Pan American Health Organization

World Health Organization
REGIONAL OFFICE FOR THE Americas

Webinar "Presentation of the Guidance on Surveillance of Congenital Rubella Syndrome: A Key Step Toward Strengthening Surveillance in the Americas", 28th October 2026.

Q&A

1. **How long does the virus survive outdoors, in the air, and on surfaces?**
   Answer:
   The rubella virus is sensitive to heat, pH, and disinfectants such as 1% sodium hypochlorite and alcohol 70 %, and has limited survival outside the host. Although experimental studies have demonstrated a progressive loss of infectivity in the environment, transmission occurs primarily through close contact with respiratory secretions from infected individuals and not through the prolonged persistence of the virus in the air or on surfaces.

2. **Will the vaccination coverage achieve through the MMR during the current measles outbreak succeed in reducing the prevalence of congenital rubella syndrome cases?**
   Answer:
   Strengthening vaccination coverage with vaccines containing components against measles, rubella, and mumps (such as the MMR vaccine) or with the MR vaccine (measles-rubella) helps maintain population-level protection against rubella and, consequently, reduces the risk of infection during pregnancy and the occurrence of CRS cases.
   However, because CRS is currently a rare occurrence in the Region of the Americas, the impact on its incidence may not be immediately observable. The main benefit is maintaining population immunity and preventing the transmission of rubella.

3. **The timeline for the congenital rubella syndrome elimination program, during which progress and impact will be evaluated, will begin in 2027. How many years will the elimination program remain in effect, and when will the impact be evaluated?**
   Answer:
   The Region of the Americas maintains its status of elimination of rubella and congenital rubella syndrome (CRS).
   Due to the risk of imported cases from regions where rubella virus transmission continues, vaccination, surveillance, and rapid response activities must be maintained so that imported cases can be detected and public health control measures implemented in a timely manner.
   Currently, there is no global rubella eradication target approved by the World Health Assembly; therefore, the regional objective remains to sustain the

elimination achieved and prevent the re-establishment of endemic transmission through robust immunization programs and high-quality surveillance systems.
In this context, there is no scheduled date for ending surveillance and sustainability activities related to elimination. The evaluation of epidemiological and programmatic indicators is part of a continuous regional monitoring and verification process that allows for the identification of opportunities for improvement in case detection, investigation, and follow-up.

4. **Why should active epidemiological surveillance be more intensive to support passive surveillance?**
   Answer:
   Surveillance based on suspected cases, or passive surveillance, constitutes the main strategy of the CRS's surveillance system. Complementarily, institutional active case searches allow for the evaluation of the system's sensitivity and the identification of events that may not have been reported in a timely manner.
   Active case searches are especially recommended in areas with epidemiological silence, when weaknesses in the surveillance system are detected, or as part of post-outbreak activities following rubella outbreaks.
   Both strategies should be considered complementary rather than substitutes for one another.

5. **What are PAHO's current guidelines regarding mandatory rubella screening during prenatal care, and how does this practice align with regional goals?**
   Answer:
   The guidelines of the Pan American Health Organization (PAHO), including those developed by the Latin American Center for Perinatology, Women's Health, and Reproductive Health (CLAP), promote the assessment of rubella immunity status as part of comprehensive prenatal care. In this context, assessing a pregnant woman's immunity status is a recommended practice for identifying susceptible women, guiding preventive measures during pregnancy, and ensuring postpartum vaccination when appropriate.
   However, how this assessment is implemented and whether it is mandatory depend on each country's policies, regulations, and procedures. Therefore, although PAHO promotes this practice from a clinical and public health perspective, its implementation as a programmatic requirement or as a universal component of prenatal care is a decision that rests with national authorities.
   While assessing immunity during pregnancy helps identify susceptible women and prevent future cases of CRS, the regional strategy for sustaining

elimination relies primarily on vaccination and sensitive surveillance systems, based on the timely detection and investigation of suspected cases and individuals exposed to confirmed cases.

