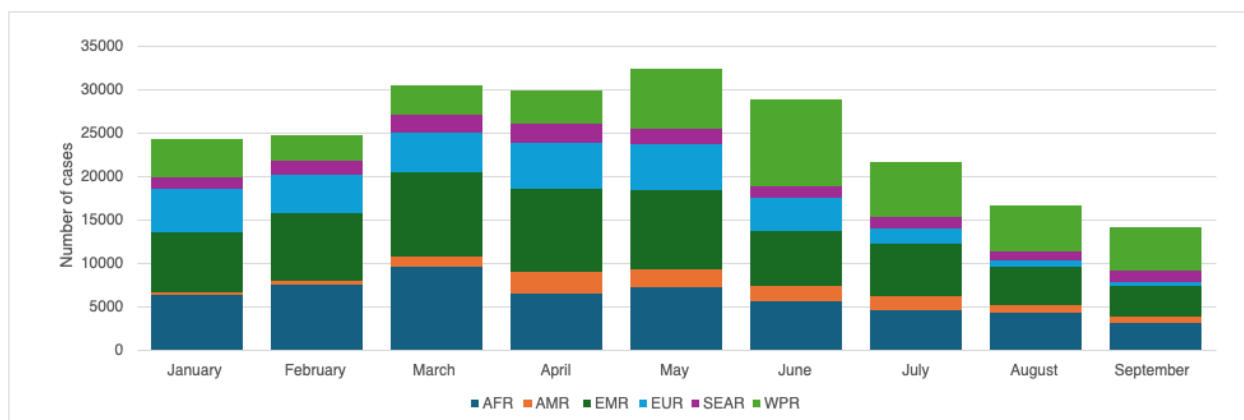


The sharp increase in measles cases in the Americas Region during 2025 and early 2026 is a warning sign that requires immediate and coordinated action by Member States. The Pan American Health Organization / World Health Organization (PAHO/WHO) urges Member States to prioritize strengthening routine surveillance and vaccination activities, and to ensure a rapid and timely response to suspected cases. The implementation of active community, institutional, and laboratory searches for early case identification, as well as developing complementary vaccination activities aimed at closing immunity gaps is also recommended.

Global summary

According to monthly data on measles and rubella surveillance published by the World Health Organization (WHO), between 1 January 2025 and 1 January 2026, a total of 552,699 suspected cases of measles were reported in 179 Member States across the six WHO regions, of which 247,623 (44.8%) were confirmed¹. Twenty-eight percent of cases were reported in the WHO Eastern Mediterranean Region, followed by the WHO African Region with 25% of cases and the WHO European Region with 22% of cases (**Figure 1**) (1).

Figure 1. Distribution of measles cases by month and WHO region, 2025.



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

Source: Adapted from data published by the World Health Organization. Immunization data—Provisional measles and rubella data. Geneva: WHO; 2026 [cited 21 January 2026]. Available from: <https://immunizationdata.who.int/global?topic=Provisional-measles-and-rubella-data&location=1> (1).

¹ Includes cases confirmed by laboratory, clinical, or epidemiological criteria.

Suggested citation: Pan American Health Organization/World Health Organization. Epidemiological Alert: Measles in the Americas Region, 3 February 2026. Washington, D.C.: PAHO/WHO; 2026.

Summary of the situation in the Americas Region

In 2025, between epidemiological week (EW) 1 and EW 53, 14,891 cases of measles were confirmed in the Americas Region, including 29 deaths, of which 22 (73%) occurred in indigenous populations (2). Cases were reported by Argentina (n= 36 cases), Belize (n= 44 cases), the Plurinational State of Bolivia (n= 597 cases), Brazil (n= 38 cases), Canada (n= 5,436 cases², including two deaths), Costa Rica (n= 1 case), El Salvador (n= 1 case), the United States of America (n= 2,242 cases, including three deaths), Guatemala (n= 1 case), Mexico (n= 6,428 cases, including 24 deaths), Paraguay (n= 49 cases), Peru (n= 5 cases), and Uruguay (n= 13 cases) (**Table 1**) (**Figure 2**) (3-21). This total represents a 32-fold increase compared with the 466 measles cases reported in 2024 (2). Compared with the historical record of measles in the Region, the number of confirmed measles cases in 2025 was the highest since 2019, which was the year with the highest number of cases in the last 22 years (n= 23,269) (**Figure 3**) (22-23).

In 2026, between EW 1 and EW 3, 1,031 cases of measles were confirmed in the Americas Region, with no deaths reported. The cases were reported by Bolivia (n= 10 cases), Canada (n= 67 cases), Chile (n= 1 case), the United States of America (n= 171 cases), Guatemala (n= 41 cases), Mexico (n= 740 cases), and Uruguay (n= 1 case) (**Table 1**) (3-21). This total represents a 45-fold increase compared with the 23 measles cases reported during the same period in 2025 (2, 25).

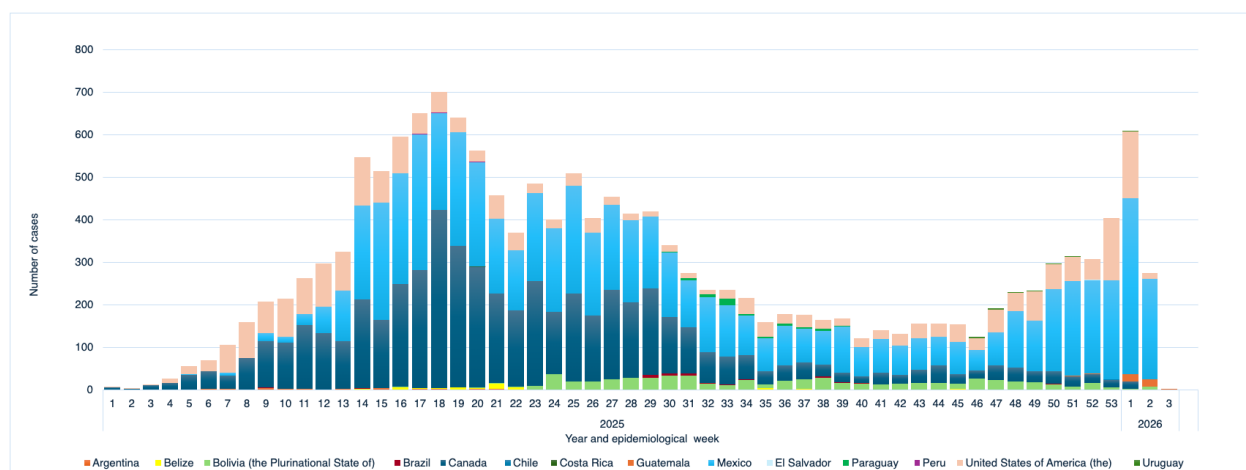
Table 1. Distribution of cases by epidemiological week 2025 and 2026, by country

Country	No. of cases EW 53 of 2025	No. of cases EW 2 of 2026	Last date of onset of rash (EW)
Argentina	36		EW 49 in 2025
Belize	44		EW 45 of 2025
Bolivia (Plurinational State of)	597	10	EW 2 of 2026
Brazil	38		EW 50 of 2025
Canada	5,436	67	EW 2 of 2026
Chile	0	1	EW 53 of 2025
Costa Rica	1		EW 20 of 2025
El Salvador	1		EW 52 of 2025
Guatemala	1	41	EW 2 of 2026
Mexico	6,428	740	EW 2 of 2026
Paraguay	49		EW 39 of 2025
Peru	5		EW 44 of 2025
United States of America	2,242	171	EW 2 of 2026
Uruguay	13	1	EW 2 of 2026
Total	14,891	1,031	

Source: Adapted from data provided by the respective countries (3-21).

