Former CDC epidemiologist Dr. Fiona Havers speaks on the collapse of evidence-based vaccine policy

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For decades, the Centers for Disease Control and Prevention (CDC) has stood as the cornerstone of public health in the United States—a scientific institution charged with monitoring disease, advising clinicians and shaping vaccine policy grounded in evidence and rigorous data. That role has come under unprecedented pressure in 2025, as political intervention and sweeping leadership changes have fractured trust in what was once considered the gold standard of American public health guidance. The shake-up has been especially visible in controversy over vaccine recommendations and the restructuring of the agency's expert advisory processes, sparking alarm among scientists, clinicians and communities that rely on CDC guidance to stay safe.

***Dr. Fiona Havers**, an infectious disease physician, epidemiologist and respected public health expert, has devoted her career to the study and prevention of respiratory viruses, including COVID-19, influenza and RSV. Dr. Havers earned her medical degree at the University of Washington and completed internal medicine and infectious diseases training at Johns Hopkins Hospital, followed by a master's degree in epidemiology from the Johns Hopkins Bloomberg School of Public Health—training that uniquely positioned her to interpret and communicate complex disease trends and vaccine data.*

*For more than a decade, she served as a medical epidemiologist and team lead at the CDC, most recently heading the **Respiratory Virus Hospitalization Surveillance Network (RESP-NET)**—a surveillance system that tracks hospitalizations for COVID-19, RSV and influenza across the country to inform vaccine policy and public health strategy. Her work has been featured in numerous Morbidity and Mortality Weekly Reports and peer-reviewed publications that helped shape vaccination recommendations and clinical guidance.*

But in June 2025, Dr. Havers made the difficult decision to resign from the agency she had served for years. Her resignation came amid a controversial overhaul of CDC leadership and advisory structures under Health and Human Services Secretary Robert F. Kennedy Jr.—including the mass dismissal of all 17 members of the CDC's independent Advisory Committee on Immunization Practices (ACIP) and the revision of longstanding vaccine recommendations, such as removing guidance for COVID-19 vaccination in healthy children and pregnant women. These changes undermined the scientific basis of national vaccine policy and disrupted nearly a century of evidence-based practice.

*In interviews with major media outlets, Dr. Havers made clear that her resignation was not only about policy disagreement—it was about the **defense of the scientific process itself**. She expressed deep concern that data collected by her team would no longer be used objectively or evaluated with appropriate scientific integrity to inform vaccine decisions, a problem she saw as potentially endangering public health.*

Against this backdrop of political pressure, institutional upheaval and genuine concern among CDC scientists, Dr. Havers gave an interview to the World Socialist Web Site. *What follows is an **edited version of that discussion**, in which she reflects on her career, her decision to resign and what she believes is at stake for the future of vaccine science and public health in the United States.*

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Benjamin Mateus: You spent years leading the Respiratory Virus Hospitalization Surveillance Network, overseeing COVID, influenza and RSV surveillance. Maybe you could describe for readers what your day-to-day role was and how these processes work. Many people see the CDC as a kind of black box, where guidance just appears, without understanding how it's produced and what kind of collaboration it entails.

Fiona Havers: Of course. COVID-NET, RSV-NET and Flu-NET are large hospitalization surveillance systems. They are partnerships between the CDC and 14 states, and they provide near–real-time data on hospitalizations for COVID, influenza and RSV.

I oversaw the COVID and RSV components for about four and a half years. What happens is that staff in state and local health departments review medical records for every hospitalization with laboratory-confirmed flu, COVID or RSV within defined catchment areas.

For example, in the Atlanta area, the catchment includes 13 counties. If someone is hospitalized with one of these infections in that area, a trained abstractor reviews their medical record. The data are de-identified, but information, such as age, ICU admission and clinical outcomes, is collected and sent to the CDC.

