HSE Public Health: National Health Protection Office
FSS Sláinte Poiblí: An Oifig Náisiúnta um Chosaint Sláinte

Measles exposure during pregnancy – guidance document

Please note that this document should be used in tandem with other national measles guidance documents.

Readers should not rely solely on the information contained with these guidance outputs. Guidance information is not intended to be a substitute for advice from other relevant sources including and not limited to, the advice from a health professional. Clinical judgement and discretion will be required in the interpretation and application of this guidance document. This guidance document is under constant review based upon emerging evidence at national and international levels and national policy decisions.

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1.3	09/06/2025	Minor updates to guidance document – additional of links to newly published algorithms. Update to "significant exposure" to include utero exposure as per national measles guidelines.

Contents

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Date reviewed: 09/06/2025 *Version 1.3*

Measles during pregnancy is associated with an increased risk of maternal, foetal, and newborn complications including pneumonia, foetal loss, preterm birth, neonatal low birth weight, maternal and neonatal death. Measles in pregnancy and perinatal measles in an infant can both result in fulminant subacute sclerosing panencephalitis (SSPE) with a short-onset latency period[1].

1. National guidance on use of human normal immunoglobulin (HNIG)[1]

National guidance recommends using human normal immunoglobulin (HNIG) for susceptible pregnant women exposed to measles. The main aim of measles post-exposure prophylaxis with HNIG for pregnant women is attenuation of disease which may potentially reduce the rate of complications.

HNIG should be administered (ideally within 72 hours of exposure) to pregnant women without evidence of measles immunity who have had significant exposure to measles. Women with measles titres reported as "positive" or "weak positive" can be considered protected and do not need HNIG [1].

2. Assessing susceptibility to measles in pregnant women:

Consider susceptible those women (particularly if born from 1978 onwards) who:

- do not provide a reliable history of measles infection or
- have not received 2 doses of measles vaccine or
- who have serological evidence of lack of immunity or

- are of migrant or ethnic minority groups or who come from low resource countries. Such women are less likely to have been vaccinated with MMR vaccine.

Assessing likely susceptibility in pregnant contacts should be based on a combination of age, ethnicity/country of origin and vaccination/infection history.

3. Assessing exposure to measles:

An exposure is considered significant if:

- A susceptible individual is exposed to a confirmed or probable case of measles who is infectious at the time of exposure (four days before to four days after rash onset) in any of the following ways:
  - There is face to face contact of any duration.
  - An immunocompetent individual is in a room with a case for more than 15 minutes. This includes those who, within the preceding six days, may have been exposed to measles in the setting of an emergency department or an outpatient clinic where the intensity of such exposure cannot accurately be judged.
  - An immunocompromised person is in the room with a case for any duration or enters a room vacated by a case within two hours of the case leaving the room[1].
  - In-utero exposure to maternal measles where maternal measles rash occurs within six days before to six days after birth.

Human Normal Immunoglobulin (usage) administration

For information on HNIG usage please refer to most recent Chapter 12: Measles Immunisation Guidelines for Ireland.

References

1. National Immunisation Advisory Committee. Immunisation Guidelines for Ireland. Chapter 12. Measles (updated December 2024). Available at Chapter 12 - Measles | HIQA (accessed 19/05/2025)