Vaccines are Good for America:

Why all the confusion?

Rev. Anthony Evans
Dr. Joseph Webster
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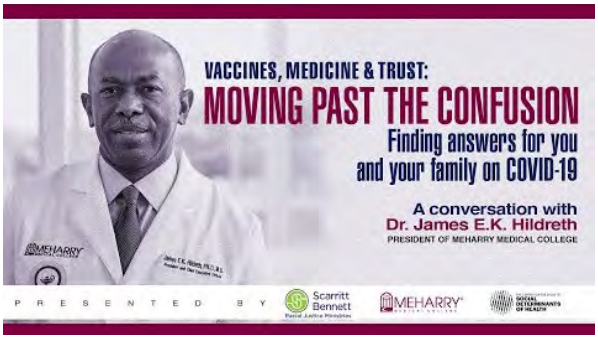
The Immunization Report

Introduction

The confusion surrounding immunization and vaccines constitutes a national health crisis for the African American community. The purpose of this report is to seek clarification, financial resources, and technical support from HHS, NIH, the CDC, and the FDA due to the evolution of the public health environment. More specifically, how do we promote immunization and health education for African Americans in the face of the “One Big Beautiful Bill Act” and the potential separation of 10 million people from the Medicaid rolls? How do you propose that we meet the goal in the National Black Church Initiative’s 10-Year Immunization Program of vaccinating our 27.7 million members according to the CDC immunization schedule?

We must warn the nation of the vulnerability of African Americans, in part due to higher rates of underlying health conditions that increase the risk of severe illness from vaccine-preventable disease (VPD). This increased risk, along with known health disparities in rates of severe illness from common VPD viral infections such as pneumococcal pneumonia, chickenpox, and measles, means that lower vaccination in African American communities will have an outsized health impact. Outbreaks are likely to be even more difficult to detect and control due to heightened mis- and disinformation about vaccines in recent years, cutbacks in funding to state and local health departments, and increasing numbers of uninsured people.



> ***"Dr. James Hildreth is president and CEO of Meharry Medical College, one of the nation's oldest historically Black medical schools. He says he's gravely concerned about the policy changes pushed by the Department of Health and Human Services and Health Secretary Robert F. Kennedy Jr.***
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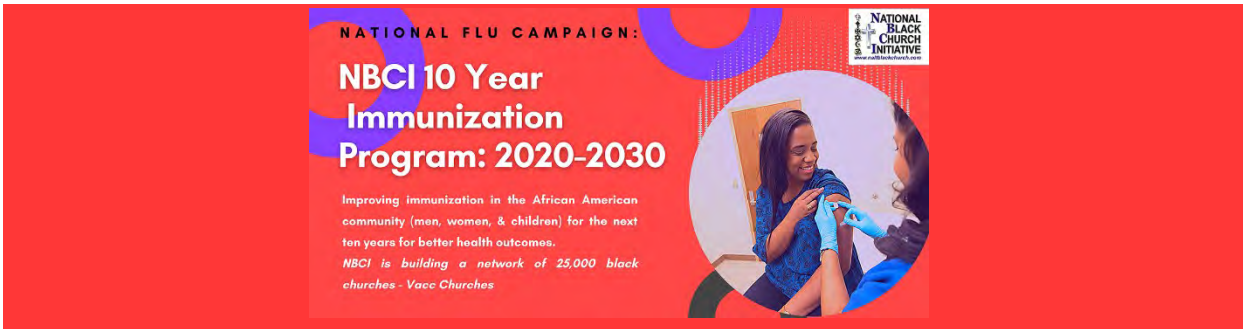
> ***When the agency that is charged with protecting the health of the public, abandoned science in doing so, I'm not sure there's anything that could scare me more than that," Hildreth tells Chief Healthcare Executive®.***

Falling vaccination rates will further contribute to public health crisis management difficulties in African American communities—with social and political implications—especially around the issues of access to care and lack of trust in a weakened post-COVID-19 health system.

The recent changes in the Medicaid safety net and the wholesale administrative changes in the nation's vaccine delivery system will add fuel to this forthcoming crisis—it is not a matter of if, but when. Please note that African Americans have the lowest life expectancy in the U.S. other than American Indian and Alaska Native (AIAN) populations, and COVID-19 mortality largely reduced life expectancy for both groups, from 71.8 to 65.2 years for AIANs, and from 74.8 to 70.8 years for African Americans, between 2019 and 2021.[1]

The National Black Church Initiative (NBCI) is a coalition of 150,000 African American churches constituting 27.7 million members working to eradicate racial disparities in healthcare, technology, education, housing, and the environment. NBCI's mission is to provide critical wellness information to all of its members, congregants, churches, and the public. The National Black Church Initiative's methodology is utilizing faith and sound health science. We also offer our member congregants and the public helpful and healthy science-based tips on how to develop and maintain a healthy lifestyle.



The National Black Church Initiative's purpose is to partner with major organizations and officials whose main mission is to reduce racial disparities in the variety of areas cited above. NBCI offers faith-based, out-of-the-box, and cutting-edge solutions to stubborn economic and social issues. NBCI's programs are governed by credible statistical analysis, science-based strategies and techniques, and methods that work.

The sad fact behind the growing national dissonance is that we thought we had an acceptable baseline of facts, vaccines, and proven scientific assumptions and approaches based on 100 years of hard and complex data. Today, this is no longer the case because our government wants us to start all over again. Those of us in the African American and minority community cannot afford to do this—it would be a death sentence. The African American population is suffering from health disparities that worsen even as the nation’s medical capabilities and technology improve. These disparities are well documented in the comprehensive 2024 report by NBCI, *Moving toward a National Black Health Agenda* (NBHA).[2] The NBHA is a call to action for achieving health equity and ending a cycle of premature African American deaths that cost our society $238 billion in 2018 alone.

[1] Hill and Artiga, “What Is Driving Widening Racial Disparities?”
[2] National Black Church Initiative, *National Black Health Agenda*.

The federal government, and particularly the U.S. Department of Health and Human Services (HHS), fails to clarify the arguments and reasoning behind its vaccine policy changes. As stated in the NBHA, African American adults are less likely than their non-Hispanic White counterparts to have received influenza, pneumonia, or human papilloma virus (HPV) vaccines.[3] Recent history tells us the African American community cannot afford to think of immunization policy as a kind of philosophical pursuit in this moment.

In 2023, a *Washington Post* article disclosed findings from a pair of *JAMA* reports on American health disparities. Among them was the conclusion that, during the first decade of this century, the racial gap in "excess deaths—the observed number of deaths vs. what would be expected if Black and White death rates were the same"—began to close. But soon this death gap widened again, until, during 2020, "the first year of the coronavirus pandemic," the difference in mortality for African Americans "exceeded that of any previous year of the study."[4]

"Like other healthcare leaders, Hildreth says he was troubled by Kennedy's ouster of all the members of a key panel advising the government on vaccine policy, and the choice of vaccine skeptics and less qualified members as replacements. In 2020, Hildreth served on a Food and Drug Administration advisory committee that reviewed COVID-19 vaccine candidates.

Hildreth points to the Oval Office press conference where Kennedy joined President Trump, who cited the debunked theory that vaccines and Tylenol cause autism."

There is no theoretical debate over the "excess [of] 1.6 million deaths compared with the White population during the past two decades," a total which can be "translated into 80 million years of potential life lost."[5] With the ongoing health disparities and their attendant morbidity and mortality, what our community is experiencing is a health crisis compounded by public policy confusion. And now, we need *answers*.

We need guidance and help at a time when some of our nation's lawmakers are unsure about whom to trust. We need policy clarification, government funding, and technical support. Yet, there does not seem to be a unified, strategic plan based on science, not politics, to make American healthcare better for the many, not the few.

[3] Ibid., p. 50.
[4] Johnson, "Black Communities Endured Wave of Excess Deaths."
[5] Ibid.

One significant influence on healthcare policy today is the "One Big Beautiful Bill Act" (OBBBA) passed this July. The Congressional Budget Office recently concluded an analysis of the OBBBA. It is estimated that "10 million people will be left without health insurance by 2034 due to the law's changes to Medicaid," and that poor families will suffer the most due to "the loss of benefits from social spending programs."[6] And, while the detrimental effect of the OBBBA's provisions on the impoverished is not in dispute, the Center on Budget and Policy Priorities actually believes the law will leave "up to 15 million more people without health insurance," noting that it "includes over $1 trillion in spending cuts to healthcare through 2034."[7] The Budget Office projects that, due to the OBBBA, the nation's "poorest 10% of households will lose an average of about $1,200 in resources per year, amounting to a 3.1% cut in their income," while households with the "highest 10% of incomes will see about a $13,600 boost in resources on average, amounting to a 2.7% increase in their incomes." Further, middle-income earners will see much smaller growth than the wealthy, at "about $800 to $1,200 on average" per year.[8] The OBBBA thus removes millions of families from the Medicaid rolls, and denies them any kind of health coverage, while simultaneously widening the divides between rich and poor, and rich and middle class.

For the U.S. healthcare system to thrive, it needs more, not less, people to pay into it. But this will not occur if the already widening income gap between the relative few wealthy households and those of the middle class and poor majority increases. As reported by Pew Research in 2024 (see fig.1 below), "From 1971 to 2023, the share of Americans who live in lower-income households increased from 27% to 30%, and the share in upper-income households increased from 11% to 19%."[9]

The OBBBA will put this half-century of division into overdrive *and* create a pool of millions more medically uninsured citizens as well. Unless Congress makes substantial amendments to the OBBBA, or otherwise improves public health policy well before 2034, our healthcare system, and the state of public health in general, could be in great jeopardy. If citizens formerly covered by Medicaid, possibly ill due to being unvaccinated, receive emergency medical services that they cannot pay for, the system will likely either experience rampant inflation, or a crash, while communicable diseases spread nationally and public health suffers.

[6] Dillard, "Trump Tax Law Squeezes Poor."
[7] Rosen, "How New Federal Legislation Will Affect Health Care."
[8] Dillard, "Trump Tax Law Squeezes Poor."
[9] Kochhar, "The State of the American Middle Class."

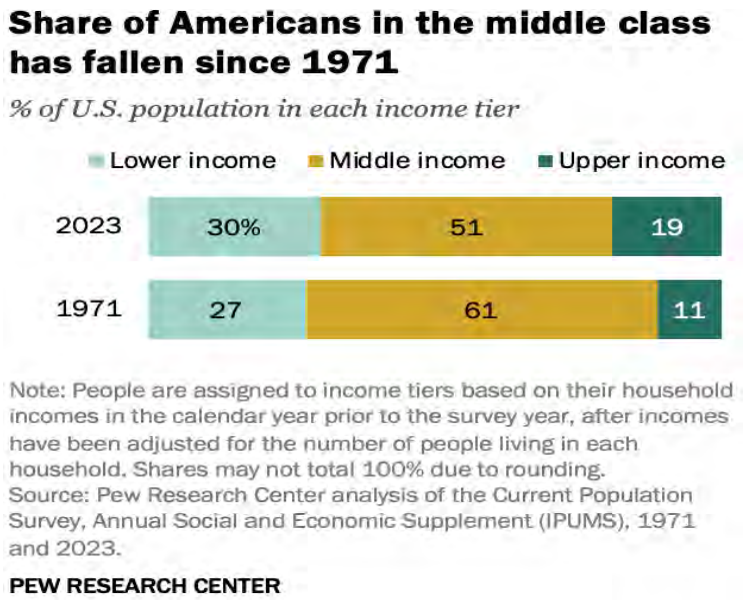


Figure 1. U.S. Income Stratification, 1971-2023. (Kochhar, "The State of the American Middle Class," https://www.pewresearch.org/race-and-ethnicity/2024/05/31/the-state-of-the-american-middle-class/.)

In its attempt to control the way many people can or cannot access healthcare for years to come, the OBBBA may prove to be a tragically shortsighted measure. There is another concern with the severe changes to Medicaid eligibility: requirements lacking in mercy and practicality. Given that Medicaid helps with medical costs for low-income households, people with disabilities, and the elderly, it seems more than unkind to add to the burdens of the eligible a "community engagement requirement" of committing at least 80 hours per month working, volunteering, or learning in school.

Although the new requirement only applies to Medicaid recipients aged 19 through 64 who are "able-bodied," Johns Hopkins University Health Policy and Management professor Gerard Anderson has doubts about its purpose.

To him, it seems little account was taken of the fact that "most Americans on Medicaid are located in geographic areas where there is no school, there are no jobs, and there is nothing to volunteer for—especially not 80 or more hours a month."[10] And, if unexpectedly bad bouts of illness prohibit a parent or grandparent from meeting their 80 hours per month minimum, where is their safety net?

[10] Rosen, "How New Federal Legislation Will Affect Health Care."

When it comes to Medicare, there are two new losses: a reduction in help for those with Low-Income Subsidy (LIS) coverage, and the exclusion from coverage of many immigrants with legal status. Professor Anderson advises the OBBBA will affect "about 40% of Medicare beneficiaries [who] receive low-income subsidies, a cost-sharing program within Medicare Part D that makes prescription drugs more affordable." For immigrants, Prof. Anderson relates that "only U.S. citizens, green card holders, and legal immigrants from a few specific locations" will still be eligible for Medicare. The change deprives "refugees, people granted asylum [or] temporary protected status, and even permanent residents" of eligibility, even if they currently have Medicare.[11]

Inevitably, the Republican-led OBBBA also made changes to the functioning of the Affordable Care Act (ACA), often called "Obamacare." According to Liz Fowler, a lawyer and distinguished scholar in Health Policy and Management at Hopkins, OBBBA "is going to make it more difficult to enroll in coverage through the Health Insurance Marketplace and then harder to keep coverage."[12] The most telling change in terms of Marketplace access is the shortening of the open enrollment period by 31 days, so it ends on December 15 instead of January 15. But the costliest change for consumers is that the OBBBA "does not extend the ACA premium tax credits, which are set to expire at the end of this year. Without those, premiums are predicted to increase for 2026 by an average of 75%."[13] Ms. Fowler advises the OBBBA also *eliminates* enrollment for Deferred Action for Childhood Arrivals (DACA) recipients, and actually ends "DACA eligibility for ACA coverage on August 25, 2025." Other "lawfully present immigrants" may not be excluded from the Marketplace until January 1, 2027.[14] For the poor in the African American community, and for many immigrant Latinos, decreased enrollment will lead to increased morbidity and mortality each year this continues.

