THE EVIDENCE COLLECTIVE
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In Response: Routine Childhood Vaccination Schedule Change

January 5, 2026

The information provided below is not a substitute for medical advice and this is meant for educational purposes only.

Executive Summary

On January 5, HHS released a memo stating that the CDC's recommendations on childhood vaccines will be updated to align more closely with those of other high-income countries.

In short, the major changes include:

- The CDC will now routinely recommend vaccines for 11 diseases instead of 17.
    - This includes a change to HPV, moving from 2 doses to 1.
- Several vaccines previously recommended for all children are now:
    - Routinely recommended only for high-risk groups. These are:
        - RSV (for children whose mom doesn't get a pregnancy vaccine)
        - Hepatitis A
        - Hepatitis B
        - Meningococcal
    - Left to "shared clinical decision-making" between parents and clinicians. These are:
        - Rotavirus
        - COVID-19
        - Influenza
        - Hepatitis A
        - Hepatitis B
        - Meningococcal

Importantly, the AAP's schedule remains unchanged and is available here.

Communication Pointers

The following talking points can be used for framing these actions:

- **Name the process failure clearly:** No disease-burden modeling, no impact assessment, and no meaningful opportunity for public or independent expert input was done before making drastic changes that affect every child in the U.S. and their families.
- **Highlight health outcomes, not number of vaccines:** The relevant metrics are illnesses, hospitalizations, deaths, and disabilities prevented—along with avoided financial burdens, missed work and school, caregiver strain, and downstream costs to families and communities.
- **Vaccine schedules cannot be treated as interchangeable lists:** Copying another country's schedule without its health and social infrastructure will not produce the same health outcomes.
- **Push back on the "U.S. outlier" framing:** Many "peer", high-income countries, including Canada, Australia, Ireland, New Zealand, France, Italy, and Spain, use similar routine childhood vaccination schedules.
- **Contextualize Denmark and similar countries carefully:** Denmark's narrower schedule works because of better disease screening, reliable and higher access to high-quality health care, paid parental leave, and centralized vaccine financing, procurement, and national coverage monitoring. They also have a smaller, more homogeneous population. Fewer socioeconomic and healthcare access differences. These are conditions the United States does not consistently meet at scale.
- **"Fewer vaccines against fewer diseases" is not a public-health metric:** providing access to more vaccines that offer protection is not a bad thing. The goal is not to minimize vaccines in the schedule, but to design a schedule optimized for a country's disease risks, health system, and population needs.
- **Emphasize that clinicians already tailor conversations to individual needs and help patients make decisions based on the benefits and risks, but that clear, population-level guidance still matters.** Applying SCDM or "individual-based decision making" to routine vaccines only muddies the waters, creates a false sense of scientific uncertainty, and shifts unnecessary burden onto clinicians and families.
    - Shared Clinical Decision Making / Individual-Based Decision Making. Clinicians discuss the benefits and risks of vaccines with all patients. The ACIP's shared clinical decision-making (SCDM) designation simply identifies a small number of situations in which the evidence is limited, individual benefit varies significantly, or more than one reasonable clinical option exists. It was never intended for routine childhood vaccines backed by decades of consistent data.
- **Explain potential impacts clearly, while asserting what providers, payers, and public health *can* do despite these changes:**
    - Despite changes in the schedule, pediatricians **can still offer** - and parents **can still request** - vaccines according to the evidence-based U.S. schedule.
    - Per a statement from AHIP in September 2025, vaccines should still be covered by private insurers until the end of 2026.

Background

What are the possible implications of this decision?

Vaccination rates will continue to decrease, and children will get hurt.

These changes will fuel confusion and doubt among parents about vaccines that remain safe and effective. They will also create chaos for clinicians and hospitals—disrupting reimbursement, requiring major changes to clinical documentation, and adding significant time to patient counseling.

In the long term, it could affect insurance coverage, school immunization requirements, liability, and vaccine manufacturing.

This could also impact access to vaccines at pharmacies. Many pharmacists vaccinate children under standing orders/protocols that explicitly rely on CDC/ACIP recommendations; when federal guidance is narrowed or shifted away from "routine," those protocols may no longer authorize pharmacies to administer these vaccines as part of normal care. Continuing to vaccinate under the prior ACIP-based standards would require state-specific policy changes (or patient-specific prescriptions/medical orders), creating delays, confusion, and fewer vaccination opportunities. Especially for families who depend on pharmacies for convenient, walk-in, after-hours immunizations.

Can this be done without an ACIP vote?

