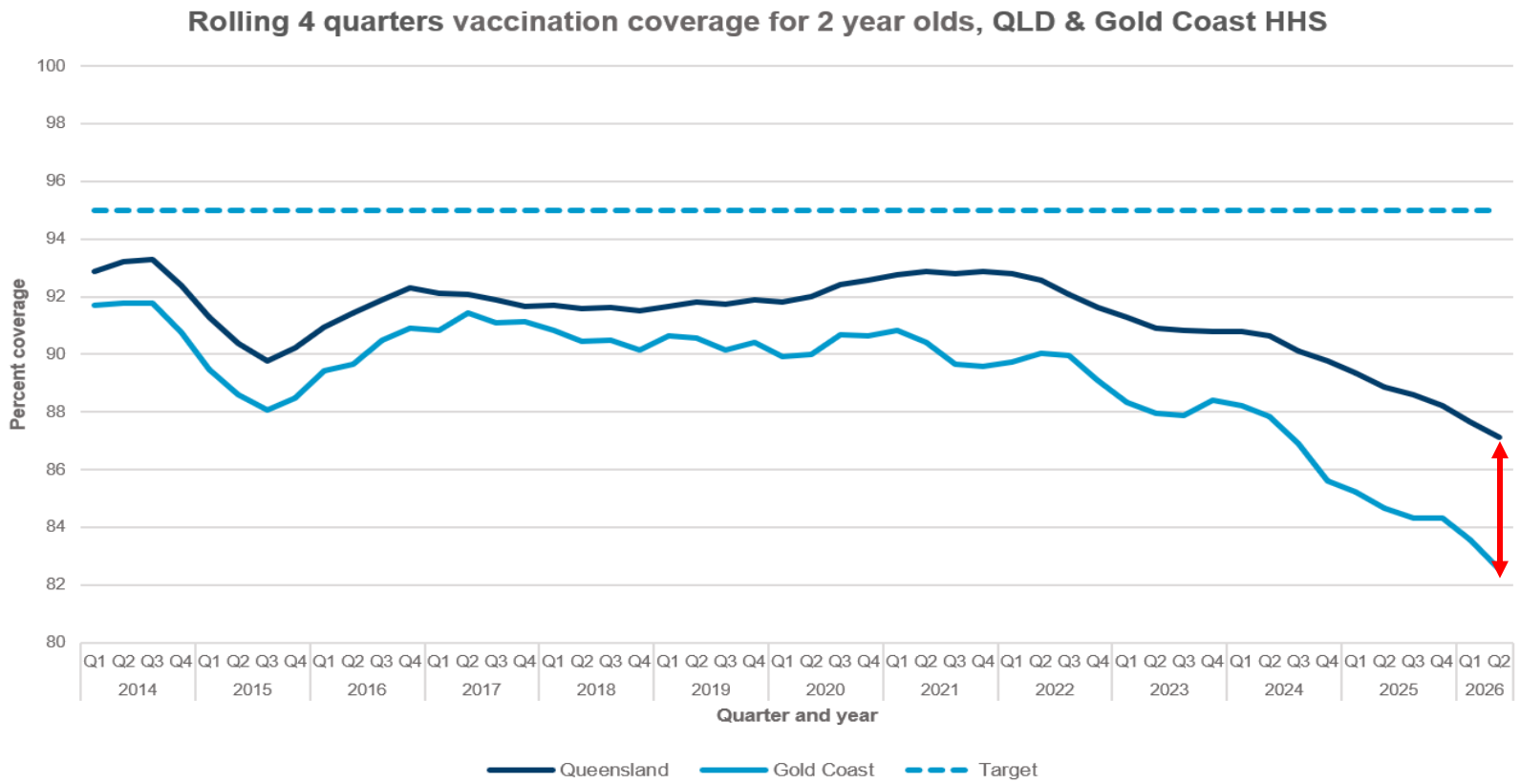


Gap widening

Coverage criteria:

DTP dose 3 Polio dose 3
HiB dose 2 or 3 Hep B dose 3
Pneumococcal dose 2

Childhood immunisation: 2 years

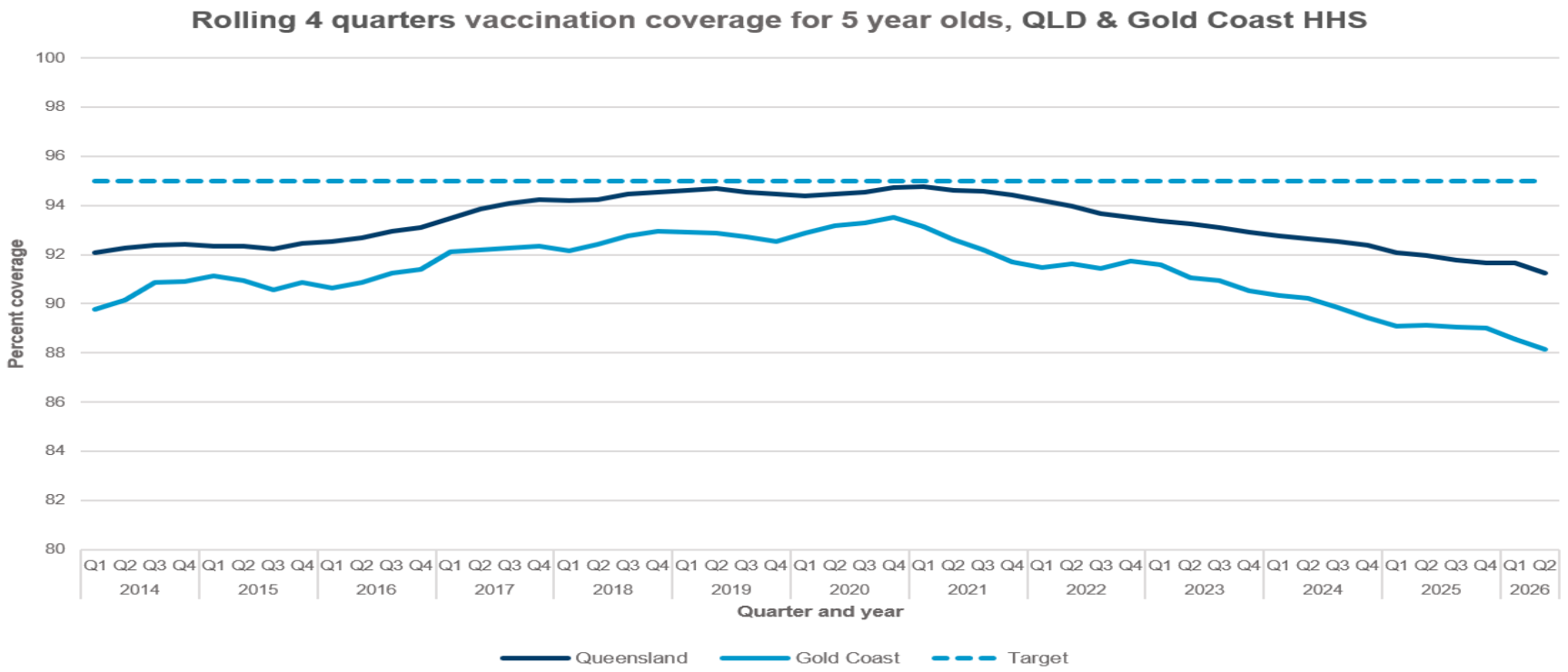


Gap widening

Coverage criteria:

DTP dose 4
Hep B dose 3
Men C dose 1
Polio dose 3
MMR dose 2
Pneumococcal dose 3
HIB dose 3 or 4
Varicella dose 1

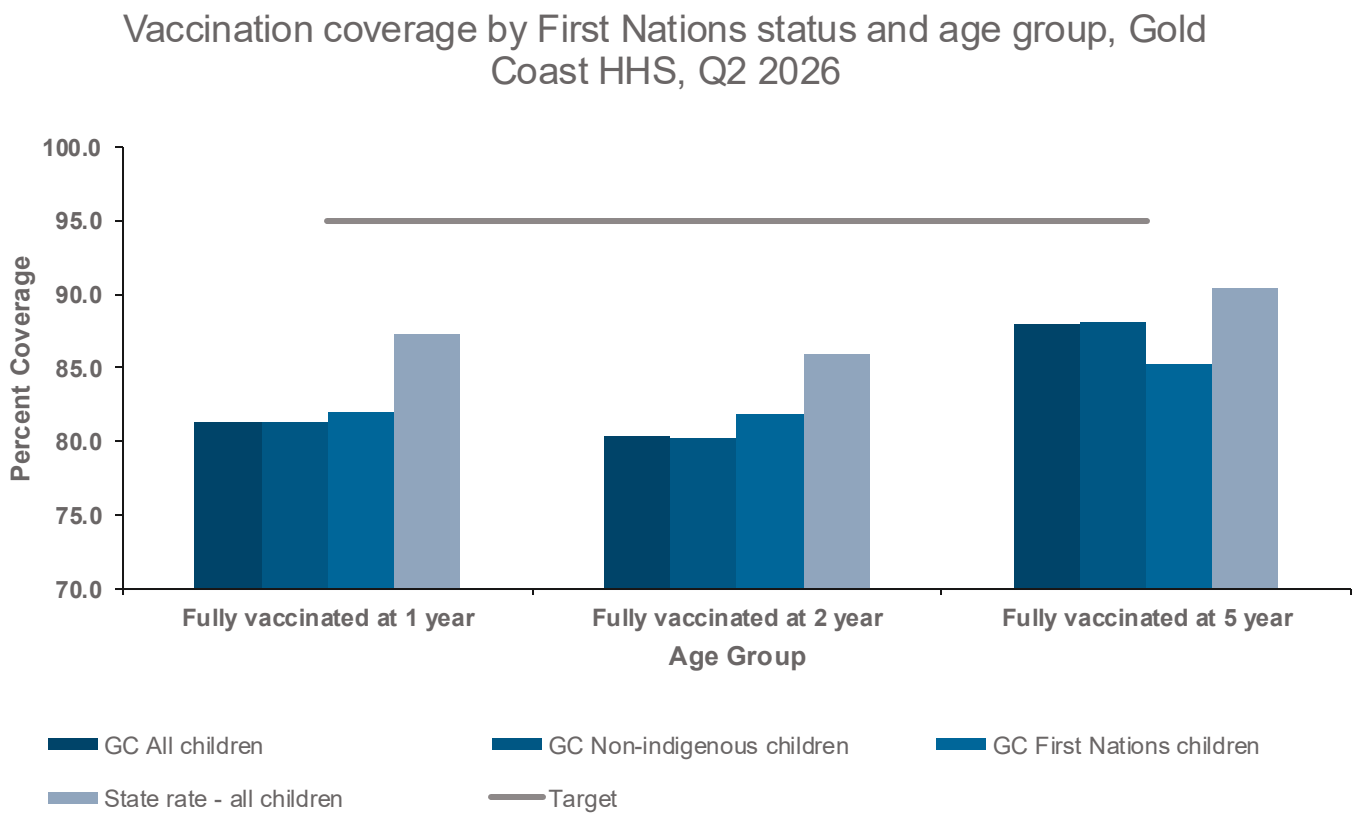
Childhood immunisation: 5 years



Coverage criteria:

DTP dose 4 or 5 Polio dose 4

Immunisation Coverage – GC and QLD



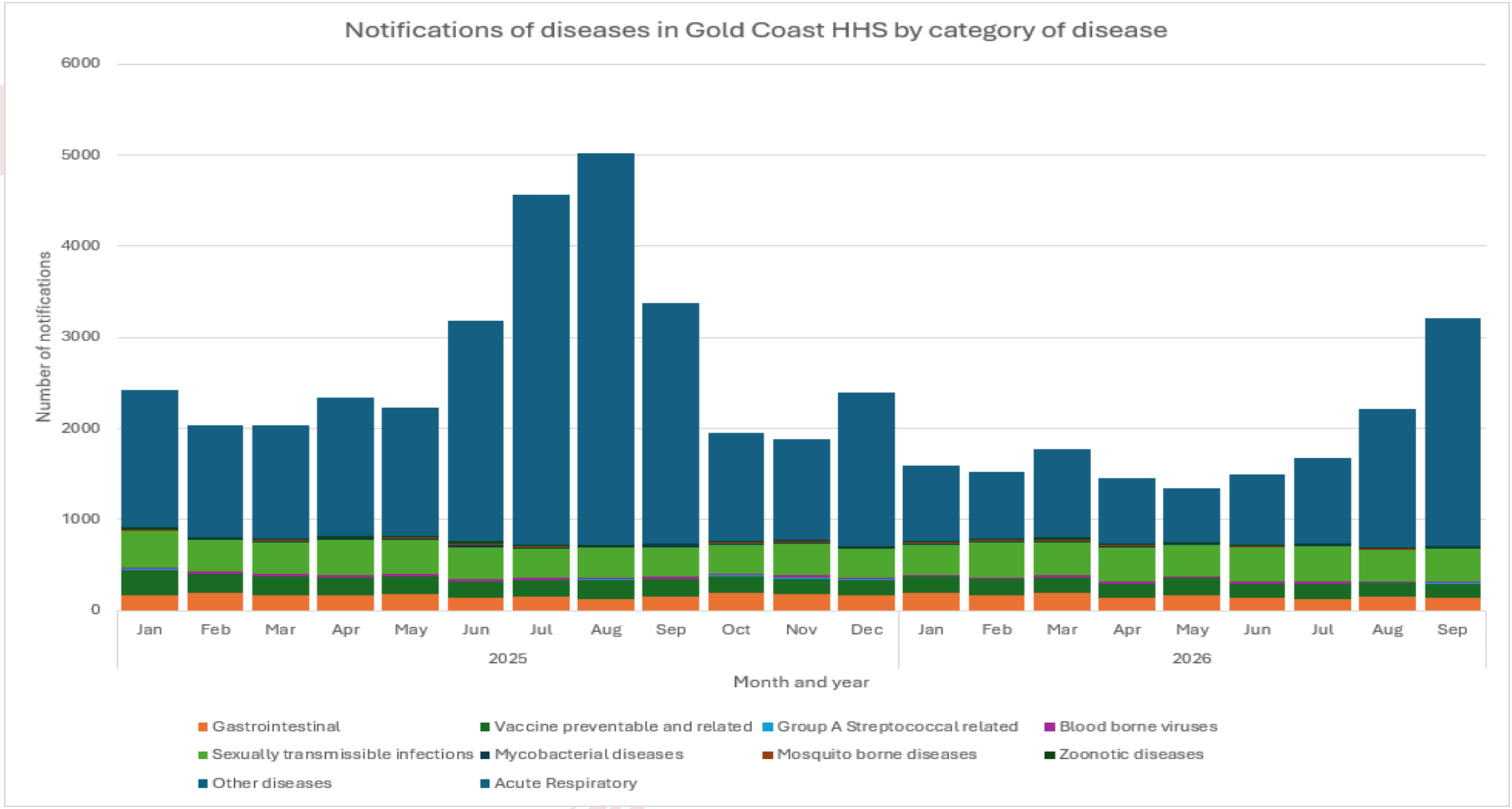
- GC coverage is lower than QLD coverage at all milestones

On the Gold Coast, local research and engagement indicate declining immunisation rates are driven less by access barriers and more by misinformation, low risk perception, vaccine hesitancy, and increasing schedule complexity.

GCPHU Initiatives to improve coverage rates

- GCHHS Community Child Health providing child health staff at a GCPHU community clinic, now embedded in Upper Coomera
- Public Health First Nations Cadet contacting parents of overdue children for discussion and catch up.
- Assisted the establishment and training of Waijungbah Jarjums independent immunisation service.
- Promotion/social media/media/direct communication
- Exploring the promotion of childhood immunisation through community pharmacies to provide more options for after hours access.

Disease Trends
January 2025 – September 2026

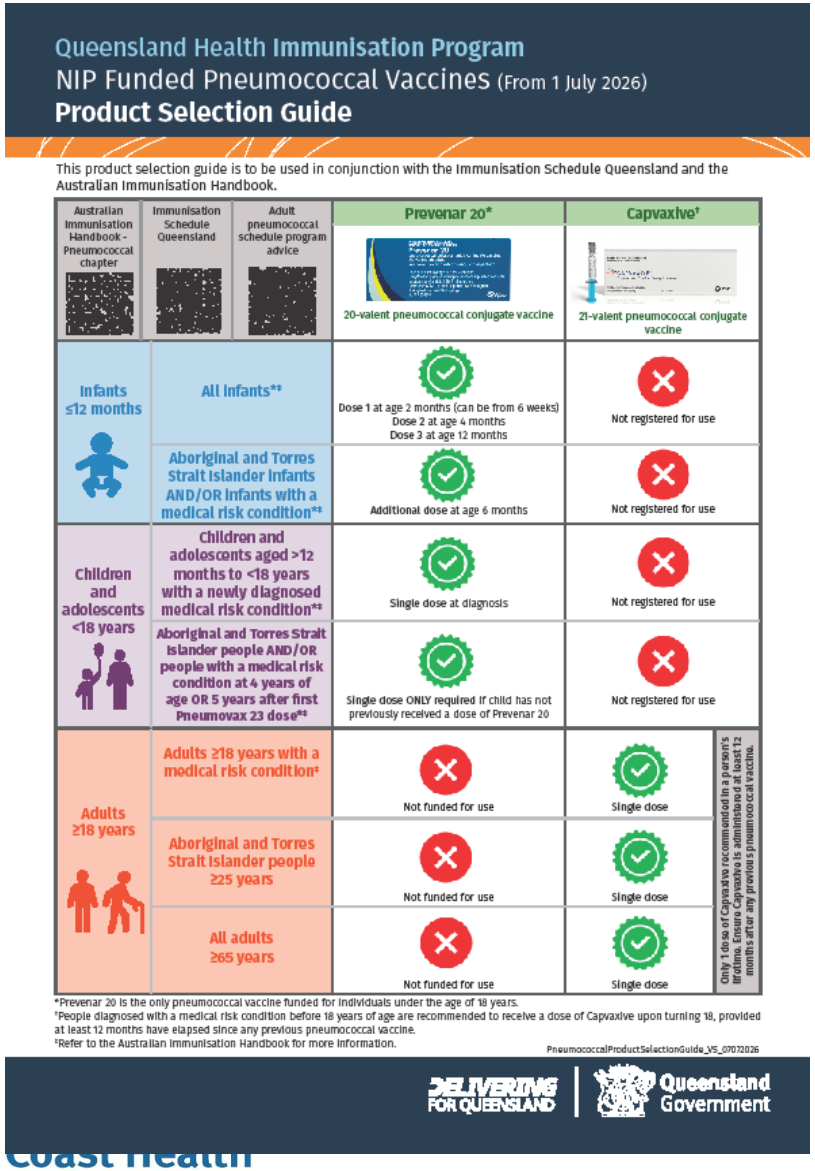

Notifications of diseases in Gold Coast HHS by category of disease
6000
5000
4000
3000
2000
1000
0
Number of notifications
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
2025
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
2026
Month and year
Gastrointestinal
Vaccine preventable and related
Group A Streptococcal related
Blood borne viruses
Sexually transmissible infections
Mycobacterial diseases
Mosquito borne diseases
Zoonotic diseases
Other diseases
Acute Respiratory

NIP updates

Schedules

- Qld schedule updated October 2026 Immunisation Schedule QLD - Oct 2026
- Catch up schedule QLD form people from !0 years of age updated June 2026 QLD catch up from those aged from 10 years - June 26
- Same updated to incorporate changes to below
- Capvaxive
- RSV
- dTpa for Aboriginal and Torres strait islanders
- Hep B for those living with HIV
- Covid

- Link to visual tools QLD Health Immunisation product selection guide (visual tool)



Queensland Health Immunisation Program
NIP Funded Pneumococcal Vaccines (From 1 July 2026)
Product Selection Guide

This product selection guide is to be used in conjunction with the Immunisation Schedule Queensland and the Australian Immunisation Handbook.

Australian Immunisation Handbook - Pneumococcal chapter	Immunisation Schedule Queensland	Adult pneumococcal schedule program advice		Prevenar 20*	Capvaxive†
				20-valent pneumococcal conjugate vaccine	21-valent pneumococcal conjugate vaccine
Infants ≤12 months			All infants**	Dose 1 at age 2 months (can be from 6 weeks) Dose 2 at age 4 months Dose 3 at age 12 months	Not registered for use
			Aboriginal and Torres Strait Islander infants AND/OR infants with a medical risk condition**	Additional dose at age 6 months	Not registered for use
Children and adolescents <18 years			Children and adolescents aged >12 months to <18 years with a newly diagnosed medical risk condition**	Single dose at diagnosis	Not registered for use
			Aboriginal and Torres Strait Islander people AND/OR people with a medical risk condition at 4 years of age OR 5 years after first Pneumovax 23 dose**	Single dose ONLY required if child has not previously received a dose of Prevenar 20	Not registered for use
Adults ≥18 years			Adults ≥18 years with a medical risk condition‡	Not funded for use	Single dose
			Aboriginal and Torres Strait Islander people ≥25 years	Not funded for use	Single dose
			All adults ≥65 years	Not funded for use	Single dose

Only 1 dose of Capvaxive recommended in a person's lifetime. Ensure Capvaxive is administered at least 12 months after any previous pneumococcal vaccine.

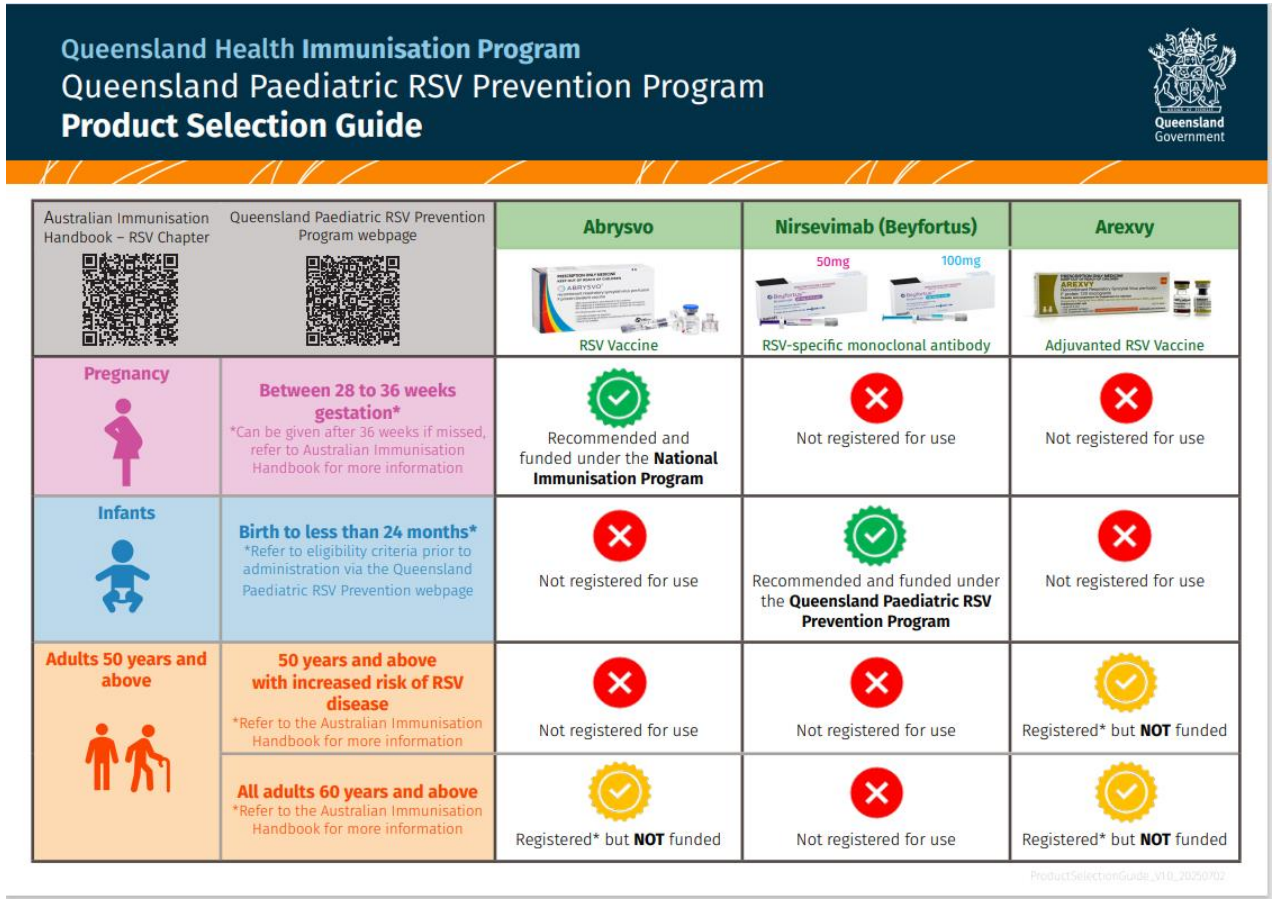
*Prevenar 20 is the only pneumococcal vaccine funded for individuals under the age of 18 years.
†People diagnosed with a medical risk condition before 18 years of age are recommended to receive a dose of Capvaxive upon turning 18, provided at least 12 months have elapsed since any previous pneumococcal vaccine.
‡Refer to the Australian Immunisation Handbook for more information.

