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World Health Organization
Americas Region

PAHO

Regional Situation Report · No. 10

Measles in the Region of the Americas

September 1, 2026 · *Next issue: September 10, 2026*

REPORTING PERIOD: W1–33, 2026 (January 4 – August 22, 2026) · 2-week change window: W31–32 vs. W29–30[1]

CUMULATIVE — WEEKS 1–33, 2026		
51,027 CONFIRMED CASES	**55** Deaths Case Fatality Rate (CFR) 0.10%	**17** COUNTRIES AND TERRITORIES (CUMULATIVE) [2]
LAST 2 WEEKS — WEEKS 31–32, 2026		
+1,162 NEW CONFIRMED CASES ↓ -28.1% *(compared to EW 29–30)* [2]	**0** NEW DEATHS	**7/17** COUNTRIES AND TERRITORIES THAT HAVE REPORTED CASES: *Bolivia (Plurinational State of), Canada, Guatemala, Honduras, Mexico, Peru and the United States of America.*[3]

Summary of the Situation

Between epidemiological week (EW) 1 and EW 33 of 2026 (which ended on August 22, 2026), the Region of the Americas reported **51,027** confirmed cases of measles in 17 countries and territories, representing a 4.6-fold increase compared with the same period in 2025. Guatemala (32,566), Mexico (12,607), the United States (2,777), and Canada (1,117) account for the vast majority (96%) of confirmed cases (**Map 1**). A total of **55** deaths have been reported, including 36 in Guatemala, 18 in Mexico, and one in Bolivia (*1*).

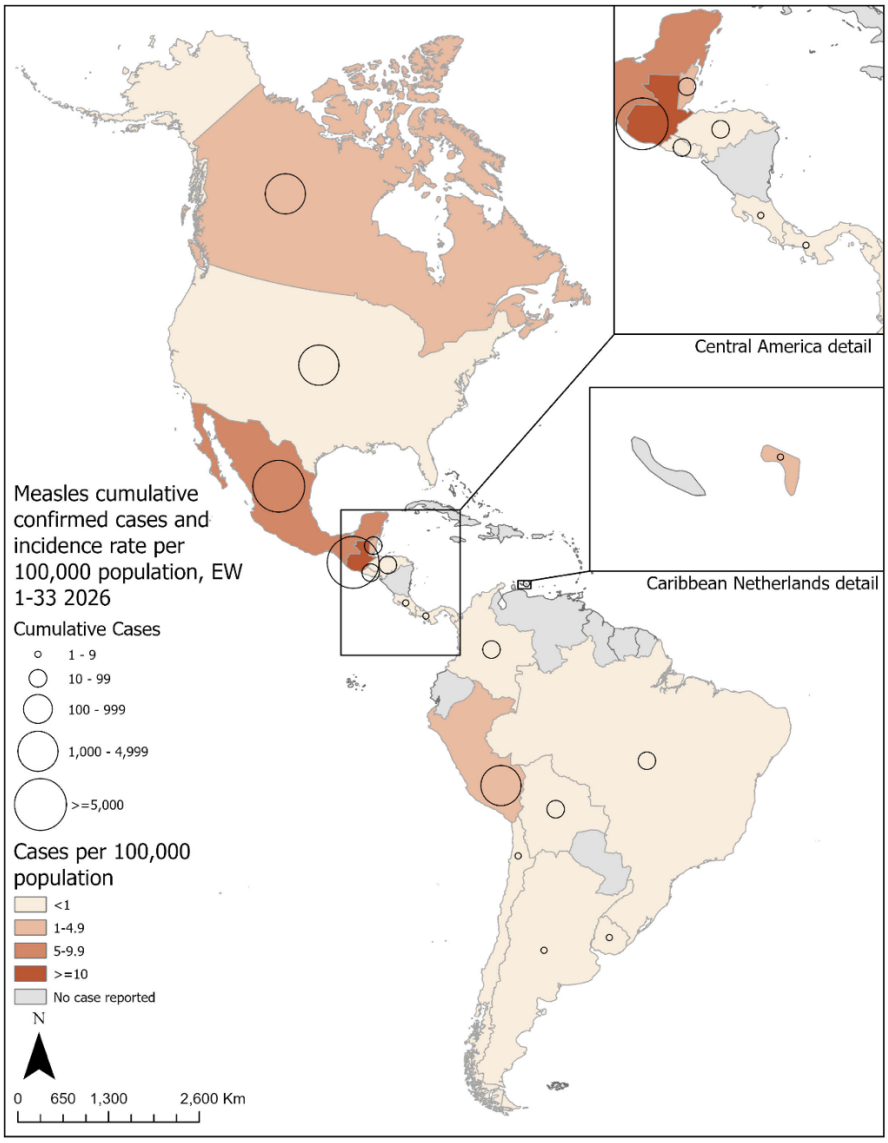
During EW 31 and 32 of 2026, the Region of the Americas reported **1,162** new confirmed cases of measles in seven countries and territories, representing a 28.1% decrease compared with the previous two-week period (EW 29–30; 1616 new cases, of which 921 were retrospectively accounted for since the last situation report was published) (**Figure 1**). **Of the 1,162 new confirmed cases reported during EW 31–32, Guatemala accounted for 611, followed by the United States with 239, Peru with 211, and Mexico with 96 while Bolivia reported three cases and Canada and Honduras one each[2].**