Yes, but this is a legal gray area. The vaccination schedule can be changed by a directive from the HHS Secretary without going to the ACIP for a vote. Precedent for this approach was set in May 2025 with changes to the pediatric and pregnancy COVID-19 vaccine schedule. That directive resulted in an immediate update to the CDC vaccine schedule.

The legality of this action is currently under litigation by the American Academy of Pediatrics (AAP). However, no injunction was issued to block implementation, meaning the revised schedule has remained in effect while the case proceeds through the courts.

What were the differences among the countries' pediatric vaccination schedules, such as Denmark's?

Before this change, the U.S. recommended 17 vaccines, compared to other countries such as Denmark (10), Germany (14), and Japan (15).

The table below shows the current and previous U.S. schedules for vaccines recommended to all children, compared with Denmark, which is often referenced in these comparisons.

	Vaccine Schedules			Key Context	Disease Burden in U.S.	
Vaccine / Disease	**U.S. (Previous)**	**U.S. (New)**	**Denmark**		**Pre-vaccine**	**Post-Vaccination**
Hepatitis B	**Yes*** (universal, birth dose ≤24 hrs + series)	**No.** High risk & SCDM	**No** (targeted to infants of HBV-positive mothers)	U.S. uses universal birth dose as a safety net for missed screening/ follow-up		
Rotavirus	**Yes** (routine infant series)	**No.** SCDM	**No**	Prevents infant hospitalizations	Hospitalizations: 55,000-70,000 per year	Rare; national totals not

					Deaths: 20-60 per year	routinely published
DTaP and Tdap	**Yes**	**Yes**	**Yes**	Core vaccine in both countries		
Polio (IPV)	**Yes**	**Yes**	**Yes**	Core vaccine in both countries		
Hib	**Yes**	**Yes**	**Yes**	Core vaccine in both countries		
Pneumococcal (PCV)	**Yes**	**Yes**	**Yes**	Core vaccine in both countries		
MMR (Measles, Mumps, Rubella)	**Yes**	**Yes**	**Yes**	Timing differs slightly (MMR1 @ 15 months Denmark)		
Varicella (Chickenpox)	**Yes**	**Yes**	**No**	Denmark accepts a higher varicella disease burden	Hospitalizations 10,500–13,500/ year Deaths: 100-150/year	
Hepatitis A	**Yes**	**No.** High risk & SCDM	**No**	Reflects lower endemic risk in Denmark	Hospitalizations: 3000-7000 per year; Deaths: 96 per year (average 1990-2004)	118 deaths (2022)
Influenza	**Yes** (annual for all ≥6 months)	**No.** SCDM	**No** (risk-based; programs vary by year)	Annual flu alone inflates U.S. dose counts **dramatically**		
Meningo-coccal (MenACWY)	**Yes** (routine adolescents)	**No.** High risk & SCDM	**No**	U.S. targets school/dorm outbreak risk		
HPV	**Yes**	**Yes**, but 1 dose instead of 2	**Yes**	Similar timing		
COVID-19	**Yes** (included in routine framework)	**No.** SCDM	**No** (offered, not routine)	Recent, evolving policy difference		
RSV (monoclonal)	**Yes,** if the mother was not vaccinated in pregnancy or baby is high risk	**No.** High risk, which is defined as the mother not being vaccinated during pregnancy**.**	**Yes,** for only high-risk infants**		50,000-80,000 hospitalizations annually in children under 5	80% effective at preventing ICU admission and 83% effective at preventing acute

						respiratory failure

SCDM = shared clinical decision-making. This means the vaccine is still available via discussion between patient and clinicians.

*Until December 16, 2025, caregivers of babies born to mothers who test negative for HBV are recommended to engage in individual decision-making regarding the birth dose

