

Regional Situation Report · No. 9

Measles in the Region of the Americas

August 14, 2026 · Next issue: August 27, 2026

REPORTING PERIOD: W1–31, 2026 (January 4 – August 8, 2026) · Two-week transition window: W29–30 vs. W27–28 ¹		
CUMULATIVE — WEEKS 1–31, 2026		
48,690 CONFIRMED CASES	51 Deaths Case Fatality Rate (CFR) 0.10%	17 COUNTRIES AND TERRITORIES (CUMULATIVE) ²
LAST 2 WEEKS — WEEKS 29–30, 2026		
+695 NEW CONFIRMED CASES ↓ -59% <i>(compared to WEEKS 27–28)²</i>	+1 NEW DEATHS <i>One new death in Mexico</i>	5/17 COUNTRIES AND TERRITORIES THAT HAVE REPORTED CASES: <i>Bolivia (Plurinational State of), Canada, Guatemala, Mexico, and the United States of America.³</i>

Summary of the Situation

Between epidemiological week (EW) 1 and EW 31 of 2026 (which ended on August 8, 2026), the Region of the Americas reported **48,690** confirmed cases of measles in 17 countries and territories, representing an approximately fourfold increase compared with the same period in 2025. Guatemala (31,140), Mexico (12,479), the United States (2,465), and Canada (1,114) accounted for the vast majority (97%) of confirmed cases (**Map 1**). In addition, **51** deaths have been reported (¹). **The increase in the regional cumulative total compared with Situation Report No. 8 is primarily due to the 695 additional cases reported in Guatemala, 199 in United States, 118 in Mexico—all three with community transmission—and 5 five in Canada as well as five additional cases in Bolivia, where transmission is limited².**

During epidemiological weeks (EW) 29 and 30 of 2026, the Region of the Americas reported **695** new confirmed cases of measles in five countries and territories, representing a 59% decrease compared with the previous two-week period (EW 27–28; 1,697 new cases)⁴ (**Figure 1**). However, the decrease is primarily attributable to reporting delays among countries with ongoing transmission.

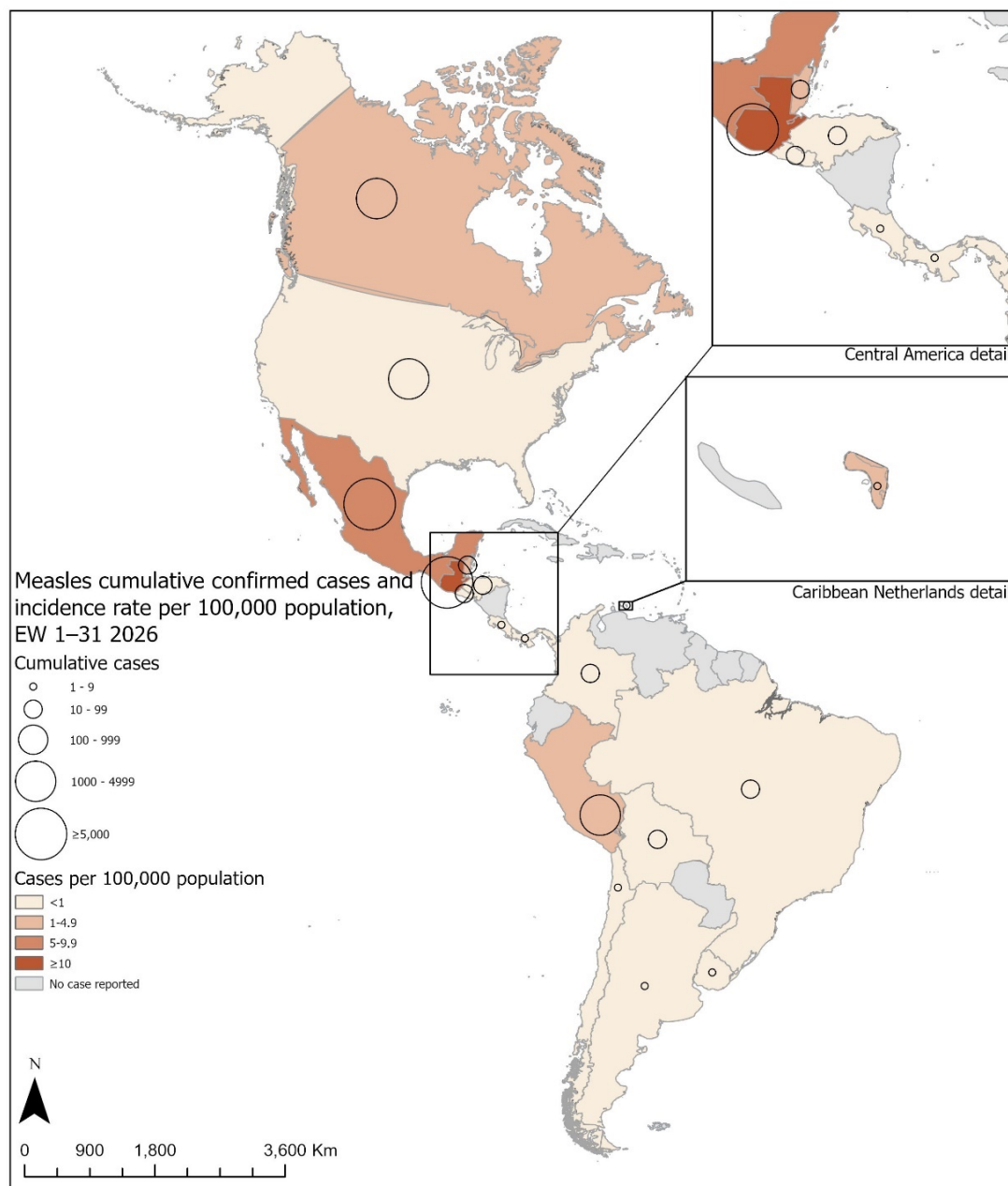
Although the risk of measles introduction and spread persists in Colombia, following the earthquake on 10 August 2026, no confirmed cases associated with the event have been reported in the country to date.

