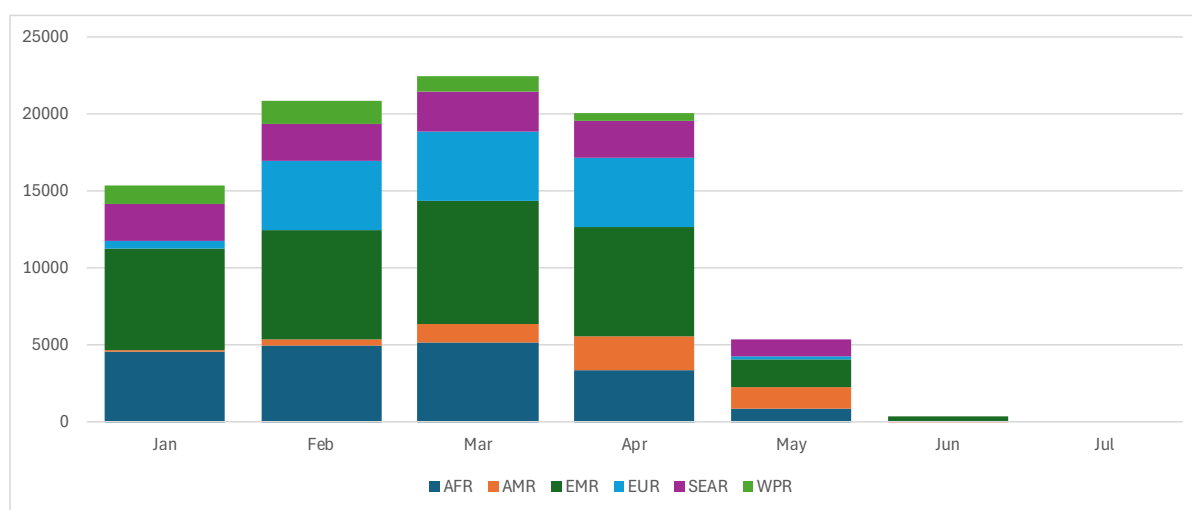


### Global overview

According to the monthly measles and rubella surveillance data, published by the World Health Organization (WHO) in 2025, 188,355 suspected cases of measles were reported as of 6 June 2025, in 168 Member States across the six WHO regions, of which 88,853 (47.1%) were confirmed.<sup>1</sup> 35% of cases are reported in the WHO Eastern Mediterranean Region (EMR), followed by the WHO Africa Region (AFR) with 21% of cases, and WHO Europe Region (EURO) with 16% of cases (**Figure 1**) (1).

**Figure 1.** WHO measles case distribution by month and region, 2025 (up to epidemiological week 24).



**WHO Regions:** **AFR:** WHO African Region; **AMR:** WHO Americas Region; **EMR:** WHO Eastern Mediterranean Region; **EUR:** WHO European Region; **SEAR:** WHO South-East Asia Region; **WPR:** WHO Western Pacific Region.

**Source:** Adapted from data published by the World Health Organization. Immunization data- Provisional measles and rubella data. Geneva: WHO; 2025 [cited 27 June 2025]. Available from: <https://immunizationdata.who.int/global?topic=Provisional-measles-and-rubella-data&location=>.