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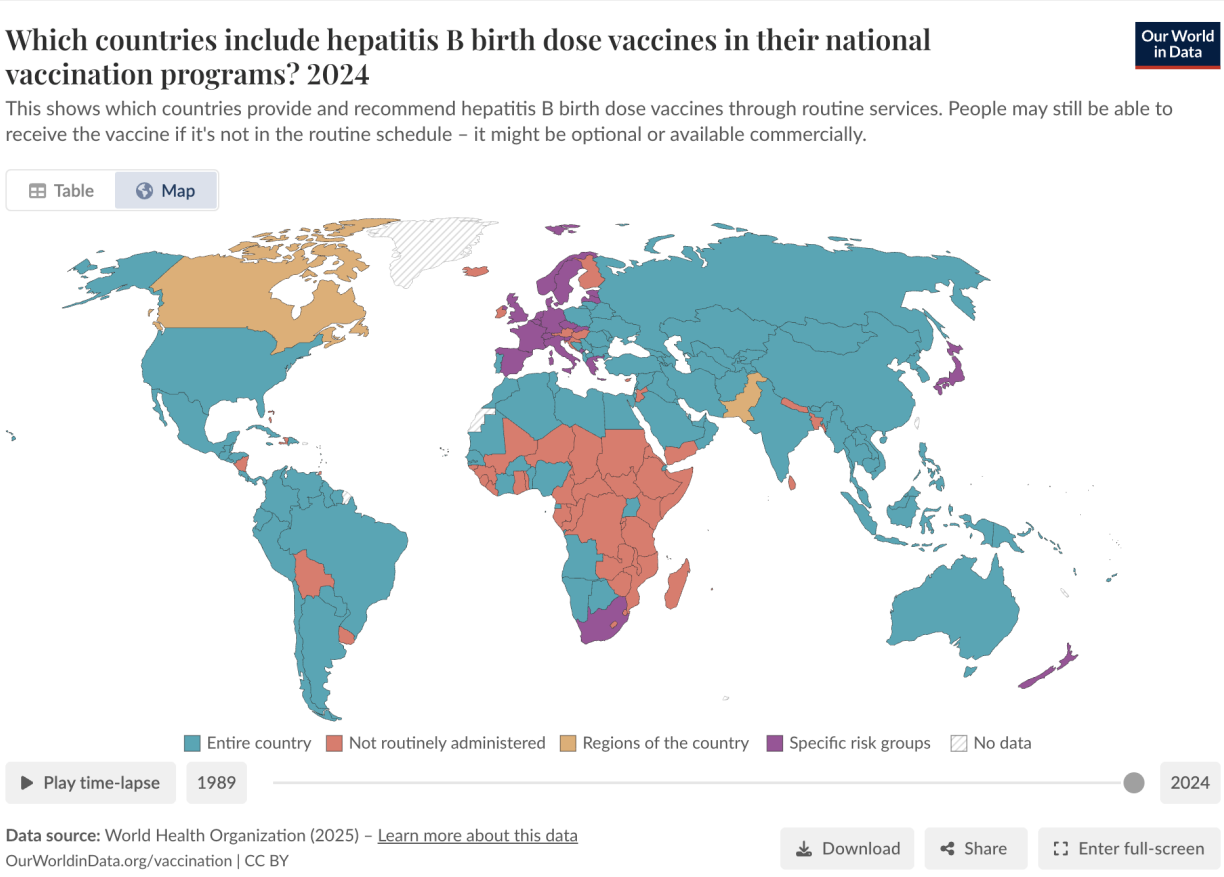
Top 6 Misconceptions

Misconception 1: "The U.S. is a high outlier — we vaccinate against way more diseases than other developed countries."

Reality: Denmark is the outlier, not the U.S. Canada, Australia, Ireland, New Zealand, France, Italy, and Spain all have childhood schedules that look far more like ours than Denmark's. The memo cherry-picked the country with the narrowest schedule to make the U.S. look "bloated." For example, the majority of countries in the world, including higher-income countries, do include birth doses of hepatitis B in their national vaccination programs:



The ones that do not tend to be lower-income countries that struggle to access vaccines due to financial constraints.

Misconception 2: "Other countries' leaner schedules prove we don't need all these vaccines."

Reality: Those schedules work for those countries because of what's underneath them — universal healthcare, 46 weeks of paid parental leave, near-universal prenatal screening, and centralized medical records from birth to death. The U.S. has none of that. Our broader recommendations exist precisely because our system has gaps. They're safety nets, not excess.

Misconception 3: "The Hep B birth dose is unnecessary — Denmark only gives it to high-risk babies."

Reality: Denmark screens nearly 100% of pregnant women for Hep B and follows up reliably to help prevent transmission. In the U.S., 12–18% of pregnant women aren't tested, and only 35% of those who test positive complete follow-up care. Before universal birth-dose recommendations, tens of thousands of U.S. babies were infected annually by family members who didn't know they carried the virus. Ninety percent of infected infants develop chronic infection, leading to liver failure, cancer, and early death.

Misconception 4: "In the U.S., children get 96 doses of vaccines by the time they are 18 years old."

People hesitant about childhood vaccines often claim children receive 72 or 96 doses—but these numbers are misleading.

By the time a child turns 18, they're recommended to receive vaccines that protect against 17 potentially serious diseases. Because some of these vaccines require more than one dose, the total over time adds up to:

- 28 doses by two years old (which includes yearly flu shots)
- 35 doses by five years old (which includes yearly flu shots)
- 54 doses by age 18, with a third coming from yearly flu vaccines.

