

Chapter 14: Rubella

Tatiana Lanzieri, MD; Susan Redd; Emily Abernathy, MS; Joseph Icenogle, PhD

I. Disease Description

Rubella is a viral illness caused by a togavirus of the genus Rubivirus and is characterized by a mild, maculopapular rash. The rubella rash occurs in 50%–80% of rubella-infected persons and is sometimes misdiagnosed as measles or scarlet fever. Children usually develop few or no constitutional symptoms, but adults may experience a 1–5-day prodrome of low-grade fever, headache, malaise, mild coryza, and conjunctivitis. Postauricular, occipital and posterior cervical lymphadenopathy is characteristic and precedes the rash by 5–10 days. Arthralgia or arthritis may occur in up to 70% of adult women with rubella. Rare complications include thrombocytopenic purpura and encephalitis.^{1–3} Rubella is transmitted through direct or droplet contact from nasopharyngeal secretions and has an average incubation period of 17 days (range: 12–23 days). Persons with rubella are most infectious when rash is erupting, but they can shed virus from 7 days before to 7 days after rash onset.

When rubella infection occurs during pregnancy, especially during the first trimester, serious consequences can result. These include miscarriages, fetal deaths/stillbirths, and a constellation of severe birth defects known as congenital rubella syndrome (CRS). The most common congenital defects are cataracts, heart defects and hearing impairment. See Chapter 15, “Congenital Rubella Syndrome (<https://www.cdc.gov/vaccines/pubs/surv-manual/chpt15-crs.html>),” for more details.

II. Background

Before the availability of rubella vaccines in the United States, rubella was a common disease that occurred primarily among young children. Incidence was highest during the spring with epidemics every 6 to 9 years.⁴ The last major epidemic in the United States occurred during 1964–1965, when there were an estimated 12.5 million rubella cases in the United States, resulting in 2,000 cases of encephalitis, 11,250 therapeutic or spontaneous abortions, 2,100 neonatal deaths, and 20,000 infants born with CRS.⁵

In 1969, live attenuated rubella vaccines were licensed in the United States. The goal of the rubella vaccination program was and continues to be to prevent congenital infections, including those that result in CRS.⁶ Following vaccine licensure, the number of reported cases of rubella in the United States has declined dramatically. During the 1990s, the incidence of rubella among children younger than 15 years of age decreased (from 0.63 per 100,000 population in 1990 to 0.06 in 1999), whereas the incidence among adults 15 to 44 years of age increased (from 0.13 per 100,000 in 1990 to 0.24 in 1999).⁷ However, since 2001, the incidence both among persons younger than 15 years of age and those 15 to 44 years of age has been less than 1/10,000,000 population.^{8,9}

During the 1990s and in 2000, rubella outbreaks occurred among members of religious communities that traditionally refuse vaccination and among adults from countries without a history of routine rubella vaccination programs.^{7,8} Since 2001, only 3 rubella outbreaks have been reported, each with 5 or fewer cases.

In 2004, an independent panel of internationally recognized experts in public health, infectious diseases, and immunizations reviewed available data and unanimously agreed that rubella elimination (i.e., the absence of endemic transmission) was achieved in the United States.⁶

Although rubella has been eliminated in the United States, it continues to be endemic in many parts of the world. It is estimated that more than 100,000 infants worldwide are born annually with CRS.¹⁰



According to a survey of the member countries in the World Health Organization (WHO), the number of countries that have incorporated rubella-containing vaccines into their routine national immunization programs increased from 83 in 1996 to 148 (76% of countries) in 2016. As of December 2016, the WHO Region of the Americas and the European Region have established rubella elimination goals, verified by the Region of the Americas in 2015.¹¹ The South-East Asia region has a rubella/CRS reduction goal of 95% by 2020;¹² the Western Pacific Region has established a rubella elimination target without a specific date; and the Eastern Mediterranean and African Regions do not currently have elimination targets. In addition, in 2011, WHO recommended that all countries providing 2 doses of measles vaccine that have not introduced rubella vaccine consider including rubella-containing vaccine in their immunization program.¹³ The United States elimination of rubella and CRS was reconfirmed in 2011 and maintenance of elimination was reported in 2014.^{12,14}

III. Maintenance of Elimination

The United States has established and achieved the goal of eliminating endemic rubella transmission and CRS. As noted above, elimination of endemic rubella was documented and verified in the United States in 2004.⁶ However, because of international travel and countries without routine rubella vaccination, imported cases of rubella remain likely. To maintain elimination, the United States should continue to maintain high vaccination rates among children; ensure that women of childbearing age, particularly women born outside of the United States, are vaccinated; and maintain sensitive surveillance to detect both rubella and CRS.