To gauge the effects of the OBBBA even more broadly, consider what will happen when the Medicaid- or Medicare-deprived need urgent care. As Prof. Anderson said, "Medicaid represents about 20% of hospital revenue. For some, especially in some rural locations, it's more like 40%–50% of their revenue," and, if a person who "has lost their Medicaid coverage comes into the emergency department, the hospital is still required to treat them"—under the Emergency Medical Treatment & Active Labor Act—at a financial loss.[15] Ms. Fowler adds that, although the OBBBA "set aside $50 billion to help rural hospitals deal with the fallout from the legislation," it seems very unlikely "for that funding to make up for the potentially seismic shifts that could start taking place very soon." She noted that when hospitals experience "an increase in the number of uninsured people who aren't able to pay their bills, they're going to increase rates for other payers. It's just not possible for 10 to 15 million people to lose health insurance and not have effects on the rest of the system."[16] And those ill effects will be exacerbated by the immunization policy debacle that is already here.

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[11] Ibid.
[12] Ibid.
[13] Ibid.
[14] Ibid.
[15] Ibid.
[16] Ibid.

Chapter 1: The Public Policy Crisis over Immunization

I. *Trust and Mistakes*

According to Kaiser Family Foundation (KFF) polling results, trust in "government health agencies declined during the COVID-19 pandemic, most notably following the rollout of the COVID-19 vaccines," but the 2020 to 2022 drop in confidence has yet to end. As polling by KFF in January 2025 revealed, "trust in the FDA, CDC, and state and local public health officials remains partisan and has continued to decline. The share who says they trust the CDC 'a great deal' or 'fair amount' has fallen slightly overall (from 66% in June 2023 to 61% in the latest poll), driven by a nine-percentage point drop among Republicans (from 48% to 39%)."[17] Further, trust in the FDA waned "from 65% to 53%," and it fell for "state and local public health officials from 64% to 54%," in the same period.[18]

On February 15, 2025, two days after Robert F. Kennedy, Jr. took office as Secretary of Health and Human Services, over 5,000 newly hired federal health workers were informed of their termination.[19] Then, on March 27, Secretary Kennedy announced a plan to reorganize HHS, lay off 10,000 more employees, and create a new agency, the Administration for a Healthy America (AHA). Xavier Becerra, the former HHS head under President Biden, said of the plan, "This has the makings of a man-made disaster." Senator Patty Murray (D-Washington) laid the possible catastrophe at the doorstep of the White House: "In the middle of worsening nationwide outbreaks of bird flu and measles, not to mention a fentanyl epidemic, Trump is wrecking vital health agencies with the precision of a bull in a china shop."[20]

But, on April 4, about 2,000 of the employees put on the chopping block received startling news from Secretary Kennedy, "Personnel that should not have been cut, were cut. We're reinstating them. And that was always the plan," he claimed, adding, "we'll make mistakes."[21] Both the extensive purge and unexpected partial reinstatement included staff at such immunization-critical agencies as the Centers for Disease Control and Prevention (CDC) and the National Institutes of Health (NIH).

Any feeling that an immunization policy crisis may have been averted, at least in part, was dispelled on June 9. In a mixed op-ed/press release in the *Wall Street Journal* entitled "HHS Moves to Restore Public Trust in Vaccines," Secretary Kennedy announced he was firing the nation's vaccine board, the Advisory Committee for Immunization Practices (ACIP).[22]

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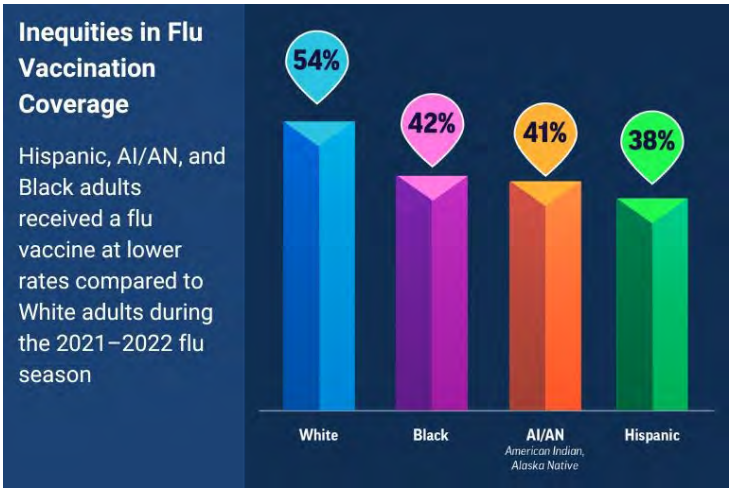
[17] Kearney et al., "KFF Tracking Poll on Health Information."
[18] Ibid.
[19] Tin, "CDC's 'Disease Detectives' Apparently Spared."
[20] Stolberg and Jewett, "10,000 Federal Health Workers."
[21] Drenon, "'We'll Make Mistakes' Says RFK."
[22] Kennedy, "HHS Moves to Restore Public Trust."

In this piece, Mr. Kennedy called it "retiring the 17 current members," namely, *all*, the Committee, and he alleged that ACIP "has been plagued with persistent conflicts of interest," yet failed to specify what these conflicts were. He also explained ACIP's primary duty as judging "the safety, efficacy, and clinical need of the nation's vaccines" before sending its findings to the CDC.[23] He neglected to mention, however, that, since its inception in 1964, ACIP has also been the main source of guidance for the CDC on how best to utilize immunizations to limit the spread and health impact of VPDs. In fact, ACIP approves pediatric and adult vaccination schedules and specifies which vaccines are recommended based on a person's age, prior vaccinations, and health conditions. The CDC also reports to ACIP regarding ongoing vaccine safety monitoring study results and vaccination rates. Importantly, ACIP is also responsible for key votes regarding the inclusion of vaccines in the Vaccines for Children program.[24]



Dr. James E.K. Hildreth, the president and CEO of Meharry Medical College, is among those who voiced his concern over the ouster of ACIP's members "and the choice of vaccine skeptics and less qualified members as replacements." Dr. Hildreth said, "When the agency that is charged with protecting the health of the public abandoned science in doing so, I'm not sure there's anything that could scare me more than that."[25] So alarmed are some of the major professional medical, nursing, and pharmacist societies that they have withdrawn their endorsement of the 2025 ACIP vaccine schedules and plan to provide their own schedules reflecting the need to vaccinate high-risk groups instead.[26]

The American Academy of Pediatrics (AAP) and American College of Obstetricians and Gynecologists (ACOG) have already issued evidence-based recommendations separate from the CDC, with AAP being particularly opposed to CDC's failure to "recommend COVID-19 vaccination for healthy children of any age," and ACOG in favor of "vaccination during pregnancy against COVID-19, influenza, and RSV" (Respiratory Syncytial Virus).[27]

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[23] Ibid.
[24] Smith, "The Structure, Role, and Procedures."
[25] Southwick, "A Medical School Leader Fears Rising Vaccine Skepticism."
[26] Schreiber, "US Medical Groups Fill Gap with Own Vaccine Guides."
[27] Shaw, "AAP, ACOG Issue Vaccine Recommendations."

The governors of "California, Oregon, and Washington announced they are forming an alliance that will issue its own vaccine recommendations" in response to "the Trump Administration's destruction of the CDC's credibility and scientific integrity," while state officials from Pennsylvania to Colorado have also taken unprecedented measures to ensure wider vaccine access.[28]

At the end of January 2026, Dr. Roger A. Mitchell, Jr., President of the National Medical Association (NMA), came out in favor of the AAP's 2026 childhood immunization schedule and rejected ACIP's. As head of the country's largest organization representing Black physicians and health professionals, Dr. Mitchell endorsed the AAP schedule because it "is thoroughly researched and rooted in science and differs significantly from recent changes to the Centers for Disease Control and Prevention's federal immunization schedule." The NMA thereby joined ACOG, the American Medical Association (AMA), the Pediatric Infectious Diseases Society (PIDS), and other leading medical groups in recommending "an evidence-based immunization schedule that protects against 18 diseases."[29]

How the CDC and U.S. healthcare providers and patients will manage without a truly functional ACIP remains to be seen. However, delays in FDA decisions regarding COVID-19 vaccine update approvals, delays in COVID-19 vaccine recommendations by CDC/ACIP, differences in FDA-approved indications compared to ACIP recommendations, and the disharmony in recommendations between CDC/ACIP and professional societies, are resulting in barriers to access for people seeking COVID-19 vaccinations.

If ACIP made prior mistakes that would necessitate his radical remedy, Mr. Kennedy has yet to adequately detail them to either the public or major professional societies. Whatever may have happened in the past, this looks like an irrational and destructive attempt to right any wrongs.

While Mr. Kennedy claimed in his op-ed that he was "putting the restoration of public trust above any pro- or anti-vaccine agenda,"[30] his abrupt decisions on immunization and HHS personnel during his first few months in office seemed to have secured a different outcome. In KFF's July 2025 poll focusing on recent changes to U.S. vaccine policy, only "about two in ten adults, including 41% of Republicans, think these changes will make people safer, while about one-third of adults, including most Democrats (62%) and independents (41%), say they will make people less safe."[31]

[28] Manto, "West Coast States Will Issue Their Own" (the governors call this the West Coast Health Alliance, and it includes Hawaii as of this writing); and AP, "States Move to Protect Vaccines."
[29] Mitchell, "NMA Endorses AAP 2026 Childhood Immunization Schedule." (See full statement later in document.)
[30] Kennedy, "HHS Moves to Restore Public Trust."
[31] Sparks et al., "KFF Tracking Poll on Health Information."

As for the rest, "31% say they 'don't know enough to say' as to whether the recent changes will make people safer or not, and about one in ten say the changes won't make a difference."[32] Polling on whether people had confidence in federal health agencies "to ensure the safety and effectiveness of vaccines approved for use" resulted in 49 percent saying they did. On the question of whether they trusted Secretary Kennedy "to provide information on vaccines," just 37 percent answered they trusted him "at least a fair amount," and this figure was "unchanged since his appointment."[33]

In other words, not only had Secretary Kennedy not advanced trust in HHS on vaccines beyond the halfway mark, but, a month after his ACIP purge, the public's trust in him on vaccines remains even lower, at less than 40 percent. It is not too much to say that no national plan or strategy on immunization has been offered that most of the public supports. With people already divided on such issues, continual attacks on our traditional health structures can only lead to more distrust.

The stance of NBCI is that federal health policy should not be turned into a zero-sum game of winners and losers. Indeed, immunization policy confusion will cause a material negative impact on the health of African Americans and many others, especially if they are poor. Given the racial health disparities mentioned in the Introduction, it is reasonable to expect that an ultimate impact of this confusion will be an increase in excess deaths in the African American population. What needs to be developed and maintained is a coherent and effective national policy on immunization. The win-win of such a policy is that it serves all Americans.

Last year, in response to the "suboptimal" usage of vaccines by American adults and related vaccine hesitancy and societal costs, the National Foundation for Infectious Diseases (NFID) published *Call to Action: Strategies to Improve Adult Immunization in the US*.[34]

[32] Ibid.
[33] Ibid.
[34] National Foundation for Infectious Diseases, *Call to Action*.

Months before either Mr. Kennedy's mass firings or the writing of the "One Big Beautiful Bill," NFID identified some major problems concerning immunization—all which HHS and Congress could still work on solutions for. High among them were:

- "the US spends nearly $27 billion each year for the treatment of vaccine-preventable diseases in adults 50 and older";
- "unvaccinated individuals are responsible for almost 80% of the financial burden related to vaccine-preventable diseases";
- "insufficient public health funding at both state and federal levels" that "predated the . . . pandemic . . . made the US more susceptible to COVID-19 deaths and disruptions compared to other industrialized countries";
- there is too much variation in Medicaid reimbursement levels for vaccines;
- vaccine schedule complexity is too great (15 categories, with added recommendations for some), and point-of-care logistics and patient data sharing are sometimes flawed;
- pneumonia "vaccine coverage was at its highest in 2017 and has since declined and remained relatively flat" among all adults;
- "adult flu vaccine coverage, which peaked during the 2020-2021 season, has dropped over the 2 subsequent seasons," especially among those over 50 and pregnant women;
- in 2021, hepatitis B and tetanus vaccination coverage was lower for African American and Hispanic adults compared to Whites; and
- in the 2022-2023 season, flu vaccine coverage was lower for African American and Hispanic adults compared to both White and Asian adults.[35]

In addition, NFID found the most prevalent reasons for suboptimal vaccine use by the public were: access and equity issues, "exacerbated by geographic, financial, cultural, and access barriers"; healthcare professional disengagement when it came to vaccine knowledge and recommendations; and "vaccine hesitancy and misinformation," including the rapid spread of "anti-vaccine propaganda" on social media.[36] The latter issues raise basic concerns about whether primary care physicians (PCPs) are properly educated in how to suggest appropriate vaccines for everyone, and whether enough PCPs understand the recommendations on the CDC's vaccine schedule. Unlike many of the systemic problems in the bullet list above, these issues can be remedied, to some degree, by increased public access, knowledge, and empowerment. NBCI has been aware of them and, in fact, already formulated strategies to address them (see Chapters 3 and 5).

[35] Ibid.
[36] Ibid.

II. *Dismantling of NIH & CDC in Favor of AHA*

With its intentional allusion to the "Make America Healthy Again" (MAHA) slogan used by Mr. Kennedy during the 2024 campaign season, one might have passed his plan for the Administration for a Healthy America off as an overly ambitious wish list item. However, the word "administration" in the title gives away the fact that, while HHS has not needed a new agency to complement or absorb others in years, Kennedy and his closest allies hoped AHA would be just that.