¹ Please note that figures presented in this Situation Report may differ from those shown in [PAHO's online measles dashboard for the Region of the Americas](#). The Situation Report reflects information available as of EW 31, 2026, while the dashboard is updated on a rolling basis as new data become available.

² Underreporting and reporting delays may result in an underestimation of the total number of measles cases reported.

³ Since Situation Report No. 6, no other country has reported any new cases of measles in 2026.

Map 1. Confirmed cases of measles and incidence rate per 100,000 inhabitants by country. Region of the Americas. EW1 – 31, 2026. (n = 48,690)



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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 ongoing operational response of the Pan American Health Organization (PAHO) to the regional measles situation. The *Operational Overview* summarizes the situation in priority countries and the technical cooperation being carried out with each of them. *PAHO's Response by Strategic Pillar* consolidates regional actions across the four operational pillars that guide the Organization's response: epidemiological surveillance and laboratory diagnosis; immunization and vaccination operations; risk communication and community engagement; and operational preparedness and partnerships.

Operational Overview — Priority Countries

Table 1. Operational Summary of Priority Countries and Joint Response Actions

Country	Joint Response During This Period	Approach for the Next 2 Weeks PAHO Actions
Mexico (2)	In coordination with the General Directorate of Epidemiology (DGE), the National Center for Child and Adolescent Health (CeNSIA), and the International Federation of Red Cross and Red Crescent Societies (IFRC), a phased work plan for October 2026, December 2026, and March 2027 was advanced, with indicators to monitor surveillance, laboratory, and vaccination efforts — targeting epidemiological control of outbreaks in Zacatecas, Durango, Jalisco, and Chiapas by November 2026 The 7-1-7 outbreak-response review workshop took place from 5-6 of August, where teams from Jalisco, Durango, and Zacatecas, identified bottlenecks and tailored actions to strengthen the response.	The Regional Verification Commission for Measles and Rubella will visit Jalisco and Mexico City, Mexico, from 17 to 19 August to review progress and recommend adjustments to strengthen outbreak control strategies. Promote greater coordination among the various entities within the health sector and the continuous adaptation of vaccination strategies to the epidemiological situation through the reactivation of the (ERRa).
Guatemala (3)	PAHO continued support the Ministry of Health on surveillance, risk assessment (using the PAHO measles risk assessment tool), and outbreak-response planning, including simulation exercises and micro-planning workshops in the context of the Chiquimula outbreak. A technical document was prepared for the United Nations agencies and the United Nations Office for the Coordination of Humanitarian Affairs (OCHA) to support a measles proposal for humanitarian funding through OCHA-managed pooled funding mechanisms, and work began on adapting the regional emergency plan to the Guatemalan context in dialogue with partners, including UNICEF and Jhpiego. Regarding vaccination, the financial operational plan for the national campaign was developed, and support was provided for logistical planning and coordination with the Ministry of Public Health and	Continue to support national authorities in their response to the outbreak, with an emphasis on mobilizing resources to ensure the continuity of priority interventions, while preserving and strengthening avenues for cooperation through which PAHO contributes its technical and coordination capacity. Likewise, promote mechanisms to strengthen coordination and collaboration between PAHO in Guatemala and implementing partners, including Jhpiego, the Executive Secretariat of the Council of Ministers of Health of Central America and the Dominican Republic (SE-COMISCA), and the Centers for Disease Control and Prevention (CDC).