PneumococcalProductSelectionGuide_VS_07072026

DELIVERING FOR QUEENSLAND | Queensland Government

Capvaxive

- Adults ≥18 years with a medical risk condition
- Aboriginal and Torres Strait Islander people ≥25 years
- All adults ≥65 years
- Only 1 dose of Capvaxive required in a lifetime.
- 12-month interval after any previous pneumococcal vaccine.



Queensland Health **Immunisation Program**

Queensland Paediatric RSV Prevention Program

Product Selection Guide

Queensland Government

Australian Immunisation Handbook – RSV Chapter	Queensland Paediatric RSV Prevention Program webpage	Abrysvo	Nirsevimab (Beyfortus)	Arexvy
		RSV Vaccine	RSV-specific monoclonal antibody (50mg / 100mg)	Adjuvanted RSV Vaccine
Pregnancy	**Between 28 to 36 weeks gestation*** *Can be given after 36 weeks if missed, refer to Australian Immunisation Handbook for more information	Recommended and funded under the **National Immunisation Program**	Not registered for use	Not registered for use
Infants	**Birth to less than 24 months*** *Refer to eligibility criteria prior to administration via the Queensland Paediatric RSV Prevention webpage	Not registered for use	Recommended and funded under the **Queensland Paediatric RSV Prevention Program**	Not registered for use
Adults 50 years and above	**50 years and above with increased risk of RSV disease** *Refer to the Australian Immunisation Handbook for more information	Not registered for use	Not registered for use	Registered* but **NOT** funded
	All adults 60 years and above *Refer to the Australian Immunisation Handbook for more information	Registered* but **NOT** funded	Not registered for use	Registered* but **NOT** funded

ProductSelectionGuide_V10_20250702

Arexvy funded for aboriginal and Torres Strait Islanders 60 years and above.
All adults 75 years and older.
Rėgistered for those over 50 but not funded

ABRYSVO funded in pregnancy 28 weeks to 36 weeks gestation (can be given later if missed- refer to the AIH)
Offered at each pregnancy.

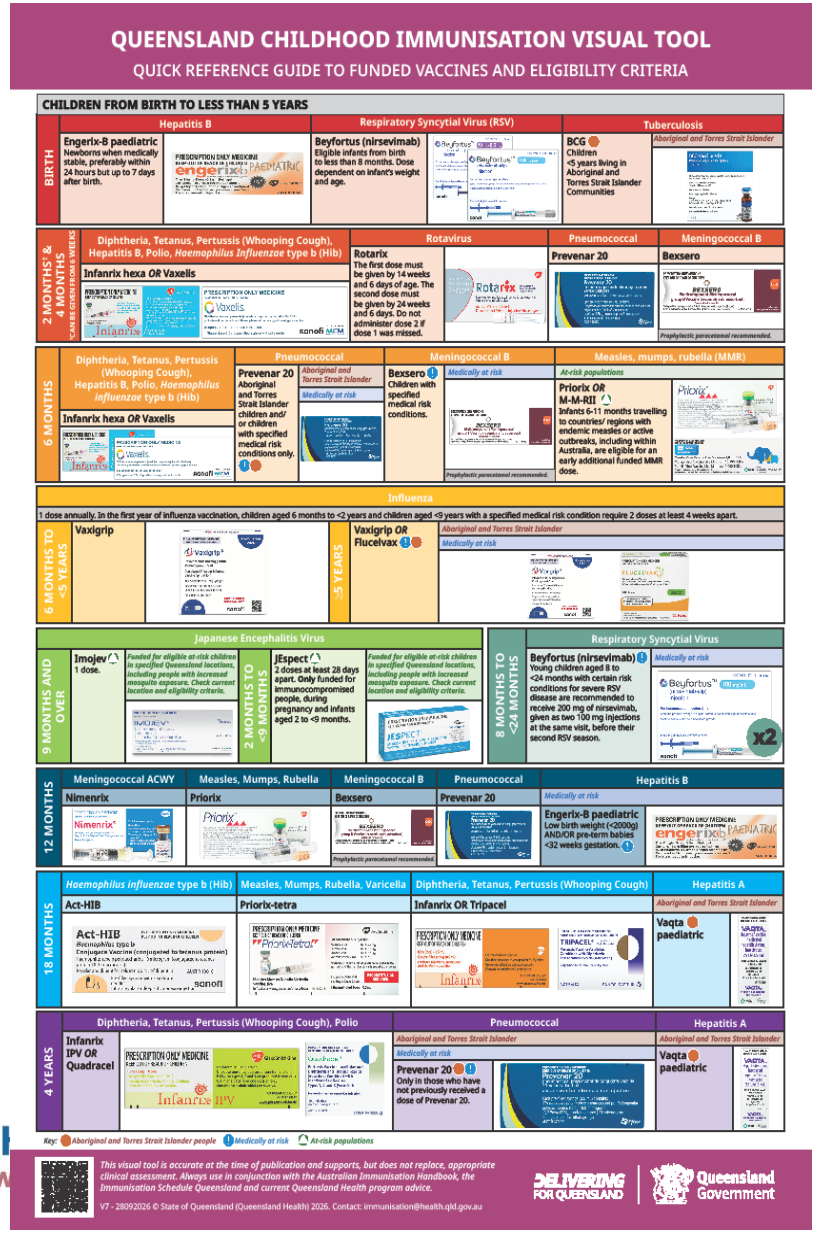
Vaccines are not interchangeable

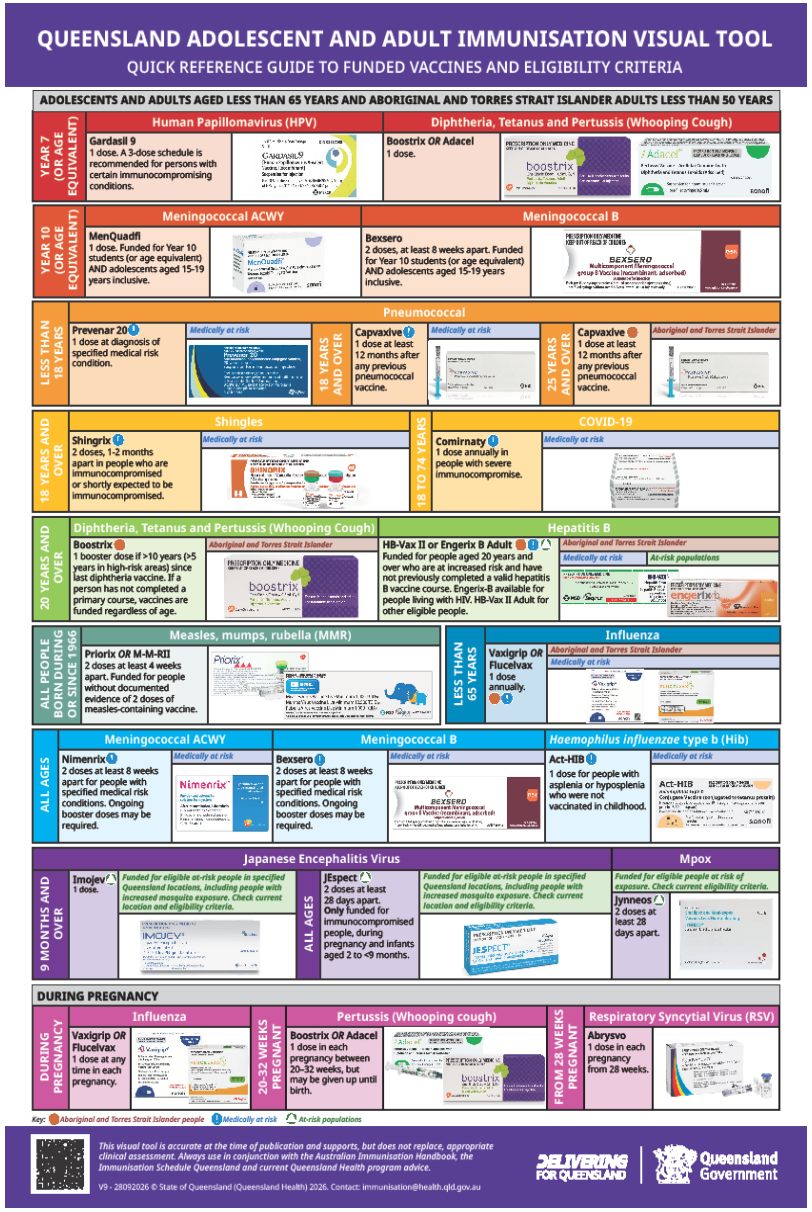
Beyfortus

- **Diphtheria, tetanus and pertussis** for Aboriginal and Torres Strait Islander people (state funded) 1 booster dose if >10 years (>5 years in high-risk areas) since last diphtheria vaccine. If a person has not completed a primary course, vaccines are funded regardless of age.

- **Hepatitis B** vaccine is funded in Queensland for individuals living with HIV aged 20 years and older if not previously vaccinated for people living with HIV, refer to the Australian Immunisation Handbook for brand recommendation.

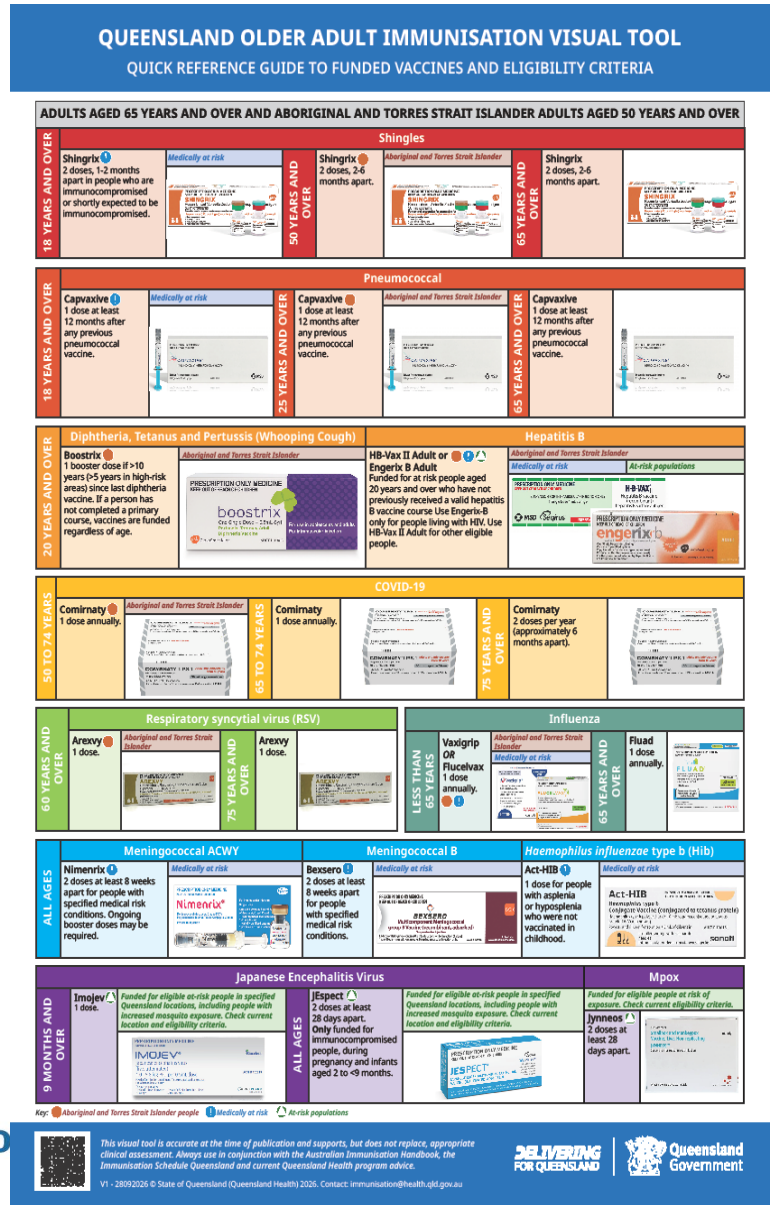
- **Covid** funded under NIP now only for those eligible
  - all adults aged 75 years and over – 2 funded doses approx. 6 months apart
  - adults aged 65 to 74 – 1 funded dose per year
  - Aboriginal and Torres Strait Islander people aged 50 to 74 years – 1 funded dose per year
  - adults aged 18 to 64 years who are severely immunocompromised – 1 funded dose per year (refer to AIH)

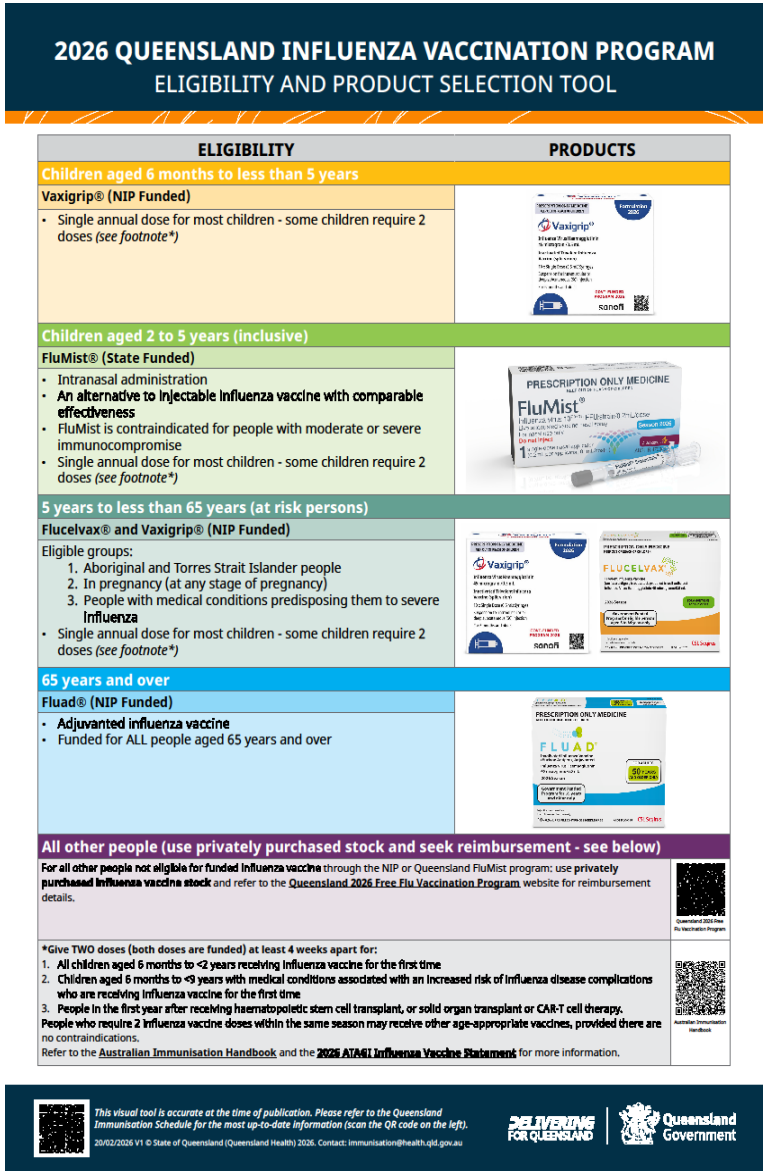




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Queensland Government





Queensland Government

Queensland Health Immunisation Program
Immunisation During Pregnancy

Queensland Government

Seasonal Influenza (Flu)

Recommended at any time during each pregnancy

Vaxigrip Tetra*



OR

FluceIvaxQuad*



*Quadrivalent Influenza Virus (QIV) vaccine 2025 formulations

Administration

- Intramuscular - deltoid
- Does not require reconstitution

Pertussis (Whooping cough)

Recommended at 20-32 weeks

Single dose recommended in each pregnancy between 20–32 weeks, but may be given up until birth

Boostrix



OR

Adacel



Administration

- Intramuscular - deltoid
- Does not require reconstitution

Respiratory Syncytial Virus (RSV)

Recommended from 28 weeks

Abrysvo*



*Abyrsvo is the only RSV vaccine registered for use in pregnancy

Administration

- Intramuscular - deltoid
- **Requires reconstitution**

Infants protected through maternal RSV immunisation do not routinely require nirsevimab at birth. For further information refer to the QPRSVP Program page by scanning the QR code above.

COVID-19

During pregnancy, those who have previously been immunised are not routinely recommended to have a further dose of COVID-19 immunisation. However, they can consider a further dose of COVID-19 immunisation based on presence of underlying risk conditions and/or personal preference.

Preconception immunisation health check
Hepatitis B
Measles
Mumps
Rubella
Varicella
COVID-19

All immunisations recommended in pregnancy are FREE, however a consultation fee may apply.
It is safe to give all three immunisations at the same time.

Where can patients receive immunisations in pregnancy?		
Antenatal clinic*	Council clinics*	Community pharmacy*
GP**	Hospital Clinics*	Community Clinic*

*only available at some services ** A consultation fee may apply

To find a local immunisation service provider call 13 HEALTH (13 43 25 84) or visit HealthDirect by scanning the QR code.

This visual tool is accurate at the time of publication. Please refer to the Queensland Immunisation Schedule for the most up to date information.

ImmunisationDuringPregnancy_V2.0_20250901
Contact: immunisation@health.qld.gov.au

Preventing VAEs

When administering any vaccine, please remember to check the **6 Rights**:

1. **Right patient**
2. **Right time**
3. **Right drug**
4. **Right dose**
5. **Right route**
6. **Right documentation**



More tips:

- ✓ Double check with another nurse or doctor to help pick up a potential error before administration
- ✓ Use labelled baskets in your vaccine fridge
- ✓ One at a time

Following vaccination

what to expect and what to do

Australian Government
Department of Health, Disability and Ageing

National Immunisation Program

All vaccinations may cause the following reactions:



Mild fever that doesn't last long <38.5°C



Where the needle was given: Sore, red, burning, itching or swelling for 1–2 days and/or small, hard lump for a few weeks



Grizzly, unsettled, unhappy or sleepy



Teenagers/adults fainting and muscle aches

SEE BACK PAGE FOR ADDITIONAL COMMON REACTIONS SPECIFIC TO EACH VACCINE

What to do at home:



If a baby/child is hot don't have too many clothes or blankets on



Breastfeed more frequently and/or give extra fluids



Put a cold wet cloth on the injection site if it is sore



For fever or pain give paracetamol. Follow instructions on the packaging

When to seek medical advice:

See your health professional, or go to the hospital if:



Pain and fever are not relieved by paracetamol (e.g. Panadol®)



The reactions are bad, not going away or getting worse or if you are worried at all



Any of the rare reactions below are experienced

How to report an adverse reaction:

Significant events that occur following immunisation should be reported to your health professional. Alternatively you can report directly to the Therapeutic Goods Administration (www.tga.gov.au) or by phone to the Adverse Events Medical Line on 1300 633 424. Calls are answered by a registered pharmacist. You can also report adverse events following vaccination to your state or territory health service.



Rare reactions requiring immediate medical attention

As with any medication, on rare occasions an individual may experience a severe reaction.

Seek medical attention immediately if you experience any of the symptoms below and inform the health professional of your recent vaccination.

Anaphylaxis

- A severe allergic reaction which occurs suddenly, usually within 15 minutes, however anaphylaxis can occur within hours of a vaccine being administered. Early signs of anaphylaxis include redness and/or itching of the skin, swelling (hives), breathing difficulties, persistent cough, hoarse voice and a sense of distress.

Intussusception (relates to rotavirus vaccine)

- This is an uncommon form of bowel obstruction where one segment of the bowel slides into the next, much like the pieces of a telescope.
- There is a very small risk of this occurring in a baby in the first week after receiving the first dose of rotavirus vaccine, and a smaller risk after the second vaccine dose.
- The baby cries more than usual, looks pale, gets very irritable and pulls legs up to the abdomen because of pain.

Seizure

- Some young children (especially aged 1–3 years) are more prone to seizures when experiencing a high fever caused by an infection or after a vaccine. The seizure usually lasts approximately 20 seconds and very rarely more than 2 minutes.

Where can I get more information?

Contact your health professional
Visit health.gov.au/immunisation
Contact your state or territory health service

Practice contact details:

Vaccines given on ____ / ____ / 20____ Time given: _____ (Please wait a minimum of 15 minutes after immunisation)

Indicate injection sites by circling appropriate box: LA = Left Arm, RA = Right Arm, LL = Left Leg, RL = Right Leg

Hepatitis B vaccine (Engerix® B Paediatric)
- See 'Common reactions'

LL RL LA RA

Diphtheria, tetanus, pertussis (whooping cough), hepatitis B, polio, *Haemophilus influenzae* type b vaccine (Infanrix® hexa or Vaxelis®)
- See 'Common reactions'

LL RL LA RA

Pneumococcal vaccine
Children and adolescents (Prevenar 20®)
Adult (Capvaxive®)
- See 'Common reactions'

LL RL LA RA

Meningococcal ACWY vaccine
Children (Nimenrix®)
Adolescents (MenQuadfi®)
- See 'Common reactions'

LL RL LA RA

***Haemophilus influenzae* type b vaccine** (ActHIB®)
- See 'Common reactions'

LL RL LA RA

Influenza vaccine
- See 'Common reactions'

LA RA LL RL

Rotavirus vaccine (Rotarix®)
- See 'Common reactions'
- Vaccine virus can come out in poo, particularly after the first dose. Handwashing is important after every nappy change.
- Intussusception
  – see 'rare reactions'

BY MOUTH

Measles, mumps, rubella vaccine (Priorix®)
- See 'Common reactions'
- Reactions that may be present 7 to 10 days after vaccination:
  – fever over 39°C
  – rash (not infectious)
  – head cold, runny nose, cough, puffy eyes
  – swelling in the neck /under the chin.

LL RL LA RA

Meningococcal B vaccine (Bexsero®)
- See 'Common reactions'
- Fever (>38.5°C) is common in young children receiving this vaccine. Paracetamol will reduce the likelihood of fever. For children less than 2 years of age, a dose of paracetamol is recommended 30 minutes before vaccination or as soon as possible afterwards. Followed by two more doses 6 hours apart even if there is no fever.

LL RL LA RA

Measles, Mumps, rubella, varicella (chickenpox) vaccine (Priorix-Tetra®)
- See 'Common reactions'
- Reactions that may be present 7 to 10 days after vaccination:
  – fever over 39°C
  – rash (not infectious)
  – head cold, runny nose, cough, puffy eyes
  – swelling in the neck/under the chin.
- Reactions 5–26 days after vaccination:
  – mild chickenpox like rash (may be infectious, seek medical advice).

LL RL LA RA

Diphtheria, tetanus, pertussis (whooping cough) vaccine
Children (Infanrix® or Tripacel®)
Adults and adolescents (Boostrix® or Adacel®)
- See 'Common reactions'
- Very rarely, large injection site reactions (>50 mm) including limb swelling may occur (with the 4th or 5th dose of a tetanus-containing vaccine in children). These reactions usually start within 24–72 hours after vaccination, and resolve spontaneously within 3–5 days. If this reaction extends beyond one or both joints, seek medical advice.

LL RL LA RA

Hepatitis A vaccine (Vaqta® Paediatric)
- See 'Common reactions'
- Rash

LL RL LA RA

Diphtheria, tetanus, pertussis (whooping cough) polio vaccine (Infanrix® IPV or Quadracel®)
- See 'Common reactions'
- Large injection site reaction of redness and swelling from the shoulder to the elbow. If this reaction extends beyond one or both joints, seek medical advice.

LA RA

Human papillomavirus (HPV) vaccine (Gardasil®9)
- See 'Common reactions'
- Mild headache
- Mild nausea

LA RA

Shingles vaccine (Shingrix®)
- See 'Common reactions'
- Reactions that may be present 1 to 3 days after vaccination:
  – tiredness
  – headache
  – fever
  – muscle aches
  – gastrointestinal symptoms.

