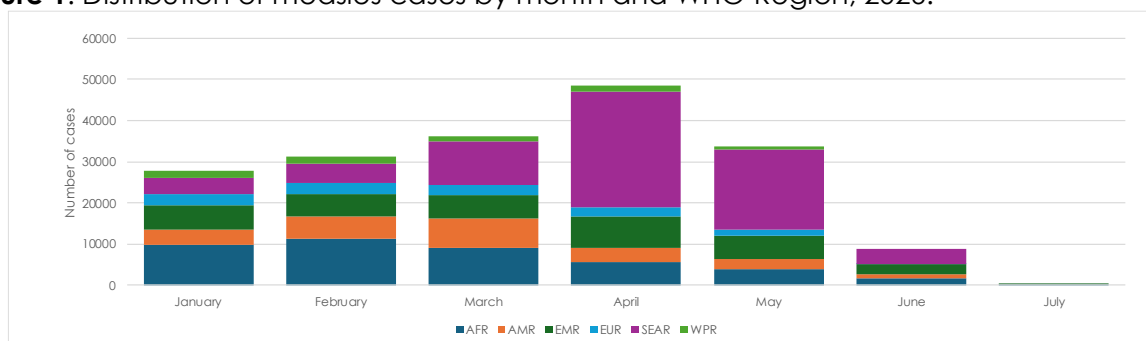


Given the increase in reported measles cases during 2026 in the Americas Region and in other regions of the world, as well as the holding of mass gatherings with broad international participation, the Pan American Health Organization / World Health Organization (PAHO/WHO) urges Member States to prioritize strengthening epidemiological surveillance and vaccination activities, and to ensure a rapid and effective response to suspected measles cases. PAHO/WHO also recommends intensifying active community, institutional, and laboratory-based case-finding efforts for the early identification of cases, as well as implementing supplementary vaccination activities aimed at closing existing immunity gaps.

Global Summary

According to monthly data on measles and rubella surveillance published by the World Health Organization (WHO), between 1 January and as of July 2026, 186,168 measles cases were reported in 165 Member States across the six WHO Regions, of which 83,201 (44.69%) were laboratory-confirmed¹. Of the confirmed¹ cases, 32% were reported in the WHO Southeast Asia Region, followed by the WHO Americas Region with 27%, the Eastern Mediterranean Region with 14% of cases, the European Region with 13%, the African Region with 9%, and the Western Pacific Region with 4% (**Figure 1**) (1).

Figure 1. Distribution of measles cases by month and WHO Region, 2026.



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 the World Health Organization. Immunization data—Provisional measles and rubella data. Geneva: WHO; 2026 [cited 5 August 2026]. Available from: <https://immunizationdata.who.int/global?topic=Provisional-measles-and-rubella-data&location=> (1).

As of July 2026, the WHO Regions of the Americas and South-East Asia have surpassed the total number of confirmed cases² for the entire year of 2025, with 23,165 confirmed cases

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

Suggested citation: Pan American Health Organization / World Health Organization . Epidemiological Alert: Measles in the Americas Region, 7 August 2026. Washington, D.C.: PAHO/WHO; 2026.

(compared with 14,640 confirmed cases in 2025) and 70,499 confirmed cases (compared to 19,943 confirmed cases in 2025), respectively. Although the WHO African Region has not yet surpassed the total recorded in 2025, it has already reported 41,598 confirmed cases (compared to 66,334 confirmed cases in 2025). If the observed trend continues, the number of cases in the African Region could exceed the total recorded for all of 2025 before the end of 2026 (1).

Summary of the Situation in the Americas Region

In 2026, between epidemiological week (EW) 1 and EW 28, 47,459 measles cases were confirmed in the Americas Region, including 44 deaths. The cases were reported by 16 countries and one territory. Guatemala (n= 30,371 cases, including 26 deaths), Mexico (n= 12,255 cases, including 17 deaths), the United States of America (n= 2,260 cases), and Peru (n= 1,277) account for the majority (95%) of confirmed cases (**Table 1**) (2–20).

Table 1. Number of measles cases by country and territory in the Americas Region in 2025 and 2026 (through EW 28 of 2026).

