

Regional Situation Report · No. 8

Measles in the Region of the Americas

31 July 2026 · Next issue: 13 August 2026

REPORTING PERIOD: EW 1–29, 2026 (4 Jan 2026 – 25 July 2026) · 2-week change window: EW 27–28 vs. EW 25–26		
CUMULATIVE — EW 1–29, 2026		
47,026 CONFIRMED CASES	48 DEATHS CFR 0.10%	17 COUNTRIES AND TERRITORIES (CUMULATIVE) ¹
LAST 2 WEEKS — EW 27–28, 2026		
+1,697 NEW CONFIRMED CASES ↓ -6.7% <i>(compared to EW 25 – EW 26)²</i>	+1 NEW DEATHS <i>One new death in Mexico</i>	7/17 COUNTRIES AND TERRITORIES REPORTING <i>Bolivia (Plurinational State of), Canada, Colombia, Guatemala, Mexico, Peru and United States of America.</i>

Situation Overview

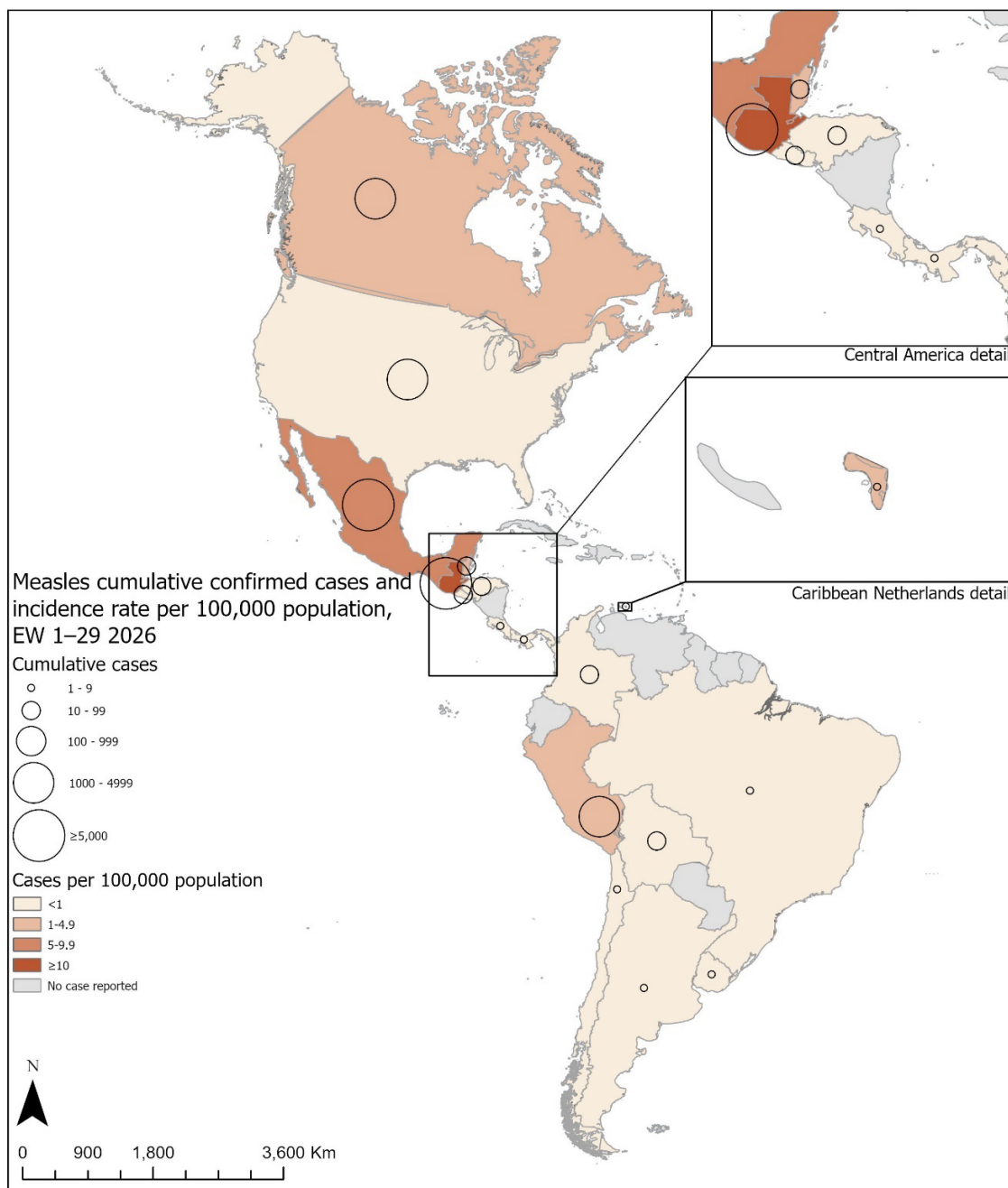
Between epidemiological week (EW) 1 and EW 29 of 2026 (ending on 25 July 2026), the Region of the Americas reported **47,026** confirmed measles cases from 17 countries and territories, representing approximately a 5-fold increase compared to the same period in 2025. Guatemala (30,040), Mexico (12,233), the United States (2,318) and Canada (1,107) accounted for the majority (97%) of confirmed cases (**Map 1**). Additionally, **48** deaths have been reported (1). **The increase in the regional cumulative total compared with Situation Report No.7 is primarily attributable to Guatemala, which remains the major contributor of newly confirmed cases** with 1395 added cases, followed by additional cases reported by Mexico with 119 added cases, Peru with 93 added cases, the United States with 77 added cases, Canada with 9 added cases, Bolivia with 3 added cases and Colombia with 1 added case.