LA RA

Respiratory syncytial virus (RSV) vaccine
Pregnant women (Abrysvo®)
Adults (Arexvy®)
- See 'Common reactions'

LA RA LL RL

COVID-19 vaccine (Comirnaty®)
- See 'Common reactions'
  – headache
  – fatigue

LA RA

Last updated October 2026

Queensland Government

Frequent Q's

- **Men B** should be offered & administered at same time as 6-week immunisations (not being offered or encouraged to separate . Researchers found that administering the vaccines at separate visits did not reduce the likelihood of adverse events.
- Infants who received Men B and routine vaccines on different days had more than one opportunity to experience side effects, which in some cases increased their overall likelihood of experiencing an adverse event. https://ncirs.org.au/more-vaccines-one-visit-doesnt-mean-more-side-effects-australian-study-finds
- Students in year 6 or 7 should be offered a **dTpa** vaccine rather than adt for an injury
- **Men ACWY** is funded in the for those aged 15-19 years or those in year 10. Healthy adolescents who have received an age-appropriate complete course of Men ACWY vaccine in the past should receive a dose of Men ACWY vaccine after they turn 14 years of age.
- **Men B** is funded in the for those aged 15-19 years or those in year 10. Men B vaccine required with a min interval of 8 weeks. Healthy adolescents who have received an age-appropriate complete course of Men B vaccine in the past should receive a single dose of Men B vaccine after they turn 14 years of age. While only one dose is recommended, a previously vaccinated adolescents can receive 2 doses if preferred. Adolescent Men B and Men ACWY

Key Message



Childhood immunisation rates continue to decline



Current PHU and partner immunisation activities are essential, evidence-based and already operating at capacity

Every encounter with your patients is an opportunity to check their immunisation status to talk about immunisation across all age groups.

Thank you and any questions?



Improving 12-month Vaccination Rates in General Practice

Presented by Emily Welch

phn GOLD COAST
An Australian Government Initiative

Shaping healthier lives

Childhood Immunisations in Practice

Increasing 12-month-olds vaccination status at Doctors@Helensvale

By Emily W

DOCTORS @ HELENSVALE
PARTNERS IN HEALTH

Immunisation Problems

- Decreased rates in Childhood vaccinations across austraila
- Vaccine hesitancy
- NIP Schedule changing
- Not returning for split immunisations

Basline Data

- 15 patients were due for their 12 months vaccination

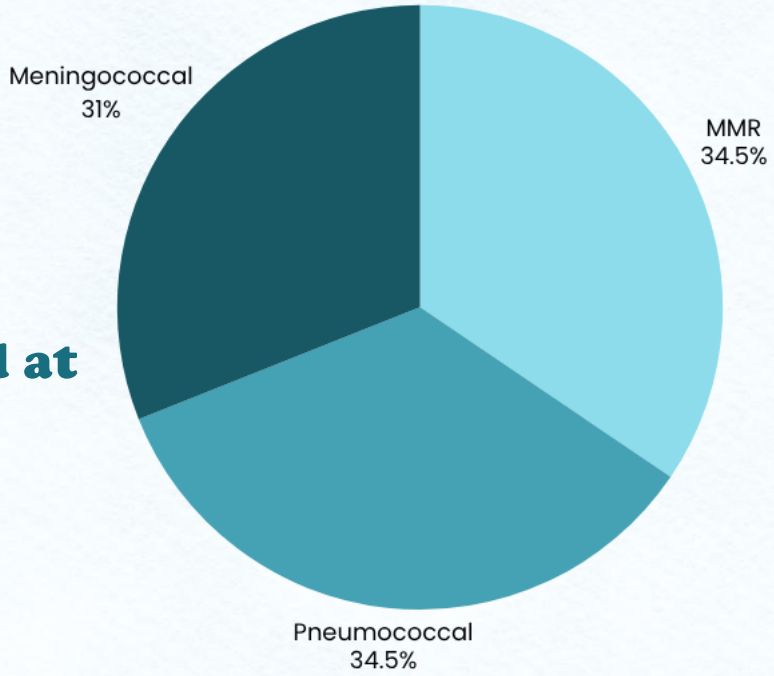
out of the 15 patients

-10 were due for pnemococcal

-9 were due for meningococcal

-10 were due for MMR

- Total precentage been fully vaccinated at Doctors@Helensvale= 0%



Obtained through primary sense

Our Goal

To increase 12 month old vaccination rates from 0% to 15% by the 30th June 2026

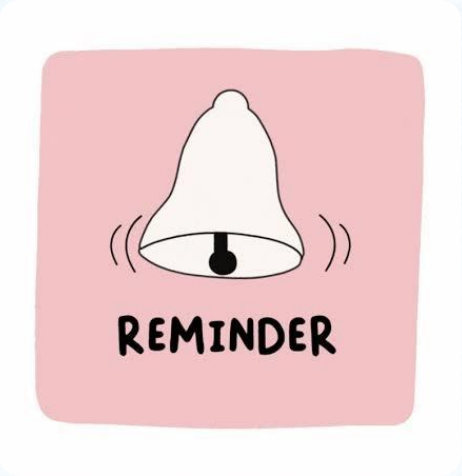


Change Ideas



Idea 1

RECALL FOR 12 MONTH IMMUNISATION



Idea 2

REMINDERS IN PATIENT FILES AFTER 6 MONTH IMMUNISAITIONS



Idea 3

GP AND NURSE TO HAVE DISCUSSIONS WITH PATIENTS DURING CONSULTS



Idea 4

DATA CLEANINSING & UPLOADING ALL PATIENTS AUSTRALIAN IMMUNISATION RECORDS TO BEST PRACTICE

Didn't Worked

Change Idea 1

Recall all patients eligable for 12 month old vaccinations

- **1 Parent booked their child in for vaccination**
- **1 Parent declined 12 month vaccinations**
- **2 Parents declined the meningococcal b (Bexsero) Vaccine**

Our prediction was 30% of parents booking vaccinations

The outcome , was only 6.6% of Parents booked in.

Worked

Change Idea 2

Add reminders into BP software post 6 month immunisations

- Patients already had reminders in the system from their 6 month old vaccinations, and if not we made sure to add them.
- Parents were receiving a reminder message via SMS. If they had made no booking, they would receive a call from the nurse's
- It was predicted that 100% of the patients would have reminders on the system and this was achieved.

Didn't Worked

Change Idea 3

Oppourtunistic patient education about vaccination and overcoming vaccination hesitancy

Dicussions, brochures and educational materials were provided to parents by GP's and Nurse's oppourtunistically and during the process of Change Idea 1

- **6.6% of Parents were hesitant and declined vaccinations.**
- **13.3% were hesitant and declined Meningococcal B vaccination**

Worked

Change Idea 4

Data cleansing and uploading all patients AIR records to Best Practice software.



Out of 15 patient, 6 of the patients were already fully vaccinated

- Our prediction was 20% of patients already vaccinated, without an up-to-date record on BP software.
- The outcome was 40% of records not up-to-date on BP software

Adopt, Adapt, Abandon

Sustainable changes that have been implemented since QI activity

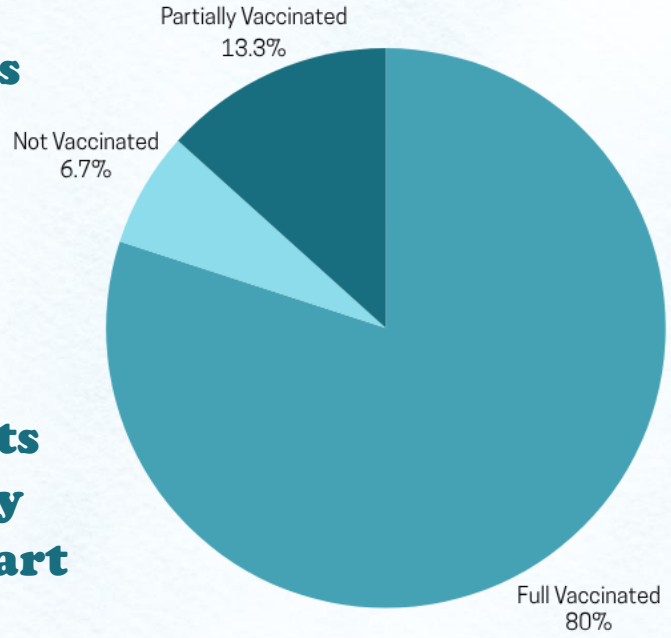
1. Monthly data cleansing
   Continue to data cleanse to ensure all immunisations are added to Best Practice from AIR
2. Continuing to add reminders post all childhood vaccinations
   Reminders being added at the patient 6 months vaccines

QI Activity Outcome

We started with 15 eligable patients

12/15 are now fully vaccinated
2/15 are partially vaccinated
1/15 refused vaccination

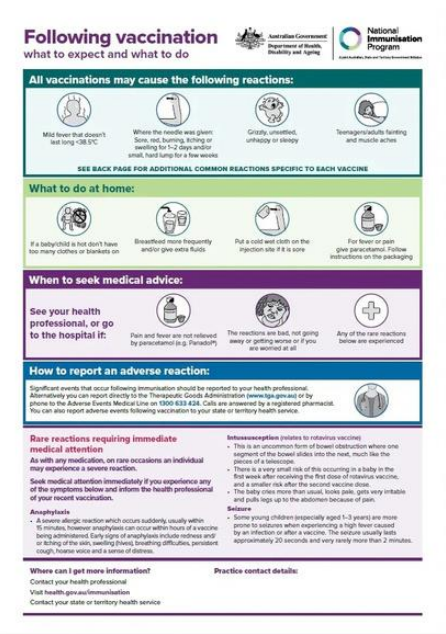
Therefore 80% of the eligable patients were vaccinated which significantly exceeded our goal of 15% set at the start of the QI activity.



Thank You!

Vaccine resource

1. https://www.health.gov.au/childhood-immunisation/resources/publications/childhood-vaccinations-brochure?language=en
2. https://www.health.gov.au/resources/publications/following-vaccination-what-to-expect-and-what-to-do?language=en
3. https://skai.org.au/
4. https://knowmeningococcal.com.au/







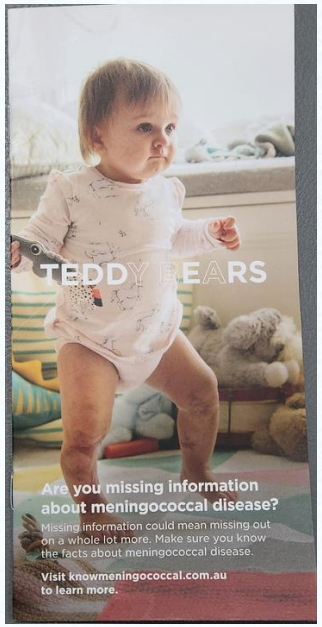


Image Source

1.https://doctorsathelensvale.com.au/
2. Canva
3.https://www.shutterstock.com/search/recall-icon?dd_referrer=https%3A%2F%2Fwww.google.com%2F
4.https://blogs.flinders.edu.au/student-health-and-well-being/2022/08/02/apps-to-provide-random-reminders/
5.https://www.kindpng.com/imgv/ioiRxmo_transparent-doctor-talking-to-patient-clipart-doctor-with/
6.https://matchdatapro.com/essential-data-cleansing-best-practices-to-improve-your-data-quality/
7.https://www.health.gov.au/childhood-immunisation/resources/publications/childhood-vaccinations-brochure?language=en
8. https://www.health.gov.au/resources/publications/following-vaccination-what-to-expect-and-what-to-do?language=en
9.https://www.health.gov.au/childhood-immunisation/resources/publications/sharing-knowledge-about-immunisation-skai-parent-website-contact-card?language=en
10.GSK Pamphlet

2021

Scholarship program delivered across

6 years

284 nurses

have successfully completed a GCPHN scholarship

Learning goals

- Managing catch-up vaccination schedules
- Education around vaccine hesitancy
- Injection techniques, especially for children
- Cold chain management and vaccine safety
- Effectively use the Australian Immunisation Handbook and Queensland Immunisation Schedule

35 nurses
enrolled and successfully completed the scholarship
in 2026

Largest intake of nurses in 2026, scholarship recipients reported:

- 100% of recipients indicated they would recommend the scholarship to colleagues, reflecting strong satisfaction with the scholarship and its relevance to clinical practice
- 100% of nurses become authorised nurse immunisers
- 97% improved knowledge & clinical competence
- 57% improve vaccine administration skills & safety
- 49% felt more confident providing education to patients and addressing vaccine hesitancy

> **Just a BIG thank you.**
> I feel enriched and encouraged with new information and skills.
>
> –Scholarship recipient 2025

> **The course and the scholarship are fantastic!** It has helped to achieve my goals, and put me on another level in terms of catch-up immunisations. I think any nurse working in general practice / actively involved in immunisation process, would benefit from the course / scholarship." –Scholarship recipient 2025

> **Thank you so so much for the amazing opportunity of participating in the scholarship.** I have learnt so much more in such a short period giving me tools to provide better service and support within my job role and scope of practice. –Scholarship recipient 2025

> **The whole set up has been amazing.** GCPHN's project officer was so supportive! I enjoyed learning more about the QI PDSA and getting the reports from AIR. I didn't know about this and now we are able to implement that into our monthly jobs to help maintain and improve our vaccination rates for our patients.
>
> –Scholarship recipient 2025

phn GOLD COAST
An Australian Government Initiative

Shaping healthier lives

Nurse Immunisation Innovators Q&A session

Emily Welch and Bo Young

phn GOLD COAST

An Australian Government Initiative

Shaping healthier lives

Communication Techniques and Empowering Parents to Navigate Misinformation Online

Dr Ketaki Sharma

phn GOLD COAST
An Australian Government Initiative

Shaping healthier lives

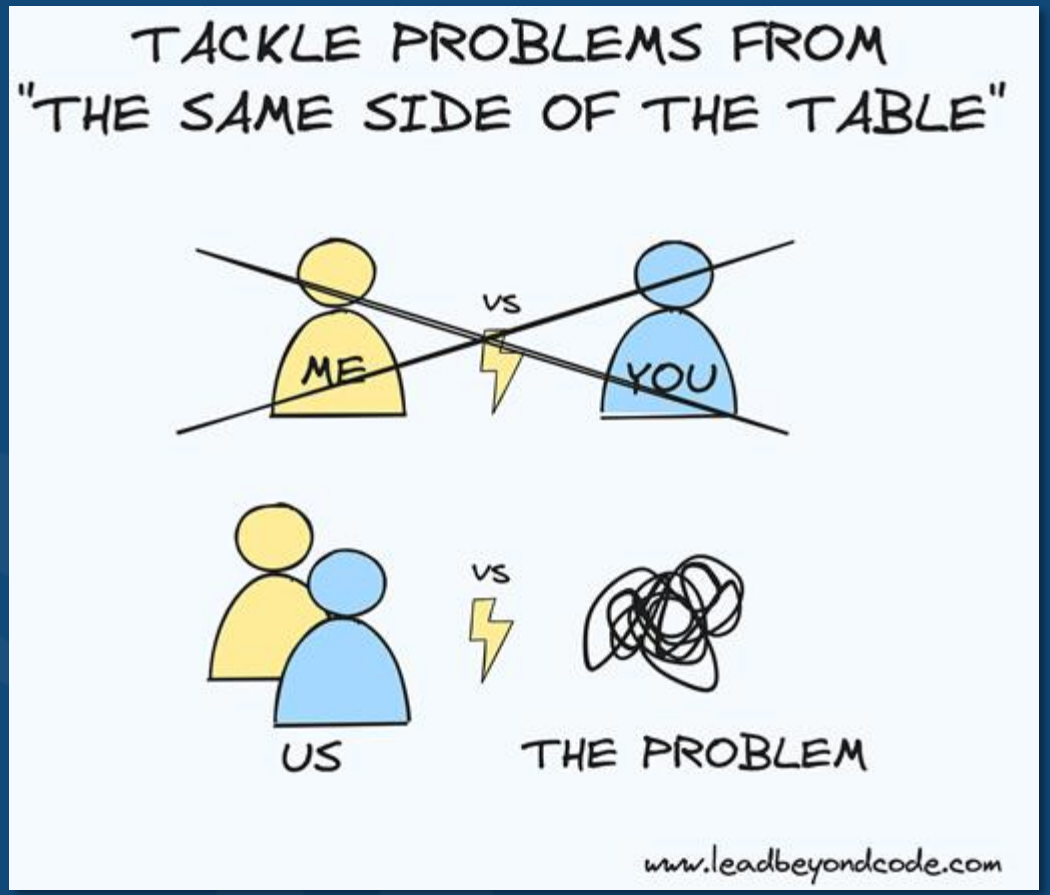
Communication Techniques and Empowering Parents to Navigate Misinformation Online

Dr Ketaki Sharma

General Paediatrician, NSW Specialist Immunisation Service, NCIRS

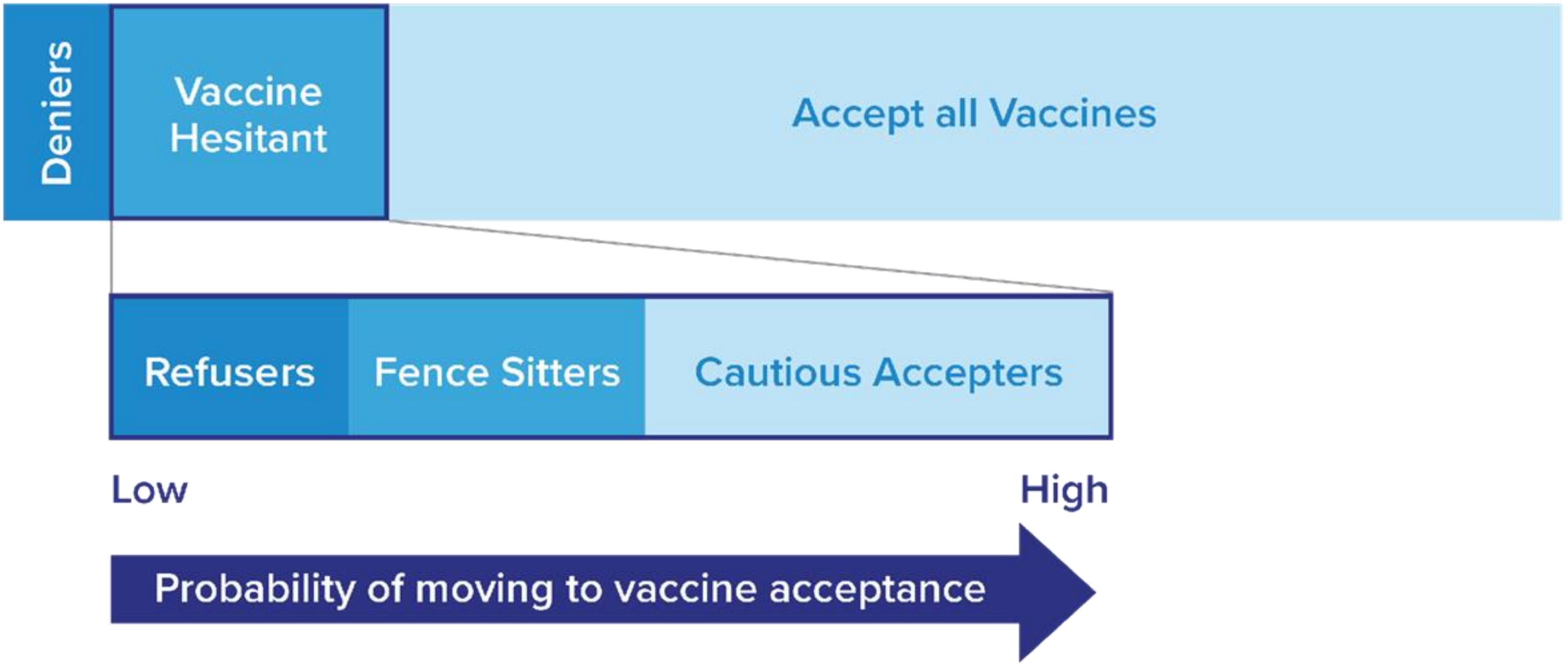
Gold Coast PHN Annual Nurse Immunisation Update

Tuesday 13 October 2026



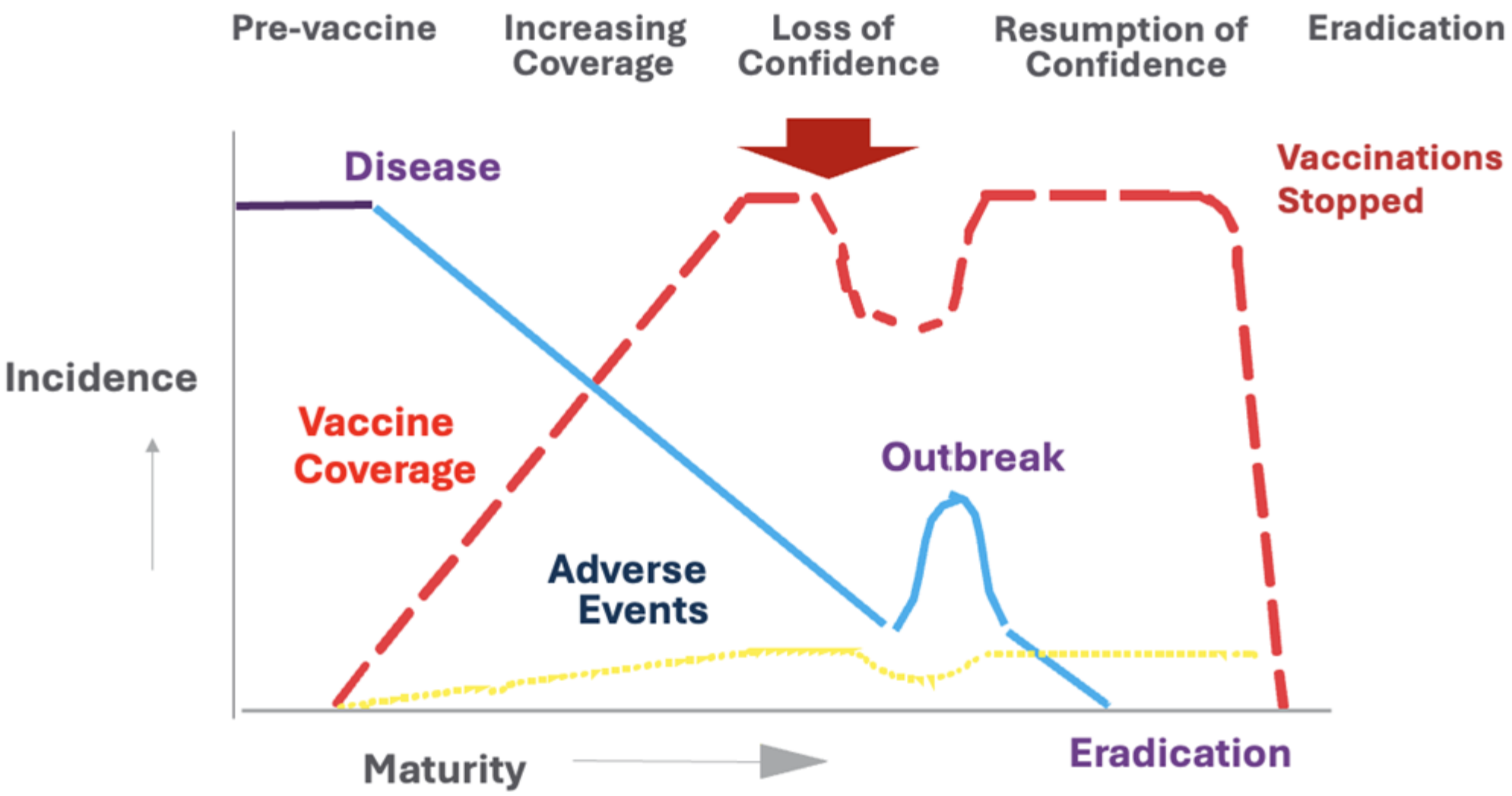
NCIRS National Centre for Immunisation Research and Surveillance Australia

Spectrum of Attitudes Towards Vaccines



https://www.oma.org/practice-professional-support/running-your-practice/patient-care/vaccines-physicians-rights-and-responsibilities/vaccine-hesitancy/