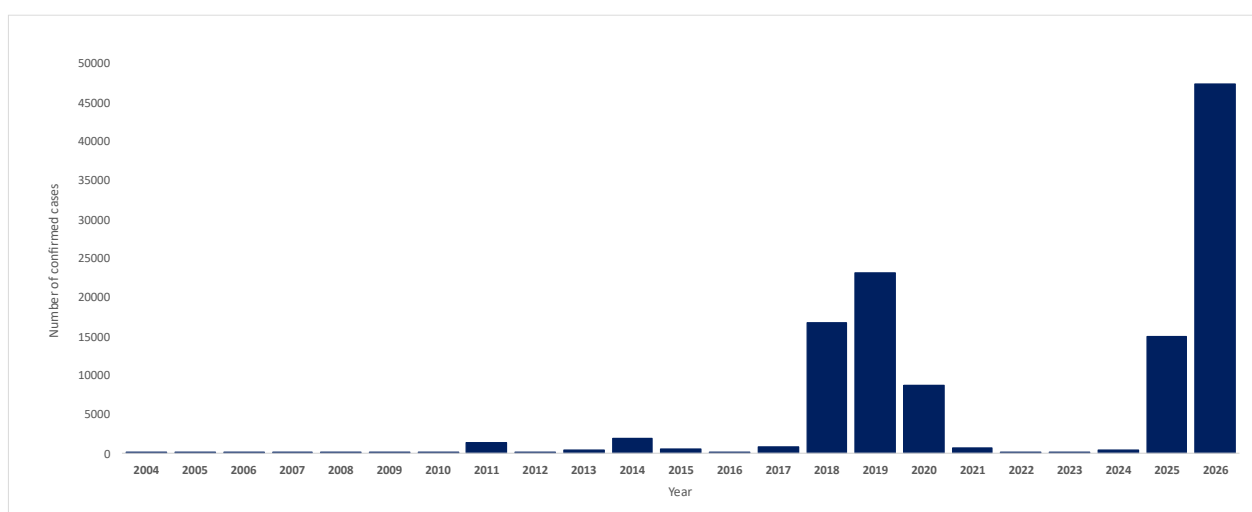
Country	Number of confirmed cases in 2025	Number of confirmed cases in 2026 through EW 28	Latest date of rash onset (EW)
Argentina	36	1	EW 6 of 2026
Belize	44	11	EW 20 of 2026
Bolivia (Plurinational State of)	449	65	EW 28 of 2026
Bonaire	0	1	EW 4 of 2026
Brazil	38	15	EW 26 of 2026
Canada	5,462	1,107	EW 28 of 2026
Chile	1	1	EW 4 of 2026
Colombia	0	14	EW 28 of 2026
Costa Rica	1	5	EW 15 of 2026
El Salvador	1	53	EW 27 of 2026
Guatemala	9	30,371	EW 28 of 2026
Honduras	0	12	EW 26 of 2026
Mexico	6,614	12,255	EW 28 of 2026
Panama	0	9	EW 23 of 2026
Paraguay	50	0	EW 39 of 2025
Peru	5	1,277	EW 29 of 2026
United States of America	2,288	2,260	EW 28 of 2026
Uruguay	13	2	EW 3 of 2026
Total	15,011	47,459	

Source: Adapted from data provided by the respective countries and territories (2–20).

The total number of confirmed cases is more than double the number reported in the 29 May 2026, PAHO/WHO epidemiological alert on measles in the Americas Region, which included data as of EW 20 of 2026 (21). This increase, observed over a period of just eight weeks, indicates a significant acceleration in the transmission of the measles virus in the Americas Region, primarily attributed to a substantial rise in cases in Guatemala and an increase in cases in Peru.

