Regional Situation Report · No. 11

Measles in the Region of the Americas

11 September 2026 · *Next issue: 24 September 2026*

REPORTING PERIOD: EW 1–35, 2026 (4 January 2026 – 5 September 2026) · 2-week change window: EW 33–34 vs. EW 31–32 [1]

CUMULATIVE — EW 1–35, 2026		
52,676 CONFIRMED CASES	**61** DEATHS Case Fatality Rate (CFR) 0.12%	**17** COUNTRIES AND TERRITORIES (CUMULATIVE) [2]
LAST 2 WEEKS — EW 33–34, 2026		
+911 NEW CONFIRMED CASES ↓ -36.6% *(compared to EW 31–32)* [3]	**+6** NEW DEATHS *Five new deaths in Guatemala and one new death in Mexico*	**6/17** COUNTRIES AND TERRITORIES THAT HAVE REPORTED CASES *Bolivia (Plurinational State of), Canada, Guatemala, Mexico, Peru and the United States of America*

Summary of the Situation

Between epidemiological week (EW) 1 and EW 35 of 2026 (which ended on 5 September 2026), the Region of the Americas reported **52,676** confirmed cases of measles in 17 countries and territories, representing a 3.8-fold increase compared with the same period in 2025. Guatemala (33,334), Mexico (12,848), the United States (3,134), Peru (1,997), and Canada (1,119) account for the vast majority (99.5%) of confirmed cases (**Map 1**). A total of **61** deaths have been reported, including 41 in Guatemala, 19 in Mexico, and one in Bolivia (*1*).

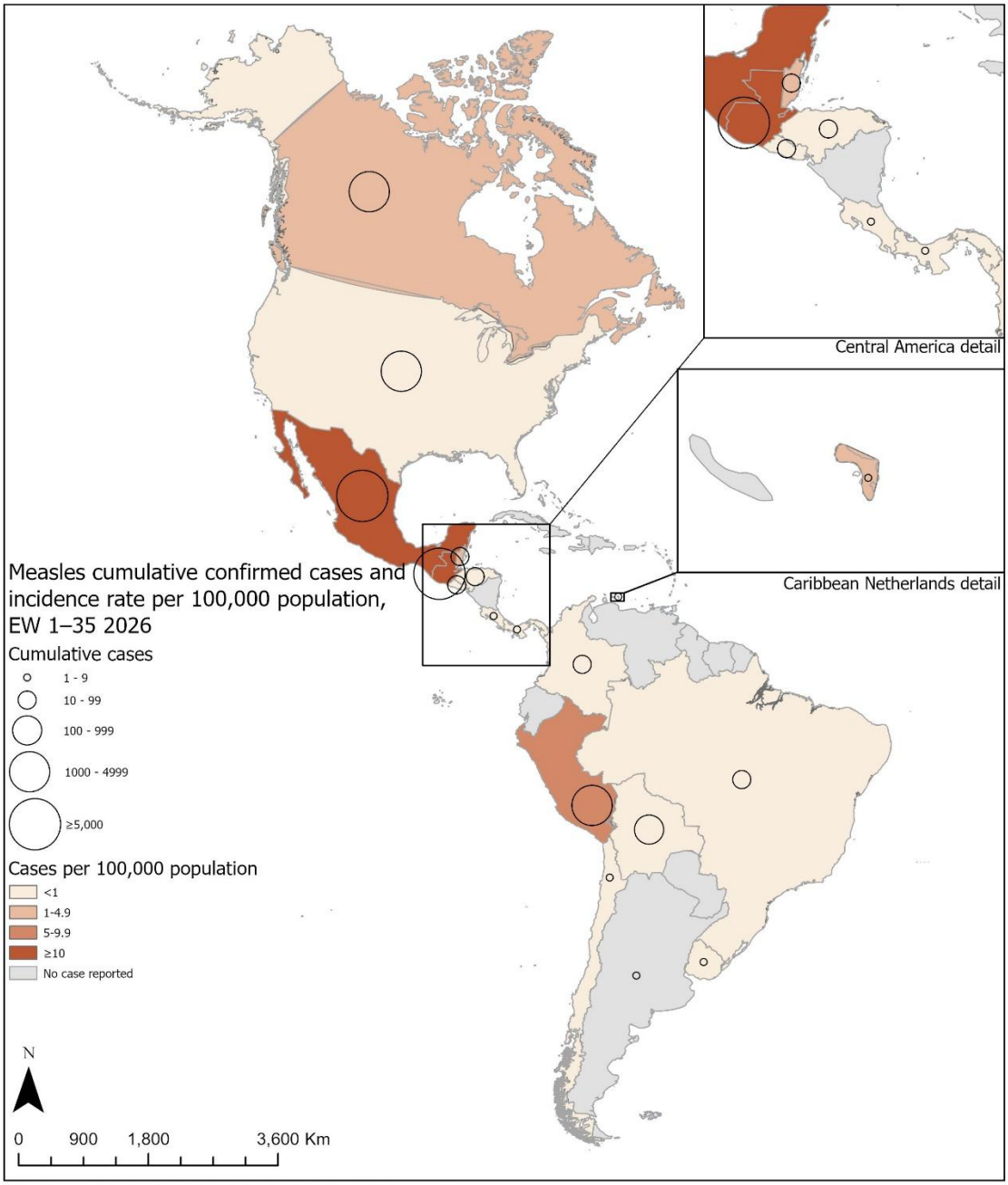
During EW 33 and EW 34 of 2026, the Region of the Americas reported **911** new confirmed cases of measles in six countries and territories, representing a 36.6% decrease compared with the previous two-week period (EW 31–32; 1,436 new cases, of which 274 were retrospectively accounted for since the last regional situation report was published) (**Figure 1**). Of the 911 new confirmed cases reported during EW 33–34, Guatemala accounted for 350, followed by the United States with 303, Peru with 171, and Mexico with 83 while Bolivia and Canada reported two cases 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 35, 2026, while the dashboard is updated on a rolling basis as new data become available.*

