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Post-Exposure Prophylaxis (PEP) for Measles

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Superior Health Council
Avenue Galilée, 5 bte 2
B-1210 Brussels

Tel.: +32 2 524 97 97
E-mail: info.hgr-css@health.fgov.be

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ADVISORY REPORT OF THE SUPERIOR HEALTH COUNCIL no. 9878

Post-Exposure Prophylaxis (PEP) for Measles

In this scientific advisory report, which offers guidance to public health policy-makers and healthcare professionals, the Superior Health Council of Belgium provides recommendations post-exposure prophylaxis for measles.

This version was validated by the Board on June 4, 2025[1]

I INTRODUCTION

Measles is a highly contagious viral disease that continues to pose a public health challenge, particularly in populations with low vaccination coverage. Due to its airborne transmission and high basic reproduction number, rapid intervention is critical to prevent outbreaks.

The Department *Zorg (Vlaanderen)* asked for advice in July 2024 by email from the Superior Health Council regarding the inclusion of non-specific immunoglobulins in post-exposure prophylaxis protocols for infants, pregnant women, and immunocompromised individuals. This inquiry arises to support harmonization on national level because different protocols are observed.

This advisory report by the Superior Health Council of Belgium provides recommendations for healthcare professionals on the appropriate use of post-exposure prophylaxis (PEP), considering the available immunoglobulin formulations, dosage guidelines, and clinical scenarios where intravenous immunoglobulin (IVIG) may be indicated.

[1] The Council reserves the right to make minor typographical amendments to this document at any time. On the other hand, amendments that alter its content are automatically included in an erratum. In this case, a new version of the advisory report is issued.

II CONCLUSION AND RECOMMENDATIONS

Administration of immunoglobulins has been shown to be effective in the setting of measles post-exposure prophylaxis. However, effectiveness is dose-depended. As information on measles-specific antibody levels in commercial preparations available on the Belgian market is scarce, recommended doses are hard to establish. **At high dose and administered ≤6d after first exposure, IVIG could at least be equally effective in preventing measles disease, as is PEP by MMR vaccination.**

However, some practical barriers need to be taken into account:

- Measles prophylaxis is not a registered indication for most of IVIG products available on the Belgian market and their use is thus off-label.

- Time frames are relatively short and IVIG administration can be hard to organize (need for hospitalization, getting an IV line and high volume of administration are all factors to take into account, especially for youngest children).

- After administration of IVIG, measles vaccination should be postponed for 6-8 months, whereas the protection offered by the IVIG would only last about 1-2 months. Especially in an epidemic situation, where future contact with measles cases is possible, this could mean that an infant is left vulnerable to measles infection for a longer period than if MMR0 would have been administered at 6-9 months of age.

In cases where MMR vaccination cannot be used (because of contraindication, young age or >72h delay from exposure), the Superior Health Council recommends clinicians to consider administration of immunoglobulins as post-exposure prophylaxis for people at risk of severe forms of measles, on a case-by-case basis after careful counselling of the patient (or his parents).

Practical Clinical Guideline

Mandatory notification

- It is mandatory to notify every *suspected* case of measles (before lab confirmation) to the regional health authorities so they can coordinate the process of contact tracing. More information through this link.

Who is considered exposed to measles?

- Anyone who had face-to-face contacts with a measles case or remained in the same room as a contagious measles case for at least 15 minutes (airborne transmission).
- In case of contact with an index case in a hospital setting, the tracing procedure should involve assessment of exposure and measles status from every person who was present in the same room as the case during the period from 1 hour before until 2 hours after the case left that room. Risk of exposure after departure of the index case depends on quality of ventilation (more info here).

Who is considered protected?

- Individuals born before 1970.
- Those with documented measles infection in childhood.
- Those who have received 2 doses of MMR vaccine after the age of 50 weeks, with at least 1 month between both doses.
- Those who have documented protective measles IgG antibody titers from a blood test.

Standard PEP Approach

1. **Vaccination** (MMR) within 72 hours of exposure for all susceptible contacts (i.e., not meeting the above protection criteria) who do not have contraindications. This can:
    - Reduce the risk of developing measles.
    - Protect against severe forms of the disease.
2. **Contraindications to MMR**
    - Infants under 6 months of age.
    - Pregnant women.
    - Immunocompromised individuals with contra-indication for live vaccines.