We receive very basic but very high-quality data in near real-time. In addition, there is a more detailed clinical review of a subsample of charts. Each week, my team—about 10 people—would receive the data, clean it, run it through analytic algorithms and update public dashboards that show whether hospitalization rates are rising or falling.

We can do this because we know both the size of the population in each catchment area and the number of hospitalizations occurring within it. While this is not every hospitalization in the United States, it's a form of sentinel surveillance that allows us to estimate national trends with a high degree of confidence.

This infrastructure had existed for influenza surveillance for many years. When COVID hit in March of 2020, the CDC was able to stand up COVID-NET rapidly on top of that existing system. Throughout the pandemic, this became one of the most important sources of high-quality clinical data—information on who was being hospitalized, how severe the illness was, ICU admission rates and risk factors for severe disease.

My role was to oversee this work. We received data weekly, developed sampling schemes—because you can't do detailed chart reviews on hundreds of thousands of hospitalizations—and modernized data systems. This required very close collaboration with the states. States collect data

differently, have different health care systems, and even hospitals within the same catchment area operate very differently. From an informatics standpoint, it's extremely complex.

Members of my team became experts in data automation and informatics, which is not my own area of expertise. But this collaboration with the states is essential—they are equal partners with the CDC, and participation depends on trust and willingness to share data.

During the pandemic and afterward, COVID-NET, RSV-NET and Flu-NET were also used to respond to urgent data requests—from the CDC director, from the White House and from other federal agencies. Questions like: What's happening with the flu right now? What's happening with COVID hospitalizations?

We also regularly supplied data to the Advisory Committee on Immunization Practices (ACIP). For example, we helped define risk factors for severe COVID as the epidemiology changed. And we extensively published dozens of MMWR reports and major peer-reviewed studies over the last several years.

The Trump-Kennedy attack on the CDC

BM: Maybe that's a good segue. You mentioned the MMWR [*Morbidity and Mortality Weekly Report. It was originally established as the Weekly Health Index in 1930, changing its title to Weekly Mortality Index in 1941 and Morbidity and Mortality in 1952. It acquired its current name in 1976. It is the principal publishing arm for the CDC to disseminate public health information and recommendations that have been received from state health departments*]. Given what's happening now, perhaps you could speak more broadly about the CDC's responsibility to the public—especially people whose health and livelihoods depend on credible public health guidance—and how that has changed.

FH: This administration has effectively destroyed the CDC's scientific credibility. Secretary Kennedy's ideologically driven anti-vaccine agenda has hijacked official CDC platforms, including the agency's own websites, to promote false information linking vaccines to autism.

Career CDC scientists were not involved in those changes. They did not go through the CDC's clearance process. For people who worked at the CDC, it has been incredibly painful to see this kind of misinformation coming from what was once a trusted scientific institution.

What makes it even more frustrating is that there are still thousands of dedicated, highly competent professionals at the CDC. My former team, for example, is still producing high-quality, reliable respiratory virus hospitalization data. But the public can no longer tell which CDC outputs are trustworthy and which are not.

By putting out unscientific and dangerous information about vaccines, this administration has destroyed the CDC's credibility in a matter of months. Entirely.

BM: Is it possible to rebuild that reputation? I've spoken to other former CDC officials who feel the repercussions may be long-lasting even if leadership changes.

FH: I think it will take at least a generation to rebuild. Secretary Kennedy spent years spreading misinformation and attacking the CDC from the outside. Now he's weaponizing his position inside the federal government to dismantle it from within.

Previously, his followers distrusted the CDC. Now you have people like me—former CDC officials—saying publicly that CDC guidance can't be trusted. That's devastating.

State and local health departments no longer trust the CDC. Historically, the CDC's central role was to support them—providing technical expertise and rigorously vetted guidance. Vaccine policy went through transparent, evidence-based review processes that health departments could rely on.

That trust is gone. The medical community doesn't trust the CDC. The scientific community doesn't trust the CDC. State and local health departments don't trust the CDC. And large portions of the public who once relied on CDC guidance no longer do, because the agency is now producing unscientific outputs.

