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Decline in UK childhood vaccine uptake

Coordinate action to improve confidence and convenience

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In England, none of the childhood vaccine programmes attained the World Health Organization recommended 95% coverage target in 2023-24.¹ Coverage across all childhood vaccine programmes has been gradually declining since 2013-14,¹ but in view of its high infectivity, measles is a particular concern. Sustained high uptake (95%) of two doses of measles, mumps and rubella (MMR) vaccine is needed to prevent outbreaks; uptake of the first dose of MMR vaccine at age 2 years was 92.7% in 2013-14 and 88.9% in 2023-24.² This decline is resulting in nationwide outbreaks disproportionately affecting children in disadvantaged areas.^{3,4} There were 2911 confirmed measles cases in England in 2024, the highest number in over two decades, and a child died in July 2025.⁵

The drivers of declining uptake are complex. The covid-19 pandemic disrupted services and raised public concerns about vaccine safety.⁶ Public confidence in childhood vaccination is generally high in the UK; 84% of over 3000 parents of young children surveyed in 2025 trusted childhood vaccines.⁷ However, confidence levels have declined since 2015.⁸

Infrastructural problems predating the pandemic have affected delivery, suggesting that confidence may not be the primary issue. The 2012 Health and Social Care Act, introduced during government austerity policies, fragmented immunisation services and centralised programme commissioning and planning.⁹ Gaps in responsibility for vaccination training

emerged and took time to remedy.¹⁰ Responsibility for commissioning, providing, and overseeing vaccination programmes remains split across different bodies, including the NHS, the UK Health Security Agency, and local authorities.^{10 11} Short term funding arrangements limit the ability of primary care networks to sustain tailored outreach with underserved communities, creating a vicious cycle of recovery followed by attrition in vaccine coverage.¹²

Austerity caused public health spending cuts and worsening child health.¹³⁻¹⁵ Vaccination coverage is sensitive to deprivation: in Italy austerity measures correlated with a decline in MMR coverage in 2014, with substantial attrition in the areas most harmed by reduced public health investment.¹⁶ In England, “Sure Start” children’s centres were launched in 1998 to consolidate early years services with the aim of giving the most deprived children equitable opportunities to thrive.¹⁷ The centres’ broader commitment to health and family wellbeing provided a trusted environment to recommend and receive vaccines. Government spending cuts have resulted in over 30% of centres closing since 2009, often in the poorest areas,¹⁷ and curtailed their role in delivering immunisations.

In July 2025, the Department for Education announced plans to roll out “Best Start” family services across England to re-integrate support for the most deprived families.¹⁸ Health visitors are reported to be the most likely to discuss vaccines with parents,⁷ but their numbers have been reduced by over 40% since 2015 and their role in immunisation delivery diminished.¹⁹ The Best Start approach will enhance vaccine access through health visiting,¹⁸ indicating potential to improve what works for parents. Universalist policy approaches improve the prospects of all children and help reduce health inequalities across the social gradient,²⁰ which should always underpin immunisation delivery strategies to reach every child.

Reversing the decline

Multipronged solutions are required. The covid-19 pandemic showed the need for a robust approach to routine vaccination delivery that can be pivoted in an emergency to attain high and equitable coverage. The covid-19 vaccination programme offers lessons for achieving greater vaccine equity, showing how responsibility for health protection could be shared with underserved communities to foster a sense of public ownership over progress.²¹ Communications were co-developed with underserved communities and vaccines routinely offered across the health system—generating new delivery models for the seasonal influenza programme.²¹

However, there are strong indications that lessons for preparedness are not being applied in England. Integrated care boards, the NHS organisations that plan and commission health services for their local populations, are expected to reduce operational costs by 50%,²² which will affect strategies for vaccine coverage recovery and community engagement. Fragmentation will persist if funding is directed to Best Start pathways but scaled back in other arms of the immunisation system. Improving vaccine equity in these circumstances requires recommending or offering vaccines opportunistically, making every contact with health services count for children.²¹

Reporting adverse events through the Yellow Card system, is critical for monitoring vaccine safety. Patient reporting of vaccine adverse reactions has increased since 2005-07, probably because the routine schedule has expanded and public awareness of self-reporting procedures increased.²³ Healthcare professionals should always take patient concerns of adverse reactions seriously to help protect confidence in vaccine recommendations. Health professionals should have annual vaccine training, but provision remains sparse or difficult to attend. This should be prioritised to ensure anybody involved in vaccination is equipped and confident to have conversations with parents and patients.

Attaining high and equitable vaccine coverage requires sustained investment. Coverage recovery can be advanced by enabling parents to draw confidence about vaccine safety from consensus. Service fragmentation can be reduced by coordinating system-wide action that clearly allocates responsibility and funding entitlements. Committing to family centred delivery strategies offers potential to reverse the decline in child health caused by austerity but will be most effective as part of a strategy to ensure vaccines are within arm's reach of every child throughout their life course.

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