For Contacts with MMR contraindications who are at risk of severe form of measles: consider IVIG The indication of IVIG will be evaluated on a case-by-case basis by the caregivers (pediatrician, doctor, infectious disease specialist) Importantly, after IVIG, vaccination with live attenuated vaccines, such as MMR, should be deferred for 6–8 months (see below)

Contact Category	Recommended Action	Timing (exposure = delay counted from the first day of exposure to the index case)	Comments
Infants aged <3 months	- Ensure that maternal vaccination status is documented (2 doses required for protection). If mother is correctly vaccinated or has a history of measles infection, infant is assumed to be protected. - If maternal status is unknown, measure maternal IgG if possible or consider it as negative. - If maternal status is negative (<2 doses of vaccine or not enough antibodies measured): consider IVIG for the infant.	- IVIG within 6 days of exposure.	- For specific situations (prematurity, HIV exposure, certain comorbidities), a case by case approach is advised to evaluate whether IVIG administration might be warranted - no hyperimmune measles-specific IG available - ~400 mg/kg IVIG for prophylaxis is recommended. - After IVIG, defer MMR vaccination for 6–8 months.
Infants aged 3-5 months	- If (reliable) history of **natural** measles infection in mother: infant is assumed to be protected - in all other cases: consider IVIG for the infant	- IVIG within 6 days of exposure.	- serology, if rapidly available, can provide additional information (cf. 3. 'protective titer' in rationale section below) - no hyperimmune measles-specific IG available - ~400mg/kg IVIG for prophylaxis is recommended - after IVIG, defer MMR vaccination for 6-8 months
Infants aged 6–11 months	**First-line**: Give MMR within 72 hours of exposure. If MMR is contraindicated or delayed (>72h): consider IVIG.	- MMR must be administered within 72 hours to be effective PEP. - IVIG if MMR not possible and still within 6 days of exposure.	- If the first MMR dose is given before 50 weeks, still administer routine MMR doses starting at 12 months as scheduled (WHO 2009). - IVIG recommended dose is ~400 mg/kg IV. - Defer subsequent MMR for 6–8 months after IVIG.

Children aged 1 year and older	Check vaccination status: - If already 2 doses of MMR at least 1 month apart: considered protected. - If only 1 dose so far, administer a second dose if at least 1 month has elapsed since the first and if within 72h of exposure. - If no doses, administer first MMR dose within 72 hours post-exposure (unless contraindicated).	-	MMR within 72 hours if susceptible (and no contraindication).	-	If a second dose is needed but the first dose was administered <1 month ago, second dose must be given later according to the standard interval. - If confirmed exposure occurred >72 hours ago and second MMR dose (≥1 month after the first dose) is needed, do not administer MMR specifically for PEP; rather, continue with the routine vaccination schedule as planned unless if advised otherwise by regional health authorities because of cluster in community setting. - IVIG rarely considered here unless immunocompromised.
Adolescents/Adults born after 1970	Verify: - Measles infection documented OR - 2 documented MMR doses OR - Protective IgG titer. If not immune, vaccinate with MMR (if no contraindication).	-	MMR within 72 hours post-exposure.	-	If immunocompetent, no IG. - If immunocompromised, consider IVIG within 6 days if not immune at dose of ~400 mg/kg IV).
Pregnant Women	Verify immunity by documentation: - Past measles infection OR - 2 doses of MMR OR - Measure IgG titer. If none of this: assume as susceptible and consider IVIG if high-risk exposure.	-	IVIG within 6 days if indicated (cannot receive MMR during pregnancy).	-	Dose IVIG 400 mg/kg - Defer postpartum MMR vaccination for 6–8 months after IVIG.
Immunocompromised individuals	- If severely immunocompromised[3]: Consider IVIG if within 6 days of exposure. - For other immunocompromised patients • Check for MMR contraindication depending on type of immunosuppression. • If contraindicated: check for natural measles history, vaccines status or IgG titers, depending on type of immunosuppression and patient history	-	IVIG within 6 days (144 hours) of exposure if high-risk.	-	Dose IVIG 400 mg/kg - Postpone MMR (if indicated in the future) at least 6–8 months after IVIG, or until immunocompetence is restored.