² In Canada, measles cases include confirmed and probable cases.

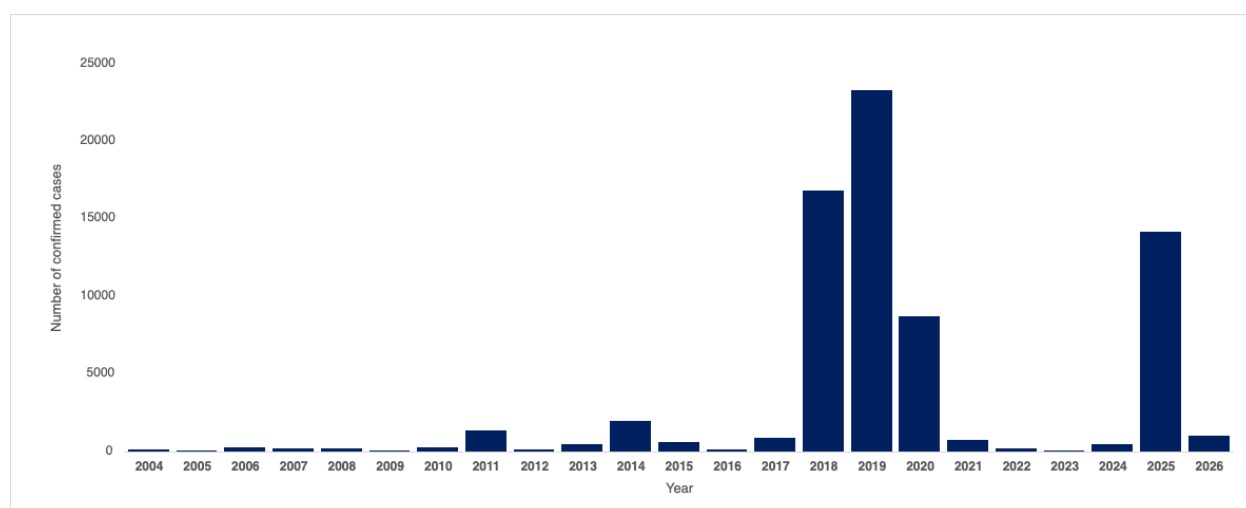
Figure 2. Confirmed* measles cases per epidemiological week of rash onset or notification and country in the Americas Region, 2025-2026 (as of EW 3 of 2026).



***Note:** Includes confirmed and probable cases for Canada.

Source: Adapted from data provided by the respective countries (3-21).

Figure 3. Confirmed* measles cases per year in the Americas Region, 2025-2026 (as of EW 3 of 2026).



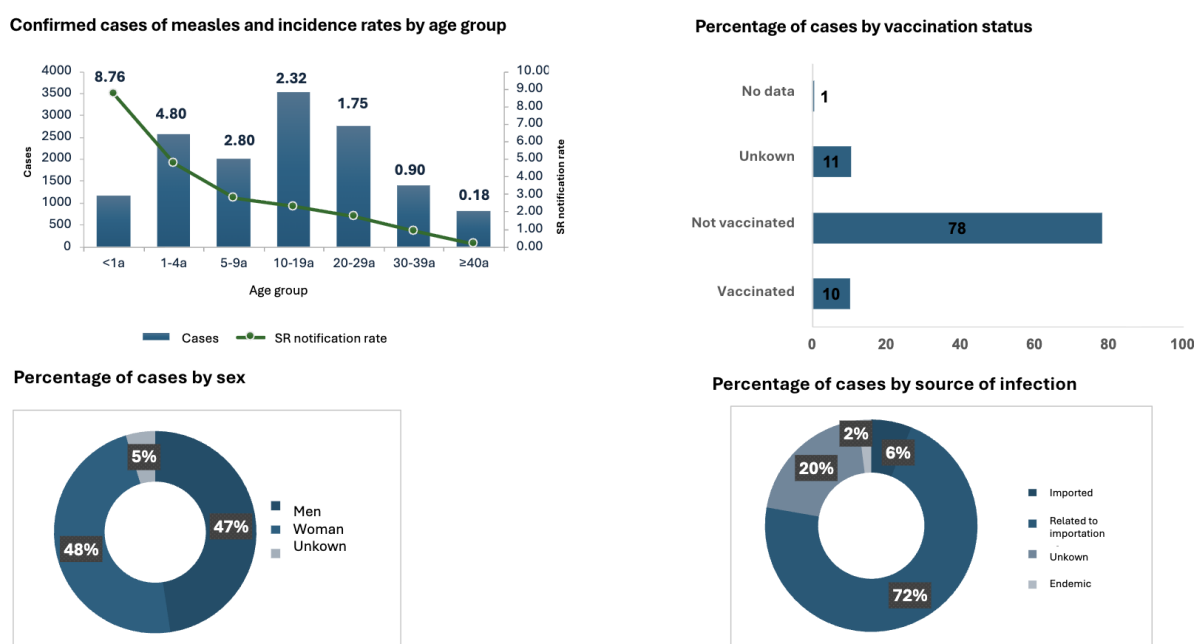
Source: Adapted from the Pan American Health Organization/World Health Organization. Number of Vaccine Preventable Disease (VPD) cases in the Americas and Weekly Measles/Rubella Bulletin (22-25).

The distribution of confirmed measles cases in the Americas Region by EW shows a gradual increase starting in EW 3 of 2025, reaching the highest number of cases in EW 18 in the context of outbreaks occurring in communities with low vaccination acceptance in several countries in the Region. In the last four epidemiological weeks of 2025 and early 2026, there was a significant increase in the number of reported cases (**Figure 2**) (21-25).

According to the information available in the Integrated Surveillance Information System (ISIS) for poliomyelitis, measles, rubella, and congenital rubella syndrome, among the cases

confirmed in 2025 (n= 14,640), the 10-19 age group accounts for the highest proportion of cases (24%), followed by the 20-29 age group (19%) and the 1-4 age group (18%). However, the incidence rate is inversely related to age, being highest in children under one year of age (8.8 cases per 100,000 population), followed by the 1-4 age group (4.8 cases per 100,000 population) and the 5-9 age group (2.8 cases per 100,000 population). The rates remain above 1 case per 100,000 population up to the 20-29 age group (2). With regard to vaccination history, 78% of cases were unvaccinated and in 11% the information was unknown or unavailable. According to the classification by source of infection, 6% of cases were imported, 71% were associated with importation, 20% were of unknown source of infection, and 2% were classified as endemic cases (**Figure 3**) (2).

Figure 3. Percentage distribution of confirmed measles cases by age group, sex, vaccination status, and source of infection in the Americas Region as of EW 53 of 2025.

