Vaccination and Children's Health

2026 Version

Written and edited by: The Review Committee for Vaccination Guidelines
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Introduction

Children are often ill and sometimes become extremely sick; vaccination can protect them from several serious illnesses.

This brochure has been created to provide you with information about vaccination and to allow you to have your child vaccinated safely.

We hope that this brochure will enhance the health and growth of your child.

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The 2026 edition is based on revisions as of February 2026.

You can receive the latest information from your municipality (including special wards; the same applies below). This information is also available from the websites of the Ministry of Health, Labour and Welfare and the Japan Institute for Health Security (infectious disease information portal).

In the event of amendments to laws or regulations, the Notice of Revision, etc. will be uploaded to our website (https://www.yoboseshu-rc.com).

1. Get your child vaccinated!

The immunity to diseases which mothers give their infants almost completely disappears 3 months after birth for pertussis and 12 months after birth for measles. Consequently, after these periods, infants must ward off disease by producing their own immunity. Vaccination supports this defense.

Children go outside more often and interact with more people as they grow; consequently, they are at higher risk of infection. We recommend that you learn about vaccination and have your child vaccinated for his/her health.

● Infections

Infections are diseases that occur when pathogens such as viruses and bacteria enter the body and multiply. Depending on the type of pathogen, a variety of symptoms may occur, such as fever, cough, headache, rash, and diarrhea.

2. What is vaccination?

"Vaccination" refers to the administration of a vaccine—typically by injection, orally, or through the nose—to help the body develop or enhance immunity against disease. There are two main types of vaccines: live attenuated vaccines, which use weakened forms of infectious viruses or bacteria, and inactivated vaccines, which are made by inactivating viruses or by eliminating the toxicity of bacteria and the toxins they produce. Recently, COVID-19 vaccines have been developed using mRNA (messenger RNA), which serves as a blueprint for producing the spike protein found on the surface of the COVID-19 virus. Vaccination involves administering vaccines to protect individuals from infectious diseases and to prevent their spread within the community. Even if they contract an infectious disease, vaccinated individuals are more likely to avoid developing severe symptoms. Vaccines cannot be prepared for all infectious diseases. Due to their nature, vaccines cannot be produced for some viruses and bacteria at present, but research to develop vaccines is continuing worldwide.

3. Vaccination validity

Vaccination is performed to prevent a target disease or reduce its severity in the event it is contracted; however, immunity is not established in some children because of their characteristics and physical condition. If there is a desire to confirm whether immunity has been established, there are blood tests which measure the levels of antibodies in the blood.

In addition, with some vaccines, immunity gradually diminishes even after it has been established, and such vaccines require boosters at specific intervals to maintain long term immunity. (See 5. (3) Vaccine types and characteristics on page 5)

4. Routine vaccination and voluntary vaccination

Vaccination includes routine vaccination and voluntary vaccination. With regard to routine vaccination, the Preventive Vaccination Law defines the target diseases, subjects and vaccination schedules.

Vaccination is carried out during periods appropriate to each disease. Please refer to "List of recommended periods for routine vaccination (Category A disease)" on page 8 for recommended vaccination periods (standard vaccination periods).

Routine vaccination

Routine vaccinations are the vaccinations stipulated by the "Preventive Vaccination Law" and are divided into vaccinations for Category A and Category B diseases. As a general rule, the cost is paid by the local governments for those subject to vaccination against Category A diseases, so they can be vaccinated at public expense. Vaccination against Category B diseases may be partly covered by public expense. From January 30, 2013, special measures have been set for children who were unable to receive routine vaccination due to a long-term serious illness. For details, please check the information of your health center/municipal office.

Category A disease	The main focus is on mass prevention and prevention of serious illnesses. The individual is obliged to make an effort to receive the vaccination, and the guardian is obliged to make efforts to ensure the individual (child) is vaccinated. In both cases, the government recommends receiving the vaccination.
・Rotavirus infection ・Hepatitis B ・Pneumococcal infection in children ・Diphtheria ・Pertussis ・Tetanus ・Polio (acute poliomyelitis) ・Hib infection ・Tuberculosis (BCG) ・Measles ・Rubella ・Varicella ・Japanese encephalitis ・Human papillomavirus (HPV) infection ・RS virus infection (for pregnant women)	

Category B disease	The main focus is on personal prevention. The individual is not obliged to make an effort to receive the vaccination, and the parent/guardian is not obliged to make efforts to ensure the individual (child) is vaccinated. In both cases, there is no government recommendation to receive the vaccination.
・Seasonal influenza infection* ・Pneumococcal infection in the elderly ・COVID-19 infection in the elderly ・Herpes zoster in the elderly	

* Vaccinations against seasonal influenza and COVID-19 infection for children are voluntary.

Voluntary vaccination

Voluntary vaccinations are vaccinations other than the "routine vaccinations" stipulated in the "Preventive Vaccination Law". As a general rule, the cost required for vaccinations is borne by the individual. Some local governments pay part or all of the cost depending on the need for vaccination. Please check the information of your health center/municipal office.

5. Let's make a vaccination plan for your child

(1) Notice of vaccination

Routine vaccination is carried out by the municipal office in accordance with the Preventive Vaccination Law. A notice of vaccination is usually sent to parents/guardians individually. Since the notice is sent on the basis of the Basic Resident Register and the Residence Card, make sure to submit a notification when a baby is born or when you move.

(2) Set a rough schedule for vaccination

Routine vaccinations are, in principle, given individually. Determine a specific schedule and order for vaccinations in consulting with your family doctor, after considering municipal programs, your child's physical condition, and the prevalence of diseases.

Note that some municipalities may offer mass vaccination (performed on specified dates at specified sites such as health centers) of the BCG vaccine.

(3) Vaccine types and characteristics

Vaccines used for immunization include live vaccine; inactivated vaccine; and for COVID-19, mRNA vaccine.

Live vaccine

Live vaccines are made of attenuated live bacteria and viruses (live bacteria and viruses whose pathogenicity has been weakened). Resistance (immunity) to the disease is established similarly to actually being infected by it. After vaccination, attenuated bacteria and viruses (bacteria and viruses whose pathogenicity has been weakened) start multiplying; consequently, vaccines can cause mild symptoms, including fever and rash, depending on the vaccine. It takes about one month to establish sufficient resistance (immunity). However, some vaccines require boosters because their resistance (immunity) may gradually decline and weaken.

Types of live vaccines	・Rotavirus vaccine ・BCG vaccine ・Measles-rubella (MR) vaccine ・Measles vaccine ・Rubella vaccine ・Varicella (chicken pox) vaccine ・Mumps vaccine ・Yellow fever vaccine ・Intranasal influenza vaccine ・Smallpox vaccine (mpox prevention)

Inactivated vaccine

Inactivated vaccines are made by killing the virus or bacteria, extracting the components required to develop resistance (immunity) and eliminating their virulence (pathogenicity). The bacteria and viruses do not multiply, and several shots are required to establish resistance (immunity). Two or three vaccine shots are given at certain intervals to establish a basic resistance (immunity), after which a booster is given several months to one year later to enhance resistance (immunity) to a sufficient level. However, the resistance (immunity) declines gradually. To keep the resistance (immunity) for a long time, a booster is required at certain intervals, depending on the characteristics of the vaccine.

Types of inactivated vaccines and toxoids	・Hepatitis B vaccine ・Pneumococcal vaccine ・5-in-1 vaccine (DPT-IPV-Hib) ・3-in-1 vaccine (DPT) ・2-in-1 vaccine (DT) ・Inactivated poliovirus vaccine (IPV) ・Hib vaccine ・Japanese encephalitis vaccine ・Human papillomavirus vaccine ・Seasonal influenza vaccine ・Meningococcal vaccine ・Hepatitis A vaccine ・Rabies vaccine ・Tetanus toxoid (T) ・Tick-borne encephalitis vaccine ・Typhoid vaccine ・Herpes zoster vaccine ・Respiratory syncytial virus vaccine ・COVID-19 vaccine

mRNA vaccine

COVID-19 vaccines include novel mRNA vaccines, which are manufactured differently from conventional methods. These vaccines encapsulate mRNA (messenger RNA)—serving as a blueprint for the protein antigen found on the surface of the COVID-19 virus—within lipid nanoparticles. As they do not fall under the traditional categories of live attenuated or inactivated vaccines, they are classified separately. Inactivated COVID-19 vaccines are also in practical use. Live vaccines are also being developed.

Types of mRNA vaccines	・COVID-19 vaccine

(4) Intervals between different types of vaccines

On October 1, 2020, the vaccination intervals when receiving different vaccines were revised. There are no longer any restrictions on the interval between vaccinations except when administering two injectable live vaccines.

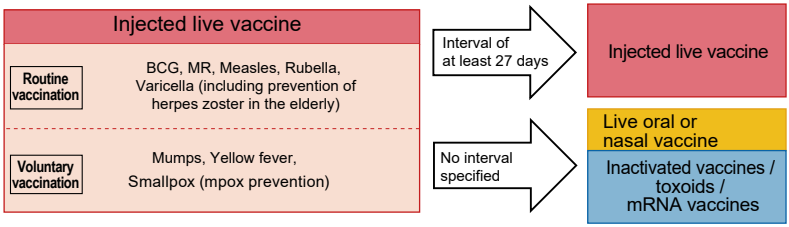
Vaccines used for immunization include live, inactivated, and mRNA vaccines. When injecting a live vaccine, it is necessary to observe a certain interval before injecting another live vaccine.

In certain cases, more than one type of vaccine may be received at the same time. Consult with your doctor thoroughly.

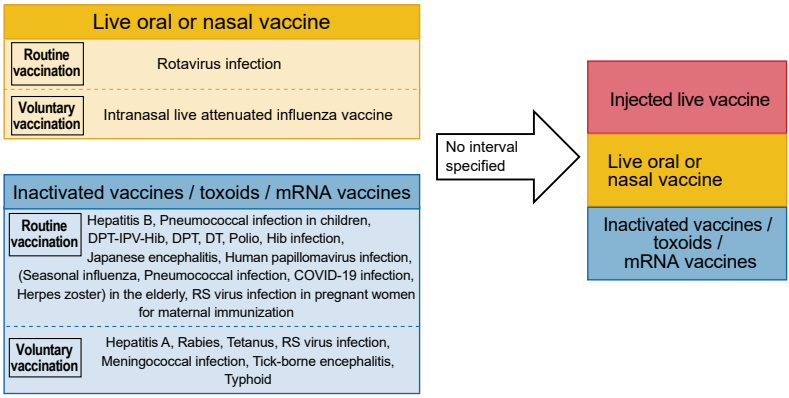
If your child is to be vaccinated several times with the same vaccine, please make sure that the specified intervals are adhered to.

Intervals between different types of vaccines

・Please follow the instructions provided in the package insert and other relevant materials regarding intervals between doses of the same vaccine.



* An interval of at least 27 days must elapse between two injected live vaccines, starting from the day after the first administration.
* There is no specified interval required between the administration of an injected live vaccine and subsequent administration of a live oral or nasal vaccine, inactivated vaccine, toxoid, or mRNA vaccine.



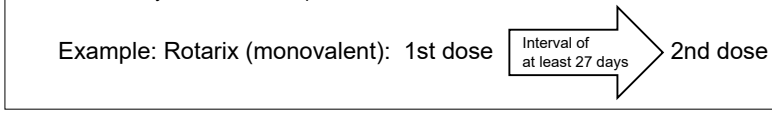
(Caution)

・Symptoms such as fever and swelling at the injection site may occur over a period of several days after vaccination. Even if within the permissible vaccination period, ensure that the individual is in good health—without symptoms such as fever or swelling at the injection site—before proceeding with vaccination.

・Vaccines may be administered simultaneously only when specifically approved by a physician.

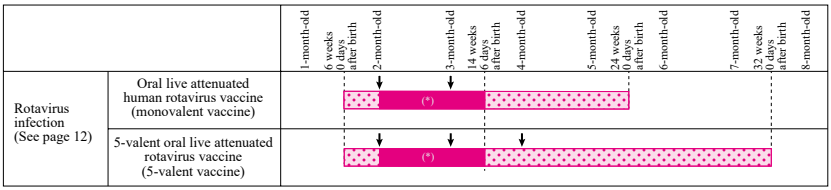
Vaccination intervals when receiving multiple doses of the same vaccine

・When receiving multiple doses of the same vaccine, it is necessary to observe the specified intervals for each vaccine.

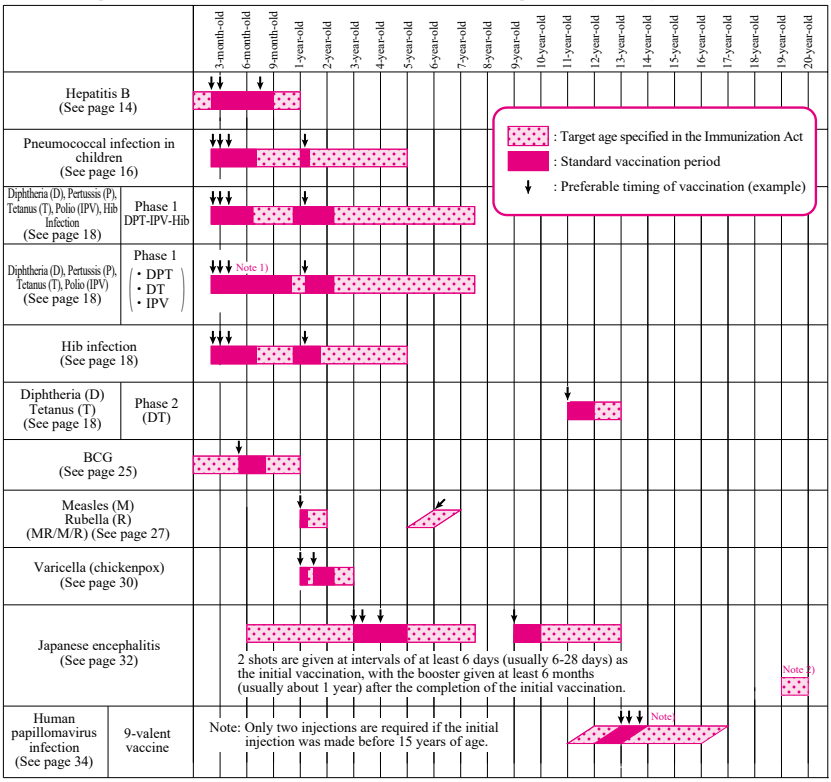


List of recommended periods for routine vaccination (Category A disease)

[Note] The starting date for calculating the vaccination interval is the day following the day of vaccination. Vaccination intervals are legally specified in days. For example, "an interval of one week" should be interpreted as "on or after the same day of the following week."