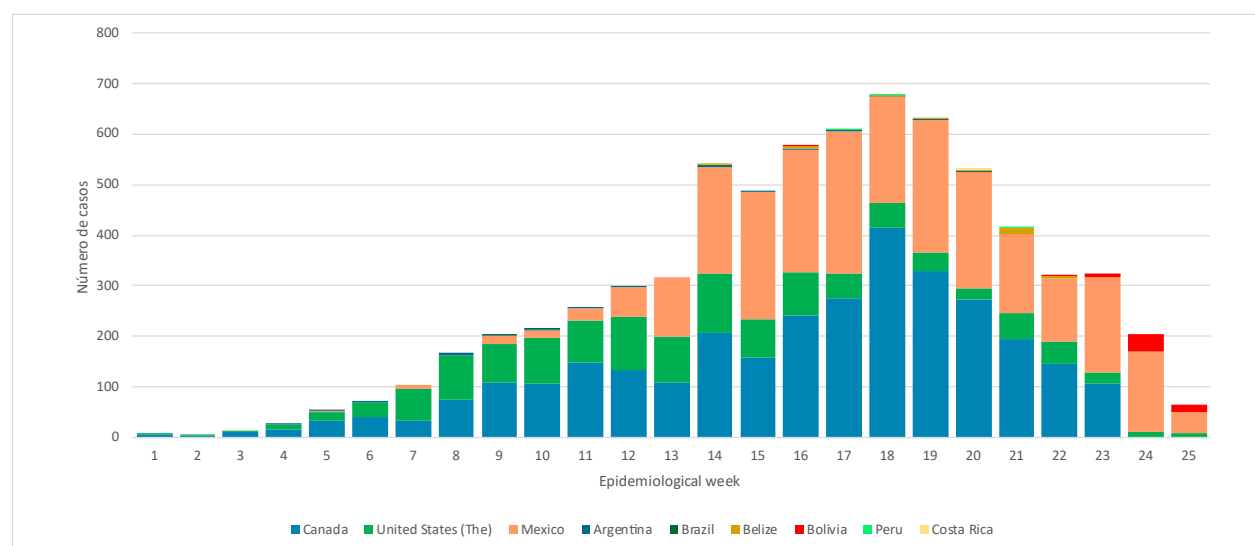
<sup>1</sup> Confirmed cases include those confirmed by laboratory, clinical, or epidemiological criteria.

## Summary of the situation in the Americas Region

In 2025, between epidemiological week (EW) 1 and EW 24, in the Americas Region, 7,132 measles cases have been confirmed, including 13 deaths, in Argentina (n= 34), Belize (n= 34), the Plurinational State of Bolivia (n= 60), Brazil (n= 5), Canada (n= 3,170, including one death),<sup>2</sup> Costa Rica (n= 1 case), Mexico (n= 2,597 cases, including nine deaths), Peru (n= 4 cases), and the United States of America (n= 1,227, including three deaths) (**Figure 2**) (2-10). This total represents a 29-fold increase compared to the 244 cases of measles reported in the same period of 2024.

The distribution of confirmed measles cases in the Americas Region by EW shows an increase in cases as of EW 3 of 2025, with the maximum number of cases recorded in EW 18 related to outbreaks in vaccine hesitant communities settled in several countries of the region. According to the information available from confirmed cases, the age group with the highest proportion of cases corresponds to the 10-19 years old group (22%), the 20-29 year old group (20%), and the 1-4 year old group (17%). However, the incidence rate is higher in children under 1 year of age (2.9 cases per 100,000 population), followed by the 1 to 4 years group (2.3 cases per 100,000 population) and 5 to 9 years (1.4 cases per 100,000 population). Regarding the history of vaccination, 56% of the cases were not vaccinated and in 35% this information was unknown or absent (**Figure 3**) (11).

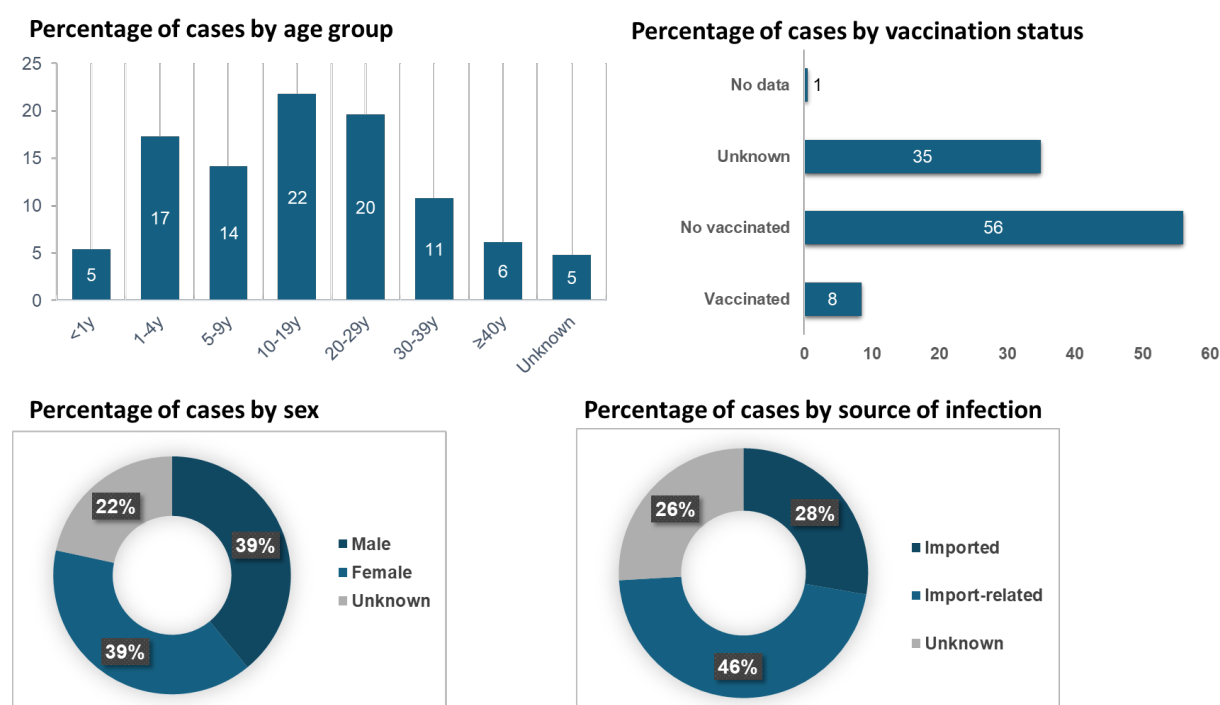
**Figure 2.** Confirmed\* measles cases by EW of onset of rash or notification and country in the Americas Region, 2025 (up to EW 25).



