A risk to child health: confusion and concern over changes to US vaccine policy

The control of severe and life-threatening infectious diseases of childhood through vaccination is one of the greatest triumphs of public health, with some 154 million lives saved through global immunisation programmes since the 1970s.[1] In countries with strong immunisation programmes, diseases that once filled hospital wards and claimed countless lives of young children have largely disappeared. The US vaccine programme has been underpinned by consistent, evidence-based scientific recommendations from the Advisory Committee on Immunization Practices (ACIP) since 1964,[2] driving these improvements in child health. Routine childhood immunisations prevented an estimated 32 million hospitalisations and over 1 million deaths in the USA from 1994 to 2023.[3] As a result, the USA has been a global leader in vaccine policy, with one of the most comprehensive immunisation programmes in the world, serving as a model for science-based vaccine programmes.

But this approach to rigorous evidence-based scientific policy changed during 2025 under the oversight of Robert F Kennedy Jr, Secretary of the US Department of Health and Human Services (HHS). Since June, 2025, members of the ACIP have been replaced by a new panel whose credentials in vaccine science, public health, or immunology have been questioned.[4,5] Some of the new ACIP appointees have expressed anti-vaccination views.[4–6] Furthermore, there have been substantial changes to US vaccination recommendations and confusion about the direction of immunisation policy. Health organisations in the country, such as the American Academy of Pediatrics and others,[7] have raised concerns about the ability of the ACIP to uphold scientific evidence-based vaccine recommendations.

At its meetings in June, September, and December, 2025,[8] discussions at the ACIP have included a focus on already debunked myths about vaccine safety that unnecessarily risks seeding further vaccine hesitancy, such as links of vaccines to autism (there are none),[9,10] the safety of the preservative thimerosal (there is no evidence of a risk),[11] and its plan to initiate discussions on the safety of aluminium adjuvants (there are no known safety concerns).[12,13] The new ACIP advised

removing the extant universal hepatitis B birth dose recommendation, recommended separation of varicella vaccine from its combination with measles, mumps, and rubella (MMR), a combination widely and safely used, and reduced recommendations for use of vaccines against COVID-19.[8] The ACIP also indicated a move towards using fewer childhood vaccines,[8] pointing to the childhood vaccination schedule in Denmark,[14] a country with less than 2% of the American population, as an example. But there are no new data to drive this change and comparing one country with another in this way without considering differences in the general health of the population, access to the health-care system, and epidemiology of each disease lacks the rigour of a scientific process to advance a policy shift.[15–17] A review of vaccine schedules in high-income countries was commissioned by the ACIP to further consider how the USA could reduce the number of vaccines included in its childhood immunisation programme,[8] leading to concerns that child health in the USA will be compromised.[7]

In an online post on Jan 2, 2026, Høeg and Kulldorff, on behalf of the HHS,[18] apparently without the involvement of the ACIP,[19] announced that the number of recommended vaccines in the USA should be reduced from 17 to 11 with an additional recommendation for the reduction of the number of doses of some

vaccines. Previously recommended vaccines

against rotavirus, influenza, COVID-19, hepatitis A, hepatitis B, and meningococcal disease were moved from the recommended category to a “shared clinical decision-making” category.[18] This HHS document downplays the importance of some vaccines by the separation into two distinct schedules of “core” vaccines (diphtheria, tetanus, acellular pertussis, *Haemophilus influenzae* type b, pneumococcal, poliovirus, MMR, varicella, and human papillomavirus) and “shared clinical decision-making” vaccines, with the implication that the latter are less important. It also suggests that vaccine safety has not been adequately assessed and that the benefit– risk is unclear for “shared clinical decision-making” vaccines, creating concern where none is warranted. For example, the authors incorrectly imply failures in previous rigorous US regulatory and policy decisions by saying “those who are convinced that vaccines are safe will welcome randomized, placebo-controlled trials, as they will show that the vaccines are safe if they are safe”.[18] Beyond the misleading suggestion that vaccines have not been properly tested, such trials are unethical for existing approved, regulated safe and effective vaccines since participants in the placebo group would be denied protection against vaccine-preventable diseases.[20]