Their plan, as included in President Donald Trump's fiscal year 2026 budget request, was to remove functions from several HHS divisions such as the CDC, the Office of the Assistant Secretary for Health, and the Health Resources and Services Administration, and transfer them to AHA.[37] What might sound like far-reaching, fair consolidation at first glance actually would involve the dismantling of NIH's structure with an $18 billion budget reduction (nearly 40% of total), and a 50 percent reduction of the CDC's budget, among other changes.[38] Halving the budget would be alarming since, as former CDC director Dr. Thomas R. Frieden advised, the agency's mission is "to protect Americans from health threats, whatever their source or form," and it "supports clinicians, the public, and domestic and international partners in implementing effective interventions with funding, staffing, laboratory services, field responses, technical assistance, and risk communication."[39]

He also decried the fact that, due to recent staff reductions, the agency could not assist "when Wisconsin sought help addressing lead poisoning," which may have been "the first time in CDC history that it has not been able to respond to a state's request for epidemiologic assistance."[40]

Thankfully, prudent thinkers on the Senate Committee on Appropriations approved a draft Labor-HHS bill on July 31 that would mostly protect the CDC's budget and *raise* the NIH's by $400 million. In addition, they blocked an attempt at undermining critically important future research efforts by maintaining the budget for the Advanced Research Projects Agency for Health, and providing increases of "$150 million for cancer research, $100 million for Alzheimer's disease, and smaller amounts" to other illness research.[41] The Senate committee also nullified a White House plan to "cap the 'indirect costs' added to NIH grants, which would drastically lower overhead reimbursement universities get for conducting research."[42]

Although the CDC received a small cut of $70 million to its budget of over $9 billion, the Senate committee's summary stated its opposition to the "haphazard plan to dismantle" it—and, tellingly, the draft bill "makes no mention of Robert F. Kennedy, Jr.'s plans to fold several CDC noninfectious disease programs into" the AHA.[43]

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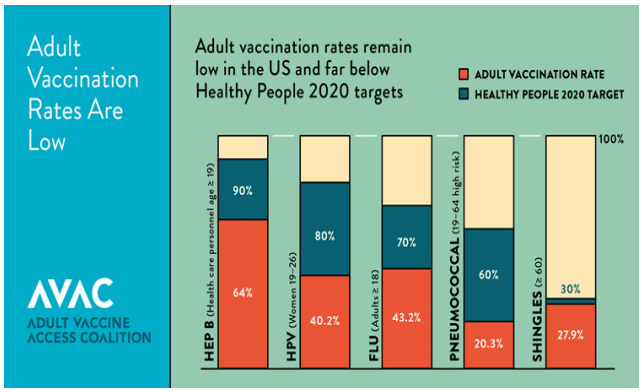
[37] U.S. Department of Health and Human Services, "Fiscal Year 2026 Budget," pp. 33–40.
[38] Kaiser, "With Boost to NIH Budget."
[39] Frieden, "Dismantling Public Health Infrastructure."
[40] Ibid.
[41] Kaiser, "With Boost to NIH Budget."
[42] Ibid.
[43] Ibid.

The Senate Appropriations Committee's prudence may have stopped NIH's 27 institutes and centers from becoming 8, restored HIV vaccine and other research funding, and fairly preserved the CDC for now, but the House Committee on Appropriations will need to approve, amend, or reject the bill in September. Even if it finds approval in a slightly modified form, the bill will then go to the desk of the president, where it could likely be stalled or vetoed.

III. *Undermining Confidence in the Vaccine Manufacturing Sector*

On August 5, Secretary Kennedy announced "that 22 projects, totaling $500 million, to develop vaccines using mRNA technology will be halted," including those led by Pfizer and Moderna, a cancellation that entails withdrawing "funding for some vaccines that are being developed to fight respiratory viruses like COVID-19 and the flu."[44] While Mr. Kennedy also proclaimed a goal of producing "a 'universal vaccine' that mimics 'natural immunity against not only coronaviruses, but also flu,'" he offered no timeline as to when this "universal vaccine" will be developed or become available to the public, or the scientific bases on which this claim was made.[45]

In canceling messenger RNA (or mRNA) projects led by two of the nation's largest pharmaceutical companies so soon after the COVID-19 pandemic, he puts a dent in their reputations in the short term while offering no credible backup plan. This unexpected cancellation is a blow to Americans' confidence in mRNA vaccines' ability to prevent COVID-19 and its complications. Further, this move undermines the readiness of the United States to respond to the next pandemic and impacts national security.



The irony is that foreign countries continue to do mRNA vaccine research and production, and the speed with which these vaccines can be produced allowed the U.S. to share them with other countries quickly during the global pandemic. Now, when the next pandemic occurs, "Americans could be last in line to receive them."[46] Given the lack of trust in recent vaccines now being fomented by HHS leadership, if the "magic bullet" of a universal vaccine is produced, how can Secretary Kennedy believe enough people will have confidence in it for it to be effective?

[44] Seitz, "RFK Jr. Pulls $500 Million in Funding."
[45] Ibid.
[46] Jarvis, "RFK Jr.'s mRNA Decision."

IV. *Muting the Vaccine and Immunization Experts*

One of HHS Secretary Kennedy's latest promises, to fix a "broken" Vaccine Injury Compensation Program, has caused some to wonder whether he has ever, in principle, left the role he once played as chair of the vaccine antagonist group Children's Health Defense (CHD). Children's Health Defense "has repeatedly sued the government over vaccines," and Mr. Kennedy, until this year, also "received payments for referring potential clients to Wisner Baum, one of the law firms suing Merck," over injuries allegedly caused by its HPV vaccine, Gardasil.[47] Since he "has been involved in the Gardasil litigation, as both an attorney and consultant," it is quite possible that he will add "new diseases and illnesses to the government table of payable injuries," and/or delete "certain vaccines from the program, making it easier to bring lawsuits against vaccine-makers" directly.[48] Either move would have the effect of reducing public trust in vaccine experts and makers while potentially enriching more lawyers and alleged victims of vaccine injury.

One condition many fear Secretary Kennedy will add to the payable injury table is autism. Although he, CHD, and the anti-vaccine community "have long suggested a link between vaccines and autism," there is a "scientific consensus that childhood vaccines don't cause the condition. Adding autism to the list of injuries covered by the plan 'would dramatically increase the number of compensable cases,'" according to Yale University public health expert Jason Schwartz.[49] Advocacy groups for patients with autism spectrum disorder (ASD) and professional medical societies have agreed with investigative studies conducted in the U.S., Canada, Denmark, Japan, and other countries that found no link between vaccines and autism.[50]

Not only has the Vaccine Injury Compensation Program (VICP) "ruled against more than 5,000 claims from families who said vaccines led to their children's autism," but adding ASD to the government's table of injuries raises the probability that this might bankrupt the VICP and lead to "increase[d] taxes on vaccines to replenish the compensation fund."[51]

This would create higher prices for vaccines, making them less accessible due to an unfairly added condition. And, if the VICP were to cease functioning, this would lead to more frivolous lawsuits against manufacturers, which would further discourage them from providing vaccines to the U.S. market. This pathway is facilitated by the fact that "under current law, people claiming injuries from vaccines covered by the program must first pursue a compensation claim before they can sue."[52]

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[47] Perrone, "RFK Jr.'s Vow to Overhaul Vaccine Injury Program."
[48] Ibid.
[49] Ibid.
[50] Autism Speaks, "Do Vaccines Cause Autism?"; and Stangland, "AAP President: Federal Study," quoting AAP head Dr. Susan J. Kressly's opposition to the proposed HHS study on a vaccine-autism link: "Devoting more research dollars to [find an] answer . . . that is already known does not add to our knowledge about the safety of vaccines."
[51] Perrone, "RFK Jr.'s Vow to Overhaul."
[52] Ibid.

The viewpoint of NBCI is that the VICP needs to be improved with thoughtful care, not attacked or revamped. When the program was created in 1986, it was "designed to provide quick, efficient compensation to Americans who report known injuries associated with vaccines," and it helped stem the outflow of "vaccine-makers [that] were exiting the business due to risks of class-action lawsuits."[53] The program's purpose was thus twofold: to pay damages to those legitimately injured by a vaccination, and to preserve vaccine access by reducing the number of frivolous lawsuits that can lead to the loss of vaccine manufacturing and availability in the United States. Improving the program with more oversight and funding, or extending its three-year statute of limitations for claims, would both be preferable to trying to fix what does not seem to be "broken." The program should be viewed as a support for the vaccines preventing millions of illnesses and deaths each year, not their adversary.

V. *Major Questions*

(1) Can HHS Secretary Kennedy "work within the current vaccine approval and safety monitoring systems," and "maintain the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices (ACIP) without changes"? (Part of this question quotes text from his Senate confirmation hearing—including a pledge he made but later broke when he fired every member of ACIP.)[54]

Back in December of last year, Y. Tony Yang of the Center for Health Policy and Media Engagement at The George Washington University warned in *The Lancet* that this nation, "long seen as a global standard-bearer for public health policy, faces a dire risk if Kennedy gains control over the Department of Health and Human Services."[55] He cited not only Kennedy's "promotion of debunked claims, such as the false link between vaccines and autism," but also how, in Samoa, "Kennedy's visit and his rhetoric" increased "vaccine hesitancy" soon before a deadly measles outbreak there.[56] Within the ensuing months, Mr. Kennedy was confirmed to lead HHS and the "2025 Southwest measles outbreak" began.

As the disease spread through an under-vaccinated Mennonite community in Texas, most wondered how Secretary Kennedy would respond. Despite the proactive, vaccination-focused moves of past HHS heads in such crises, Kennedy would not explicitly promote the measles vaccine for the areas affected.[57] When the advocacy group Doctors for America called for the "resignation or removal" of Kennedy as HHS Secretary in April, they cited, among other things, his mishandling of the measles situation, particularly his providing of "misinformation" to the public and refusal to admit that "**All measles deaths are preventable with vaccination**" (emphasis in original).[58]

[53] Ibid.
[54] Woolf and Rosenthal, "RFK Jr. Is Systematically Undermining Vaccine Science."
[55] Yang, "The Perils of RFK Junior's Anti-Vaccine Leadership."
[56] Ibid.
[57] Rosenbluth, "Federal Officials Underplaying Measles Vaccination."
[58] Doctors for America, "Calls for the Resignation or Removal."

NBCI's main concern is that the Secretary's inability to stand fully behind the science of vaccines during health crises will drive an avoidance of immunization that will have an impact on the morbidity and mortality of African Americans, particularly young children and immunocompromised adults.

(2) Will the FDA work with the pharmaceutical industry (Pharma) to maintain a commitment to diversity and inclusion in clinical trials?

Although Pharma "has been loud and proud about its quest to bring more diverse patient populations into R&D—a goal tied to the longer-term aim of improving health outcomes,"[59] earlier this year, "the FDA's draft guidance on ensuring diversity in clinical trials was removed from its website."[60]

The DEI (Diversity, Equity, and Inclusion) question has yet to be answered clearly by the FDA or HHS Secretary Kennedy. With anti-DEI policies being all the rage in the Trump White House, the draft guidance later reappeared "with a note that the agency and administration 'reject' it because it's 'disconnected from the immutable biological reality that there are two sexes.'"[61] If this administration decides to fully reject the FDA's guidance, it will create more issues around prevention, morbidity, and mortality for African Americans.

The only leeway in this rejection is that it appears to be partial—there is more in diversity to consider with clinical trials than gender inclusivity—though it leaves no direction for Pharma to follow as a partner on this matter. The Association of Clinical Research Organizations (ACRO) executive director Doug Peddicord believes "there is strong evidence that having a more representative population in trials is good science, it's good ethics, and it's good business."[62] Indeed, the DEPICT Act (Diverse and Equitable Participation in Clinical Trials Act) of 2022 "stipulates that clinical trial sponsors establish enrollment goals based on age, sex, racial characteristics, explain the rationale for those goals, and create a strategy for execution."[63] Aman Khera, president of TOPRA (The Organization for Professionals in Regulatory Affairs), adds, "stronger ties with community organizations" will serve to "boost trust and access, and leverage digital tools and tailored outreach plans to reach different patient populations."[64] One such nationwide community organization is NBCI. With its National Clinical Trial Strategic Plan (NCTSP), NBCI can mobilize one of the country's largest clinical trial outreach plans to enroll African American and Latino participants. A prime factor in the cohesion of NCTSP is that it utilizes NBCI's network of 150,000 churches and includes tens of thousands of health professionals in its congregational life.

[59] Parrish, "FDA's 'Mixed Signals' on Diversity."
[60] Parrish, "What Should Pharma Make of the FDA?"
[61] Parrish, "FDA's 'Mixed Signals.'"
[62] Ibid.
[63] Parrish, "What Should Pharma Make of the FDA?"
[64] Parrish, "FDA's 'Mixed Signals.'"

(3) Will there be a health crisis if we fall further behind in vaccinations without a national immunization plan?

When Secretary Kennedy halted 22 mRNA technology projects worth half a billion dollars in August 2025, the move was ominous. The grave concern is not just because it is set against Kennedy's criticism of mRNA vaccines, his firing of the ACIP panel, or his handling of the measles outbreak in Texas. He is also sending a dangerous signal to the rest of the world. Professor Jennifer Nuzzo, founding director of the Pandemic Center, Brown University School of Public Health, called it "a message to our adversaries that the United States is uncommitted to preparing for future health emergencies—that the U.S. is now more vulnerable than it has ever been because we are systematically taking off the table multiple approaches to protect ourselves."[65]

The specter of germ warfare against the U.S. could become a reality, particularly since mRNA technology has been widely credited "for the fast turnaround of the COVID-19 vaccines" that protected so many here.[66] We also know from history that having vaccine manufacturing capacity on U.S. soil is essential to obtaining timely vaccine supplies for the nation. Cancellation of funding and the uncertainty generated by this HHS decision will further discourage vaccine manufacturers from investing in American-based manufacturing infrastructure. In order to bring us out of health emergencies, including those caused by VPDs, we need stable, scientifically grounded leadership at HHS, and so far that is wanting under this administration.

(4) Is Pharma politically afraid to defend its lifesaving immunizations?