Some counts—like the commonly cited 72—include every yearly flu and Covid-19 shot administered through age 18, and sometimes count combination vaccines (such as MMR, which protects against three diseases) separately (as 3 different vaccines). Others may even include vaccines given to pregnant mothers, which are intended to protect newborns in the first weeks of life.

The exact number of doses a child receives can vary depending on timing, catch-up schedules, health conditions, and the availability of vaccine formulations.

In practice, kids today can and often do get fewer doses because we have combination vaccines that bundle several vaccines together. For example, there is a single vaccine that can protect against diphtheria, tetanus, pertussis, hepatitis B, *Haemophilus influenzae* type B (Hib), and polio in a single shot that's given at 2, 4, and 6 months, meaning that instead of 12 vaccines

(diphtheria, tetanus, and pertussis are a single vaccine—DTaP—regardless), you only need 3 to get the same amount of protection.

It helps to remember that little kids are exposed to a lot of illness: healthy kids can have up to 8 to 12 colds per year, especially if they attend daycare. Vaccines can't prevent every illness, but they do offer protection from some of the most serious ones—helping reduce the risk of complications, hospitalizations, and long-term effects.

Misconception 5: "More vaccines are more dangerous."

Children born before the 1990s received fewer vaccines than today's kids, but there were fewer vaccines available. Moreover, kids received far more antigens (substances that trigger the immune response). Over the years, we have improved our ability to develop vaccines in two ways:

1. ***Target immune protection far more efficiently.*** Over the years, scientists have become more adept at targeting viruses and bacteria—exposing children to fewer and fewer parts of those pathogens (the antigens) to stimulate the immune system.

Figure by Your Local Epidemiologist

2. ***Advances in medical research*** have also led to the development of new vaccines, further reducing the burden of childhood illnesses. For example, a safe and effective Haemophilus influenzae type b ("Hib") vaccine was developed in the late 1980s. It has dramatically reduced rates of childhood meningitis (brain infections), pneumonia, and epiglottitis (an infection of the epiglottis that prevents breathing). The same can be said for vaccines against varicella, pneumonia, rotavirus, and others capable of causing severe illness and deaths of children.

Misconception 6: "There are no studies on the safety of the entire vaccine schedule."

Hundreds of studies have examined individual vaccines and combinations. The Institute of Medicine (now the National Academy of Medicine) report found that while individual vaccines have been extensively studied, few studies have evaluated the entire childhood immunization schedule. Of 421 candidate articles, only four addressed schedule-level safety, and just two provided valuable evidence on health outcomes (most focused on parental concerns, communication, or uptake)—none compared fully vaccinated vs unvaccinated children in the long term. This is largely due to practical constraints in studies that would attempt to examine the entire vaccination schedule. Despite limited schedule-wide research, the committee found

no evidence of harm and concluded the recommended schedule is safe, while also calling for additional high-quality studies.

A study not included in the review from Germany afterwards compared the vaccine schedule and found that, after adjusting for confounders, unvaccinated individuals have a much higher rate of vaccine-preventable diseases.

We don't have randomized trials in which one arm receives a specific schedule and another a different schedule, or no vaccines, due to ethical considerations. This would require denying the standard of care for preventing vaccine-preventable diseases, which violates Article 33 of the Declaration of Helsinki, which outlines ethical guidelines for human trials.

It is important to note, though, that for every new vaccine trial, participants (kids) still get all the other vaccines included on the childhood schedule, and the new vaccine being tested is simply added on top of that. This means the trial is effectively evaluating the full existing schedule, including the new vaccine, and any potential interactions.

There are also studies known as concomitant use studies that specifically examine the effects of administering vaccines together. Regulators explicitly require these studies so that vaccines are tested the way they'll be used in real life, alongside other vaccines in the schedule.

Vaccine-specific Changes and Concerns

Hepatitis B: Moving this out of universal recommendation is deeply concerning. The birth dose protects infants from potential maternal-to-baby infections during labor and after, and serves as a safety measure when the maternal infection status is unknown. There have also been many cases where babies were infected by other family or household members, even when the mom was negative. Hep B causes liver cancer, cirrhosis, and several other conditions outside the liver. Babies go on to have a greater than 90% chance of developing a chronic infection if infected in the first year of life. Later on in infection, about 25% of those with chronic infection will develop cirrhosis, liver cancer, or liver failure. Hep B isn't a "low-risk" infection, and this vaccine has proven safe for newborns for over 30 years of vaccination.