During EW 27 and EW 28 of 2026, the Region of the Americas reported **1,697** new confirmed measles cases across seven countries and territories, representing a 6.7% decrease compared with the previous two-week period (EW 25–26; 1,818 new cases)² (**Figure 1**). The decrease was driven mainly by fewer cases reported in Guatemala after the retrospective update was incorporated in the previous situation report.

Following the earthquakes, while the risk of measles introduction and spread in Venezuela remains a concern, there have been no confirmed cases reported in the country thus far.

¹ Since Situation Report 6, no additional country has reported measles cases for the first time in 2026.

**Map 1. Confirmed measles cases and incidence rate per 100,000 population by country. Region of the Americas.
EW 1 – EW 29, 2026. (n=47,026)**



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The designations employed and the presentation of the material in these maps do not imply the expression of any opinion whatsoever on the part of the Secretariat of the Pan American Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement.
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 (2)	PAHO continued supporting the national measles response through technical coordination on surveillance, immunization, clinical management, and risk communication; installation of mobile vaccination posts in the three FIFA World Cup 2026 host cities, including at high-concentration areas such as the 2026 Global Village in Mexico City and FIFA Fan Fests in Guadalajara and Monterrey; a coordination meeting with the National Center for the Health of Children and Adolescents (CeNSIA, per its acronym in Spanish) to follow up on ongoing technical cooperation activities; hosting a virtual seminar on the 7-1-7 methodology, with participation from CeNSIA and the Directorate General of Epidemiology (DGE, per its acronym in Spanish); and continued preparations for the workshop to evaluate the outbreak response and conduct a strategic analysis for interruption of measles transmission in Mexico.	A workshop to review the outbreak response in Mexico is scheduled for August 5-7, 2026, using the 7-1-7 methodology. During the workshop, the 7-1-7 approach will be applied and complemented by an in-depth analysis of the outbreak's epidemiological evolution and vaccination strategies, with particular emphasis on the most recent eight-week period. The objective is to identify operational bottlenecks, population groups, and geographic areas that continue to sustain transmission, and to define targeted strategic actions that will accelerate outbreak control and interrupt transmission as quickly as possible.
Guatemala (3)	In support of the Ministry of Health-led response, PAHO continued providing technical cooperation across the five response pillars, including strengthening national and subnational surveillance through training, weekly consultations, IHR notification, Go.Data-ISIS interoperability, and data-quality improvement; continued support to the National Measles Commission for mortality and case-fatality analyses and identification of gaps in clinical management and primary care interventions; advanced preparations for surveillance, response, and micro-planning training and simulation exercises in Quiché, Chiquimula, Alta Verapaz, Ixil, and Huehuetenango; supported the reassessment of susceptible populations and estimation of human resources, transportation, logistics, and vitamin A needs for vaccination activities and case	Continue supporting national authorities in strengthening outbreak response; submitting the request for additional vaccines for the national vaccination campaign and securing funding for the procurement of additional vaccine doses and syringes as planned by health districts; advancing resource mobilization efforts to secure funding for continued technical support; and advancing culturally appropriate community engagement and communication materials, including guidance for teachers, midwives, and community leaders in Mayan languages.