Rationale

1. **Effectiveness**: IG prophylaxis can reduce measles infection risk if administered adequately (400 mg/kg IV) and must be given within 6 days (<144 hours post-exposure).

2. **Timing**: MMR is effective if given within 72 hours of exposure. For household contacts or similar, if exposure occurred >72 hours ago and second MMR dose is needed, do not administer MMR specifically for PEP as it will increase the likelihood of febrile reactions and diagnostic challenges; rather, continue with the routine vaccination schedule as planned. In educational and daycare settings, MMR2 can sometimes be advanced, after advice of the regional health authorities, to prevent from future infectious waves. IVIG must be administered within 6 days to be beneficial.

3. **Protective titers:** duration of infant protection by maternal antibodies is variable, so it can be of value to determine antibody levels in either mothers or infants. However, it might not always be possible to obtain blood samples and serology results timely. At birth, levels of measles antibodies in infants are similar to those in mothers (Sauerbrei et al., 2002; Leuridan et al. 2010; Varma et al. 2025), and a modelling study found a half-life of ~1 month (Waaijenborg et al., 2013). Classically, a minimum level of 120mIU/mL has been thought to confer protection, but the evidence underlying this cut-off is limited (Bolotin et al., 2020; Plotkin et al., 2020) and some studies have used higher cut-offs. Moreover, cut-offs against severe disease might differ from protection against infection.

4. **Cost & Practical Considerations**:
   - Measles PEP is a registered indication only for Octagam 10%, but currently not reimbursed (RIZIV/INAMI website: link). Use as measles prophylaxis is off-label for all other products.
   - IV infusion logistics can be challenging.

5. **Impact on Future Vaccination**: After IVIG, live vaccines (including MMR) should be postponed for ~6–8 months due to the risk of neutralizing antibodies decreasing vaccine effectiveness (Siber et al., 1993), However, IVIG probably only offer full protection against disease for 1-2 months.

Keywords

Keywords	***Sleutelwoorden***	***Mots clés***	***Schlüsselwörter***
Measles	*Mazelen*	*Rougeole*	*Masern*
Post-Exposure Prophylaxis	*Profylaxe na blootstelling*	*Prophylaxie post-exposition*	*Postexpositionelle Prophylaxe*
Vaccination	*Vaccinatie*	*Vaccination*	*Impfung*
Immunoglobulins	*Immunoglobulinen*	*Immunoglobulines*	*Immunglobuline*

III METHODOLOGY

The experts provided a general and an *ad hoc* declaration of interests and the Committee on Deontology assessed the potential risk of conflicts of interest.

This advisory report is based on a review of the scientific literature published in both scientific journals and reports from national and international organisations competent in this field (peer-reviewed), as well as on the opinion of the experts.

Once the advisory report was endorsed by the by the standing working group Vaccination (National Immunization Technical Advisory Group - NITAG), it was ultimately validated by the Board.

IV ELABORATION AND ARGUMENTATION

List of abbreviations used

AAP	American Academy of Pediatrics
ACIP	Advisory Committee on Immunization Practices
ATAGI	Australian Technical Advisory Group on Immunisation
CDC	Centers for Disease Control and Prevention
GVH	Graft-versus-host disease
HGR	Hoge Gezondheidsraad (Superior Health Council)
HSCT	Hematopoietic Stem Cell Transplantation
IgG	Immunoglobulin G
IM	Intramuscular
IV	Intravenous
IVIG	Intravenous Immunoglobulin
MMR	Measles, Mumps, and Rubella vaccine
NHIG	Normal Human Immunoglobulin
NITAG	National Immunization Technical Advisory Group
PEP	Post-Exposure Prophylaxis
RIVM	Rijksinstituut voor Volksgezondheid en Milieu (Dutch National Institute for Public Health and the Environment)
SCID	Severe Combined Immunodeficiency
STIKO	Ständige Impfkommission (German Standing Committee on Vaccination)
UKHSA	UK Health Security Agency

1 Context

During 2024, Belgium saw a very high number of measles cases, specifically in younger age groups. Upon notification of cases to the regional health authorities and tracing procedure by health care workers, close contacts are identified. **For non-immune contacts at high risk of severe disease and ineligible for vaccination, some international guidelines recommend administration of human immunoglobulins**. These target groups are particularly infants below 12 months of age, pregnant women and immunocompromised adults. In Belgium, only non-specific human immunoglobulins are available on the market. Post-exposure prophylaxis for measles is not a registered indication for most of these products and there is thus no minimum required measles-specific antibody titer for those products. Exceptions are Octagam 10 % and Panzyga 10 %.