IV. Vaccination

For specific information about the use of rubella vaccines, refer to The Pink Book [<https://www.cdc.gov/vaccines/pubs/pinkbook/index.html>], which provides general recommendations, including vaccine use and scheduling, immunization strategies for providers, vaccine content, adverse events and reactions, vaccine storage and handling, and contraindications and precautions.

V. Presumptive Evidence of Rubella Immunity

Persons who have written documentation of adequate vaccination with at least 1 dose of live rubella virus-containing vaccine on or after 12 months of age, laboratory evidence of rubella immunity, laboratory confirmation of disease, or who were born before 1957, have acceptable presumptive evidence of rubella immunity. Persons who do not have acceptable presumptive evidence of rubella immunity should receive 1 dose of MMR vaccine.

VI. Case Definition

Case definition for case classification

The following case definition for rubella was approved by the Council of State and Territorial Epidemiologists (CSTE) in 2012.¹⁵

Suspected: Any generalized rash illness of acute onset that does not meet the criteria for probable or confirmed rubella or any other illness.

Probable: In the absence of a more likely diagnosis, an illness characterized by all of the following:

- acute onset of generalized maculopapular rash; **and**
- temperature greater than 99.0° F or 37.2° C, if measured; **and**
- arthralgia, arthritis, lymphadenopathy, or conjunctivitis; **and**
- lack of epidemiologic linkage to a laboratory-confirmed case of rubella; **and**
- noncontributory or no serologic or virologic testing.

Confirmed: A case with or without symptoms who has laboratory evidence of rubella infection confirmed by one or more of the following:

- isolation of rubella virus; **or**
- detection of rubella-virus specific nucleic acid by reverse-transcription polymerase chain reaction (RT-PCR); **or**
- significant rise between acute-and convalescent-phase titers in serum rubella immunoglobulin G (IgG) antibody level by any standard serologic assay; **or**
- positive serologic test for rubella immunoglobulin M (IgM) antibody (not explained by MMR vaccination during the previous 6–45 days, and not otherwise ruled out by more specific testing in a public health laboratory)

OR

An illness characterized by all of the following:

- acute onset of generalized maculopapular rash; **and**
- temperature greater than 99.0° F or 37.2° C; **and**
- arthralgia, arthritis, lymphadenopathy, or conjunctivitis; **and**
- epidemiologic linkage to a laboratory-confirmed case of rubella.

Epidemiologic classification of internationally imported and US-acquired cases

Internationally imported case: An internationally imported case is defined as a case in which rubella results from exposure to rubella virus outside the United States, as evidenced by at least some of the exposure period (12–23 days before rash onset) occurring outside the United States and the onset of rash within 23 days of entering the United States, and no known exposure to rubella in the United States during that time. All other cases are considered US-acquired cases.

US-acquired case: A US-acquired case is defined as a case in which the patient had not been outside the United States during the 23 days before rash onset or was known to have been exposed to rubella within the United States.

US-acquired cases are subclassified into four mutually exclusive groups

Import-linked case: Any case in a chain of transmission that is epidemiologically linked to an internationally imported case.

Imported-virus case: A case for which an epidemiologic link to an internationally imported case was not identified but for which viral genetic evidence indicates an imported rubella genotype, i.e., a genotype that is not occurring within the United States in a pattern indicative of endemic transmission. An endemic genotype is the genotype of any rubella virus that occurs in an endemic chain of transmission (i.e., ≥ 12 months). Any genotype that is found repeatedly in US-acquired cases should be thoroughly investigated as a potential endemic genotype, especially if the cases are closely related in time or location.

Endemic case: A case for which epidemiologic or virologic evidence indicates an endemic chain of transmission. Endemic transmission is defined as a chain of rubella virus transmission continuous for ≥ 12 months within the United States.

Unknown source case: A case for which an epidemiologic or virologic link to importation or to endemic transmission within the United States cannot be established after a thorough investigation. These cases must be carefully assessed epidemiologically to assure that they do not represent a sustained US-acquired chain of transmission within the United States.