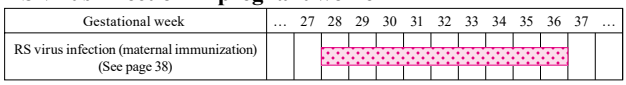
*: The standard period for the initial vaccination is from when the infant is 2 months old up to 14 weeks and 6 days after birth.



Note 1: If DT is used for phase 1, it is to be given no earlier than 3 months after birth.

Note 2: Persons born between April 2, 1995 and April 1, 2007 who were unable to receive the phase 1 or 2 vaccines are able to receive the missed doses as routine vaccinations, if they are under the age of 20.

RS virus infection in pregnant women



* Eligible for those between 28 weeks 0 days and 36 weeks 6 days of gestation

6. Before having your child vaccinated

Please confirm the following before vaccination

1 Is your child in good health?
2 Do you understand the necessity, effectiveness, and potential adverse reactions of the vaccine that will be given to your child today?
If you have any questions, please write them down.
3 Did you bring your maternal and child health handbook with you?
4 Did you complete a vaccination screening questionnaire?

(1) General precautions

Vaccination should be performed when your child is in good health. Always take note of the physical condition and characteristics of your child. If you have any concerns, do not hesitate to consult your family doctor, healthcare center, or the municipal office in charge, in advance.

To have your child vaccinated safely, we recommend that you make the decision whether to receive the vaccination on the appointed day after taking the following into consideration:

a) Observe your child carefully from the morning on the day of vaccination, and confirm that he/she is well.
If your child is scheduled to receive a vaccination but seems unwell, consult your family doctor to determine whether to proceed with the vaccination.

b) Thoroughly read the information about vaccination provided by the municipal office so that you fully understand the necessity and possible adverse reactions of the vaccines. If you have any questions, ask the doctor who is to vaccinate your child before vaccination.

c) Make sure to bring your maternal and child health handbook.

d) The screening questionnaire contains important information for the doctor in charge of vaccination. Please fill in the form completely and accurately.
* From June 2026 onward, in municipalities that have started the digitalization of vaccination administration, the screening questionnaire can be completed via Mynaportal.

e) We recommend that the child being vaccinated be accompanied by a parent/guardian who is familiar with the child's usual physical condition.

A child can only be vaccinated if a parent/guardian fully understands the effectiveness and potential adverse reactions to vaccination and agrees to have the child vaccinated.

(2) The following persons cannot receive vaccination:

a) A child with an obvious fever (37.5℃ or higher)

The vaccinating doctor and guardian (patient) are to thoroughly check the health condition of persons presenting with a body temperature slightly higher than 37.5℃ due to such reasons as a high baseline body temperature, and make judgments accordingly as to whether to perform the vaccination.

b) A child with a serious acute illness

As a general rule, children with acute, serious illnesses should not be vaccinated on that day, as the course of such illness can be unpredictable.

c) A child who has had anaphylaxis to any component of the vaccine preparation to be given on that day

"Anaphylaxis" is an acute, severe systemic allergic reaction, usually within 30 minutes after vaccination, including excessive sweating, a swollen face, systemic severe urticaria, nausea, vomiting, hoarseness, and respiratory distress, resulting in shock.

d) Women eligible for the measles, rubella, varicella (chickenpox), and mumps vaccination and are known to be pregnant

(This is a regulation not directly concerning children but important for persons who will receive voluntary vaccination.)

e) As concerns the BCG vaccination (hereinafter referred to BCG), a child with a predisposition to keloids

f) Children eligible for rotavirus vaccination who have a clear history of intussusception, who have a congenital abnormality of the gastrointestinal tract (except for children who have completed treatment for said abnormality), or who have been found to have a severe combined immunodeficiency disease

g) Other conditions that a doctor considers inappropriate

Even if your child does not meet the above criteria a) to f), he/she cannot be vaccinated if a doctor decides that doing so would be inappropriate.

- Children who are eligible for the hepatitis B vaccination and who have received the hepatitis B immunoglobulin and hepatitis B vaccine after birth under health insurance coverage as part of the mother-to-infant transmission prevention program are excluded from the routine vaccination program. However, subsequent vaccinations and related treatments will continue to be covered by health insurance.

(3) Children who require careful consideration in receiving a vaccination

Parents/guardians to whom the following may apply should have their child seen by their family doctor in advance to determine whether the child can be vaccinated. If vaccination is to take place, it should be performed by the family doctor, or at another medical institution provided a note or letter, etc. can be obtained from the family doctor.

a) A child who is being treated for a heart, kidney, liver, or blood disease, or a developmental disorder.

b) A child who has had a fever within 2 days of a previous vaccination or an allergic reaction, including rash and urticaria.

c) A child who has had a seizure in the past.
The decision of whether a child should be vaccinated depends on the age at which the seizure occurred, the presence or absence of fever, subsequent seizures, and the type of vaccine. Please consult the child's doctor before vaccination.

d) A child who has been diagnosed with immunodeficiency in the past or has a family member or relative with immunodeficiency (for example, a person who repeatedly had perianal abscesses as a baby).

e) A child who is allergic to the vaccine's components, such as eggs, antibacterial agents, and the stabilizers, which may be used in the culture process in vaccine manufacturing.

f) In the case of BCG vaccination, a child who is suspected to have been infected with tuberculosis in the past, such as having had extended contact with a tuberculosis patient in the family.

g) In the case of rotavirus vaccination, a child with an active gastrointestinal illness or gastrointestinal disorder such as diarrhea.

h) In vaccination against RS virus infection, individuals who have a history of hypertensive disorders of pregnancy or who are considered to be at high risk of developing such conditions

(4) General precautions after receiving vaccination

a) For 30 minutes after the vaccination, observe your child at the medical institution (facility) or ensure that a doctor can be contacted immediately. Acute adverse reactions often develop during that time.

b) Watch for possible adverse reactions for up to 4 weeks (for live vaccines and mRNA vaccines) or 1 week (for inactivated vaccines) after vaccination.

c) Keep the vaccination site clean. Bathing is allowed, but avoid rubbing the vaccination site.

d) Avoid strenuous physical activity on the day of vaccination.

e) If a child experiences an abnormal reaction at the vaccination site or has a change in physical condition after vaccination, consult a doctor immediately.

7. Diseases preventable by vaccination and vaccines

Each child has a unique physiological makeup. In rare cases, varying degrees of adverse reactions may occur. It is important for you to decide whether to have your child vaccinated after detailed consultation with your family doctor, who understands the physical status of your child.

◆ Rotavirus infection

(1) Cause and course

Rotavirus is a cause of acute gastroenteritis seen around the world and often seen primarily in infants and children under the age of 5 years old. Primary symptoms include diarrhea, vomiting, and fever and may also occasionally be accompanied by dehydration, seizures, liver dysfunction, and renal failure, and, rarely, acute encephalopathy. It can infect and cause illness any number of times, regardless of age, but first-time infection during infancy causes the most serious illness, with repeated infection thereafter resulting in more and more mild illness.

(2) Rotavirus vaccines (live vaccines)

There are two rotavirus vaccines – the oral live attenuated human rotavirus vaccine (Rotarix®; hereafter referred to as the monovalent vaccine), which uses attenuated rotavirus; and the 5-valent oral live attenuated human rotavirus vaccine (RotaTeq®; hereafter referred to as the 5-valent vaccine), which uses human-bovine reassortant rotavirus. Both vaccines provide about 80% protection from gastroenteritis caused by rotavirus infection, and about

95% protection from serious rotavirus infection.

Rotavirus can infect and cause illness any number of times, regardless of age, but first-time infection during infancy causes the most serious illness, with repeated infection thereafter resulting in more and more mild illness. Accordingly, with the primary aim of preventing such first-time infection, vaccination is administered in early infancy.

With the first rotavirus vaccine introduced in the United States, it was found that intussusception, a serious illness in infants and young children, frequently occurred as an adverse reaction, and marketing of this product was discontinued. Both of the two varieties of rotavirus vaccine in use around the world today have been confirmed to have a lower risk of intussusception than the first rotavirus vaccine introduced in the United States via large-scale clinical trials.

The risk of intussusception is increased during the week after receiving the first rotavirus inoculation.

In comparing the risks (the occurrence of adverse reactions such as intussusception) and benefits (prevention of serious rotavirus infection) of rotavirus vaccination, it is believed that preventing rotavirus infection is more beneficial to children, and more and more countries around the world are introducing the rotavirus vaccines.

If you notice even one of the following in your child after rotavirus vaccination, consider the possibility of intussusception and consult with a doctor immediately: periodic dysphoria, abdominal pain, repeated vomiting, intense crying, or bloody stool.

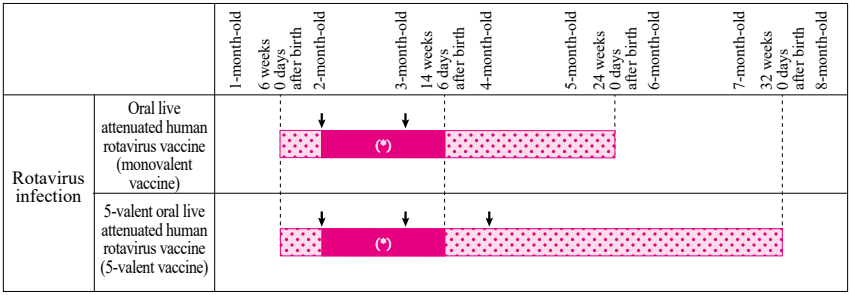
The rotavirus vaccine was added to the routine vaccination program starting October 1, 2020, and children born on or after August 1, 2020, have been eligible for routine vaccination since then.

The inoculation ages and number of inoculations differ according to the type of vaccine used. The monovalent vaccine (Rotarix®) is given in 2 inoculations separated by an interval of 27 days or more for children between 6 weeks 0 days after birth and 24 weeks 0 days after birth. The 5-valent vaccine (RotaTeq®) is given in 3 inoculations separated by intervals of 27 days or more for children between 6 weeks 0 days after birth and 32 weeks 0 days after birth. Note that in order to avoid the period in which there is a high incidence of intussusception, it is considered desirable to complete the initial inoculation by 14 weeks 6 days after birth.

The incidence of serious cases (cases deemed to be serious by the reporter) among suspected cases of adverse reactions (adverse events) reported by medical institutions was 0.0030% for the monovalent vaccine (Rotarix®) and 0.0021% for the 5-valent vaccine (RotaTeq®). (The incidence reported from April 1, 2013 to September 30, 2025. Source: February 2026

documents 2-27 and 2-28 from the 110th Working Group Meeting on Adverse Events, the Subcommittee on Vaccination and Vaccines of the Health Sciences Council.)

(3) Vaccination schedule



*: The standard period for the initial vaccination is from when the infant is 2 months old up to 14 weeks and 6 days after birth.

◆ Hepatitis B

Since October 2016, the hepatitis B (HB) vaccine has been given as a routine vaccination to all children born on or after April 1, 2016. The cost of vaccinations to newborns of hepatitis B-positive (HBs antigen positive) mothers will continue to be covered by health insurance, and in the case of accidental exposure to hepatitis B positive blood etc., the cost of vaccinations will continue to be covered by workers' compensation or health insurance.

(1) Cause and course

When a person is infected by the hepatitis B (HB) virus, he or she may develop acute hepatitis and recover, or progress to chronic hepatitis. In some cases, fulminant hepatitis may occur with severe symptoms which may result in death. In other cases, the virus may hide in the liver without causing any obvious symptoms, and develop into chronic hepatitis, cirrhosis, or hepatic cancer after a period of years. It is known that the younger the patient, the less clear the symptoms of acute hepatitis and the more likely the virus will hide, resulting in persistent infection. Infections occur through mother-infant transmission from an HBV-positive (HBs antigen positive) mother to her newborn, through direct contact with HBV-positive blood or bodily fluids, or through sexual contact with an individual who is HBV positive.

(2) Hepatitis B vaccine (inactivated vaccine)

Vaccination with the HB vaccine, especially in children, is aimed primarily at preventing persistent infection by the virus and the future potential occurrence of chronic hepatitis, cirrhosis, or hepatic cancer, rather than at preventing hepatitis in the short term.