6. **At what stage of pregnancy should testing be performed?**

   Answer:

   In countries where testing for IgG antibodies against rubella is part of routine prenatal care, the test is usually performed during the first prenatal visit or in the first trimester of pregnancy, with the goal of determining the pregnant woman's immune status and identifying women susceptible to infection.

   When there is clinical suspicion of rubella, or exposure to a confirmed case of rubella in addition to routine prenatal screening, IgM and IgG testing is indicated at the time clinical suspicion arises.

   Results should be interpreted considering vaccination history, clinical history, exposure, and the country's epidemiological situation. In the Region of the Americas, where rubella and congenital rubella syndrome have been eliminated, any suspicion of rubella virus infection during pregnancy requires careful evaluation to confirm or rule out the case.

7. **In the event of exposure in a previously vaccinated pregnant woman, is it also recommended to proceed with serological testing?**

   Answer:

   Yes. When exposure or infection during pregnancy is suspected, the evaluation should be conducted regardless of vaccination history. Vaccination history provides relevant information for risk assessment but does not replace clinical, epidemiological, and laboratory investigations when there is a history of exposure or a suspicion of rubella during pregnancy.

8. **Would intrauterine microcephaly be considered a suspected case, or could it be managed as a screening case while awaiting TORCH test results?**

   Answer:

   Microcephaly is not a classic major clinical manifestation of CRS. However, it may be observed in some cases of congenital rubella infection along with other neurological or developmental abnormalities.

   Isolated microcephaly should be considered a finding that warrants etiological investigation, but it does not, on its own, constitute a major criterion for suspecting CRS. The evaluation should be supplemented with an epidemiological history, a search for other compatible manifestations, and the

appropriate diagnostic tests for other congenital infections and causes of microcephaly.

9. **Are congenital heart defects in a case of CRS solely structural?**
   Answer:
   Congenital heart defects associated with Congenital Rubella Syndrome (CRS) primarily consist of structural abnormalities of the heart and great vessels, resulting of fetal rubella virus infection during organogenesis.
   Among the cardiac manifestations classically associated with CRS are patent ductus arteriosus, stenosis of the pulmonary artery and its branches, as well as other septal defects, including atrial septal defect and ventricular septal defect.
   For epidemiological surveillance purposes, the heart conditions considered in the definition and classification of CRS cases are primarily congenital structural anomalies documented clinically or through diagnostic tests, such as echocardiography.

10. **Group A includes congenital heart defects; will they only be taken in account with the related ICD codes for patent ductus arteriosus? How long must the condition remain open before it is reported?**
    Answer:
    The ICD codes included in the guidelines are used for active institutional surveillance and allow for the identification of clinical records that may correspond to suspected cases of CRS.
    Regarding patent ductus arteriosus (PDA), if the newborn meets the definition of a suspected case of CRS, the case must be immediately entered into the surveillance system without waiting for the lesion's progression or possible spontaneous closure. Subsequent epidemiological and clinical investigation will determine the case's final classification. Whether or not the PDA persists at follow-up visits is relevant information for clinical evaluation, but it should not delay the reporting and investigation of a suspected case that meets the criteria established by the surveillance system.

11. **There are congenital defects associated with prematurity, such as patent ductus arteriosus and patent foramen ovale. From what week of gestation should cases be considered for reporting?**
    Answer:
    Cardiac defects observed in preterm newborns must be interpreted considering gestational age and the overall clinical context. Both patent ductus arteriosus and patent foramen ovale are particularly common in preterm newborns; therefore, their isolated presence should not be directly interpreted as evidence of an anomaly attributable to congenital rubella syndrome (CRS).

There is no defined gestational age that, by itself, determines the inclusion or exclusion of a case. The evaluation must consider clinical findings, epidemiological history, and the presence of other manifestations consistent with congenital rubella.
However, if the infant meets the definition of a suspected case of CRS, the case must be reported and investigated regardless of gestational age at birth.