Country	Joint Response During This Period	Approach for the Next 2 Weeks PAHO Actions
	Social Assistance (MSPAS) for a measles vaccination drive targeting United Nations System staff and their families. In the area of risk and crisis communication and community engagement, the Guide for Teachers, Midwives, and Community Leaders on Measles, Community Surveillance, and Vaccination was reviewed and revised (Mayan languages is in progress), and a lead midwife was trained as a facilitator for departmental awareness-raising sessions with midwives and community leaders.	
Bolivia (4)	PAHO continued to provide technical assistance to strengthen activities to bring the measles outbreak to a close and vaccination efforts in Bolivia. Case-closure documentation has been completed and validated in seven of Bolivia's nine departments, with the national final report at 70% of expected completion — including regional case closures, epidemiological information, and methodological annexes. Following the confirmation of a positive measles case in La Paz, the municipalities of La Paz and El Alto declared an epidemiological alert and agreed on joint actions to strengthen surveillance, intensify vaccination, and manage risk communication. Within this framework, operational guidelines for an immediate response and an institutional graphic package consisting of six digital banners were developed, and a working group was established with the communications units. Inter-institutional coordination was maintained through daily situation-room participation, communications and reporting and media monitoring, alongside a vaccination-scheduling campaign for conscripts and pre-military-service trainees, jointly led by the Ministry of Health and Sports, the Expanded Program on Immunization (EPI), and military units. Additionally, plans are underway to hold two community meetings in Oruro and Potosí aimed at restoring vaccination coverage—including measles vaccination—following recent social unrest. These activities are scheduled for the week of August 10–14.	Strengthen technical capacities for outbreak investigation, contact tracing, and rapid response in the departments of Santa Cruz and La Paz, as well as within their health networks. Furthermore, strengthen political commitment in Santa Cruz to prioritize halting the measles outbreak by promoting the timely and sustained implementation of interventions and the allocation of necessary resources.

Country	Joint Response During This Period	Approach for the Next 2 Weeks PAHO Actions
Peru (5)	PAHO is providing support for the management of a Letter of Agreement with the Regional Health Directorate (DIRESA) of Alto Amazonas to facilitate the deployment of 59 vaccination brigades in high-risk areas.	Continue advocating for the procurement of a greater number of doses of the measles-rubella (MR) vaccine; strengthen the capacity of local teams for the timely identification of cases and the implementation of control measures; and support the identification of high-risk areas to target vaccination interventions in the jungle region, particularly in Loreto, Amazonas, and Ucayali.

PAHO Response by Strategic Pillars ⁵

Coordination

- PAHO held a meeting with the PAHO team in Guatemala and national authorities to analyze the main bottlenecks currently affecting the response to the measles outbreak and to explore actions to address them.
- Based on the Measles Preparedness and Response Matrix—which provides Member States with a framework for adjusting response actions according to epidemiological scenarios—preparedness and response materials available in Spanish have been distributed to counterparts in Spanish-speaking countries. The English version is currently being finalized.

Partnerships and Communications

- A presentation was held with PAHO offices in Member States on options for mobilizing resources at the national level, with the aim of strengthening capacities to identify and capitalize on funding opportunities and partnerships.
- Regional meetings were held with the Centers for Disease Control and Prevention (CDC), Gavi, and the Public Health Agency of Canada (PHAC) to strengthen coordination and explore opportunities for collaboration in support of the regional response to the measles outbreak.