**\*Note:** Includes confirmed and probable cases for Canada.  
**Source:** Adapted from data provided by the respective countries (2-10).

<sup>2</sup> In Canada, measles cases include confirmed and probable cases.

**Figure 3.** Percentage distribution of confirmed measles cases by age group, sex, vaccination status, and source of infection in the Americas Region through EW 25 of 2025.



**Source:** Adapted from the Pan American Health Organization. Integrated Surveillance Information System (ISIS) for polio, measles, rubella and congenital rubella syndrome and country reports to CIM/PAHO. Washington, D.C.: PAHO; 2025 [cited 25 June 2025]. Unpublished.

## Measles epidemiological situation in 2025 by country in the Americas Region

The following is an update on the epidemiological situation of measles in countries that have reported confirmed cases in the Americas in 2025. Since the 2 May 2025 Pan American Health Organization / World Health Organization (PAHO/WHO) epidemiological update on measles in the Americas, the countries that have reported confirmed cases are Argentina, Belize, Bolivia, Brazil, Canada, Costa Rica, Mexico, Peru, and the United States (**Figure 4**) (2-10, 12).

In **Argentina**, between EW 1 and EW 24 of 2025, 34 measles cases have been confirmed, in the Autonomous City of Buenos Aires (CABA) (n= 13), the province of Buenos Aires (n= 20) and San Luis (n= 1). Of the total number of confirmed cases, six are imported, 24 are import related, and four remain under investigation to establish the possible link with the chains of transmission of imported cases (2, 13). As for the cases classified as imported, two are from Russia (Genotype B3 DSID 9240), one from Thailand (Genotype D8 DSID 5963 Jerk lineage), one from Mexico (Genotype D8 DSID 9171 Ontario lineage), and two are from England (Genotype B3 DSID 6418 Quetta lineage). Regarding the import related cases, the epidemiological investigation and/or genotyping of the National Reference Laboratory (NRL) was able to identify that 24 of the cases belong to the same chain of transmission of the cases imported from Russia. Four of the cases are still under investigation to determine their possible relationship with the chains linked to confirmed cases (2, 13).

Measles cases in Argentina are distributed in an age range of 5 months to 40 years, 47% (n= 16) of the cases correspond to children under 5 years of age, 21% (n= 7) to cases between 5

and 19 years of age, and 32% (n= 11) to adults over 20 years of age. Regarding the history of measles vaccination, in 21% (n= 7) of the cases, vaccination was not appropriate because they were under one year of age; 41% (n= 14) had an unknown vaccination history or had no dose applied, 12% (n= 4) had a single dose of MMR vaccine, and 26% (n= 9) had two doses of MMR. 6% (n= 2) of the cases required hospitalization due to pneumonia (2, 13).