[2] *Since Situation Report No. 10, no other country has reported any new cases of measles in 2026.*

[3] *Underreporting and reporting delays may result in an underestimation of the total number of measles cases reported.*

Map 1. Confirmed cases of measles and incidence rate per 100,000 inhabitants by country. Region of the Americas. EW1 – EW35, 2026. (n = 52,676)



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 supporting national authorities in the control and closure of the measles outbreak through technical coordination with CeNSIA, epidemiological surveillance authorities, and the International Federation of Red Cross and Red Crescent Societies (IFRC). Work advanced on the joint technical assistance plan to prioritize support missions in states with active transmission and focus resources on areas at highest risk. PAHO and IFRC also supported preparation of the Annual Country Report for the Regional Verification Commission, including analysis and mapping of national and subnational vaccination coverage. Vaccination response activities continued through blocking vaccination, documented sweeps, and macro-vaccination modules, while preparations also advanced for technical support to Quintana Roo and intensified outbreak-control actions in Zacatecas, Durango, Jalisco, and Chiapas.	Continue supporting implementation and validation of the joint technical assistance plan, with priority given to states with active transmission and higher risk of sustained spread. Support efforts to increase vaccination coverage in susceptible populations, strengthen epidemiological surveillance, active case finding and contact follow-up, and ensure adequate vaccine supply and cold-chain capacity. Continued emphasis will also be placed on strengthening national and subnational coordination, reactivating the national Rapid Response Strategy (ERRa per its acronym in Spanish), and adapting vaccination strategies to the evolving epidemiological situation.
Guatemala (3)	PAHO continued to support Guatemala's national and subnational outbreak response activities, including microplanning and information analysis workshops in Ixil, Izabal, and Quetzaltenango, and community engagement with community leaders and traditional birth attendants in Totonicapán and Sololá. Technical cooperation on clinical management and infection prevention and control continued in coordination with the Ministry of Health and the National Measles Commission, and the recruitment of four consultants to reinforce subnational response and vaccination-campaign implementation is underway.	Continue supporting implementation of priority outbreak-response interventions, with emphasis on mobilizing resources and strengthening national and subnational capacity for vaccination planning and response. PAHO will also support stronger coordination with implementing partners, including Jhpiego, SE-COMISCA and CDC, and promote coordination mechanisms to facilitate dialogue among health authorities in the Region.
Bolivia (4)	PAHO continued to support Bolivia's outbreak-response and verification preparations, including technical review of national and departmental presentations for Beni and Santa Cruz ahead of the Revalidation Commission mission (9–11 September), informed by the 7-1-7 Early Action Assessment conducted on 25–27 August. A centralized digital repository was also established to consolidate and track clinical and epidemiological documentation for new cases. In response to three imported cases from Peru,	Continue supporting follow-up to the 7-1-7 assessment and Revalidation Commission mission, including implementation of recommendations and strengthening of documentation for outbreak review. Maintain coordination with the education sector to help ensure complete vaccination schedules among students in La Paz and El Alto, while sustaining