[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 33, 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 – 33, 2026. (n = 51,027)



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)	PAHO continued to support the outbreak response. An on-site evaluation using the 7-1-7 methodology was conducted during the first week of August, followed by a field visit by the Measles and Rubella Elimination Regional Monitoring and Re-Verification Commission (RVC) during the third week of the month. Additional funds have been committed to support the mobilization of epidemiological investigation and vaccination brigades in prioritized areas. PAHO also managed the contracts of two consultants through the International Federation of Red Cross and Red Crescent Societies (IFRC).	An official report containing the recommendations provided by the RVC will be shared with the national health authorities. Periodic meetings will be held with national authorities to follow up on the actions identified during the 7-1-7 evaluation.
Guatemala (3)	PAHO continued supporting the Ministry of Health in strengthening the outbreak response, including the development of an updated departmental risk analysis to prioritize intensified surveillance and vaccination activities based on active transmission, mortality, and the PAHO measles risk assessment tool. Simulation exercises and outbreak-response and microplanning workshops were implemented in Chiquimula, Quiché, Ixil, and Izabal. Support also included mortality and case-fatality analysis, initiation of the adaptation of the regional emergency plan to the Guatemalan context, and the recruitment process for four subnational consultants to support outbreak response, microplanning, and vaccination campaign implementation. The vaccination campaign and the administered-dose dashboard were also updated.	Continue supporting national authorities in their response to the outbreak, with an emphasis on resource mobilization to ensure continuity of priority interventions, while preserving and strengthening areas of cooperation where PAHO provides technical and coordination capacity. Support mechanisms to strengthen coordination and joint work between PAHO Guatemala and implementing partners, including Jhpiego, SE-COMISCA, and CDC.
Bolivia (4)	PAHO continued providing technical assistance to support the review and documentation of outbreak closure in municipalities and departments with more than 90 days without cases. In La Paz and El Alto, PAHO supported the mobilization of 100 vaccination brigades across 10 health networks in response to three imported cases from Peru. Preliminary results include 2,505 children under five vaccinated and 14,676 households visited, alongside active community case finding. Risk communication and community engagement activities included support for institutional media coverage of vaccination brigades; development and validation of measles alert and vaccination campaign materials; and facilitation of the "Potosí United for Vaccination" workshop with 46 community, institutional, and health-sector representatives. Communication materials are also being prepared for La Paz in response to the imported cases.	Continue supporting coordination with the education sector to ensure that students arriving from Peru have complete vaccination schedules and strengthen political and technical commitment in Santa Cruz. Ongoing evaluation of the outbreak response using the 7-1-7 methodology. An RVC visit is scheduled for September 9–11.

Peru (5)	PAHO continued supporting vaccination efforts in high-risk areas, including coordination with the health network of the Datem del Marañón for vaccination activities in San Lorenzo and Cahuapanas.	Continue advocating for the procurement of additional doses of measles-rubella (MR) vaccine and strengthen local teams for timely case identification and implementation of control measures.

PAHO Response by Strategic Pillars [4]

Clinical Management

- PAHO is coordinating with regional experts to organize a series of webinars on measles clinical management for countries across the Region.

Collaborative Surveillance

- PAHO continued supporting the monitoring and response to ongoing measles transmission across affected countries. In Brazil, PAHO continues to support response activities in São Paulo, including financial support for field activities, particularly case investigation. In Guatemala, financial resources were provided to support outbreak response activities, while efforts to mobilize additional resources are ongoing.
- Country-level assessments using the 7-1-7 methodology and other outbreak-response review mechanisms continue to support the identification of operational bottlenecks and opportunities to strengthen surveillance and response. In Bolivia, a 7-1-7 evaluation is underway, supported by a regional field mission, In Mexico, the 7-1-7 evaluation was conducted during the first week of August with support from the regional and country offices, and the Regional Verification Commission (RVC) visit took place during the third week of August.
- Sustained transmission in the southern part of Peru remains a concern, including the exportation of measles cases to neighboring countries, including Bolivia and Brazil. PAHO continues to closely monitor the epidemiological situation and support response activities, with an RVC visit scheduled for September.