In **Belize**, between EW 1 and EW 26 of 2025, 34 measles cases of measles have been confirmed. Of these, ten were confirmed by laboratory tests and 24 by epidemiological link. The confirmed cases have been identified in the Districts of Cayo (n= 33 cases) and Corozal (n= 1 cases). Of the total number of confirmed cases, four are imported and 30 are import related. The imported cases have a history of travel to Mexico between January and April 2025. The cases were distributed in an age range of 0 to 45 years, with 20.6% (n= 7) being under 5 years of age, 58.8% (n= 20) between 5 and 19 years of age, and 20.6% (n= 7) over 20 years of age. Regarding the history of measles vaccination, 100% (n= 34) were not vaccinated or had an unknown vaccination history at the time of diagnosis. Only one case required hospitalization (3).

In **Bolivia**, between EW 1 and EW 24 of 2025, 60 measles cases have been confirmed, one import related and the rest with a source of infection under study. Of the total confirmed cases, 95% (n= 57) are in the department of Santa Cruz, distributed in 10 municipalities. The remaining 5% (n= 3) occurred in two departments: La Paz (n= 2) and Potosí (n= 1 case). The first case reported in 2025 corresponds to a 14-month-old child, with a history of travel to Brazil. The second case, reported on 2 June, corresponds to a 22-year-old female, who participated in a massive event with national and international attendees, which took place in the municipality of Santa Cruz de la Sierra (4, 14).

The cases were distributed in an age range of 9 months to 44 years, 30.0% (n= 18) of the cases corresponded to children aged 5 to 9 years, 28.3% (n= 17) to people aged 10 to 19 years, 25.0% (n= 15) to children aged 1 to 4 years, 3.3% (n= 2) to those over 40 years of age, and 3.3% (n= 2) to children under 1 year of age. 37% (n= 22) are female and 63% (n= 38) are male. Regarding the history of measles vaccination, 80% of the cases (n= 48) were unvaccinated or had an unknown vaccination history, including 26 cases that correspond to people from communities with low levels of coverage who interact with each other; 7% (n= 4) had one dose of measles vaccine; 7% (n= 4) had two doses of measles vaccine; and 7% (n= 4) had three doses of measles vaccine. None of the cases required hospitalization (4, 14).

In **Brazil**, between EW 1 and EW 22 of 2025, five measles cases were confirmed in the Federal District (n= 1 case), Rio de Janeiro (n= 2 cases), São Paulo (n= 1 case), and Rio Grande do Sul (n = 1 case) (5). The cases in Rio de Janeiro correspond to two unvaccinated infants under 8 months of age. The B3 genotype was identified, with 99.8% genomic identity with the MVs/Quetta.PAK/44.20 strain, corresponding to the MVs/São João de Meriti.BRA/9.25 (case 1) and MVs/São João de Meriti.BRA/10.25 (case 2) lineage. The cases in the Federal District and Rio Grande do Sul were classified as imported. Both correspond to adult females with a history of international travel. The case from Mexico City involves a 35-year-old female with five doses of measles vaccine and a history of travel to the United States, Singapore, the Philippines, and Australia before the onset of symptoms. The D8 genotype was identified, with 100% genomic identity with strains detected in the Western Pacific (Philippines) and Southeast Asia (Indonesia), and 99.8% genomic similarity with the MVs/Pasaman Barat strain.IDN/13.22. The case of Rio Grande do Sul corresponds to a 50-year-old female with a history of travel to the United States, whose genotype B3 was identified, with 100% genomic identity with the

MVs/New South Wales lineage.AUS/10.24 and with another 180 sequences detected in the Americas (Canada, the United States and Mexico), Europe (Austria, Belarus, France, Germany, Italy, Spain, Sweden, Switzerland, and the United Kingdom), South-East Asia (Thailand), and the Western Pacific (Australia, Cambodia, China, Japan, Malaysia, Mongolia, New Zealand, the Republic of Korea, Singapore, and Viet Nam) (5). The case reported in São Paulo corresponds to a 31-year-old male, with no history of international travel and vaccinated with three doses against measles. The source of infection for this case remains unknown (5).