Vaccine programs are victims of their own success



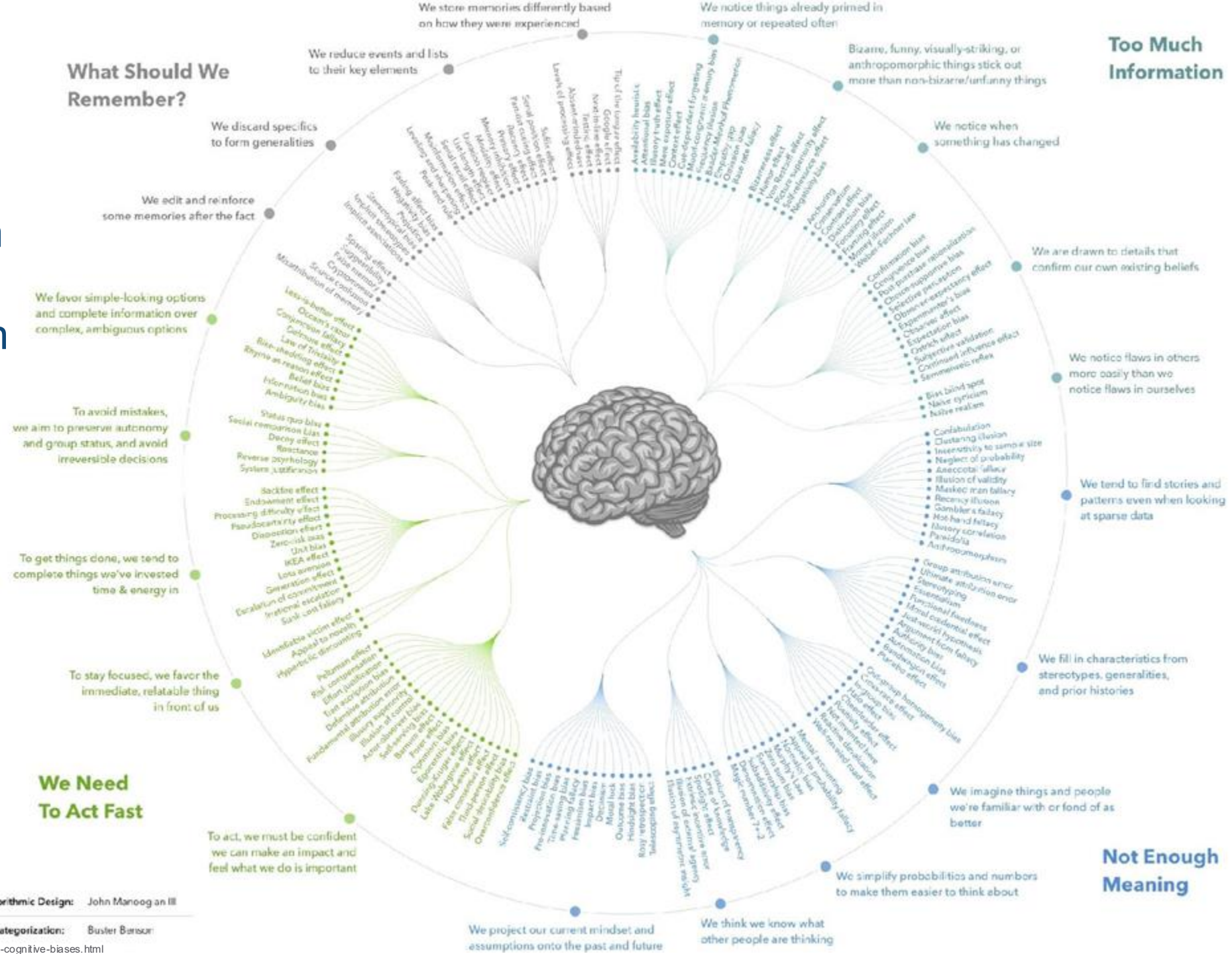
Adapted from Chen RT, Vaccine 2015 - https://www.ncbi.nlm.nih.gov/pubmed/2643392

Contributing factors =

Disinformation

Misinformation

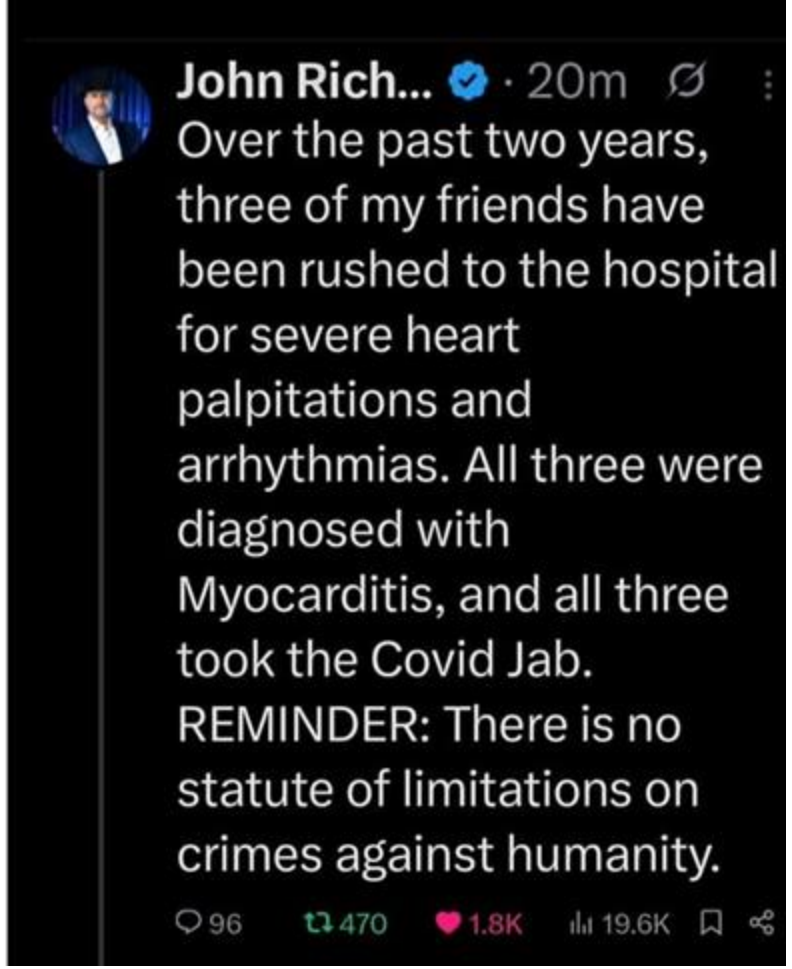
Cognitive biases



Visual & Algorithmic Design: John Manoog an III

Concept & Categorization: Buster Benson

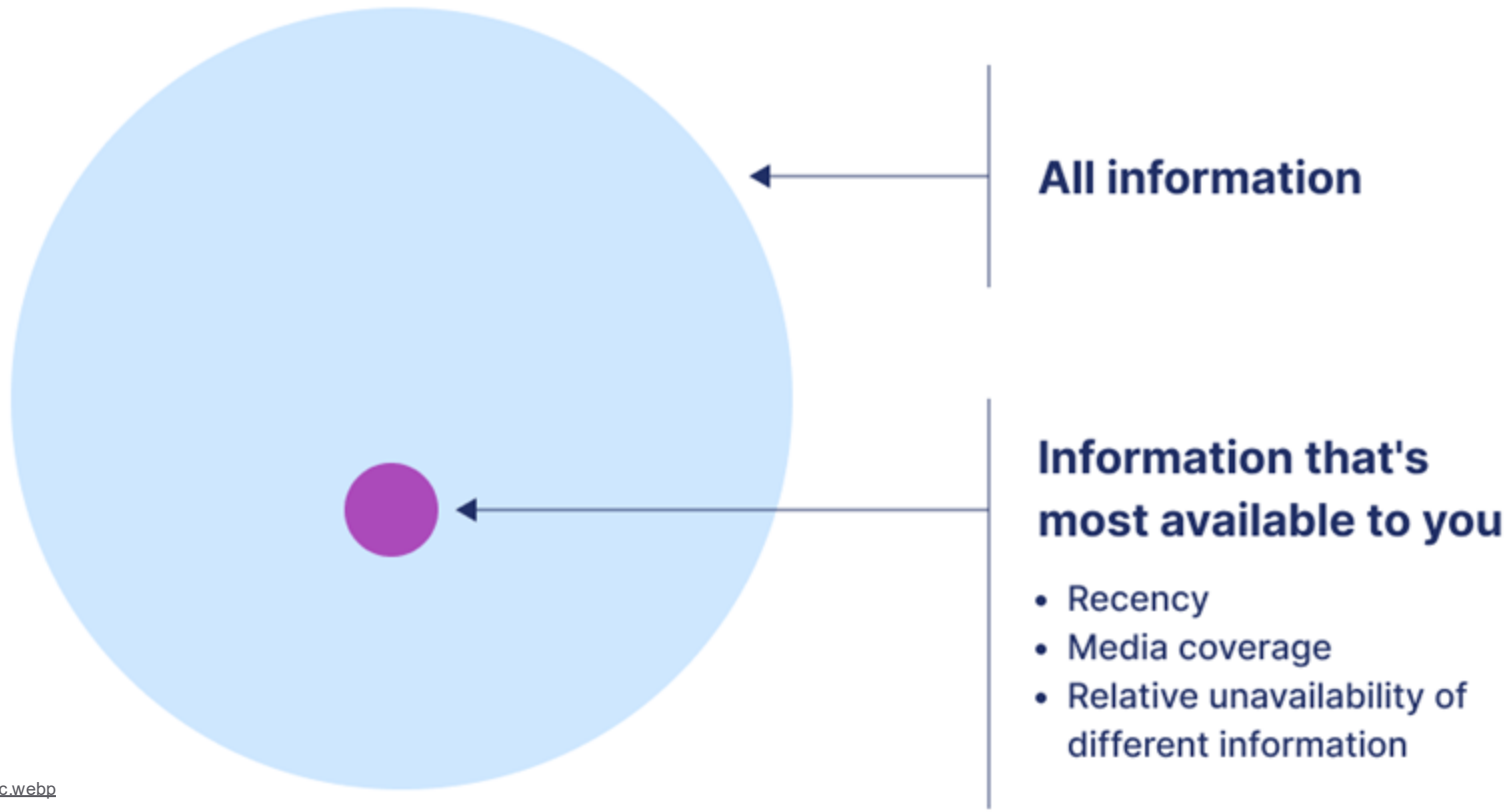
https://www.visualcapitalist.com/wp-content/uploads/2021/08/all-188-cognitive-biases.html





We judge likelihood based on how recently we can recall similar events

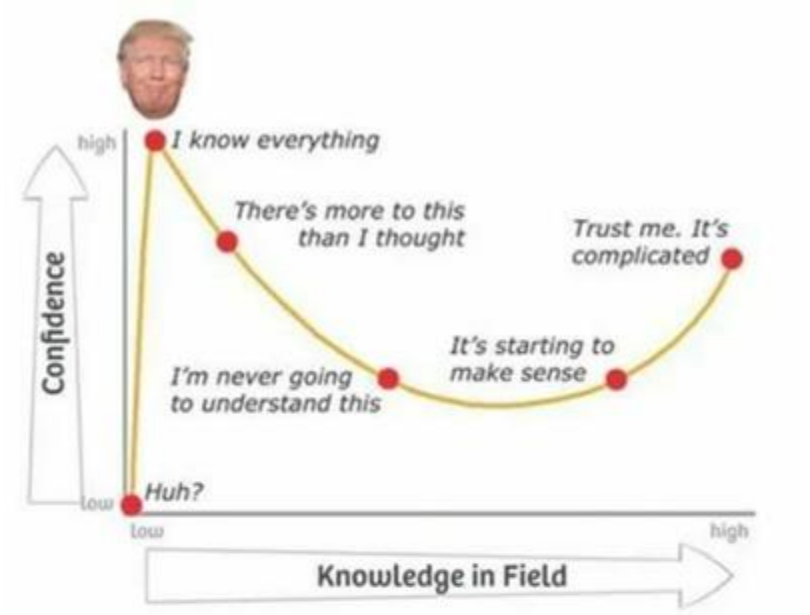
= Availability heuristic



https://pubmed.ncbi.nlm.nih.gov/36105535/

https://www.scribbr.com/wp-content/uploads/2023/03/the-availability-heuristic.webp

https://www.instagram.com/p/DLIMLdYASZd/





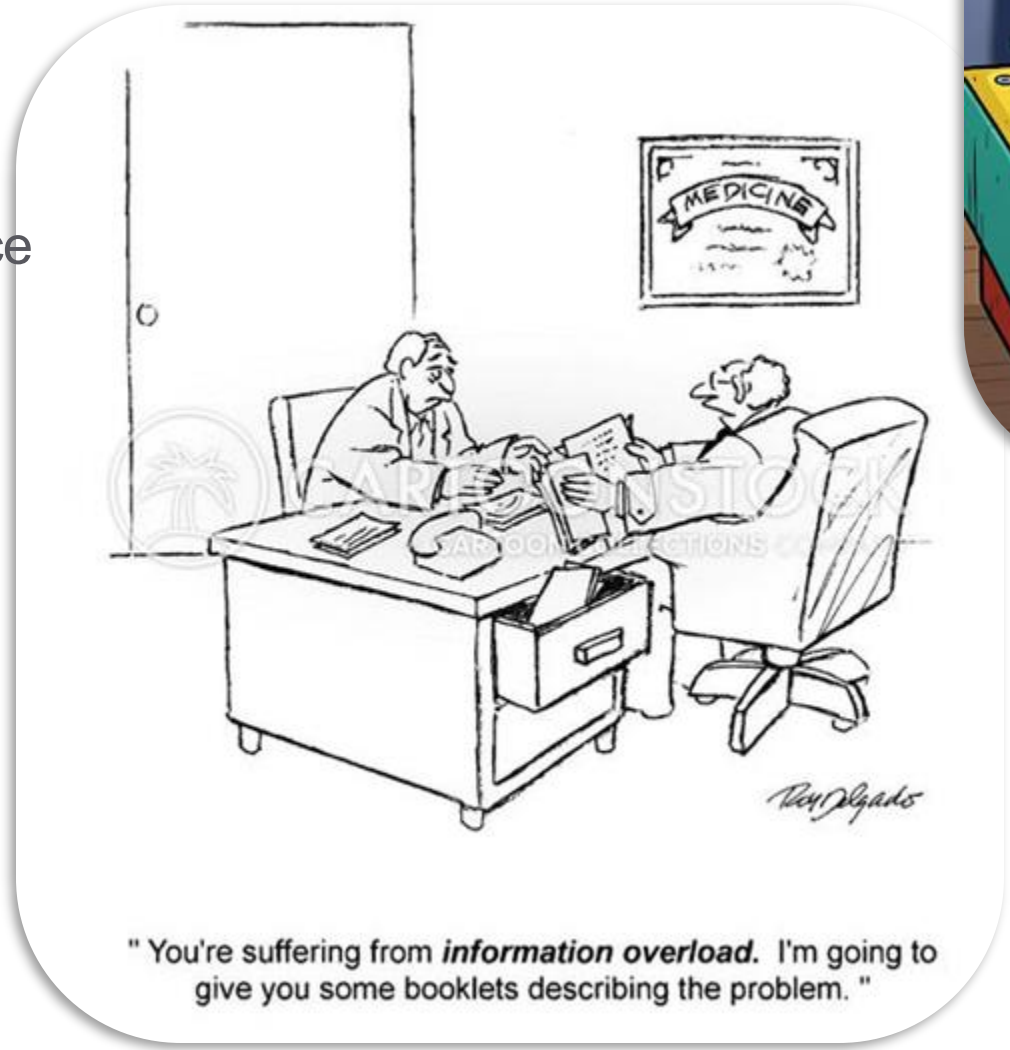
Dunning-Kruger effect

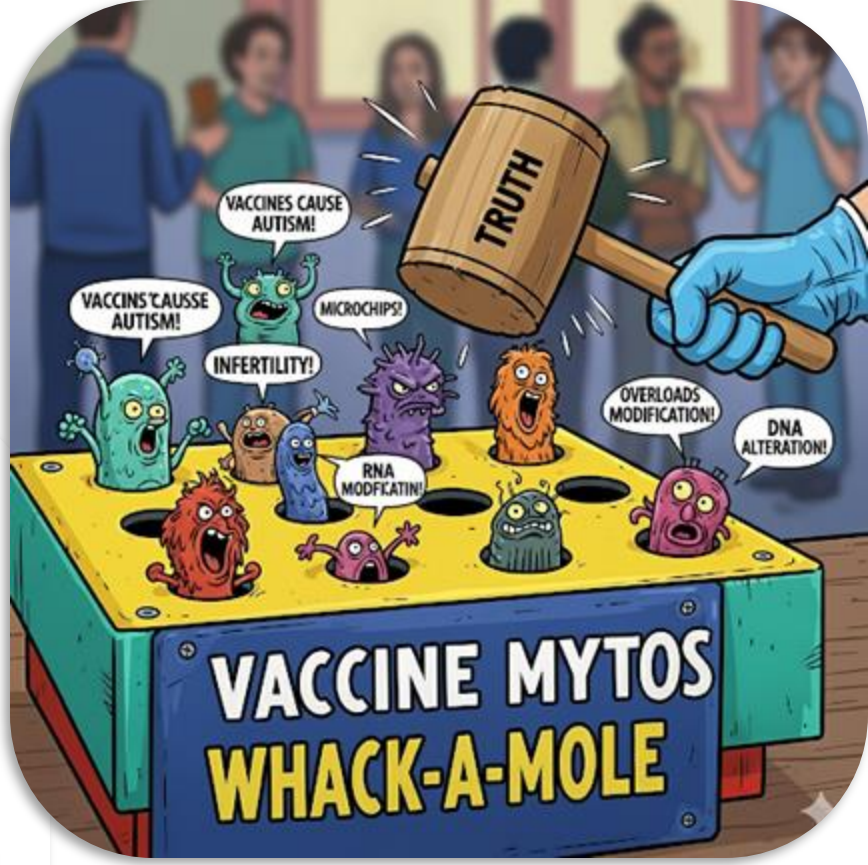
Survey of 1310 US adults: over one third thought they knew more about the causes of autism than doctors and scientists

https://dev.to/iwooky/unpacking-the-dunning-kruger-effect-in-software-development-1i5l
https://www.sciencedirect.com/science/article/abs/pii/S027795361830340X

What not to do:

- Focus on the myth(s)
- Focus on stats
- Overload with information
- Take an oppositional stance





What to do:

- Acknowledge & validate concerns
- Focus on the child
- **Pivot to disease risk**
- **Give a strong, personalised recommendation**
- **Keep it simple**
- Unmask the myth
- End with the facts





https://www.rki.de/EN/Topics/Infectious-diseases/Immunisation/Information-material/Vaccination-myths/effectively-debunking-misinformation.html; https://vaccinemisinformation.guide/

Addressing concerns about specific serious adverse events

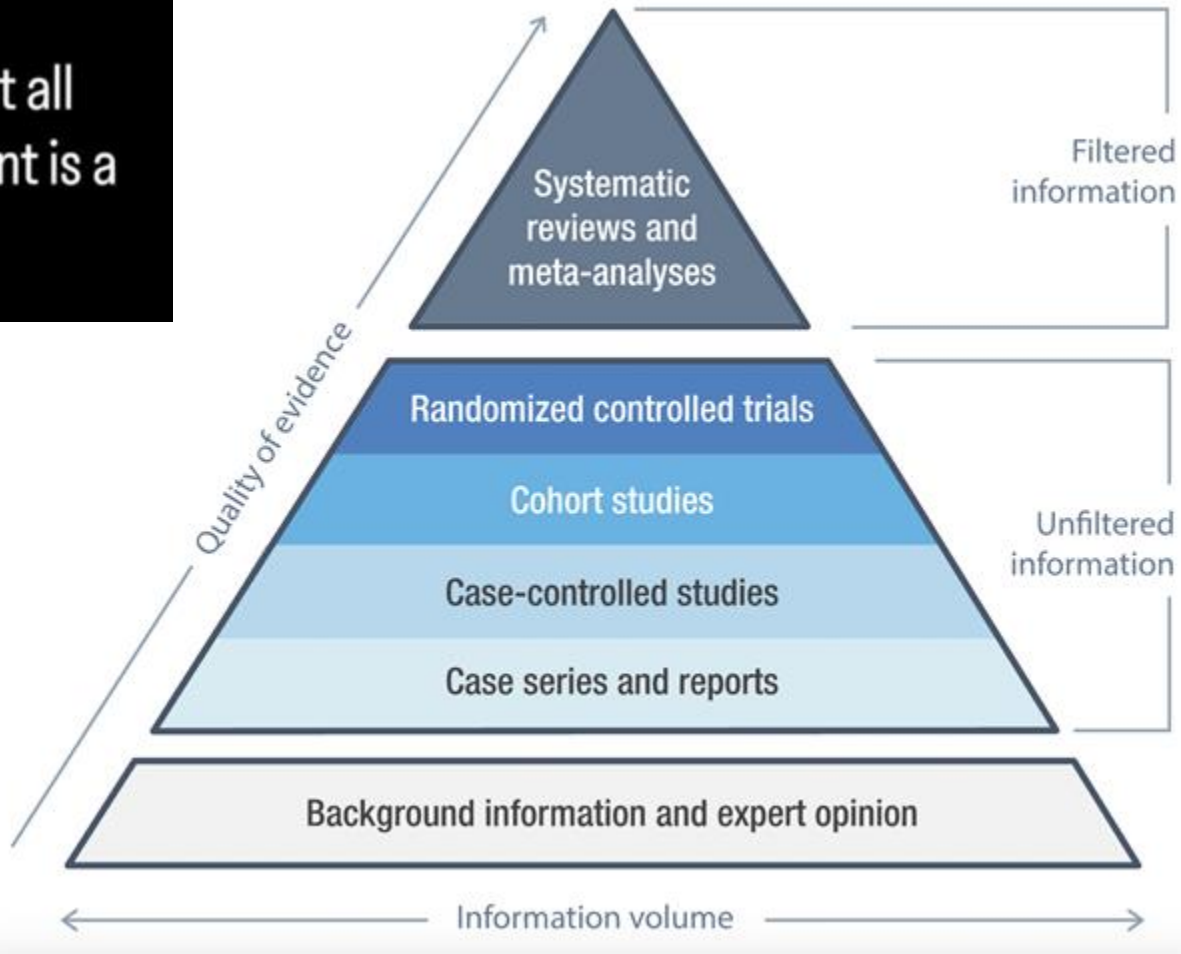
- Acknowledge serious adverse events do rarely occur
- Use frequencies e.g. “about 1 in 10,000” people instead of “0.01%” or “8.9 in 100,000”
- Pivot to disease risk, e.g.
  - “the risk of myocarditis is 7 times higher with COVID infection than with the vaccine”
  - For every 20,000 babies vaccinated with Rotarix:
    - 1 might develop vaccine-related intussusception (usually treatable)
    - Hundreds of severe rotavirus illnesses would have been prevented
    - Several hospitalisations would have been prevented
- Return focus to the patient & make a personalised recommendation

“I’ve done my research”

Many people think that a scientific consensus is a large group of scientists who all agree that something is true.

In reality, it’s a large body of scientific studies that all agree with and support each other. The agreement is a by-product of the consistent evidence.

