Children's Hospital of Philadelphia℠
Vaccine Education Center

March 11, 2026 Vaccine Update Webinar Q&A

General questions

Dr. Offit has pointed out we should be proud of vaccines as arguably the safest, best tested things we put in our bodies. How long are vaccines typically tested before licensure?
This is a question frequently asked by the public, who are eager to better understand how vaccines are studied and evaluated. For this reason, we have a section on our website with detailed information on the vaccine development process. Notably, it takes years for a vaccine to get through the development process, and even once a vaccine is approved for use, it continues to be monitored for safety.

We are working to provide accurate vaccine information to HCPs and patients in order to increase vaccination rates. How would you suggest restoring that trust and reducing confrontation, particularly when families have concerns about the pharmaceutical industry?
Building trust takes time. We recently published a series of articles on communication practices, and focused on trust in the final piece of the series.

There are a few principles discussed in the article that can help when discussing pharmaceutical companies with families. Build credibility with your families by learning a bit about the industry and sharing your resources with them. Clinical trials, manufacturing, and vaccine distribution require large infrastructure and expertise, which is why pharmaceutical companies play an important role in vaccine development. We often recommend clinicians check out this film on Maurice Hilleman, a scientist highly motivated to end diseases that hurt children. During his time at Merck, Dr. Hilleman helped develop vaccines that protect us from chickenpox, hepatitis A, hepatitis B, pneumococcus, meningococcus, measles, mumps, and rubella. At the same time, vaccines are reviewed and monitored by independent regulatory agencies and scientific advisory committees.

How do you suggest pediatricians and primary care doctors manage families who refuse vaccination?
There are two approaches to families who refuse vaccination. Neither is more correct. One option is for the clinician to let the family know that they cannot continue to care for the patient who refuses vaccines, as it demonstrates that the family and clinician have different approaches to medical care, and the family would be better served by a clinician who aligns with their approach. The other option is to continue to care for the family and use each interaction to continue to build trust and emphasize the importance of vaccination. Over time, some clinicians have success counseling families after building a long-term relationship. If a family truly refuses vaccination, they should also be informed of how to protect their unvaccinated children. For this reason, we have developed a handout that clinicians can review with families. This helps families with unvaccinated individuals recognize that they do, in fact, need to take additional precautions — particularly during outbreaks. When families follow these steps, not only can they better protect their own family member, but their efforts can also help reduce the risk of exposures in your practice setting, particularly if they are made aware of any special practices your team follows when unvaccinated children are arriving for a sick visit that may involve an infectious disease.

Could Dr. Offit comment on this: "The U.S. Food and Drug Administration today launched a new unified platform for analyzing adverse event reports."

This platform was launched March 11, 2026. As of publication of our Q and A (March 17, 2026), it is too early to understand the goals for this platform, compared with historical programs, such as VAERS, or how it will be used.

Part of what we are seeing is people asking why we are no longer following the CDC after decades of being told that they were the "gold standard" and that we followed their recommendations. This is such a difficult path to work through without venturing into the challenging conversations involving opinions not science. Any recommendations on how to couch these conversations?

Clinicians can help families understand that clinical recommendations are not based on politics. One way to establish this without getting into antivaccine conversations is simply to state that while the politics have changed, the science related to vaccines has not. While historically, federal public health agencies were insulated from politics, many recent changes have occurred that make this less so. Further, many recent changes to federal vaccine policy have lacked transparency. For these reasons, many clinicians are looking to guidance created by organizations with long-standing missions to protect the health of patients, such as the American Academy of Pediatrics, American Academy of Family Physicians, American College of Obstetrics and Gynecology, and others. These organizations have continued to use the historical principles of transparency and data-based analyses when making vaccine recommendations.

Is it true that the childhood schedule was licensed without the use of any saline placebo control groups?