The question is raised whether the use of human immunoglobulins as post-exposure prophylaxis should be recommended in Belgium to severe forms of measles and complications

2 Current Belgian and international guidelines

Country	Organisation	Recommended as PEP for risk group?	
Belgium	DepZorg	**Consider**	Only non-specific Ig available. Prefer IM
	AVIQ	**Consider** if risk very high	
	HGR/CSS	**No** because only non-specific Ig available	Advice 2017, not public
Australia	ATAGI	**Yes**	Infants 0-5m only if - the mother has had <2 doses of MMR vaccine and no history of past measles infection, or - or if the mother is negative for measles IgG Infants 6-11m, if ≥72 hours since exposure: - Give NHIG - 0.2 mL/kg
NL	RIVM	**Yes**	Infants 6-8m only if household No PEP if infant <2m and mother measles
UK	UKHSA	**Yes**	Infants 6-8m only if household
DE	STIKO	**Yes**	Consider serology first Give IV 400mg/kg Q not required if vaccination status correct for age?
FR	SPF	**Yes**	Give IV 200mg/kg Infants 6-11m if too late for MMR Infants <6m not if mother naturally immune
USA	CDC	**Yes**	Min. titer required for Ig preparations (CDC 2024) Infants IM, others IV Q maintained in healthcare settings If Q maintained: 28d instead of 21d
	AAP (Red Book)	**Yes**	

Table 1. Overview of Belgian and international guidelines, status Nov 2024. Source: see links in table

3 Evidence available from literature

3.1 Effectiveness of Non-specific Immunoglobulins as PEP

A Cochrane review from 2014 examines the question whether post-exposure passive immunization is effective for preventing measles (Young et al., 2014). The authors conclude that immunoglobulins are effective to prevent measles, with the effect depending on the blood

product being used. The conclusions were based on moderate quality evidence from 7 studies for an overall total of 1432 participants. Effectiveness is dose-depended and hence (unconcentrated) adult serum is less effective than convalescent serum, which is in turn less effective than gammaglobulin (a concentrated fraction of serum). Two studies compared administration of gammaglobulins vs. no treatment and found an effectiveness of 83 % (95 % CI 64-92 %). The number needed to treat varies from 2 to 27, depending on the presumed attack rate. The first included study is from the US and dates back to 1944 (Ordman et al., 1944). Results therefore need to be interpreted with caution, as population levels of immunoglobulin have decreased in recent decades, owing to lower titers of vaccine-induced immunoglobulins compared to natural infection-induced immunity (McQuillan et al., 2007) The second included study is a study from a 2006 outbreak in Australia (Sheppeard et al., 2009). Due to a very large definition of 'susceptible contacts' attack rates were particularly low in this study. Among susceptible contacts who did not receive any prophylaxis, 4.5 % developed measles (13/288). In contrast, only 2 of the 183 contacts (1.09 %) who received non-specific, polyvalent immunoglobulins (also called normal human immunoglobulin or NHIG) developed measles, yielding an effectiveness of 75.8 % [0-94]. Both contacts received NHIG on day 7 after exposure. None of the 183 contacts who received PEP vaccination subsequently developed measles.