12. **Should a small apical muscular ventricular septal defect be reported?**
Answer:
A small apical muscular ventricular septal defect (VSD) is a relatively common congenital heart defect and, on its own, does not constitute a finding particularly suggestive of CRS.
However, the decision to report should not be based solely on the isolated presence of a VSD. The epidemiological history, the presence of other clinical manifestations consistent with CRS, and compliance with the suspected case definition established by the surveillance system must be considered together.
If the case meets the definition of a suspected case, it must be reported and investigated regardless of the size or location of the heart defect.

13. **If I identify a case of CRS, is the mother retrospectively reported as a case of rubella? What is the recommendation?**

Answer:

The detection and reporting of a case of congenital rubella syndrome (CRS) should trigger a comprehensive epidemiological investigation that includes a retrospective evaluation of the mother during pregnancy. However, the mother should not be automatically reported as a confirmed case of rubella because the confirmation of CRS in the child.
The investigation should review the mother's clinical and epidemiological history, including a history of rash during pregnancy, available laboratory results, vaccination status, exposure to suspected or confirmed cases of rubella, and any relevant information contained in prenatal records.
A confirmed case of CRS implies that rubella virus infection occurred during pregnancy, regardless of whether there is documented evidence of maternal infection. Therefore, the investigation should seek to characterize the maternal infection, identify the possible source of infection, and determine, when possible, whether exposure occurred within or outside the country.
From a surveillance perspective, the primary focus of follow-up is the infant with CRS, as the infant can shed the virus for prolonged periods and pose a potential risk of transmission to susceptible individuals. In contrast, by the time CRS is identified, the mother has generally already exceeded the period of

transmissibility associated with the infection that occurred during pregnancy, for that no longer poses a public health risk.
In all cases, the priority of surveillance is to complete the epidemiological investigation of CRS, document the maternal-fetal link, and identify the probable source of infection, rather than retrospectively reclassifying the mother in the absence of sufficient evidence.

14. **Can the same kits and protocols be used for CSF testing? Would it be molecular testing only?**
Answer:
In CSF samples, RT-PCR testing for viral RNA and IgM and IgG antibody testing can be performed; it is recommended to collect a serum sample to simultaneously detect IgG antibodies in both serum and CSF, to determine whether antibodies are being produced in the central nervous system, given that IgG can cross the blood-brain barrier.
Regarding commercial IgM and IgG tests, it is recommended to review the kit inserts and follow the instructions provided. It is important to correlate the laboratory test results with the clinical presentation.

15. **What is the survival rate for children with CRS?**

Answer:

Mortality and morbidity in children with CRS depend largely on the type and severity of the congenital manifestations present. Severe forms, particularly those associated with complex heart defects, neurological involvement, or multisystem disease, carry a higher risk of mortality during the first year of life. However, many children with CRS survive into adulthood and require long-term follow-up due to permanent sequelae, especially hearing loss, visual impairments, congenital heart defects, and neurodevelopmental disorders.

16. **What is the immunization schedule for a child born with the syndrome, or when is the best time for their first rubella vaccine or other vaccines?**

Answer:

Children with CRS should follow the national immunization schedule appropriate for their age, including the vaccine containing the rubella component at the age recommended by each national immunization program.

The presence of CRS is not a contraindication for routine vaccination. However, certain associated medical conditions or specific treatments may require an individual assessment by the treating team.

Even when a child has a history of congenital rubella infection, they should follow the current national immunization schedule for their age, unless there is a specific contraindication unrelated to CRS.

In the Region of the Americas, monovalent rubella vaccines are not used in national immunization programs. Protection against rubella is provided through combination vaccines, such as the MMR (measles-rubella) vaccine or the MMRV (measles-mumps-rubella-varicella) vaccine, according to the current national schedule.

The use of combination vaccines offers programmatic and public health advantages, as it provides simultaneous protection against several vaccine-preventable diseases, simplifies vaccine administration, improves the efficiency of immunization programs, and helps maintain coverage levels to sustain the elimination or control of vaccine-preventable diseases.