The pharmaceutical industry is an internationally powerful one, and it cannot be assumed that it will abandon 100 years of vaccine history in the face of less than a year of political adversity. When speaking of anti-DEI challenges, TOPRA's Khera stated, "The work does not stop here. There is much to do. Albeit a little quieter, I see a commitment in the industry that's there and is not going away."[67] And, if the HHS secretary's far-fetched "universal vaccine" somehow becomes a reality, Pharma will be involved. Similarly, if the Vaccine Injury Compensation Program undergoes adverse changes, Pharma will likely fight them.

(5) Why are these changes to public health policy happening now, in the midst of a vaccination crisis?

Some may wonder if this could be part of a marketing scheme from Pharma, but it is best to recall that the industry shares the legitimate fears of healthcare cuts that worry the public. Theirs is an industry that depends on consumers using their health products, and the beneficial results they gain from them.

[65] Jarvis, "RFK Jr.'s mRNA Decision."
[66] Smith-Schoenwalder, "Calling the Shots."
[67] Parrish, "FDA's 'Mixed Signals.'"

As we have seen earlier, these changes stem from the Trump administration's desire to almost make anew the U.S. healthcare system, even if the approach seems based on empty assumptions that put lives in jeopardy instead of saving them. It has already been reported that "State and local health departments responsible for invisible but critical work such as inspecting restaurants, monitoring wastewater for new and harmful germs, responding to outbreaks before they get too big—and a host of other tasks are being hollowed out."[68] NBCI is wondering how many more health departments will be unable to protect all of their people, including African Americans, with preventive measures not limited to inspections or vaccines, in this evolving public health environment.

[68] Ungar and Smith, "Trump Administration's Deep Cuts."

Chapter 2: The Data Tells the Story

Implications of Pursuing the Wrong Policy

As related in the Introduction, the first two years of the COVID-19 pandemic were particularly deadly for African Americans. In point of fact, the lack of early vaccine readiness and other public health factors proved COVID-19 was a major indicator of what can go wrong. As of July 2021, "Black and Latino individuals in the US [were] 3 times more likely than White individuals to be hospitalized for COVID-19 and twice as likely to die from the disease."[69] The factors driving these disparities included differences in vaccination rates caused, in part, by "Black and Latino individuals [having] substantially worse access to primary care and specialty care, and [being] more likely to lack health insurance than White individuals."[70]

"It's unfortunate to me that the president of the United States should ignore decades and decades and decades of, in some cases, really superb science refuting any connection between vaccines and autism, Hildreth says. And I've been doing my best to advise the communities that we care about here at Meharry to let them know that if you're a parent of a school-aged child, you should get them vaccinated.

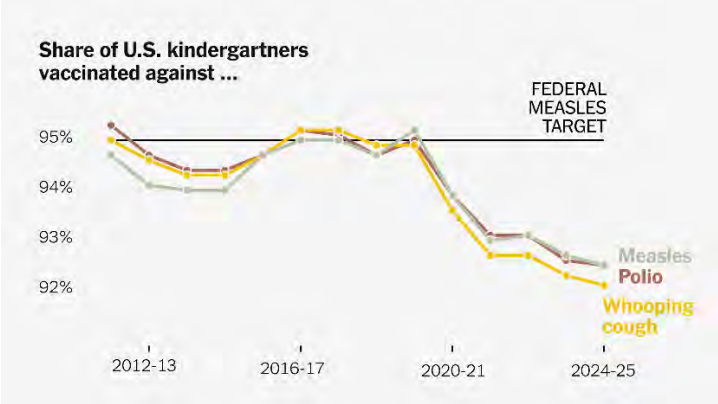
Hildreth says that he is worried that the government's changes in vaccine guidance are only going to increase vaccine hesitancy, at a time when vaccination rates have been dropping. He says that undercuts the government's stated plan to 'Make America Healthy Again.'"

Interestingly, a study concerning disparities in income, vaccination rates, and COVID-19 incidence among 5,083,093 citizens of Los Angeles, California, during the first years of the pandemic may point the way ahead during future outbreaks.

In this study involving 81 communities in Los Angeles, the authors found that, while "COVID-19 incidence during two surges before vaccine availability (July 2020 and January 2021) was higher in lower-income communities," during "the first surge after vaccines became available (September 2021)," the positive impact of vaccination actually "was highest in the lowest-income communities."[71]

[69] Evans, Webster, and Flores, "Partnering with the Faith-Based Community."
[70] Ibid.
[71] Masterson et al., "Disparities in COVID-19 Disease Incidence."

Although the lower-income communities had less vaccination coverage when the first surge after wide vaccine availability occurred, their "20% increase in community vaccination was estimated to have resulted in an additional 8.1% reduction in COVID-19 incidence. compared with that in the highest-income communities."[72] The authors do allow that the lowest-income communities' greater population density and higher percentage of positive COVID-19 test results before vaccine availability may have resulted in elevated, though unquantifiable, post-infection immunity before the September 2021 surge. Still, the chance of such immunity being effective as a preventative measure during a growing health crisis is very low.



What they found to be scientifically quantifiable for this population was the turnaround caused by immunization, and the "impact of vaccination in reducing disparities" in COVID-19 incidence *after* the third surge.[73] The meaning is clear: more actions need to be taken both to protect poorer communities before pandemic vaccines are available and, once they are available, to prioritize access for these communities since they have the most to gain from vaccination. Improving vaccine access to lower-income communities is essential to decreased incidence of illness for these populations and, by extension, the nation during a pandemic. The other important benefit is reducing historic disparities in health across class and race strata when such crises occur.

Similarly, the widespread use of vaccines in healthier times has been shown to reduce disparities in VPDs. For example, the introduction of pneumococcal conjugate vaccine for children in 1999 resulted in an 83 percent reduction of invasive pneumococcal disease (IPD) in non-Hispanic African American children and a 76 percent reduction for non-Hispanic White (NHW) children younger than 2 years of age—all in just 3 years.

[72] Ibid.
[73] Ibid.

Rev. Anthony Evans, President, National Black Church Initiative

The rate of invasive pneumococcal disease was still higher in African American children (though dropping from 2.1 times to 1.4 times higher than for Whites); however, only 31.2 percent of African American children were vaccinated, compared to 47.6 percent of NHW children.[74] The difference highlights the fact that further community health benefits were missed due to racial disparities in vaccination rates.

Since its inception in 1994, the Vaccines for Children Program (VFC), which provides vaccines at no cost to half of all U.S. children, has contributed to largely eliminating racial and ethnic disparities in early childhood vaccination rates, with the lowest pediatric vaccination rates now among NHWs.

The VFC program has been an overwhelming success, preventing over 500 million illnesses and over 1.1 million deaths, while also saving the U.S. nearly $2.7 trillion in societal costs.[75]

Yet, there has been a notable falloff in certain childhood immunization rates since the pandemic. Last month a KFF study revealed that: "Routine vaccination rates for kindergarten children continue to decline in the U.S., while exemptions from school vaccination requirements, particularly non-medical exemptions, have increased. These trends began during the COVID-19 pandemic and have continued."[76]

For example, up from just 3 states during the 2019-2020 school year, a total of 16 states had measles, mumps, rubella (MMR) vaccine rates below 90 percent for the 2024-2025 school year—over 5 percent lower than the HHS "Healthy People 2030" 95 percent standard.

Moreover, during the last year, a total of 17 states had more than 5 percent of kindergarteners claiming at least one vaccine exemption, and "over half of states experienced declines in vaccination rates across *all* state required vaccines, including MMR, DTaP [diphtheria, tetanus, acellular pertussis], polio, and varicella."[77]

The alternative, and what makes the current amount of vaccination decrease particularly significant, is that, in the opinion of Stanford University infectious diseases professor Nathan Lo, "Increasing vaccination levels by just 5% brings the number of measles cases down."[78]

[74] Talbot et al., "Elimination of Racial Differences."
[75] Valier et al., "*Vital Signs*: Trends and Disparities."
[76] Williams, Kates, and Michaud, "Kindergarten Routine Vaccination Rates Continue."
[77] Ibid. (emphasis added).
[78] Savchuk, "Measles May be Making a Comeback."

Chapter 3: NBCI Has an Effective Strategy

In 1985, then HHS Secretary Margaret Heckler issued the *Report of the Secretary's Task Force on Black and Minority Health*, often referred to as the Heckler Report. This was the first government investigation of racial and ethnic health disparities, a "landmark" document that instigated many similar reports,[79] and yet, 40 years later, there is still no coherent strategy on the federal level to minimize these inequities and excess deaths. A significant portion of the mortality and morbidity of African Americans stems from VPDs.

NBCI realized years ago it must act about the immunization crisis. In fact, for 30 years, NBCI has worked to prevent health problems, and currently runs a 10-year immunization program that has been underway since 2020. The objective is for all 27.7 million NBCI members to meet their immunization requirements.

We have the most effective, proven model in the U.S. to achieve this goal with education, oversight, outreach, and literature (the publications *VACCNEWS* and *Immunization Now*). (See more on NBCI's 10-year plan in Chapter 5 below.)

As a coalition of 150,000 African American and Latino churches aiming to eradicate racial and ethnic disparities in healthcare, technology, education, housing, and the environment, NBCI provides critical wellness information to all members, congregants, churches, and the public at large.

Developing Prevention Material:

In January of this year, NBCI launched the "Immunization Now" campaign, which has already impacted over 3,300,000 African Americans nationwide and resulted in close to 350,000 new vaccinations at last count. In agreement with, though not inspired by, an NFID recommendation to "develop culturally appropriate educational materials,"[80]

NBCI educates members with the *Immunization Now* newspaper along with videos on YouTube of the campaign's Health Sermons and related events. This is the kind of approach Dr. Hildreth, Meharry Medical College's president and CEO, spoke of recently when he said, "If you meet people where they are, answer their questions, provide some data to them, and all I think we can convince people, reasonable people, that vaccines should be taken." His experience during the COVID-19 pandemic prompted him to add, "One of the things that seemed to especially resonate in the African-American community was the idea that, by vaccinating yourself, you're protecting the larger community. And maybe that's related to a deep grounding in faith or religion, or this idea that we're all each other's keeper."[81]

During the COVID-19 pandemic, NBCI's work on immunization paralleled that of various community-based organizations (CBOs) around the country receiving aid from CDC's Partnering for Vaccine Equity (P4VE) program.

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[79] Johnson, "Black Communities Endured Wave of Excess Deaths."
[80] NFID, *Four Ways to Address Disparities*.
[81] Southwick, "A Medical School Leader Fears Rising Vaccine Skepticism."

Supported in part by CDC's REACH (Racial and Ethnic Approaches to Community Health) program, P4VE has continued to improve vaccine equity for minority communities. From 2021 through April 2024, P4VE found success in using five strategies: (1) training "trusted messengers" to do vaccine education outreach in their own communities; (2) engaging community members during promotional events; (3) communicating with doctors and other medical personnel; (4) facilitating flu and COVID-19 vaccinations; and (5) initiating "674 educational campaigns in 45 languages."[82] However, there are a number of reasons to believe that REACH, P4VE, and similar programs are now in danger.

Dr. James A. McCoy, MD, FACS

In late January, Isabel Perez, a REACH program manager in central California, received an email from CDC about her grant. It read, in part, "'Any vestige, remnant, or re-named piece of any DEI programs funded by the U.S. government under this award are immediately, completely, and permanently terminated,'" pursuant to an executive order from President Trump.[83] This message also went to other diverse CBOs around the country, threatening their program funding. Around the same time, the CDC's "Social Vulnerability Index" (SVI), which "state and local health departments and nonprofits use. to guide community-based health promotion initiatives," disappeared from CDC webpages.

While it is true the federal government later restored the SVI because of a court order,[84] removing or altering this necessary data is a blow to CBOs' health initiatives nationwide. Though it was rejected by the Senate Committee on Appropriations (see Chapter 1, part II above), a similar cut to the NIH budget that the White House asked for was "the closure of the National Institute on Minority [Health] and Health Disparities" or NIMHD.[85]

The anti-DEI and uncaring attitudes toward attempts to remedy racial and ethnic health disparities are self-evident in these actions. It is no wonder that, on July 30, Dr. Frieden warned in the *New England Journal of Medicine* that the CDC "—and its ability to support clinicians, communities, and organizations—is under assault."[86] This assault will have a direct, negative effect on the health of African American, Latino, and other vulnerable communities now served by the CDC.

[82] CDC, "Partnering for Vaccine Equity"; and CDC, "Strategies for COVID-19, Flu, and Other Adult Vaccines."
[83] Aguilar, "Feds Disrupt DEI Program."
[84] CDC, "Social Vulnerability Index." (The restored SVI includes a box with a statement against "gender ideology," that asserts, "Information on this page may be modified and/or removed in the future.")
[85] USAFacts, "What's in Trump's 2026 Budget Proposal?"
[86] Frieden, "Dismantling Public Health Infrastructure."

Chapter 4: Of Hope and the Disaster

Dr. Joseph L. Webster, Sr, MD, MBA, FACP

Our Hope:

In NBCI's thoroughly researched and pragmatically hopeful document, "*Moving toward a National Black Health Agenda* (NBHA)", the proposition was put forth that the nation's persistent health disparities could be addressed with cost-saving additions to the HHS budget. Using the President's Fiscal Year (FY) 2025 Budget proposal for $130.7 billion in discretionary and $1.7 trillion in mandatory proposed budget authority as a baseline, NBHA requested "an additional $2 trillion with free enrollment at the FY2021-2024 COVID-19 level for Medicaid and Medicare and an additional $25 billion in discretionary spending."

While the NBHA sought an HHS mandatory budget cap of $3.7 trillion, with the addition made "to restore the healthcare of the 15-20 million uninsured who received temporary coverage under the pandemic emergency authorization," discretionary spending should rise to $155.7 billion. The NBHA also desired "consistent increases within discretionary spending on an average of $25 billion annually to specifically attack, and in some cases eliminate, health disparities through efficiency, technology, and additional funding."[87]

The NBHA advised 14 cost-saving strategies to facilitate this proposal:

1. Allow President Trump's tax cuts to die to have sufficient revenue to fund the asked amount of $2.025 trillion. An additional $4.6 trillion, including the cost of debt service, would be saved over the next decade, according to the Congressional Budget Office.