In **Canada**, between EW 1 and EW 23 of 2025, 3,170 cases of measles (2,885 confirmed and 285 probable), including one death, were reported in nine provinces and territories: Alberta (n= 843), British Columbia (n= 12), Manitoba (n= 106), Northwest Territories (n= 1), New Scotia (n= 1), Ontario (n= 2,118, including one death), Prince Edward Island (n= 2), Québec (n= 36), and Saskatchewan (n= 51). Measles cases reported to date in 2025 far exceed the 177 confirmed and probable cases detected in 2024 and constitute the highest annual number of cases since elimination was achieved in 1998 (6, 16). One death has been reported, corresponding to an infant with congenital measles, born prematurely and with other serious medical complications not related to the virus (15).

Of the total cases reported in 2025, 93% (n= 2,935) were exposed in Canada, 1% (n= 45) were imported cases, and 6% (n= 190) have an unknown or investigational source of exposure. 46% of cases were between 5 and 17 years old, followed by 28% who were over 18 years old and 19% who were children between 1 and 4 years old. In terms of vaccination history, 85% were unvaccinated, 2% had received one dose of measles vaccine, and 5% had received two or more doses. By age group, the percentage of cases that received one or more doses of measles vaccine was 2% in children aged 1 to 4 years, 3% in cases aged 5 to 17 years, and 21% in adults aged 18 years and older. 8% of the cases were hospitalized (n= 243). Among the confirmed cases with available genotyping information, genotype D8 was identified in 687 cases and genotype B3 in 29 cases (6, 16).

Most of the cases reported in 2025 are related to a multi-jurisdictional outbreak affecting unvaccinated people in communities with low levels of coverage that interact with each other. The outbreak began in late 2024. Between 27 October 2024 and 7 June 2025, 2,248 cases have been reported in ten provinces and territories associated with this outbreak (Alberta, British Columbia, Manitoba, New Brunswick, Northwest Territories, New Scotia, Ontario, Prince Edward Island, Québec and Saskatchewan). The outbreak originated from an imported case who attended an event in New Brunswick in October 2024, which was attended by people from multiple provinces. The majority of cases related to this outbreak were either unvaccinated (84%) or had unknown vaccination status (12%) (6, 16).

In **Costa Rica**, between EW 1 and EW 24 of 2025, an imported case of measles was confirmed in the province of Guanacaste. It is an 18-year-old female who entered the country on 3 May 2025 from Canada. The case had no history of vaccination. The patient began symptoms on 11 May with fever and general malaise, presenting with rash on 12 May. The case was hospitalized on 13 May as a precautionary measure, without developing complications associated with the disease, and was confirmed by RT-PCR on 15 May by the Costa Rican Institute for Research and Teaching in Nutrition and Health (INCIENSA). No secondary cases or deaths have been recorded (7).

In **Mexico**, between EW 1 and EW 24 of 2025, 2,597 measles cases have been confirmed, including nine deaths. Cases were reported in Campeche (n= 6), Chihuahua (n= 2,417, including eight deaths), Coahuila (n= 13), Durango (n= 15), Guanajuato (n= 2), Guerrero (n= 5), Michoacán (n= 13), Oaxaca (n= 4), Querétaro (n= 1), Quintana Roo (n= 1), San Luis Potosí (n= 1), Sinaloa (n= 2), Sonora (n= 78, including one death), Tabasco (n= 1), Tamaulipas (n= 12), Yucatán (n= 1), and Zacatecas (n= 20) (8).

Of the confirmed cases, 52.5% are female (n= 1,364) and 47.5% male (n= 1,233). The most affected age group was 25 to 29 years old with 14.9% (n= 368), followed by the 30 to 34 year old group with 12.3% (n= 320). Regarding vaccination history, 92.4% (n= 2,396) did not have vaccination, 3.8% (n= 101) had one dose of MMR, and 3.8% (n= 100) had two or more doses of MMR documented in the national vaccination card. Among the confirmed cases with available genotyping information, genotypes B3 and D8 were identified (8).

In **Peru**, between EW 19 and EW 24 of 2025, four measles cases were confirmed in the province of Lima. Two imported cases and two import-related cases. The first two cases correspond to two children aged 8 and 11 years, residents of the district of Ate, without a history of vaccination against measles and with a history of travel and stay in the United States where they had direct contact with a confirmed measles case. The two import related cases correspond to two adults aged 23 and 34 years, health personnel who provided direct care to the index case, the first with a history of two doses of measles vaccine and the second case without evidence of vaccination history (9).