Collaborative Surveillance

- Additional resources were allocated to strengthen rapid response teams and other prevention and response interventions related to the measles outbreak.

⁵ PAHO's response is organized around strategic pillars. This section describes the regional and international activities carried out throughout the Region—by PAHO headquarters, subregional offices, and country offices—in coordination with national authorities during the reporting period. Country-specific operational support is summarized in Table 1.

- Technical support to Canada continues through a meeting with Canadian authorities to present and discuss the national response plan.
- In coordination with Brazilian authorities, the measles outbreak in São Paulo and ongoing response actions were monitored.
- The virtual review and accreditation of Venezuela's national measles and rubella laboratory was completed, with satisfactory results.
- A regional analysis of measles using the 7-1-7 methodology is underway to evaluate surveillance and response performance, identify common gaps, and guide actions to strengthen detection and timely response.

Immunization and Vaccination Operations

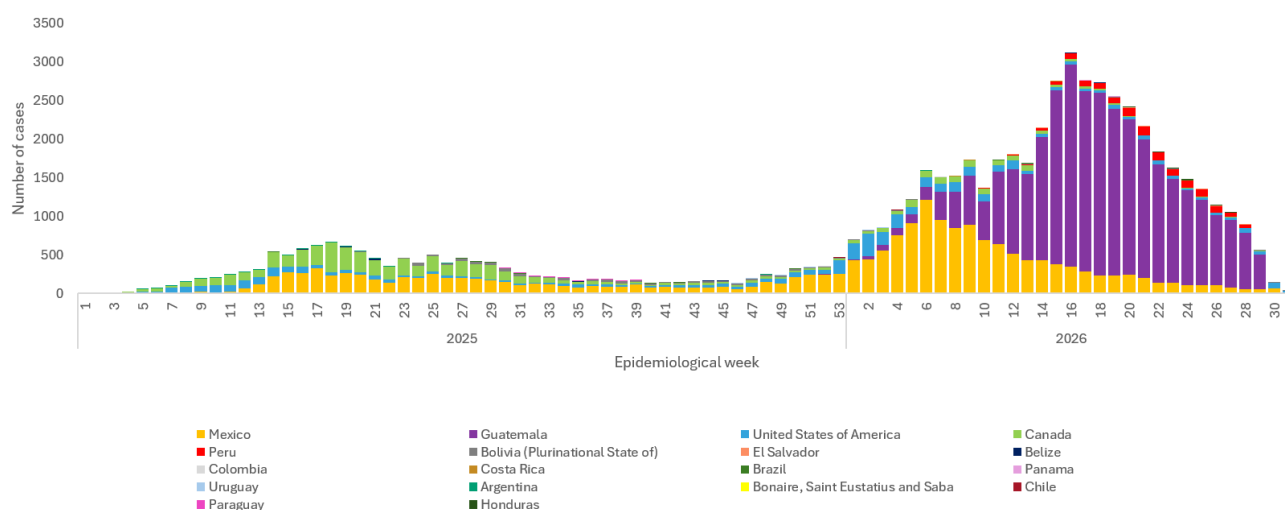
- An information exchange was initiated with Colombia to share the vaccination plan implemented in Venezuela, with the aim of providing information that could be useful for vaccination activities in that country, while maintaining communication with the authorities to assess the potential impact of the earthquake on vaccination activities.
- Advocacy efforts with Peruvian authorities continue to support the procurement of measles vaccines.
- The imported case from Peru reported in Bolivia was tracked to help reconstruct the timeline and identify contacts during the transmissibility period.
- In Venezuela, vaccination teams have been trained and deployed in the three most affected federal entities — La Guaira, the Capital District, and Miranda — with ongoing coordination with Gavi to secure additional doses for these entities.