***Note:** Internationally imported, import-linked, and imported-virus cases are considered collectively to be import-associated cases.*

States may also choose to classify cases as “out-of-state-imported” when imported from another state in the United States. For national reporting, however, cases will be classified as either internationally imported or US-acquired.

VII. Laboratory Testing

Clinical diagnosis of rubella is unreliable; therefore, cases must be laboratory confirmed. Virus detection and serologic testing can be used to confirm acute or recent rubella infection. Serologic tests can also be used to screen for rubella immunity. For detailed information on laboratory testing for rubella and for specific information on specimen collection and shipment, see Chapter 22 (<https://www.cdc.gov/vaccines/pubs/surv-manual/chpt22-lab-support.html>), “Laboratory Support for Surveillance of Vaccine-Preventable Diseases.”

Specimen collection

Specimen collection and shipping are important steps in obtaining laboratory diagnosis or confirmation for vaccine preventable diseases. Guidelines have been published for specimen collection and handling for microbiologic agents (<https://stacks.cdc.gov/view/cdc/7590>). Information is also available on using CDC laboratories as support for reference and disease surveillance (<https://www.cdc.gov/nceid/dsr/specimen-management-branch.html>); this includes

- a central website for requesting lab testing (<https://www.cdc.gov/laboratory/specimen-submission/index.html>);
- the form required for submitting specimens to CDC (See Appendix 23, Form # CDC 50.34, <https://www.cdc.gov/laboratory/specimen-submission/form.html>);
- information on general requirements for shipment of etiologic agents (Appendix 24, <https://www.cdc.gov/vaccines/pubs/surv-manual/appx/appendix24-etiological-agent.pdf>)—although written to guide specimen submission to CDC, this information may be applicable to submission of specimens to other laboratories; and
- the CDC Infectious Diseases Laboratories Test Directory (<https://www.cdc.gov/laboratory/specimen-submission/list.html>), which not only contains a list of orderable tests for that institution, but also detailed information on appropriate specimen types, collection methods, specimen volume, and points of contact.

The APHL/CDC Vaccine Preventable Disease Reference Centers (https://www.aphl.org/programs/infectious_disease/Documents/ID_VPDQuickReferenceGuide_updated62016.pdf) can perform real-time RT-PCR and genotyping for rubella.

Specific instructions for specimen collection and shipping may be obtained from the CDC rubella website (<https://www.cdc.gov/rubella/lab/specimen-collection-shipment.html>) or by contacting the CDC Viral Vaccine Preventable Diseases Branch at 404-639-4557. Specimens for virus isolation should be sent to CDC as directed by the State Health Department.

VIII. Importance of Rubella Surveillance

Surveillance data are needed to identify and control rubella virus introductions to prevent congenital rubella infections and consequent CRS as well as monitor maintenance of disease elimination.

Promote awareness of rubella and CRS in the United States

Although only 94 cases of rubella and 8 cases of CRS were reported between 2005 and 2015, it is likely that not all cases were identified. Efforts should continue to promote physicians’ awareness of the possibility of rubella and CRS. When evaluating patients with suspected measles who have negative serologic tests for acute measles infection (i.e., negative serum measles IgM), officials may request additional testing for rubella.

Promote awareness of groups at high risk for rubella infection and CRS birth

Rubella-containing vaccines are not administered routinely in many countries; in others, rubella-containing vaccine was only recently added to the childhood immunization schedule. Thus, many persons born outside the United States or who received childhood immunizations in other countries may have never received rubella vaccine. Healthcare providers should have a heightened index of suspicion for rubella and CRS births in persons from countries without a history of routine rubella vaccination programs or with recently implemented programs.

IX. Reporting and Case Notification

Case reporting within a jurisdiction

Each state and territory (jurisdiction) has regulations or laws governing the reporting of diseases and conditions of public health importance.¹⁶ These regulations and laws list the diseases to be reported and describe those persons or groups who are responsible for reporting, such as healthcare providers, hospitals, laboratories, schools, daycare and childcare facilities, and other institutions. Persons reporting should contact the jurisdiction/state health department for jurisdiction-specific reporting requirements.