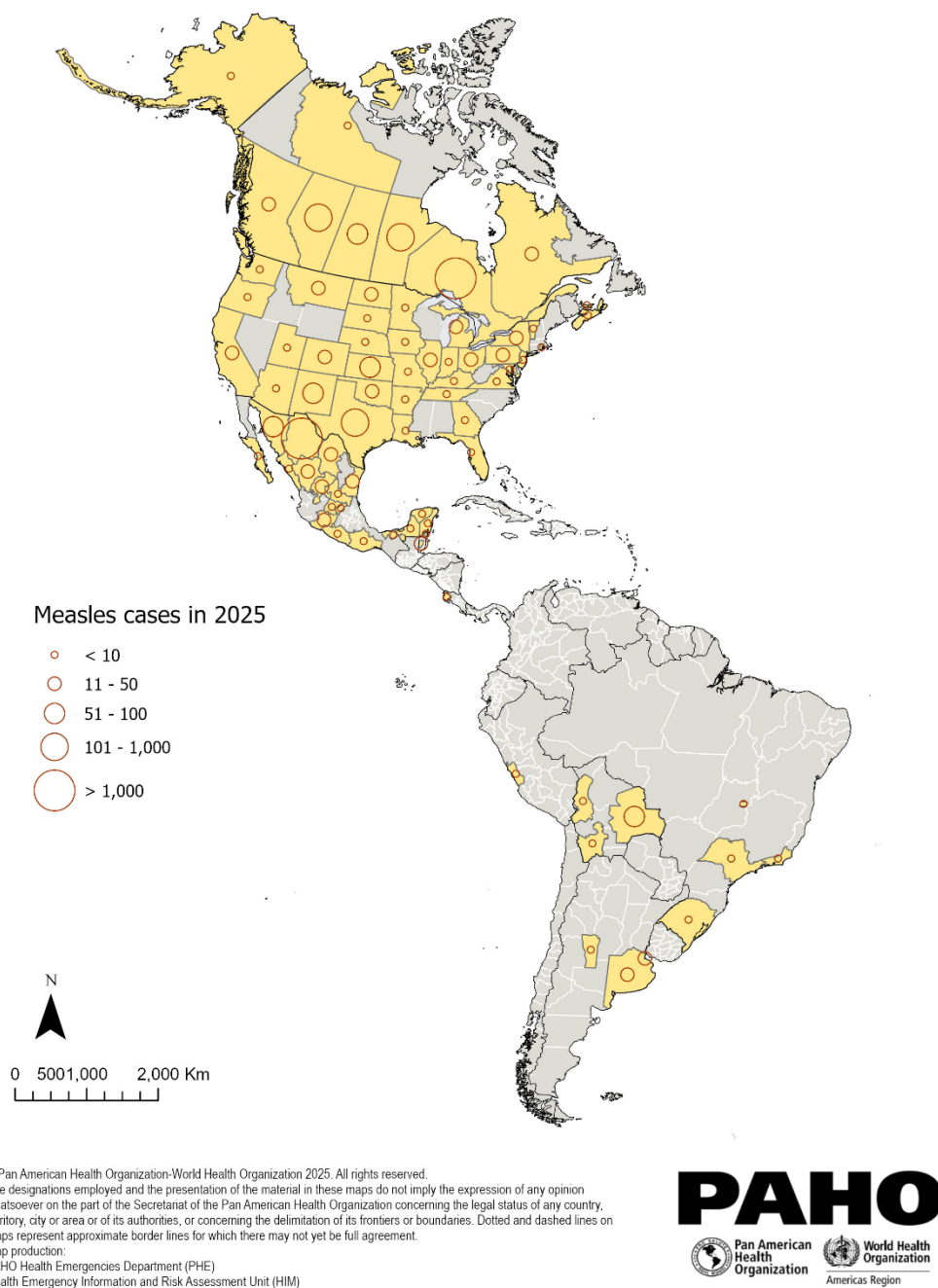
In the **United States**, between EW 1 and EW 25 of 2025, 1,227 measles cases, including three deaths, have been reported in 37 jurisdictions: Alaska, Arkansas, Arizona, California, Colorado, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maryland, Michigan, Minnesota, Missouri, Montana, Nebraska, New Jersey, New Mexico (including one death), New York City, New York State, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Dakota, Tennessee, Texas (including two deaths), Utah, Vermont, Virginia, and Washington (10, 17).