Rotavirus: Before the vaccine, rotavirus caused more than 50,000 hospitalizations in young children each year in the US. It's one of the most common causes of severe dehydration in infants. There is also evidence that rotavirus may increase the risk of type 1 diabetes, and that rotavirus vaccines reduce this risk (though this finding is not universal).

Meningococcal: Meningococcal disease is rare in the US, but devastating when it happens. Even with treatment, 10-15% of cases are fatal (without it, it can be as high as 80%), and 20-60% experience permanent disability (including loss of limbs—sometimes loss of all 4). It can also cause massive meningitis epidemics, which tend to occur in settings where people live close together like dorm rooms. Recently, rates of antibiotic resistance to meningitis treatments have increased, making vaccination for prevention even more important. There's also some evidence of cross-protection against gonorrhea for meningococcal B vaccines (the UK has

recommended these for men who have sex with men and individuals with multiple recent sexual partners), which may argue in support of broader vaccination.

HPV (1 dose): Reducing the HPV vaccine to one dose will likely still have good protection against cervical cancer—especially against the main cancer-causing strains (HPV 16 and 18). But many different types of HPV can cause other diseases, including head and neck cancer, and genital warts. We don't yet know whether a single dose offers the same protection against these, and recent evidence suggests that as many as 1 in 4 people who get only one dose might not mount an antibody response against important HPV strains in the vaccine. It is likely based on the antibody response from the vaccines that protection even from one dose will be long-lived but the longest period of follow-up so far has only been 5 years. It is also critical to note that HPV vaccines protect from more than just cervical cancer, and in these cases, it is not known whether 1 dose is as good as 2. For example, HPV 6 is a cause of oropharyngeal cancers as well as a condition called recurrent respiratory papillomatosis, and in a recent study, 19.7% of vaccinees did not make a detectable antibody response against it from a single dose at 3 years. Moreover, antibody responses were lower for all strains with one dose compared with 2 in this study, which might be important. The female reproductive tract has unique properties that make HPV vaccines particularly effective in this environment. Other important mucosal surfaces, however, like the upper respiratory tract, lack these properties. Because of this, we do not know that it holds that preventing cancers at these sites is as readily accomplished as it is for preventing cancers of the female reproductive tract, and we do not have data on how well one dose versus two of the HPV vaccine compares for these outcomes.

Flu: Every year, hundreds of kids in the US die of the flu. The sad reality is that most of these deaths happen to kids who aren't vaccinated—in 2024, 89% of the 280 pediatric flu deaths were unvaccinated. We also know that vaccinating children helps to protect other vulnerable members of the community, like their grandparents. More countries have been switching to universal flu vaccination in recent years.

RSV: RSV is the number one reason infants are hospitalized—every year, 58,000-80,000 children under five are hospitalized, many without known risk factors. We recently had a breakthrough, though—after recommending RSV antibodies for all kids in eligible age groups, data showed that RSV hospitalizations substantially declined. But now, these new recommendations suggest that only high-risk kids should get RSV antibodies—even when we have no real way of knowing who is truly high-risk. Shifting away from a strategy that we know keeps babies out of hospitals is not sensible.

In summary, changing the recommendations for these vaccines is not just a minor change. These vaccines prevent hospitalizations, chronic illness, cancer, and death. Weakening childhood vaccine recommendations, when they show clear, life-saving benefits, undermines decades of public health progress and will result in more kids suffering from vaccine-preventable illnesses. It also risks reducing access in community pharmacies, where pediatric vaccination authority is often protocol-based and tied to ACIP. Meaning changes in federal guidance can trigger state-level barriers and delays.

The Evidence Collective

The Evidence Collective is a group of trusted health communicators who unite to deliver clear, evidence-based information directly on social platforms and other communities, meeting people where they are with empathy and speed. The collective includes 25+ subject matter specialists spanning infectious disease, chronic illness, nutrition, health policy, and more, with a combined reach of 150+ million monthly across trusted media and digital platforms and 10+ million combined social followers across their expert network. When health topics become complicated, this multidisciplinary team collaborates across disciplines and platforms to help the public understand the full picture, enabling them to spot falsehoods early and respond quickly to emerging health issues. Their vision is to empower the general public with timely, evidence-based information so they can lead healthy lives and thrive by translating science into plain language and addressing public concerns and confusion.

Contributors for this report include (in alphabetical order): Marisa Donnelly, PhD; David Higgins, MD, MPH; Katelyn Jetelina, MPH, PhD; Christina M. Madison, PharmD, FCCP, AAHIVP; Elisabeth Marnik, PhD; Edward Nirenberg; Jessica Steier, DrPH

Contact: info@evicollective.org