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World Health Organization
Americas Region

PAHO

Regional Situation Report · No. 5

Measles in the Region of the Americas

18 June 2026 · *Next issue: 2 July 2026*

REPORTING PERIOD: EW 1–23, 2026 (4 Jan 2026 – 13 June 2026) · 2-week change window: EW 21–22 vs. EW 19–20

CUMULATIVE — EW 1–23, 2026		
22,324 CONFIRMED CASES	**38** DEATHS CFR 0.17%	**17** COUNTRIES AND TERRITORIES (CUMULATIVE) [1]
LAST 2 WEEKS — EW 21–22, 2026		
+827 NEW CONFIRMED CASES ↓ -29.1% *(compared to EW 19 – EW 20)*	**+7** NEW DEATHS *Two new deaths in Mexico and five new deaths in Guatemala*	**7/17** COUNTRIES AND TERRITORIES REPORTING *Canada, Colombia, Guatemala, Honduras, Mexico, Peru, United States of America*

Situation Overview

Between epidemiological week (EW) 1 and EW 23 of 2026 (ending on 13 June 2026), the Region of the Americas reported **22,324** confirmed measles cases from 17 countries and territories, including **38** deaths, representing a 207% increase compared to the same period in 2025. Mexico (11,532), Guatemala (6,895), the United States (2,073) and Canada (1,071) accounted for the majority (97%) of confirmed cases (**Map 1**) (*1*).

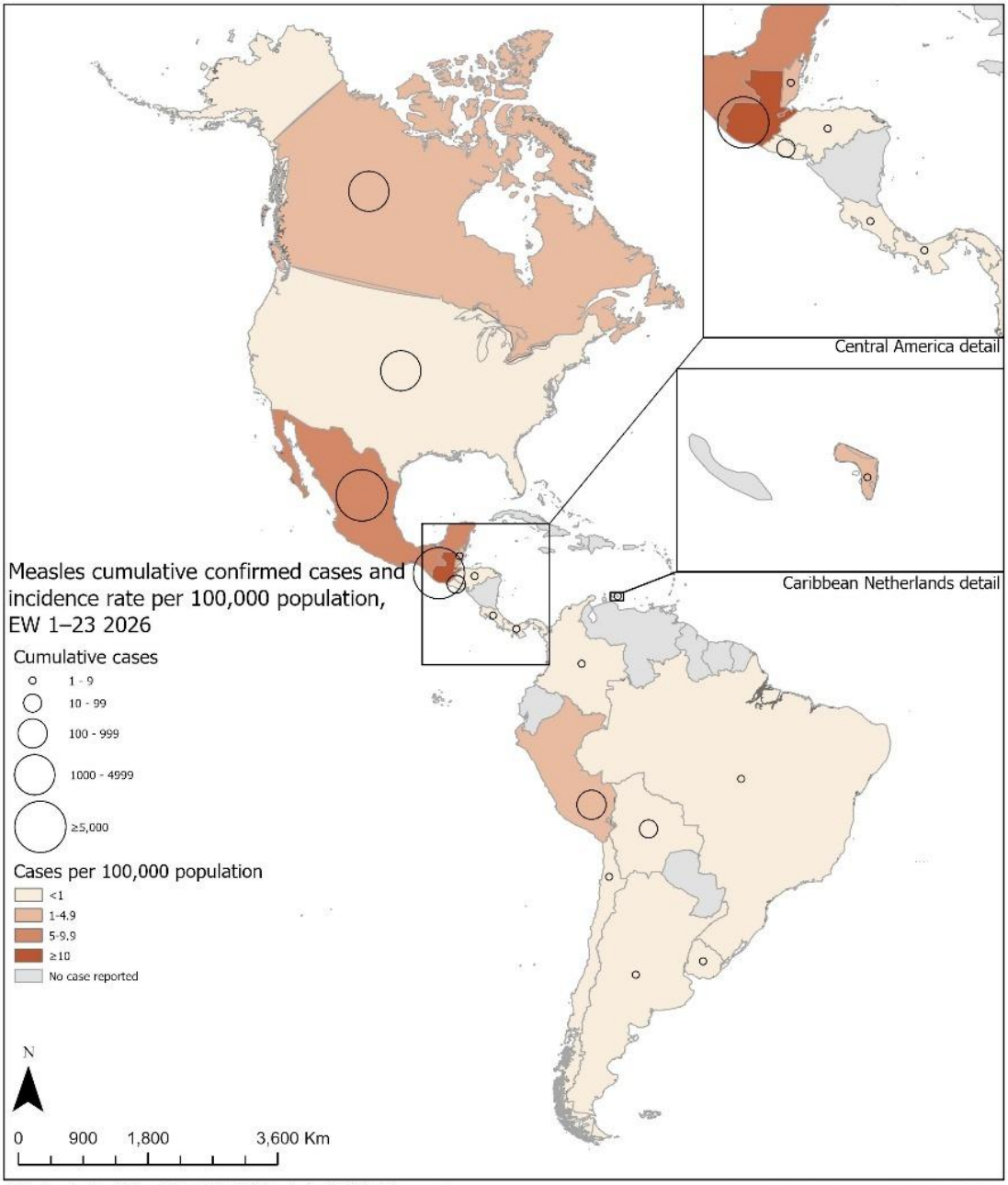
During EW 21 and EW 22 of 2026, the Region of the Americas reported **827** new confirmed measles cases across seven countries and territories, representing a 29.1% decrease compared with the previous two-week period (EW19-20; 1,166 new cases) (**Figure 1**). This decline was driven primarily by continued decreases in Canada and Mexico. The United States showed plateauing trends, while Peru's recent weekly case counts appear stable at the national level, with transmission remaining concentrated in Puno. Trends in Guatemala should be interpreted with caution, given possible reporting delays or updates in recent weeks[2].