Of the total cases, 89% (n= 1,088) are associated with outbreaks (defined as three or more cases), with 23 outbreaks identified this year. An outbreak in the states of Texas, New Mexico, and Oklahoma accounts for 69% of reported cases. By age group, 29% (n= 355) of the cases correspond to children under 5 years of age, 37% (n= 455) to cases between 5 and 19 years of age, 33% (n= 404) to adults over 20 years of age, and 1% (n= 13) to cases of unknown age. In terms of vaccination, 95% of cases were unvaccinated or had an unknown vaccination history, 2% had one dose of measles vaccine, and 3% had two doses. Among the confirmed vaccinated cases, 17% are under 5 years of age, 13% are cases between 5 and 19 years of age, 68% adults over 20 years of age, and 2% of unknown age (10, 17).

Of the total cases, 12% (n= 148) required hospitalization, mainly children under 5 years of age with 20% (n= 72). MMR vaccination coverage in children has decreased in recent years, from 95.2% in 2019-2020 to 92.7% in 2023-2024 (10, 17).



**Figure 4.** Geographic distribution of confirmed measles cases by subnational level (in yellow) in the Americas Region, 2025 (up to EW 25).



**Source:** Adapted from data provided by the respective countries (2-10).

## Guidance to Member States

In the current context of the persistence of measles cases in the Americas Region thus far in 2025, the Pan American Health Organization / World Health Organization (PAHO/WHO) recommends that Member States intensify efforts to sustain the elimination of measles, rubella, and congenital rubella syndrome.

Considering the risk factors mentioned above, and the current regional context, the following are recommendations related to vaccination, surveillance, and rapid response (18, 19):

### Vaccination

#### a. Countries with active outbreaks:

- In countries with community transmission, with long chains of transmission, wide geographical dispersion and difficulty in identifying the source of infection, implement indiscriminate mass vaccination activities (an additional dose of MMR or SR vaccine) to affected groups.
- In countries with outbreaks with small chains of transmission, limited number of cases in clearly identified geographical areas and sources of known transmission:
  - I. Implement selective vaccination strategies starting with containment vaccination within the first 48 to 72 hours after the notification of a suspected or confirmed case, in an area of 25 blocks surrounding the residence of each case (an area of 5 by 5 blocks). Containment vaccination should also be implemented along the movement route of the case, considering frequently visited places, educational institutions, or workplace during the period of transmissibility.
  - II. If the intervention occurs after the first 72 hours from case notification (whether suspected or confirmed), or if the containment vaccination was ineffective, a documented mop-up vaccination should be implemented. The mop-up should cover a larger area than the containment vaccination, ideally a radius of 5 blocks from the block of residence of the case (121 blocks in urban areas) and in other locations considered to have or potentially have an increased risk of new case occurrence.
  - III. In the event of community transmission with long chains of transmission or a high proportion of confirmed cases without a known source of infection and/or spread to other geographical areas, selective vaccination strategies should shift to mass vaccination strategies, including the use of an additional vaccine dose regardless of prior vaccination history, in the most affected age groups and populations.
  - IV. Conduct rapid vaccination monitoring in the intervened areas to identify zones that require additional vaccination interventions.



**b. All countries:**

- **Vaccinate all close contacts** of confirmed cases and suspected cases, up to 39 years of age (or according to local epidemiological analysis), with an additional dose of measles-rubella (MR) or MMR vaccine, as appropriate, in the first 72 hours. This should include the areas of movement of confirmed cases during the period of transmissibility of the disease.
- **Maintain a stockpile of** MR and/or MMR vaccine, and syringes/supplies for prevention and control actions in the event of imported cases.
- **Implement vaccination intensification activities** based on the results of the measles and rubella risk analysis, with the aim of closing coverage gaps, prioritizing municipalities at greatest risk.
- **Strengthen micro-planning of routine immunization services** to achieve vaccination coverage of at least 95% with two doses of the vaccine. PAHO has developed guidelines that can be very useful for this work.
- **Offer vaccination to travelers** through medical brigades or fixed vaccination posts, ensuring their access at strategic points. Implement zero doses in children from 6 to 11 months of age who visit areas with active transmission of the disease.
- **Increase efforts to achieve vaccination coverage in reluctant populations**, including awareness-raising activities aimed at local authorities, community and religious leaders, as well as other social actors and key government sectors, such as the education sector. In addition, carry out complementary vaccination activities in host communities or areas surrounding reluctant populations to close immunity gaps and strengthen community protection.