Country	Joint response this period	Focus for the next 2 weeks PAHO actions
	management; reviewed and revised the Guide for Teachers, Midwives, and Community Leaders on measles community surveillance and vaccination, with translation into Mayan languages underway; and continued development of the vaccination campaign dashboard to monitor the outbreak response and track doses administered.	
United States	Ongoing technical exchange with national authorities.	Continued coordination and collaboration on measles outbreak response
Bolivia (4)	PAHO continued providing technical assistance to strengthen measles outbreak-closure activities and vaccination efforts in Bolivia. In Santa Cruz, a technical mission supported the review and validation of departmental documentation, addressed reporting gaps, and established coordination with the new Director of Epidemiology, with documentation progress exceeding 95%. Inter-agency coordination also continued among the Health Promotion Directorate, EPI, and Ministry of Defense to plan vaccination activities in military units. In La Paz, an interdepartmental and inter-institutional meeting in Copacabana focused on strengthening measles vaccination plans and restoring coverage in priority municipalities, while a mission in Cochabamba monitored activities, supported operational planning, assessed communication interventions, and coordinated vaccination of conscripts and pre-military personnel. Regarding communication and social mobilization, 100% of PAHO technical cooperation resources allocated for June–July had been utilized, while overall implementation reached 83% based on departmental reports. Performance was strongest in La Paz, Pando, Oruro, Chuquisaca, and Tarija; good in Beni and Cochabamba; and fair in Potosí and Santa Cruz. The latter two departments were encouraged to intensify communication efforts on vaccination and immunization, strengthen internal coordination, and improve monitoring of planned activities.	Continue providing technical follow-up on outbreak-closure documentation and support the implementation of the VacunaTok strategy, scheduled for the second half of August. Technical capacities for outbreak investigation, contact tracing, and rapid response will also be strengthened in Santa Cruz and its health networks.

PAHO Response by Strategic Pillar (5)³

Coordination

- PAHO has finalized a [Strategic Response Plan for the regional measles outbreak](#), developed by the IMST into a donor-ready Appeal format. The Appeal sets out the resource requirements for the regional response and is being disseminated via the PAHO webpage and social media, with direct outreach underway to strategic humanitarian donors. Its objective is to mobilize the financial resources needed to sustain surveillance, immunization, and clinical response activities across affected and at-risk countries.
- To operationalize the response, the IMST developed a [Measles Preparedness and Response Matrix](#), organizing recommended actions across six technical pillars — Coordination; Surveillance, Laboratory, Case Investigation and Contact Tracing; Clinical Management; Immunization; Risk Communication and Community Engagement; and Rapid Response — differentiated by three epidemiological scenarios (no transmission, characterizable transmission chains, community transmission). The matrix was produced through regional and country office consultation and gives Member States a single reference to calibrate their response posture as local epidemiology evolves.