In the context of the upcoming FIFA World Cup 2026™, countries are encouraged to strengthen preparedness and prevention measures, particularly in host countries and in countries receiving travelers returning from areas with active transmission. This includes ensuring early detection and reporting of suspected measles cases, strengthening laboratory capacity for timely testing and confirmation, and maintaining timely investigation and response capacities.

[1] *Since Situation Report 4, no additional country has reported measles cases for the first time in 2026.*

[2] *Trends in Guatemala should be interpreted with caution. Under Guatemala's Ministry of Health (MSPAS per its acronym in Spanish) Protocol V3, issued on 16 March 2026, laboratory samples are no longer collected for epidemiologically linked or clinically confirmed cases. As reported figures include only laboratory-confirmed cases, recent weekly trends may be affected by changes in surveillance and testing practices, please refer to: https://saludjuntos.gt/docs/protocolo-opeativo-sectorial-respuesta-sarampion-V3.pdf (2)*

Map 1. Confirmed measles cases and incidence rate per 100,000 population by country. Region of the Americas. EW 1 – EW 23, 2026. (n=22,324)



Map production:
PAHO Health Emergencies Department (PHE)
Health Emergency Information and Risk Assessment Unit (HIM)

The following sections describe the Pan American Health Organization's (PAHO) ongoing operational response to the regional measles situation. The *Operational Snapshot* summarizes the status of priority countries and the technical cooperation underway with each. The *PAHO Response by Strategic Pillar* consolidates regional actions across the four operational pillars guiding the Organization's response: epidemiological surveillance and laboratory diagnosis; immunization and vaccine operations; risk communication and community engagement; and operational readiness and partnerships.