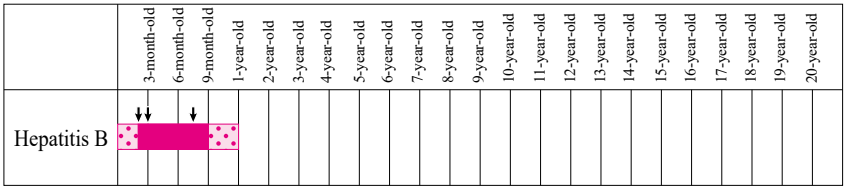
Previously, newborn infants of HBV-positive mothers were given the hepatitis B vaccine plus hepatitis B human immunoglobulin as soon as possible after birth to prevent mother-to-child transmission. Now, however, in order to have more people receive the hepatitis B vaccine and reduce the number of future sufferers of chronic hepatitis, cirrhosis, and hepatic cancer, routine vaccination began in October 2016 for all children born on or after April 1, 2016, in addition to the mother-to-child transmission prevention program.

Note that the mother-to-child transmission prevention program will continue to be covered by health insurance.

Children eligible for routine HB vaccination are those born on or after April 1, 2016 and under 1 year of age, who are not subject to the Mother-to-child transmission prevention project. The standard schedule is between the time the child turns 2 months and up to 9 months, in which two subcutaneous injections are given with an interval of at least 27 days between the first and second injections, and another (i.e. third) subcutaneous injection given after an interval of at least 139 days after the first injection.

Adverse reactions to the HB vaccine have been reported in about 10% of people who received the vaccine to date, and include lethargy, headache, and swelling/redness/pain at the vaccination site, etc. However, the vaccine is being given to newborns and infants without problems. The incidence of serious cases (cases deemed to be serious by the reporter) among suspected cases of adverse reactions (adverse events) reported by medical institutions was 0.0009%. (The incidence reported from April 1, 2013 to September 30, 2025. Source: February 2026 documents 2-24 from the 110th Working Group Meeting on Adverse Events, the Subcommittee on Vaccination and Vaccines of the Health Sciences Council.)

(3) Vaccination schedule



◆ Pneumococcal infection in children

(1) Cause and course

Streptococcus pneumoniae is one of two major causes of bacterial pediatric infections. This is a bacterium carried deep in the noses of many children and occasionally causes bacterial meningitis, bacteremia, pneumonia, sinusitis, and otitis media.

Prior to the introduction of the vaccine, the prevalence of bacterial meningitis caused by Streptococcus pneumoniae was 2.6-2.9 out of a population of 100,000 aged less than 5 years. It was estimated that about 150 experienced meningitis per year*. Case fatality rate and frequency of long-term effects (e.g. hydrocephalus, deafness, mental disabilities) are higher than that of Hib-induced meningitis, with about 21% experiencing a poor prognosis. (*Cited from material provided by the Vaccination Working Group, Section of Infectious Diseases, Health Science Council of MHLW.) Now that the pneumococcal conjugate vaccine is in wide use, invasive infections such as pneumococcal meningitis have decreased dramatically.

(2) Pneumococcal conjugate vaccine (inactivated vaccine)

The pediatric pneumococcal conjugate vaccine (pneumococcal vaccine) was developed to prevent bacterial meningitis in children, including serotypes causing serious conditions in children.

This vaccine was first introduced in the United States as a 7-valent vaccine in 2000. In 2010, it was replaced by the 13-valent vaccine, which is now routinely used in over 100 countries worldwide.It has been reported in many countries that vaccination with this vaccine reduces bacterial meningitis and bacteremia. In Japan, the 7-valent vaccine was authorized for use in February 2010, followed by the 13-valent vaccine in November 2013, and the incidence of invasive pneumococcal disease has decreased similarly. Since April 2024, the 15-valent pneumococcal vaccine has been included in the routine vaccination program, and starting in October of the same year, the 20-valent vaccine has also been included in the routine vaccination. (The 13-valent vaccine, which had been used until then, was removed from the routine vaccination program in October 2024 following the manufacturer's decision to discontinue its supply.)

Adverse reactions include local vaccination site reactions such as erythema (57.3-66.2%) and swelling (45.1-50.9%), and systemic reactions including fever (39.4-55.6%). (For Prevenar 20®, refer to the package insert revised in August 2024 [2nd edition]; for Vaxneuvance®, refer to the package insert revised in February 2024 [4th edition].)

The incidence of serious cases (cases deemed to be serious by the reporter) among suspected

cases of adverse reactions (adverse events) reported by medical institutions was 0.0017% for the 20-valent vaccine and 0.0014% for the 15-valent vaccine. (The incidence reported from the market launch to September 30, 2025. Source: February 2026 documents 2-20 and 2-21 from the 110th Working Group Meeting on Adverse Events, the Subcommittee on Vaccination and Vaccines of the Health Sciences Council.)

Pneumococcal vaccination for children is administered according to the following methods, based on the child's age in months at the start of the initial vaccination. The standard vaccination procedure is as described in a) below:

In principle, the 20-valent vaccine is used, and the 15-valent vaccine can also be used for the time being.

a) A child aged 2 to 7 months (not exceeding the first day of 7 months) at the time of initiating the initial vaccination.

   The initial vaccination is conducted using a 20-valent or 15-valent pneumococcal conjugate vaccine provided three times at intervals of at least 27 days usually by the time the child is 12 months of age. The booster is conducted once at an interval of at least 60 days after the initial vaccination, given no earlier than one day after the child turns 12 months (the standard vaccination period is between 12-15 months after birth). However, the second and third injection of the initial vaccination is to be given by the time the child is 24 months of age, and is not to be given if the child exceeds 24 months (the booster is allowed after this time). The second injection of the initial vaccination is to be given by 12 months of age. If the second dose is given after 12 months of age, the third injection of the initial vaccination is not to be given (the booster is allowed after this time).

b) A child aged 7 months (the second day of 7 months) to 12 months (not exceeding the first day of 12 months) at the initiation of the initial vaccination

   The vaccination is conducted using a 20-valent or 15-valent pneumococcal conjugate vaccine. The initial vaccination is provided twice at intervals of at least 27 days usually by the time the child is 12 months of age. The booster is conducted once at an interval of at least 60 days after the initial vaccination 12 months after birth. However, the second injection of the initial vaccination is to be given by the time the child is 24 months of age, and is not to be given if the child exceeds 24 months (the booster is allowed after this time).

c) A child aged 12 (the second day of 12 months) to 24 months (not exceeding the first day of 24 months) at the initiation of the initial vaccination.

   The vaccination is conducted using a 20-valent or 15-valent pneumococcal conjugate vaccine provided twice at intervals of at least 60 days.

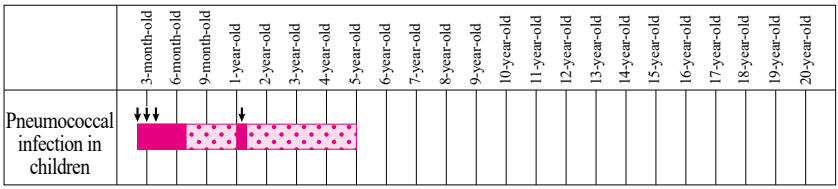
d) A child aged 24 (the second day of 24 months) to 60 months (not exceeding the first day of 60 months) at the initiation of the initial vaccination.

The vaccination is conducted using a 20-valent or 15-valent pneumococcal conjugate vaccine provided once.

A child who could not be vaccinated due to disease requiring long-term care is also vaccinated in this manner.

e) In principle, the same type of pneumococcal vaccine should be used to complete the vaccination series in each child. However, if there are unavoidable circumstances—such as when a child, after having received a certain number of doses, moves to a municipality where only the 20-valent vaccine is available, and the mayor of that municipality recognizes the reason—then the remaining doses in a child who began vaccination with the 15-valent vaccine may be administered using the 20-valent vaccine. If you have any questions regarding your child falling under this case, consult with your municipal office in charge of vaccination.

(3) Vaccination schedule



◆ Diphtheria, pertussis, tetanus, polio (acute poliomyelitis), and Hib infection

(1) Cause and course

a) Diphtheria

Diphtheria is caused by Corynebacterium diphtheriae and is spread by droplet infection.

The improved diphtheria-pertussis-tetanus vaccine (DPT) (acellular) was introduced to the market in 1981. Today, the annual incidence of diphtheria in Japan has been zero (0) for many consecutive years, but in the Asian region, epidemic outbreaks have occasionally been seen.

The bacterium infects mainly the throat but also the nasal cavity. Even when infection occurs, diphtheria causes symptoms in only about 10% of people, while the rest of those infected become asymptomatic carriers who can transmit the disease to other people. Symptoms include high fever, sore throat, a barking cough, and vomiting; a false membrane may also form in the throat which can cause asphyxia. Patients must be monitored carefully because the

bacterium produces a toxin that can cause a serious myocardial disorder or paralysis two to three weeks after the development of symptoms.

b) Pertussis

Pertussis is caused by Bordetella pertussis and is spread by droplet infection.

Since pertussis vaccination was begun in 1950, the number of patients has decreased, but in recent years, there have been cases of pertussis in children ranging from school age to adolescence as well as in adults characterized by persistent coughing. Such people are potential sources of infection to small children, and require caution since the disease can become serious, especially in newborns and infants.

Prototypical pertussis begins with symptoms mimicking a common cold. The child then begins to cough violently and repeatedly, with a flushed face. After coughing, the patient is forced to inhale rapidly, creating a whooping sound similar to a whistle. Usually, fever does not develop. Infants sometimes present with blue lips (cyanosis), seizures (fits) or suddenly stop breathing because they are unable to breathe due to coughing. Severe complications such as pneumonia or encephalopathy are likely to develop, and these diseases may lead to death in newborns or infants.

● Droplet infection

Droplet infection is the transmission of viruses and bacteria through coughing, sneezing, conversation, etc. Viruses and bacteria enveloped in sprays of saliva and airway secretions are spread through the air to people within one meter.

c) Tetanus

Clostridium tetani does not spread from person to person. The bacteria are usually found in soil and enter the body through wounds in the skin. The bacteria multiply in the body and produce a toxin, causing tonic muscle spasms. Tetanus is a serious disease that often begins with symptoms such as difficulty opening the mouth (lockjaw). As the condition progresses, it can lead to generalized tonic convulsion. If treatment is delayed, tetanus can be fatal. Half of all patients are infected through a small puncture wound not noticed by themselves or the people around them. As the bacteria are found in soil, opportunities for infection are constant. If a pregnant mother has immunity, the newborn is protected from tetanus during delivery.

d) Polio (acute poliomyelitis)

Polio (acute poliomyelitis) is also known as “infantile paralysis.” Pandemics occurred repeatedly in Japan until the early 1960s. Owing to vaccination, the last occurrence of a patient

paralyzed by a wild strain of the polio virus was in 1980. The WHO declared the eradication of poliomyelitis from the Western Pacific Region including Japan in 2000. At present, there are only two polio-endemic countries, Pakistan and Afghanistan, and global polio eradication seems no longer a dream, but the world remains vigilant against polioviruses.

The poliovirus infects through the mouth and proliferates in the cells of the pharynx and small intestine. The poliovirus is said to multiply for 4 to 35 days (mean: 7-14 days) in the cells of the small intestine. Viruses thus multiplied are excreted in feces and may enter the mouth of another person. If that person has no resistance (immunity) to the poliovirus, the viruses multiply in the intestine, resulting in infection from person to person. Most people who are infected with the poliovirus are asymptomatic and gain lifelong protection (lifelong immunity). In some people who experience symptoms, the viral infection spreads via the blood to the spinal cord, thereby causing paralysis. Out of 100 children infected with the poliovirus, 5-10 experience symptoms like those of the common cold, accompanied by fever, and followed by headache and vomiting.

About 1 of 1,000-2,000 people infected with the poliovirus experiences paralysis of the limbs. Some are permanently paralyzed or suffer from progression of symptoms, sometimes dying of respiratory distress.

e) Hib infection

Hib infection is a disease caused by a bacterium called Haemophilus influenzae type b. Haemophilus influenzae, especially Haemophilus influenzae type b, is a problematic pathogen for infants and small children, causing not only superficial infections such as otitis media, sinusitis, and bronchitis, but also serious deep (systemic) infections (also called invasive infections) such as meningitis, sepsis, and pneumonia. Prior to 2010, the incidence of meningitis caused by Hib was 7.1-8.3 out of a population of 100,000 aged less than 5 years. It was estimated that about 400 became infected with meningitis per year and about 11% of those experienced poor outcomes*. Children aged 4 months or more and less than 1 year accounted for a half of total patients. (*Cited from material provided by the Vaccination Working Group, Section of Infectious Diseases, Health Science Council of MHLW.) Now that the Hib vaccine is widely used, invasive Hib disease is nearly unseen.

(2) Diphtheria, pertussis, tetanus, inactivated polio and Haemophilus influenzae type b 5-in-1 combination vaccine (DPT-IPV-Hib), Diphtheria, pertussis and tetanus 3-in-1 combination vaccine (DPT), and diphtheria-tetanus 2-in-1 combination vaccine (DT) (inactivated vaccine)

In phase 1, the initial vaccination is administered on or after 2 months of age, followed by three doses of either the DPT-IPV-Hib or DPT vaccine, each given at intervals of at least

20 days, typically within a range of 20 to 56 days. If the DT vaccine is used, it is to be administered in two doses no earlier than 3 months after birth. The phase 1 booster is given at least 6 months (usually 6 to 18 months for DPT-IPV-Hib) after the completion of the initial vaccination. Take care not to miss any vaccinations, as multiple doses are required. Phase 2 vaccination is given once at the age of 11-12 years using DT. In principle, the same type of vaccine used for the initial dose should be used to complete the phase 1 vaccination series. However, if the mayor of the municipality acknowledges unavoidable circumstances, it is permissible to select a different type of vaccine.

Although it is a voluntary vaccination, your child may also receive the DPT vaccine during phase 2 to further strengthen immunity against pertussis.

To acquire sufficient immunity, your child must be vaccinated according to fixed intervals. However, even in the event the interval between injections becomes longer than that specified, there are several methods which can be taken, so please consult with your family doctor or the municipal office.