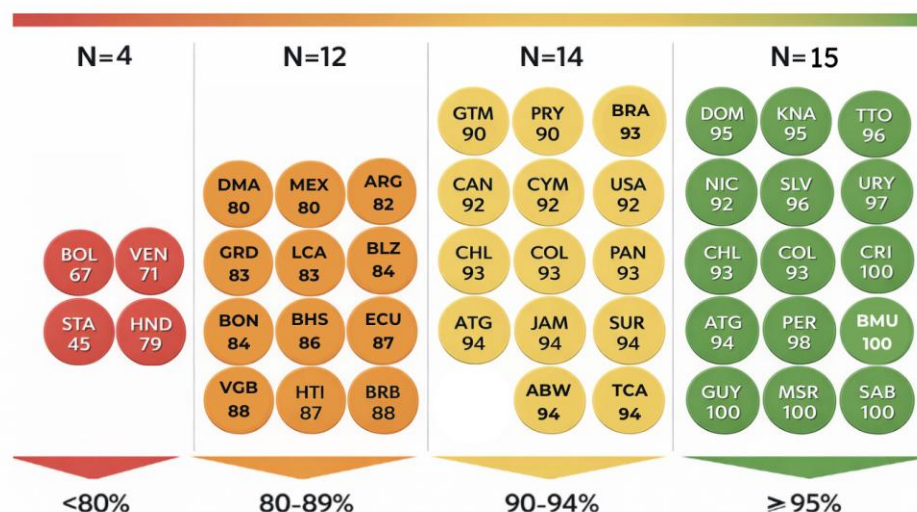


Source: Adapted from Pan American Health Organization. Integrated Surveillance Information System (ISIS) for poliomyelitis, measles, rubella, and congenital rubella syndrome, and country reports to PAHO Comprehensive Immunization. Washington, D.C.: PAHO; 2026 [cited 28 January 2026]. Unpublished (2).

Vaccination coverage in the Americas Region

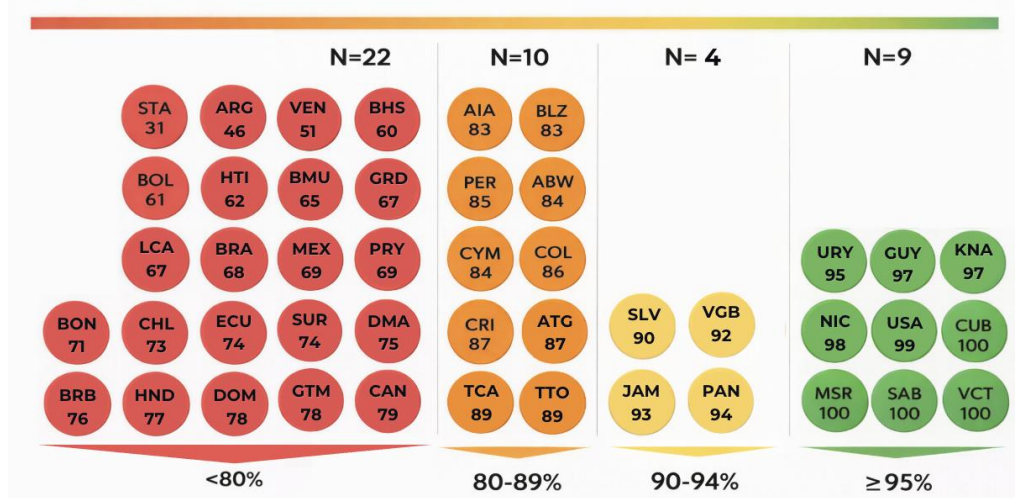
In 2024, a slight increase in regional coverage of the first and second doses of the measles, rubella, and mumps (MMR) vaccine compared to 2023 was observed: from 87% to 89% for MMR1 and from 76% to 79% for MMR2 (15). Likewise, 45 countries and territories in the Americas reported MMR1 and MMR2 vaccination coverage to PAHO (15). With regard to the administration of the first dose of MMR1, 33.3% (n= 15/45) of the countries and territories in the Region reported coverage greater than 95%, 31% (n= 14/45) reported coverage between 90-94%, 27% (n=12/45) reported coverage between 80% and 89%, and 8% (n=4/45) reported coverage below 80% (**Figure 4**) (26). With regard to the administration of the second dose of MMR2, only 20% of countries and territories (n= 9/45) reported coverage levels above 95%, while 48.9% (n= 22/45) reported coverage levels below 80% (**Figure 5**) (26).

Figure 4. Distribution of countries and territories* by coverage range for the first dose of the measles, rubella, and mumps vaccine (MMR1) in the Americas Region, 2024.



Source: Adapted from the Pan American Health Organization/World Health Organization. Immunization coverage throughout the life course in the Americas. Washington, D.C.: PAHO/WHO; 2026 [cited 21 January 2026]. Available from: <https://paho-cim.shinyapps.io/immunization-dashboard/#> (26).

Figure 5. Distribution of countries and territories* by coverage range for the second dose of the measles, rubella, and mumps vaccine (MMR2) in the Americas Region, 2024.



Source: Adapted from Pan American Health Organization/World Health Organization. Immunization coverage throughout the life course in the Americas. Washington, D.C.: PAHO/WHO; 2026 [cited 21 January 2026]. Available from: <https://paho-cim.shinyapps.io/immunization-dashboard/#> (26).

***Note:** ABW: Aruba; AIA: Anguilla; ARG: Argentina; ATG: Antigua and Barbuda; BHS: the Bahamas; BLZ: Belize; BMU: Bermuda; BOL: Bolivia; BON: Bonaire; BRA: Brazil; BRB: Barbados; CAN: Canada; CHL: Chile; COL: Colombia; CRI: Costa Rica; CUB: Cuba; CYM: Cayman Islands; DMA: Dominica; DOM: the Dominican Republic; ECU: Ecuador; GRD: Grenada; GTM: Guatemala; GUY: Guyana; HND: Honduras; HTI: Haiti; JAM: Jamaica; KNA: Saint Kitts and Nevis; LCA: Saint Lucia; MEX: Mexico; MSR: Montserrat; NIC: Nicaragua; PAN: Panama; PER: Peru; PRY: Paraguay; SAB: Saba; SLV: El Salvador; STA: Saint Eustatius; SUR: Suriname; TCA: Turks and Caicos Islands; TTO: Trinidad and Tobago; URY: Uruguay; USA: United States of America; VCT: Saint Vincent and the Grenadines; VEN: Venezuela; VGB: the British Virgin Islands.

Epidemiological situation of measles by country in the Americas Region

The following is a summary of the epidemiological situation of measles in the countries, in alphabetical order, that have reported confirmed cases in the Americas in 2025 and 2026 (**Figure 6**). Since the last epidemiological update on measles in the Americas Region published by PAHO/WHO on 19 September 2025, the countries that have reported confirmed cases are Argentina, Belize, Bolivia, Brazil, Canada, Chile, El Salvador, Guatemala, Mexico, Paraguay, Peru, the United States, and Uruguay (3-21, 27).

In **Argentina**, between EW 1 and EW 53 of 2025, 36 cases of measles have been confirmed. The confirmed cases were reported in the Autonomous City of Buenos Aires (CABA) (n= 21 cases), the provinces of Buenos Aires (n= 13 cases), Entre Ríos (n= 1 case), and San Luis (n= 1 case). Of the total cases, six were imported, 15 were related to importation, 14 had no known source of infection, and one was confirmed with the source of infection under investigation (3). The cases are distributed across an age range between 5 months and 40 years; 50% (n= 18) correspond to children under 4 years of age, 19% (n= 7) to people between 5 and 19 years of age, and 31% (n= 11) to adults 20 years of age or older. The incidence rate by age group shows that the most affected group is children under 4 years of age (5.6 cases per 100,000 population) (3).