Operational Snapshot — Priority Countries

Table 1. Operational snapshot of priority countries and joint response actions

Country	Joint response this period	Focus for the next 2 weeks PAHO actions
Mexico (3)	PAHO carried out a simulation exercise of an imported measles case at the international airport Benito Juarez in Mexico City. The country continues offering vaccination to all visitors coming to FIFA World Cup™ up to 30 June 2026.	Continued technical cooperation to support outreach vaccination activities in FIFA World Cup™ host cities: Mexico City, Monterrey and Guadalajara (FIFA Fan Fest).
Guatemala (4)	In support of the Ministry of Health-led response, PAHO provided mortality analysis and gap detection in clinical management and infection prevention and control; organization of a microplanning workshop with technical teams across 25 health areas (covering population estimates and cold-chain capacity at the district level); and continued logistical and technical support for vaccination brigades and campaign supervision in the Guatemala Central and Northwest health areas.	Continue supporting national authorities through risk-based planning of the mass vaccination campaign and calculation of the susceptible population and vaccine dose estimates required to sustain vaccination efforts.
United States	Ongoing technical exchange with national authorities.	Continued coordination and collaboration on measles outbreak response
Peru (5)	With emphasis in Puno, PAHO is supporting the mobilization of vaccination brigades; microplanning for outbreak response at the local level; implementation of triage of suspected cases and infection prevention and control measures in prioritized health facilities; multisectoral coordination with education authorities, universities, institutes, and local governments; field support and coordination with national and subnational health authorities, technical teams, and the regional reference laboratory; implementation and use of geographic information systems alongside daymetric population mapping, to support vaccination activities and identification of missing children; transfer of technical	Sustain support for the mobilization of technical teams, the use of geographic information systems for data management, laboratory and cold chain support; and provide technical support to facilitate the relocation of the laboratory and vaccine bank of the Regional Health Department of Puno, ensuring continuity of operations.

Country	Joint response this period	Focus for the next 2 weeks PAHO actions
	expertise alongside laboratory materials and cold-chain support.	
Bolivia (6)	PAHO's ongoing assistance includes delivering outbreak-closure training across 5 departments (Cochabamba, Chuquisaca, La Paz, Oruro and Santa Cruz); supporting the deployment of brigades across 22 high-risk municipalities – prioritized for 2026 case presence or for bordering Peru; conducting microplanning tool training in Chuquisaca, Cochabamba, La Paz, and Santa Cruz; and providing virtual induction on microplanning, Rapid Vaccination Monitoring (RVM), and outbreak-closure reporting to offset turnover of authorities and health staff.	Amid the ongoing political and social crisis vaccine supply monitoring continues as a preventive measure; national measles vaccination relaunch plan is in development (including mass media dissemination, digital outreach, and partner mobilization); alongside a contract to support communication and social mobilization across 5 municipalities in Santa Cruz and 8 departmental health services.

PAHO Response by Strategic Pillar (7)[3]

Collaborative Surveillance

- Sustained communication and coordination with countries on measles-related events, including technical guidance and discussion of priority actions.
- Opened the virtual accreditation process for Venezuela's National Measles and Rubella Laboratory (Instituto Nacional de Higiene "Rafael Rangel" — INHRR per its acronym in Spanish), based on the Pan American Health Organization/World Health Organization (PAHO/WHO) criteria and the laboratory's performance over the previous 12 months. The session was convened by the Deputy Minister of Health, INHRR leadership, and PAHO technical staff.
- Facilitated a binational Mexico–Peru exchange on laboratory response during measles outbreaks, with Mexico's Institute of Epidemiological Diagnosis and Reference (InDRE per its acronym in Spanish) sharing their experience as a national reference laboratory and as coordinator of the national laboratory network, including the decentralization of serological testing and rRT-PCR detection, and the implementation of a quality assurance program.
- Supported virtual training organized by Peru to strengthen and decentralize measles and rubella diagnosis (12 June 2026), including a technical presentation laboratory surveillance.