Risk and Crisis Communication and Community Engagement

- Support continues for the production of a video on vaccine hesitancy and measles in Ecuador, which is scheduled for release soon.
- An updated epidemiological alert on the regional measles situation was published. Available on: <https://www.paho.org/en/documents/epidemiological-alert-measles-americas-region-7-august-2026>
- An updated risk assessment on the epidemiological situation of measles in the Region was published. Available on: <https://www.paho.org/en/documents/public-health-risk-assessment-related-measles-implications-americas-region-v3-following>

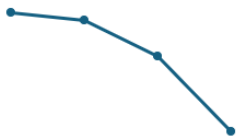
Epidemiological Situation

Figure 1. Epidemiological curve of confirmed measles cases in the Region of the Americas, by country and epidemiological week (EW), from EW 1 of 2025 to EW 31 of 2026

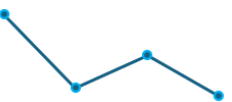


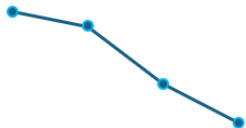
The table below summarizes the epidemiological situation in countries that have reported confirmed cases of measles.

Table 2. Measles cases in the Region of the Americas by country, as of EW 31 of 2026

Country	New cases through EW 29-30	Cases in 2026 (through EW 31) (1)	Deaths in 2026 (through Week 31) (1)	Trend (last 4 weeks)**	Classification by the Revalidation Commission (6)	Epidemiological Notes
Guatemala*	+448	31,140 ⁶ (latest available data is as of EW29)	32	 ↓ declining	Sustained decline	As of EW 29, transmission has been reported in 20 of the 22 departments. The overall downward trend continues at the national level; however, at the departmental level, transmission remains sustained in Alta Verapaz. The highest incidence rates continue to be observed in Izabal (329 cases per 100,000 inhabitants), followed by Central Guatemala (310 per 100,000 inhabitants) and Sololá (292.5 per 100,000 inhabitants). Of all confirmed measles cases, 63% occurred in people aged 15 to 39, with the 20- to 29-year-old age group being the most affected. Among children under one year of age, those aged 4 to 11 months continue to account for the highest proportion of cases. 67.1% of cases had no history of vaccination. The most recent case was reported in epidemiological week 29 of 2026.
Mexico*	+118	12,479	18	 ↑ increasing	Sustained with major concerns	Most cases in 2026 are concentrated in three states: Jalisco, with 6,728 cumulative cases in 2026; Mexico City, with 1,027 cases; and Chiapas, with 858 cases. The most recent case was recorded in epidemiological week 31 of 2026.

⁶ The reported figures reflect data as of epidemiological week 29..

Country	New cases through EW 29-30	Cases in 2026 (through EW 31) (1)	Deaths in 2026 (through Week 31) (1)	Trend (last 4 weeks)**	Classification by the Revalidation Commission (6)	Epidemiological Notes
United States*	+119	2,465	0	↑increasing 	Sustained elimination with significant concerns	In recent weeks, new cases have been concentrated mainly in Pennsylvania, with 82 new cases in the last two weeks. In 2026, the highest number of cases has been reported in South Carolina (670), Utah (524), Texas (190), Virginia (176), Florida (141), Pennsylvania (216), and Arizona (109). The most recent case was reported in epidemiological week 31 of 2026.
Canada*	+5	1,114	0		Endemic	In Week 30, 5 new cases were reported in British Columbia (n=4) and Ontario (n=1), provinces with limited transmission. However, the source of infection has not been identified in 4 of these cases. For the year 2026 through epidemiological week 30, the highest number of cases has been reported in Manitoba (677) and Alberta (311), neither of which reported any cases this week; followed by British Columbia (49), Quebec (31), and Ontario (30). The most affected age group remains those aged 5 to 17 (41%). The most recent case was recorded in epidemiological week 30 of 2026.