Regarding vaccination history, 39% (n= 14) of cases were unvaccinated or had an unknown vaccination history, 17% had received one dose of DPT (n= 6), and 22% had received two doses of DPT (n= 8). Of the total number of cases, 6% required hospitalization (n= 2) (3). According to genotyping performed on samples from confirmed cases (n= 26 samples), the following genotypes have been identified: B3 DSID 9240, D8 DSID 5963 Patán lineage, D8 DSID 9171 MVs/Ontario lineage.CAN/47.24 and genotype B3 DSID 6418 MVs/Quetta lineage.PAK/44.20 (3). Between EW 1 and EW 3 of 2026, no measles cases were confirmed (3). During 2024, national MMR vaccination coverage reached 82.1% for the first dose and 46.4% for the second dose (3).

In **Belize**, between EW 1 and EW 53 of 2025, a total of 44 measles cases were confirmed. Of these, 13 were confirmed by laboratory testing and 31 by epidemiological link. Confirmed cases were identified in the districts of Cayo (n= 43) and Corozal (n= 1). Of the total confirmed cases, seven were imported and 37 were related to importation. Four of the imported cases reported a history of travel to Mexico between January and April 2025, while three imported cases reported a history of travel to Canada between May and September 2025 (4). The cases ranged in age between 0 and 45 years, with 18% (n= 8) under 5 years of age, 64% (n=28) between 5 and 19 years of age, and 18% (n=8) 20 years of age and older. Regarding measles vaccination history, 100% (n= 44) of cases were unvaccinated or had an unknown vaccination history at the time of diagnosis. Only one case required hospitalization (4). Between EW 1 and EW 3 of 2026, no measles cases were confirmed (4). During 2024, national vaccination coverage with the MMR vaccine reached 83.5% for the first dose and 82.9% for the second dose (4).

In **Bolivia**, between EW 1 and EW 53 of 2025, 597 cases of measles have been confirmed in nine departments. Confirmed cases were reported in the departments of Santa Cruz (n= 467 cases), La Paz (n= 41 cases), Cochabamba (n= 36 cases), Beni (n= 14 cases), Tarija (n= 12 cases), Potosí (n= 10 cases), Oruro (n= 9 cases), Chuquisaca (n= 7 cases), and Pando (n= 1 case) (5, 6). The cases are distributed across an age ranging from 0 months to 57 years; 12% (n= 72) correspond to children under 1 year of age, 21% (n= 128) to people between 1 and 4 years of age, 20% (n= 122) to people between 5 and 9 years old, 14% (n= 81) to people between 10 and 14 years old, 12% (n= 70) to people between 15 and 19 years old, and 21%

(n= 124) to adults aged 20 years or older. The incidence rate by age group shows that the most affected group is children under 1 year of age (113 cases per 100,000 population), followed by the 1-4 age group (24 cases per 100,000 population) (5, 6).

In terms of vaccination history, 82% (n= 492) of cases were unvaccinated or had an unknown vaccination history, 8% had received one dose of MMR (n=49), 7% (n=43) had two doses of MMR, and 2% (n= 13) had three or more doses. Of the total cases, 5% (n= 31) required hospitalization (5, 6). According to the genotyping performed on samples from two confirmed cases, genotypes B3 and D8 have been identified (5, 6).

Between EW 1 and EW 3 of 2026, ten cases of measles were confirmed. The cases were reported in two departments. The confirmed cases were reported in the departments of Santa Cruz (n= 9 cases) and Tarija (n= 1 case). The cases correspond to individuals aged between 0 months and 41 years. Regarding vaccination status, none of the confirmed cases had a documented history of vaccination. During this period, no cases required hospitalization (5, 6). During 2025, national MMR vaccination coverage reached 82% for the first dose and 74% for the second dose (7).

In **Brazil**, between EW 1 and EW 53 of 2025, 38 cases of measles have been confirmed in the Federal District and six states. Of the total cases, ten are imported cases, 25 are import-related, and three have an unknown source of infection. Confirmed cases were reported in the Federal District (n= 1 case) and in the states of Maranhão (n= 1 case), Mato Grosso (n= 6 cases), Rio de Janeiro (n= 2 cases), São Paulo (n= 2 cases), Rio Grande do Sul (n= 1 case), and Tocantins (n= 25 cases) (8). The cases are distributed across the following age groups: 30.6% (n= 11) of cases correspond to children under 5 years of age, 22.2% (n= 8) to people between 5 and 19 years of age, and 50.0% (n= 19) to adults over 20 years of age. The incidence rate by age group shows that the most affected age group is children under 5 years of age (0.015 cases per 100,000 population), followed by the 20-29 age group (0.002 per 100,000 population) (8). Regarding the vaccination history of the cases, 94.7% (n= 36) were unvaccinated or had an unknown vaccination history, and 5.3% had a history of measles vaccination (n= 2) (8).

Between EW 9 and EW 49 of 2025, 26 confirmed cases of measles were characterized by genomic analysis in Brazil. Phylogenetic analyses performed with reference strains revealed that two sequences detected in the state of Rio de Janeiro, in EW 9 and EW 10, belong to genotype B3, with 99.8% genomic identity to the strain named MVs/Quetta.PAK/44.20 and the distinct sequence DSId (9299). In the Federal District, a sequence belonging to genotype D8 DSId (9267) was identified in EW 9, with 99.8% genomic identity to the strain named MVs/Pasaman Barat.IDN/13.22. In EW 14 and EW 15, two sequences of genotype B3 DSId (8841) were detected, corresponding to the strain named MVs/New South Wales.AUS/10.24, in the states of São Paulo and Rio Grande do Sul, respectively. Between EW 29 and EW 42, 20 measles cases were genomically characterized in the states of Tocantins, Maranhão, and Mato Grosso, all belonging to genotype D8 DSId (9171) lineage MVs/Ontario.CAN/47.24). In EW 49, genotype B3 DSId (6418), lineage MVs/Quetta.PAK/44.20, was detected in the state of São Paulo (8). Between EW 1 and EW 3 of 2026, there were no confirmed cases of measles in Brazil (8).

During 2024, national MMR vaccination coverage reached 96% for the first dose and 80.6% for the second dose (8).

In **Canada**, between EW 1 and EW 53 of 2025, 5,436 cases of measles (5,056 confirmed and 380 probable) were reported, including two deaths, in ten provinces: Alberta (n= 2,008

cases), British Columbia (n= 424 cases), Manitoba (n= 355 cases), New Brunswick (n= 16 cases), Northwest Territories (n= 1 case), Nova Scotia (n= 62 cases), Ontario (n= 2,396 cases), Prince Edward Island (n= 3 cases), Quebec (n= 45 cases), and Saskatchewan (n= 126 cases). The number of weekly cases peaked in EW 18 of 2025, declined through EW 35, and has since remained stable at lower levels. Two deaths were reported in congenital measles cases born prematurely (9, 10). Of the 5,436 cases reported in 2025, 98% (n= 5,313) were exposed in Canada, 2% (n= 98) were imported cases, and less than 1% (n= 25) had an unknown or under investigation source of exposure. Forty-five percent of cases were in individuals aged between 5 and 17 years, followed by 29% in those aged 18 years and older and 20% in children between 1 and 4 years of age. In terms of vaccination history, 89% were unvaccinated, 3% had received one dose of a measles-containing vaccine, 4% had received two or more doses of a measles-containing vaccine, and 4% had an unknown vaccination status. The vaccination history by age group was as follows: the percentage of cases that had received one or more doses of a measles-containing vaccine was 2% in children aged between 1 and 4 years, 3% in cases between 5 and 17 years, and 18% in adults aged 18 years and older. Seven percent of cases were hospitalized (n= 400). Among confirmed cases with genotyping information available, genotype D8 was identified in 1,732 cases and genotype B3 in 51 cases (9, 10).

