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## DEPARTMENT OF HUMAN SERVICES



NEVADA DIVISION of PUBLIC  
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**DATE:** February 17, 2026  
**TO:** Nevada State Board of Health  
**THROUGH:** Laura Rich, Director, DHS  
Andrea Rivers, Administrator, DPBH  
**FROM:** Ihsan Azzam, PhD, MD, MPH, Chief Medical Officer  
**RE:** Report to the State Board of Health for March 06, 2026

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### Introduction

The United States is experiencing a multi-focal resurgence of measles, driven largely by lack of or under-vaccination and serious gaps in *Herd Immunity* that led to a significantly reduced collective community resilience. While measles viral activity has reached its highest levels in more than three decades, national prevention efforts continue to be challenged by vaccine hesitancy, hindered by questionable decisions, and stalled by changing national policy landscapes. However, measles and other vaccine-preventable disease rates in Nevada remain comparatively stable due to sustained surveillance activities, extensive public health education and outreach campaigns, and ongoing vaccination efforts to prevent localized outbreaks.

While continue to be slightly elevated, seasonal respiratory illnesses are not exhibiting any dramatic surges beyond the familiar and regularly observed seasonal patterns.

Concerning public health threats such as the emergence of the New World Screwworm, aggravated by continuously evolving healthcare coverage dynamics and an inadequate access to health services further underscores the complexity and serious challenges that the national public health system is facing. Together, these trends highlight the critical importance of increasing our vaccination coverage, enhancing disease tracking and surveillance, coordinating public health planning and response, and developing effective public health communication system in order to reverse these alarming trends and protect the population health.

### Vaccination Effectiveness and Policy Changes

Research continues to demonstrate the effectiveness of vaccination. Recent CDC *Morbidity and Mortality Weekly Report (MMWR)* titled “*Effectiveness of 2024–2025 COVID-19 Vaccines in Children in the United States*” found that compared with unvaccinated children, those who received the 2024–2025 COVID-19 vaccine had significantly lower risk of COVID-19–associated emergency and urgent care visits. According to this MMWR

protection levels acquired by the vaccine were similar to those observed during the 2023–2024, as during the first six months after vaccination, effectiveness was around 76% among children aged 9 months to 4 years and 56% among children aged 5 to 17 years.

Despite these encouraging findings, and in contrast to the CDC Schedule for Child and Adolescent Vaccination from 2024, which recommended 18 immunizations for all children, the federal immunization policy has recently shifted, and as of the 5<sup>th</sup> of January vaccinations for extremely prevalent infections were unexplainably removed from the universal CDC recommendations and assigned to a shared clinical decision-making or high-risk group recommendations. Earlier CDC changes also removed routine COVID-19 vaccination recommendations for pregnant women.

Prestigious academic institutions, national healthcare and public health professional associations including the American Academy of Pediatrics (AAP) and the American Academy of Family Physicians (AAFP), in addition to the American Association for State and Territorial Health Officials (ASTHO), the National Council of State and Territorial Epidemiologists (CSTE) and many other national organizations strongly disagreed with this unjustifiable significant federal policy shift.

Additionally, the AAP - has criticized the CDC's changes and described them as "dangerous and unnecessary," is challenging them in court [AAP Publications](#), and in its 2026 Recommended Childhood and Adolescent Immunization Schedule, AAP continued to recommend routine immunization against these 18 infection **Diphtheria, Tetanus, Pertussis, Haemophilus influenzae type b (Hib), Pneumococcal disease, Poliomyelitis, Measles, Mumps, Rubella, Varicella (chickenpox), Human papillomavirus (HPV), Hepatitis A, Hepatitis B, Rotavirus, Meningococcal disease (ACWY and B), Influenza, COVID-19, and Respiratory syncytial virus (RSV)** (*infant immunization/monoclonal antibody preventive strategy*) , [AAP Publications+1](#). This AAP Schedule differ from the Centers for Disease Control and Prevention (CDC) Schedule, which in early 2026 removed or downgraded routine recommendations for **Hepatitis A and B, COVID-19, Rotavirus, Influenza and Meningococcal disease**, and moved **RSV** to a high-risk group [AAP Publications+1](#).

Additionally, the American College of Obstetricians and Gynecologists (ACOG) is in the process of finalizing its own maternal immunization guidance in collaboration with independent experts. This initiative aims to provide evidence-based recommendations for immunization during pregnancy, such as vaccination for influenza, COVID-19, and other vaccines, to protect both the mother and the newborn.