Rebuilding from that will take a very long time.

BM: Maybe you could speak more to how scientific evidence is traditionally supposed to move from surveillance data, through internal review and leadership, to ACIP recommendations. What norms and safeguards historically protected that process from political interference?

FH: That's a great question. I'll use ACIP as an example.

Historically, if a new vaccine was coming to market, well in advance—often one or two years ahead—a work group would be formed. That work group consisted of outside experts. There would be a CDC work group lead who worked closely with the chair of the work group, who was a voting member of ACIP and an outside expert.

That group would do a deep dive into all available data. FDA approval is required before a recommendation is made, but the CDC begins reviewing evidence even before licensure. If you look at RSV vaccines, for example, products were in the pipeline 10 years ago. Because we didn't know how many adults in the United States were hospitalized with RSV, we set up RSV-NET years in advance to build the evidence base for future vaccine policy.

A work group would then evaluate which groups should be recommended to receive the vaccine. As licensure of a vaccine approached, the group would review safety data, efficacy data and clinical trial results in great depth.

Once a vaccine was licensed, ACIP would vote on whether to recommend it. FDA evaluates safety and efficacy, but the CDC's role is broader. The CDC considers cost-effectiveness, feasibility, risk–benefit balance, equity and implementation issues.

If ACIP recommends a vaccine and the CDC director signs off, that becomes official CDC policy. Under the Affordable Care Act (ACA), those vaccines must be covered by insurance. There is also a separate vote for the Vaccines for Children Program, which pays for about half of all childhood vaccines in the United States. So ACIP recommendations are critically important.

The formal structure includes something called the ***Evidence to Recommendations framework.*** All studies used to evaluate a vaccine are graded using an established hierarchy—randomized placebo-controlled trials receive the highest weight, while observational studies receive a lower weight. The CDC work group lead compiles this framework.

The work group votes across multiple domains: benefits, harms, resource use, feasibility, equity and acceptability. That information is presented at a public ACIP meeting, where the full committee votes. What may look like rubber-stamping is years of dedicated work by multiple scientists at all levels.

The purge of ACIP and its consequences

These processes were intentionally designed to counter claims from the anti-vaccine movement that CDC policy was corrupted by pharmaceutical interests or lacked transparency. The entire process is public. The studies are listed online. Meetings are open. Voting language is usually known in advance. Those procedures are not bureaucratic formalities—They are what make vaccine policy scientifically legitimate and publicly defensible. That is what makes the contrast with the first ACIP meeting after the

committee was fired so stark.

After RFK Jr. removed all 17 voting members and replaced them with handpicked appointees, the committee held a meeting where a last-minute vote was added without proper public notice. There was a scheduled vote on seasonal influenza vaccines, which is routine. At the last minute, they added a vote on **thimerosal**, a preservative used in some multi-dose flu vials that has long been targeted by the anti-vaccine movement.

They invited a single speaker, Lynn Redwood, a longtime anti-vaccine activist. She introduced herself as a private citizen and had no relevant scientific qualifications. She presented claims against thimerosal. No CDC or FDA experts were allowed to speak at the meeting.

There was no *Evidence to Recommendations framework*. No transparency. No consultation with the influenza work group. The briefing document was briefly posted online and then taken down. The single presentation by an unqualified outside individual was the sole basis for the vote. Some of the studies cited did not even exist.

It was a complete abandonment of every safeguard that had been put in place over decades.

BM: In that regard, when scientific conclusions are effectively dictated in advance—when evidence is expected to align with ideology rather than guide policy—what does that do to the CDC's ability to function as a public health institution?

FH: It makes it impossible.

What we are seeing now is a sham process. The committee has been stacked with ideologically aligned appointees, and votes are predetermined. They are attacking the immunization schedule piece by piece.

This is why organizations like the American Academy of Pediatrics (AAP) are boycotting ACIP meetings. This is not a legitimate scientific body. We should not pretend that it is.