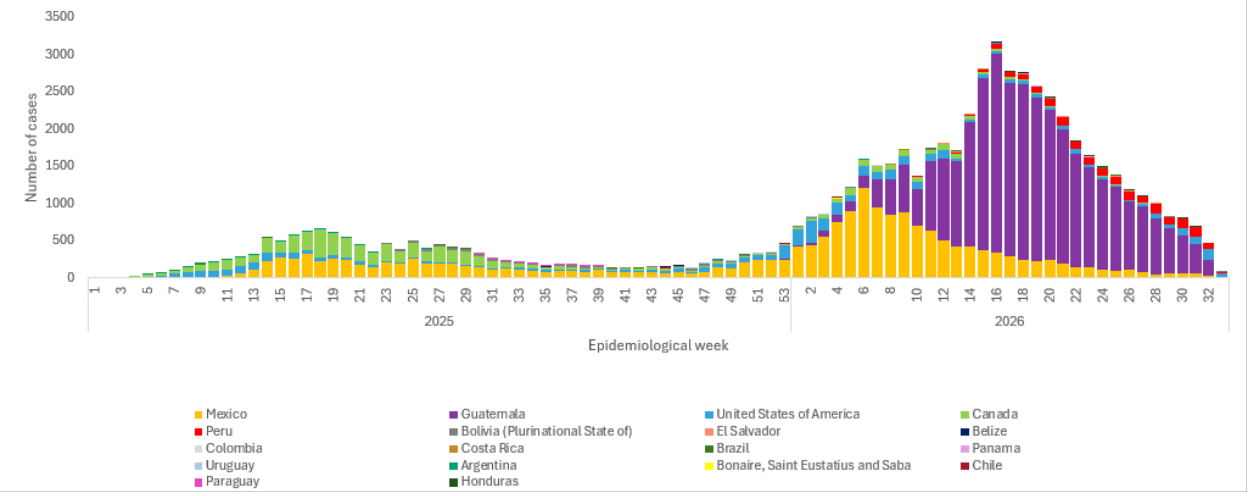
Immunization and Vaccination Operations

- In Venezuela, a line of credit was approved to facilitate the procurement of MMR and MR vaccines for emergency vaccination activities in areas affected by the earthquake, as well as to support routine immunization activities nationwide.

[4] *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.*

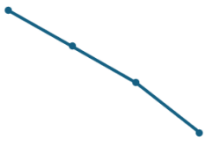
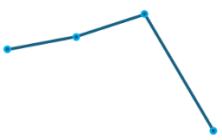
Epidemiological Situation

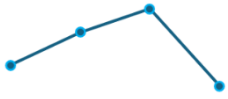
Figure 1. Epidemiological curve of confirmed measles cases in the Region of the Americas, by country and epidemiological week (EW), from EW 1 of 2025 to EW 33 of 2026



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

Table 1. Measles cases in the Region of the Americas by country, as of EW 33 of 2026

Country	New cases reported through EW 31-32	Cases in 2026 (through EW 33) (*1*)	Deaths in 2026 (through Week 33) (*1*)	Trend (EW 29-32)**	Classification by the Revalidation Commission (6)	Epidemiological Notes
Guatemala*	+611	32,566	36	↓ declining 	Sustained elimination	As of EW 33, transmission has been reported in 19 of the 22 departments. The overall downward trend continues at the national level; at the departmental level, transmission remains sustained in Alta Verapaz. The highest incidence rates continue to be observed in Izabal (353.6 cases per 100,000 inhabitants), followed by Sololá (319.2 per 100,000 inhabitants) and Central Guatemala (310 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 10 months continue to account for the highest proportion of cases. 67.3% of cases had no history of vaccination. The most recent case was reported in epidemiological week 33 of 2026.
Mexico*	+96	12,607	18	↓ declining 	Sustained elimination with major concerns	Most cases in 2026 are concentrated in three states: Jalisco, with 6,754 cumulative cases in 2026; Mexico City, with 1,031 cases; and Chiapas, with 871 cases. The most recent case was recorded in epidemiological week 33 of 2026.