In 2026, as of EW 2, 67 cases of measles were reported (63 confirmed and 4 probable). These cases were reported by five provinces: Alberta (n= 31 cases), British Columbia (n= 9 cases), Manitoba (n= 24 cases), Quebec (n= 1 case), and Saskatchewan (n= 2 cases). Of the 67 reported cases, 61 (91%) were associated with the multijurisdictional outbreak that began in October 2024; during 2025, 97% of cases were associated with this outbreak. Of the total cases, 28% (n= 19) were children under 5 years of age, 39% (n= 26) were persons between 5 and 17 years of age, and 32% (n= 22) were persons 18 years of age or older. Ninety-five percent of all reported cases were unvaccinated or had unknown vaccination status, and one hospitalization (1%) was reported (9, 10).

Since 2024, a total of 4,966 confirmed cases and 414 probable cases have been linked to a multijurisdictional outbreak in Canada, which remains active. Most cases associated with the outbreak were unvaccinated or had unknown vaccination status (94%) and resided in interconnected communities with low vaccination coverage. In addition to the multijurisdictional outbreak described above, between EW 1 of 2025 and EW 1 of 2026, eleven outbreaks were reported, of which nine had been closed as of 21 January 2026. These outbreaks consisted of two or more epidemiologically or virologically linked cases and were directly related to imported cases (9, 10).

In **Chile**, in EW 1 of 2026, a confirmed imported case of measles was reported in the Metropolitan Region. The case involved a 43-year-old female who entered the country on 31 December 2025, from Spain and Uruguay. The case had no verifiable vaccination history but reported having received two doses of MMR vaccine. The case developed a rash on 30 December 2025, and was confirmed by RT-PCR on 9 January 2026, by the Chilean Institute of Public Health (ISP per its acronym in Spanish). No secondary cases or deaths related to this case have been reported in the country (11). During 2024, national MMR vaccination coverage reached 95.7% for the first dose and 79.2% for the second dose, and preliminary data for 2025 show MMR vaccination coverage of 86.8% for the first dose and 64.4% for the second dose (11).

In **Costa Rica**, in EW 20 of 2025, an imported case of measles was confirmed in the province of Guanacaste. The case involved an 18-year-old female who entered the country on 3 May 2025, from Canada (12). The case had no history of vaccination, developed a rash on 12

May, and was confirmed by RT-PCR on 15 May by the Costa Rican Institute for Research and Teaching in Nutrition and Health (INCIENSA per its acronym in Spanish). No secondary cases or deaths have been reported (12). During 2024, national MMR vaccination coverage reached 102% for the first dose and 82.9% for the second dose (12).

In **El Salvador**, during EW 53 of 2025, an imported case of measles was reported in the department of Santa Ana. The case involved a 24-year-old male who entered the country on 14 December 2025, after participating in a mass event that took place in Santiago de Atitlán, Guatemala, between 10 and 14 December. The case developed a rash on December 24, 2025, and was confirmed by RT-PCR and positive IgM on December 30, 2025, by the National Public Health Laboratory of El Salvador. No secondary cases or associated deaths were reported in the country (13). During 2024, national vaccination coverage with MMR reached 96.2% for the first dose and 90.1% for the second dose (13).

In the **United States**, between EW 1 and EW 53 of 2025, 2,242 confirmed cases of measles were reported, including three deaths. Of these, 2,217 measles cases were reported by 45 jurisdictions: Alabama (n= 1 case), Alaska (n= 4 cases), Arizona (n= 213 cases), Arkansas (n= 8 cases), California (n= 26 cases), Colorado (n= 35 cases), Connecticut (n= 1 case), Florida (n= 8 cases), Georgia (n= 10 cases), Hawaii (n= 2 cases), Idaho (n= 14 cases), Illinois (n= 14 cases), Indiana (n= 10 cases), Iowa (n= 9 cases), Kansas (n= 91 cases), Kentucky (n= 13 cases), Louisiana (n= 3 cases), Maryland (n= 3 cases), Michigan (n= 29 cases), Minnesota (n= 26 cases), Missouri (n= 6 cases), Montana (n= 36 cases), Nebraska (n= 5 cases), Nevada (n= 2 cases), New Jersey (n= 11 cases), New Mexico (n= 100 cases, including one death), New York City (n= 15 cases), New York State (n= 26 cases), North Carolina (n= 2 cases), North Dakota (n= 36 cases), Ohio (n= 40 cases), Oklahoma (n= 17 cases), Oregon (n= 1 case), Pennsylvania (n= 16 cases), Rhode Island (n= 1 case), South Carolina (n= 299 cases), South Dakota (n= 16 cases), Tennessee (n= 8 cases), Texas (n= 803 cases, including two deaths), Utah (n= 187 cases), Vermont (n= 2 cases), Virginia (n= 6 cases), Washington (n= 11 cases), Wisconsin (n= 36 cases), and Wyoming (n= 15 cases). A total of 25 measles cases were reported among international visitors to the United States (14, 15).

Of the total cases, 89% (n= 1,994) were associated with outbreaks (defined as three or more cases), with 49 outbreaks identified during 2025 (14, 15). Twenty-six percent (n= 575) of cases were in children under 5 years of age, 44% (n= 983) were in people aged between 5 and 19 years, 30% (n= 669) were in people over 20 years of age, and 1% (n= 15) were in people of unknown age. The incidence rate by age group shows that the most affected group was children under one year of age (3.59 cases per 100,000 population), followed by the group aged 1 to under 5 years (2.92 per 100,000 population) (14, 15).

Regarding the vaccination history of the cases, 93% were unvaccinated or had an unknown vaccination history, 3% had received a single dose of the MMR vaccine, and 4% had received two doses. Among the confirmed vaccinated cases, 22% were children under 5 years of age, 19% were people between 5 and 19 years of age, and 59% were adults over 20 years of age. Eleven percent (n= 245) of cases required hospitalization, mainly in children under 5 years of age, with 18% (n= 106) of hospitalized cases concentrated in this age group (n= 575) (14, 15).

In the United States, between EW 1 and EW 2 of 2026, 171 confirmed cases of measles were reported. These cases were reported by nine jurisdictions: Arizona (n= 1 case), Florida (n= 2 cases), Georgia (n= 1 case), North Carolina (n= 2 cases), Ohio (n= 3 cases), Oregon (n= 2 cases), South Carolina (n= 145 cases), Utah (n= 14 cases), and Virginia (n= 1 case). No measles cases were reported among international visitors (14, 15). Of the total cases, 96% (n=

165) were associated with outbreaks identified in 2025. Twenty-five percent (n= 42) of cases were in children under 5 years of age, 60% (n= 103) were in people between 5 and 19 years of age, 10% (n= 17) were in people over 20 years of age, and 5% (n= 9) were in people of unknown age. The incidence rate by age group shows that the most affected group was children aged 1 to under 5 years (0.26 per 100,000 population), followed by the group aged 5 to under 20 years (0.16 per 100,000 population) (14, 15).