The DPT-IPV-Hib can be used even with children who have already contracted one or more of pertussis, diphtheria, poliomyelitis (acute poliomyelitis), or tetanus.

In November 2012, the DPT (diphtheria, pertussis, tetanus) and IPV (inactivated polio) 4-in-1 vaccine Quattrovac® (manufactured by KM Biologics, with the last lot expiring June 5, 2025) and Tetrabik® (manufactured by the Research Foundation for Microbial Diseases of Osaka University, with the last lot expiring December 12, 2025) were introduced to the market. In December 2015, the DPT-IPV 4-in-1 vaccine, Squarekids® subcutaneous injection syringe (manufactured by Daiichi Sankyo Vaccine Co., Ltd.), was introduced to the market. However, Quintovac® (manufactured by KM Biologics Co., Ltd.) and GOBIK® (manufactured by the Research Foundation for Microbial Diseases of Osaka University), which are 5-in-1 vaccines, have become available for routine vaccination, and all 4-in-1 vaccines have been discontinued and are no longer marketed in Japan.

The incidence of serious cases (cases deemed to be serious by the reporter) among suspected cases of adverse reactions (adverse events) reported by medical institutions was 0.0017% for DPT-IPV-Hib, 0.0012% for DPT-IPV, 0.0016% for DPT vaccine, and 0.0003% for DT vaccine. (The incidence reported from April 1, 2013 or from the initial marketing in March 2024 for 5-in-1 vaccines only to September 30, 2024. Source: February 2026 documents 2-17, 2-16, 2-11, and 2-12 from the 110th Working Group Meeting on Adverse Events, the Subcommittee on Vaccination and Vaccines of the Health Sciences Council.)

Even in the absence of a serious adverse reaction, if your child is cranky or swelling occurs, consult with a doctor.

Although the incidence of diphtheria, tetanus, and polio (acute poliomyelitis) has decreased, these diseases are all associated with serious complications, disabling sequelae, or even death. In addition, a large-scale outbreak of pertussis occurred in Japan in 2025. Therefore, it is recommended to receive vaccination for their prevention.

(3) Polio vaccine (inactivated vaccine)

An oral polio vaccine (OPV) had been used to eradicate polio in Japan and this state had been maintained up until August 2012; however, the OPV was replaced with an inactivated poliovirus vaccine (IPV) as a routine vaccination on September 1, 2012 in order to avoid vaccine-associated paralytic poliomyelitis (VAPP), a rare but serious adverse reaction to the OPV which develops in about one out of one million vaccine recipients. Since September 2012, the standalone inactivated poliovirus vaccine IMOVAX POLIO® subcutaneous (manufactured by Sanofi) has been utilized. In November 2012, the 4-in-1 vaccine DPT-IPV, which combines vaccines for diphtheria, pertussis, tetanus, and inactivated polio (manufactured by KM Biologics Co., Ltd. and the Research Foundation for Microbial Diseases of Osaka University), was introduced. However, due to discontinuation of marketing, the 4-in-1 vaccines are no longer available for use as of their final expiration date of December 12, 2025. Furthermore, since April 2024, the 5-in-1 vaccine DPT-IPV-Hib, which adds protection against Hib to the aforementioned combination (also manufactured by KM Biologics Co., Ltd. and the Research Foundation for Microbial Diseases of Osaka University), has been used.

The IPV includes antigens of three types of polio viruses (I, II and III). Resistance (immunity) to these three types of polio viruses reaches almost 100% with three IPV vaccinations; however, the fourth vaccination is needed because IPV maintains immunocompetence for a shorter time than the OPV.

A domestic clinical trial of IMOVAX POLIO® subcutaneous showed that pain (18.9%), erythema (77.0%), swelling (54.1%), fever of 37.5°C or more (33.8%), drowsiness (35.1%), and irritability (41.9%) were observed after the third vaccination. Precautions of shock and anaphylaxis (frequency unknown) and against convulsions as they were observed in 1.4% are described in the package insert. (See package insert [4th ver.] revised in February 2025).

The incidence of serious cases (cases deemed to be serious by the reporter) among suspected cases of adverse reactions (adverse events) reported by medical institutions was 0.0010%. (The incidence reported from April 1, 2013 to September 30, 2025. Source: February 2026 documents 2-15 from the 110th Working Group Meeting on Adverse Events, the Subcommittee on Vaccination and Vaccines of the Health Sciences Council.)

The switch from OPV to IPV is taking place all over the world. However, there are many cases that OPV-derived viruses (circulating vaccine-derived poliovirus: cVDPV) still lurking in sewage and river water infect non-vaccinated individuals and cause paralysis in regions where vaccination rates are low. As cases of cVDPV infection have recently been reported in the United States, Israel, the United Kingdom, Indonesia, and Papua New Guinea, there is a need to improve polio vaccination coverage in these countries. In Japan, the DPT-IPV vaccination rate is high, and cVDPV has not been detected. However, to prevent the spread of infection within the country even if cVDPV is imported from overseas, it is recommended to receive a vaccine containing IPV.

(4) Hib vaccine (inactivated vaccine)

Haemophilus influenzae is classified into 7 types, with type b being the main cause of serious disease; consequently, type b is used for vaccination. This vaccine is used extensively throughout the world, and was authorized for use in Japan in December 2008 and made a routine vaccination in April 2013.

In Europe and the United States, invasive Hib infections decreased dramatically after the vaccine was introduced. Reduction has been similarly dramatic in Japan after introduction of routine vaccination, and Hib infections are now nearly unseen. The World Health Organization (WHO) highly recommended routine Hib vaccinations for infants and children in 1998; consequently, Hib vaccination has been introduced in more than 190 nations and its efficacy has been evaluated highly.

Adverse reactions (at the time of approval) are mainly local reactions including redness (44.2%), swelling (puffiness) (18.7%), induration (lump) (17.8%), and pain (5.6%); as well as systemic reactions including fever (2.5%), dysphoria (14.7%), and loss of appetite (8.7%). (See package insert [5th ver.] revised in February 2025).

The incidence of serious cases (cases deemed to be serious by the reporter) among suspected cases of adverse reactions (adverse events) reported by medical institutions was 0.0019%. (The incidence reported from April 1, 2013 to September 30, 2025. Source: February 2026 documents 2-18-1 from the 110th Working Group Meeting on Adverse Events, the Subcommittee on Vaccination and Vaccines of the Health Sciences Council.)

Vaccination against Hib infection is basically provided with the 5-in-1 DPT-IPV-Hib combination vaccine. In cases where the Hib vaccine is used, the following procedures are followed according to the age in months at the time of initial vaccination. The standard vaccination procedure is as described in a) below:

7. Diseases preventable by vaccination and vaccines

a) A child aged 2 to 7 months (not exceeding the first day of 7 months) at the time of initiating the initial vaccination

The initial vaccination is conducted using a Hib vaccine provided three times at intervals of 27 days or more (20 days if required by a physician), with the standard interval being 27 (20 if required by a physician) to 56 days. The booster is conducted once at an interval of 7 months or more (usually 7 to 13 months) after the initial vaccination. It should be noted that the second and third injections of the initial vaccination are to be given by the time the child is 12 months of age, and are not to be given if the child exceeds 12 months. One booster may be given after an interval of at least 27 days (20 days if required by a physician) after the last vaccination of phase 1.

b) A child aged 7 months (the second day of 7 months) to 12 months (not exceeding the first day of 12 months) at the initiation of the initial vaccination

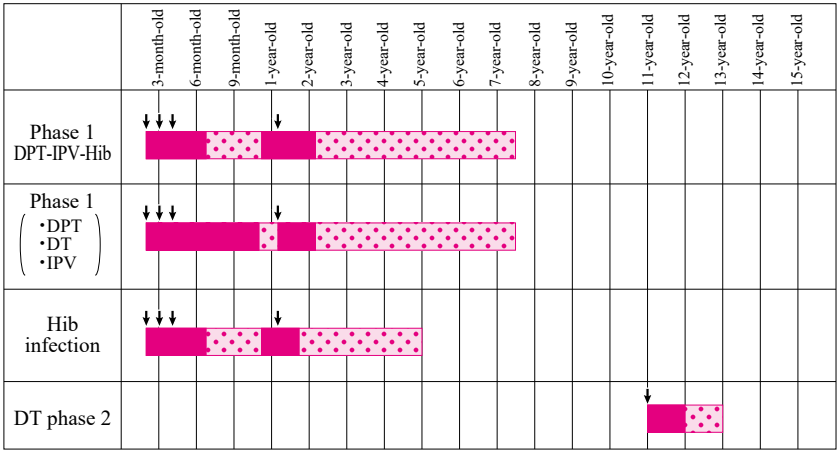
The initial vaccination is conducted using a Hib vaccine provided two times at intervals of 27 days or more (20 days if required by a physician), with the standard interval being 27 (20 if required by a physician) to 56 days. The booster is conducted once at an interval of 7 months or more (usually 7 to 13 months) after the initial vaccination. It should be noted that the second injection of the initial vaccination is to be given by the time the child is 12 months of age, and is not to be given if the child exceeds 12 months. One booster may be given after an interval of at least 27 days (20 days if required by a physician) after the last vaccination of phase 1.

c) A child aged 12 months (the second day of 12 months) to 60 months (not exceeding the first day of 60 months) at the initiation of the initial vaccination.

The vaccination is conducted using a Hib vaccine provided once.

A child who could not be vaccinated due to disease requiring long-term care is also vaccinated in this manner.

(5) Vaccination schedule



- The DPT-IPV-Hib, DPT, and DT can also be given to children who have already experienced pertussis.
  If DT is used, it is to be delivered in two doses with the initial injection given no earlier than 3 months after birth.
  The DPT-IPV-Hib, DPT, and DT can also be given to children who have already experienced any of the diseases of diphtheria, tetanus, polio, or Hib.
- In the phase 1 initial vaccination, the same type of vaccine is usually given the required number of times.
- When using the 5-in-1 vaccine in phase 1, refer to the top row.

◆ Tuberculosis

(1) Cause and course

Tuberculosis is caused by Mycobacterium tuberculosis infection. The number of tuberculosis patients has markedly decreased in Japan, and the number of new cases in 2024 was 8.1 cases/100,000 population, falling below the WHO standard for low tuberculosis incidence (10.0 cases/100,000 population). However, tuberculosis can be transmitted to children from adults. Immunity against tuberculosis cannot be acquired in the womb, so newborn babies are also at risk of contracting the disease. Infants and children have low immunity against tuberculosis; as a result, they sometimes contract systemic tuberculosis or tuberculous meningitis, resulting in severe secondary complications.

It is recommended to receive a BCG vaccination within 1 year after birth as the BCG vaccine has the effect of preventing serious tuberculosis, such as meningitis and miliary tuberculosis, in infants.

The standard vaccination period is from 5 to 8 months after birth.

(2) BCG vaccine (live vaccine)

The BCG vaccine is made from attenuated Mycobacterium bovis.

The method used to administer the BCG vaccination in Japan is a percutaneous injection

using a specific multiple-puncture device, called the stamping method, that is pressed into two locations on the upper arm. The vaccine should not be given elsewhere on the body due to possible adverse reactions, including keloid formation. The vaccination site should be allowed to dry away from light for about 10 minutes.

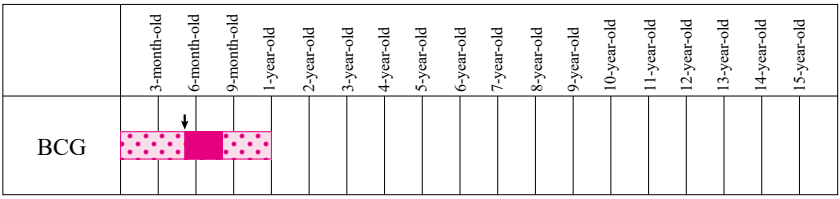
Red pockmarks appear on the vaccination site around 10 days after vaccination, and some may discharge a small amount of pus (fester). This reaction peaks about 4 weeks after vaccination; subsequently, the pockmarks are covered with scabs and heal completely by three months after vaccination, leaving only tiny scars. This scarring is not an abnormal reaction but evidence that a person has acquired immunity through the BCG vaccination. As the vaccination site will heal naturally, keep it clean and do not cover it with a bandage or plaster. However, if the vaccination site is still oozing three months after vaccination, please consult a doctor.

One rare adverse reaction is swelling in the lymph nodes below the armpit on the same side as the vaccination. This reaction can generally be left untreated; however, occasionally the area can become eroded, severely swollen, or, rarely, may fester and naturally tear. Should such a reaction occur, please consult a doctor.

The incidence of serious cases (cases deemed to be serious by the reporter) among suspected cases of adverse reactions (adverse events) reported by medical institutions was 0.0026%. (The incidence reported from April 1, 2013 to September 30, 2025. Source: February 2026 documents 2-22 from the 110th Working Group Meeting on Adverse Events, the Subcommittee on Vaccination and Vaccines of the Health Sciences Council.)

In cases where a child is infected with tuberculosis due to transmission from a family member etc., within 10 days (usually within 3 days) of the injection the vaccination site may show an inflammatory reaction called Koch's phenomenon (redness, swelling, and suppuration at the vaccination site, generally followed in 2 to 4 weeks by decreased redness, swelling, and inflammation, after which the wound scarifies [leaves a scar] and heals). Unlike the usual reaction time (generally about 10 days after vaccination), the Koch's phenomenon appears at an early stage, within several days of vaccination. If your child develops a reaction which suggests the Koch's phenomenon, promptly consult your municipality or a physician, as your child may require treatment. In such cases, family members and other individuals close to the child who may have transmitted tuberculosis will also require a medical examination.