BM: The CIDRAP *(*Center for Infectious Disease Research and Policy) recently reported that the CDC has funded a study by the Danish Bandim Health Project, known for their anti-vaccine positions in Guinea-Bissau examining the hepatitis B birth dose, involving researchers who have been widely criticized. At the same time, the acting CDC director rubber-stamped recent ACIP votes abandoning long-standing vaccine schedules. What does this signal to you? Also, if I understand the methodology of their study correctly, they will withhold a known protective vaccine from a placebo group?

FH: There are so many things happening right now that are ethically and scientifically deeply troubling.

With hepatitis B, the birth dose vaccine has been a cornerstone of prevention for over 30 years. It has been extraordinarily successful. We already have decades of experience with hundreds of millions of doses of hepatitis B vaccine administered worldwide. Universal birth dose is recommended in many countries. There is no scientific justification for this.

Furthermore, there was no evidence presented by the current ACIP that changing the recommendation would make children safer in any way.

Now they are proposing a randomized, placebo-controlled trial for a vaccine that is already known to be safe and effective, conducted in a low-income country with a vulnerable population. That is extremely concerning.

If the United States government funds a foreign group to conduct this study in a low- or middle-income country, it will be looked back on as a historical and ethical travesty. It will be a shameful marker in US public health history if it is allowed to proceed.

I should add that the evidence has shown that removing or delaying the birth dose will cause infants to fall through the cracks—particularly those born to mothers with unknown hepatitis B status. When a universal safeguard is removed, the risk does not disappear—It shifts to the most vulnerable infants.

We will see more infections in infancy and early childhood. And 10 or 15 years from now, we will see the consequences: cirrhosis, liver failure and liver cancer that could have been prevented.

The crisis at the CDC

BM: Turning to your own experience, this dynamic at the CDC began earlier in the Trump administration. At what point did you conclude that you could no longer do your job with the scientific integrity you required? What crossed that line for you, and how supported did you feel by colleagues inside the CDC when you resigned from your position?

FH: Early on, when it became clear that RFK Jr. was going to be Secretary of Health and Human Services, I knew it would probably come down to vaccine policy—particularly the COVID vaccines—because I had spent years preparing data for ACIP and related decision-making.

He had publicly promised Senator Cassidy that he would not interfere with ACIP. But the warning signs started when Peter Marks was pushed out of the FDA. He had overseen vaccines on the FDA side, and I knew that would cause serious damage to the regulatory process.

I came close to resigning when RFK Jr. announced on *X* that the CDC was changing COVID vaccine policy for healthy children and pregnant women—without consulting CDC scientists. One of my colleagues, who was leading the COVID ACIP work group, resigned immediately after that announcement. All of us had been working for months to prepare data for a scheduled vote that would move toward more risk-based recommendations while still maintaining access to vaccines for anyone who wanted them.

What the CDC leadership managed to do at that moment was mitigate some of the damage by framing the policy as shared clinical decision-making, which preserved insurance coverage. That gave me a pause. I thought, if we can still limit the harm from inside, maybe I can stay a little longer.

But the following week, I was away from the office at a medical appointment when my deputy texted me: "He fired everyone from ACIP." At that moment, I knew I was done.

That action signaled the complete destruction of evidence-based vaccine policy. Anything I did from that point forward would legitimize a process that was no longer legitimate. At that point, participation itself would have functioned as an endorsement of a corrupted process. For my own integrity, I could not participate in that.

It was an immediate, gut-level decision. I went home and told my spouse I was resigning. Many of my colleagues are still struggling with the same dilemma—whether to stay inside institutions to preserve what remains, or whether staying makes them complicit in legitimizing anti-science policies.

For me, that was the line.

BM: You studied the effectiveness of COVID vaccines closely. What does the data show? How effective are these vaccines for different populations?