Regarding the vaccination history of cases during 2026, 95% were unvaccinated or had an unknown vaccination history, 2% had received a single dose of the MMR vaccine, and 2% had received two doses. Among the confirmed vaccinated cases, 25% were children under 5 years of age, 38% were people between 5 and 19 years of age, and 38% were adults over 20 years of age. One percent (n= 2) of cases required hospitalization, corresponding to children under 5 years of age and persons between 5 and 19 years of age (14, 15).

During 2025 and 2026, of the 751 rRT-PCR-positive samples from confirmed measles cases that have undergone genotyping to date, 86% (n= 648) corresponded to genotype D8 and 14% (n= 103) to genotype B3. Among the D8 genotype detections, the majority, 88% (n= 567), were identified as distinctive sequence (DSId) 9171 (14, 15).

Vaccination coverage with the triple viral vaccine (MMR) in children has declined in recent years, from 95.2% during the 2019–2020 school year to 92.5% during the 2024–2025 school year (14, 15).

In **Guatemala**, in EW 43 of 2025, a confirmed case of measles was identified in a 2-year-old girl residing in the department of Guatemala, in which the source of exposure could not be identified. Additionally, between EW 51 of 2025 and EW 3 of 2026, (as of 21 January) 41 cases of measles in nine departments of the country, of which 31 are related to participation in a mass international event in the municipality of Santiago Atitlán, Sololá, between 10 and 14 December 2025. The confirmed cases were reported in the departments of Sololá (n= 20 cases), Guatemala (n= 9 cases), Izabal (n= 3 cases), Escuintla (n= 3 cases), Totonicapán (n= 1 case), Quetzaltenango (n= 1 case), Jalapa (n= 1 case), Baja Verapaz (n= 1 case), and Petén (n= 2 cases) (16).

Of the total number of confirmed cases during 2026, 54% are male (n= 22). The cases range in age from 5 months to 46 years, distributed across the following age groups: 10% (n= 4) of cases correspond to children aged 0 to 4 years, 10% (n= 4) are children aged 5 to 9 years, 5% (n= 2) are people aged 10 to 14 years, 20% (n= 8) are people aged 15 to 19 years, 5% (n= 2) are people aged 20 to 24 years, 15% (n= 6) to people aged 25 to 29, 27% (n= 11) to people aged 30 to 39, and 10% (n= 4) to people aged 40 to 49. The incidence rate by age group shows that the most affected age group is 15 to 19 years old (0.46 cases per 100,000 population), followed by the 30 to 39 age group with 0.41 cases per 100,000 population (16). Regarding the vaccination history of the cases, 44% (n= 18) were not vaccinated, 12% (n= 5) had an unknown vaccination history, and 18% (n= 8) had verbal reference MMR doses. Seventeen percent of cases required hospitalization (n= 7), and no related deaths have been reported (16). Of the 41 rRT-PCR-positive samples from confirmed measles cases, 12 are undergoing genotyping (16).

By 2024, the country had achieved national MMR vaccination coverage of 91% for the first dose and 79% for the second dose (16).

In **Mexico**, between EW 1 of 2025 and EW 2 of 2026, 7,168 cases of measles have been confirmed in 32 states, with 24 deaths. The majority of the confirmed cases were reported in

the following states: Chihuahua (n= 4,495 cases, including 21 deaths), Jalisco (n= 1,034 cases, including one death), Chiapas (n= 432 cases), Michoacán (n= 261 cases), and Guerrero (n= 257 cases). Of the total cases, 275 were imported, 4,054 were related to importation, and 2,839 were confirmed with the source of infection under investigation (17, 18).

With regard to age group, confirmed cases of measles reported between EW 1 of 2025 and EW 2 of 2026 were most frequently distributed in the 1-4-year age group (1,097 cases), followed by the 5-9 age group (836 cases) and the 25-29 age group (794 cases). In terms of incidence rate, those under 1 year reported the highest rate with 42.52 cases per 100,000 population, followed by the 1-4 and 5-9 age groups, with rates of 12.80 and 7.90, respectively. Of the confirmed cases, 50.9% are female (3,650) (17, 18).

Regarding the vaccination history of confirmed cases, 91.2% (n= 6,534) had no vaccination history, 6.2% (n= 444) had received one dose of MMR, and 2.65% (n= 190) had received two or more doses of MMR documented in the national vaccination card. Of the total number of confirmed cases, 1,354 required hospitalization, of which 962 were from the state of Chihuahua (17, 18). According to the genotyping performed on samples from confirmed cases (n= 220), genotypes D8 and B3 have been identified (20, 21).

Twenty-four deaths from measles complications have been confirmed, all in people with no vaccination history, with comorbidities in some cases. The deaths are distributed among the states of Chihuahua (n=21), Durango (n=1), Jalisco (n=1), and Sonora (n=1) (17, 18).

In **Paraguay**, between EW 30 and EW 53 of 2025, 49 cases of measles were confirmed, with cases reported in the departments of San Pedro (n= 47 cases) and Central (n= 2 cases). Of the total number of cases, 48 are related to importation and one corresponds to an imported case (19).

In terms of demographic characteristics, 61% of cases (n= 30) were female. The age range of those affected is between 3 months and 54 years. Of the total, 45% (n= 22) of cases correspond to children under 5 years of age, 39% (n= 19) to ages 5 to 19, and 16% (n= 8) to the 20+ age group. The incidence rate shows that the most affected age group is children under 1 year of age (7.2 cases per 100,000 population), followed by the 1-4-year age group (3.7 per 100,000 population) and the 15-19 age group (1.3 cases per 100,000 population) (19).

Regarding measles vaccination history, 76% of cases (n= 37) were unvaccinated or had an unknown vaccination history, while 14% had received a single dose of MMR (n= 7) and 10% had received two doses of MMR (n= 5). Fourteen percent of cases required hospitalization (n= 7). No related deaths were reported, and the last confirmed case was recorded in EW 39 (19). The Regional Reference Laboratory has reported genotype D8 in five samples sent from the National Reference Laboratory (19). In Paraguay, in 2025, national vaccination coverage with MMR reached 94% for the first dose and 87% for the second dose (19).

In **Peru**, between EW 19 and EW 53 of 2025, five cases of measles have been confirmed, all registered in the department of Lima. Of the total cases, three are imported cases and two are import-related. The cases range in age from 11 months to 34 years; one case corresponds to a child under one year of age, two cases correspond to persons between 5 and 19 years of age, and two correspond to adults aged 20 years and older. Regarding measles vaccination history, three of the cases were unvaccinated, one had an unknown vaccination history, and one had received two doses of MMR vaccine. Of the cases, two required hospitalization; no related deaths have been reported (20).