Partnerships and Communications

- Presentations were delivered to PAHO Country Offices on resource mobilization, highlighting opportunities for creative approaches to securing in-kind contributions and strengthening partnerships, alongside traditional funding mobilization efforts.
- Public communication was strengthened through the publication of a news article on the PAHO website highlighting WHO and UNICEF estimates showing that routine immunization coverage has rebounded across the Americas, while declining measles vaccination coverage continues to leave communities vulnerable to outbreaks (5).

Collaborative Surveillance

- Provided financial and technical support for measles outbreak response activities in Brazil and Ecuador.
- In collaboration with the International Federation of Red Cross and Red Crescent Societies (IFRC), two consultants were deployed to support the response in Mexico and established weekly coordination meetings. With their support, preparations are underway to conduct a 7-1-7 evaluation in the country.
- In collaboration with national authorities in Peru, supported the implementation of response activities aimed at halting measles transmission among Indigenous populations in Yurimaguas.
- Conducted training on the 7-1-7 methodology in Costa Rica with immunization focal points from Guatemala and Bolivia. In addition, a virtual training on the methodology was conducted with participation from the majority of countries in the Region.
- Continued coordination with national authorities in Guatemala to strengthen the national information system, contributing to improved data quality and ensuring that epidemiological data remain updated in the system.

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.

Immunization & Vaccine Operations

- Supported vaccination activities in Guatemala.
- The initial shipment of vaccines procured through the Regional Revolving Fund and donated by Brazil was delivered to Venezuela to support the ongoing emergency response.
- Vaccination activities and progress reported by countries with community transmission and those classified as high risk are summarized in the following table:

Table 2. Vaccination Situation and Response Progress in Priority Countries

Country	Classification	Vaccination activities and progress
Peru	Community transmission	Limited progress in activities and changes in the representation of local authorities have been reported.
Mexico	Community transmission	Immunization response through the implementation of vaccination blocks, documented vaccination sweeps, and the establishment of large-scale vaccination sites including the installation of mobile vaccination posts in the three FIFA World Cup 2026 host cities, including at high-concentration areas such as the 2026 Global Village in Mexico City and FIFA Fan Fests in Guadalajara and Monterrey
Venezuela	High risk	The initial shipment of vaccines procured through the Regional Revolving Fund and donated by Brazil was delivered to Venezuela on 21 July 2026 to support the ongoing emergency response. Additional donations are pending.

Risk & Crisis Communication and Community Engagement

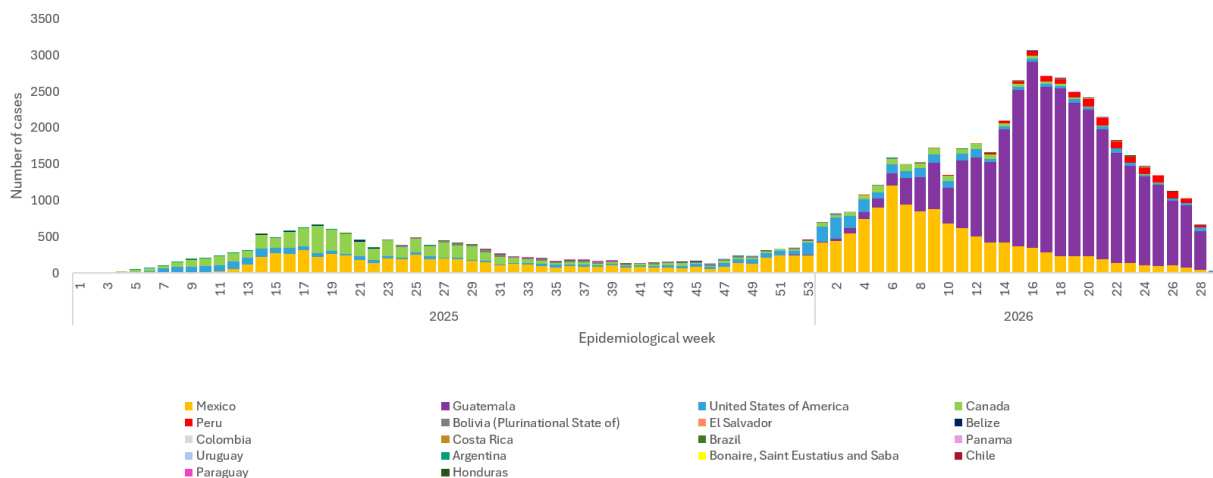
- Launched a virtual course in English for health workers on combating vaccine misinformation. Available from: <https://www.paho.org/en/news/23-7-2026-paho-launches-virtual-course-health-workers-combating-vaccine-misinformation>
- Supported the preparation of a video for vaccination campaign in Ecuador. Available from: <https://www.facebook.com/reel/1672786067351447>
- Supported the Ministry of Health of Peru in developing a module on risk communication and community engagement for a course on epidemic surveillance, investigation, and response to measles outbreaks for rapid response teams.