Prompt identification and reporting of suspected, probable, or confirmed cases of rubella is important to avoid exposure of susceptible pregnant women. Rapid case identification and investigations are also important so that control measures can be initiated to prevent spread of the disease. The Rubella Surveillance Worksheet is included as Appendix 16, to serve as a guide for data collection during investigation of reported cases.

Case notification to CDC

Since continuous endemic rubella transmission has been eliminated, rubella is an immediately notifiable disease. Rubella cases should be reported promptly (within 24 hours³) by the jurisdiction/state health department to the CDC or directly to Susan Redd at NCIRD, CDC by telephone: 404-639-8763 or by e-mail (SBR1@cdc.gov). Notification of suspected, probable, or confirmed cases of rubella should be sent to CDC using event code 10200 in the National Notifiable Diseases Surveillance System (NNDSS) with the next regularly scheduled electronic transmission. Case notification should not be delayed because of incomplete information or confirmation; following completion of case investigations, data previously submitted to NNDSS should be updated with the available new information.

The following data elements are epidemiologically important and should be collected in the course of a case investigation. Additional information may be collected at the direction of the state or local health department.

- Demographic information
 - Name
 - Address
 - Age
 - Sex
 - Ethnicity
 - Race
 - Country of birth
 - Length of time in United States
- Reporting source
 - County
 - Earliest date reported
- Clinical
 - Date of illness onset
 - Date of rash onset
 - Duration of rash
 - Symptoms
 - Fever
 - Arthralgia or arthritis
 - Lymphadenopathy
 - Conjunctivitis
 - Complications
 - Encephalitis
 - Thrombocytopenia
 - Other

- Hospitalizations and duration of stay
- Outcome (patient survived or died)
 - Date of death
- If female, pregnancy history
 - If pregnant, pregnancy status
 - Number of weeks gestation at onset of illness
 - Prior evidence, date of serologic immunity, or both
 - Prior diagnosis and date of rubella
 - Number and dates of previous pregnancies and location (e.g., state or country) of these pregnancies
 - Pregnancy outcome, when available (e.g., normal infant, termination, CRS)
- Laboratory
 - Serology
 - Virus isolation
 - Genotype
 - PCR results
- Vaccine information
 - Number of doses of rubella-containing vaccine received
 - Dates of vaccination
 - Country of vaccination
 - Types of vaccine (rubella, MMR, MMRV)
 - If not vaccinated, reason
- Epidemiologic
 - Transmission setting (e.g., infection acquired at home, healthcare setting, in daycare, school, or workplace)
 - Relationship to outbreak (Is case part of an outbreak or is it sporadic?)
 - Source of exposure
 - Travel history (countries, dates)

X. Case Investigation, Contact Investigations, and Outbreak Control

Consider a single case of rubella as a potential outbreak

Because rubella has been eliminated in the United States, health agencies should consider one case a potential outbreak. Rubella is an infectious disease for which up to 50% of cases are asymptomatic, and investigation of an apparently isolated case could reveal additional cases.

Confirm a diagnosis of rubella

Clinical diagnosis of rubella is unreliable, therefore, cases must be laboratory confirmed, especially if the reported cases are not epidemiologically linked to a laboratory-confirmed case. Laboratory testing should be conducted for all suspected cases of rubella.

Laboratory confirmation of rubella infection may be difficult in pregnant women with unknown immune status who experience a rash illness or who are exposed to rubella. A serum specimen should be obtained as soon as possible.

Conduct case investigations and vaccinate contacts without evidence of immunity

Aggressive response to rubella cases may interrupt disease transmission and will increase vaccination coverage among persons who might otherwise not be protected. The main strategies are to define populations at risk, to ensure that persons without evidence of immunity are rapidly vaccinated (or excluded from exposure if a contraindication to vaccination exists); and to maintain active surveillance to permit modification of control measures if the situation changes.

The goal of rubella case investigation is to identify rubella infections, particularly infection in pregnant women, and to prevent exposure of susceptible pregnant women, and thereby prevent cases of CRS. It is essential that exposed pregnant women be identified, evaluated, and counseled (see section on laboratory evaluation of exposed pregnant women). The Rubella Surveillance Worksheet (<https://www.cdc.gov/vaccines/pubs/surv-manual/appx/appendix16-2-rubella-wrsh.pdf>) may be used as a guideline in conducting a case investigation. Case investigation and identification of contacts should be conducted for all suspected cases of rubella.