The recommendation by the ACIP, and now also the HHS, to suspend the universal offer of a hepatitis B vaccine dose given at birth to prevent transmission of hepatitis B virus (HBV) from an infected mother to the infant is made despite the fact that 90% of infants infected with HBV will develop chronic infection with long-term risks of cirrhosis and hepatocellular

carcinoma.[21] This recommendation has caused alarm among the paediatric community in the USA.[22,23] In a memorandum on Jan 5, 2026,[24] the HHS argued for this change on the basis of their proposed targeted approach—ie, only giving the dose at birth to babies whose mothers are known to be infected and those of unknown status—and underlined that this approach is already used in some countries in Europe. Although this change to the hepatitis B vaccine schedule is similar to the approach in the UK[25] and various other European countries, it does not account for the inequity in healthcare access and the fragmented health system in the USA.

The UK has a National Health Service that coordinates the hepatitis B programme and screens 99·8% of pregnant women for infection, 0·3–0·4% of whom are found to be hepatitis B positive.[26] Babies of mothers with HBV infection are routinely vaccinated at birth, and timely vaccination, essential to prevent transmission, occurs for 98% of newborns.[26] As a result of this programme, the rate of mother-to-child HBV transmission in 2024 was only 0·06% in England, far below the WHO target of under 2%.[26] The situation in the USA differs. According to the US Centers for Disease Control and Prevention,[21] the rate of hepatitis B detection in pregnancy in the USA was 0·5%, 12–16% of pregnant women in the USA do not receive screening for hepatitis B in pregnancy (in the UK it is <1%),[27] and less than half of those with HBV infection are identified before birth which makes it difficult to run a targeted programme. Even with the previously recommended universal programme in the USA with a birth dose of HBV vaccine offered to all babies, only 80% of infants were vaccinated (compared with 99% of those at risk in the UK),[28] potentially leading to about one in five babies missing the important birth dose vaccination and a predicted 625 hepatitis B cases per year.[29] A targeted approach is more difficult to implement and the number of hepatitis B cases is expected to increase with the new recommendations.

If the aim is to reduce the incidence of hepatitis B infection, universal birth dose vaccination is likely to be the best policy for populations with high prevalence of infection, incomplete screening, or difficulty linking antenatal screening data to birth dose vaccination, supporting the calls to retain universal vaccination in the USA, and leaving experts perplexed by the new ACIP and HHS decisions.

There is also foreboding about the likely effects on vaccine confidence and uptake caused by confusing messaging about the safety of vaccines and the changes newly advised by the HHS in the list of recommended vaccines. Moreover, these developments and recent chaotic meetings of the new ACIP[30] exist in the context of wider political rhetoric on vaccines in the USA and globally in which the overwhelming scientific evidence for immunisation is dismissed in favour of unfounded myth and baseless speculation about safety, and conspiracy.[31,32]

The role of the USA as a leading light in science-led immunisation policy is already dimmed and other countries can no longer rely on recommendations from the ACIP as a reference point for evidence-based policy decisions. They should look instead to the recommendations on immunisation from WHO.[33] In the USA, clinicians must depend on independent organisations such as the American Academy of Paediatrics to step in. Immunisation has shielded children in the USA from the ravages of infectious disease over recent decades but they are now on the front line of a scientifically incomprehensible battle against vaccines, the casualties of which will be our children.

AJP was the Chair of the UK Department of Health and Social Care's (DHSC) Joint Committee on Vaccines and Immunisation (JCVI) until October, 2025; the views expressed in this Comment do not necessarily reflect the views of the JCVI or DHSC. He is a member of WHO's Product Development Advisory Committee and technical advisory group on Salmonella vaccines. AJP declares grant funding for research on vaccines from the Wellcome Trust, Innovate UK, the Medical Research Council, the National Institute for Health Research, the European Commission, the Bill & Melinda Gates Foundation, the Ellison Institute of Technology, the Serum Institute of India, and AstraZeneca; is a contributor to intellectual property licensed by Oxford University Innovation to AstraZeneca; and has acted as a consultant for the Ellison Institute of Technology. SP declares consulting fees from AstraZeneca, Codagenix, Curevac, Inovio, Janssen, Merck, Moderna, NTxBio, Rational Vaccines, Sanofi, Sequirus, Vaxinnity and honoraria from Valneva; he is Principal at Vaxconsult, a consulting company.

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