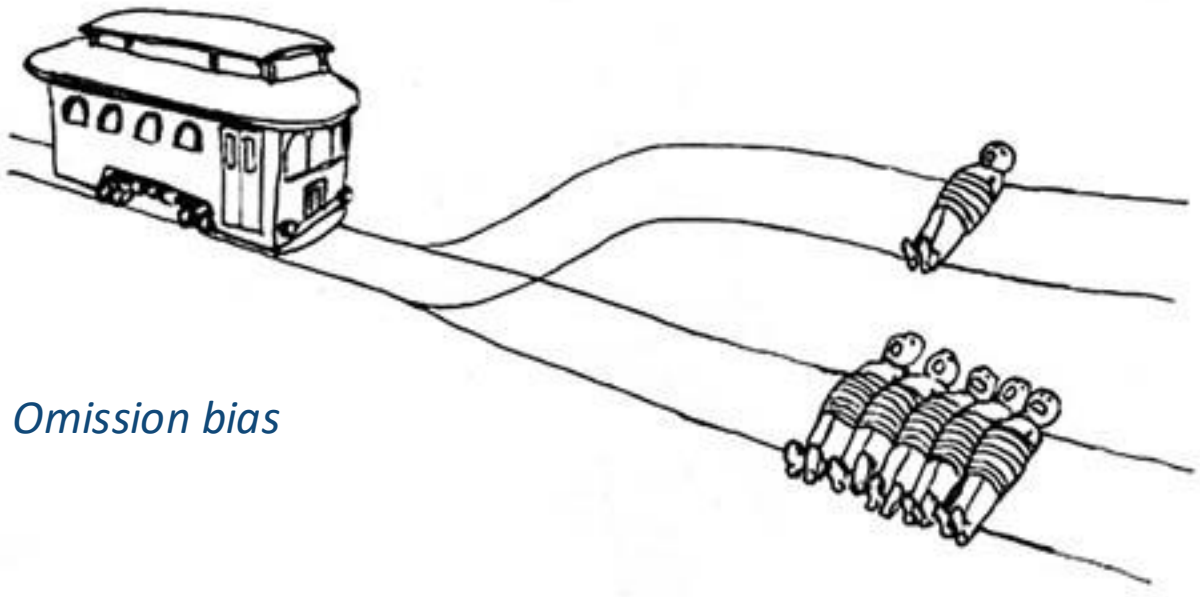
- "I can see you've done research - that shows you care”
- “We try to look at the whole body of evidence” – which can take multiple people many months for a single policy question: see more here
- Explain misinformation tactics – cherry-picking, causal fallacies, hasty generalisations



https://x.com/jonathanstea/status/1952344297514451164

"I'd rather take my chances with natural infection”

We tend to judge harm from action (e.g. giving a vaccine) as worse than harm from inaction



Omission bias

Losses are psychologically twice as powerful as gains, making people more motivated to avoid losing something than to gain something

Loss Aversion

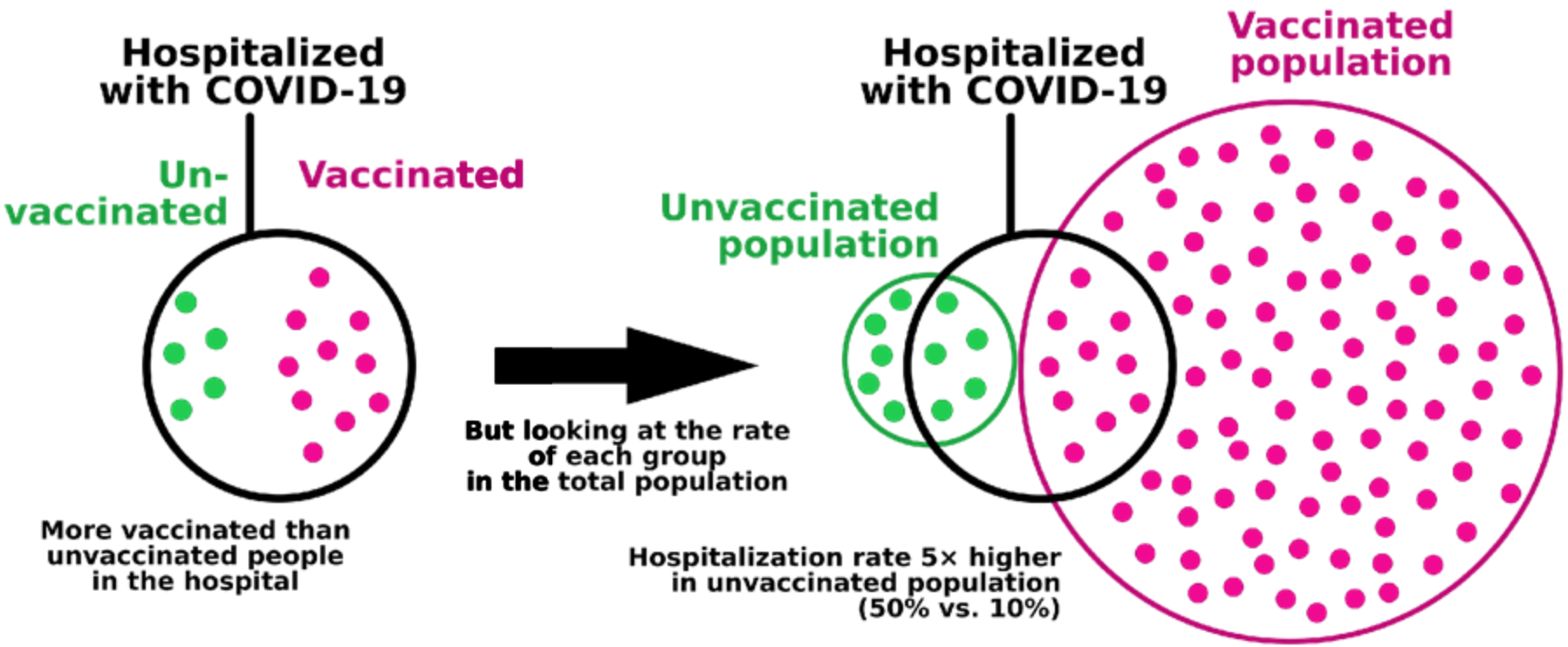
How to respond:

- Analogy: being unvaccinated is like choosing not to put a seat belt on
- Reframe: vaccination prevents greater losses (health, life) and carries a tiny risk vs being unvaccinated



Base rate fallacy

- Responding with an analogy: "Most car accident injury victims were wearing seatbelts”



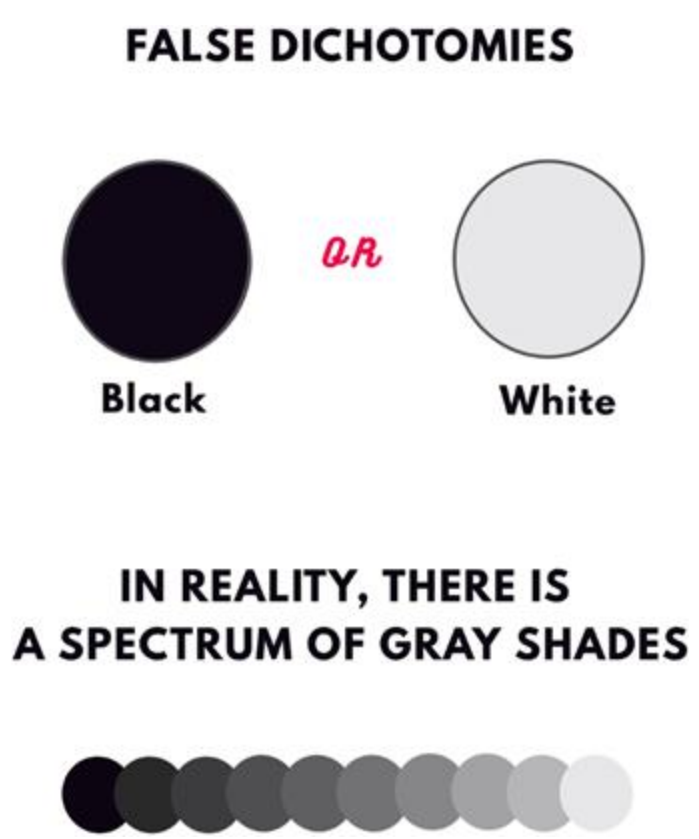
https://en.wikipedia.org/wiki/Base_rate_fallacy#/media/File:Base_rate_fallacy_with_vaccines.svg

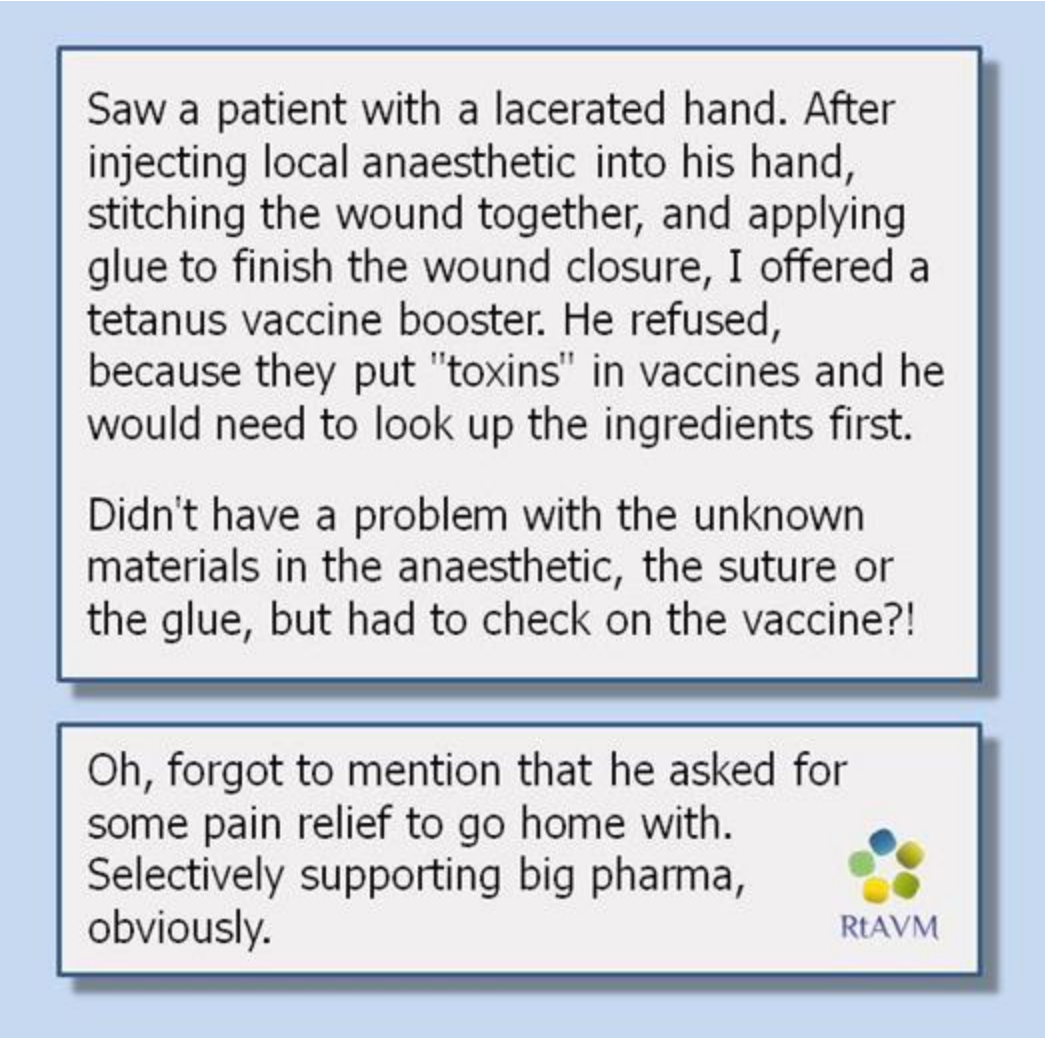
“Vaccines aren’t 100% safe, therefore they’re dangerous”

“Vaccines can’t stop you getting infected, so they’re useless”

Perfect solution fallacy

- You're right that vaccines aren't risk-free. No medical intervention is - neither is doing nothing. "Safe" doesn't mean "perfect"
- Safety is measured by comparing risks and benefits. Vaccines are among the safest medical interventions we have because the benefits very greatly outweigh the risks.
- Orders of magnitude:
  - We usually talk about serious vaccine reactions in terms of “1 in a million doses”
  - Serious complications from vaccine-preventable diseases happen in 1 in hundreds or thousands of cases.”





We tend to prioritise immediate, tangible concerns over future benefits or risks

Temporal discounting

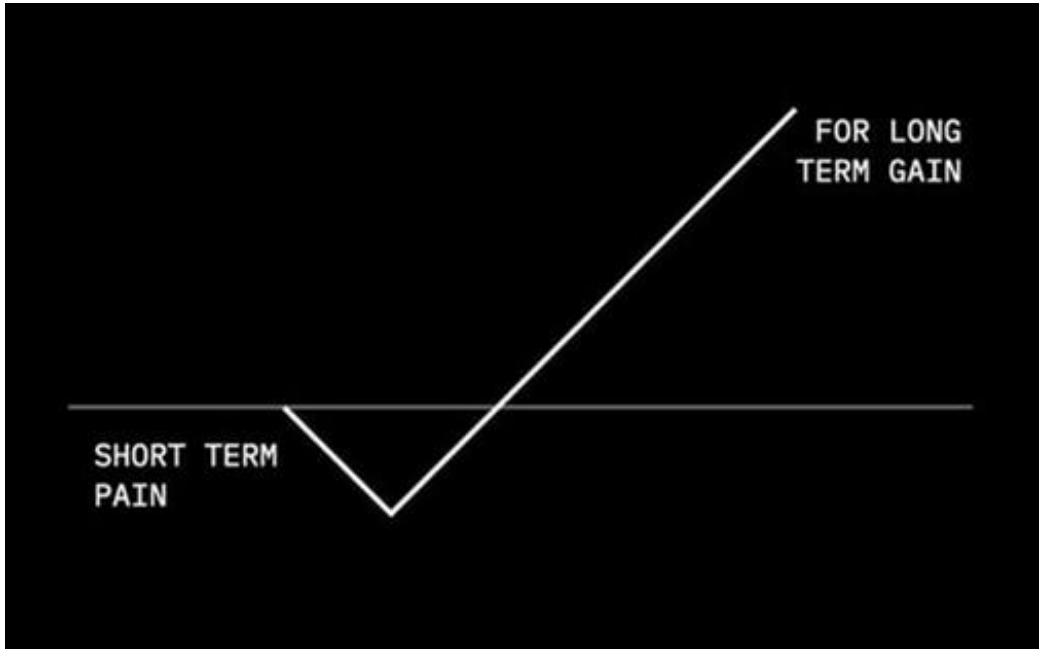
Other examples:

- “Babies don’t need hep B vaccine”
- Greater concern over mild immediate risks (pain, fever, rash from vaccine) that are visible, familiar and tangible, vs greater long-term benefits that are unfamiliar

https://www.facebook.com/share/p/19fNtvmjg9/

How to respond

- Acknowledge & explain time discounting
- Use **scenarios and stories** to describe how risks remain present:
  - E.g. measles deaths in USA
  - “Billie could step on a needlestick at the playground / be bitten by a child at daycare and contract a long-term chronic illness that causes cancer”
  - “She could be exposed to measles or whooping cough at the local shopping centre”
- Address immediate concerns (pain management, scheduling)







- "Natural immunity is superior"
- "Vaccines are full of chemicals/toxins"
- Preference for 'natural' alternatives or traditional health practices

Appeal to nature bias
Equivocation/ambiguity

https://www.facebook.com/reel/1709774322992255

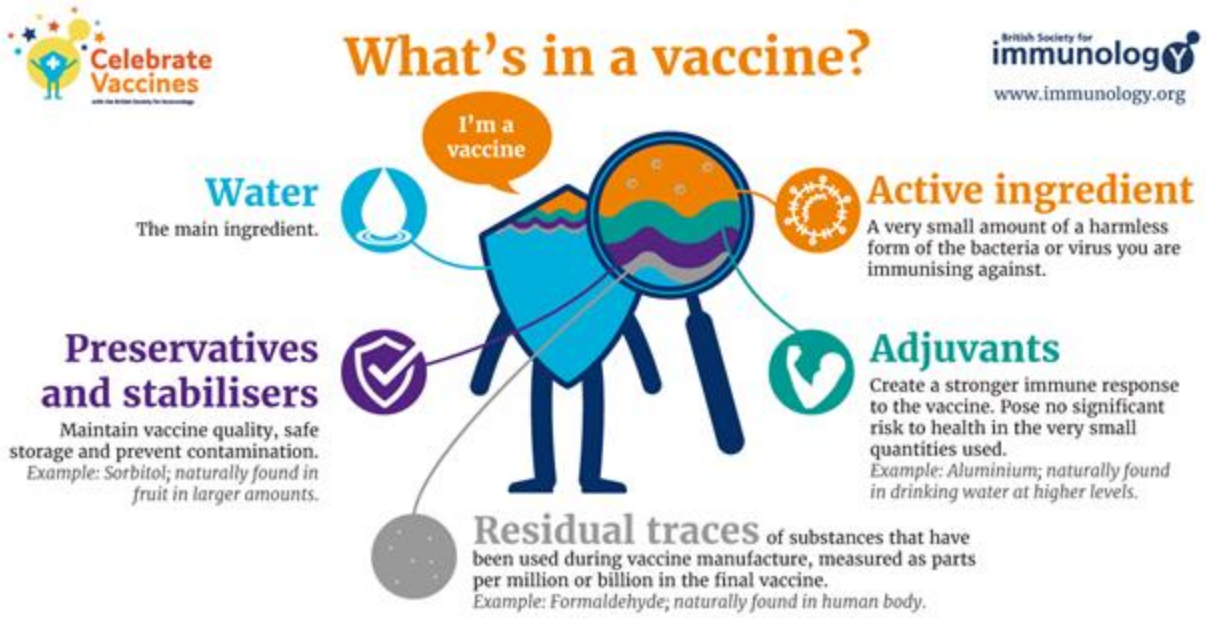
How to respond

- “I understand the appeal of natural approaches”
- “Water, salt and sugar are also chemicals; our bodies contain many chemicals (including small quantities of formaldehyde, aluminium)
- Many “natural” substances are very dangerous (venom, deadly nightshade)
- "Insulin and antibiotics are also “chemicals” and are life-saving”
- Vaccines take advantage of your immune system’s natural processes using small components of the bacteria/virus greatly reducing the risk of needing antibiotics/antivirals/hospitalisation
- Natural immunity argument - "Before measles vaccine, 100 Australian children died yearly from measles; now it's zero”
- Vaccination can complement traditional health practices
- Combination vaccines reduce the number of needles needed

https://www.aihw.gov.au/getmedia/c828baef-75d9-4295-9cc9-b3d50d7153a2/aihw-phe-236_measles.pdf.aspx

Responding to concerns about specific components

- **Formaldehyde** is produced naturally by the body in much higher quantities than found in a vaccine
- **Aluminium** is found in plants, air, food and water and a tiny amount is in our blood – the amount in vaccines doesn't cause a noticeable rise
- **mRNA** degrades within hours and doesn't even enter the cell nucleus where the DNA is
- **Thiomersal** was previously used in vaccines as a preservative, and contained ethyl mercury, not methyl mercury- but as a precaution was removed from all routine vaccines

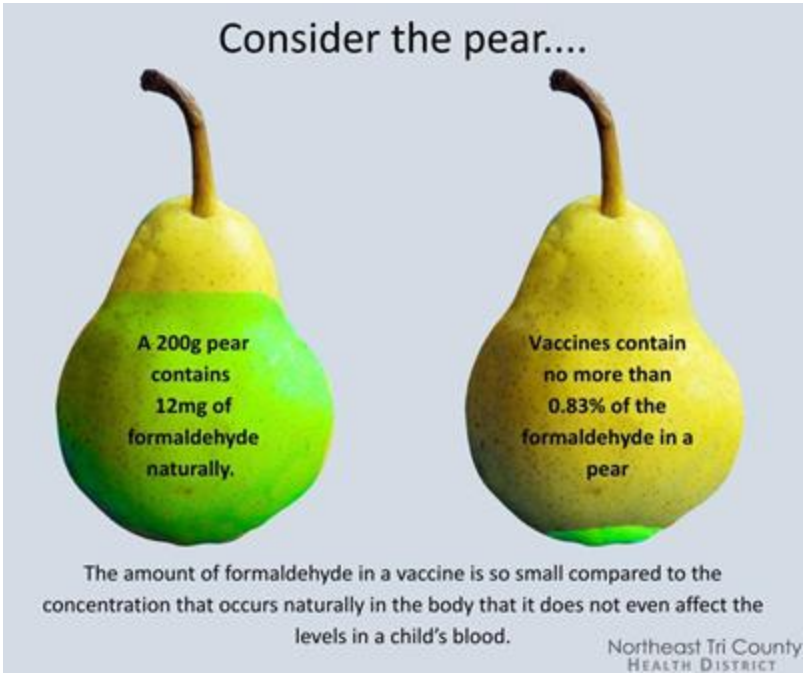


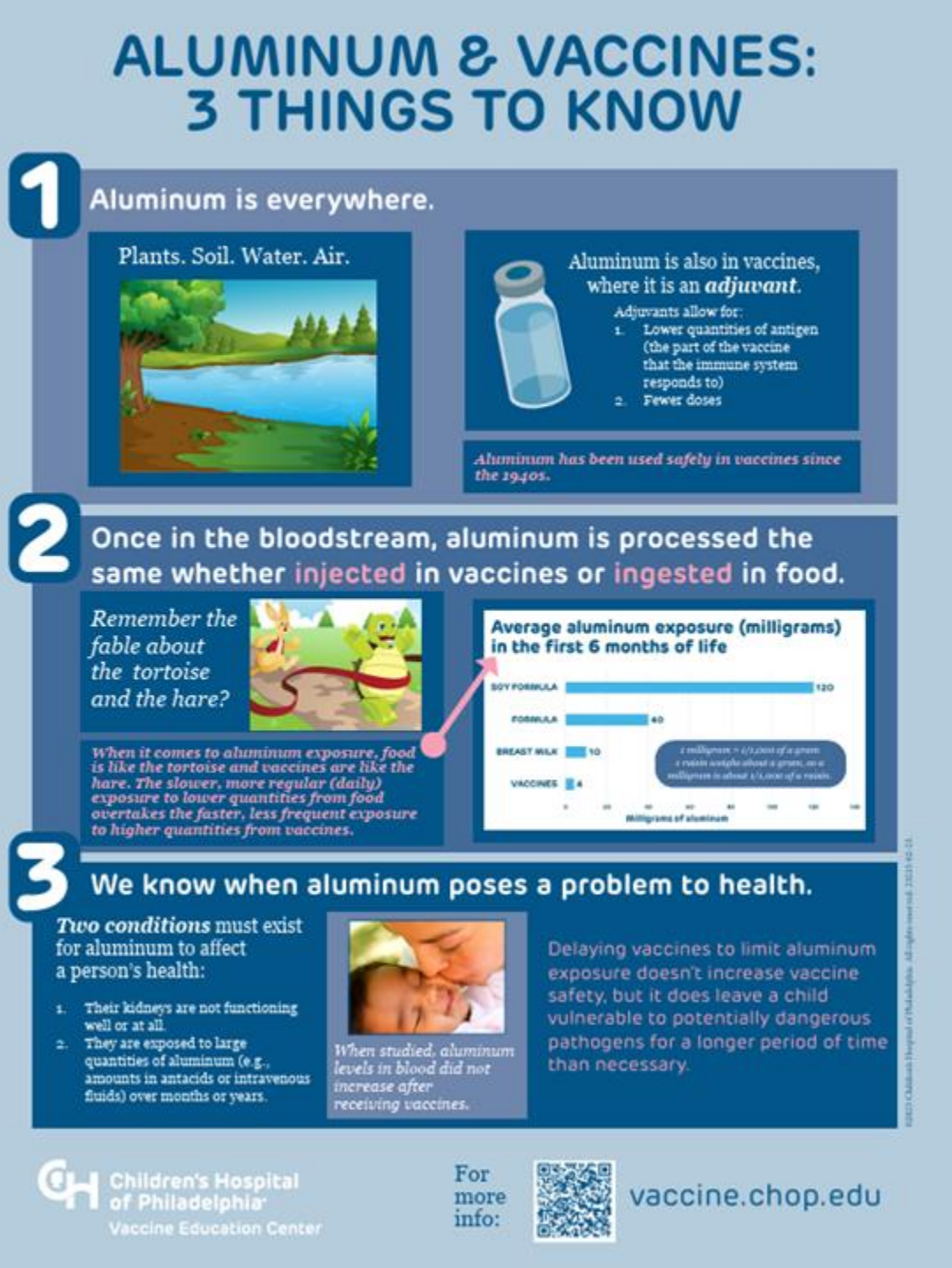
https://skai.org.au/childhood/questions/what-vaccines; https://www.immunology.org/public-information/vaccine-resources/childhood-vaccines/vaccine-infographics/whats-vaccine



INGREDIENTS: WATER (75%), **SUGARS (12%)** (GLUCOSE (48%), FRUCTOSE (40%), SUCROSE (2%), MALTOSE (<1%)), STARCH (5%), **FIBRE (3%)** (E460, E461, E462, E464, E466, E467) **AMINO ACIDS** (GLUTAMIC ACID (19%), ASPARTIC ACID (16%), HISTIDINE (11%), LEUCINE (7%), LYSINE (5%), PHENYLALANINE (4%), ARGININE (4%), VALINE (4%), ALANINE (4%), SERINE (4%), GLYCINE (3%), THREONINE (3%), ISOLEUCINE (3%), PROLINE (3%), TRYPTOPHAN (1%), CYSTINE (1%), TYROSINE (1%), METHIONINE (1%)), **FATTY ACIDS (1%)** (PALMITIC ACID (30%), OMEGA-6 FATTY ACID: LINOLEIC ACID (14%), OMEGA-3 FATTY ACID: LINOLENIC ACID (8%), OLEIC ACID (7%), PALMITOLEIC ACID (3%), STEARIC ACID (2%), LAURIC ACID (1%), MYRISTIC ACID (1%), CAPRIC ACID (<1%)), ASH (<1%), PHYTOSTEROLS, E515, OXALIC ACID, E300, E306 (TOCOPHEROL), PHYLLOQUINONE, THIAMIN, **COLOURS** (YELLOW-ORANGE E101 (RIBOFLAVIN), YELLOW-BROWN E160a), **FLAVOURS** (ETHYL HEXANOATE, ETHYL BUTANOATE, 3-METHYLBUT-1-YL ETHANOATE, PENTYL ACETATE), E1510, NATURAL RIPENING AGENT (ETHENE GAS).

Bananas contain unpronounceable ingredients, too





https://jameskennedymonash.wordpress.com/2016/02/
https://www.facebook.com/netchd.org/photos/formaldehyde-in-vaccines-separating-fact-from-fictionevery-month-we-are-posting-/1142837594552694/?
https://www.chop.edu/sites/default/files/vec-aluminum-qa-infographic.pdf





EARLY REPORT

Early report

Ileal-lymphoid-nodular hyperplasia, non-specific colitis, and pervasive developmental disorder in children

A J Wakefield, S H Murch, A Anthony, J Linnell, D M Casson, M Malik, M Berelowitz, A P Dhillon, M A Thomson, P Harvey, A Valentine, S E Davies, J A Walker-Smith

RETRACTED

Summary

Background We investigated a consecutive series of children with chronic enterocolitis and regressive developmental disorder.