**Surveillance**

**a. Countries with active outbreaks:**

- Activate the rapid response teams that are trained, incorporating all relevant sectors.
- Implement the situation room for data analysis and decision-making. This should include detailed analysis of cases, including their route of movement and analysis of vaccination activities implemented.
- In areas with community transmission, it is recommended to use a more specific case definition and document the definition change.
- Likewise, in case of not being able to confirm suspected cases by laboratory, use the classifications of confirmed case by clinical criteria (presence of fever, rash, cough, coryza, and conjunctivitis) and epidemiological link, so as not to delay the implementation of response actions.

**b. All countries:**

- **Strengthen epidemiological surveillance** in areas considered high-risk, border areas, and areas with epidemiological silence, through the implementation of active searches both in health services and in the community.
- **Adopt and adapt PAHO's recent guidance** on active case finding when implementing this surveillance strategy, following the recommendations of the Regional Commission for Measles, Rubella, and Congenital Rubella Syndrome issued at its 2024 meeting, available in Spanish from: <https://www.paho.org/es/documentos/orientaciones-para-busqueda-activa-casos-paralisis-flacida-aguda-sarampion-rubeola> (20).
- **Obtain serum, nasopharyngeal swab, and urine samples** (21) from all suspected cases of measles or rubella, to enhance the corresponding analysis for both laboratory confirmation through real-time RT-PCR serological and molecular testing and genomic sequencing to document the genotype associated with the infection.
- **Classify suspected cases** with positive IgM results considering clinical, epidemiological, and laboratory criteria, with the participation of surveillance, laboratory, and immunization delegates, as well as the national commission for the sustainability of measles and rubella elimination.

**Rapid Response**

- **Review and, if necessary, adjust operational preparedness and rapid response plans**, strengthening the capacity of health systems mainly in the risk areas mentioned in the **Vaccination** section.
- **Initiate a timely response to imported measles or rubella cases**, including the activation of trained rapid response teams and the implementation of national rapid response protocols (22, 23).
- **Establish adequate in-hospital management for cases** to avoid nosocomial transmission, particularly during outbreaks. This involves maintaining an adequate flow of patient referral in isolation rooms (at any level of care), avoiding contact with other patients in common rooms such as waiting rooms and hospitalization rooms.
- **Train health personnel**, with emphasis on rapid response teams, in response to outbreaks. PAHO has self-study online courses, available in Spanish, for this purpose: 1) Rapid Response to Measles and Rubella Outbreaks in the Americas <https://campus.paho.org/es/curso/brote-sarampion-rubeola> (22); 2) Measles Outbreak in the post-elimination era: A case study. <https://campus.paho.org/es/curso/BroteSarampionPostEliminacion> (23).
- **Activate administrative measures** that facilitate the directing of resources and articulated work with the different related sectors (education, tourism, transportation, labor, among others) to implement rapid response measures to measles outbreaks.

## Mass gatherings and international travelers

The latest recommendations on mass events and international travelers in the Region of the Americas are available in the PAHO/WHO epidemiological alert on measles published on February 28, 2025, available at: <https://www.paho.org/es/documentos/alerta-epidemiologica-sarampion-region-americas-28-febrero-2025> (24).

## Guidance on dissemination

PAHO/WHO recommends national authorities consider disseminating the guidance in this document through the following channels:

- Public awareness campaigns to promote and improve the health of travelers before and after their trip to enable them to behave responsibly in relation to measles vaccination, as well as awareness of the signs and symptoms of measles. For this activity, considering medical care services or clinics for travelers, airports, ports, train and bus stations, airlines operating in the country, among others, is recommended.
- Travel agencies, tourism-related entities, and diplomatic corps should also be aware of and disseminate the necessary recommendations that a traveler should take into account prior to traveling.
- Communication with doctors and other health workers of the contents of existing national surveillance guidelines, as well as timely dissemination of any new protocols that the country develops in relation to travelers.

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