## Measles – National Situation and Outbreaks

The United States (US) continues to experience the highest measles activity in more than 30 years. As of February 12, a total of 910 confirmed cases of measles have been reported in 2026 across 20 jurisdictions, which reflects an increase of 177 measles cases since February 5. Approximately 95% of cases occurred in unvaccinated individuals or those with unknown vaccination status, and 3% required hospitalization. Earlier surveillance data documented 1,912 cases across 42 states as of December 9, 2025, and more than 2,400 cases have occurred since January of last year. This concerning continuous transmission places the US at risk of losing its measles elimination status, which has been maintained since 2000.

South Carolina continues to experience the largest single-state outbreak in more than three decades, with 933 confirmed cases. Most cases are among unvaccinated school-aged children. To contain this outbreak a legislation has been introduced to eliminate religious exemptions for measles vaccination. However, the proposal has faced opposition citing personal liberty concerns. Additional exposure incidents have been reported at Disneyland in

California and at Ave Maria University in Florida, where outbreaks have affected dozens of individuals. These events underscore the rapid spread of measles especially in congregate settings.

Nevada reported so far two measles cases in 2025 (one in Clark and another in Washoe county). These were the first in Nevada since 2018. It's important to emphasize that Nevada Rate of the MMR (Mumps, Measles and Rubella) Vaccination is approximately 92% which is just slightly below the 95% threshold required for an effective Herd Immunity level in order to limit and control measles community transmission. This Nevada rate is significantly higher than MMR rates of vaccination reported in neighboring states including Arizona, Utah, and Idaho. While localized transmission remains a possibility, low density of clusters with unvaccinated and under vaccinated individuals, may help reduce the likelihood of widespread outbreaks.

Measles vaccine is very effective as two MMR doses can provide 97% protection against measles, and even one single dose can significantly reduce the risk of contracting and developing measles.

To control and limit disease transmission, the Nevada Division of Public and Behavioral Health (DPBH) continues to

- Conduct active surveillance and case investigation, to early detect measles cases and limit further transmission, and monitor geographic clustering of exemptions.
- Coordinate with the local health authorities (LHAs), community healthcare providers and facilities and continues to issue focused health alerts and advisories, and technical bulletins to ensure rapid reporting and contact tracing.
- Provide promotional public education and vaccination campaigns, especially in rural and frontier Nevada counties where MMR vaccination rates are below the state average.
- Increase MMR coverage statewide in order to reach an MMR vaccination rate of 95% or more.
- Strengthen outbreak planning and preparedness protocols.

## Seasonal Respiratory Illness Update

- **Influenza**

Nevada influenza-like illness (ILI) remains above baseline at 3.4% but seems to be declining slightly - following a mid-season peak. Influenza A predominates, with 976 hospitalizations and 18 deaths reported so far. Influenza B activity remains low. Nationally, influenza activity remains elevated but stable or decreasing in many regions.

- **COVID-19**

COVID-19 activity in Nevada remains low, with a modest winter increase followed by a return toward baseline. Most COVID-19 viral activity is occurring in outpatient settings and among younger age groups. Nationally, COVID-19 transmission remains at low-to-moderate intensity without a sharp hospitalization surge.

- **RSV**

RSV activity in Nevada is currently low and consistent with a late-season phase. Nationally, RSV continues to contribute to seasonal respiratory morbidity, particularly among infants and older adults.

## New World Screwworm (NWS)

The parasitic fly *Cochliomyia hominivorax*, known as New World screwworm (NWS), is causing significant outbreaks in Central America and Mexico, with more than 150,000 animal cases and over 1,240 human cases reported so far. NWS is not currently present in the United States.

A recent travel-associated human case was identified in Maryland. Federal and state agencies have responded with enhanced surveillance, livestock import suspensions, and renewed implementation of sterile insect technique (SIT) to prevent spread into the United States. The current public health risk domestically remains low.

## **Health Care Coverage**

Following the expiration of enhanced premium subsidies, Affordable Care Act (ACA) marketplace enrollment declined from 24.2 million to approximately 23 million in 2026. Early data indicate increased cancellations of healthcare coverage in several states and a shift toward lower-premium plans with higher deductibles. The Centers for Medicaid and Medicare (CMS) have proposed regulatory changes expanding access to catastrophic plans and strengthening income verification requirements.

Since January 2026, approximately 20 million low-income adults in 42 states and Washington, D.C., could have been required to meet work or qualifying activity (80 hours per month) to maintain Medicaid coverage. As a result, the Congressional Budget Office projects at least 5 million fewer Medicaid enrollees over the next decade. Health policy experts have raised concerns about long-term health and cost subsequent negative implications to the national healthcare and public health systems.