Methods 12 children (mean age 6 years [range 3–10], 11 boys) were referred to a paediatric gastroenterology unit with a history of normal development followed by loss of acquired skills, including language, together with diarrhoea and abdominal pain. Children underwent gastroenterological, neurological, and developmental assessment and review of developmental records. Ileocolonoscopy and biopsy sampling, magnetic-resonance imaging (MRI), electroencephalography (EEG), and lumbar puncture were done under sedation. Barium follow-through radiography was done where possible. Biochemical, haematological, and immunological profiles were examined.

Findings Onset of behavioural symptoms was associated by the parents, with measles, mumps, and rubella vaccination in eight of the 12 children, with measles infection in one child, and otitis media in seven. All 12 children had intestinal abnormalities ranging from lymphoid nodular hyperplasia to aphthoid ulceration. Histology showed patchy chronic inflammation in 11 children and reactive lymphoid hyperplasia in seven, but no granulomas. Behavioural disorder included autism (nine), disintegrative psychosis (one), and possible postviral or vaccinal encephalitis (one). There were no focal neurological abnormalities and MRI and EEG tests were normal. Abnormal laboratory results were significantly raised urinary methylmalonic acid compared with age-matched controls (p<0·001), low haemoglobin in four children, and low serum IgA in two children.

Interpretation We identified associated gastrointestinal disease and developmental regression in a group of previously normal children, which was generally associated in time with possible environmental triggers.

Lancet 1998; 351: 637–41
See Commentary page

Inflammatory Bowel Disease Study Group, University Departments of Medicine and Histopathology (A J Wakefield FRCS, A Anthony MB, J Linnell MD, A P Dhillon MRCPath, S E Davies MRCPath) **and the University Departments of Paediatric Gastroenterology** (S H Murch MB, D M Casson MRCP, M Malik MRCP, M A Thomson FRCP, J A Walker-Smith FRCP), **Child and Adolescent Psychiatry** (M Berelowitz FRCPsych), **Neurology** (P Harvey FRCP), **and Radiology** (A Valentine FRCR), **Royal Free Hospital and School of Medicine, London NW3 2QG, UK**

Correspondence to: Dr A J Wakefield

Introduction

We saw several children who, after a period of apparent normality, lost acquired skills, including communication. They all had gastrointestinal symptoms, including abdominal pain, diarrhoea, and vomiting and, in some cases, food intolerance. We describe the clinical findings, and gastrointestinal features of these children.

Patients and methods

12 children, consecutively referred to the department of paediatric gastroenterology with a history of a pervasive developmental disorder with loss of acquired skills and intestinal symptoms (pain, diarrhoea, abdominal distension, bloating and food intolerance), were investigated. All children were admitted to the ward for a week, accompanied by their parents.

Clinical investigations

A history including details of immunisations and exposure to infectious diseases, and assessed the children. In 11 cases the history was obtained by the senior clinician (JW-S). Neurological and psychiatric assessments were done by consultant staff (PH, MB) with HMS-4 criteria.[7] Developmental history included a review of prospective developmental records from parents, health visitors, and general practitioners. Four children did not undergo psychiatric assessment in hospital; all had been assessed professionally elsewhere, so these assessments were used as the basis for their behavioural diagnosis.

After bowel preparation, ileocolonoscopy was performed by SBM or MAT under sedation with midazolam and pethidine. Paired frozen and formalin-fixed mucosal biopsy samples were taken from the terminal ileum; ascending, transverse, descending, and sigmoid colons, and from the rectum. The procedure was recorded by video or still images, and were compared with images of the previous seven consecutive paediatric colonoscopies (four normal colonoscopies and three on children with ulcerative colitis), in which the physician reported normal appearances in the terminal ileum. Barium follow-through radiography was possible in some cases.

Also under sedation, cerebral magnetic-resonance imaging (MRI), electroencephalography (EEG) including visual, brain stem auditory, and sensory evoked potentials (where compliance made these possible), and lumbar puncture were done.

Laboratory investigations

Thyroid function, serum long-chain fatty acids, and cerebrospinal-fluid lactate were measured to exclude known causes of childhood neurodegenerative disease. Urinary methylmalonic acid was measured in random urine samples from eight of the 12 children and 16 age-matched and sex-matched normal controls, by a modification of a technique described previously.[8] Chromatograms were scanned digitally on computer, to analyse the methylmalonic-acid areas from cases and controls. Urinary methylmalonic-acid concentrations in patients and controls were compared by a two-sample t test. Urinary creatinine was estimated by routine spectrophotometric assay.

Children were screened for anticardiolipin antibodies and boys were screened for fragile-X if this had not been done

Relying too heavily on the first piece of information encountered (the "anchor") when making decisions, with subsequent judgments being influenced by this initial reference point.

Anchoring bias

https://en.wikipedia.org/wiki/Lancet_MMR_autism_fraud, https://www.facebook.com/share/v/1CPT6abvmp/

Example 2. Debunking the "MMR Causes Autism" Myth

FACT

A huge study of over 500,000 Danish children found that unvaccinated children were just as likely to develop autism as vaccinated children.

MYTH

One common vaccine myth is that vaccines can cause negative health impacts. The evidence cited is often specific examples where a child received a vaccination then suffered adverse health impacts just afterwards.

FALLACY

Some people believe that vaccines can cause unrelated diseases that usually appear around the same time that we give children vaccines. They mistake correlation for causation.

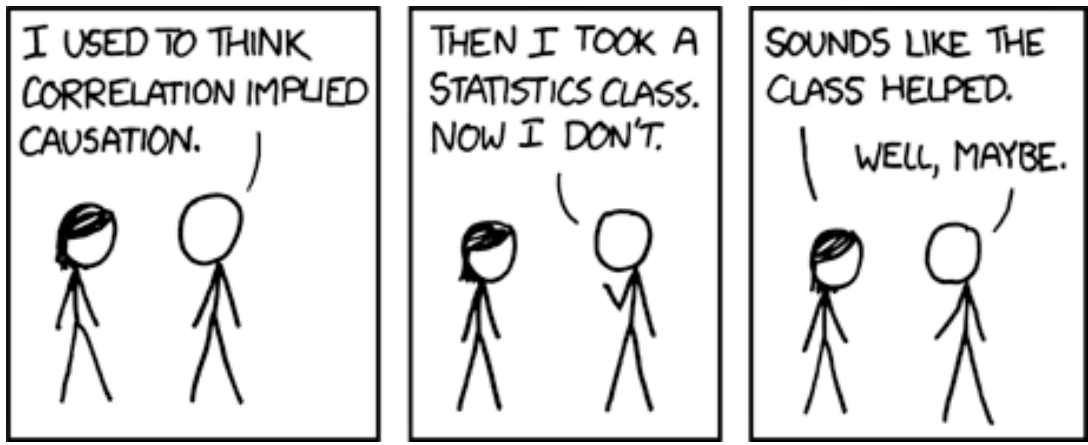
For example, if children who receive a teddy bear and children who receive a vaccine both have their teeth fall out, it doesn't mean that either receiving a teddy bear or receiving a vaccine caused this to happen – it's just a coincidence.

Also, this concern began with a study led by an English doctor which was retracted because he was found to have lied about the findings, creating an elaborate fraud. He subsequently lost his medical license for acting dishonestly, unethically, and with "callous regard" for the children, and was shown to have major undisclosed financial conflicts of interest[138].

FACT

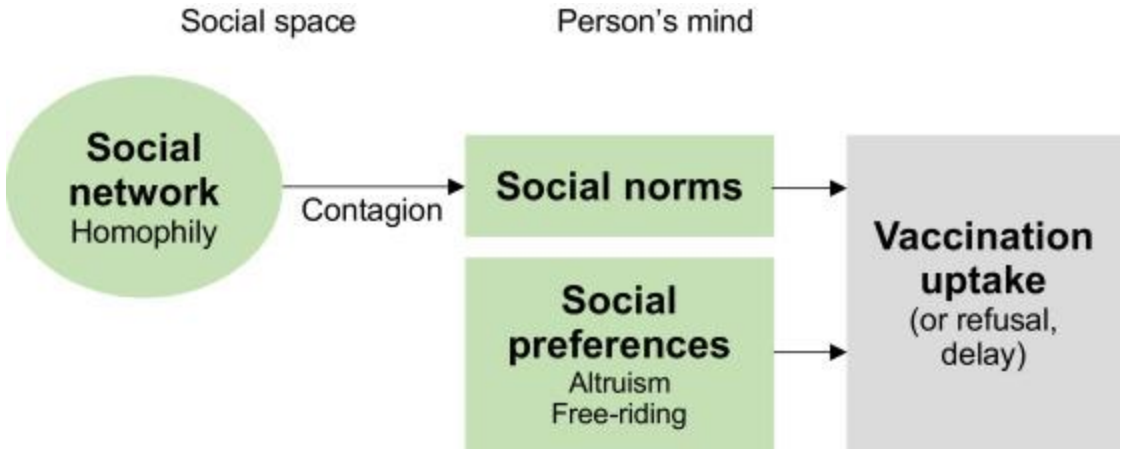
We still don't know exactly what causes autism, but over 10 high-quality studies show that it is not caused by vaccines. The observed rise in autism rates is mostly due to broadened diagnostic criteria and heightened awareness of the condition[139].

https://vaccinemisinformation.guide/



https://fidelandrada-writing.medium.com/post-hoc-ergo-propter-hoc-24700f2079d0

Social influence

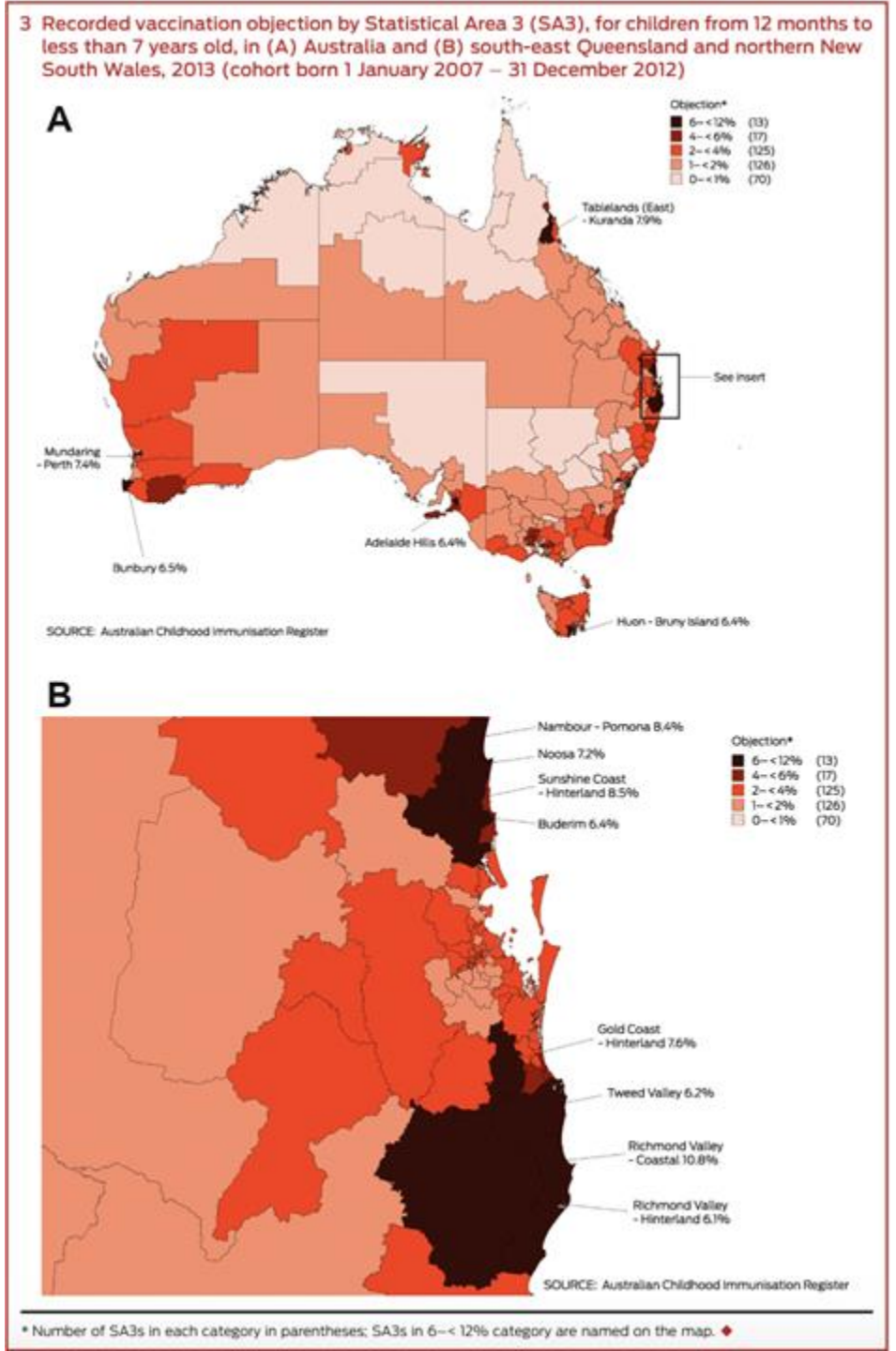


Bandwagon effect

How to respond:

- Reframe the bandwagon:
  - It's really common for parents to ask these questions before getting the vaccine
  - In Australia, close to 95% of children in Australia are fully vaccinated
  - Most of those who aren't vaccinated are struggling with access to vaccines, rather than refusing

https://www.mja.com.au/system/files/issues/204_07/10.5694mja15.01226.pdf
https://www.academicpedsjnl.net/article/S1876-2859%2821%2900051-6/fulltext



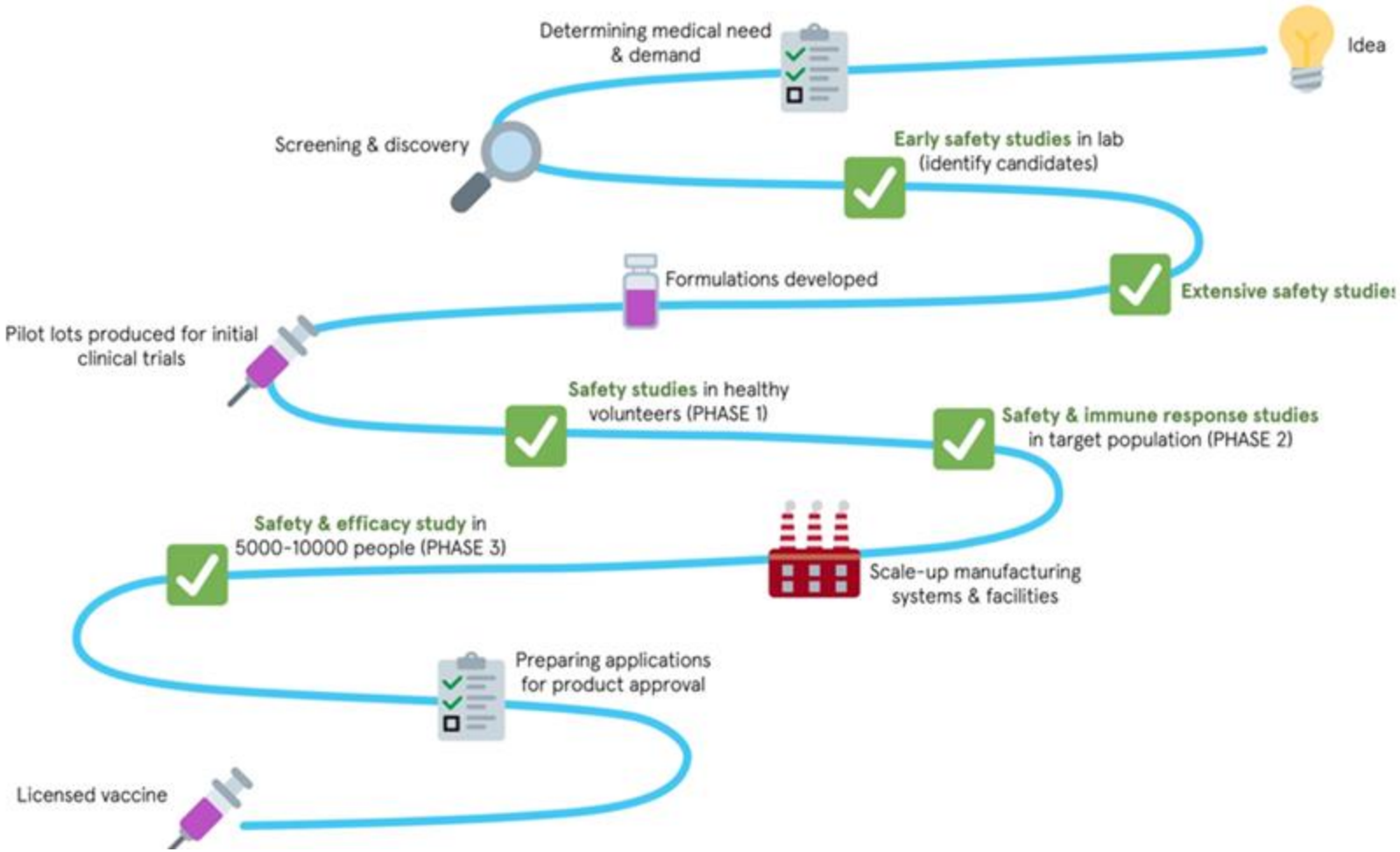
Concerns about long-term or late-onset side effects



- “That’s a fair question.”
- Vaccine-related adverse effects occur within 6–8 weeks of administration, because vaccines don’t remain in the body long — they trigger an immune response and are cleared
- Massive long-term real-world data exists now (billions of doses)
- Global safety monitoring can detect extremely rare side effects e.g. 1 in a million
- Pivot to disease risk: risk of death or long-term disability from the vaccine-preventable disease in question

https://absolutelymaybe.plos.org/2025/06/27/digging-into-the-evidence-on-covid-vaccines-in-pregnancy/

“I’m not taking an experimental vaccine”





https://www.who.int/news-room/feature-stories/detail/safety-of-covid-19-vaccines

Religious or ethical concerns

Examples:

- Vaccine ingredients conflict with religious dietary laws”
- Concerns about fetal cell lines

How to Respond:

- Respect their faith
- Fact: "No vaccine contains fetal cells - some were manufactured using fetal cell lines which were developed decades ago"
- Offer alternatives when available: "We can discuss which specific vaccines align with your beliefs” [e.g. for concerns about gelatin; priorix instead of MMR-II – see AIH components table)
- Guidance may be available from religious authorities

https://lozierinstitute.org/wp-content/uploads/2022/11/11.02.20-Fetal-Cell-Line-Fact-Sheet-3.pdf

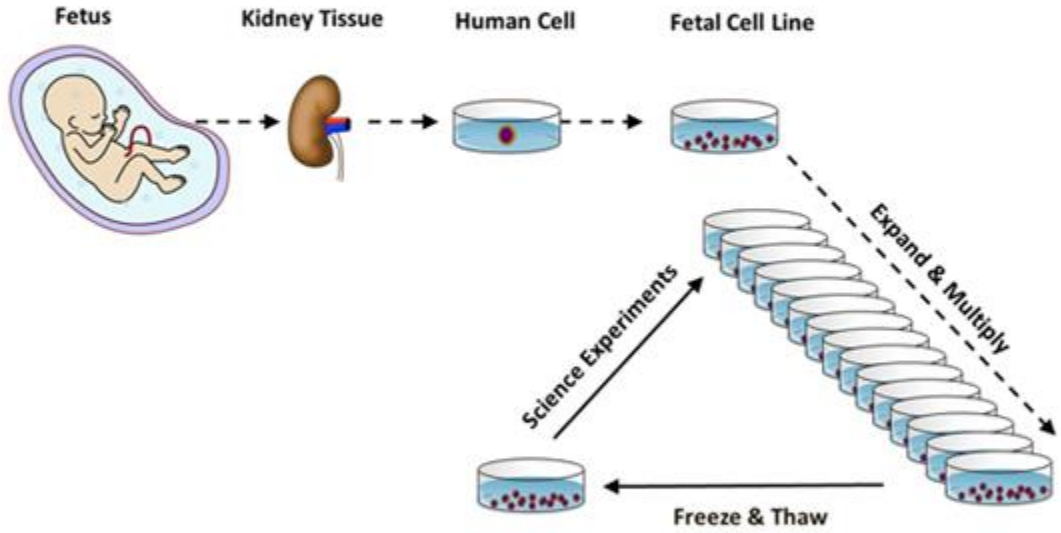
Fact Sheet:

COVID Vaccines & Fetal Cell Lines

CHARLOTTE LOZIER INSTITUTE

What is a fetal cell line?

A cell taken from an aborted baby is multiplied into many cells of the same kind. These can be grown indefinitely and further multiplied, creating lines of cells that are sometimes used for science experiments, even after being frozen and stored for years.



Are fetal cell lines the same as fetal tissue?

Fetal cell lines are not the same as fetal tissue. Fetal tissue requires the ongoing destruction of human life. Researchers buy body parts from tissue procurement companies to conduct lab experiments. Once the tissue is gone, researchers must go back and purchase more body parts from new abortions. Fetal cell lines *do not* rely on the ongoing destruction of “fresh” (or primary) human fetal tissue from aborted babies and will not require new abortions. Most fetal cell lines are commercially available and are not regulated by the federal government.

Thank you

- ncirs.org.au
- schn-ncirs@health.nsw.gov.au
- @NCIRS

National Centre for Immunisation Research and Surveillance Australia

The Weekly Jab

Subscribe to the/our/NCIRS' Weekly Jab newsletter

Presenter's name
Presenter's title
Presenter's email address

Update on 2026 FluMist Implementation, State-wide and Innovations in Vaccine Delivery

Laurelle Nelson

phn GOLD COAST
An Australian Government Initiative

Shaping healthier lives



GCPHN

Immunisation Program Nurse Update

Laurelle Nelson QHIP

The Queensland Government respectfully acknowledges the Aboriginal and Torres Strait Islander peoples as the Traditional and Cultural Custodians of the lands on which we live and work to deliver healthcare to all Queenslanders and recognises the continuation of First Nations peoples' cultures and connection to the lands, waters and communities across Queensland.

Overview

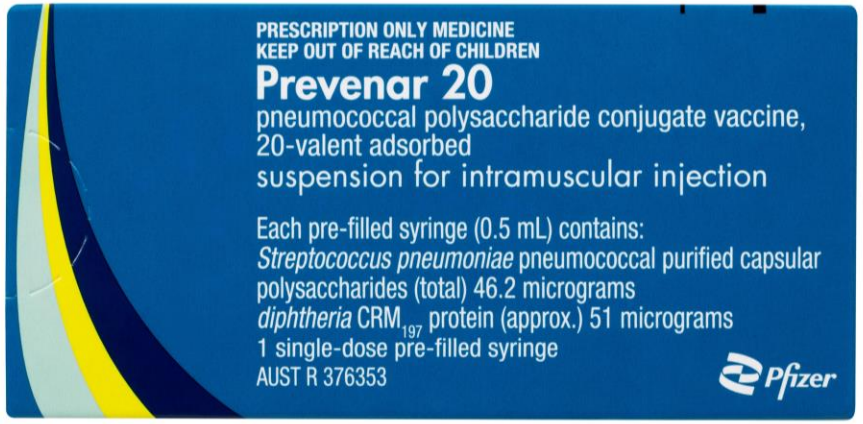
- Changes to the National Immunisation Program - Prevenar 20, Capvaxive, Arexvy, COVID 19
- Influenza overview
- Diphtheria
- VAE reporting
- Resources - Prevenar and Abrysvo decision making tool, Visual tools, product selection tools, educational resources, modules, SKAI adolescent resources, Mpox resource kit, flu resources and webinars



Changes to the NIP

- From July 1 2026, only two pneumococcal vaccines are recommended and funded on the NIP
- Prevenar 20 (20vPCV) is the ***only*** pneumococcal vaccine recommended for use in children and adolescents <18 years of age
- For children eligible for (legacy) pneumococcal vaccine at 4yrs (medically at risk or Aboriginal or Torres Strait Islander), 20vPCV recommended as a single dose if **no previous dose** of PCV20
- Single dose of Prevenar 20 at diagnosis of specified medical risk condition





Pneumococcal changes – Capvaxive for adults ≥ 18 years



Adults ≥ 18 years with specified medical risk factors that predispose them to IPD

- single dose of Capvaxive at diagnosis and one per lifetime (no booster schedule currently)
- must have one year interval between any previous legacy pneumococcal vaccine (Prevenar 13 and/or Pneumovax 23)

All First Nations adults 25 years and older are eligible for a single dose of Capvaxive

- must have one year interval between any previous legacy pneumococcal vaccine (Prevenar 13 and/or Pneumovax 23)



Capvaxive - adults

- All older people aged 65 and over are eligible for one single dose of Capvaxive.
- One year interval must be observed since any legacy pneumococcal vaccine administration.
- Adults aged 18 years and over diagnosed with a specified medical condition associated with increased risk of invasive pneumococcal disease are eligible for **one funded dose at diagnosis**.