Immunization & Vaccine Operations

Followed up on vaccination strategies across affected countries, with non-selective dose-zero administration in infants 6–11 months now operational in El Salvador, Guatemala, Mexico, and in priority subnational areas

[3] *PAHO's response is organized through the strategic pillars. This section reflects regional and cross-country activities undertaken across the Region — by PAHO headquarters, sub-regional offices, and country offices — in coordination with national authorities during this reporting period. Country-specific operational support is summarized in Table 1.*

of Bolivia (Santa Cruz) and Peru (Puno). Selective vaccination and schedule completion continue in parallel, with age ranges calibrated to each country's epidemiological profile (**Table 2**).

Table 2. Summary of vaccination strategies in affected countries

Country	Non-selective scope	Selective / schedule completion
Mexico	Dose zero (6–11 mo)	1–49 years
Guatemala	6–11 mo (Dose zero); 16–39 yrs (1 dose)	1–15 years schedule completion (2 doses)
El Salvador	Dose zero (6–11 mo)	≥1 year, plus contacts without vaccination history
Peru	Puno: 6 mo – 29 yrs	Outbreak-control and schedule completion in other departments
Bolivia	Santa Cruz: 6 mo – 19 yrs	Outbreak-control and schedule completion in other departments

Risk & Crisis Communication and Community Engagement

- Launched the regional campaign “With Health, We All Win” to promote vaccination and support risk communication efforts, including collaboration with content creators such as Mellanie da Fonte, Chef Oropeza, and Parisa Fitz-Henley. Available from: https://www.paho.org/en/campaigns/health-we-all-win
- Supported a virtual Risk Communication and Community Engagement (RCCE) workshop for communicators from the Ministry of Health of Honduras, held on 11 June 2026, focused on strategies to address vaccine-related misinformation.
- Provided technical input to regional and international media on measles risk and response, including in the context of the FIFA World Cup 2026™ and the upcoming Regional Verification Commission (RVC) meeting.
- Organized a YouTube master class for content creators on addressing vaccine-related misinformation, with more than 65 participants.
- Continued coordination meetings with country communication focal points to support alignment of risk communication and community engagement activities related to the measles response.

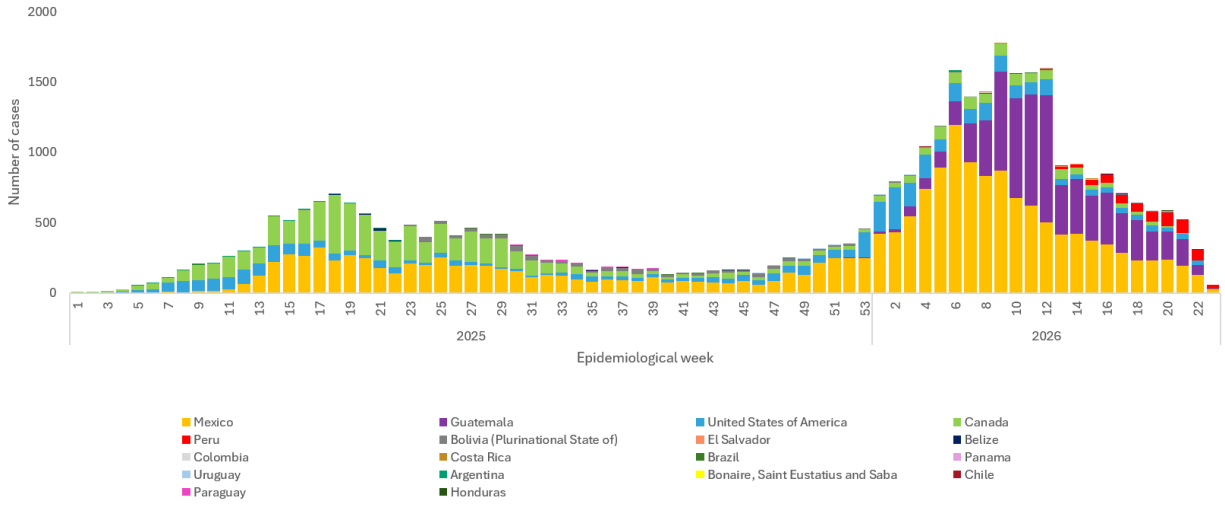
Operations support & logistics

- Supported training on the Logistics Support System (LSS) for supply management in El Salvador and Honduras.