Operations support and Logistics

- Deployed two experts to provide technical support for vaccination activities in areas affected by the earthquake in Venezuela.

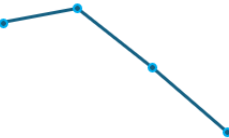
Epidemiological Situation

Figure 1. Epidemiological curve of confirmed measles cases in the Region of the Americas by country and EW, from EW 1 2025 to EW 29 2026

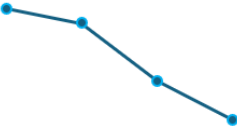


The table below summarizes the epidemiological situation in countries that have reported confirmed measles cases.

Table 3. Measles cases in the Region of the Americas by country, as of EW 29 2026

Country	Cases 2026 (up to EW 29) (1)	Deaths 2026 (up to EW 29) (1)	Trend (last 4 weeks)**	Re-Verification Commission classification (6)	Epidemiological notes
Guatemala*	30,040 ⁴	29	 ↓ declining	Sustained elimination	Transmission continues to be reported across all 22 departments. Despite the overall national declining trend, in recent weeks, transmission appears to be primarily driven by cases reported in a limited number of departments including Guatemala Central, Izabal and Alta Verapaz. The highest incidence rates are observed in Izabal (314.6 cases per 100,000 inhabitants), followed by Guatemala Central (295.5 per 100,000 inhabitants) and Sololá (289.4 per 100,000 inhabitants). Of all confirmed measles cases, 63% occurred among individuals aged 15–39 years, with the 20–29-year age group being the most affected. Among children under one year of age, those aged 4–11 months accounted for the largest proportion of cases. The sex distribution was relatively balanced, with females accounting for 51% of cases and males for 49%. Last case was on EW 28 of 2026.
Mexico*	12,233	18	 ↓ declining	Sustained elimination with major concerns	Most new cases in 2026 were reported in Jalisco (6,701), Ciudad de Mexico (1,013), and Chiapas (858). Last case was on EW 29 of 2026.

⁴ Reported figures now include laboratory-confirmed, epidemiologically linked, and clinically confirmed cases

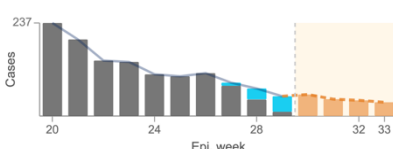
Country	Cases 2026 (up to EW 29) (1)	Deaths 2026 (up to EW 29) (1)	Trend (last 4 weeks)**	Re-Verification Commission classification (6)	Epidemiological notes
United States*	2,318	0	↑increasing 	Sustained elimination with major concerns	In 2026, the highest numbers of cases have been reported in South Carolina (670), Utah (522), Texas (188), Virginia (176), Florida (141), Pennsylvania (134) and Arizona (108). Last case was on EW 29 of 2026.
Canada*	1,107	0		Endemic	In 2026, the highest numbers of cases have been reported in Manitoba (677), Alberta (311), British Columbia (43), Quebec (31) and Ontario (29). In recent weeks, transmission appears to be primarily driven by cases reported in a limited number of provinces including British Columbia, Manitoba and Quebec. The most affected age group ranges from 5-17 years of age (41%). Last case was on EW 28 of 2026.
Peru*	1,139	0	↓ declining 	Sustained elimination	Cases reported in 2026 continue to be concentrated in Puno with 90% of the cases, followed by Arequipa, Lima, Cusco, Moquegua, Lambayeque, Huánuco, Tacna, Madre de Dios, and Junin. The most affected age group is between 10-29 years of age. Last case was on EW 28 of 2026.
Bolivia*	85	1	Drop by drop transmission with sporadic cases that are part of the same outbreak	Sustained elimination with major concerns	Last case was on EW 29 of 2026.
El Salvador	42	0	Sporadic importations	Sustained elimination	Last case was on EW 26 of 2026.
Colombia	14	0	Sporadic importations	Sustained elimination	Last case was on EW 27 of 2026.
Belize	11	0	Sporadic importations	Sustained elimination	Last case was on EW 20 of 2026.