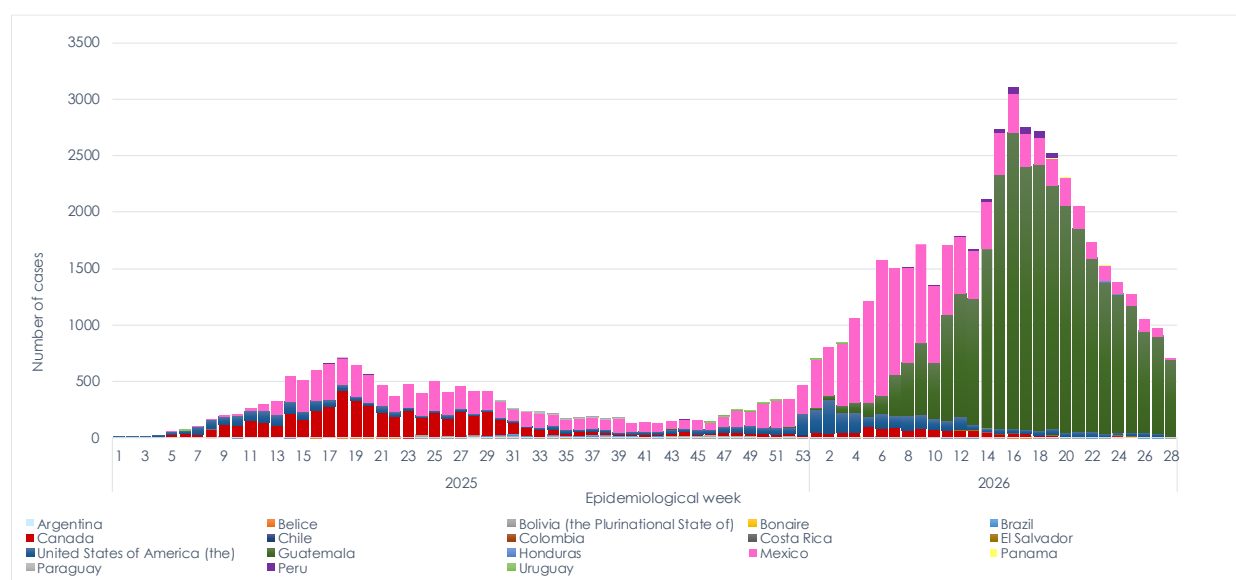
The number of cases reported in 2026 as of EW 28 represents an increase of more than eightfold compared with the 5,123 measles cases reported during the same period in 2025 (22, 23). Furthermore, compared with historical measles records in the Region, the number of confirmed measles cases in 2026 is the highest recorded since 2004, making 2026 the year with the highest number of confirmed measles cases in the past 22 years (**Figure 2**) (22–24).

Figure 2. Confirmed measles cases by year in the Americas Region, 2004–2026.



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 (22–24).

Figure 3. Confirmed* measles cases by epidemiological week (EW) of rash onset and country or territory in the Americas Region, 2025–2026 (as of EW 28 of 2026).



***Note:** Includes confirmed and probable cases for Canada; for Guatemala, includes cases confirmed by laboratory, clinical findings, and epidemiological link.

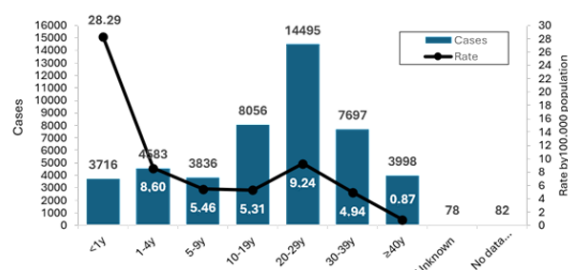
Source: Adapted from data provided by the respective countries and territories (2–20).

According to information available in the Immunization Data Repository and country surveillance reports submitted to PAHO, among confirmed cases in 2026 for which data are available ($n = 46,541$), the 20–29 age group accounts for the largest proportion of cases (31%), followed by the 10–19 age group (17%) and the 30–39 age group (16%) (25). However, the incidence rate shows an inverse relationship with age, being highest among children under one year of age (28.2 cases per 100,000 population), followed by the 20–29 age group (9.24 cases per 100,000 population) and the 1–4 age group (8.6 cases per 100,000 population). Rates remain above one case per 100,000 population up to the 30–39 age group (**Figure 4**) (25). Regarding vaccination history, 73% of cases were unvaccinated, and for 17%, the information was unknown or unavailable. According to classification by source of infection, 4% of cases were endemic, 12% were associated with imported cases, 27% had an unknown source of infection, and 2% were classified as imported cases (**Figure 4**) (25).

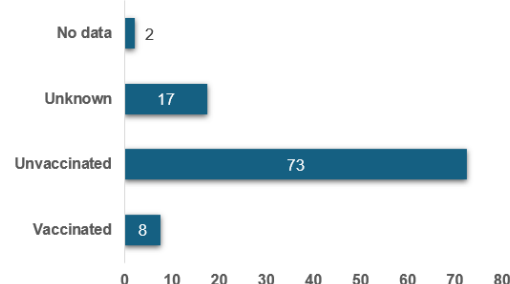
Of the cases confirmed in 2026, 598 genetic sequences from the N-450 region of the measles virus have been reported to MeaNS (Measles Nucleotide Surveillance database); 97.2% ($n = 583$) corresponded to genotype D8 and 2.8% ($n = 15$) to genotype B3 (26).

Figure 4. Percentage distribution of confirmed measles cases by age group, sex, vaccination status, and source of infection in the Americas Region as of EW 28 of 2026.