NIP schedule changes continued

From 1 September 2025, **children** under 5 years, who have:

- not yet started their pneumococcal schedule will receive Prevenar 20
- previously received 1 or 2 doses of Prevenar 13 should receive Prevenar 20 for all subsequent doses to complete the recommended vaccination course (where required).
- already completed a Prevenar 13 vaccination course, and are specified medical at risk or First Nations, should receive 1 dose of Prevenar 20 **at 4 years of age.**

Individuals that begin their Pneumococcal vaccination course with Prevenar 20 will no longer require 'boosting' with any other pneumococcal vaccine.

Pneumovax 23 is no longer recommended or funded on the NIP – please dispose of any Prevenar 13 or Pneumovax 23 vaccines.



For full details please refer to The Australian Immunisation Handbook.

20vPCV - Prevenar 20

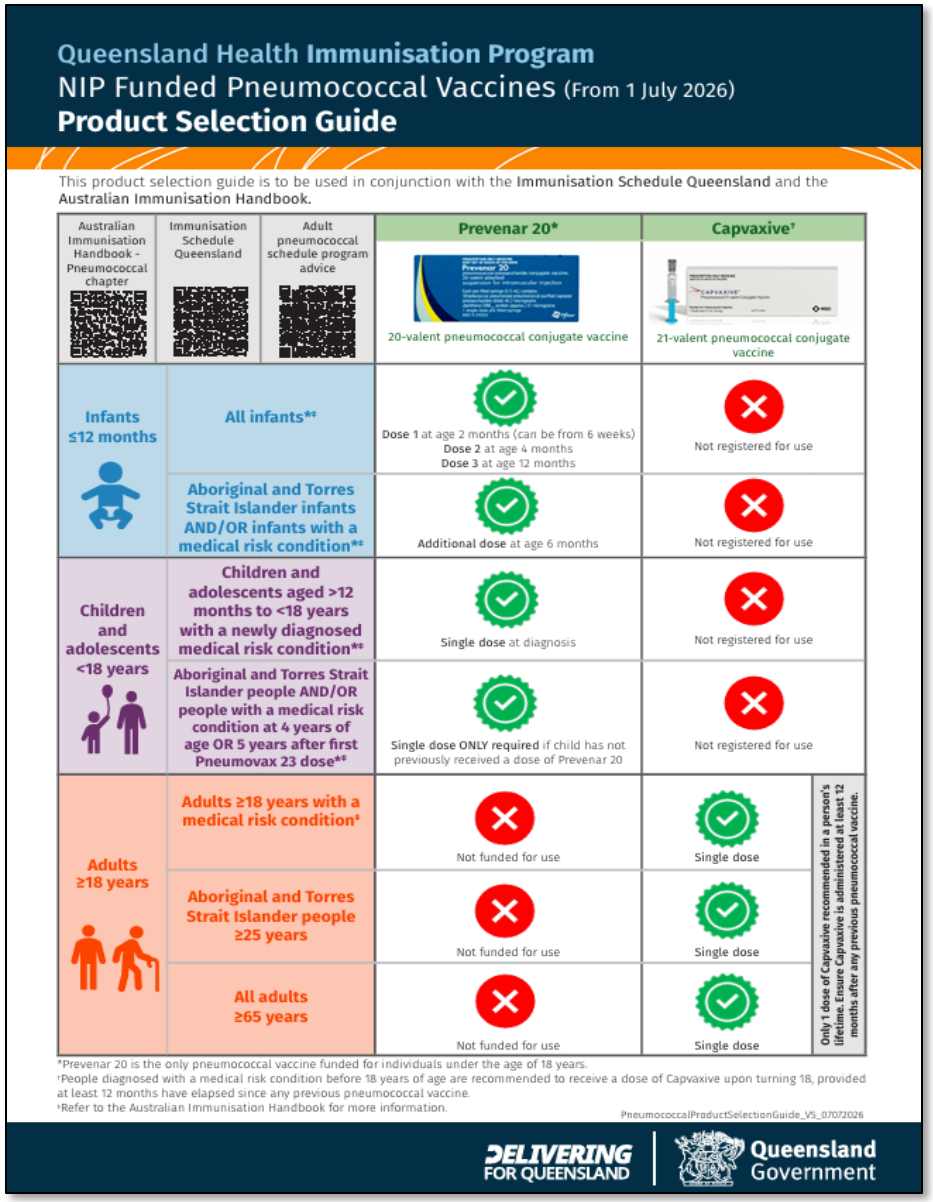
- Administration route: Intramuscular injection
- Registered for use in people aged ≥6 weeks.
- 20vPCV - 20-valent pneumococcal conjugate vaccine.
- aluminium phosphate adjuvant



Reference: Australian Immunisation Handbook

Pneumococcal

- Simplified NIP program moving forward, but can be complex especially for catchup
- QHIP Pneumococcal Product Selection Guide
- For full details refer to The Australian Immunisation Handbook



Queensland Health Immunisation Program
NIP Funded Pneumococcal Vaccines (From 1 July 2026)
Product Selection Guide

This product selection guide is to be used in conjunction with the **Immunisation Schedule Queensland** and the **Australian Immunisation Handbook.**

Australian Immunisation Handbook – Pneumococcal chapter	Immunisation Schedule Queensland	Adult pneumococcal schedule program advice		Prevenar 20*	Capvaxive†	
				20-valent pneumococcal conjugate vaccine	21-valent pneumococcal conjugate vaccine	
	Infants ≤12 months		All infants*‡	Dose 1 at age 2 months (can be from 6 weeks) Dose 2 at age 4 months Dose 3 at age 12 months	Not registered for use	
			Aboriginal and Torres Strait Islander infants AND/OR infants with a medical risk condition*‡	Additional dose at age 6 months	Not registered for use	
	Children and adolescents <18 years		Children and adolescents aged >12 months to <18 years with a newly diagnosed medical risk condition*‡	Single dose at diagnosis	Not registered for use	
			Aboriginal and Torres Strait Islander people AND/OR people with a medical risk condition at 4 years of age OR 5 years after first Pneumovax 23 dose*‡	Single dose ONLY required if child has not previously received a dose of Prevenar 20	Not registered for use	
	Adults ≥18 years		Adults ≥18 years with a medical risk condition§	Not funded for use	Single dose	Only 1 dose of Capvaxive recommended in a person's lifetime. Ensure Capvaxive is administered at least 12 months after any previous pneumococcal vaccine.
			Aboriginal and Torres Strait Islander people ≥25 years	Not funded for use	Single dose	
			All adults ≥65 years	Not funded for use	Single dose	

*Prevenar 20 is the only pneumococcal vaccine funded for individuals under the age of 18 years.
†People diagnosed with a medical risk condition before 18 years of age are recommended to receive a dose of Capvaxive upon turning 18, provided at least 12 months have elapsed since any previous pneumococcal vaccine.
‡Refer to the Australian Immunisation Handbook for more information.

PneumococcalProductSelectionGuide_VS_07072026

DELIVERING FOR QUEENSLAND | Queensland Government

Co-administration with other vaccines

- Infants can and should receive Prevenar 20 at the same time as other vaccines or immunisation products, including influenza vaccine and RSV monoclonal antibodies i.e. nirsevimab , Bexsero (do not delay) and Infanrix Hexa/Vaxelis.

- Adults can receive pneumococcal vaccines with the herpes zoster vaccine, seasonal influenza vaccines, RSV vaccines and COVID-19 vaccines at the same time if required.

Bexsero can be safely given with other routine vaccines.

Children <2 years of age are recommended to receive prophylactic paracetamol if they are receiving Bexsero at the same time as other routinely scheduled vaccines. However, this is not a contraindication to co-administration of Bexsero with other vaccines.

Table. Risk conditions for pneumococcal vaccination and eligibility for NIP funding | The Australian Immunisation Handbook

Table. Risk conditions for pneumococcal vaccination and eligibility for NIP funding

Children, adolescents and adults with the risk conditions listed below are at increased risk of pneumococcal disease and are recommended by ATAGI to receive additional doses of pneumococcal vaccine.

Some of these additional doses are funded under the National Immunisation Program (NIP), as indicated in the table below. The specific type of pneumococcal vaccine recommended varies by age.

See:

- Recommendations for pneumococcal vaccination for people with risk conditions
- Vaccination for people who are immunocompromised for recommendations for immunocompromised people including specific revaccination recommendations
- Infographic: Pneumococcal vaccination for people who have previously received a pneumococcal vaccine

Risk category	Details or specific conditions	NIP funded
Previous episode of invasive pneumococcal disease	**Any previous episode of invasive pneumococcal disease**	**Yes**
Functional or anatomical asplenia	**Sickle cell disease or other haemoglobinopathies**	**Yes**
	Congenital or acquired asplenia (for example, splenectomy) or hyposplenia	
Immunocompromising conditions	**Inborn errors of immunity, including primary immunodeficiency, such as symptomatic IgG subclass or isolated IgA deficiency**	**Yes**
	Haematological malignancies	
	Solid organ transplant	
	Haematopoietic stem cell transplant	
	HIV infection	
	Immunosuppressive therapy, where sufficient immune reconstitution for vaccine response is expected; this includes those with underlying conditions requiring but not yet receiving immunosuppressive therapy	No
	Non-haematological malignancies receiving chemotherapy or radiotherapy (currently or anticipated)	No
Proven or presumptive cerebrospinal fluid (CSF) leak	**Cochlear implants**	**Yes**
	Intracranial shunts	
Chronic respiratory disease (individual conditions listed and those that are similar based on clinical judgement)	**Suppurative lung disease, bronchiectasis and cystic fibrosis**	**Yes**
	Chronic lung disease in preterm infants	
	Chronic obstructive pulmonary disease (COPD) including chronic bronchitis and emphysema	Yes
	Severe asthma (defined as requiring frequent medical consultations or the use of multiple medications)	No
	Interstitial and fibrotic lung disease	No
Chronic renal disease	**Relapsing or persistent nephrotic syndrome**	**Yes**
	Chronic renal impairment – eGFR < 30 mL/min (stage 4 or 5 disease)	**Yes**, if eGFR < 15 mL/min only (including patients on dialysis), otherwise no.
Infants born to mothers who received biological therapies during pregnancy	Infants exposed to anti-CD20 therapies (such as rituximab) in utero. See biological therapies	No
Cardiac disease (individual conditions listed and those that are similar based on clinical judgement)	**Congenital heart disease**	**Yes**, for children who are aged <5 years when they start their recommended schedule, otherwise no.
	Coronary artery disease	
	Congestive heart failure	
Prematurity	**Any person born less than 28 weeks gestation**	**Yes**, for children who are aged <5 years when they start their recommended schedule, otherwise no.
Chromosomal abnormality	**Trisomy 21 or another genetic condition that increases the risk of severe disease**	**Yes**, for children who are aged <5 years when they start their recommended schedule, otherwise no.
Chronic liver disease	Conditions with progressive deterioration of liver function for more than 6 months including cirrhosis and other advanced liver diseases	Yes
Chronic metabolic disorder	Type 1 or 2 diabetes	No
Smoking	Current smoker or in the immediate past	No
Harmful use of alcohol	Consuming on average ≥100 g of alcohol (10 Australian standard drinks) per week or ≥40 g of alcohol (4 Australian standard drinks) per day.	No

Page history

Last updated: 22 June 2026

Last reviewed: 22 June 2026

Pneumococcal scenarios

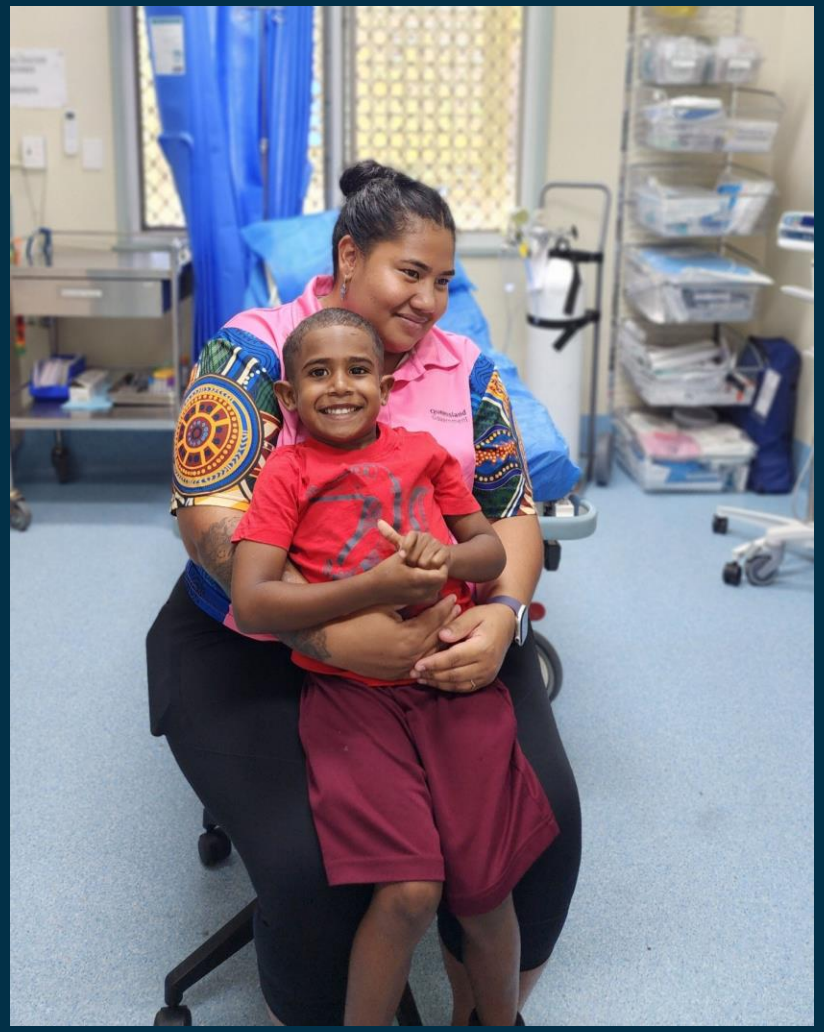
Aboriginal and Torres Strait Islander child presenting at 4 years of age.

- Has had four scheduled Prevenar 13 vaccines at 2,4,6 and 12 months.

What are they due: ??

- Aboriginal and Torres Strait Islander child presenting at 12 months, has received Prevenar 13 at 2,4,6 months of age

What are they due: ??



Answer

Aboriginal and Torres Strait Islander child presenting at 4 years of age.

- Has had four scheduled Prevenar 13 vaccines at 2,4,6 and 12 months.
- Due: one further dose of Prevenar 20 now along with other scheduled NIP and Qld schedule vaccines.

Answer

- Aboriginal and Torres Strait Islander child presenting at 2 1/2 years, has received Prevenar 13 at 2,4,6 months of age
- Due one dose of Prevenar 20 now and no further doses of pneumococcal vaccine will be due in the future (i.e. not due at 4, or 9 years)

Common scenarios

Aboriginal and Torres Strait Islander child presenting at 9 years. Has received 3 doses of Prevenar 13 at various times in infancy. Has received one dose of Pneumovax 23 at 4 years.

- Due one dose of Prevenar 20 now, no further doses Pneumococcal in childhood due

Child with no medical at-risk factors and not Indigenous, presents at 12 months for scheduled vaccines. Has received 2 doses of Prevenar 20 at 2 and 4 months.

- Due Prevenar 20 now at 12 months

Common scenarios

Child presenting at 18 months with only one dose of Prevenar 13 given at 2 months.

- Give one dose of Prevenar 20 now

Child presenting at 18 months with two doses of Prevenar 13 given at 2 and 12 months

- No further doses due

Catch up scenarios

Unvaccinated 4-year-old

What are they due today:

1. Hexavalent DTPa IPV, hep B, IPV (Vaxelis or Infanrix Hexa)*
2. MMRV (can have as first dose as child is 4 years)
3. Pneumococcal – one dose of Prevenar 20 (no further doses)
4. Meningococcal ACWY – Nimenrix
5. Influenza

COVID-19 vaccine

- COVID-19 vaccine moving to the NIP | Australian Government Department of Health, Disability and Ageing
- From 1 October 2026, COVID-19 vaccines will be provided via the National Immunisation Program (NIP). This will replace the stand-alone National COVID-19 Vaccine Program (NCVP).
- The NCVP was established under emergency arrangements to support broad access to COVID-19 vaccines during the pandemic response when most people had little or no immunity against the disease.
- COVID-19 is now endemic in Australia and continues to disproportionately affect certain populations.

COVID-19

- Vaccination remains an important measure to protect those at risk of severe disease from COVID-19.
- COVID-19 affects people of all ages, but older adults, older Aboriginal and Torres Strait Islander people, and people with severe immunocompromise or certain medical conditions have the highest risk of severe disease or death.
- The current COVID-19 vaccine available for use is Comirnaty LP.8.1.
- COVID-19 vaccines can be co-administered with any other vaccine for people aged ≥5 years.

- All 'recommended' doses of COVID-19 vaccine are funded under the NIP.
- All 'consider' doses of COVID-19 vaccine are not funded under the NIP. People who are not eligible for a funded COVID-19 vaccine may choose to purchase the vaccine privately based on a risk-benefit discussion with their healthcare provider.

Note: no paediatric doses recommended

- From 1 October 2026, COVID-19 vaccines will be funded through the NIP for the following groups:
  - all adults aged 75 years and over (two funded doses per year)
  - adults aged 65–74 years (one funded dose per year)
  - Aboriginal and Torres Strait Islander adults aged 50–74 years (one funded dose per year)
  - adults aged 18-64 years with severe immunocompromise (one funded dose per year)



Measles

MMR is recommended for infants 6 months and over travelling to areas where measles is endemic

Parents and carers presenting for 6-month infant vaccination should be screened to determine if there is any planned travel

Drop off in passive immunity from 4 months

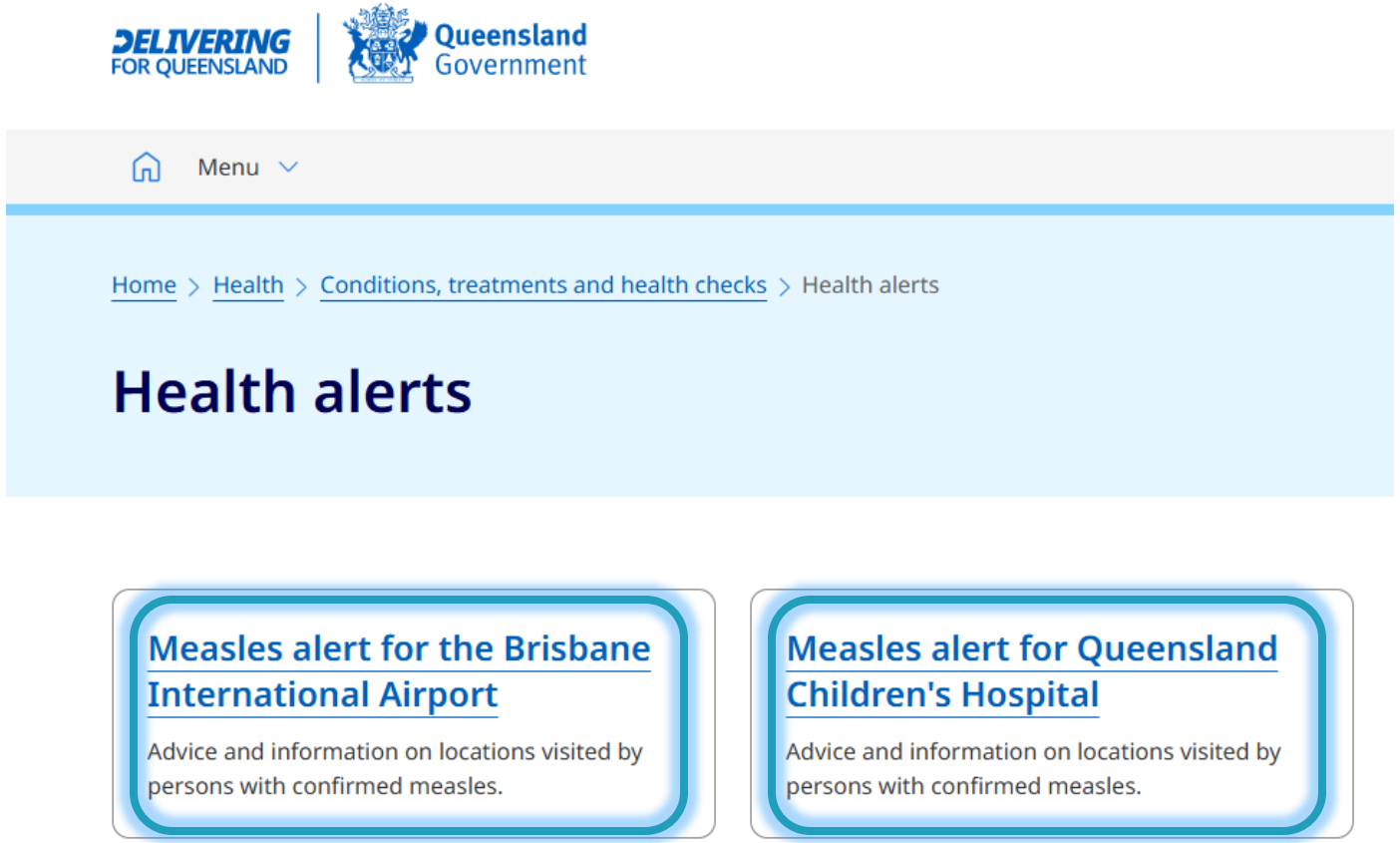
Dose requirements are dependant on what the child receives prior to 11 months old

Opportunity to provide MMR to parents/carers as well. Two doses are funded for all people born during or since 1966.



Let's keep measles out of Australia!

Measles | Communicable disease control guidance





Free Influenza Vaccine Program 2026

Key points from this year's program

FluMist
Funded for all children ages 2, 3, 4 and 5 years from March 2026

FluMist Expansion
Extended to children aged 6-17 years who struggle with needles on 19 May 2026

FluMist Expiry
The vaccine expired on 7 August 2026

NIP
ATAGI Statement

FluMist

The nasal spray has been given to:

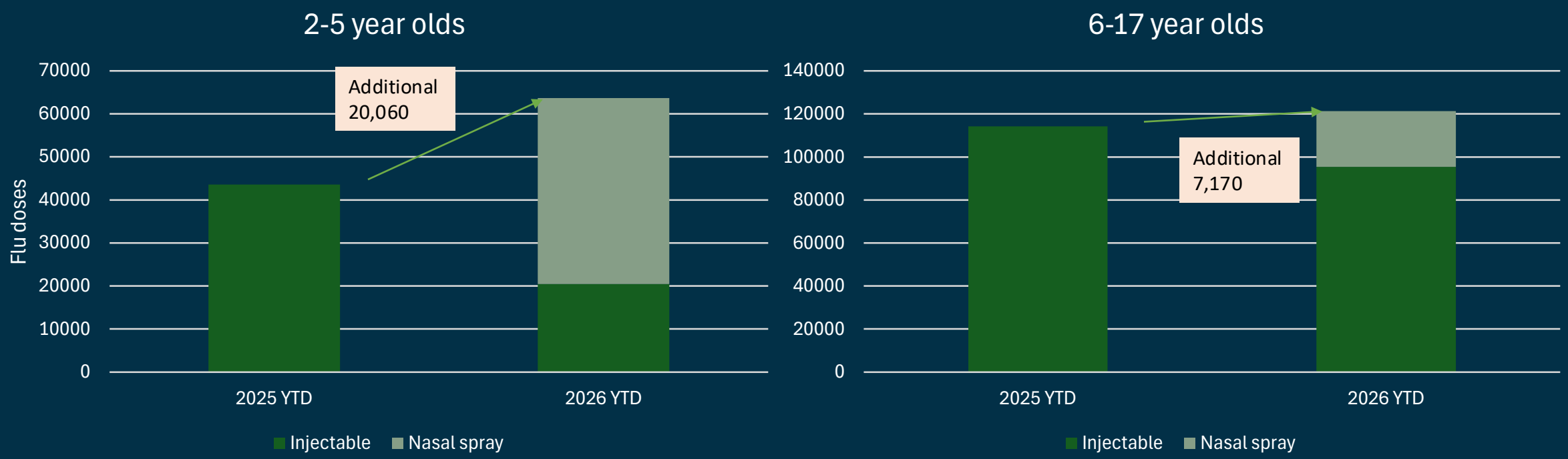
43,210 children aged 2 to 5 years

25,890 children aged 6 to 17 years

Flu vaccine coverage for children 2-5 years has increased by approximately 8 percentage points, from **16% in 2025 to 24%** in 2026 (YTD)

Source: PHIB influenza snapshot, unpublished

FluMist Queensland Uptake



Source: PHIB influenza snapshot, unpublished



Diphtheria

Diphtheria

What is diphtheria??