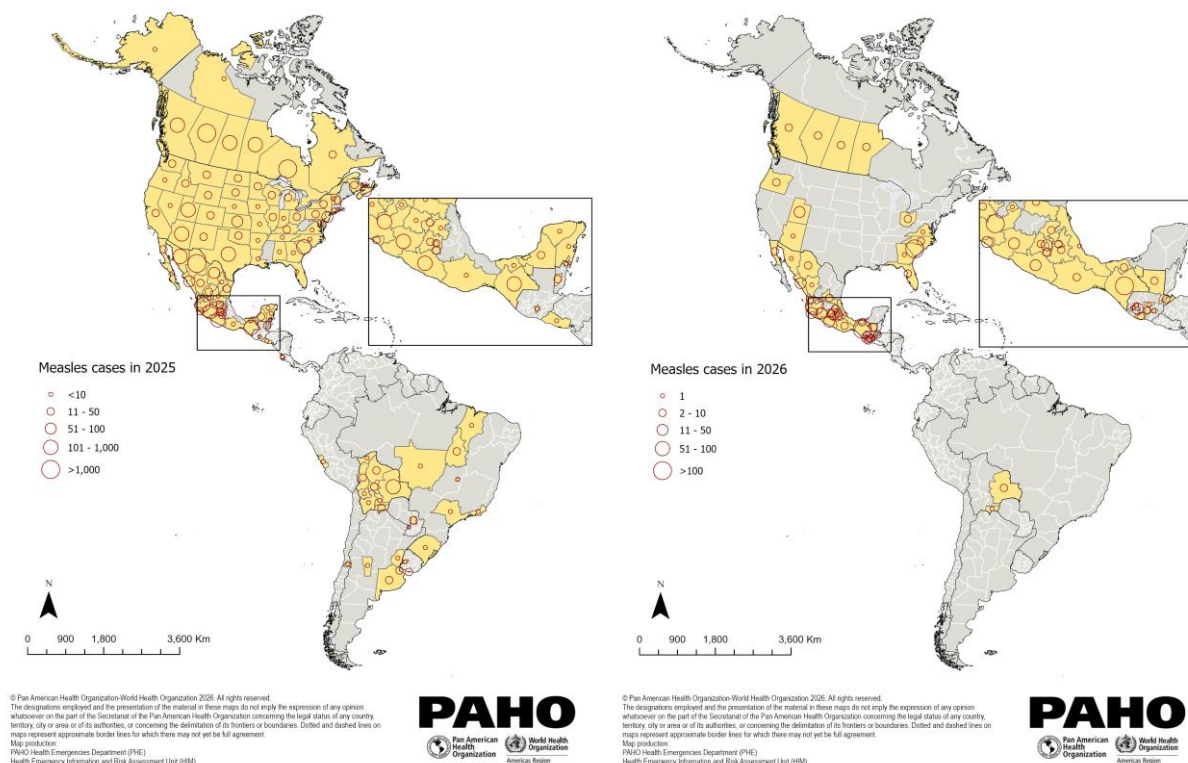
Genotyping of samples from two confirmed cases identified genotype D8 DSId 9171 and genotype MVs/Ontario.CAN/47.24 (DSId 9171). In Peru, in 2024, MMR vaccination coverage reached 97.6% nationwide for the first dose and 83.2% for the second dose (20).

In **Uruguay**, in EW 6 of 2025, a confirmed case of measles was reported in a foreign national with a history of travel to Argentina and no history of measles vaccination. This was an isolated case, with no evidence of secondary transmission documented in the subsequent period (21).

Additionally, between EW 46 of 2025 and EW 3 of 2026, 13 cases of measles have been confirmed in two departments of the country. The cases were reported in the departments of Montevideo (n= 1 case) and Rio Negro (n= 12 cases). Of the total cases, four were imported and nine were related to importation (21). The cases are distributed across an age range of 11 to 51 years; 23.1% (n= 3) correspond to adolescents aged 11 to 15 years, and 76.9% (n= 10) correspond to people aged 21 to 51 years. No cases were reported in children or older adults. The incidence rate by age group shows that the most affected group is 11 to 15 years old, corresponding to 1.26 cases per 100,000 population. Regarding vaccination history, 69.3% (n= 9) of cases were unvaccinated and 30.7% had received one dose of MMR (n= 4). Of the total, one case required hospitalization with a favorable outcome (21).

During 2024, national MMR vaccination coverage reached 97% for the first dose and 95% for the second dose (21).

Figure 6. Geographic distribution of confirmed measles cases at the subnational level (in yellow) in the Americas Region, 2025–2026 (As of EW 2 of 2026)



Source: Adapted from data provided by the respective countries (3-21).

Guidance for Member States

The high incidence of cases in young children, the high percentage of unvaccinated individuals, and the persistence of outbreaks in communities reluctant to vaccinate associated with imports reflect the urgent need to restore and sustain $\geq 95\%$ coverage with two doses of MMR vaccine, strengthen sensitive and timely epidemiological surveillance, and consolidate rapid response capacity to prevent the reintroduction and endemic transmission of the virus in the Region.

Taking into account the aforementioned risk factors and the current regional context, the following recommendations are offered regarding vaccination, surveillance and rapid response, mass events, and international travel (28, 29):

Vaccination

a. Countries with active outbreaks:

- In municipalities with community transmission, long chains of transmission, wide geographic spread, and difficulty in identifying the source of infection, implement indiscriminate mass vaccination activities (an additional dose of MMR or MR vaccine) for affected groups.
- In municipalities with outbreaks with short chains of transmission, a limited number of cases in clearly identified geographic areas, and known sources of transmission, the following measures are recommended to prevent further transmission of the virus:
 - i. Implement vaccination blocking from the identification of a suspected case (without waiting for laboratory confirmation), within the first 72 hours in 25 blocks around where the case resides (an area of 5 by 5 blocks with the case's block of residence at the center) and following the route of movement of cases during their period of transmissibility. Conduct joint active community case finding.
 - ii. Implement documented sweeping if the intervention occurs after the first 72 hours or if the blockade was ineffective. Sweeping should be implemented in an area larger than that of the vaccination blockade. Where feasible, consider an area of five blocks around the case's residence (an area of 121 blocks, 11 blocks per side with the case's residence block in the center). This should be adapted depending on whether it is an urban, marginal urban, or rural area. Conduct active community case finding during this activity.
 - iii. Conduct rapid coverage vaccination monitoring (RCM) in the areas targeted for intervention in order to identify areas that require additional vaccination interventions. Collect the reasons for non-vaccination during RCM. Continue active community case finding during this activity.
 - iv. The age groups to be included in vaccination activities will depend on the epidemiological analysis of the distribution of cases by age, as well as the analysis of the accumulation of susceptible individuals by birth cohort. This may include the administration of the zero dose to children aged 6 months to 1 year.

b. All countries:

- **Vaccinate all close contacts** of confirmed 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, within the first 72 hours. This should include the travel route of confirmed cases during the period of disease transmissibility.
- **Maintain a reserve of MR and/or MMR vaccine** and syringes/supplies for prevention and control actions in response to 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 highest risk.
- **Strengthen microplanning of routine vaccination services** to achieve vaccination coverage of at least 95% with two doses of the MMR 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 access at strategic locations. Implement zero doses in children aged 6 to 11 months who are traveling to areas with active transmission of the disease. Ideally, vaccination should be done at least 14 days before travel.
- **Increase efforts to achieve vaccination coverage in vaccine-hesitant populations**, including awareness-raising activities targeting local authorities, community and religious leaders, as well as other key social actors and government sectors, such as the education sector. In addition, carry out complementary vaccination activities in host communities or areas surrounding vaccine-hesitant populations to close vaccination gaps and strengthen population immunity.