- Reinforced operational readiness through a Global Outbreak Alert and Response Network (GOARN) webinar on deployments and the use of Go.Data for outbreak response, featuring experiences from Brazil (measles) and Uganda (ebola) and reaching more than 200 participants.
- Held Prevention and Response to Sexual Exploitation, Abuse and Harassment (PRSEAH) meeting on 10 June 2026 with all Comprehensive Immunization (CIM) focal points, focused on response activities related to measles.

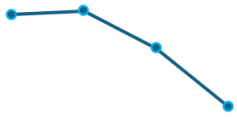
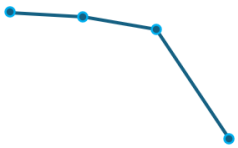
Epidemiological Situation

Figure 1. Epidemiological curve of confirmed measles cases in the Region of the Americas by country and EW, from EW 1 2025 to EW 23 2026



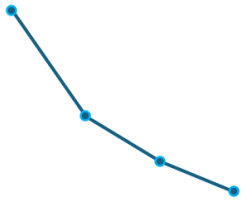
The table below summarizes the epidemiological situation in countries that have reported confirmed measles cases.

Table 3. Measles cases in the Region of the Americas by country, as of EW 23 2026

Country	Cases 2026 (up to EW 23) (*1*)	Deaths 2026 (up to EW 23) (*1*)	Trend (last 4 weeks)**	Re-Verification Commission classification (*8*)	Epidemiological notes
Mexico*	11,532	16	↓ declining 	Sustained elimination with major concerns	Most new cases between epidemiological week (EW) 22 and EW 23 were reported in Jalisco, Coahuila, and Durango. Two additional deaths were registered during this period, bringing the 2026 total to 16 and the cumulative toll since the outbreak began in 2025 to 43. The most recent death was reported in EW 23 of 2026. Last case was on EW 23 of 2026.
Guatemala*	6,895	22	*only laboratory confirmed cases*[4] 	Sustained elimination	Transmission reported across all 22 departments, particularly in Guatemala Central. In addition to the laboratory confirmed cases, more than 9,000 probable cases[5] have been registered in the country so far (9). During EW 22 and EW 23, five additional deaths were reported. The most recent laboratory-confirmed case was reported in EW 22 of 2026.
United States*	2,073	0	plateau 	Sustained elimination with major concerns	In 2026, the highest numbers of cases have been reported in South Carolina (670), Utah (490), Texas (182), Florida (141), Virginia (110), and Arizona (84). Last case was on EW 23 of 2026.

4 Trends in Guatemala should be interpreted with caution. Under Guatemala's Ministry of Health (MSPAS) Protocol V3, issued on 16 March 2026, laboratory samples are no longer collected for epidemiologically linked or clinically confirmed cases. As reported figures include only laboratory-confirmed cases, recent weekly trends may be affected by changes in surveillance and testing practices, please refer to : https://saludjuntos.gt/docs/protocolo-opeativo-sectorial-respuesta-sarampion-V3.pdf (2)

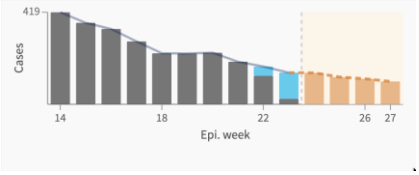
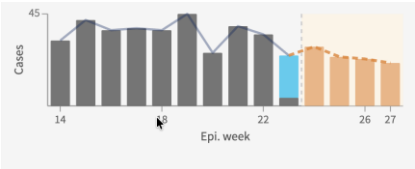
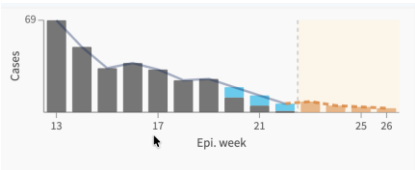
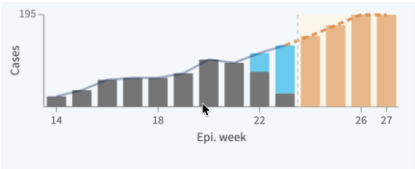
5 Probable case definition: Cases by clinical criteria or epidemiological link