Cases of rubella occurring within 10 days of rubella vaccination should be investigated, and specimens should be obtained for virus isolation to determine if the rash is attributable to vaccine virus or wild-type virus. Cases in persons vaccinated within 7 days of a rubella-like illness who are IgM positive should be classified as confirmed cases of wild-type rubella if they are epidemiologically linked to a laboratory-confirmed case.

Any direct contact with a patient with rubella during the infectious period (7 days before to 7 days after rash onset) is defined as an exposure. Every effort should be made to identify all pregnant women who might have been exposed to a patient and evaluate them serologically for rubella-specific IgM and IgG antibodies. All women of childbearing age who are contacts of a person with a suspected or confirmed case should have their pregnancy status determined. If a pregnant woman is infected with rubella, immediate medical consultation is necessary. If a pregnant woman lacks laboratory evidence of rubella immunity, precautions should be taken to prevent any type of exposure to persons infected with rubella; these precautions may include ensuring rubella immunity of household contacts and isolating women from settings where rubella virus has been identified.

Identify the source of infection

Efforts should be made to identify the source of infection for every confirmed case of rubella. Case-patients or their caregivers should be asked about contact with other known cases. Since many rubella cases are asymptomatic, identification of a source will not always be possible. When no history of contact with a known case can be elicited, opportunities for exposure to unidentified cases in populations at high risk (e.g., foreign-born persons) should be sought. Investigating sources of exposure should be directed to the place and time period in which transmission would have occurred.

Obtain specimens for virus detection

Efforts should be made to obtain clinical specimens (throat swabs and urine) for virus detection from all case-patients (or from at least some patients in each outbreak) at the time of the initial investigation.

See Appendix 15, (<https://www.cdc.gov/vaccines/pubs/surv-manual/appx/appendix15-rubella.pdf>) for the procedure to follow in collection of specimens.

Conduct laboratory evaluation of exposed pregnant women

Exposed pregnant women should be tested for the presence of rubella IgG and IgM antibodies regardless of symptom history. A blood specimen should be taken as soon as possible, tested for rubella IgG and IgM antibody, and stored for possible retesting. See Chapter 22, “Laboratory Support for Surveillance of Vaccine-Preventable Diseases” for information on laboratory testing.

Report the pregnancy outcome for women diagnosed with rubella during pregnancy

All pregnant women infected with rubella during pregnancy should be followed to document the pregnancy outcome (e.g., normal infant, termination, CRS). Outcomes that are documented should be reported to CDC.

Conduct enhanced surveillance

Active surveillance for rubella should be maintained for at least 2 incubation periods (46 days) following rash onset of the last case. Two incubation periods allow for the identification of transmission from a subclinical case. In addition, surveillance for CRS should be implemented when confirmed or probable rubella cases are documented in a setting where pregnant women might have been exposed. Women who contract rubella infection while pregnant should be monitored for birth outcome, and appropriate testing should be performed on the infant after birth.

Implement control measures

Control measures should be implemented as soon as at least 1 case of rubella is confirmed in a community. In settings where pregnant women may be exposed, control measures should begin as soon as rubella is suspected and should not be postponed until laboratory confirmation. Patients with rubella should be isolated for 7 days after rash onset. All persons at risk who cannot readily provide acceptable evidence of rubella immunity should be considered susceptible and should be vaccinated.

In schools and other educational institutions, exclusion of persons without acceptable evidence of rubella immunity may limit disease transmission and may help to rapidly raise the vaccination level in the target population. All persons who have been exempted from rubella vaccination for medical, religious, or other reasons also should be excluded from attendance. Exclusion should continue until 23 days after the onset of rash of the last reported case-patient in the outbreak setting. Unvaccinated persons who receive MMR vaccine as part of the outbreak control may be immediately readmitted to school provided all persons without documentation of immunity have been excluded.