This is a talking point that can cause confusion and doubt among parents trying to make the best decision for their families. If a family has this question, let them know that all studies use control groups, but the control groups can differ to support the strongest study designs. Saline placebo controls are used in some vaccine trials, but not always. The choice of control group depends on what will provide the most scientifically useful and ethical comparison. For example, if a vaccine already exists, researchers usually compare a new vaccine to the existing one rather than withholding protection. In fact, it would not be ethical to use a saline control, nor would it provide the best information, as scientists would be interested to determine how the new vaccine compares to an existing vaccine.

Another example relates to using a control group that gets the vaccine diluent. In the case of aluminum, it often causes injection site reactions, so if a saline placebo is used, the scientists may be able to figure out which participants are in which group based on their side effects. This could inadvertently lead to other biases in the data. The "phase III trials" section of our "Vaccine Science: Process of Vaccine Development" webpage shows what placebo controls were used in different vaccine trials.

Where can I obtain the slides for this presentation?
The slides are available on the event archive page. To access, use the link for the event of interest from the webinar archive page at: https://www.chop.edu/pages/vaccine-webinar-archive and then locate the link for the slides.

Rotavirus-related questions

Does use of medications, like Zofran, change your rotavirus data of protracted vomiting and dehydration?
There is no clear study on the impact of antiemetics on the clinical course of rotavirus infection. That being said, it is important to consider the risks and benefits of vaccine-based immunity versus natural infection. The two rotavirus vaccines on the market have excellent safety profiles. Even before licensure, large numbers of children were enrolled in clinical trials so that rare events could be detected. Rotavirus infection, on the other hand, carries the risk of vomiting, diarrhea, dehydration, need for hospitalization related to dehydration, and death from dehydration. Even if a medication may mitigate symptoms, these are all real risks that will be encountered with an infection. As such, these disease-related risks need to be weighed against the very small risks of vaccination.

Of interest, Zofran, which was first licensed in 1991, did little to alter the incidence of rotavirus hospitalizations in the 15 years before a rotavirus vaccine became available in 2006.

Schedule-related questions

As we move forward with AAP publishing its own schedule while also receiving donations from vaccine makers, any advice on how to talk with skeptical parents who raise this as an issue? The current donor page does list the big vaccine makers.
Donations are to the AAP's foundation, whereas recommendations are part of work of AAP. It is easy for families to see all of this online and assume there is some *quid pro quo*. However, it can be useful to explain that the people who review the data and create the schedule are clinicians who volunteer on the Committee of Infectious Diseases. They are experts in pediatrics, infectious diseases, vaccinology, immunology, epidemiology, and public health, and they are not employed by AAP.

Do you think the change to SCDM really makes a difference, or is it just another drop of misinformation in an already large amount?

Historically, a *routine recommendation* on the immunization schedule meant that the benefits of a vaccine were applicable to an entire population of individuals. It signaled that the family did not need to consider their circumstances specifically to understand their risk. For example, all babies will encounter COVID-19 virus during their childhood. All people are at risk of influenza infection if they interact with other people during influenza season. A *shared clinical decision making (SCDM) recommendation* on the immunization schedule, in contrast, was used to signal that there were differences between population-level benefits and individual benefits. For example, meningococcal B vaccine costs at the population level to prevent one case in a population were high, but for an individual family seeking to protect their child based on their risks, those costs wouldn't be relevant. These benefits could be determined through a conversation with a care provider. Regardless of whether a recommendation was routine or SCDM, informed consent was still completed as part of the process.

Unfortunately, in this moment, SCDM has been co-opted to suggest that informed consent was not being done and that by changing a recommendation to SCDM, it will ensure informed consent. Therefore, as frontline clinicians already completing informed consent, the change is unlikely to change your process much; however, it may cause confusion for families, causing fewer people to vaccinate, and in the future, it may create challenges for vaccine administration in pharmacies, particularly for certain payment models.

Has the AAP stated their plan for vaccine schedule review in the absence of ACIP? For example, the cadence, who will be part of that decision making, what data they will use?
We do not know the long-term plan for data evaluation or evaluation of new vaccines. At present, they have been aided by data shared by the Vaccine Integrity Project and have used their traditional infrastructure through the Committee on Infectious Diseases.