Country	Cases 2026 (up to EW 23) (*1*)	Deaths 2026 (up to EW 23) (*1*)	Trend (last 4 weeks)**	Re-Verification Commission classification (*8*)	Epidemiological notes
Canada*	1,071	0	↓ declining 	Endemic	Approximately 98% of cases are linked to the 2024 New Brunswick (NB) outbreak. In 2026, the highest numbers of cases have been reported in Manitoba (668), Alberta (310), British Columbia (31), and Ontario (27). Last case was on EW 22 of 2026.
Peru*	627	0	plateau 	Sustained elimination	Cases reported in 2026 have been mainly concentrated in Puno (603), followed by Arequipa (15), Lambayeque (3), Cusco (3), Lima (2), and Tacna (1). Last case was on EW 23 of 2026.
Bolivia*	72	0	Drop by drop transmission with sporadic cases that are part of the same outbreak	Sustained elimination with major concerns	Last case was on EW 20 of 2026.
El Salvador	18	0	Sporadic importations	Sustained elimination	Last case was on EW 20 of 2026.
Belize	9	0	Sporadic importations	Sustained elimination	Last case was on EW 20 of 2026.
Colombia	8	0	Sporadic importations	Sustained elimination	Last case was on EW 22 of 2026.
Costa Rica	5	0	Sporadic importations	Sustained elimination	Last case was on EW 15 of 2026.
Other (≤5 cases) * **	See dashboard (*1*)	See dashboard (*1*)	—	—	—

**Countries with active outbreaks: measles cases have been reported for a period of 12 weeks or longer. **Last EW excluded from observed counts to mitigate reporting delay. ***Argentina, Bonaire Saint Eustatius and Saba, Brazil, Chile, Honduras, Panama, and Uruguay. See PAHO/WHO Measles Dashboard: https://tinyurl.com/3xtcjv84 (1)*

To complement the cases summary above, this section presents model-based estimates of transmission dynamics for countries with sustained outbreaks and sufficient data (***Table 4***). Nowcasting corrects the most recent weeks for reporting delays. Short-term forecasting projects expected case incidence over the next four weeks based on the current estimated effective reproduction number (R_t) — the average number of secondary infections per case. R_t above 1 indicates sustained or accelerating transmission; below 1 indicates a declining outbreak. Full methodology is provided in Technical Notes.

Table 4. Model-based estimates of measles transmission dynamics, by country, as of EW 23, 2026

Country	R_t (95% CrI)[1] Effective reproduction number	Model-based trend[2]	4-week forecast (EW 24–27) median [95% PrI][3]	Modeling interpretation
Mexico	0.82 [0.76 – 0.88]	↓ *declining*	~487 [385–600] cases 	R_t below 1 with a narrow interval — model points to continued decline over the next 4 weeks, with the upper bound also below unity.
Guatemala	—[4]	—[4]	—[4]	Modeling not performed — see footnote 4.
United States	0.85 [0.71 – 1.01]	~ *stabilizing*	~97 [54–155] cases 	R_t below 1 but with a credible interval crossing unity — model suggests possible slowing, though sustained decline is not yet confirmed
Canada	0.62 [0.48 – 0.79]	↓ *declining*	~20 [5–47] cases 	R_t below 1 — model projects continued decline; ~98% of cases remain linked to the 2024 New Brunswick outbreak.
Peru[6]	1.35 [1.23 – 1.48]	↑ *increasing*	~754 [596–938] cases 	R_t clearly above 1 with a narrow interval — model projects continued growth, consistent with concentrated transmission in Puno.