Country	New cases through EW 29-30	Cases in 2026 (through EW 31) (1)	Deaths in 2026 (through Week 31) (1)	Trend (last 4 weeks)**	Classification by the Revalidation Commission (6)	Epidemiological Notes
Peru*	+0	1,277 ⁷ (latest available data is as of EW28)	0	↓ declining 	Sustained elimination	Cases reported in 2026 continue to be concentrated in the Puno Department, with 1,106 cases spread across 13 provinces and 14 districts, of which 716 (64.73%) are concentrated in the province of San Román... The province with the second-highest number of cases is Puno, with 208 cases (18.80%). The most affected age group continues to be those aged 10 to 29. The most recent case was recorded in epidemiological week 28 of 2026.
Bolivia*	+5	88	1	Droplet transmission with sporadic cases that are part of the same outbreak	Sustained elimination with causes for serious concern	The last case was reported in epidemiological week 30 of 2026.
El Salvador	0	53	0	Sporadic imports	Sustained elimination	The last case was reported in epidemiological week 28 of 2026.
Colombia	0	14	0	Sporadic imports	Sustained elimination	The last case was reported in epidemiological week 27 of 2026.
Belize	0	11	0	Sporadic imports	Sustained Elimination	The most recent case was reported in epidemiological week 20 of 2026.
Honduras	0	12	0	Sporadic imports	Sustained elimination with significant concerns	The last case was reported in epidemiological week 27 of 2026.
Panama	0	9	0	Sporadic imports	Sustained elimination	The last case was reported in epidemiological week 23 of 2026.

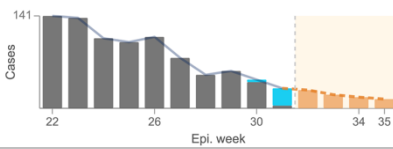
⁷ The reported figures reflect data as of epidemiological week 28.

Country	New cases through EW 29-30	Cases in 2026 (through EW 31) (1)	Deaths in 2026 (through Week 31) (1)	Trend (last 4 weeks)**	Classification by the Revalidation Commission (6)	Epidemiological Notes
Brazil	0	15	0	Sporadic imports	Sustained elimination with moderate concerns	The last case was reported in week 27 of 2026.
Costa Rica	0	5	0	Sporadic imports	Sustained elimination	The last case was reported in epidemiological week 15 of 2026.
Others (≤5 cases) ***	—	See dashboard (1)	See dashboard (1)	—	—	—

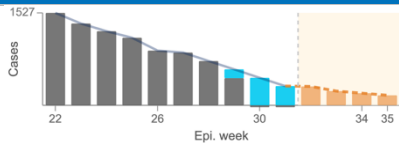
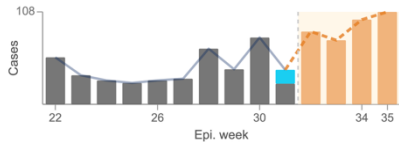
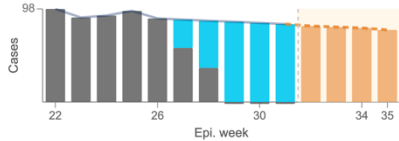
*Countries with active outbreaks: Measles cases have been reported over a period of 12 weeks or more. **The most recent epidemiological week (EW) was excluded from the observed counts to account for delays in reporting. ***Argentina, Bonaire, St. Eustatius, and Saba; Chile; and Uruguay. See the Pan American Health Organization/World Health Organization (PAHO/WHO) measles dashboard: <https://tinyurl.com/3xtciv84> (1)

To supplement the case summary above, this section presents model-based estimates of transmission dynamics for countries with sustained outbreaks and sufficient data (**Table 3**). The immediate forecast (shown in blue bars) adjusts the most recent weeks to account for reporting delays. The short-term projection (shown in orange bars) forecasts the expected incidence of cases over the next four weeks based on the current estimated effective reproduction number (R_t)—that is, the average number of secondary infections per case. An R_t value greater than 1 indicates sustained or accelerating transmission; a value less than 1 indicates a declining outbreak. The complete methodology is presented in the Technical Notes.

Table 3. Model-based estimates of measles transmission dynamics, by country, as of Week 31 of 2026⁸

Country	R_t (95% CrI) ¹ Effective reproduction number	Based on the model ²	4-week forecast (weeks 32–35) Median [95% PrI] ³	Model interpretation
Mexico	0.62 [0.53–0.71]	↓ declining	~80 [43–125] cases 	R_t below 1 with a narrow range — the model points to a continued decline over the next 4 weeks, with the upper bound also below 1.
Guatemala	0.66 [0.63–0.69]	↓ declining	~913 [782–1,058] cases	R_t is estimated to be 0.66 [0.63–0.69], which remains well below the epidemic threshold. This indicates a decline in

⁸ Please note that the information presented in this table for Guatemala and Peru reflects data received through epidemiological week 29 and epidemiological week 28, respectively.