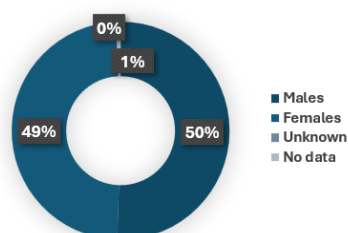
Confirmed measles cases and rates by age group



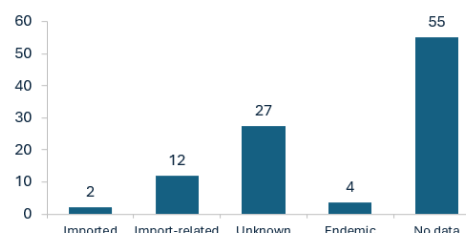
Percentage of cases by vaccination status



Percentage of cases by sex



Percentage of cases by source of infection



Source: Adapted from the Pan American Health Organization. Immunization Data Repository and Country Surveillance Reports Submitted to PAHO: Comprehensive Immunization. Washington, D.C.: PAHO; 2026 [cited 31 July 2026]. Unpublished (25).

Measles epidemiological situation by country in the Americas Region

The following is an update on the epidemiological situation of measles in the countries of the Region, listed in alphabetical order, that have reported confirmed cases in the Americas between EW 20 and EW 28 of 2026. Argentina, Bonaire, Chile, Costa Rica, Peru, and Uruguay did not report any new confirmed cases during this period. Summaries of the epidemiological situation in these countries are available in the epidemiological alert on measles in the Americas Region dated 29 May 2026 (2-20).

In **Belize**, between EW 20 and EW 28 of 2026, two additional cases were confirmed, bringing the total number of measles cases in 2026 to 11. The confirmed cases were identified in the districts of Toledo (n= 9 cases), Cayo (n= 1 case), and Belize (n= 1 case), and were confirmed through reverse transcription polymerase chain reaction (RT-PCR) laboratory testing; the samples were processed at the Caribbean Public Health Agency (CARPHA) reference laboratory (3). Of the total confirmed cases, seven were imported, three were linked to imported cases, and one had a source of exposure under investigation. The imported cases reported a history of travel to or stay in Guatemala prior to the onset of symptoms. The cases ranged in age from 8 months to 54 years. Regarding measles vaccination history, all cases were unvaccinated or had an unknown vaccination history at the time of diagnosis (3).

In **Bolivia**, between EW 20 and EW 28 of 2026, 10 cases were confirmed, bringing the total number of measles cases in 2026 to 65. Confirmed cases were reported in the departments of Beni (n= 8 cases), Cochabamba (n= 7 cases), La Paz (n= 1 case), Santa Cruz (n= 47 cases), and Tarija (n= 2 cases) (4). The cases span an age range from 0 months to 65 years; 32% (n= 21 cases) were children under 1 year of age, 18% (n= 12 cases) were children between 1 and

4 years of age, 14% (n= 9 cases) to children aged 5 to 9 years, 14% (n= 9 cases) to those aged 10 to 14 years, 5% (n= 3 cases) to those aged 15 to 19 years, and 17% (n= 11 cases) to adults aged 20 years or older (4). The incidence rate by age group shows that the most affected age group is children under 1 year of age (25 cases per 100,000 population), followed by the 1- to 4-year-old age group (5 cases per 100,000 population). Regarding measles vaccination history, 88% of all confirmed cases had no documented history of measles vaccination or their vaccination status was unknown. Based on the genotyping of samples from 42 confirmed cases, genotypes B3 and D8 were identified (4).

In **Brazil**, between EW 20 and EW 28 of 2026, 12 measles cases were confirmed, bringing the total number of cases in the country to 15. The source of infection in these cases is unknown, and the patients have no history of travel. The cases confirmed between EW 20 and EW 28 were reported in the municipalities of São Paulo (n= 10 cases) and São Bernardo do Campo (n= 2 cases) in the state of São Paulo. The cases were distributed among the following age groups: under 1 year of age (n= 5 cases), 1 to 2 years of age (n= 2 cases), 20 to 24 years of age (n= 2 cases), and over 25 years of age (n= 3 cases) (6). Regarding measles vaccination history, two cases had an unknown vaccination history, four had a history of measles vaccination, and six were unvaccinated. Based on genotyping of samples from 10 of the 12 confirmed cases between EW 20 and EW 28, genotype D8 was identified (6).