Country	R_t (95% CrI)[1] Effective reproduction number	Model-based trend[2]	4-week forecast (EW 24–27) median [95% PrI][3]	Modeling interpretation
Bolivia	—[5]	—[5]	—[5]	Modeling not performed — see footnote 5.

[1] R_t = effective reproduction number — the average number of secondary infections per case at a given point in time. Estimated using the EpiEstim method with a 4-week sliding window (10). 95% CrI = 95% credible interval. See Technical Notes.

[2] Trend classified from the full 95% credible interval (CrI) of R_t: increasing (lower bound > 1), declining (upper bound < 1), or uncertain (interval includes 1).

[3] Median 4-week forecast and 95% prediction interval (PrI) for projected new cases over EW 24–27, conditional on the current estimated R_t.

[4] Guatemala: modeling not performed for this period because the change in case-definition criteria under MSPAS Protocol V3 (16 March 2026) — under which only laboratory-confirmed cases are reported — affects the comparability of the case series across recent weeks.

[5] Bolivia: modeling not performed because weekly incidence has fallen below the threshold (<5 cases/week) at which R_t estimation becomes unreliable and short-term forecasting is not robust enough to inform operational decisions.

[6] Peru: Between the 4 June and 18 June model runs, Peru's effective reproduction number rose from 1.21 [1.07–1.35] to 1.35 [1.23–1.48], with observed incidence (181 new cases over 2 weeks) falling within the 95% PrI band of the prior forecast (~418 [307–553] over 4 weeks). The upward revision of R_t reflects continued transmission momentum and improved precision as additional case data has accumulated, consistent with the geographically concentrated outbreak in Puno and predating the projected impact of the May 2026 vaccination response

Technical Notes

This sitrep uses two complementary modeling steps. First, **nowcasting** corrects the most recent epidemiological weeks for reporting delays, producing estimates of cases that have already occurred but are not yet fully reported. Second, **short-term forecasting** projects expected case incidence over the next four weeks based on the current estimated effective reproduction number (Rt).

Case data. Weekly confirmed measles case counts were obtained from national surveillance systems reported to PAHO/WHO.

Nowcasting. To account for reporting delays inherent to passive surveillance, a nowcasting model was applied to estimate the true incidence of the most recent epidemiological weeks. Depending on the length of the available training window, either a negative binomial generalized linear model (6–14 weeks) or a generalized additive model with penalized splines (≥15 weeks) was fitted to the historical reporting pattern and used to project the expected final case count for incomplete weeks, with 95% credible intervals. Thresholds were set based on internal model stability assessment, consistent with general guidance on data-adaptive nowcasting (*11*).

Effective reproduction number (Rt). Rt was estimated using the EpiEstim method (*10*), which applies a Bayesian sliding-window approach to the nowcast-corrected incidence series. A 4-week (28-day) sliding window was used, corresponding to approximately two serial intervals — a commonly applied default that balances statistical stability against temporal resolution. A discrete gamma serial interval distribution was assumed (mean 15 days, SD 4 days), consistent with the measles literature (*12*). The serial interval was treated as fixed; this simplification modestly underestimates Rt uncertainty but does not affect the qualitative trend classifications presented. Rt credible intervals are computed conditional on the nowcast point estimate and therefore do not formally propagate nowcasting uncertainty. Trend classification was based on the full 95%

credible interval of Rt: **increasing** (lower bound > 1), **declining** (upper bound < 1), or **uncertain** (interval includes 1).

Short-term forecasting. Four-week projections were generated via a renewal model simulating 10,000 stochastic Poisson trajectories anchored to the estimated Rt. Results are expressed as median and 95% prediction interval.

Limitations. Estimates depend on the completeness and timeliness of country-level reporting and on the assumed serial interval. Country-specific surveillance changes — including the expanded case definition adopted by Guatemala under MSPAS Protocolo V3 (16 March 2026) — may affect interpretation of trends in individual countries and are flagged in the country annex.

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