Country	R_t (95% CrI) ¹ Effective reproduction number	Based on the model ²	4-week forecast (weeks 32–35) Median [95% PrI] ³	Model interpretation
				transmission, and projections suggest that the downward trend will continue.
United States	1.35 [1.18 – 1.53]	↓ on the rise	~367 [259–500] cases 	R_t is estimated to be 1.35 (CI: 1.18–1.53). The estimate and its uncertainty interval are above 1, indicating an increase in transmission in the most recent period, following the previously observed downward trend. Continued monitoring is recommended to assess the persistence of this change.
Canada	— ⁴	— ⁴	— ⁴	No modeling was performed—see footnote 4. Of the 1,107 cases recorded in 2026, 1,021 remain linked to the outbreak that began in October 2024, which is now showing a sustained decline.
Peru	0.97 [0.87 – 1.07]	↓ declining	~313 [228–413] cases 	R_t is estimated to be 0.97 (95% CI: 0.87–1.07). Although the point estimate is slightly less than 1, the uncertainty interval includes 1, so it is not possible to clearly conclude whether transmission is decreasing or increasing. Continued monitoring is recommended to assess the evolution of transmission.
Bolivia	— ⁴	— ⁴	— ⁴	No modeling was performed—see footnote 4.

¹ R_t = effective reproduction number — the average number of secondary infections per case at a given time. Estimated using the EpiEstim method with a 4-week moving window (8). 95% CrI = 95% credibility interval. See Technical Notes.

² Trend classified based on the full 95% credibility interval (CrI) of R_t : increasing (lower limit > 1), decreasing (upper limit < 1), or uncertain (the interval includes 1).

³ Median of the 4-week projection and 95% prediction interval (PrI) for projected new cases during epidemiological weeks (EW) 33–35, conditional on the currently estimated R_t .

⁴ Bolivia and Canada: Modeling was not performed because the weekly incidence has fallen below the threshold (<5 cases/week) at which the R_t estimate is no longer reliable and the short-term forecast is not robust enough to inform operational decisions.

Technical Notes

This status report uses two complementary modeling stages. First, **nowcasting** adjusts the most recent epidemiological weeks to account for reporting delays, generating estimates of cases that have already occurred but have not yet been fully reported. Second, **the short-term forecast** projects the expected incidence of cases for the next four weeks based on the current estimated effective reproduction number (R_t).

Case data. Weekly counts of confirmed measles cases were obtained from national surveillance systems that report to the Pan American Health Organization/World Health Organization (PAHO/WHO).

Immediate forecast. To account for reporting delays inherent in passive surveillance, an immediate forecast model was applied to estimate the actual incidence for the most recent epidemiological weeks. Depending on the length of the available training period, either a negative generalized linear binomial 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% credibility intervals. Thresholds were established based on an internal assessment of model stability, in accordance with general guidelines on data-adaptive short-term forecasting (8).

Effective reproduction number (R_t). R_t was estimated using the EpiEstim method (8), which applies a Bayesian sliding-window approach to the short-term forecast-adjusted incidence series. A 4-week (28-day) sliding window was used, which corresponds approximately to two serial intervals—a commonly applied default value that balances statistical stability with temporal resolution. A discrete gamma distribution was assumed for the serial interval (mean of 15 days, standard deviation of 4 days), consistent with the literature on measles (8). The serial interval was treated as fixed; this simplification slightly underestimates the uncertainty of R_t but does not affect the qualitative trend classifications presented. The credibility intervals for R_t are calculated based on the point estimate of the immediate forecast and, therefore, do not formally propagate the uncertainty of that forecast. The classification of trends was based on the full 95% credibility interval of R_t : **increasing** (lower bound > 1), **decreasing** (upper bound < 1), or **uncertain** (the interval includes 1).

Short-term forecasts. Four-week projections were generated using a renewal model that simulated 10,000 stochastic Poisson trajectories anchored to the estimated R_t . The results are expressed as the median and 95% prediction interval.

Limitations. The estimates depend on the completeness and timeliness of national-level reports, as well as on the assumed serial interval. Country-specific changes in surveillance—including the expanded case definition adopted by Guatemala in Protocol V3 of the Ministry of Public Health and Social Assistance (MSPAS) (March 16, 2026)—may affect the interpretation of trends in each country and are noted in the country appendix.

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