In **Canada**, between EW 1 and EW 28 of 2026, 1,107 measles cases (1,025 confirmed and 82 probable) were reported in eight provinces: Alberta (n= 311 cases), British Columbia (n= 43 cases), Manitoba (n= 677 cases), New Brunswick (n= 1), Nova Scotia (n= 10 cases), Ontario (n= 29 cases), Quebec (n= 31), and Saskatchewan (n= 5 cases). In 2026, the weekly case count peaked at 90 cases in EW 5 and has been gradually declining since then (7, 8). Of the 1,107 cases reported in 2026, 96% (n= 1,063 cases) were exposed in Canada, 3% (n= 34 cases) were imported cases, and less than 1% (n= 10 cases) had an unknown or under-investigation source of exposure. Forty-one percent of the cases were reported in people aged 5 to 17 years, followed by 40% in people aged 18 years or older, and 15% in children aged 1 to 4 years. Regarding measles vaccination history, 86% were unvaccinated, 4% had received one dose of a vaccine containing the measles virus, 5% had received two or more doses of a vaccine containing the measles virus, and 5% had an unknown vaccination status. Seven percent of the cases were hospitalized (n= 75); four laboratory-confirmed cases of congenital measles have been reported, and no deaths have been reported. Among confirmed cases with available genotyping data, genotype D8 was identified in 564 cases and genotype B3 in 12 cases. (7, 8).

In **Colombia**, between EW 20 and EW 28 of 2026, seven measles cases have been confirmed in the country, bringing the total number of confirmed cases in Colombia to 14. Of the total cases, eight are imported and six are import-related. The confirmed cases were reported in Bogotá, D.C. (n= 7 cases), in the departments of Antioquia (n= 2 cases), Cundinamarca (n= 1 case), Risaralda (n= 1 case), and Santander (n= 1 case), and in the district of Cartagena (n= 2 cases) (10). The cases range in age from 18 to 53 years (12). Regarding measles vaccination history, 11 cases had an unknown vaccination history, and three had a history of measles vaccination. Regarding genotyping, based on the analysis of samples from six of the cases, the identified genotype was D8 (10). During 2025, national vaccination coverage with the measles, mumps, and rubella (MMR) vaccine reached 91% for the first dose and 86% for the second dose (10).

In **El Salvador**, between EW 20 and EW 28 of 2026, 35 measles cases were confirmed in the country, bringing the total cases this year to 53. All cases were imported: 52 of the cases had a history of travel to Guatemala, and one had a history of travel to Mexico. The departments with the highest number of cases are San Salvador (n= 31 cases) and San Miguel (n= 10 cases) (12). Most cases are among people aged 20 to 40. Regarding measles vaccination history, 17% had received two or more doses of a measles-containing vaccine, and 83% had an unknown vaccination status or were unvaccinated. During 2025, national MMR vaccination coverage reached more than 95% for the first dose and more than 95% for the second dose (12).

In **Guatemala**, between the 20th and 28th of EW 2026, 11,455 confirmed measles cases were reported, including three deaths. Since the beginning of 2026, 30,371 confirmed cases and 26 deaths have been reported. Cases were reported in all 22 departments of the country. Most of the confirmed cases were reported in the departments of Guatemala (n= 11,496 cases, including four deaths), Quiché (n= 2,302 cases, including seven deaths), Sololá (n= 1,464 cases, including two deaths), Totonicapán (n= 1,058 cases, including two deaths), Chimaltenango (n= 571 cases, including two deaths), and Huehuetenango (n= 1,797 cases) (13).

Regarding the age distribution of confirmed cases in 2026, the most common age group is 20–29 years, at 37.2% (n= 11,284 cases), followed by the 0–4 age group at 17.28% (n= 5,284 cases, with a predominance of children under 1 year of age, among whom 2,755 cases were recorded) and the 10–19 age group at 14.76% (n= 4,484 cases). The incidence rate by age group shows that the most affected group is 0 to 4 years old, with children under 1 year of age recording 776.30 cases per 100,000 population, followed by the 20 to 29 age group with 333 cases per 100,000 population (14). Regarding measles vaccination history among the 30,371 confirmed cases, 67.1% were unvaccinated, 25.9% (n= 7,865) had an unknown vaccination history, and 3.79% (n= 1,150 cases) had a documented dose of MMR. 9.2% of the cases required hospitalization (n= 2,793 cases), and 25 related deaths have been confirmed (13). According to genotyping conducted at the National Health Laboratory on samples from confirmed cases (n= 88), only genotype D8 has been identified. Of the 26 deaths recorded due to measles complications, 36% were among children under one year of age (13).