2. Limit, by act of the U.S. Congress, private equity firms' investments to no more than 10% ownership of any patient-delivery services, including hospitals. Private equity firms are a direct threat to achieving any health disparities goals because of their overriding profit motive objective. FRONTLINE and NPR investigated the growing inequities in American healthcare exposed by COVID-19. The Healthcare Divide examines how pressure to increase profits—and uneven government support—are widening the divide between rich and poor hospitals, endangering care for low-income populations.

3. Transform the USA's 'sick-based' healthcare delivery model into a preventive health model.

4. Deduct the Federal Assistance to the States dollar amount based on the Opioid Payout unless the state agrees to spend at least 99% of its dollars on opioid care.

5. Provide that the Centers for Medicare & Medicaid Services' (CMS) hospital supplements should only go to those hospitals—rural or urban—that have a hospital-based patient population that is at least 50% poor as defined by the Federal Poverty Level (FPL). We base this figure on the current formula used by CMS. We are arguing that there will either be a major realignment in CMS rules and regulations or the Congress to achieve the desirable outcomes.

[87] NBCI, *National Black Health Agenda*, pp. xiii, xv.

6. Reform health insurance companies, reduce the "automatic denial rate" for service to less than 75%, and increase requirements for justification of denial.

7. Place a moratorium on healthcare insurance premium increases for at least five years.

8. Restore Rural and Critical Urban Hospitals that were closed within the last seven years.

9. Reform Urgent Care Centers and modernize them and their role in outpatient healthcare services.

10. Promote Alternative and Holistic Medicine, and incorporate the Faith-based Community in re-envisioning a holistic design that amplifies preventive medicine.

11. Reform and Restructure CMS completely—including the implementation of a plan to reduce waste, abuse, and fraud in CMS by at least 75%—by hiring an additional 5,000 "loss officers."

12. Implement a minimum tax of 17% or higher for people making more than $5 million annually.

13. Implement a 0.7% increase in the Leisure Tax on guns, tobacco, alcohol, lottery tickets, and travel.

14. Cancel two new weapon systems from the Department of Defense budget that are projected to cost over $1 TRILLION over the next five years."[88]

The NBHA's recommendation concluded: "Leading healthcare experts, and the Center on Budget and Policy Priorities in their article 'More Revenue Is Required to Meet the Nation's Commitments, Needs, and Challenges,' agree that if the items listed above are fully implemented, **the federal government will save more than $3 to $5 TRILLION over the next 10 years**" (emphasis in original).[89]

The Disaster:

The emerging healthcare crisis is evolving due to the planned absence of an effective immunization policy for health-compromised populations, along with a severe lack of public education and culturally sensitive and competent literature. If the absurd stance on immunization continues, *and* the federal government fails to implement recommended NBHA policy, then, given the unaddressed morbidity and mortality rates before COVID-19, and what followed during that pandemic, another pandemic that disproportionately impacts both African American and Latino populations will likely occur.

It is sobering to realize that the CDC, in its own FY 2026 "Justification of Estimates for Appropriation Committees," had made a request for "**$963,291,000** for Immunization and Respiratory Diseases [that] is **$44,000,000** above the FY 2025 enacted level" (emphases in original).[90]

[88] Ibid., p. xiv.
[89] Ibid., p. xv.
[90] CDC, "Justification of Estimates," p. 17.

The writers justified this by stating that the "increase will strengthen the nation's early warning detection and response system for routine respiratory and other vaccine-preventable disease threats which can easily overwhelm our healthcare systems, including influenza, RSV, or novel respiratory viruses."[91] Professor Nuzzo at Brown University's School of Public Health reminds us that recent and proposed staffing cuts at the CDC occur against "the backdrop of a public health workforce that has been systematically decimated over time. We started the COVID-19 pandemic with a dearth of personnel. And we suddenly saw a scrambling and billions of dollars spent to try to hire temporary workers to deploy to health departments and backfill them for the activities needed during the pandemic." She concludes with what could be a warning for future immunization and disease crises: "Well, that's not a great way to build a workforce."[92]

And neither is ousting the head of the CDC just weeks into her tenure, as happened to Susan Monarez in late August. According to her lawyers, Mark Zaid and Abbe David Lowell, Director Monarez's fate was sealed when "she 'refused to rubber-stamp unscientific, reckless directives and fire dedicated health experts.'"[93] Four other CDC leaders also resigned: "Dr. Debra Houry, the agency's deputy director; Dr. Daniel Jernigan, head of the agency's National Center for Emerging and Zoonotic Infectious Diseases; Dr. Demetre Daskalakis, head of its National Center for Immunization and Respiratory Diseases; and Dr. Jennifer Layden, director of the Office of Public Health Data, Surveillance, and Technology."[94] In her resignation email viewed by The Associated Press, Dr. Houry shared that "the ongoing changes prevent me from continuing in my job as a leader of the agency." She also stated, "For the good of the nation and the world, the science at CDC should never be censored or subject to political pauses or interpretations."[95]

In his resignation letter, Dr. Daskalakis added, "I am unable to serve in an environment that treats CDC as a tool to generate policies and materials that do not reflect scientific reality."[96] What we are experiencing is a loss of infectious disease expertise and health policy leadership that may take many years to replace. The Infectious Diseases Society of America (IDSA) has now published a "Joint Statement Calling for Secretary Kennedy Resignation" that is co-signed by 20 other professional medical and scientific societies and related organizations.[97] The Statement cites the Secretary's "repeated efforts to undermine science and public health," and practically calls his "forcing high-level CDC expert leaders to turn their back on decades of sound science to meet [his] agenda" a last straw.

On September 4, ousted CDC head Susan Monarez explained her dismissal in a piece in the *Wall Street Journal*. She wrote that she was pressured "to preapprove the recommendations of a vaccine advisory panel newly filled with people who have publicly expressed anti-vaccine rhetoric."

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[91] Ibid.
[92] Infection Control Today Editorial Staff, "The CDC at a Crossroads."
[93] Muller et al., "Trump Administration Ousts CDC Director."
[94] Stobbe, "CDC Director Susan Monarez is Fired."
[95] Ibid.
[96] Ibid.
[97] IDSA, "Joint Statement Calling for Secretary Kennedy."

She also decried this stacking of ACIP and firing of experienced scientists as nothing less than a form of "sabotage."[98] In her testimony before the Senate on September 17, Susan Monarez revealed that, contrary to Secretary Kennedy's prior claim to the Senate that she called herself "untrustworthy," his statement to Monarez was that he could not trust her "because I had shared information related to our conversation beyond his staff." This disclosure referred to her telling the Senate HELP Committee that he had "asked her to make pre-commitments about ACIP recommendations" without ascertaining "whether there was scientific evidence to support those recommendations."[99]

Whether or not the Secretary's preferred ACIP membership shall continue to serve is now central to a lawsuit brought by professional medical societies such as AAP and IDSA, and concerned others, in U.S. District Court. The complaint is available to read here: https://www.documentcloud.org/documents/26218841-aap-v-kennedy-3rd-amended-complaint/.

A recent *MedPage Today* report about the lawsuit is worth quoting in its entirety:

The American Academy of Pediatrics (AAP) and other medical groups have updated their lawsuit against HHS Secretary Robert F. Kennedy Jr., calling for his novel Advisory Committee on Immunization Practices (ACIP) to be disbanded and its decisions overturned.

They also want ACIP to be reconstituted under court supervision, according to the updated lawsuit, which was filed on Wednesday.

New ACIP appointees lack the credentials and experience necessary to be part of ACIP, and their votes should be declared null and void, according to the lawsuit.

"You have an ACIP that shouldn't be making policy, now starting to make policy. We want it disbanded," Richard H. Hughes IV, lead counsel on the lawsuit and partner at the Epstein Becker Green law firm, told MedPage Today.

Hughes noted that he doesn't know of any precedent for a panel established under the Federal Advisory Committee Act to be reconstituted under court supervision, but he is optimistic about the chances for this to happen.

"The nation's children are already paying the price in avoidable illnesses and hospitalizations," AAP President Susan Kressly, MD, said in a statement. "We urge federal leaders to restore the science-based deliberative process that has made the United States a global leader in public health. Urgent action is needed."

AAP, along with five other medical groups—including the Infectious Disease Society of America, the American College of Physicians, and the American Public Health Association--originally sued Kennedy and HHS in July, for unilaterally changing COVID vaccine recommendations without any evidence.

[98] Bendix and Haake, "Ousted CDC Chief Warns."
[99] Moniuszko and Quinn, "Ousted CDC Director Susan Monarez Testifies."

The original lawsuit also called out Kennedy's firing of the 17 members of ACIP in June.

The updated lawsuit noted that at the September meeting of ACIP, its COVID workgroup "presented information that contained material inaccuracies, including an allegation that the COVID-19 vaccine resulted in 'DNA contamination.'" It also noted that the workgroup didn't conduct a systematic review ahead of the meeting, and that information about rare side effects was given disproportionate attention.

In its press release on the updated complaint, AAP also noted other problems with recent ACIP policy decisions, including its recommendation against flu shots containing thimerosal, despite studies showing the preservative is safe. It also challenged the committee's decision that kids under 4 should get the measles, mumps, and rubella vaccine separate from the varicella vaccine, instead of the combination shot.

AAP said it's also concerned about the group's deliberations about the hepatitis B birth dose, and its investigation into the childhood vaccination schedule, which it says has long been proven safe.[100]

Given this lawsuit, the upheaval at CDC, and Secretary Kennedy's cancellation of 22 projects for the development of mRNA vaccines *without* providing a timeline for the availability of their replacements, the state of affairs for infectious disease control at the start of the next major health crisis could be much worse than at the beginning of the COVID-19 pandemic. The door is open for the possibility that known communicable diseases, from measles and chickenpox to COVID-19 and the flu, will be ravaging African American and Latino neighborhoods across the country due to a lack of available or reliable vaccines, and that these communities will also be more vulnerable to the ravages of the next pandemic. It is already true that pneumococcal vaccination rates in African American adults lag behind those for NHW adults even though the burden of disease from pneumococcal infections is higher in African Americans.[101] And researchers report that invasive pneumococcal disease "rates among Black adults peaked at a younger age (55–59 years) compared with rates among non-Black adults whose IPD rates increased with increasing age."[102] Without immunizations, people are more vulnerable to preventable pneumonia, bacteremia, and meningitis from pneumococcal bacteria, and to the health impacts of other vaccine-preventable diseases. In response to recent comments by the current head of ACIP, Dr. Mitchell of the NMA said, "Undercutting routine vaccination places the public at serious risk and threatens decades of progress in preventing disease, disability, and death." He went on to remind us that "there is no cure for paralytic polio," and prior to the polio vaccine, "the virus caused approximately 15,000 cases of paralysis each year, primarily among children" in the U.S.[103]

[100] Fiore, "Disband CDC Vaccine Panel, Updated Lawsuit Says."
[101] Hung et al., "Vaccination Coverage among Adults."
[102] Kobayashi et al., ""Expanded Recommendations for Use."
[103] Mitchell, "National Medical Association Rejects Proposal." (See full statement later in document.)

One byproduct of the significant falloff in childhood immunization rates since the pandemic (discussed in Chapter 2) has been the reemergence of deadly measles cases. Two scientists at Stanford University who were engaged in an epidemiological study for *JAMA* on the likelihood and extent of the spread of infectious diseases due to further decreases in childhood vaccination rates were able to predict disturbing scenarios. Professors Mathew Kiang and Nathan Lo shared some of their conclusions in an interview with *Stanford Medicine*. According to Prof. Kiang, "With measles, we found that we're already on the precipice of disaster." He added, "If vaccination rates remain the same measles may become endemic within about 20 years. That means an estimated 851,300 cases over 25 years, leading to 170,200 hospitalizations and 2,550 deaths."[104] And Lo offered, "Polio, diphtheria, and rubella are still far more infectious than COVID-19," while Kiang revealed, "If [childhood] vaccination rates were cut in half, we'd expect 51.2 million cases of measles, 9.9 million cases of rubella, 4.3 million cases of polio, and 200 cases of diphtheria over 25 years. This would lead to 10.3 million hospitalizations and 159,200 deaths," along with thousands of lifelong disabilities.[105]

An avoidable addition to the projected healthcare disaster is the OBBBA's denial of Medicaid coverage to some 10 million people. The ACA included Medicaid expansion provisions because its "central purpose" was "to cover the entire American population, providing all and each with access to health care of quality."[106] However, in a perverse exercise of states' rights, ten states, mostly in the South, have refused to participate in the Medicaid expansion, leaving many of their low-income households, people with disabilities, and even the elderly with either no or incomplete healthcare coverage. Providing a likely inspiration to the OBBBA, three of these states—Georgia, Mississippi, and South Carolina, all with sizeable African American populations—currently condition some Medicaid eligibility on compliance with work requirements.[107] Millions will lose their health insurance by 2034, and OBBBA's changes to Medicaid, Medicare, and the ACA will be the main cause. If the newly uninsured do not die before entering a hospital or clinic, they *will* need care. And what happens if hospitals around the country start to collapse under the weight of both lost Medicaid revenue and caring for the uninsured without the necessary level of compensation? What the OBBBA seems to have created is an oncoming, manmade, and unsustainable healthcare access crisis.

There needs to be consistency and clarity on what we need to make and keep "America healthy again." We need to focus on what has to take place in terms of bringing together industry and government to have the right public policy. Then we can work toward a national strategy and plan, a sensible initiative, in light of this confusion. It must be added that the fight between the pharmaceutical industry and the lawyers is not NBCI's fight; as a faith-based community, we do not care about their differences in opinion. We do not have the luxury to sit on the sidelines and listen to their argument over immunization.

[104] Savchuk, "Measles May be Making a Comeback."
[105] Ibid.
[106] Smith and Moore, *Medicaid Politics and Policy*, p. 396.
[107] KFF, "Status of State Medicaid Expansion."

We care about what is best for the health and well-being of our 27.7 million parishioners in 150,000 African American and Latino churches, and the nation.

Chapter 5: The NBCI 10-Year Immunization Program

The goal of our 10-year immunization plan is to educate and vaccinate NBCI's 27.7 million members (*see* https://naltblackchurch.com/health/flu-campaign.html). We are in the fifth year of this 10-year program. From its inception in 2019 through the present year, this is what we have been involved in.