FH: The vaccines are very effective at preventing severe disease. They are particularly important for high-risk groups—older adults, people with underlying medical conditions and very young children.

Young children, especially those under two, are often overlooked. Many of them have never had COVID and have no underlying immunity. We still see high hospitalization rates in infants and young children.

One issue we struggled with was that the FDA used a list of risk factors from the CDC that was never designed for vaccine policy and did not include young age as a risk factor. As a result, infants were often excluded from recommendations.

What we were working toward was a more nuanced approach—recommending vaccination universally for younger children while allowing shared decision-making for healthy adolescents. That is essentially where the American Academy of Pediatrics is now.

In short, these vaccines are safe and effective at preventing severe illness, hospitalization and death. Last year, 30,000 to 50,000 Americans died of COVID. It remains a major public health problem, especially for older adults, young children and people with underlying conditions.

Hundreds of millions of people have received these vaccines. Serious adverse events are very rare and have been monitored closely. The rhetoric surrounding mRNA vaccines has been highly politicized, and Secretary Kennedy has targeted them specifically. That is a major problem.

BM: You recently testified before Congress. Can you describe what that hearing was about and your overall impression?

FH: That was an unusual experience. The hearing focused on artificial intelligence at the intersection of biology and security and was held by the Oversight and Investigations Subcommittee of the House Energy and Commerce Committee.

The Republican witnesses argued that AI and technologies like CRISPR pose risks for the creation of novel pathogens with pandemic potential. That concern is not unfounded.

I was invited as the Democratic minority witness. My central point was that regardless of how the next pandemic originates, this administration has made the United States less prepared.

They have cut funding, dismantled public health infrastructure at the federal and state levels, destroyed the CDC's scientific credibility, promoted anti-vaccine misinformation, and destabilized the FDA's regulatory environment. They have also pulled funding from mRNA vaccine development and cut NIH grants.

As a result, scientific innovation is being undermined. The tools we will need for the next pandemic may not be developed in the United States, and we may not have access to them when we need them.

This hearing became one of the only opportunities for Democrats to publicly document the damage being done, because Republicans have refused to bring Secretary Kennedy in for oversight testimony.

BM: To what extent do you think the COVID pandemic itself shaped the current anti–public health sentiment?

FH: It had a profound impact. It occurred in a media environment where misinformation spreads rapidly. The anti-vaccine movement used the pandemic to expand its reach and recruit supporters.

COVID accelerated these dynamics to the point where we now have federal leadership actively working to dismantle the immunization schedule. The hepatitis B birth dose is only the beginning. Much more is coming.

BM: Do you want to share what you see as the next steps or strategies RFK Jr. might employ?

FH: One major concern is changes to the Vaccine Injury Compensation Program. If conditions like autism are added as compensable injuries, manufacturers will leave the US market. Vaccines will simply become unavailable.

Another possibility is bypassing ACIP entirely by adopting another country's vaccine schedule, such as Denmark's. That would eliminate access to several vaccines currently used in the United States.

They are also laying the groundwork to challenge aluminum adjuvants—another well-studied component—creating doubt and instability that further undermines vaccine confidence.

Even discussing these issues publicly from a federal platform drives vaccination rates down.

BM: So even if legal structures remain intact, the practical effect is vaccine unavailability?

FH: Exactly. Any requirement to redesign vaccines—removing adjuvants, separating combination vaccines—would take decades of development and clinical trials. It is unnecessary and would severely restrict access.

These discussions themselves undermine trust. Regardless of what policies are ultimately enacted, the damage is already being done.

BM: A final comment. What would you like to say to the public?

FH: Public health and vaccines are not partisan issues. Vaccines are among the most effective tools we have in order to prevent infectious disease.

This administration is doing enormous harm to scientific, medical and public health institutions, and it will cost lives. Secretary Kennedy must be removed. If he remains in this role, more Americans will die, and we risk the return of diseases we have not seen in decades.

If another pandemic were to occur now, the consequences would be catastrophic.