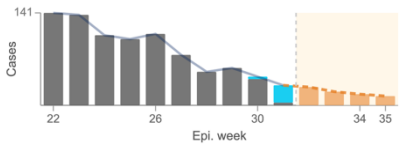
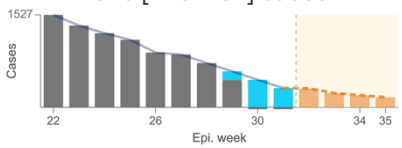
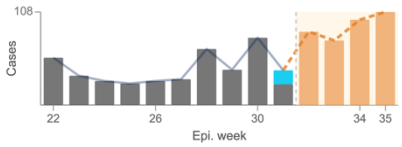
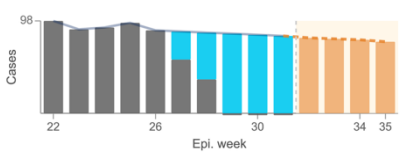
Country	New cases reported through EW 31-32	Cases in 2026 (through EW 33) (*1*)	Deaths in 2026 (through Week 33) (*1*)	Trend (EW 29-32)**	Classification by the Revalidation Commission (6)	Epidemiological Notes
United States*	+239	2,777	0	↑increasing 	Sustained elimination with major concerns	In recent weeks, new cases have been concentrated mainly in Pennsylvania, with 155 new cases in the last two weeks. In 2026, the highest number of cases has been reported in South Carolina (670), Utah (526), Pennsylvania (371), Texas (190), Virginia (176), Florida (142), and Arizona (110). The most recent case was reported in epidemiological week 33 of 2026.
Canada*	+1	1,117	0	— 	Endemic	For the year 2026 through epidemiological week 32, the highest number of cases has been reported in Manitoba (680) and Alberta (311); 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 31 of 2026.
Peru*	+211	1,726	0	↓ declining 	Sustained elimination	The most recent case was recorded in epidemiological week 33 of 2026.
Bolivia*	+3	97	1	Droplet transmission with sporadic cases that are part of the same outbreak	Sustained elimination with major concerns	The last case was reported in epidemiological week 33 of 2026.
El Salvador	0	53	0	Sporadic imports	Sustained elimination	The last case was reported in epidemiological week 28 of 2026.

Country	New cases reported through EW 31-32	Cases in 2026 (through EW 33) (*1*)	Deaths in 2026 (through Week 33) (*1*)	Trend (EW 29-32)**	Classification by the Revalidation Commission (6)	Epidemiological Notes
Honduras	+1	15	0	Sporadic imports	Sustained elimination with major concerns	The last case was reported in epidemiological week 31 of 2026.
Brazil	0	15	0	Sporadic imports	Sustained elimination with moderate concerns	The last case was reported in week 27 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.
Panama	0	9	0	Sporadic imports	Sustained elimination	The last case was reported in epidemiological week 23 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/3xtcjv84 (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 2. Model-based estimates of measles transmission dynamics, by country, as of Week 33 of 2026

Country	R_t (95% CrI)[1] Effective reproduction number	Based on the model [2]	4-week forecast (weeks 34–37) Median [95% PrI][3]	Model interpretation
Mexico	0.95 [0.83–1.07]	↓ *declining*	~194 [127–271] cases 	R_t is close to 1, with uncertainty spanning both below and above 1 — the model suggests broadly stable transmission, with a slight tendency toward decline.
Guatemala	0.54 [0.51 – 0.57]	↓ *declining*	~349 [273–434] cases 	R_t is estimated to be 0.54 [0.51–0.57], which remains well below the epidemic threshold. This indicates a decline in transmission, and projections suggest that the downward trend will continue.
United States	1.71 [1.57 – 1.86]	↑ *on the rise*	~1,455 [1,193–1,760] cases 	R_t is estimated to be 1.71 (CI: 1.57–1.86). The estimate and its uncertainty interval remain well above 1, indicating a sustained increase in transmission in the most recent period. Continued monitoring is recommended to assess the persistence and magnitude of this upward trend.
Canada	—[4]	—[4]	—[4]	No modeling was performed—see footnote 4. Of the 1,117 cases recorded in 2026, 1,021 remain linked to the outbreak that began in October 2024, which is now showing a sustained decline.
Peru	1.12 [1.03 – 1.22]	↑*on the rise*	~614 [483–762] cases 	R_t is estimated to be 1.12 (95% CI: 1.03–1.22). The point estimate and its uncertainty interval are above 1, indicating an increase in transmission in the most recent period. Continued

Country	R_t (95% CrI)[1] Effective reproduction number	Based on the model [2]	4-week forecast (weeks 34–37) Median [95% PrI][3]	Model interpretation
				monitoring is recommended to assess whether this upward trend persists.
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) 34–37, 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 (Rt).

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 (Rt). Rt 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 Rt but does not affect the qualitative trend classifications presented. The credibility intervals for Rt 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 Rt: **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 Rt. 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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