In 2019, we geared up for the ill effects of the disease known as COVID-19 by activating over 35,000 churches.

In 2020, we activated these churches to address the growing pandemic.

In 2021, our activation grew to 75,000 churches.

In 2022, the activation became 150,000 churches.

In each year, we re-emphasized the importance of immunization.

From 2023 to 2025, we did this in response to the CDC's message that the nation had fallen behind on routinely recommended vaccinations due to COVID-19 and increases in vaccine skepticism. Now we are fulfilling the CDC's vaccine recommendations to immunize all NBCI members, ensuring they are caught up on those vaccines, as we work with the ever-changing vaccine schedules.

NBCI's 10-year initiative on immunization began as part of its national flu campaign shortly before the COVID-19 pandemic arose. A major objective of the "NBCI 10-Year Immunization Program: 2020-2030" is building a network of "Vacc churches" to facilitate the protection of African Americans of all ages against certain diseases. These include an array of vaccine-preventable and communicable illnesses.

The NBCI 10-Year Immunization Program: 2020-2030 is a national strategy including these elements:

- National Advisory Committee - Comprised of 5 African American and 4 Latino physicians who evaluate and report on vaccine effectiveness and safety. The Committee also publicizes the program via African American and Latino radio stations, writes articles targeting African American and Latino newspapers and magazines, including our own *Immunization Now* paper, and leverages social media to eliminate vaccine myths and correct misinformation. It directly addresses the concerns of African American and Latino populations, and mobilizes neighborhood influencers, civic groups, and local public health officials to advocate for vaccination.

- Critical Response Teams - Sent to zip code–based locations with the highest proportions of impoverished residents, those living in public housing, or both. Each team consists of a local team leader, Latino and African American health professionals, a community representative, 5 to 10 outreach workers/volunteers, and mental health specialists. The teams: develop and disseminate culturally and linguistically diverse, multimedia outreach programs about vaccinations; promote use of best practices for disease prevention, detection, and treatment; and identify future healthcare priorities for the communities they serve.

- Stakeholder Roundtable - Individualizes the needs of identified local communities to develop tailored resources with healthcare provider (HCP), community leader, and community member feedback.

- Health Sermons - Trusted HCP congregant members present evidence-based patient education on the importance of vaccination, the appropriate schedule, and solutions to social drivers to communities where they are from.

- Health Information Fairs - Address access to culturally sensitive information from local advocates and community HCPs in a safe environment for asking questions about science, access, and schedules.

- Online Modules - Reinforce the idea and remind community members that there is a trusted place to find vetted, evidence-based information on vaccination—and to build confidence in discussions with HCPs.

- *Vaccine News Special Edition* - Provides community members with reminders for health information events, access to an online hub, a quick guide to adult vaccination schedules, and a copy of a vaccination diary. *VACCNEWS* addresses HCP gaps of underserved community members, those who may not have a regular provider or access to vaccination records in one place, by empowering them to manage their records as they access care.

(*See:* more on NBCI's website: https://naltblackchurch.com/health/flu-campaign.html.)

As NBCI pursues our 10-Year Immunization Program goal of vaccinating 27.7 million members, can we still trust the CDC immunization schedule? And with over 10 million people projected to be cut from Medicaid rolls, how does HHS expect to promote the health of the uninsured and the millions more who live with and around them? In this changing public health environment with less guarantees than before, what help can NBCI expect from the federal government to meet the healthcare needs of our members?

CDC Panel Targets Size of Childhood Vaccine Schedule, Safety of Aluminum Adjuvants

— "What you have said is a terrible, terrible distortion of all the facts," one panel member said

By Terrence Rudd, Staff Writer, MedPage Today

December 5, 2025 3 min read

The CDC's revamped Advisory Committee on Immunization Practices (ACIP) discussed shrinking the childhood vaccination schedule and setting up a working group to assess the safety of aluminum adjuvants in vaccines during the final day of its 2-day meeting. The committee, which was completely overhauled by HHS Secretary Robert F. Kennedy Jr. earlier this year, took no votes Friday on any topics. Instead, the day's agenda showcased vaccine-skeptical arguments and sidelined decades of data and the CDC's own subject matter experts.

ACIP presenters launched broadsides against the safety data underpinning approved childhood vaccines, questioned the need for a relatively extensive childhood immunization schedule, and proposed a closer look at the safety of vaccine adjuvants like aluminum, including possible links to autism.

Earlier in the day, the panel had voted to stop recommending that every newborn receive a hepatitis B vaccine at birth.

Hours after the meeting's end, President Donald Trump announced he'd direct HHS to review the U.S. childhood vaccine schedule, compare it with other nations' schedules, and make changes.

The panel gave the presentation stage to vaccine injury lawyer and author Aaron Siri, along with ACIP committee member Evelyn Griffin, MD, an ob/gyn at Baton Rouge General Medical Center in Louisiana, and Tracy Beth Høeg, MD, PhD, the newly appointed acting director of the FDA's Center for Drug Evaluation and Research.

In a presentation that lasted over an hour and a half, Siri delivered an extensive overview of the immunization schedule's history and expansion and questioned the safety data used to license many vaccines. He asserted that there are no studies that have ruled out a causal relationship between autism and vaccines such as the diphtheria, tetanus, and pertussis (DTaP) shot, and repeatedly cited a common argument among vaccine

Siri's presentation prompted an incredulous response from ACIP member H. Cody Meissner, MD, of the Geisel School of Medicine at Dartmouth in Hanover, New Hampshire.
"What you have said is a terrible, terrible distortion of all the facts," he countered.

"You clearly confuse associations, that is, there is a temporal association and a causal association," he said. "Just because there's an adverse event that occurs around the time of vaccine administration, it doesn't mean there's any causal association. And you're jumping to the conclusion that, yes, there is."

Denmark's Schedule Svelter Than U.S.?

Høeg's presentation compared and contrasted the childhood vaccination schedules in Denmark and the U.S. "Why are we so different from other developed nations, and why is it scientifically justified?" she asked.

Høeg showcased a slide showing 72 total core childhood vaccine doses in the U.S. schedule, compared with 11 in Denmark, though she noted that European countries give more combination vaccines.

She also questioned a vaccines-for-all approach. "Just because the U.S. has a larger population of high-risk children, should the core childhood vaccination schedule be larger?" she asked. "Or should healthy children without underlying risk factors really receive different vaccines than they do in Denmark or other high-income nations?"

"Just because a vaccine is approved, it doesn't mean it should be approved for all children," she added.

The ACIP liaison for the Infectious Diseases Society of America, Flor Munoz-Rivas, MD, questioned the value of Høeg's comparison with Denmark, a nation of 6 million people. "It seems to be irrelevant to compare U.S. policy with Danish policy, given that the data and the decisions need to be based on our local information and needs," she said.

Stacy Buchanan, DNP, RN, of the National Association of Pediatric Nurse Practitioners, agreed. "There are lots of pockets of communities within the United States that are unvaccinated," she said. "It doesn't look like Denmark has those pockets of communities. ... When we talk about changing policy for the entire United States, we need to take that into consideration."

Aluminum Adjuvants Under the ACIP Microscope

In the day's final presentation, panel member Griffin floated the idea of an ACIP working group focused on the safety and effectiveness of adjuvants in vaccines. Griffin's talk included alleged data gaps in aluminum adjuvant safety studies, and the potential risks to infants and children of cumulative aluminum exposure through multiple vaccines.

Among the areas she posed as potential group topics were the administration of multiple aluminum-containing vaccines on the same day in early infancy, a potential preference for lower-aluminum vaccine formulations, and establishing an evidence-based safety margin for the adjuvant.

Such a push is a solution in search of a problem, some experts countered.

"This ingredient is only present in safe, trace amounts," said Sean O'Leary, MD, of the University of Colorado Denver, who is the chair of the American Academy of Pediatrics' (AAP) Committee on Infectious Diseases, during a press briefing hosted by the AAP. "It has been used in vaccines for more than 100 years. Plenty of research has found no evidence that aluminum in vaccines causes any of the conditions that they say it does, including autoimmune conditions, neurodevelopmental disorders, or other serious adverse events."

For example, a recent large Danish study showed that cumulative aluminum exposure from vaccination during the first 2 years of life did not raise the risk of neurodevelopmental, autoimmune, atopic, or allergic disorders. The journal in which it was published rejected a call from Kennedy to retract the study.

"Removing aluminum or any ingredient from these vaccines could impact their effectiveness and reduce children's immune systems' ability to protect against disease," O'Leary said.

During a briefing sponsored by the National Foundation for Infectious Diseases, Peter Hotez, MD, PhD, of the Baylor College of Medicine in Houston, pointed out that "if you don't have an aluminum adjuvant, you're going to have to have another substitute."

"If you now have to substitute a different adjuvant, that's 5 to 7 years of research and development, tens or hundreds of millions of dollars -- who pays for that? The pharma companies aren't going to do that," he said.

"When you talk about ... taking out aluminum adjuvants, remember what they're really saying," Hotez added. "This is a device to remove vaccines out of the ecosystem and to jeopardize the American public."

Terrence Rudd is a staff writer at MedPage Today, covering the infectious diseases beat. He has been a medical writer and editor for more than 30 years.

Increases in Vaccine-Preventable Disease Outbreaks Threaten Years of Progress, Warn WHO, UNICEF, Gavi

Agencies call for sustained investments in immunization efforts amidst looming funding cuts

24 April 2025
News release

Geneva, Switzerland; New York, United States of America

Immunization efforts are under growing threat as misinformation, population growth, humanitarian crises and funding cuts jeopardize progress and leave millions of children, adolescents and adults at risk, warn WHO, UNICEF, and Gavi during World Immunization Week, 24–30 April.

Outbreaks of vaccine-preventable diseases such as measles, meningitis and yellow fever are rising globally, and diseases like diphtheria, that have long been held at bay or virtually disappeared in many countries, are at risk of re-emerging. In response, the agencies are calling for urgent and sustained political attention and investment to strengthen immunization programmes and protect significant progress achieved in reducing child mortality over the past 50 years.

“Vaccines have saved more than 150 million lives over the past five decades,” said WHO Director-General, Dr Tedros Adhanom Ghebreyesus. “Funding cuts to global health have put these hard-won gains in jeopardy. Outbreaks of vaccine-preventable diseases are increasing around the world, putting lives at risk and exposing countries to increased costs in treating diseases and responding to outbreaks. Countries with limited resources must invest in the highest-impact interventions – and that includes vaccines.”

Rising outbreaks and strained health systems

Measles is making an especially dangerous comeback. The number of cases has been increasing year on year since 2021, tracking the reductions in immunization coverage that occurred during and since the COVID-19 pandemic in many communities. Measles cases reached an estimated 10.3 million in 2023, a 20% increase compared to 2022.

The agencies warn that this upward trend likely continued into 2024 and 2025, as outbreaks have intensified around the world. In the past 12 months, 138 countries have reported measles cases, with 61 experiencing large or disruptive outbreaks – the highest number observed in any 12-month period since 2019.

Meningitis cases in Africa also rose sharply in 2024, and the upward trend has continued into 2025. In the first three months of this year alone, more than 5500 suspected cases and nearly 300 deaths were reported in 22 countries. This follows approximately 26 000 cases and almost 1400 deaths across 24 countries last year.

Yellow fever cases in the African region are also climbing, with 124 confirmed cases reported in 12 countries in 2024. This comes after dramatic declines in the disease over the past decade, thanks to global vaccine stockpiles and use of yellow fever vaccine in routine immunization programmes. In the WHO Region of the Americas, yellow fever outbreaks have been confirmed since the beginning of this year, with a total of 131 cases in 4 countries.

These outbreaks come amidst global funding cuts. A recent WHO rapid stock take with 108 country offices of WHO – mostly in low- and lower-middle-income countries – shows that nearly half of those countries are facing moderate to severe disruptions to vaccination campaigns, routine immunization and access to supplies due to reduced donor funding. Disease surveillance, including for vaccine-preventable diseases, is also impacted in more than half of the countries surveyed.

At the same time, the number of children missing routine vaccinations has been increasing in recent years, even as countries make efforts to catch up children missed during the pandemic. In 2023, an estimated 14.5 million children missed all of their routine vaccine doses – up from 13.9 million in 2022 and 12.9 million in 2019. Over half of these children live in countries facing conflict, fragility, or instability, where access to basic health services is often disrupted.

“The global funding crisis is severely limiting our ability to vaccinate over 15 million vulnerable children in fragile and conflict-affected countries against measles,” said UNICEF Executive Director Catherine Russell. “Immunization services, disease surveillance, and the outbreak response in nearly 50 countries are already being disrupted – with setbacks at a similar level to what we saw during COVID-19. We cannot afford to lose ground in the fight against preventable diseases.”

Continued investment in the ‘Big Catch-Up initiative’, launched in 2023 to reach children who missed vaccines during the COVID-19 pandemic, and other routine immunization programmes will be critical.

How immunization addresses these challenges

Joint efforts by WHO, UNICEF, Gavi and partners have helped countries expand access to vaccines and strengthen immunization systems through primary health care, even in the face of mounting challenges. Every year, vaccines save nearly 4.2 million lives against 14 diseases – with nearly half of these lives saved in the African Region.

Vaccination campaigns have led to the elimination of meningitis A in Africa’s meningitis belt, while a new vaccine that protects against five strains of meningitis holds promise for broader protection, with efforts underway to expand its use for outbreak response and prevention.

Progress has also been made in reducing yellow fever cases and deaths through increasing routine immunization coverage and emergency vaccine stockpiles, but recent outbreaks in Africa and in the Region of the Americas highlight the risks in areas with no reported cases in the past, low routine vaccination coverage and gaps in preventive campaigns.

In addition, the past two years have seen substantial progress in other areas of immunization. In the African Region, which has the highest cervical cancer burden in the world, HPV vaccine coverage nearly doubled between 2020 and 2023 from 21% to 40%, reflecting a concerted global effort towards eliminating cervical cancer. The progress in immunization also includes increases in global coverage of pneumococcal conjugate vaccines, particularly in the South-East Asia Region, alongside introductions in Chad and Somalia, countries with high disease burden.