In **Honduras**, between epidemiological weeks (EW) 20 and EW 28 of 2026, eleven measles cases were confirmed, bringing the year-to-date total to twelve cases. Of the total cases, six were imported cases and six had a source of infection under investigation. The confirmed cases were reported in the departments of Cortés (n= 7 cases), Islas de la Bahía (n= 3 cases), Yoro (n= 1 case), and Ocotepeque (n= 1 case). Five of the cases had a history of travel to Guatemala, and one was a foreign national from Italy. The cases range in age from <1 year to 43 years (14). Regarding measles vaccination history, 11 cases had an unknown vaccination history, and one had no history of measles vaccination. During 2025, nationwide MMR vaccination coverage reached 86.7% for the first dose and 84.4% for the second dose. (14).

In **Mexico**, between EW 20 and EW 28 of 2026, 1,144 measles cases have been confirmed, including three deaths. In total, 12,255 confirmed cases and 17 deaths have been reported in 2026. Cases were reported in 31 states across the country; the majority of confirmed cases were reported in the state of Jalisco (n= 6,603 cases, including three deaths), Ciudad de México (n= 1,011 cases, including three deaths), and in the states of Chiapas (n= 846 cases), Sonora (n= 371 cases), Durango (n= 573 cases, including one death), Mexico (n= 349 cases),

and Zacatecas (n= 313 cases, including six deaths). Regarding the distribution by age group, confirmed cases are most common among children aged 1 to 4 years (12.1%, n= 1,480 cases), followed by the 5–9 age group (11.9%, n= 1,454 cases) and the 30–34 age group (11.8%, n= 1,444 cases). Regarding the incidence rate, the age group under one year reported the highest rate at 52.15 cases per 100,000 population, followed by the 1–4-year-old and 5–9-year-old age groups, with rates of 17.60 and 13.95, respectively. Regarding measles vaccination history of the confirmed cases, 91.60% (n= 11,226) had no vaccination history, 6.05% (n= 741) had received one dose of MMR, and 2.35% (n= 288 cases) had two or more doses of MMR documented in their national immunization record. Of the total confirmed cases, 1,589 required hospitalization, of which 584 were from the state of Jalisco. According to genotyping performed on samples from confirmed cases (n= 83), genotype D8 has been identified (16). In 2026, as of EW 28, 17 deaths due to measles complications have been confirmed; 13 of these individuals had no history of vaccination, and four had received one dose within 10 days prior to the onset of the rash. The deaths are distributed among Zacatecas (n= 6), Jalisco (n= 3), Ciudad de México (n= 3), Michoacán (n= 1), Guerrero (n= 1), Durango (n= 1), Sinaloa (n= 1), and Tlaxcala (n= 1) (15).

In **Panama**, between EW 20 and EW 28 of 2026, six measles cases have been confirmed: one imported case and five secondary cases resulting from an imported case. The total number of confirmed cases in 2026 is nine. The confirmed cases were reported in the provinces of Panama (n= 8 cases) and Chiriquí (n= 1 case). Genotype B3 has been identified in three of the cases (16).

In **Peru**, between EW 20 and EW 29 of 2026, 916 measles cases have been confirmed in eight departments. This represents an increase of more than 2.5 times over a nine-week period. In 2026, the total number of confirmed cases is 1,277. The cases are concentrated in the department of Puno (n= 1,061 cases); other cases were detected in the department of Lima (n= 25 cases) (17). Regarding the distribution of cases by age group, 30% are in the 10–19 age group (n= 380 cases), followed by the 20–29 age group with 36% (n= 465 cases) and the 5–9 age group with 13% (n= 161 cases). Regarding the incidence rate, the 20–29 age group reported the highest rate at 8.88 cases per 100,000 population, followed by the 0–4 and 10–19 age groups, with rates of 8.24 and 6.92 per 100,000 population, respectively (18). Regarding measles vaccination history of the confirmed cases, 54% (n= 690 cases) had no history of vaccination, 3% (n= 38 cases) had received one dose of MMR, and 26% (n= 332 cases) had received two or more doses of MMR. Of the total confirmed cases, 143 required hospitalization. Based on genotyping performed on 11 samples from confirmed cases, genotypes D8 and B3 were identified (18).