(3) Vaccination schedule



◆ Measles and rubella

(1) Cause and course

a) Measles

Measles is caused by infection by the measles virus. Measles is highly contagious and spreads not only through droplets and contact but also through airborne transmission. Without vaccination, many people will contract the disease and there is risk of an epidemic. The main symptoms of prototypical measles are high fever, cough, runny nose, bloodshot eyes, eye discharge, and rash. For the first 3 to 4 days, patients have a fever of 38°C, which appears to decline but increases again to 39°C to 40°C, with a rash over the entire body. The fever goes down within 3 to 4 days, and the rash gradually disappears. The parts affected by the rash may remain darker for a while.

The main complications are bronchitis, pneumonia, otitis media, and encephalitis. About 7 to 9 out of 100 people with measles also get otitis media and about 1 to 6 get pneumonia. 1 to 2 out of 1,000 experiences encephalitis. One or two out of 100,000 measles patients develop subacute sclerosing panencephalitis (SSPE), a chronic progressive form of encephalitis. Reports indicate that the incidence is higher when the infection occurs in children under five years of age.

Measles is a severe disease; even in advanced countries with sophisticated medical care, around 1 out of 1,000 measles patients dies. In Japan, approximately 20 to 30 people died annually during the epidemic which occurred in the years around 2000. However, in March 2015, the Western Pacific Regional Office (WPRO) of the World Health Organization (WHO) certified that measles had been eliminated in Japan. On the other hand, globally, cases of measles are once again on the rise, and many children, primarily in developing countries, die from measles.

● Airborne infection (droplet nuclei infection)

With an airborne infection, the virus or bacterium is discharged into the air and infects people in open spaces. Measles, varicella (chickenpox), and tuberculosis are airborne diseases.

b) Rubella

Rubella is caused by the rubella virus and is spread by droplet and contact transmission. The incubation period is 2 to 3 weeks. Prototypical rubella develops with mild cold-like symptoms, and the main symptoms are rash, fever, and posterior cervical lymphadenopathy (lymph nodes swelling in the back of the throat). Conjunctival congestion also occurs. Older children and adults experience a high frequency of arthritis. The prognosis is generally good, but thrombocytopenic purpura and encephalitis may also be observed, and, rarely, hemolytic anemia. According to the National Epidemiological Surveillance of Infectious Diseases, during the rubella outbreak from 2018 to 2019 (with a total of 5,239 cases), there were 21 reported cases of thrombocytopenic purpura and 2 reported cases of encephalitis. Adult patients experience severe symptoms.

When a pregnant woman is infected by the rubella virus before around the 20th week of pregnancy, there is a high risk of her infant being born with congenital rubella syndrome which may include heart abnormalities, cataracts, hearing impairment, and delayed growth and development.

In September 2025, the Western Pacific Regional Office (WPRO) of the World Health Organization (WHO) certified that Japan had newly achieved rubella elimination.

(2) Combined measles-rubella (MR) vaccine, measles (M) vaccine, rubella (R) vaccine (live vaccine)

The MR live vaccine contains attenuated measles and rubella viruses.

Once your child turns 1 year old, you should have him or her receive the phase 1 vaccination as soon as possible.

Both the measles and rubella vaccines give 95% or more of children immunity after one injection, but as a precaution in case of non-response to the first dose and to prevent age-related decline of immunity, a second injection (phase 2 vaccination) is now performed.

Even if your child received an emergency measles and rubella vaccination before his or her first birthday, it is not counted in the number of vaccinations received because vaccination under one year of age is insufficient for acquiring immunity. Have him or her receive the routine phase 1 vaccination once he or she turns 1 year old, and the phase 2 vaccination once the appropriate age is reached.

Eligibility for the phase 2 vaccination is the year before admission into elementary school, that is, children in their final year of kindergarten or nursery school.

For the phase 1 and 2 vaccinations, the combined measles-rubella (MR) vaccine is used.

The combined measles-rubella (MR) vaccine can also be used for individuals who have already contracted measles or rubella.

If your child has received a human immunoglobulin injection for the purpose of treating or

preventing illness, please consult your family doctor for the appropriate timing of vaccination.

The data concerning adverse reactions to the measles and the rubella vaccines shows that anaphylaxis, thrombocytopenic purpura, encephalitis, and seizure may occur rarely.

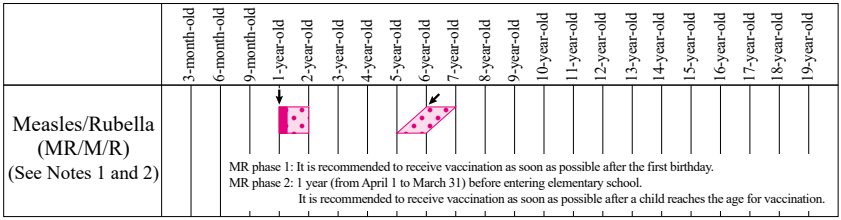
Febrile seizures (seizures caused by a fever) have occasionally (about 1 out of 300) been reported after measles vaccination. In addition, there have been reports of children experiencing encephalitis/encephalopathy in extremely rare cases (no more than 1 in 1 to 1.5 million children).

The incidence of serious cases (cases deemed to be serious by the reporter) among suspected cases of adverse reactions (adverse events) reported by medical institutions was 0.0010%. (The incidence reported from April 1, 2013 to September 30, 2025. Source: February 2026 documents 2-1 from the 110th Working Group Meeting on Adverse Events, the Subcommittee on Vaccination and Vaccines of the Health Sciences Council.)

Although the rubella vaccine is a live vaccine and the rubella virus multiplies in the body similarly to the measles vaccine, a vaccinated person does not infect those around him or her.

Measles causes severe symptoms and may result in sequelae or death. When a pregnant woman contracts rubella, her infant may be born with congenital rubella syndrome which may include heart abnormalities, cataracts, retinopathy, hearing impairment, and intelligence impairment. Make sure you are vaccinated so as to prevent contracting these diseases or transmitting them to others.

(3) Vaccination schedule



Note 1: A simultaneous vaccination for measles and rubella in phases 1 and 2 is given using the combined measles-rubella (MR) vaccine.

Note 2: Individuals with a confirmed history of either measles or rubella may receive either the vaccine for the disease they have not contracted or the combined measles-rubella (MR) vaccine; however, the MR vaccine is typically administered.

(4) Special measures in response to the uneven distribution of the freeze-dried live attenuated measles–rubella (MR) vaccine

In response to the uneven distribution of the MR vaccine that occurred in fiscal year 2024, an administrative notice dated March 11, 2025 was issued, pursuant to Article 3, Paragraph 2 of The Preventive Vaccination Law Enforcement Ordinance, stating that individuals who are

expected to be unable to receive vaccination within the designated vaccination period may be vaccinated beyond that period during the period specified below.

・Target period

Two years from April 1, 2025 to March 31, 2027

・Eligibility

Phase 1	Individuals who will reach or have reached 24 months of age within fiscal year 2024 (born between April 2, 2022 and April 1, 2023), and who are recognized by the mayor of the municipality as having been unable to receive the MR vaccine due to factors such as uneven vaccine distribution.
Phase 2	Individuals eligible for Phase 2 in fiscal year 2024 (those aged 5 years to under 7 years, who are within the period from one year before reaching the start date of elementary school enrollment to the day before the start date), and who are recognized by the mayor of the municipality as having been unable to receive the MR vaccine due to factors such as uneven vaccine distribution.
Phase 5	Male individuals born between April 2, 1962 and April 1, 1979, who underwent an antibody test by the end of fiscal year 2024 and were found to have insufficient rubella antibodies, and who are recognized by the mayor of the municipality as having been unable to receive the MR vaccine due to factors such as uneven vaccine distribution. Note: Individuals who undergo antibody testing in or after fiscal year 2025 are not eligible.

◆ Varicella (chickenpox)

(1) Cause and course

Varicella (chickenpox) is an acute infectious disease caused by initial infection with the varicella-zoster virus (hereinafter referred to as VZV). It is one of the most infectious diseases, spread by direct contact, droplets, and airborne infection. Once a person is infected, the virus remains latent in the body (in the trigeminal ganglia and other cerebral ganglia, and in the dorsal root ganglia) and reactivates to cause herpes zoster (shingles) when the person ages, or when the immune system is compromised.

The incubation period of varicella (chickenpox) is generally about 2-3 weeks (10-21 days). The main symptom of prototypical varicella (chickenpox) is a characteristic rash with itching. There may also be a fever. The rash begins as spotted red papules, progressing in 3 or 4 days to blisters that crust over and form scabs before healing. Although the rash tends to be distributed on the abdomen, back, and face, it also characteristically appears on the scalp and other parts which are covered with hair.

Varicella usually clears spontaneously in about 1 week, but in rare cases it can be accompanied by encephalitis, pneumonia, or liver function abnormality. Antiviral medication (e.g. Acyclovir) is sometimes used. It is not unusual for bacterial infections to develop via

the skin and lead to purulence. In some cases, complications such as sepsis and other severe bacterial infections may occur. High-risk patients (patients with malignant tumors such as acute leukemia or patients who are or may be immunosuppressed due to treatment) are particularly likely to develop severe symptoms.

In accordance with regulations such as the Enforcement Regulations for the School Health and Safety Act, children are to refrain from attending nursery school, kindergarten, or elementary/middle/high school until all of the rash has crusted over (formed scabs).

When adults develop varicella (chickenpox), symptoms become more severe compared to children.

(2) Varicella (chickenpox) vaccine (live vaccine)

This is a live vaccine containing attenuated VZV. It was developed in Japan ahead of the rest of the world. About 20% of the individuals who receive this vaccine once experience varicella (chickenpox) later, but in a milder form. The vaccine is given twice to ensure that infection does not occur.

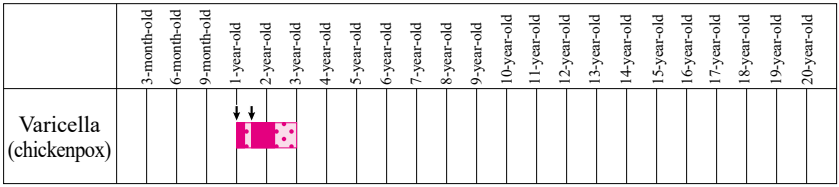
It has been shown that vaccine administration within 3 days of exposure to a varicella patient is effective in preventing disease. This kind of vaccination is also used to prevent hospital-acquired infection.

Almost no adverse reactions are observed in healthy children and adults; however, fever and rash occasionally develop, and local redness, swelling (puffiness), and induration (stiffness) are observed in rare cases. High-risk patients (patients who may be immunosuppressed due to the effects of treatment for acute lymphatic leukemia or nephrotic syndrome) may receive the vaccination, provided that certain conditions are met. However, the patient may develop a fever with papules and blisters 14 to 30 days after vaccination. (See package insert [6th ver.] revised in December 2025).

The incidence of serious cases (cases deemed to be serious by the reporter) among suspected cases of adverse reactions (adverse events) reported by medical institutions was 0.0010%. (The incidence reported from April 1, 2013 to September 30, 2025. Source: February 2026 documents 2-5 from the 110th Working Group Meeting on Adverse Events, the Subcommittee on Vaccination and Vaccines of the Health Sciences Council.)

After being made a routine vaccination on October 2014, the incidence of varicella (chickenpox) decreased dramatically. The varicella vaccine can be given at the same time as the MR vaccine. Children aged 12 months to no later than 36 months are given a freeze-dried live attenuated varicella vaccine, with the first injection given when the child is 12 months to no later than 15 months as the standard vaccination period, and the second injection given after an interval of at least 3 months with the standard interval being between 6 to 12 months. Children with a history of varicella are not eligible for routine vaccination.

(3) Vaccination schedule



◆ Japanese encephalitis

(1) Cause and course

Japanese encephalitis is caused by the Japanese encephalitis virus. The Japanese encephalitis virus is transmitted by mosquitoes carrying viruses that have multiplied in pigs and other hosts. After an incubation period of 7 to 10 days, it may develop into acute encephalitis with symptoms such as high fever, headache, vomiting, disturbance of consciousness, and convulsions. Japanese encephalitis does not spread from person to person.

One in 100-1,000 people infected with the virus develops encephalitis, etc. Some people develop meningitis, while others may only experience symptoms like a summer cold. The fatality rate of encephalitis is about 20-40%, but many people suffer from nervous system sequelae after recovering from the disease.

In Japan, the disease occurs mainly in the western areas, but the Japanese encephalitis virus is found throughout the nation and especially in western Japan. Japanese encephalitis outbreaks among domesticated pigs occur yearly from June to around October, during which time approximately 80% of pigs are infected in some geographical areas. In the past, the disease was prevalent among small and school-age children, but due to the wider use of vaccination and changes in living environments, the number of patients has decreased. In recent years, patients have mostly been elderly, but in 2015, a 10-month-old infant in Chiba prefecture was determined to have Japanese encephalitis. There were also 11 reported incidents in 2016, mostly in elderly people. This was the first time the number of patients exceeded 10 per year since 1992. In 2025, 4 incidents were reported. (Japan Institute for Health Security, Infectious Disease Weekly Report (IDWR) 52nd week 2025)

(2) Freeze-dried Japanese encephalitis vaccine (inactivated vaccine)

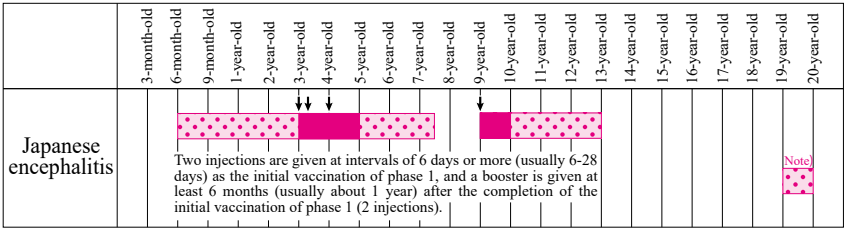
The freeze-dried cell culture-derived Japanese encephalitis vaccine in use in Japan today is created by growing the virus in Vero cells and killing (inactivating) the virus with a substance such as formalin, after which it is refined.