Another milestone is the sub-national introduction of malaria vaccines in nearly 20 African countries, laying the foundation to save half a million additional lives by 2035 as more countries adopt the vaccines and scale-up accelerates as part of the tools to fight malaria.

Call to action

UNICEF, WHO, and Gavi urgently call for parents, the public, and politicians to strengthen support for immunization. The agencies emphasize the need for sustained investment in vaccines and immunization programmes and urge countries to honour their commitments to the Immunization Agenda 2030 (IA2030).

As part of integrated primary health-care systems, vaccination can protect against diseases and connect families to other essential care, such as antenatal care, nutrition or malaria screening. Immunization is a ‘best buy’ in health with a return on investment of $54 for every dollar invested and provides a foundation for future prosperity and health security.

“Increasing outbreaks of highly infectious diseases are a concern for the whole world. The good news is we can fight back, and Gavi’s next strategic period has a clear plan to bolster our defences by expanding investments in global vaccine stockpiles and rolling out targeted preventive vaccination in countries most impacted by meningitis, yellow fever and measles,” said Dr Sania Nishtar, CEO of Gavi, the Vaccine Alliance. “These vital activities, however, will be at risk if Gavi is not fully funded for the next five years and we call on our donors to support our mission in the interests of keeping everyone, everywhere, safer from preventable diseases.”

Gavi’s upcoming high-level pledging summit taking place on 25 June 2025 seeks to raise at least US$ 9 billion from our donors to fund our ambitious strategy to protect 500 million children, saving at least 8 million lives from 2026–2030.

Vaccines are good for America!

YOUR GUIDE TO VACCINES

Protecting Yourself and Your Community

Let's talk about vaccines, those important shots that keep you, your loved ones, and your neighbors healthy. We'll review how vaccines work in easy-to-understand language, bust some common myths, and give you the facts you need to feel confident about rolling up your sleeve.

Why Are Vaccines Important?

Vaccines save lives. They're one of the best ways to protect against serious diseases that can make you very sick, send you to the hospital, or even cause death. Getting vaccinated protects you and those around you, like babies, older adults, and people who can't get certain vaccines because of health problems. This is called *community protection* or *herd immunity*.

How Do Vaccines Work?

Here's an easy way to think of it:

Think of your body's *immune system* as an army that protects you from germs (like viruses and bacteria).

When you get a vaccine, you're giving your army "practice rounds." The vaccine doesn't cause the real disease, but it teaches your body how to fight off specific germs if they ever show up.

Later, if the real germ comes around, your army is ready. They identify the enemy, and they fight back fast to protect you. You may never get sick at all, or if you do, the illness will likely be much milder.

Why Focus on Flu and Pneumonia Shots?

Every year, flu (influenza) and pneumonia put thousands of people in the hospital and can even lead to death, especially for older adults and people with certain health conditions. These two vaccines are especially important:

- **Flu Shot:** Get it every fall. Even healthy adults can get very sick from flu. The shot can stop you from getting very sick, and it means fewer missed days of school and work.
- **Pneumococcal Vaccine (Pneumonia Shot):** Protects you from serious lung infections and things that can happen when someone has pneumonia and complications like sepsis (the body's extreme response to an infection). It is especially important for adults over 50 and people with ongoing health problems.

CME OUTFITTERS

NATIONAL BLACK CHURCH INITIATIVE
www.naltblackchurch.com

BUSTING THE MYTHS

The Real Truth About Vaccines

Let's set the record straight on some things you might have heard.

MYTH: Vaccines aren't tested and "I don't want to be a guinea pig."

FACT: Vaccines are tested very carefully—for years before you can get them. Scientists and doctors make sure they're safe and work well. Even after approval, vaccines are always checked for side effects. You are NOT a guinea pig! **Bonus Fact:** Many people don't know that mRNA vaccines, like some of the COVID vaccines, are not new - they were in development and tested for over 30 years. That is why they were able to rapidly use the technology so quickly during COVID.

MYTH: Vaccines cause the illnesses they're meant to prevent.

FACT: You can't get the flu from a flu shot, and you can't get COVID-19 from the COVID shot. Sometimes, people feel mild side effects, like a sore arm or a low fever, which is your body building protection. If you do get sick after your vaccine, it might be a different virus, or you might have been exposed before the shot had a chance to work. On average, it takes about 3 weeks for your body to build immunity after a vaccine.

MYTH: Vaccines cause autism.

FACT: Many studies from around the world show that vaccines do NOT cause autism. This claim has been fully disproven by science. The largest vaccine study ever followed 1.2 million children for 24 years and found vaccines do not cause autism or 49 other health conditions.

MYTH: Vaccines aren't necessary; "people should just get sick naturally."

FACT: Getting the "natural" disease can be dangerous or deadly—for you and the people around you. For example: flu, pneumonia, and measles kill thousands every year. Getting the shot is much safer than risking severe illness.

MYTH: "I got the flu even though I had my shot. Was it worth it?"

FACT: This is a common worry. Here's why you should still get your vaccine:

- Sometimes, people catch a different strain of flu than what's in the shot, or get exposed before the vaccine "kicks in."
- Even if you do get sick, the vaccine makes your illness **milder**—you're less likely to end up in the hospital, have pneumonia, get blood infections, lose limbs, or die.
- The flu and pneumonia shots protect the most vulnerable: grandparents, babies, people with weak immune systems. Your shot helps protect them, too.
- Studies show that flu and pneumonia vaccines save lives every year!

My Adult Vaccine Checklist & Record

(FOR PERSONAL USE, 2025)

☐ **Flu** (Influenza) DATE(S) RECEIVED NEXT DOSE DUE	Every adult, every year (every flu season) 1 each year Get each fall for best protection
☐ **Pneumococcal** DATE(S) RECEIVED NEXT DOSE DUE	All adults age 50+; adults 19–49 with certain long-term health problems 1 or 2 Ask which version is right for you
☐ **COVID-19** DATE(S) RECEIVED NEXT DOSE DUE	**When Should Adults Get It?** 1 dose for adults 19 -64; 2 doses for age 65 or older **How Many Doses?** 1 or 2 **Extra Info/Questions:** Yearly in the fall; May need more than 1 dose if younger 65 but have specific health issues
☐ **RSV** DATE(S) RECEIVED	60+ years (always); 50–59 with health risks (ask your HCP) 1 Ask about risks if 50–59 years
☐ **Tdap/Td** DATE(S) RECEIVED NEXT DOSE DUE	1 dose Tdap as an adult, then Tdap or Td booster every 10 years. 1 dose Tdap during each pregnancy 1+ boosters Booster = shot to keep you protected
☐ **Shingles** (Zoster) DATE(S) RECEIVED NEXT DOSE DUE	All adults age 50 and older 2 Even if you had chickenpox as a child, you should get a shingles vaccine
☐ **MMR** (Measles, Mumps, Rubella) DATE(S) RECEIVED NEXT DOSE DUE	Most born after 1957 should get this as an adult if never had 2 doses or aren't sure. 1 or 2 Ask if you have never had these diseases or are unsure about your history
☐ **Chickenpox** (Varicella) DATE(S) RECEIVED NEXT DOSE DUE	Adults born after 1980 who never had chickenpox or haven't had 2 shots 2 Ask if you're unsure about your history

My Adult Vaccine Checklist & Record

(FOR PERSONAL USE, 2025)

☐ HPV

DATE(S) RECEIVED

NEXT DOSE DUE

All adults up to age 26; some ages 27–45 (ask a HCP)

2 or 3

Best if given at younger ages, but sexually active people who did not receive the vaccine when they were younger should ask their HCP.

☐ Hepatitis A

DATE(S) RECEIVED

NEXT DOSE DUE

Adults who want protection or have risks (travel, certain jobs, some health, or lifestyle factors)

2 or 3

Ask if you travel or want liver protection

☐ Hepatitis B

DATE(S) RECEIVED

NEXT DOSE DUE

All adults up to age 59; age 60+ if desired or at risk (kidney, liver, diabetes, certain jobs)

2, 3, or 4

For everyone, not just high risk

☐ Meningococcal

DATE(S) RECEIVED

NEXT DOSE DUE

College students, military, certain health, or travel risks

1 or more

Ask if living in group settings like a dorm, military housing, assisted living, group home, or nursing home

☐ HIB

DATE(S) RECEIVED

NEXT DOSE DUE

Only for special health problems (like removed spleen, stem cell transplant)

1 or 3

Most adults do NOT need

☐ Mpox

DATE(S) RECEIVED

NEXT DOSE DUE

For those with specific risk factors or during outbreaks

2

Most adults do NOT need

☐ Polio

DATE(S) RECEIVED

NEXT DOSE DUE

Only for adults who were not fully vaccinated as children or need it for travel or work

1 or more

Most adults in U.S. have had the full vaccination series, ask if you are unsure.

** Ask your healthcare professional yearly if there have been changes to vaccine schedules.*

CME OUTFITTERS

NATIONAL BLACK CHURCH INITIATIVE
www.naltblackchurch.com

Why Do I Need Vaccines EVERY YEAR?

- **One of the things viruses love to do most is adapt and change to their surroundings – and they can do it fast!** That's why the flu shot is needed every year.
- **Some vaccines need boosters** (an extra shot every so many years) to keep your protection strong.
- New vaccines come out to fight new illnesses (like COVID-19).

TAKE-HOME MESSAGE
Vaccines Keep Us Safe

Vaccines help protect you from getting very sick or having long-term problems from certain diseases.

You help protect your family and friends when you get your shots.

Shots are safe, carefully tested, and can save your life—and someone else's.

Even if you get sick, vaccines will help keep it mild and keep you out of the hospital.

Do your part: Check which vaccines you need, ask your health-care professional questions, and get vaccinated to stay healthy, strong, and ready for life's adventures!

For more information, visit the CDC website or ask your healthcare provider or local pharmacist. If you have questions or concerns, talk to them—they're here to help!

Stay safe, stay healthy, and keep shining!

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Appendix

NATIONAL BLACK CHURCH INITIATIVE
www.naltblackchurch.com

IMMUNIZE NOW!

Please Get Vaccinated!

AMERICAN CLINICAL HEALTH DISPARITIES COMMISSION INC.

Our Goal-Vaccinate 65%
Over The Next 10 Years

THE CENTERS FOR DISEASE CONTROL (CDC) SAYS AFRICAN-AMERICAN AND LATINO IMMUNIZATION RATES ARE DANGEROUSLY LOW

VACCINES SAVE LIVES by PREVENTING DISEASE

BLACK DOCTORS AND THE BLACK CHURCH ENCOURAGE IMMUNIZATIONS FOR THE ENTIRE FAMILY

Rev. Anthony Evans
President of National Black Church Initiative
**Ministers are not Doctors.*

Dr. Elena Rios
President & CEO of the National Hispanic Medical Association, (NHMA)

Marcus Christopher Griffith, MD
Psychiatrist and Obesity Medicine physician, Southeast Permanente Medical Group

Dr. Yolanda Lawson M.D
President- of the National Medical Association
Board Certified OBGYN is the founder of MadeWell OBGYN

Immunization Rates in the African American Community

African American adults are less likely than non-Hispanic White adults to have received a flu vaccine in the past year or to have ever received the pneumonia vaccine. **Influenza adults 18 and older for 2023-2024 season: White, non-hispanic (49.1%), Black, non-hispanic (42.1%), Hispanic (34.6%). Source: https://tinyurl.com/bd36uc25.**

Pneumonia data from 2021: Coverage with ≥1 dose of any type of pneumococcal vaccine among adults aged ≥65 years was 64.0%, similar to the estimate for 2021. Coverage among White adults aged ≥65 years (69.1%) was higher compared with Black (53.5%), Hispanic (41.7%), Asian (50.2%), and other race (54.0%) adults.

Composite 2021 data: Coverage with all age-appropriate vaccines in the composite adult vaccination measure (including influenza vaccination) was lower among Black (12.1%) and Hispanic (17.0%) adults compared with White (26.1%), Asian (26.2%) and other race (24.5%) adults aged ≥19 years. Source: https://www.cdc.gov/vaccines/imz-managers/coverage/adultvaxview/pubs-resources/vaccination-coverage-adults-2022.html

Marcus C. Griffith, MD, Says Black and Latino Physicians Can Better Connect with Vaccine-Hesitant People of Color

"When it's someone who looks like you, who lives where you live, goes to the same places as you — the same barbershop, the same church — it does help with that," said Dr. Griffith, a psychiatrist and obesity medicine physician with The Southeast Permanente Medical Group. Dr. Griffith's leadership in addressing vaccine hesitancy initially began around educating communities on the flu shot, which naturally transitioned into COVID-19 vaccination. He regularly speaks with patients from historically marginalized racial and ethnic groups — such as Black, Latino, and Native American populations — about vaccine hesitancy.

NBCI: Are these patients sharing some of the reasons for their vaccine hesitancy with you? **Dr. Griffith:** One of the most troubling ones I had was a patient whom I encountered just two days ago. She's a schoolteacher. She has a BMI of 70. She weighs 500 pounds. So, if she were to have COVID, she might not make it to the hospital in time because she'd deteriorate quickly. She's a ventilator candidate. ***What was very disturbing to me—during this interview, I asked everyone about their vaccination status.*** And she said, "No." And I then wanted to find out why. Her explanation was this: She had never gotten sick before. She's never come down with the flu. She never had chicken pox. And she believes that she is immune and won't get COVID. And then she said, in fact, "I've been intentionally trying to catch it. Going around people who have tested positive so I can perhaps get this, get it naturally, and develop a natural immunity."

Vaccines are our best defense against severe illness, hospitalization, and death from disease.