In the **United States**, between EW 20 and EW 28 of 2026, 308 confirmed measles cases were reported, bringing the total for 2026 to 2,260 cases. Of these, 2,245 measles cases were reported by 44 jurisdictions: Alaska (n= 1 case), Alabama (n= 1 case), Arizona (n= 99 cases), California (n= 48 cases), Colorado (n= 24 cases), Connecticut (n= 2 cases), District of Columbia (n= 1 case), Florida (n= 141 cases), Georgia (n= 5 cases), Iowa (n= 1 case), Idaho (n= 3 cases), Illinois (n= 4 cases), Kansas (n= 1 case), Kentucky (n= 4 cases), Louisiana (n= 1 case), Maine (n= 5 cases), Maryland (n= 9 cases), Massachusetts (n= 2 cases), Michigan (n= 13 cases), Minnesota (n= 17 cases), Missouri (n= 2 cases), Montana (n= 5 cases), Nebraska (n= 1 case), New Jersey (n= 1 case), New Mexico (n= 17 cases), New York City (n= 5 cases), New York State (n= 8 cases), North Carolina (n= 22 cases), North Dakota (n= 38 cases), Ohio (n= 11 cases), Oklahoma (n= 1 case), Oregon (n= 32 cases), Pennsylvania (n= 110 cases), Rhode Island (n= 1 case), South Carolina (n= 670 cases), South Dakota (n= 11 cases),

Tennessee (n= 2 cases), Texas (n= 182 cases), Utah (n= 518 cases), Vermont (n= 1 case), Virginia (n= 176 cases), Washington (n= 45 cases), Wisconsin (n= 2 cases), and Wyoming (n= 2 cases). A total of 15 measles cases were reported among international visitors to the United States (19).

Of the total number of cases, 93% (n= 2,108 cases) were associated with outbreaks (defined as three or more related cases), and 34 outbreaks were identified in 2026. Twenty percent (n= 451 cases) of the cases occurred in children younger than 5 years of age, 50% (n= 1,130 cases) were among people aged 5 to 19 years, 30% (n= 672 cases) were among people aged 20 years and older, and less than 1% (n= 7 cases) were among people of unknown age. The incidence rate by age group shows that the most affected group was children aged 1 to under 5 years (2.46 per 100,000 population), followed by children under 1 year of age (2.24 cases per 100,000 population) (19).

Regarding measles vaccination history of the cases, 93% were unvaccinated or had an unknown vaccination history, 3% had received a single dose of the MMR, and 4% had received two doses. Among the confirmed vaccinated cases, 9% were children under 5 years of age, 34% were individuals aged 5 to 19 years, and 57% were adults over 20 years of age. Six percent (n= 146 cases) of the cases required hospitalization, and 31% (n= 45 cases) of the hospitalizations involved children under 5 years of age (19).

In 2026, of the 771 samples that tested positive by real-time reverse transcription polymerase chain reaction (rRT-PCR) from confirmed measles cases that have undergone genotyping to date, 97% (n= 747) were genotype D8 and 3% (n= 24) were genotype B3. Among the genotype D8 detections, the majority—91% (n= 683)—were identified as the distinctive sequence (DSId) 9171 (19).

In **Uruguay**, between EW 1 and EW 20 of 2026, two imported measles cases were confirmed, both in the country's capital, Montevideo. The cases were 48 and 51 years old. Regarding measles vaccination history, one of the cases was unvaccinated, and the other had received two doses of the measles-rubella vaccine (MRV). The cases did not require hospitalization. During 2025, nationwide MMR vaccination coverage reached 97.92% for the first dose and 87.9% for the second dose (20).

Guidance for Member States

The occurrence of large-scale, prolonged outbreaks in several countries highlights the fragility of the achievement of measles elimination in the Region. This situation is characterized by an increased risk of morbidity and mortality among children under 5 years of age—especially those under 1 year of age—as well as significant transmission among young adults, a group with high mobility, and the particular vulnerability of the indigenous population, all of which shape the epidemiological dynamics and impact of the disease on the population.

In light of this, it is urgent to achieve and sustain herd immunity by attaining $\geq 95\%$ coverage with two doses of the measles, mumps, and rubella (MMR) vaccine uniformly nationwide; strengthen epidemiological surveillance for the timely detection of cases; and consolidate the capacity for rapid and effective response to prevent the emergence of long chains of transmission. This combined strategy will prevent the reintroduction and endemic transmission of the virus in non-endemic countries in the Americas Region, as well as restore elimination status in those where endemic transmission has re-emerged.

Taking into account regional transmission dynamics, three epidemiological scenarios have been identified: areas with no cases, areas with limited transmission and identifiable chains of transmission, and areas with community transmission. In each of these scenarios, the progressive implementation of preparedness and response activities for measles outbreaks is recommended; these activities have been grouped into five pillars/components: coordination, surveillance, clinical management and infection prevention and control, immunization, and risk communication and community engagement. All this information has been organized into the PAHO **measles preparedness and response matrix**, which is available (in Spanish) from: <https://iris.paho.org/items/6e7fdf61-bd6f-4f22-99ac-71c5e2a6d3fd> (27).