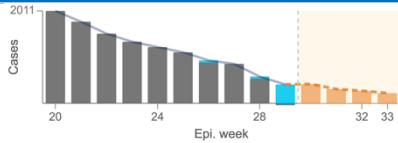
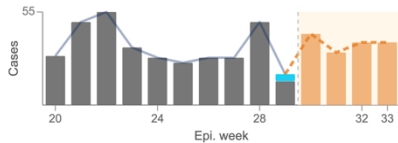
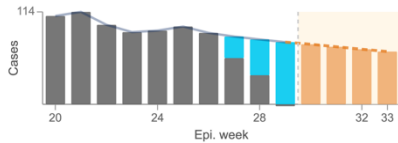
Country	Cases 2026 (up to EW 29) (1)	Deaths 2026 (up to EW 29) (1)	Trend (last 4 weeks)**	Re-Verification Commission classification (6)	Epidemiological notes
Honduras	10	0	Sporadic importations	Sustained elimination with major concerns	Last case was on EW 26 of 2026.
Panama	9	0	Sporadic importations	Sustained elimination	Last case was on EW 23 of 2026.
Brazil	8	0	Sporadic importations	Sustained elimination with moderate concerns	Last case was on EW 24 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, Chile, and Uruguay. See Pan American Health Organization / World Health Organization (PAHO/WHO) Measles Dashboard: <https://tinyurl.com/3xtciv84> (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 (in blue bars) corrects the most recent weeks for reporting delays. Short-term forecasting (in orange bars) 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 29, 2026

Country	R_t (95% CrI) ¹ Effective reproduction number	Model-based trend ²	4-week forecast (EW 30–33) median [95% PrI] ³	Modeling interpretation
Mexico	0.77 [0.68 – 0.85]	↓ declining	~173 [114–240] 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	0.67 [0.64 – 0.69]	↓ declining	~1,225 [1,070–1,388] cases	R_t is estimated at 0.67 [0.64–0.69], remaining substantially below the epidemic threshold. This indicates ongoing

Country	R_t (95% CrI) ¹ Effective reproduction number	Model-based trend ²	4-week forecast (EW 30–33) median [95% PrI] ³	Modeling interpretation
				contraction of transmission, with projections supporting a continued downward trend.
United States	1.08 [0.90 – 1.28]	↓ declining	~147 [87–226] cases 	R_t is estimated at 1.08. Although the point estimate is slightly above 1, the uncertainty around the estimate does not allow a clear conclusion regarding changes in transmission. Continued monitoring is warranted.
Canada	— ⁴	— ⁴	— ⁴	Modeling not performed — see footnote 4. Of 1,107 cases in 2026, 1,021 remain linked to the outbreak that began in October 2024, now in sustained decline.
Peru	0.92 [0.82 – 1.02]	↓ declining	~278 [199–370] cases 	R_t is estimated at 0.92. While the point estimate is below 1, current uncertainty does not allow a clear inference of declining transmission. Continued monitoring is needed to confirm whether this trend is sustained.
Bolivia	— ⁴	— ⁴	— ⁴	Modeling not performed — see footnote 4.