The incidence of serious cases (cases deemed to be serious by the reporter) among suspected cases of adverse reactions (adverse events) reported by medical institutions was 0.0007%.

(The incidence reported from April 1, 2013 to September 30, 2025. Source: February 2026 documents 2-23 from the 110th Working Group Meeting on Adverse Events, the Subcommittee on Vaccination and Vaccines of the Health Sciences Council.)

Eligibility for the phase 1 routine vaccination is children between 6 and 90 months after birth. The standard schedule is to give two injections separated by an interval of 6 to 28 days from the day the child turns 3 and before his or her fourth birthday, and one injection from the fourth birthday to before the child turns 5. Eligibility for the phase 2 routine vaccination is children from 9 years to before he or she turns 13. The standard schedule is to give one injection between the child's ninth and tenth birthdays.

(3) Vaccination schedule



Note: Persons born between April 2, 1995 and April 1, 2007 who were unable to receive the phase 1 or 2 vaccines are able to receive the missed doses as routine vaccinations, if they are under the age of 20.

(4) Special consideration for vaccination (to secure opportunities for vaccination for children who were unable to receive the vaccine due to suspension of active recommendation in 2005)

Persons under the age of 20 who were born between April 2, 1995 and April 1, 2007 and who may not have received the phase 1 (three injections) and phase 2 (one injection) vaccine due to suspension of active recommendation on May 30, 2005 are eligible for the following measures to secure opportunities for vaccination.

a) Persons who are to receive 3 injections remaining of phase 1 and 2 (persons who received 1 injection of the initial vaccination in phase 1 [persons who received the first injection]) are to be given 2 injections of freeze-dried cell culture-derived Japanese encephalitis vaccine separated by an interval of at least 6 days, with the fourth injection for persons at least 9 years of age to be given after an interval of at least 6 days following the third injection.

b) Persons who are to receive 2 injections remaining of phase 1 and 2 (persons who received two injections of the initial vaccination in phase 1 [persons who received the second injection]) are to be given the third injection of freeze-dried cell culture-derived Japanese encephalitis vaccine after an interval of at least 6 days, with the fourth injection for

persons at least 9 years of age to be given after an interval of at least 6 days following the third injection.

c) Persons who are to receive phase 2 of the vaccination (persons who have completed phase 1 injections [persons who received the third injection]) are to be given the fourth injection of freeze-dried cell culture-derived Japanese encephalitis vaccine, for persons at least 9 years of age after an interval of at least 6 days following the third injection.

d) Persons who have not received any of the phase 1 and 2 vaccinations are to be given freeze-dried cell culture-derived Japanese encephalitis vaccine with two (i.e., first and second) injections separated by an interval of at least 6 days (usually 6 to 28 days), followed by 1 booster at least 6 months (usually about 1 year) after the second injection (i.e., third injection), with the fourth injection for persons at least 9 years of age to be given with one injection after an interval of at least 6 days after the third injection.

In principle, vaccination should not be administered to women aged 13 or older if they are pregnant or possibly pregnant, and may be given only if the benefits are confirmed to outweigh the risks.

You can ask questions on vaccination and receive latest information from your municipality. A Q&A is available from the website of the Ministry of Health, Labour and Welfare: "Q&A on Japanese encephalitis vaccination" (Japanese) (https://www.mhlw.go.jp/bunya/kenkou/kekkaku-kansenshou21/dl/nouen_qa.pdf).

◆ Human papillomavirus infection (protection against cervical cancer)

(1) Cause and course

The human papillomavirus (HPV) is a common virus which infects many people, of whom some women develop cervical cancer. Out of more than 100 genotypes of HPV, types 16 and 18 are considered to cause approximately 50 to 70% of cases of cervical cancer. Most HPV infections clear spontaneously and the virus becomes undetectable. However, in some women, over the course of several years to several decades, precancerous lesions and then cervical cancer will develop. Every year, 10,000 or more women develop cervical cancer in Japan, and an estimated 3,000 die from the disease (source: "Cancer Information Service," Center for Cancer Control and Information Services, National Cancer Center). In addition to vaccines to prevent HPV infection, early detection and early treatment of precancerous lesions through cervical cancer screening tests hold promise for decreasing incidence and mortality rates of this disease.

(2) HPV vaccine (inactivated vaccine)

Up to fiscal year 2025, vaccines to prevent cervical cancer that are available as routine vaccinations in Japan are a bivalent vaccine (Cervarix®) containing antigens of the HPV type 16 and 18 viruses, which are most frequently detected from domestic and foreign patients with cervical cancer, and a tetravalent vaccine (Gardasil®) containing antigens of the type 6 and 11 viruses which cause condyloma acuminatum and recurrent respiratory papillomatosis, as well as a 9-valent vaccine (Silgard® 9) containing additional antigens of types 31, 33, 45, 52, and 58. However, from fiscal year 2026, only the 9-valent vaccine is available for routine vaccination. In foreign studies of persons not infected with HPV, each vaccine has been shown to be highly effective in preventing both infection and precancerous lesions. Therefore, countries are recommending that the vaccination be given to young people before their first sexual contact.

Adverse reactions described in domestic package inserts include local reactions such as pain (83-98%), redness (30-85%) and swelling (25-81%) at the injection site; and systemic reactions including slight fever (3-6%) and malaise; however, most of these are transient and disappear. (see the following package inserts: Cervarix® [1st ver.] revised in December 2023; Gardasil® [5th ver.] revised in February 2026; Silgard® 9 [4th ver.] revised in February 2026).

The incidence of serious cases (cases deemed to be serious by the reporter) among suspected cases of adverse reactions (adverse events) reported by medical institutions was 0.0079% for Cervarix®, 0.0054% for Gardasil®, and 0.0017% for Silgard® 9. (The incidence reported from the market launch to September 30, 2025. Source: February 2026 documents 2-8, 2-9, 2-10 from the 110th Working Group Meeting on Adverse Events, the Subcommittee on Vaccination and Vaccines of the Health Sciences Council.)

Vaccinated persons still need routine cervical cancer screening because the vaccine may not always provide sufficient immunization or does not protect against HPV types which are not contained in the vaccine, causing cervical cancer.

a) The 9-valent vaccine should be used for the prevention of human papillomavirus infection. Vaccination is provided to individuals between the first day of the fiscal year in which the individual turns 12 and the last day of the fiscal year in which the individual turns 16. The standard vaccination period is from the first day to the last day of the fiscal year in which the individual turns 13. One of the two schedules is to be followed (the schedule shown in i) is to be followed only when giving the vaccine to an individual between the first day of the fiscal year in which the individual turns 12 and the date the individual turns 15 at the time of the first injection).

i) The standard schedule is to give 2 injections separated by an interval of 6 months. If said schedule cannot be followed, 2 injections are given separated by an interval of at least 5 months.

ii) The standard schedule is to give 2 injections separated by an interval of 2 months, followed by another injection after an interval of at least 6 months after the first injection. If said schedule cannot be followed, 2 injections are given separated by an interval of at least 1 month, followed by 1 injection after an interval of at least 3 months after the second injection.

b) For an individual who has completed the first or second injection using the bivalent or tetravalent vaccine and who wishes to receive the 9-valent vaccine in or after fiscal year 2026, one of the two schedules is to be followed. It should be noted that the safety, immunogenicity, and effectiveness of administering both the bivalent or tetravalent vaccine, in combination with the 9-valent vaccine to the same individual have been clarified to a certain extent.

i) An individual given the bivalent or quadrivalent vaccine for their first injection is given 1 intramuscular injection of the 9-valent vaccine after an interval of 2 months from the first injection, followed by 1 injection of the same vaccine after an interval of 6 months from the first injection. However, if said schedule cannot be followed, the individual is given 1 intramuscular injection of the 9-valent vaccine after an interval of 1 month from the first injection, followed by anther injection given intramuscularly using the same vaccine after an interval of at least 3 months from the second injection.

ii) An individual given the bivalent or quadrivalent vaccine for their first and second injections is given 1 intramuscular injection of the 9-valent vaccine after an interval of 6 months from the first injection. However, if said schedule cannot be followed, the individual is given 1 intramuscular injection of the 9-valent vaccine after an interval of at least 3 months from the second injection.

c) If the type of human papillomavirus-like particle vaccine given in the past is unknown, the choice of which vaccine to give should be made upon consultation between the vaccine recipient and the doctor of the medical institution conducting the vaccination.

d) Syncope, a vasovagal reaction, sometimes occurs after vaccination against human papillomavirus infection. Therefore, to prevent falls or other accidents due to syncope, children who have been vaccinated should be accompanied and supported by their parent/guardian or healthcare professional when moving after the injection. After injection, they should be seated in a place where they can safely rest their weight, instructed not to stand as much as possible, and observed for 30 minutes after injection.

(3) Vaccination schedule

		3-month-old	6-month-old	9-month-old	1-year-old	2-year-old	3-year-old	4-year-old	5-year-old	6-year-old	7-year-old	8-year-old	9-year-old	10-year-old	11-year-old	12-year-old	13-year-old	14-year-old	15-year-old	16-year-old	17-year-old	18-year-old	19-year-old	20-year-old
Human papillomavirus infection	9-valent vaccine	Note: Only two injections are required if the initial injection was made before 15 years of age.															Note)							

(4) Routine HPV vaccination

At the June 14, 2013 joint meeting of Working Group Meeting on Adverse Events, the Subcommittee on Vaccination and Vaccines of the Health Science Council and the Subcommittee on Drug Safety of the Committee on Drug Safety in the Pharmaceutical Affairs and Food Sanitation Council, it was set forth that “due to sustained pain whose relationship with the vaccine cannot be ruled out being observed after vaccination with the HPV vaccine, the routine vaccination should not be actively recommended until the frequency of onset of this adverse reaction is further elucidated and appropriate information can be provided to citizens,” and the decision was made by the Ministry of Health, Labour and Welfare to suspend active recommendation of the vaccination. After that, since November 2021, at the same meeting, it has been discussed how to evaluate the efficacy and safety of HPV vaccines, how to deal with the symptoms that occur after HPV vaccination, and how to provide information about HPV vaccines. In conclusion, it was confirmed that there were no particular concerns about safety, and that the efficacy of vaccination clearly outweighed the risk of adverse reactions. Then, in November 2021, a notice was issued to end “the suspension of active recommendation.” In December 2021, a notice was issued stating that vaccination shall be provided temporally beyond the target age of conventional routine vaccinations (hereinafter referred to as “catch-up vaccinations”) as a measure for those who missed the opportunity of vaccination due to the suspension of active recommendation. The Preventive Vaccination Law Enforcement Ordinance (Cabinet Order No. 197 of 1948) was revised and came into effect on April 1, 2022.

To ensure fair vaccination opportunities for those who missed the vaccination opportunity due to the suspension of active recommendation, a temporary program was implemented from fiscal year 2022 until March 31, 2025. This program provided vaccinations beyond the conventional routine vaccination age to females born between fiscal years 1997 and 2007.

In addition, in light of limited supply caused by a significant increase in demand since the summer of 2024, a transitional measure has been established to ensure that individuals who have received at least one dose during the catch-up vaccination period can complete the full three-dose series at public expense even after the end of the period. Accordingly, this measure applies to females born between April 2, 1997 and April 1, 2009 who have received at least

one dose during the three-year period from April 1, 2022 to March 31, 2025, and is in effect from April 1, 2025 to March 31, 2026.

Note that the WHO and the Japanese Medical Society have positioned the HPV vaccine as a "vaccine necessary to protect women from cancer." In Japan, to prevent certain types of cancer in males, the indication for the quadrivalent HPV vaccine was extended to include males in December 2020, and the indication for the 9-valent vaccine was also extended in August 2025, making vaccination available for males aged 9 and older (as a voluntary vaccination). Routine HPV vaccination for men is currently under review.

For more information on the safety and efficacy of the HPV vaccines, please refer to the brochure on the HPV vaccines posted on the Ministry of Health, Labour and Welfare website (https://www.mhlw.go.jp/bunya/kenkou/kekkaku-kansenshou28/index.html). Please check the latest information from the Ministry of Health, Labour and Welfare and your municipality.

◆ RS virus infection in pregnant women (maternal immunization)

(1) Cause and course

RS virus is widely distributed worldwide, and it is estimated that more than 50% of children are infected by 1 year of age, and nearly 100% by 2 years of age. In primary infection, approximately 20–30% of children develop lower respiratory tract infections such as bronchiolitis and pneumonia. In particular, infection in neonates and infants younger than 6 months of age is more likely to become severe, and in addition to lower respiratory tract infections, it may also cause apnea and acute encephalopathy in neonates and infants.

RS virus infection is a serious infectious disease for infants and young children, accounting for approximately 50% of pneumonia cases and 50–90% of bronchiolitis cases in this population. In Japan, it is estimated that approximately 120,000 to 140,000 children under 2 years of age are diagnosed with RS virus infection each year, of whom about one quarter (approximately 30,000) require hospitalization. Although individuals may be infected with RS virus multiple times throughout their lives, symptoms generally become milder with each subsequent infection. Therefore, older children and adults rarely develop severe disease; however, older adults and individuals with underlying conditions (such as immunodeficiency or cardiopulmonary diseases) may develop severe lower respiratory tract infections.