The Cochrane review only included prospective studies up to 2014. An update of the literature search with the same criteria in 2018 did not yield any new results (Matysiak-Klose et al., 2018). However, some observational studies can provide additional clues on the effectiveness of NHIG as PEP. In a NYC outbreak in 2013, 318 nonimmune contacts were included in analysis of which 15 % developed measles (15 %). Attack rates stratified by prophylaxis were 0 % (0/77) of those receiving NHIG, 4.5 % (2/44) for those receiving MMR and 23 % (46/197) for those not receiving any PEP. This results in estimated effectiveness of 100 % [56.2-100] for NHIG and 83.4 % [56.2-99.8] for MMR vaccination. Of note is that infants <6m of age were excluded from the analysis. In contrast, a very low protective effect was seen for Ig administration in 14 children in Japan (Endo et al., 2001). However, upon further analysis, the measles-specific Ig titer was predictive for protection, with a 100 % effectiveness if titers were >40 IU/mL. Finally, data from Austria in 2019 showed high effectiveness for NHIG. In 63 (96.9 %) of 65 infants PEP with IVIG was administered. The parents of two infants declined NHIG. None of the infants with NHIG got measles or symptoms suggestive for measles, but both infants who did not receive PEP were infected. Effectiveness of NHIG was thus calculated to be 99.3 % (CI 95 %: 88.7-100 %) (Kohlmaier et al., 2021). So far, there is no rationale to provide IVIG beyond 6 days after exposure. When IVIG is administered to patients with active measles, it may interfere with the development of specific anti-measles antibodies. This could, in theory, allow for latent measles virus to persist in the brain, potentially leading to SSPE months or even years later. This hypothesis has however not been proven, the authors raise the concern based on a case report and supporting animal studies (Ferren et al., 2019).

3.2 Dosage

As described above, adequate dosage of gammaglobulines is essential to obtain a protective effect. In Europe, no preparations of measles-specific (hyperimmune) human immunoglobulins are available. For the commercial preparations of polyvalent normal human immunoglobulins that are available on the market, post-exposure prophylaxis is often not mentioned as an indication. Hence, in contrast to the US, **for most products there is no minimal required titer of anti-measles Ig and information is not readily available. Only for Octagam 10 %** (not 5 %) **and Panzyga 10 % (not commercialized in Belgium at the time of writing) measles post-exposure is an official indication and a minimum titre of 9 IU/mL is guaranteed.**
Some results have been published in the literature. A 2018 publication from Germany tested different batches and lists results from several previous studies (Matysiak-Klose et al., 2018).

Additionally, the UKHSA 2024 guidance mentions “Based on testing results of products from 3 manufacturers the mean content of measles antibody by plaque neutralisation varies from 4 to 34 IU/ml (80 to 330 IU/g) for IVIG.” (UKHSA 2024) RIVM also tested batches of 2 different brands. No results are given, but based on the dosing scheme provided, it can be inferred that minimal concentrations were around 16 IU/mL (RIVM 2020). Finally, in a 2014 study from Brazil, Nobre et al. tested 38 lots of 8 different brands of IVIG and showed considerable variation between different lots. Antibody levels ranged between 9,65-43,15 IU/mL (Nobre et al., 2014).

Table 2. Titers in commercially available polyvalent IVIG solutions (IU/ml). *Adapted from Matysiak-Klose et al*.

	US	**Australia**	**Germany**	**UK**	**NL**	**Brazil**
Lowest value	6.2	5.0	7.4	4.0	*+-16*	9.7
Highest value	18.0	20.0	21.8	34		43
Source	Audet et al., 2006	Young et al., 2017	Matysiak-Klose et al., 2018	UKHSA 2024	RIVM 2020	Nobre et al., 2014

Because of the potentially lower concentrations in the available products, some authorities have recommended to increase the recommended dose to 400mg/kg. With a dosage of 400 mg/kg, a trough serum level of minimum 120mIU/ml persisting for 26-28 days would still be obtained with concentrations of measles-specific Ig as low as 0.6 IU/ml (Matysiak-Klose et al., 2018).

This means that effective protection can still be obtained using the currently commercially available IG products. However, higher recommended doses necessitate the administration of higher volumes. Whilst none of the products on the market are officially indicated for IM use, the UKHSA recommends IM administration of products licensed for subcutaneous use (UKHSA 2024). They cite the need for urgent treatment, quick absorption and lack of contraindications as arguments in favour of IM over SC use. Moreover, IM use can be easily performed in an outpatient setting. However, high dosages and therefore high administration volumes are unsuitable for IM administration (in addition to the off-label use and potential local side-effects). For this reason, UKHSA prefers a slightly lower dose in infants and pregnant women, aiming to attenuate rather than prevent disease.