An ‘old’ disease – it was the leading cause of childhood death from severe respiratory illness before the widespread use of vaccines

Often referred to as the ‘children’s plague’ after severe outbreaks surged in the 1700s and it was considered a death sentence due to suffocation from a thick grey throat

Diphtheria was named from the Greek word meaning ‘leather hide’ which was what the throat resembled





Diphtheria timeline

The microbe was identified in 1883 - bacterium secreted a powerful toxin causing systemic organ and nerve damage

First bacterium toxin ever identified

Early management

In the 1880s, laryngeal intubation was introduced to help children survive suffocation

Serotherapy – an antitoxin was which drastically improved survival rates (modern day DAT)

Is it diphtheria?

Look out for symptoms including:



Swollen neck



A thick grey or white coating in throat



Sores or ulcers that take a long time to heal



Noisy breathing or hoarse voice

Torres and Cape Hospital and Health Service

Search diphtheria on QHEPS

Queensland Government

SC2600495 07/26

Diphtheria – early vaccines

- Toxoid development – 1914 and a safe diphtheria toxoid vaccine was developed in the early 1920s
- The DTP vaccine: diphtheria was combined with the tetanus and pertussis (whooping cough) vaccine in the 1940s

How is it spread??

- An infected person releases germs into the air when they cough or sneeze or skin contact (particularly close contact or overcrowded conditions) with infected sores

Why are we talking about diphtheria in 2026?



Australia is currently experiencing its largest recorded outbreak in decades

More than 530 have been reported across the country in 2026 – previously rare!

Affected regions include NT, WA, SA and Qld

Public health response: Federal and State authorities declared the situation a Communicable Disease of National Significance and are actively monitoring the situation with the States and Territories purchasing and distributing vaccine, DAT and human resources

Who is mainly affected

- Unfortunately, it is our Aboriginal and Torres Strait Islander population that is disproportionally affected
- Close living conditions and overcrowding
- Food and housing security can contribute to susceptibility
- Compromised skin from previous infections
- Bubba Jabs so important to give on time and access to child health

Symptoms

Respiratory diphtheria

- Respiratory diphtheria affects the throat/airways.
- Symptoms can include:
  - sore throat
  - runny nose
  - fever
  - swollen glands in the neck (and sometimes, major swelling on both sides of the neck, called 'bull neck')
  - trouble swallowing and noisy breathing
  - a hoarse voice that gets worse over time
  - a white or grey film can form over the throat and tonsil which can make it hard to breathe.

Cutaneous diphtheria

- Cutaneous diphtheria affects the skin.
- Symptoms can include:
- skin sores that do not heal
- ulcers on exposed areas of the body, especially the legs.



Prevention



- Vaccination is the best protection against diphtheria
- Diphtheria vaccines are funded under the National Immunisation Program for:
- babies and children at the age of 2, 4, 6 and 18 months of age and 4 years of age
- young people aged 11-13 years through the School Immunisation Program
- people under 20 years of age who have not had all their recommended childhood vaccines
- every pregnancy (a single dose of diphtheria, tetanus and pertussis vaccine).

Qld's response to the outbreak

- Diphtheria outbreak update | Australian Centre for Disease Control
- Diphtheria – CDNA National Guidelines for Public Health Units | Australian Centre for Disease Control
- ATAGI Advice regarding diphtheria vaccination in outbreak settings 2026 | Australian Government Department of Health, Disability and Ageing
- Surveillance
- Identification of priority populations
- Provision of state funded vaccines – dTpa to also include pertussis



Who is eligible for vaccine

State funded for all Aboriginal and Torres Strait Islander people 20 years and over –

- One booster dose for those that have previously completed childhood and adolescent schedule
- 3 funded doses for people for a full course, or partial for those that have not completed a course

Table 1. Vaccination based on exposure risk in outbreak settings

Contacts	Completed childhood and adolescent vaccination course	Unvaccinated or Incomplete vaccination or Vaccination status unknown
Low risk	Booster dose if more than 5 years have passed since their last diphtheria-toxoid vaccine.	Commence a primary or catch-up vaccination schedule. *See serological testing below.*
Medium Risk	Booster dose if more than 12 months have passed since their last diphtheria-toxoid vaccine.	
High Risk		

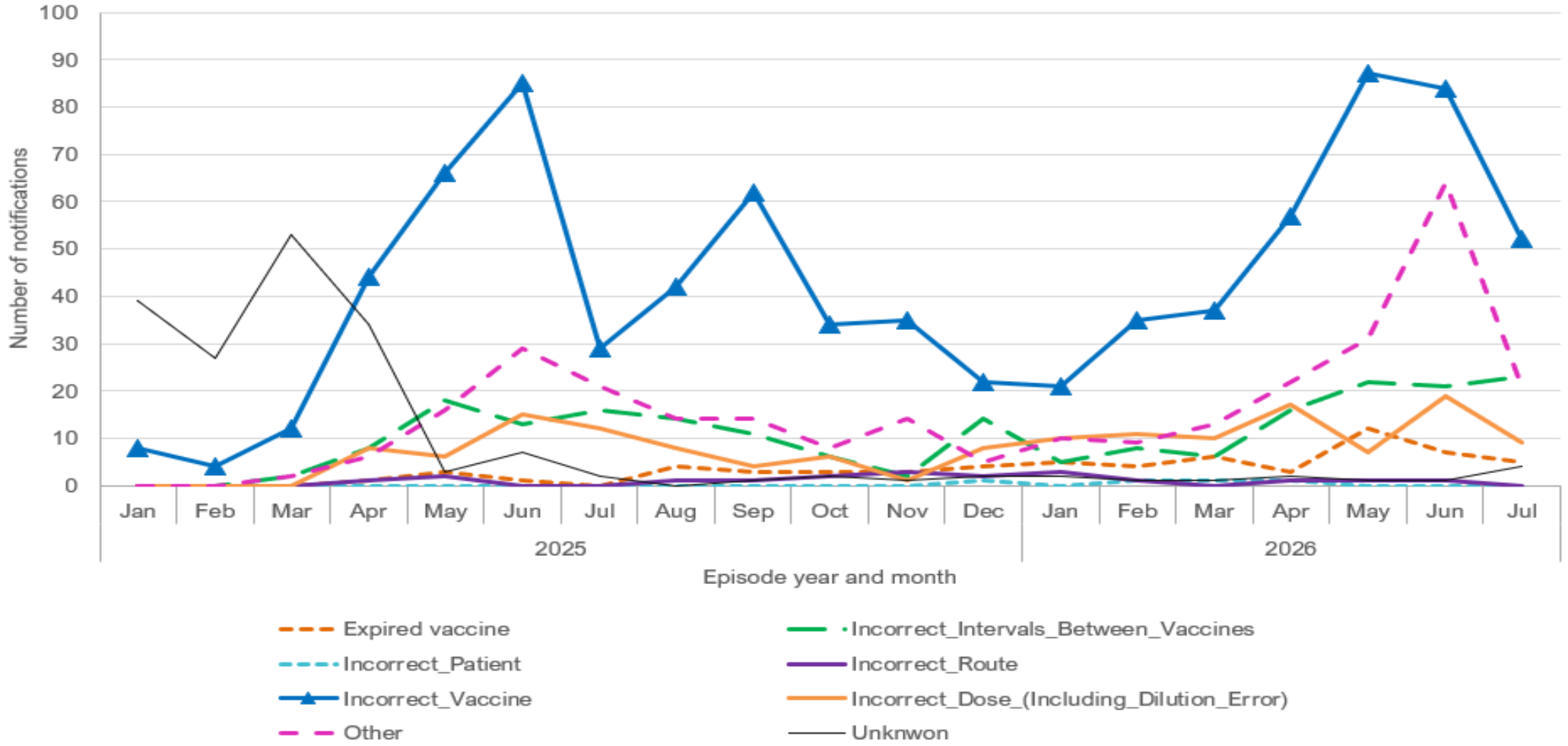
Further details on recommended primary course vaccination are available in the Diphtheria chapter of the Australia Immunisation Handbook.



AEFI and VAE

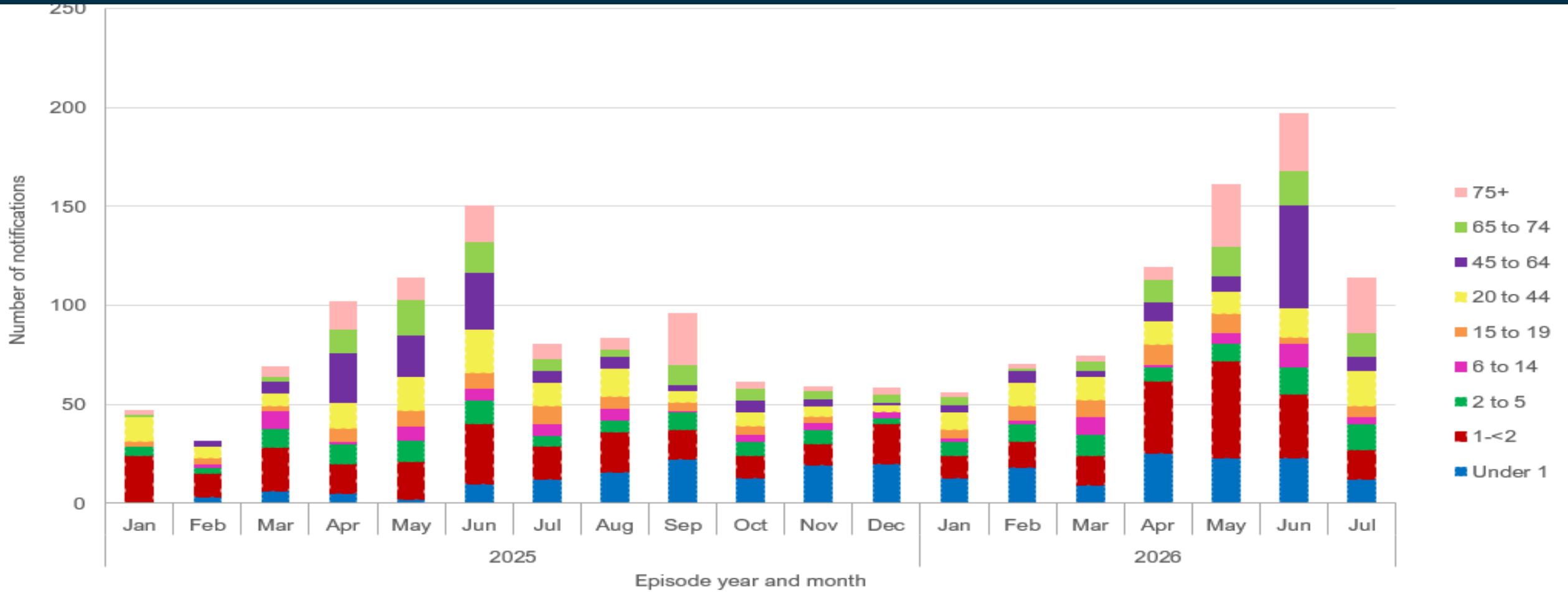
- Public health Act 2005 – mandatory to report AEFIs
- Qld Health requirement to report VAEs
- TGA and national interest in VAEs
- Non punitive approach to manage – important for recall and revaccination, ensuring that efficacious vaccines are administered
- Examples of common VAEs next slide

Queensland Health received more than 1,700 Vaccine Administration Error (VAE) notifications between 1 January 2025 and 31 July 2026. Administration of the incorrect vaccine accounted for 47% of all reported VAEs.



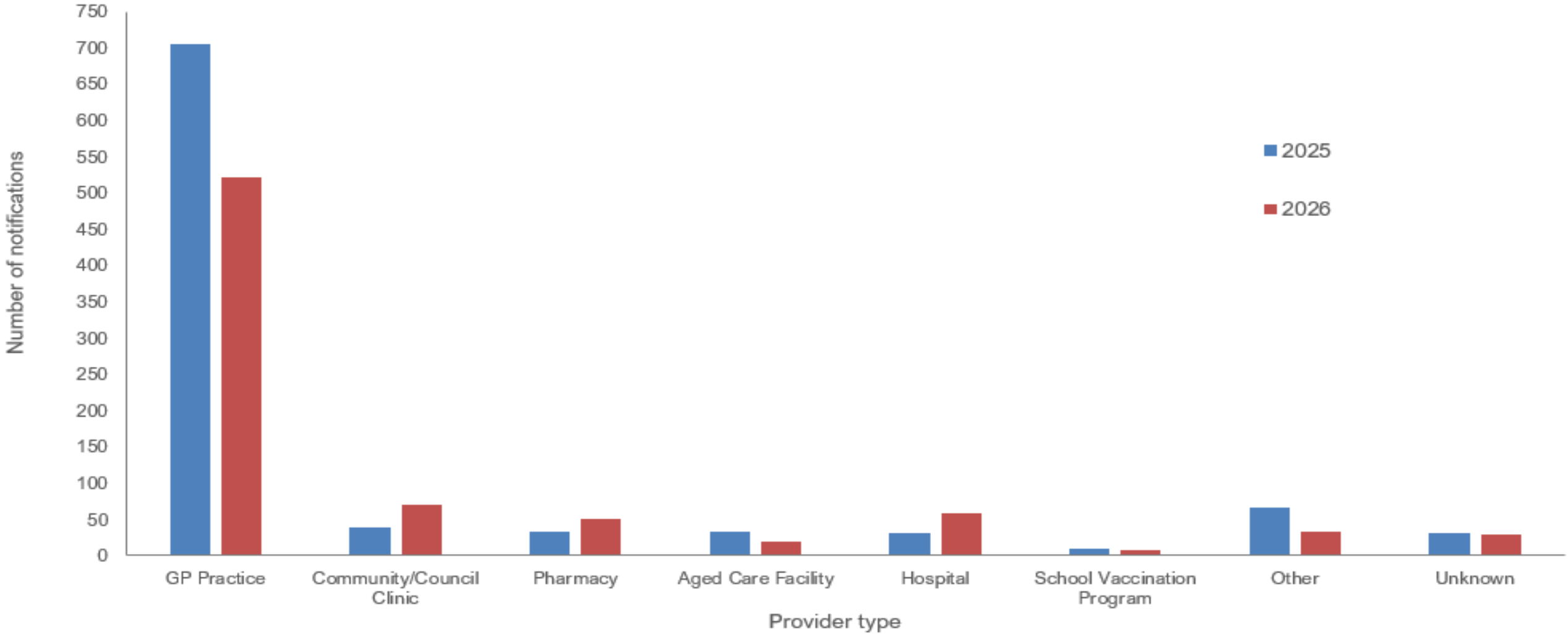
Data source: Queensland Notifiable Conditions System (NOCS). Prepared by: Communicable Disease Epidemiology (CDE), Public Health Intelligence Branch..

Almost half (47%) of all VAEs occurred in children aged under 6 years.



Data source: Queensland Notifiable Conditions System (NOCS). Prepared by: Communicable Disease Epidemiology (CDE), Public Health Intelligence Branch..

GP clinic settings accounted for 70% of all VAEs.



Data source: Queensland Notifiable Conditions System (NOCS). Prepared by: Communicable Disease Epidemiology (CDE), Public Health Intelligence Branch..

Queensland Meningococcal B Program

- Largest state-funded immunisation program ever implemented in Queensland – ongoing
- Catch up to 2 years (eligible for second dose if first dose given within eligibility period)
- Prophylactic paracetamol <2 years
- Adolescent program through SIP and 15-19 years of age



Adolescents previously vaccinated against meningococcal B are still recommended to receive a two-dose course in adolescence.



Healthy adolescents aged 15–19 years are recommended to receive 2 doses of MenB vaccine | The Australian Immunisation Handbook

Meningococcal B

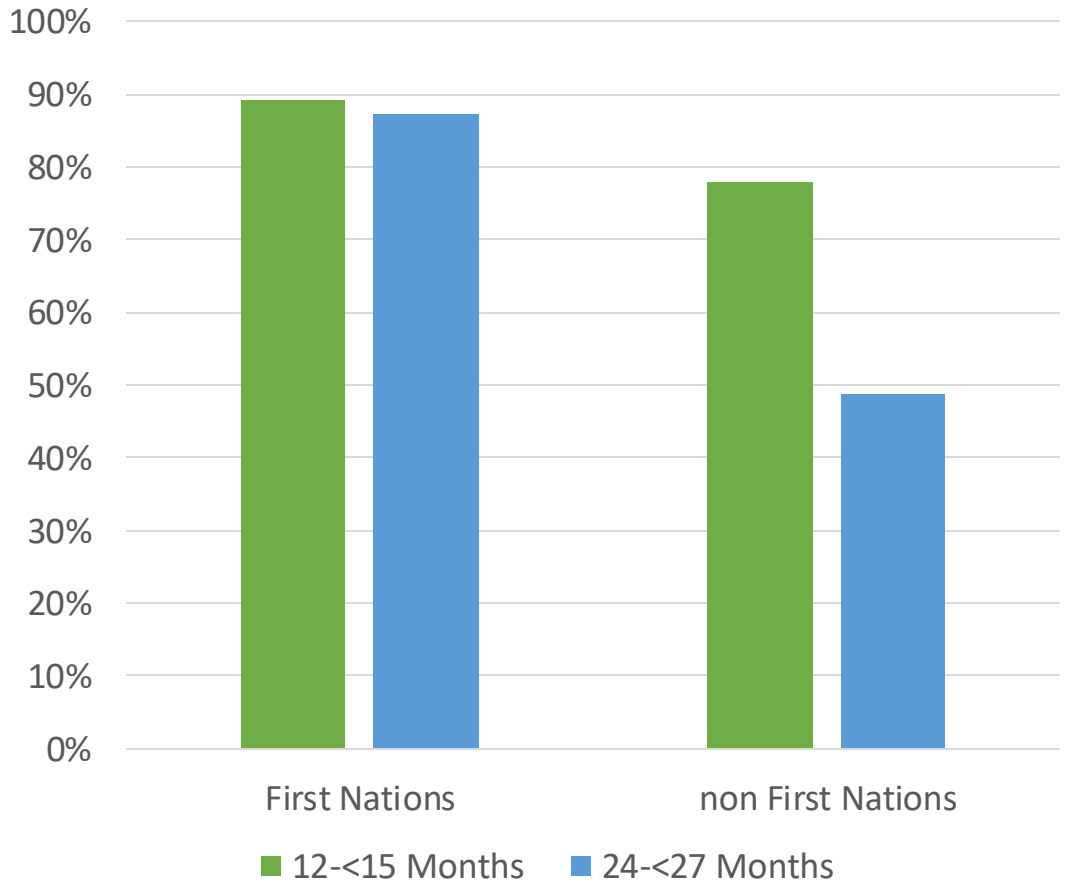
Doses administered over time

Doses	2024	2025	2026 (YTD)	Total
Under 2 years	160,526	151,478	100,929	**412,933**
15-19 years	93,178	97,596	75,677	**266,451**

Uptake – School Immunisation Program (2025)

Dose 1 – 58.8%
Dose 2 – 50.7%

Coverage - childhood



Respiratory Syncytial Virus

RSV is the most significant pathogen in early childhood; common cause of bronchiolitis and pneumonia in infants <6 months.

- Abrysvo® is recommended and funded for pregnant women between 28 to 36 weeks gestation
- Nirsevimab (Beyfortus®) is recommended and free for babies up to less than 8 months of age if Abrysvo was not given 14 days prior to birthing, and all infants with complex medical conditions with associated increased risk of RSV- despite maternal Abrysvo up to less than 24 months of age
- Nirsevimab is free for infants (up to 8 months and those with complex medical conditions up to 24 months)

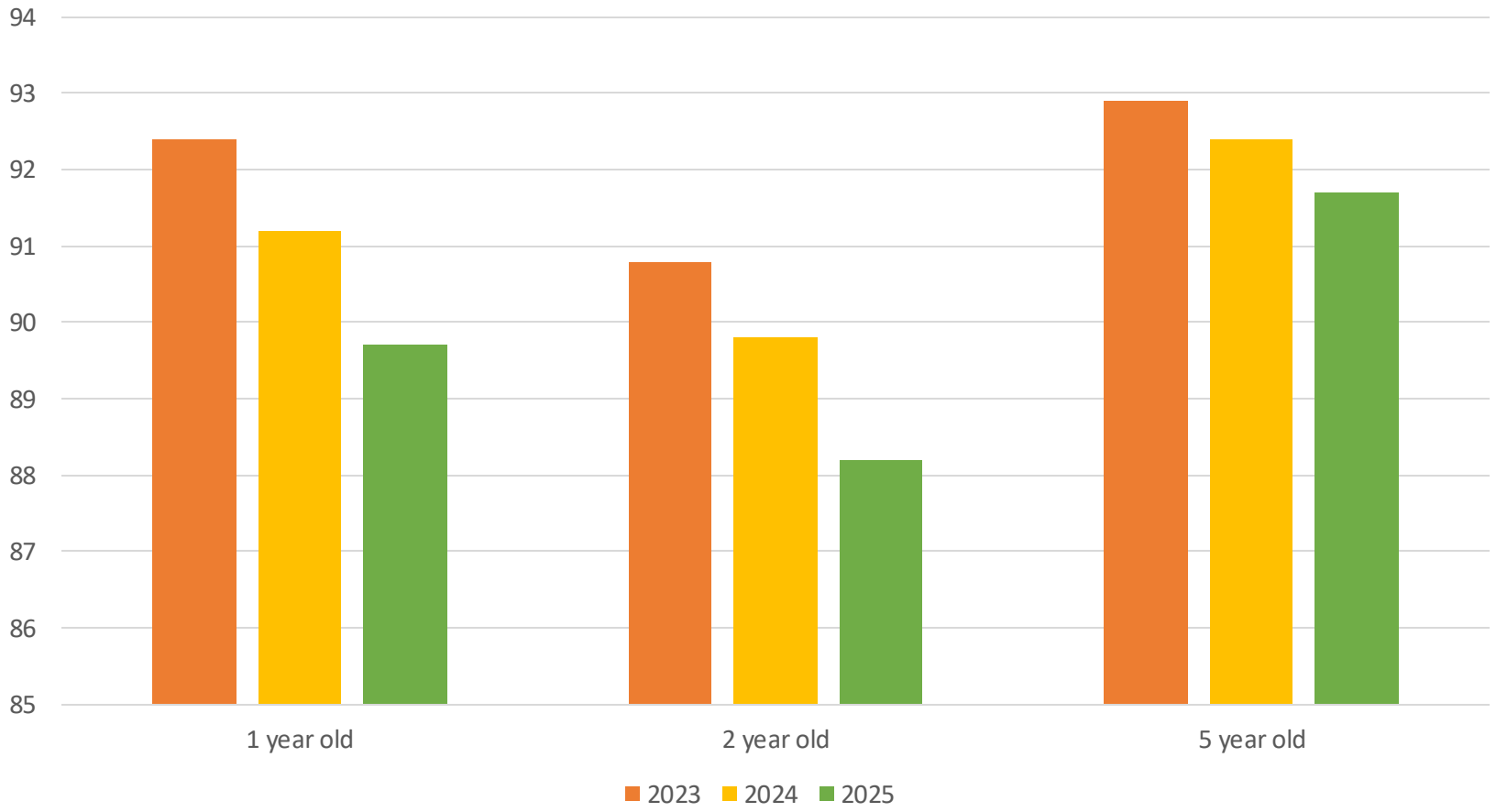
RSV paediatric vaccinations has been successful in reducing childhood hospitalisations by 75% in Queensland. The program will continue in 2026.

Queensland Paediatric Respiratory Syncytial Virus Prevention Program | Queensland Health



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Queensland Childhood Immunisation Coverage



Source: PHIB Childhood Immunisation Dashboard, unpublished

Links

- Immunisation Schedule Queensland | Queensland Health

- Queensland Health Education Page for Immunisation Providers (Link to Modules, Multiple vaccine administration, Clinical guidelines, resources
- QHIP Newsletter- 3 monthly
- Education for immunisation service providers | Queensland Health
- Australian Immunisation Handbook (Pneumococcal Chapter)
- QHIP Modules (RSV, Meningococcal B, Influenza, 2025)

Contact details:

- Immunisation (Immunisation@health.qld.gov.au)

Thank you!

Please complete tonight's evaluation survey