Risk factors for severe lower respiratory tract infection caused by RS virus in children include prematurity, chronic lung disease, hemodynamically significant congenital heart disease, immunodeficiency, and Down syndrome. In children with these underlying conditions, anti-RS virus humanized monoclonal antibodies (palivizumab and nirsevimab) are used to prevent the onset of RS virus lower respiratory tract infection. However, although

the majority of hospitalizations due to RS virus infection occur in children without underlying conditions, these antibodies were not indicated for use in, nor covered by health insurance for, such children. Therefore, there has been a need for measures to protect all neonates and infants from RS virus-related lower respiratory tract infection.

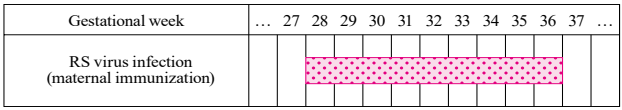
(2) RS virus vaccine (inactivated vaccine)

In the 1960s, development of a formalin-inactivated RS virus vaccine was undertaken; however, vaccination in infants failed to prevent severe lower respiratory tract infection in infancy and instead led to more severe disease upon subsequent RS virus infection, and the effort was unsuccessful. As a result, development of vaccines against RS virus has been stalled for many years. In recent years, the RS virus maternal immunization vaccine has been developed, for administration to pregnant women to induce high levels of anti-RS virus antibodies in the mother that are transferred to the fetus, thereby protecting the newborn from severe RS virus infection. In April 2026, maternal immunization using the recombinant RS virus vaccine ABRYSVO® for intramuscular injection was included in the routine vaccination program.

Pregnant women between 28 weeks 0 days and 36 weeks 6 days of gestation are eligible for the routine vaccination. In pre-approval clinical trials, the vaccine efficacy was reported to be 81.8% at 90 days of age and 69.4% at 180 days of age against severe RS virus–associated lower respiratory tract infection, and 57.1% at 90 days of age and 51.3% at 180 days of age against RS virus–associated lower respiratory tract infection requiring medical attention. Since the efficacy in infants born within 14 days after vaccination has not been established, pregnant women who are expected to deliver by 36 weeks 6 days of gestation should consult their doctor. Concomitant administration with other vaccines is possible if deemed necessary by a physician; however, overseas data have reported a reduced immune response to pertussis antigens when co-administered with vaccines containing protective antigens against Bordetella pertussis. Therefore, please consult your doctor regarding appropriate intervals between vaccinations.

In addition, when considering routine RS virus vaccination, please review the precautions described in “6. Before having your child vaccinated” on page 9, applying them as appropriate to your own situation, and decide whether to receive the vaccination.

(3) Vaccination schedule



* Eligible for those between 28 weeks 0 days and 36 weeks 6 days of gestation

8. What to do if your child experiences an adverse reaction to a vaccination

(1) Normally observed reactions

Depending on the type of vaccine, fever, redness, swelling (puffiness), and induration (stiffness), and rashes at the injection site occur fairly often (several percent to several tens of percent). In many cases, these symptoms disappear within several days and are not a cause for concern.

(2) Severe adverse reactions

If your child has severe swelling at the vaccination site, or has fever or seizures after vaccination, consult a doctor. If your child's symptoms meet the criteria for reporting adverse reactions after vaccination, the doctor will inform the Pharmaceuticals and Medical Devices Agency (PMDA).

Although adverse reactions depend on the type of vaccine, vaccination extremely rarely (about one in several million people) causes serious adverse reactions, such as encephalitis and neuropathy. Such cases will be evaluated on the basis of Japan's basic approach in regard to relief programs, namely that "rigorous medical causation is not imperative and that relief shall also apply in cases where the possibility of symptoms which appeared after vaccination having been caused by the vaccination cannot be ruled out." On this basis, the patient is considered eligible for compensation for the health damage under the Preventive Vaccination Law if the Minister of Health, Labour and Welfare gives authorization.

(3) Coincidental reactions

Symptoms that occur soon after vaccination are often thought to have been caused by vaccination. However, sometimes these symptoms are caused by another infection that happens to develop simultaneously. This is then called a "coincidental reaction."

(4) Relief system for people with health damage due to vaccination

a) A person who has an adverse reaction due to routine vaccination or provisional vaccination and whose ability to perform daily activities is impaired due to health damage can be compensated by the government according to the Preventive Vaccination Law.

b) The compensation consists of payment of medical expenses, medical benefits, an annuity for disabled children, a disability annuity, lump-sum death benefits, and funeral expenses, all of which are designated by law according to the severity of the health damage. All compensation, except lump-sum death benefits and funeral expenses, is continually paid until the completion of treatment or improvement in the impairment.

c) Compensation is paid to the patient after the relevant health damage has been certified to be caused by vaccination by a governmental review committee comprising specialists in vaccination, infection medicine, law, and related disciplines, who discuss the causal relationship of the relevant health damage with vaccination, i.e., whether it was caused by vaccination or other factors (infection before or after vaccination, or other causes).

d) When vaccination is desired after the designated period for routine or provisional vaccination, said vaccination is considered not to be controlled under the Preventive Vaccination Law (voluntary vaccination). In the event a child suffered health damage from such a vaccination, he/she will receive relief according to the Pharmaceuticals and Medical Devices Agency Law; however, the subject and the amount of compensation differ from those of the Preventive Vaccination Law.

* In the event you need to submit an application for compensation, consult with your municipal office in charge of vaccination.

* The following topics include content partially quoted from the "Vaccination Guidelines 2026 Version" published by the Public Foundation of Vaccination Research Center, regarding COVID-19 vaccination.

[Reference 1] Novel coronavirus (COVID-19) infection

(1) Overview of the disease

An outbreak of unexplained pneumonia in Wuhan City, Hubei Province, China at the end of December 2019 was reported. On January 9, 2020 it was announced that the causative virus was a novel coronavirus. The international name of the disease was announced as COVID-19 and the causative virus was designated as severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2). With the virus expected to spread rapidly to other countries across the world, the World Health Organization (WHO) declared the situation a Public Health Emergency of International Concern (PHEIC) on January 30, 2020 and characterized the outbreak as a pandemic on March 11 of the same year.

In Japan, COVID-19 was specified on January 28, 2020 as a "Designated Infectious Disease" according to the Infectious Diseases Control Law. In terms of the School Health and Safety Act, it was deemed to be equivalent to Category 1 on the basis of the Infectious Diseases Control Law. On March 13, 2020, the Act on Special Measures against Novel Influenza, etc., was amended to stipulate that measures against COVID-19 would be taken on the basis of this Act. On December 9, 2020, COVID-19 became a target for provisional vaccination. Subsequently, Japan faced roughly 8 waves of outbreaks by May 2023. However, COVID-19 was classified as a Category 5 infectious disease under the Infectious Diseases Control Law and became subject to sentinel surveillance in the infectious diseases surveillance on May 8, 2023, when the eighth wave showed signs of decrease. Accordingly, it was classified as a Category 2 infectious disease under the School Health and Safety Act.

On May 5, 2023, the WHO declared that COVID-19 is no longer a PHEIC, although with a warning that it still remained a global threat.

Since the emergence of the Omicron strain, the incubation period has shortened to 2 or 3 days in most cases. The route of transmission is mainly by droplets, although aerosol transmission also occurs in closed spaces. Contact infection is possible but less frequent.

As it is a respiratory disease, the symptoms are mainly fever, sore throat, coughing, etc. When it first began to spread, pediatric cases were few and asymptomatic or mostly mild even in case of symptoms being present. However, infections in children have increased since the Omicron strain became predominant, with more cases developing complications of febrile seizures and croup-like symptoms. Children under the age of 2 and persons with underlying

conditions are considered at risk for severe disease. Rates of severe disease and case-fatality rates are high in the elderly.

(2) Effectiveness of vaccination

Vaccination has been shown to be effective in preventing the onset of disease and reducing the severity (including hospitalization) of COVID-19, as confirmed by numerous reports both domestically and internationally Furthermore, reinfection is not uncommon even among individuals who have previously been infected with COVID-19. Studies have demonstrated that vaccination provides additional protective effects against the onset of disease in such cases. Furthermore, it has been observed across all age groups that the effectiveness of the vaccine in preventing severe disease (hospitalization) is higher than its effectiveness in preventing the onset of illness.

(3) Vaccine characteristics

Although COVID-19 vaccines were being developed in Japan and abroad, the first vaccine to be used for practical vaccination was an mRNA vaccine containing the mRNA of the SARS-CoV-2 spike protein encapsulated in lipid nanoparticles. Other vaccines in practical use include recombinant viral vector vaccines which use non-pathogenic viruses carrying SARS-CoV-2 spike protein, and live-attenuated vaccines. In Japan, the Pfizer mRNA vaccine was approved for marketing on February 14, 2021. Provisional vaccination under the Preventive Vaccination Law began on February 17, 2021 for healthcare personnel and on April 12, 2021 for the elderly. On May 21, 2021, the Takeda/Moderna mRNA vaccine and the AstraZeneca recombinant chimpanzee adenovirus vector vaccine were approved for marketing. At large-scale vaccination centers, vaccination using the Takeda/Moderna mRNA vaccine started on May 24, 2021 for the elderly, and workplace vaccinations started on June 21, 2021. Vaccination with the AstraZeneca recombinant chimpanzee adenovirus vector vaccine ended at the end of September 2022.

From fiscal year 2024, COVID-19 has been designated a Category B infectious disease under the Preventive Vaccination Law. Consequently, the routine vaccination (once annually) commenced in October 2024. For the routine vaccination in the 2025/26 season, the antigen composition of the vaccines to be used has been determined, in line with WHO recommendations, to include “a monovalent antigen targeting JN.1, KP.2, or LP.8.1, or an antigen that has demonstrated broad and robust neutralizing antibody responses or effectiveness against JN.1 lineage variants circulating as of May 2025.” In addition, XEC, for which information on vaccine development status and related matters was reported by

manufacturers, was determined to fall under "antigens that have demonstrated broad and robust neutralizing antibody responses or effectiveness against JN.1 lineage variants circulating as of May 2025," and was therefore included in the antigen composition to be used in Japan (Third Meeting of the Health Science Council [Subcommittee on Vaccination and Vaccines, Subcommittee on Research, Development, Production, and Distribution, and Subcommittee on the Manufacturing Strains of Seasonal Influenza Vaccines and COVID-19 Vaccines: May 28, 2025]). Vaccination against COVID-19 using vaccines tailored to circulating variants is expected to elicit higher neutralizing antibody titers, thereby enhancing not only protection against severe disease but also improving the prevention of symptomatic infection. Based on these scientific findings, the Ministry of Health, Labour and Welfare has decided, following discussions in its advisory council, to review annually, for the time being, the type of COVID-19 vaccine (i.e., the strain included in the vaccine) used for routine immunization.

(4) Precautions for injection

As of the present, all of the COVID-19 vaccines are delivered intramuscularly. It is necessary to check the vaccine recipient's age against the vaccine type in advance of injection.

Presently, individuals aged 65 and older, as well as those aged 60 to 64 with certain underlying health conditions, are eligible for routine vaccination.

(5) Adverse reactions

A variety of symptoms including injection site pain, malaise, headache, and fever have been identified, but most are mild to moderate. No significant safety concerns have been identified from the information obtained to date. There are also reports indicating that the incidence of adverse reactions is lower in older people. In Japan, cases of myocarditis and pericarditis classified as Brighton Collaboration levels 1 to 3 have been reported, particularly among young males.In Japan, anaphylactic shock has been reported as a serious adverse reaction. Vaccine recipients should be remained at the site and observed for a minimum of 30 minutes after vaccination, and must seek medical attention in the event of symptoms such as chest pain, palpitations, shortness of breath, or edema within several days post-vaccination.

[Reference 2] Diseases preventable by voluntary vaccination and overview of vaccines

Voluntary vaccination, which is not subject to the Preventive Vaccination Law, is conducted in consultation between a vaccine recipient (parents/guardians) and a doctor and is not promoted by the government; however, the vaccines used are approved by the Ministry of Health, Labour and Welfare under the Act on Securing Quality, Efficacy and Safety of Pharmaceuticals, Medical Devices, Regenerative and Cellular Therapy Products, Gene Therapy Products, and Cosmetics (Pharmaceuticals and Medical Devices Act).

Voluntary vaccinations include vaccinations to prevent seasonal influenza, COVID-19 infection, herpes zoster (routine vaccination for adults from 65 years), mumps, hepatitis A, yellow fever, rabies, tetanus, meningococcal infection, herpes zoster (shingles), RS virus infection (routine vaccination for pregnant women between 28 weeks 0 days and 36 weeks 6 days of gestation), tick-borne encephalitis, typhoid fever, and Mpox, as well as routine vaccinations when they are given outside the eligible age range or period.

The seasonal influenza and mumps vaccines that many children receive are explained below.

In the unlikely event a child suffers health damage by a voluntary vaccination, he/she may be eligible for relief according to the Pharmaceuticals and Medical Devices Agency Law; However, the subject and the amount of compensation differ from those of the Preventive Vaccination Law (routine vaccination).

* In the event you need to submit an application for compensation, consult with your municipal office in charge of vaccination.

◇ Seasonal influenza vaccine (inactivated vaccine, live intranasal vaccine)

The seasonal influenza vaccination (inactivated vaccine) for the elderly is designated as a routine vaccination by the Preventive Vaccination Law Enforcement Ordinance; that for children is considered a voluntary vaccination.

(1) Cause and course

Seasonal influenza is an acute respiratory infection which suddenly develops systemic symptoms including fever, chills, headache, and muscle pain. The incubation period is 24-72 hours. Respiratory symptoms (stuffy nose, sore throat, and cough, etc.) often appear later. Patients without complications recover within 2-7 days. Complications, especially pneumonia and encephalopathy, are serious.