In healthcare settings, exposed healthcare personnel without adequate presumptive evidence of immunity should be excluded from duty beginning 7 days after exposure to rubella and continuing through either 23 days after last exposure or 7 days after rash appears. Exposed healthcare personnel who are vaccinated as part of control measures should be excluded from direct patient care for 23 days after the last exposure to rubella because effectiveness of postexposure vaccination in preventing rubella infection has not been shown. In addition, because birth before 1957 does not guarantee rubella immunity, during outbreaks in healthcare settings, healthcare facilities should recommend one dose of MMR vaccine for unvaccinated personnel born before 1957 who lack laboratory evidence of rubella immunity or laboratory confirmation of infection or disease.¹⁷

References

1. Sherman FE, Michaels RH, Kenny FM. Acute encephalopathy (encephalitis) complicating rubella. Report of cases with virologic studies, cortisol-production determinations, and observations at autopsy. *JAMA* 1965;192:675–81. doi: 10.1001/jama.1965.03080210019005
2. Margolis FJ, Wilson JL, Top FH. Post rubella encephalomyelitis: report of cases in Detroit and review of literature. *J Pediatr* 1943;23:158–65. doi: 10.1016/S0022-3476(43)80115-3
3. Bayer WL, Sherman FE, Michaels RH, Szeto IL, Lewis JH. Purpura in congenital and acquired rubella. *N Engl J Med* 1965;273(25):1362–66. doi: 10.1056/NEJM196512162732504
4. Witte JJ, Karchmer AW, Case G, et al. Epidemiology of rubella. *Am J Dis Child* 1969;118(1):107–11. doi: 10.1001/archpedi.1969.02100040109018
5. National Communicable Disease Center. Rubella surveillance. Washington, DC: U.S. Department of Health, Education, and Welfare; 1969.
6. CDC. Achievements in public health: elimination of rubella and congenital rubella syndrome—United States, 1969–2004. *MMWR Morb Mortal Wkly Rep* 2005;54(11):279–82. <https://www.cdc.gov/mmwr/preview/mmwrhtml/mm5411a5.htm>
7. Reef SE, Frey TK, Theall K, et al. The changing epidemiology of rubella in the 1990s: on the verge of elimination and new challenges for control and prevention. *JAMA* 2002;287(4):464–72. doi: 10.1001/jama.287.4.464
8. Reef SE, Redd SB, Abernathy E, Zimmerman L, Icenogle JP. The epidemiological profile of rubella and congenital rubella syndrome in the United States, 1998–2004: the evidence for absence of endemic transmission. *Clin Infect Dis* 2006;43(Suppl 3):S126–32. doi: 10.1086/505944
9. Papania MJ, Wallace GS, Rota PA, et al. Elimination of endemic measles, rubella and congenital rubella syndrome from the Western hemisphere: the US experience. *JAMA Pediatr* 2014; 168(2): 148–55. doi: 10.1001/jamapediatrics.2013.4342
10. Vynnycky E, Adams EJ, Cutts FT, et al. Using seroprevalence and immunization coverage data to estimate the global burden of congenital rubella syndrome, 1996–2010: a systematic review. *PLoS One* 2016;11(3):e0149160 doi: 10.1371/journal.pone.0149160

11. PAHO. Americas region is declared the world's first to eliminate rubella (press release). Washington, DC:PAHO;2015 April 25. http://www.paho.org/hq/index.php?option=com_content&view=article&id=10798%3A2015-americas-free-of-rubella&catid=740%3Apress-releases&Itemid=1926&lang=pt
12. WHO. Rubella and congenital rubella syndrome control and elimination—global progress, 2000–2014. *Wkly Epidemiol Rec* 2015;90(39):510–6.
13. WHO. Rubella vaccines: WHO position paper. *Wkly Epidemiol Rec* 2011;86(29):301–16.
14. CDC. Documentation and verification of measles, rubella and congenital rubella syndrome elimination in the Region of the Americas, United States National Report 2012 Atlanta, GA: CDC; 2012. <https://stacks.cdc.gov/view/cdc/21191>
15. CSTE. Update to rubella case definition. CSTE position statement 12-ID-09. Atlanta, GA:CSTE; 2012. <http://c.ymcdn.com/sites/www.cste.org/resource/resmgr/PS/12-ID-09FINAL.pdf>
16. Roush S, Birkhead G, Koo D, Cobb A, Fleming D. Mandatory reporting of diseases and conditions by health care professionals and laboratories. *JAMA* 1999;282(2):164–70. doi: 10.1001/jama.282.2.164
17. CDC. Immunization of health-care personnel: recommendations of the Advisory Committee on Immunization Practices (ACIP). *MMWR Recomm Rep* 2011;60(RR-7):1–45. <https://www.cdc.gov/mmwr/preview/mmwrhtml/rr6007a1.htm>