3.3 Susceptibility of infants

The first dose of MMR1 vaccine is in Belgium administered at the age of 12 months. In outbreak situations, an extra dose of vaccine can be administered from 6 months of age. Vaccination in early life (particularly <9 months) yields lower protection and results in lower titers later in life than vaccination ≥12 months (Varma et al., 2025). Young infants will be protected by maternal antibodies. However, duration of protection is dependent on maternal antibody titers. As vaccine-induced immunity results in lower titers than natural infection, infants born from mothers will lose protection earlier in life**.** A study of 207 Flemish women found a median time to loss of immunity of 0.97 months for infants of vaccinated women and 3.78 months for infants of naturally immune women (Leuridan et al., 2010). However, the cut-off for ‘protection’ in this study was put rather high, at 300 mIU/mL. Using a cut-off of 200 mIU/mL, a study on sera collected in 2006 in the Netherlands found 3,3 months to be the median time to loss of protection in a highly-vaccinated population (Waaijenborg et al., 2013). In Austria, review of testing results of the National Reference Centre showed that at the age of 3 months, 60 % of infants had antibody levels below the cut-off of 150 mIU/mL (Springer et al., 2025). In contrast, recent analysis of sera from the Netherlands and the UK, using a cut-off of 120 mIU/mL show that at 3 months still 60 % (NL) or 80 % of the infants are above the threshold. (Teley et al., 2024; Varma et al., 2025). It is likely that lower levels of antibodies, whilst not adequately protecting against infection, would still provide some protection against

severe disease. For these reasons, we advise to consider infants from the age of 3 months as potentially susceptible to measles infection. Indeed, over the past 15 years in Belgium, only 10% of cases in children <1 year of age occurred in children <4 months (Sciensano, unpublished data).

3.4 Safety

Safety data on the use of polyvalent IVIG in the context of PEP remain relatively limited. In a study by Kohlamier *et al*, no immediate adverse events were observed in a cohort of 63 infants receiving IVIG as PEP during a measles outbreak in Austria. Among 58 infants that were subsequently monitored for symptoms for 7 days, two developed mild self-limiting fever on the first day after infusion (Kohlmaier et al., 2021). The overall safety profile of IVIG across all indications, is however well established (Cherin et al., 2016; Bonilla et al., 2008; Stiehm et al., 2013). Common immediate side effects include headache, nausea, malaise, myalgia, arthralgia, fever, chills, chest discomfort and flushing. These reactions can occur in 20 % or more of IVIG recipients, are generally mild, and may be mitigated by reducing the infusion rate or temporarily pausing administration. Common skin reactions include urticaria and rash, while anaphylactic and anaphylactoid reactions remain rare. Overall, severe reactions occur in less than 1 % of patients. For a complete list of side effects, please refer to the summary of product characteristics: SKP

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VI COMPOSITION OF THE WORKING GROUP

The composition of the Committee and that of the Board as well as the list of experts appointed by Royal Decree are available on the following website: About us.

All experts joined the working group ***in a private capacity***. Their general declarations of interests as well as those of the members of the Committee and the Board can be viewed on the SHC website (site: conflicts of interest).

The following experts were involved in drawing up this advisory report:

BLUMENTAL Sophie	Pediatrics, Infectious Disease Medicine, Vaccinology	ULB, CHIREC
CALLENS Steven	Internal Medicine, Infectious Disease Medicine, Emerging Communicable Diseases, Travel Medicine, Vaccinology	UZ Gent
CORNELISSEN Laura	Obstetrics, Gynecology, Epidemiology	Sciensano

The National Immunization Technical Advisory Group (NITAG) has endorsed the advisory report by email on May 13, 2025. The standing working group was chaired by **Steven CALLENS and David TUERLINCKX**; the scientific secretary was Veerle MERTENS.
The following experts sent their approval by email.