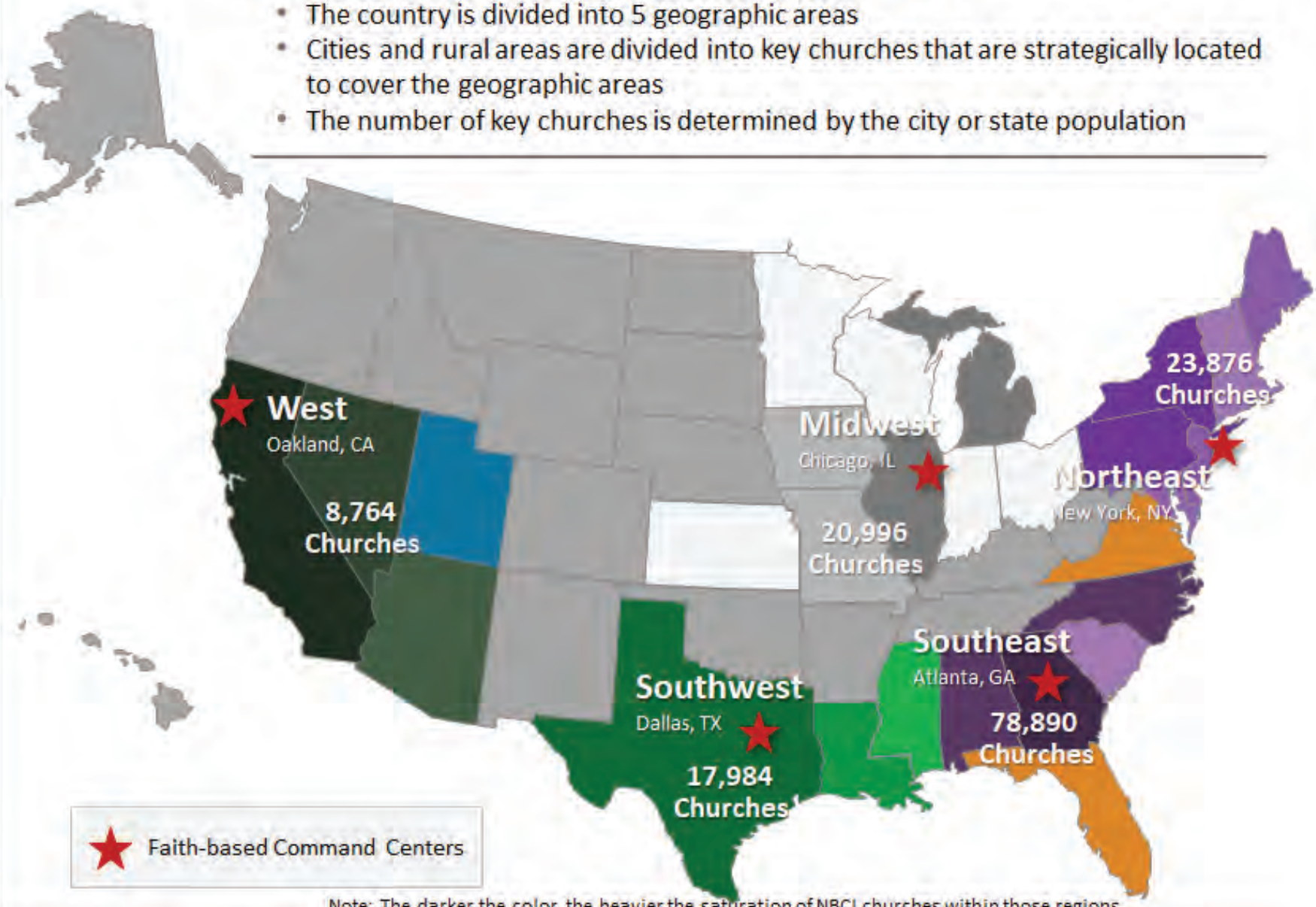
National Vaccine Injury Compensation Program

Most people who get vaccines have no serious problems. Vaccines, like any medicines, can cause side effects, but most are very rare and very mild. Some health problems that follow vaccinations are not caused by vaccines. In very rare cases, a vaccine can cause a serious problem, such as a severe allergic reaction.

In these instances, the National Vaccine Injury Compensation Program (VICP) may provide financial compensation to individuals who file a petition and are found to have been injured by a VICP-covered vaccine. Even in cases in which such a finding is not made, petitioners may receive compensation through a settlement.

HOW NBCI IS ORGANIZED

- The country is divided into 5 geographic areas
- Cities and rural areas are divided into key churches that are strategically located to cover the geographic areas
- The number of key churches is determined by the city or state population

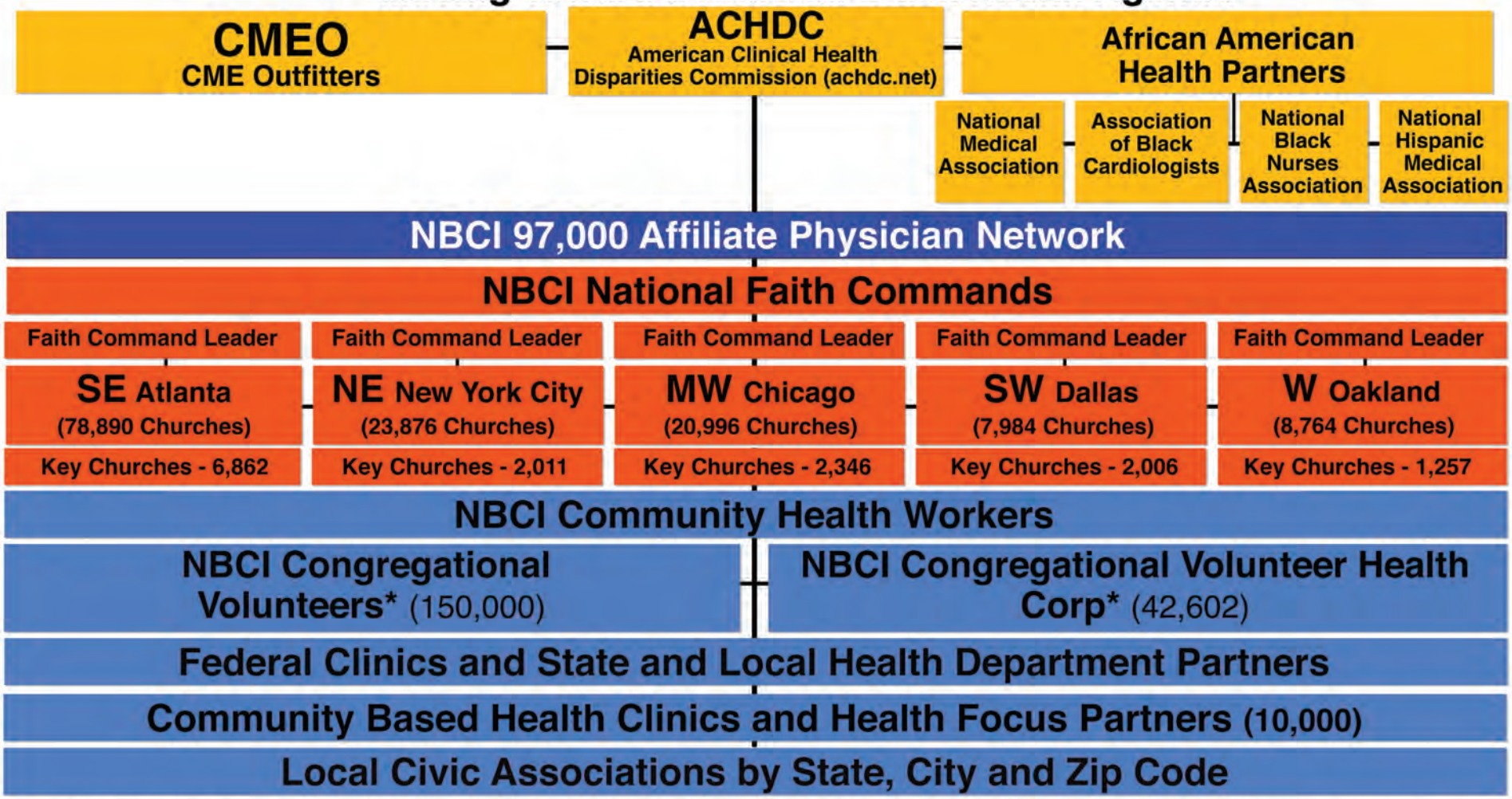


Note: The darker the color, the heavier the saturation of NBCI churches within those regions

National Black Church Initiative

COMMUNITY SERVICE DELIVERY PROGRAM STRUCTURE

Moving Toward a National Black Health Agenda



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January 23, 2026

National Medical Association Rejects Proposal to Make Life-Saving Vaccines Optional

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For Immediate Release:

January 23, 2026

Statement attributable to:

Dr. Roger A. Mitchell, Jr.
126th President, National Medical Association

The National Medical Association (NMA) strongly disagrees with recent comments from the Chair of the Advisory Committee on Immunization Practices (ACIP) suggesting that vaccines for polio, measles, and other infectious diseases should be optional.

Undercutting routine vaccination places the public at serious risk and threatens decades of progress in preventing disease, disability, and death. The measles and polio vaccines represent extraordinary public health achievements. Before the polio vaccine was widely administered in the United States, the virus caused approximately 15,000 cases of paralysis each year, primarily among children.

Any policy approach that would again place Americans at risk of paralysis from a completely preventable disease is irresponsible. As physicians committed to science and evidence-based medicine, we know there is no cure for paralytic polio. Treatment is limited to supportive care and rehabilitation. Prevention through vaccination remains the most effective and proven protection and has been validated through decades of use and research.

We urge lawmakers to intervene to prevent further erosion of our nation's public health infrastructure. Framing vaccination solely as an individual choice ignores the collective impact on communities. It also places the most vulnerable, including infants, immunocompromised individuals, and those who cannot be vaccinated, at unnecessary risk from diseases we have already learned how to effectively prevent.

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About the National Medical Association:

The National Medical Association is the nation's oldest and largest organization representing Black physicians and health professionals in the U.S. and promotes the collective interests of physicians and patients of African descent. We serve as the voice of Black physicians and a leading voice for parity in medicine, elimination of health disparities and promotion of optimal health. To learn more about the NMA, please visit https://www.nmanet.org/.

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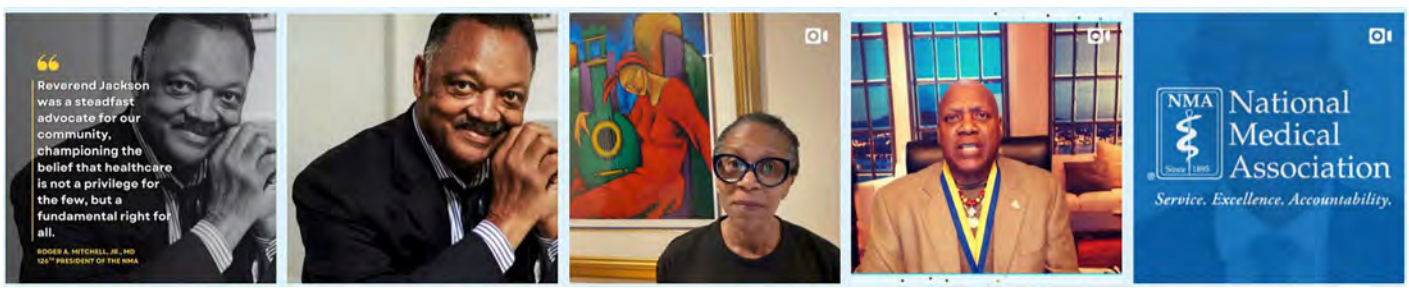

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For Immediate Release:

January 26, 2026

Statement attributable to:

Dr. Roger A. Mitchell, Jr.

126th President, National Medical Association

The physician members and leaders of the National Medical Association (NMA) continue to recommend an evidence-based immunization schedule that protects against 18 diseases and have endorsed the 2026 childhood immunization schedule released today by the American Academy of Pediatrics (AAP). The AAP schedule is thoroughly researched and rooted in science and differs significantly from recent changes to the Centers for Disease Control and Prevention's (CDC) federal immunization schedule, which have created unnecessary and harmful confusion about routine childhood vaccinations.

The NMA encourages health care providers, families, and caregivers to rely on the AAP schedule and continue vaccinating children to protect them and their communities from preventable diseases.

The full AAP 2026 Immunization Schedule is available here: https://downloads.aap.org/AAP/PDF/AAP-Immunization-Sched ule.pdf

The AAP schedule is endorsed by the following medical and health organizations: the American Academy of Family Physicians (AAFP), American College of Nurse-Midwives (ACNM), American College of Obstetricians and Gynecologists (ACOG), American Medical Association (AMA), American Pharmacists Association (APhA), Council of Medical Specialty Societies (CMSS), Infectious Diseases Society of America (IDSA), National Association of Pediatric Nurse Practitioners (NAPNAP), National Medical Association **(NMA),** Pediatric Infectious Diseases Society (PIDS), Pediatric Pharmacy Association (PPA), and the Society for Adolescent Health and Medicine (SAHM).

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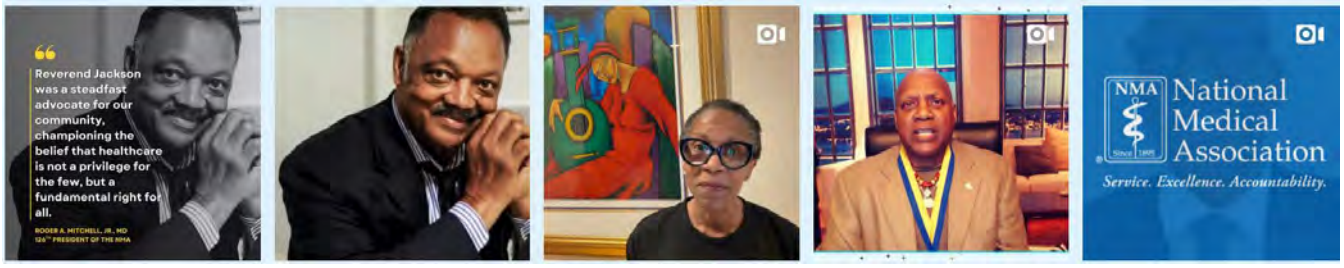

NMA National Medical Association

Service. Excellence. Accountability.

Join a community of over 50,000 dedicated African American physicians and professionals committed to making a positive impact on healthcare. Discover the benefits of NMA membership, access professional development opportunities, and become a part of a network dedicated to advancing health equity.

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