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 (8). 95% CrI = 95% credible interval. See Technical Notes.

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

³Median 4-week forecast and 95% prediction interval (PrI) for projected new cases over EW 30–33, conditional on the current estimated R_t .

⁴Bolivia and Canada: 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.

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 (R_t).

Case data. Weekly confirmed measles case counts were obtained from national surveillance systems reported to Pan American Health Organization / World Health Organization (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 (8).

Effective reproduction number (R_t). R_t was estimated using the EpiEstim method (8), which applies to 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 (8). The serial interval was treated as fixed; this simplification modestly underestimates R_t uncertainty but does not affect the qualitative trend classifications presented. R_t 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 R_t : **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 R_t . 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 Ministry of Public Health and Social Assistance (MSPAS per its acronym in Spanish) Protocolo V3 (16 March 2026) — may affect interpretation of trends in individual countries and are flagged in the country annex.

References

1. Pan American Health Organization. PAHO Regional Measles Dashboard. Washington D.C.: PAHO; 2026 [cited 27 July 2026]. Available from: <https://app.powerbi.com/reportEmbed?reportId=71eebf72-f738-4475-b404-d84f41c7e05a&autoAuth=true&ctid=e610e79c-2ec0-4e0f-8a14-1e4b101519f7>.
2. Pan American Health Organization. Mexico Measles IMST Update, 24 July 2026. Mexico City: PAHO; 2026. Unpublished.
3. Pan American Health Organization. Guatemala Measles IMST Update, 27 July 2026. Guatemala City: PAHO; 2026. Unpublished.
4. Pan American Health Organization. Bolivia Measles IMST Update, 27 July 2026. Sucre: PAHO; 2026. Unpublished.
5. Pan American Health Organization. WHO and UNICEF estimates show routine immunization has rebounded in the Americas, but declining measles coverage leaves communities vulnerable to outbreaks. Washington, D.C.: PAHO; 15 July 2026. Available from: <https://www.paho.org/en/news/15-7-2026-who-and-unicef-estimates-show-routine-immunization-has-rebounded-americas-declining>.
6. Pan American Health Organization. Fifth annual meeting of the Measles and Rubella Elimination Regional Monitoring and Re-Verification Commission. Mexico City, 4–7 November 2025. Washington D.C.: PAHO; 2026. Available from: <https://iris.paho.org/items/e47bcb10-404d-496e-b864-004139518b36>.
7. Government of Canada. Epidemiological week 24 (June 14 to 20, 2026) - Measles and rubella weekly monitoring report. Ottawa: GC; 2026. Available from: <https://health-infobase.canada.ca/measles-rubella/>
8. Cori A, Ferguson NM, Fraser C, Cauchemez S. A new framework and software to estimate time-varying reproduction numbers during epidemics. *Am J Epidemiol*. 2013;178(8):1505–1512. Available from: https://www.researchgate.net/publication/256666227_A_New_Framework_and_Software_to_Estimate_Time-Varying_Reproduction_Numbers_During_Epidemics.
9. McGough SF, Johansson MA, Lipsitch M, Menzies NA. Nowcasting by Bayesian smoothing: A flexible, generalizable model for real-time epidemic tracking. *PLoS Comput Biol*. 2020;16(4):e1007735. Available from: https://www.researchgate.net/publication/340470847_Nowcasting_by_Bayesian_Smoothing_A_flexible_generalizable_model_for_real-time_epidemic_tracking.
10. Groendyke C, Welch D, Hunter DR. A network-based analysis of the 1861 Hagelloch measles data. *Biometrics*. 2012 Sep;68(3):755–65. doi: 10.1111/j.1541-0420.2012.01748.x. Epub 2012 Feb 24. PMID: 22364540; PMCID: PMC4553425. Available from: <https://pmc.ncbi.nlm.nih.gov/articles/PMC4553425/>.