BLUMENTAL Sophie	Pediatrics, Infectious Disease Medicine, Vaccinology	ULB, CHIREC
BOIY Tine	Pediatrics, Rare Diseases, Congenital Hereditary and Neonatal Diseases and Abnormalities	UAntwerpen, UZA
CALLENS Steven	Internal Medicine, Infectious Disease Medicine	UGent, UZ Gent
CHATZIS Olga	Pediatrics, Infectious Disease Medicine	UCLouvain, Cliniques universitaires Saint-Luc
CORNELISSEN Laura	Obstetrics, Gynecology, Epidemiology	Sciensano
DAELEMANS Siel	Pediatrics, Infectious Disease Medicine, Pulmonary Medicine, Cystic Fibrosis, RSV, COVID-19.	VUB, UZ Brussel
DOGNE Jean Michel	Pharmacy and pharmacovigilance	U Namur, AFMPS, EMA
GOETGHEBUER Tessa	Pediatrics and infectiology	CHU St Pierre, ONE
LEROUX-ROELS Isabel	Vaccinology, infection prevention and microbiology	UZ Gent
MANIEWSKI-KELNER Ula	Infectiology and travel medicine	ITG
SCHELSTRAETE Petra	Pediatrics, pneumology and infectiology	UZ Gent
SCHIRVEL Carole	Epidemiology, infection prevention and control	UC Louvain, Saint-Luc
SOENTJENS Patrick	Travel medicine, vaccinology	ITG, Defense
TILMANNE Anne	Pediatrics and infectiology	CHU Tivoli
TUERLINCKX David	Pediatrics and vaccinology	CHU UCL Namur

VAN DAMME Pierre	Epidemiology, vaccinology, infectiology, public health	U Antwerpen
VAN LAETHEM Yves	Infectiology, vaccinology and travel medicine	ex-CHU Saint-Pierre
VANDEN DRIESSCHE Koen	Pediatrics, infectiology,	UZA
WAETERLOOS Geneviève	Quality of vaccines and blood products	Sciensano

The following administrations and experts were heard:

DAEMS Joêl	Directorate Drugs	RIZIV-INAMI
SABBE Martine	Vaccinovigilance and safety of vaccines	AFMPS-FAGG
TEUGHELS Stefan	Medical Director Domus Medica, General medicine, public health, EBM	Domus Medica
THEETEN Heidi	Vaccinology	VAZG

About the Superior Health Council (SHC)

The Superior Health Council is a federal advisory body. Its secretariat is provided by the Federal Public Service Health, Food Chain Safety and Environment. It was founded in 1849 and provides scientific advisory reports on public health issues to the Ministers of Public Health and the Environment, their administration, and a few agencies. These advisory reports are drawn up on request or on the SHC's own initiative. The SHC aims at giving guidance to political decision-makers on public health matters. It does this on the basis of the most recent scientific knowledge.

Apart from its 25-member internal secretariat, the Council draws upon a vast network of over 500 experts (university professors, staff members of scientific institutions, stakeholders in the field, etc.), 300 of whom are appointed experts of the Council by Royal Decree. These experts meet in multidisciplinary working groups in order to write the advisory reports.

As an official body, the Superior Health Council takes the view that it is of key importance to guarantee that the scientific advisory reports it issues are neutral and impartial. In order to do so, it has provided itself with a structure, rules and procedures with which these requirements can be met efficiently at each stage of the coming into being of the advisory reports. The key stages in the latter process are: 1) the preliminary analysis of the request, 2) the appointing of the experts within the working groups, 3) the implementation of the procedures for managing potential conflicts of interest (based on the declaration of interest, the analysis of possible conflicts of interest, and a Committee on Professional Conduct) as well as the final endorsement of the advisory reports by the Board (ultimate decision-making body of the SHC, which consists of 30 members from the pool of appointed experts). This coherent set of procedures aims at allowing the SHC to issue advisory reports that are based on the highest level of scientific expertise available whilst maintaining all possible impartiality.

Once they have been endorsed by the Board, the advisory reports are sent to those who requested them as well as to the Minister of Public Health and are subsequently published on the SHC website (www.hgr-css.be). Some of them are also communicated to the press and to specific target groups (healthcare professionals, universities, politicians, consumer organisations, etc.).

In order to receive notification about the activities and publications of the SHC, please contact: info.hgr-css@health.belgium.be.

www.superiorhealthcouncil.be

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