Surveillance

a. Countries with active outbreaks:

- Activate and train rapid response teams, 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 travel and analysis of vaccination activities implemented.
- In areas with community transmission, it is recommended to use a more specific case definition (fever and maculopapular rash, accompanied by cough, coryza, or conjunctivitis) and to document the change in definition.
- Likewise, to optimize the use of laboratory resources, use the classifications of confirmed cases based on 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 by implementing active case finding in both health services and 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 from: <https://www.paho.org/en/documents/guidance-active-case-finding-acute-flaccid-paralysis-measles-and-rubella> (30).
- **Obtain serum, nasopharyngeal swab, and urine samples** (31) in all suspected cases of measles or rubella for laboratory confirmation through serological and real-time RT-PCR molecular testing, as well as genomic sequencing to document the genotype and lineage 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 cases of measles or rubella**, including the activation of trained rapid response teams and the implementation of national rapid response protocols (32, 33).
- Administer vitamin A immediately after diagnosis of measles and repeat the following day in children aged 6 to 59 months, regardless of previous vitamin A doses received. The recommended dose is 50,000 IU for infants younger than 6 months, 100,000 IU for infants 6 to 11 months, and 200,000 IU for children 12 months and older. If the case presents clinical ophthalmic signs of vitamin A deficiency, such as Bitot's spots, a third dose should be administered 4–6 weeks later (34).
- **Establish appropriate in hospital management for cases** to prevent nosocomial transmission, particularly during outbreaks. This involves maintaining an adequate flow of referred patients in isolation rooms (at any level of care), avoiding contact with other patients in common areas such as waiting rooms and hospital wards.
- **Train health personnel**, with an emphasis on rapid response teams, in responding to outbreaks. PAHO has self-learning online courses available for this purpose (in Spanish) at: 1) Rapid response to measles and rubella outbreaks in the Americas <https://campus.paho.org/es/curso/brotos-sarampion-rubeola> (33); and 2) Measles outbreak in the post-elimination era: Case study. <https://campus.paho.org/es/curso/BroteSarampionPostEliminacion> (34).
- **Activate administrative measures** that facilitate the allocation of resources and coordinated work with different related sectors (education, tourism, transportation, labor, among others) to implement rapid response measures to measles outbreaks.

Mass events and international travelers

With regard to mass events and international travelers in the Americas Region, consider the following recommendations:

- **Strengthening epidemiological surveillance and vaccination.**

PAHO recommends that countries review their performance in measles and rubella surveillance, as well as vaccination coverage levels, in order to identify areas of highest risk and implement preventive actions. Specifically, and in the context of the FIFA World Cup 2026™, countries should increase the sensitivity of their surveillance systems through the implementation of active searches to document the absence of measles and rubella cases and offer information and vaccination services to travelers.

- **In relation to travelers**

Before travel

PAHO/WHO recommends that Member States advise all travelers aged six months³ or older who cannot show proof of vaccination or immunity to **receive a dose of measles and rubella vaccine at least two weeks before traveling to areas where measles or rubella transmission has been documented.**

Health authorities are advised to inform travelers before departure about the signs and symptoms of measles and rubella, which include:

- Fever
- Rash
- Cough, runny nose, or conjunctivitis (red eyes)
- Joint pain
- Lymphadenopathy (swollen lymph nodes)

During travel

Recommend that travelers who develop symptoms during their trip that make them suspect they have contracted measles or rubella do the following:

- Seek immediate medical attention from a healthcare professional.
- Avoid close contact with other people for seven days from the onset of the rash to reduce the risk of transmission (the period of measles transmissibility is four days before to four days after the onset of the rash, and the period of rubella transmissibility is seven days before to seven days after the onset of the rash; since it is difficult to differentiate between the two diseases, it is recommended to use the longer period). Wearing a mask during this same period will further reduce the risk of transmission.
- Remain at your place of accommodation (e.g., hotel or home, etc.), except to visit the doctor or as recommended by a health professional. When going out, always wear a mask during the period of transmissibility. Wear a mask at your place of accommodation, with the room closed, if you live with unvaccinated people.

Health authorities should note that **a measles vaccination certificate is not a requirement for entry** into countries under the IHR (2005).

³ The dose of measles, mumps, and rubella (MMR) or measles and rubella (MR) vaccine given to children aged 6 to 11 months does not replace the first dose of the recommended schedule at 12 months of age.

Upon return

- If travelers suspect that they have contracted measles or rubella upon their return, they should contact their health service and inform their doctor about their trip.

- **For doctors and other health professionals**

PAHO/WHO recommends:

- Promote and verify full vaccination (two doses) against measles and rubella for health sector personnel, including medical, laboratory, administrative, cleaning, and security personnel, among others.
- Raise awareness among private sector health workers of the need for immediate notification of all suspected cases of measles or rubella to ensure a timely response by national public health authorities in accordance with national surveillance and rapid outbreak response system standards.
- Remind health personnel of the need to inquire about patients' travel history and vaccination status.

- **Identification and contact tracing of confirmed cases of measles or rubella**

- Carry out identification and contact tracing activities for contacts identified and present in the national territory, in accordance with the country's guidelines and directives.
- Take into account the international implications that may arise in contact tracing, and consider the following scenarios and operational aspects in carrying out these activities:
 - a. When a case is identified by the national authorities of another Member State and the national authorities are asked to locate the contact(s) whose most likely place of residence is their country. National authorities are urged to use all available coordination mechanisms to locate these individuals. The information available for this action may be limited, and efforts should be rational and based on existing resources. Health services should be alerted to the possibility of such contacts so that they can be vigilant and detect any suspected cases in a timely manner.
 - b. When a case is identified at the local level and depending on when detection occurs in the natural history of the disease, it may require:
 - *Current case*: national authorities should obtain information on the possible source of infection and the location of contacts abroad and inform the relevant national authorities of the country where the case is presumed to have been infected or where the contact is located.
 - *Retrospectively identified case*: based on the case's travel history, national authorities should inform the national authorities of the relevant country, as this situation could be the first sign of virus circulation or an outbreak in the other country/countries concerned.

- i. Conduct active institutional and community searches to rapidly detect cases among contacts who have not been identified in the outbreak investigation, following the travel route of the case(s).

Operational considerations

For the international search for contacts of confirmed cases of measles or rubella, one of the following two scenarios of exposure to a confirmed case may occur:

- **When there is no involvement of international means of transport (e.g., airplanes, cruise ships, trains)**, national authorities should communicate with their counterparts in other countries through the International Health Regulations National Focal Point (IHR NFP) or through other existing bilateral and multilateral programmatic mechanisms, with a copy to the WHO IHR Regional Contact Point. If deemed necessary, national authorities may request support from the WHO IHR Regional Contact Point in the Americas to facilitate communications related to international contact tracing.
- **When international means of transport (e.g., airplanes, cruise ships, trains) are involved**, national port health authorities or their equivalents should activate existing mechanisms to obtain relevant information from companies (e.g., airlines) in order to locate travelers, or establish such mechanisms if they are not in place. For subsequent communication between national authorities, see the previous point.

PAHO/WHO recommendations regarding advice for travelers are available in the Epidemiological Update on Measles published by PAHO/WHO on 28 February 2025 (35).

Channels for disseminating guidance

PAHO/WHO recommends that national authorities consider disseminating the guidance in this epidemiological update through:

- Public awareness campaigns to promote and improve the health of travelers before and after their trip so that they adopt responsible behaviors regarding measles vaccination and are aware of the signs and symptoms of measles. For this activity, it is also recommended to consider health care services or clinics for travelers, airports, ports, train and bus stations, airlines operating in the country, among others.
- Travel agencies, tourism-related entities, and diplomatic corps should also be aware of and disseminate the necessary recommendations that travelers should take into account before traveling.
- Communication to physicians and other health workers of the contents of existing national surveillance guidelines, as well as timely dissemination of any new protocols developed by the country in relation to travelers.

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