Furthermore, another factor that can facilitate the importation and spread of the virus nationwide is the occurrence of mass gatherings and international travel.

Mass gatherings and international travelers

Regarding mass gatherings 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 high-risk areas and implement preventive measures. In the context of large gatherings, countries should increase the sensitivity of their surveillance systems through the implementation of active case-finding to document the absence of measles and rubella cases and to provide information and vaccination services to travelers.

- **Regarding travelers**

Before Travel

PAHO/WHO recommends that Member States advise all travelers aged six months³ or older who cannot provide proof of vaccination (with two doses of the measles-rubella vaccine) or immunity to **receive one dose of the measles-rubella vaccine, preferably two weeks before traveling to areas where measles or rubella transmission has been documented.**

It is recommended that health authorities 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)

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

During the trip

Advise travelers that if they develop symptoms during their trip that lead them to suspect they have contracted measles or rubella, they should do the following:

- Seek immediate care from a healthcare professional.
- Avoid close contact with others for seven days starting from the onset of the rash. To reduce the risk of transmission (the contagious period for measles is four days before to four days after the onset of the rash, and the contagious period for rubella is seven days before to seven days after the onset of the rash; since it is difficult to distinguish between the two diseases, it is recommended to use the broader timeframe) wear a mask for seven days starting from the date the rash appears; this will reduce the risk of transmission.
- Stay at your place of lodging (e.g., hotel or home, etc.), except to visit a doctor or as recommended by a healthcare professional. When going out, always wear a mask during the contagious period. Wear a mask in your room with the door closed if you are living with unvaccinated people.

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

Upon Return

- If travelers suspect upon their return that they have contracted measles or rubella, they should contact their health care provider and inform the doctor about their trip.
- **For physicians and other health professionals**
PAHO/WHO recommends:
 - Promote and verify that health sector personnel—including medical, laboratory, administrative, cleaning, and security staff, among others—are fully vaccinated (two doses) against measles and rubella.
 - Raise awareness among health workers, including those in the private sector, about the need for immediate reporting of all suspected cases of measles or rubella to ensure a timely response from national public health authorities, in accordance with the guidelines of the national surveillance and rapid outbreak response system.
 - Remind health care workers of the need to inquire about patients' travel history and vaccination history.
- **Identification and contact tracing for confirmed cases of measles or rubella**
 - Conduct contact identification and tracing activities for contacts identified and present within the country, in accordance with national guidelines and directives.
 - Take into account the international implications that may arise during contact tracing, and consider the following scenarios and operational aspects when carrying out these activities:

- a. When a case is identified by the national authorities of another Member State and the national authorities are requested 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 remain vigilant and can promptly detect any suspected cases.
- b. When a case is identified locally—and depending on the stage of the disease's natural history at the time of detection—it may require:
 - *Current case*: National authorities should obtain information on the possible source of infection and the location of contacts abroad and accordingly notify the relevant national authorities in the country where the case is presumed to have been infected or where the contacts are located.
 - *Retrospectively identified case*: Based on the case's travel history, national authorities should notify the national authorities of the relevant country, as this situation could be the first indication of virus circulation or an outbreak in the other country or countries concerned.
 - i. Conduct active institutional and community-based contact tracing to rapidly detect cases among contacts not identified during the outbreak investigation, by tracing the movement of the case(s).

Operational Notes

For the international contact tracing of confirmed cases of measles or rubella, either of the following two scenarios of exposure to a confirmed case may arise:

- **When international modes of transportation (e.g., airplanes, cruise ships, trains) are not involved**, national authorities should communicate with their counterparts in other countries through the National IHR Focal Point (NFP) or through other existing bilateral and multilateral programmatic mechanisms, with a copy to the Regional WHO IHR Contact Point. If deemed necessary, national authorities may request support from the Americas Regional WHO IHR Contact Point to facilitate communications related to international contact tracing.
- **When international modes of transportation (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 do not exist. For subsequent communication among national authorities, see the previous point.

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

Channels for Disseminating the Guidance

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

- Public awareness campaigns to promote and improve travelers' health 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 include healthcare services or travel clinics, airports, ports, train and bus stations, and airlines operating in the country, among others.
- Travel agencies, tourism-related organizations, and diplomatic missions should also be aware of and disseminate the necessary recommendations that travelers should follow before their trip.
- Communicate the contents of existing national surveillance guidelines to physicians and other health care workers and promptly disseminate any new protocols the country develops regarding travelers.

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