(2) Overview of vaccine

There are two types: one is an inactivated vaccine made by inoculating each of the 2 lineages of seasonal influenza type A (H1N1 and H3N2) and 1 of type B (Victoria) into the

chorioallantoic membrane of embryonated chicken eggs, allowed to multiply, extracting the hemagglutinins from the virus surface with ether, and inactivating it with formalin; the other is a live attenuated intranasal spray vaccine (containing two types of A viruses and one type of B virus [Victoria lineage]) for individuals aged 2 to under 19 years. There is no significant difference in the effectiveness of inactivated influenza vaccines and live intranasal vaccines, and both have no major issues concerning adverse reactions.Decisions are made each year on which viral strains to include in the seasonal influenza vaccine, on the basis of epidemiological and virological assessments.

Reports vary on the effectiveness of the influenza vaccine in infants and young children. In a 2015/16 season study in children under 6 years of age, the efficacy of the influenza vaccine in preventing disease was reported to be 60%. Influenza vaccines are considered to be effective to a certain extent in preventing the onset of disease as well as in preventing severe illness and death in the event symptoms develop. (Quoted from the Ministry of Health, Labour and Welfare website, Influenza Vaccine [Seasonal] Q&A [Q1].) Regarding the intranasal live attenuated influenza vaccine, the Japan Pediatric Society states that, because this is an intranasal vaccine and there is a possibility of horizontal transmission of the vaccine virus via droplets or contact, the use of inactivated influenza HA vaccine is recommended for individuals with more severe asthma or those presenting with wheezing symptoms, as well as for breastfeeding women and those in close contact with immunocompromised individuals.

Embryonated chicken eggs are used in the manufacturing process of the seasonal influenza vaccine; however, the egg components are eliminated in the purification process. Nevertheless, caution is necessary when vaccinating persons with clear allergies to eggs. Persons who experience an anaphylactic reaction to chicken eggs and meat are asked to consult with a specialized facility if they wish to receive the vaccine.

The incidence of serious cases (cases deemed to be serious by the reporter) among suspected cases of adverse reactions (adverse events) reported by medical institutions was 0.00011%. (The incidence reported from October 1, 2024 to March 31, 2025. Source: July 2025 documents 2-31 from the 107th Working Group Meeting on Adverse Events, the Subcommittee on Vaccination and Vaccines of the Health Sciences Council.)

◇ Mumps vaccine (live vaccine)

(1) Cause and course

Mumps is caused by the mumps virus and is spread by droplet or contact infection. The virus proliferates and spreads throughout the body, causing lesions in various internal organs. The incubation period is 2-3 weeks. The period which an infected person may infect those around them is believed to be from several days before onset to 5 days after start of swelling of the

parotid gland, submaxillary gland, or sublingual gland. The primary symptom is swelling of the parotid gland, which exhibits indistinct borders and uniform, and is painful. The submaxillary gland and/or sublingual gland may also develop swelling, and may also be accompanied by fever.When older children or adults contract the disease, symptoms tend to be more pronounced, and the frequency of complications increases. The most common complication is aseptic meningitis, with a reported diagnostic frequency ranging from 1% to 10%. Although rare, other complications include encephalitis and pancreatitis. In post-pubertal males, orchitis may occur, while in females, oophoritis may develop. Particular attention should be paid to the risk of mumps-related hearing loss, which can be difficult to treat.

(2) Overview of vaccine

This is a live vaccine containing attenuated mumps viruses. The post-vaccination seroconversion rate is high, at more than 90%, and in domestic outbreak investigation, the effect of the vaccine is believed to be about 80%. Most people who develop the disease despite being vaccinated generally experience a milder form of the disease. (Report by Mumps Vaccine Working Team of the Vaccination Working Group)

Possible adverse reactions to mumps vaccines available on the market include mild swelling of the parotid glands in around 1%. The frequency of the adverse reaction of aseptic meningitis is stated to be 13.4 per 100,000 vaccinations (see the package insert, January 2026 [4th edition]); however although the frequency varies by age, it has been reported to be low, at less than 0.1%. Given the 1–10% incidence of aseptic meningitis as a complication of natural infection, as well as the risk of hearing loss, the need for extended absence from nursery or elementary school when infected, and the high incidence in children aged 3-6, it is recommended that children be vaccinated at the same time as, or as soon as possible after, MR vaccine phase 1, the first varicella vaccine injection, the 5-in-1 DPT-IPV-Hib combination vaccine booster, and the pediatric pneumococcal vaccine booster, etc., and at the very latest, no later than 3 years of age, which is the high incidence age. In addition, the Japan Pediatric Society recommends administering a second dose concurrently with phase 2 of the MR vaccine to ensure its preventive effectiveness.

[Reference 3] Vaccination screening questionnaire

Please check the format of the screening questionnaire as provided by your municipality or on the website of the Ministry of Health, Labour and Welfare.
(It is also available on the website of the Vaccination Research Center; see the QR code.)

[Reference 4] Post-vaccination health survey

This table summarizes numerical data on representative post-vaccination symptoms that may occur relatively frequently, based on the Ministry of Health, Labour and Welfare 2024 post-vaccination health survey summary report. The data include both single vaccinations and simultaneous vaccinations. Please refer to the report for the health condition after simultaneous vaccination.

2024 Survey on Health Status after Vaccination

*Includes all the incidence rates during the survey period (28 days). (For BCG only, the survey period is 4 months.)

Vaccine type*	Number of people surveyed	All cases of fever (%)	37.5°C to 38.4°C (%)	38.5°C or higher (%)	Local reaction (%)
DPT-IPV phase 1 1st dose (primary) *1	1	0.0	0.0	0.0	0.0
DPT-IPV phase 1 2nd dose (primary) *1	1	0.0	0.0	0.0	0.0
DPT-IPV phase 1 3rd dose (primary) *1	6	0.0	0.0	0.0	16.7
DPT-IPV phase 1 booster	408	9.6	3.7	5.9	5.6
DPT-IPV-Hib phase 1 1st dose (primary)	477	9.2	6.3	2.9	2.7
DPT-IPV-Hib phase 1 2nd dose (primary)	343	10.2	8.2	2.0	8.5
DPT-IPV-Hib phase 1 3rd dose (primary)	306	7.5	5.6	2.0	4.6
DPT-IPV-Hib phase 1 booster	44	20.5	9.1	11.4	4.5
DT phase 2	592	2.7	1.2	1.5	7.3
MR phase 1	412	16.7	4.6	12.1	2.2
MR phase 2	358	4.5	2.0	2.5	1.4
Japanese encephalitis phase 1 1st dose (primary)	343	9.3	3.8	5.5	0.6
Japanese encephalitis phase 1 2nd dose (primary)	253	4.7	2.4	2.4	1.6
Japanese encephalitis phase 1 booster	310	5.2	1.9	3.2	0.6
Japanese encephalitis phase 2	319	4.1	1.6	2.5	3.4
Hib phase 1 1st dose *1	16	12.5	12.5	0.0	0.0
Hib phase 1 2nd dose *1	13	0.0	0.0	0.0	0.0
Hib phase 1 3rd dose*1	12	0.0	0.0	0.0	0.0
Hib booster	330	13.9	5.2	8.8	3.6
Pediatric pneumococcus phase 1 1st dose	365	12.6	9.3	3.3	7.1
Pediatric pneumococcus phase 1 2nd dose	279	13.6	9.7	3.9	7.2
Pediatric pneumococcus phase 1 3rd dose	267	10.5	6.7	3.7	9.0
Pediatric pneumococcus booster	309	15.9	5.5	10.4	12.9
Varicella 1st dose	460	11.7	4.6	7.2	2.6
Varicella 2nd dose	422	7.8	4.5	3.3	1.7
Hepatitis B 1st dose (primary)	345	7.2	6.1	1.2	1.7
Hepatitis B 2nd dose (primary)	257	10.5	5.8	4.7	8.9
Hepatitis B 3rd dose (primary)	339	3.8	1.2	2.7	3.5

*1 Since the routine vaccination with DPT-IPV-Hib commenced in April 2024, the number of responses is significantly low.

Vaccine type*	Number of people surveyed	All cases of fever (%)	37.5°C to 38.4°C (%)	38.5°C or higher (%)	Diarrhea (%)
Rotavirus phase 1 1st dose	563	7.8	5.0	2.8	3.9
Rotavirus phase 1 2nd dose	389	7.2	4.6	2.6	4.4
Rotavirus phase 1 3rd dose	106	5.7	2.8	2.8	8.5

Vaccine type	Number of people surveyed	Lymphadenopathy (%)	Local skin weeping (%)	Total incidence of all symptoms (%)
BCG	759	0.0	0.0	0.0

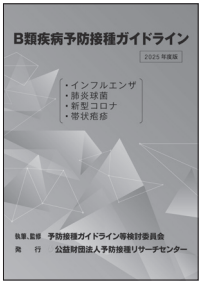
Vaccine type*	Number of people surveyed	Local reaction (%)	General malaise (%)	Headache (%)	Total incidence of all symptoms (%)
HPV 1st dose	435	5.3	2.8	3.2	9.7
HPV 2nd dose	547	3.1	2.4	2.6	6.9
HPV 3rd dose	179	3.4	2.8	1.7	6.1

References (for details, see: https://www.yoboseshu-rc.com/publics/index/7)

1 Vaccination Guidelines

March 2026 revised edition (A5 size)
A guidebook on medical and regulatory information about vaccination for medical staff in practice to conduct safe and appropriate vaccination.

2 Vaccination Guidelines for Category B Diseases

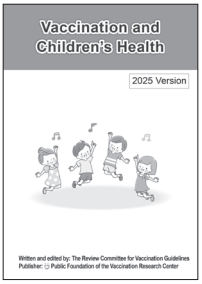


2025 revised edition (A5 size)
An overview of medical and regulatory information on routine vaccinations for influenza, pneumococcal infection in the elderly, COVID-19 infection, and herpes zoster.

3 Vaccination handbook

2025 edition (A4 size)
A handbook for doctors who give vaccination and municipal staff in charge of vaccination.

4. Editions in foreign languages "Vaccination and children's health"



March 2025 revised edition
"Vaccination and children's health," a brochure containing correct knowledge and information concerning vaccination for parents/guardians and the vaccination screening questionnaire, is translated in the following languages and available from the following site. Please download them as required.
https://www.yoboseshu-rc.com/publics/index/8/

The entire brochure is available in the following 10 languages:
English, Chinese, Korean, Vietnamese, Spanish, Portuguese, Thai, Indonesian, Tagalog, and Nepalese
The vaccination screening questionnaire alone is available in the following seven languages:
Arabic, Italian, German, French, Mongolian, Russian, and Ukrainian.

5 Learn about vaccinations with your children

With a comic aimed at children and guidance aimed at parents/guardians, this one book will allow you to better understand vaccinations.

List of Members of the Review Committee for Vaccination Guidelines

	Name	Institution / Job title
	Tetsu Isobe	Professor, Keio University Law School
○	Kenji Okada	Visiting Professor, Fukuoka Nursing College Chief, Vaccination Center, Fukuoka Dental College Hospital
◎	Nobuhiko Okabe	Advisor of Kawasaki City Institute for Public Health
	Hajime Kamiya	Professor, Department of Public Health and Occupational Medicine, Mie University Graduate School / Faculty of Medicine
	Yoichi Sasamoto	Executive Board Member of the Japan Medical Association
	Sayaka Takanashi	Director of Office 1, Department of Immunization Research, National Institute of Infectious Diseases, Japan Institute for Health Security
	Keiko Taya	Director, Kanagawa Prefectural Institute of Public Health
	Osamu Tokunaga	Director, Pediatrics, National Hospital Organization Minami Kyoto Hospital
	Kuniko Nakayama	President/Director, Medical corporation MEFA Jinaikai My Family Clinic Gamagori
	Mitsuaki Hosoya	Professor, Department of Perinatology and Pediatrics for Regional Medical Support, Fukushima Medical University
	Masago Minami	Managing Director/Researcher, Yomiuri Shimbun Tokyo Headquarters
	Shunichiro Yokota	Advisor, Odawara Medical Association Director of Yokota Children's Clinic
	Hiroshi Watanabe	Facility Director, Teikyo University Health Service Center For The Elderly

◎: Chairperson, ○: Vice-chairperson (In order of the Japanese syllabary, titles omitted)

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Public Foundation of the Vaccination Research Center

14-1, Nihonbashi Odenmacho, Chuo-ku, Tokyo 103-0011, Japan
Phone: (03) 6206-2113 Fax: (03) 5643-8300
https://www.yoboseshu-rc.com

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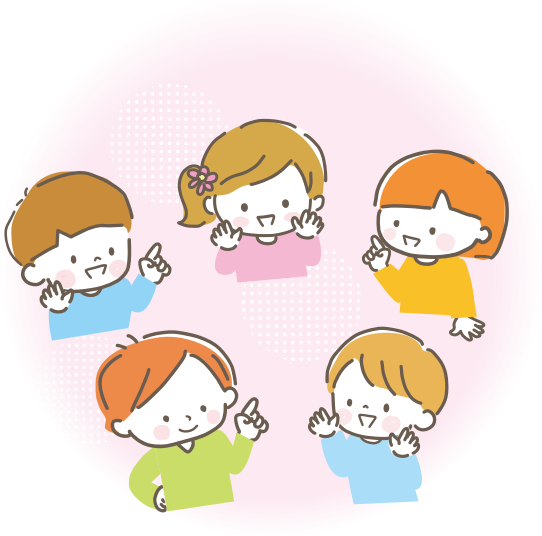
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