	PAHO supported the deployment of 100 vaccination brigades across 10 health networks in La Paz and El Alto, with preliminary results of 2,505 children under 5 vaccinated, 14,676 households visited, and active community case-finding underway.	political and technical engagement with authorities in Santa Cruz.
Peru (5)	PAHO continued supporting outbreak-response activities, including coordination of the 7-1-7 early response review workshop scheduled for 14–15 September and a follow-up visit from 15–17 September to assess progress in control measures. Support to vaccination activities also continued, including a transfer to the Datem del Marañón Health Network to facilitate deployment of vaccination brigades in accordance with the approved plan.	Continue supporting the implementation and monitoring of outbreak-control measures, including follow-up through the 7-1-7 review and field visit. Maintain advocacy for the procurement of additional measles-rubella (MR) vaccine doses, strengthen local teams for timely case identification and control actions, and support risk communication on the importance of vaccination.

PAHO Response by Strategic Pillars (6)[4]

Collaborative Surveillance

- PAHO continued providing technical support to strengthen laboratory-based surveillance and diagnostic capacities in Bolivia, Colombia, Honduras, and Peru.
- A retrospective regional analysis of measles outbreaks reported during 2025–2026 is ongoing using the 7-1-7 methodology, combining timeliness indicators, qualitative findings, and country validation adapted to measles surveillance and response. Methodological guidance, questionnaires, and the country review process have been developed, country interviews are underway, and analyses are advancing as information becomes available. An R/Shiny dashboard has been developed to monitor submissions and key indicators and support technical interviews.

Clinical Management

- In Guatemala, clinical management and infection prevention and control (IPC) training is ongoing to strengthen early clinical management and IPC capacities. The training began on 28 August, with the first technical session taking place in September.
- Updated clinical management and IPC recommendations have been incorporated and are undergoing the publication process.

[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.*

Immunization and Vaccination Operations

- In Brazil, analysis of the safety of the Measles, Mumps and Rubella (MMR) vaccine among adolescents and adults is ongoing. Historical vaccination data have been requested to support the analysis, with a first draft expected by the end of September.
- PAHO continued supporting activities to strengthen Adverse Event Following Immunization (AEFI) surveillance systems in 10 countries of the Region.
- Vaccination response activities continued in affected countries, including the implementation and monitoring of vaccination strategies among priority population groups. Recent progress reported in Bolivia and Peru is summarized below:

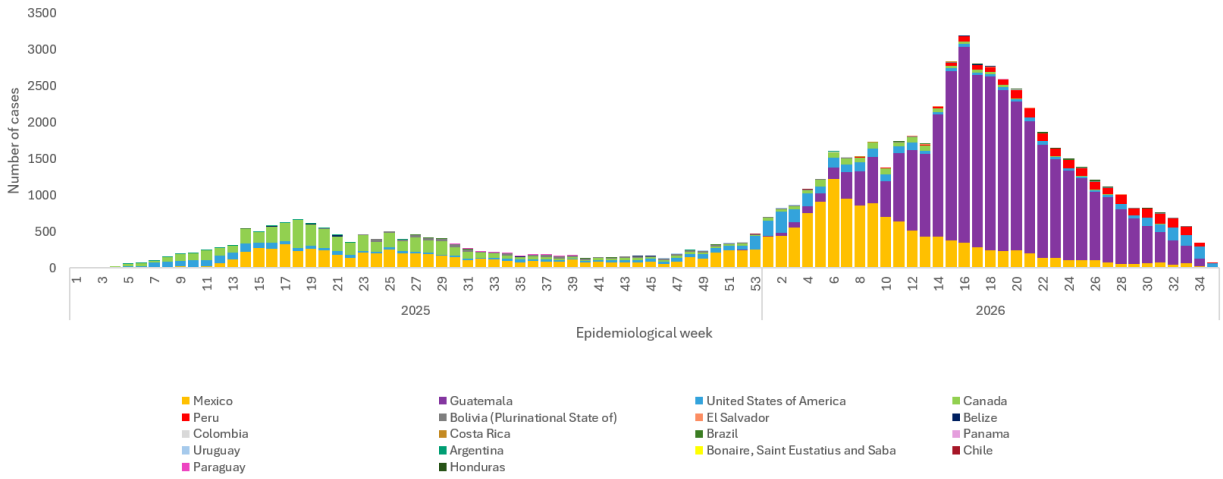
Country	Vaccination response progress

Bolivia	• Vaccination activities continued in affected departments:
	  • 57.8% coverage among children under 1 year of age.
	  • 58.8% coverage with the first dose among children aged 1–4 years.
	  • 61.3% coverage among children and adolescents aged 5–19 years (from June 2025 to 7 September 2026).

Peru	• In Puno, vaccination activities continued across priority populations:
	  • Educational institutions: 74% of the target reached.
	  • Children aged 1 year: 40% coverage.
	  • All age groups: 51% coverage.
	• In other departments, activities focused on completing vaccination schedules

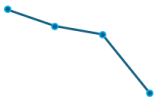
Epidemiological Situation

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 35 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 35 of 2026

Country	New cases reported through EW 33-34	Cases in 2026 (up to EW 35) (*1*)	Deaths in 2026 (up to EW 35) (*1*)	Trend (EW 31-34)**	Response scenario (7)****	Epidemiological notes
Guatemala*	+350	33,334	41	↓ declining 	Scenario C – Community transmission	As of EW 35, 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 (374.9 cases per 100,000 inhabitants), followed by Central Guatemala (322.4 per 100,000 inhabitants) and Sololá (302.4 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. Infants under one year of age remain the group at highest risk. 67.5% of cases had no history of vaccination. The most recent case was reported in EW 34 of 2026.
Mexico*	+83	12,848	19	↓ declining 	Scenario C – Community transmission	Most cases in 2026 are concentrated in three states: Jalisco, with 6,797 cumulative cases in 2026; Mexico City, with 1,033 cases; and Chiapas, with 874 cases. The most recent case was recorded in EW 35 of 2026.
United States*	+303	3,134	0	↑increasing 	Scenario C – Community transmission	In 2026, the highest number of cases has been reported in South Carolina (670), Pennsylvania (557), Utah (526), Texas (191), Virginia (178), Florida (144), Wisconsin (112), and Arizona (110). The most recent case was reported in EW 35 of 2026.
Peru*	+171	1,997	0	↓ declining 	Scenario C – Community transmission	The most recent case was recorded in EW 35 of 2026.

Country	New cases reported through EW 33-34	Cases in 2026 (up to EW 35) (*1*)	Deaths in 2026 (up to EW 35) (*1*)	Trend (EW 31-34)**	Response scenario (7)****	Epidemiological notes
Canada*	+2	1,119	0	Droplet transmission with sporadic cases that are part of the same outbreak	Scenario C – Community transmission	For the year 2026 through EW 35, the highest number of cases has been reported in Manitoba (680) and Alberta (311); followed by British Columbia (49), Ontario (32), and Quebec (31). The most affected age group remains those aged 5 to 17 (41%). The most recent case was recorded in EW 34 of 2026.
Bolivia*	+2	104	1	Droplet transmission with sporadic cases that are part of the same outbreak	Scenario B – Identifiable transmission chains	The last case was reported in EW 33 of 2026.
El Salvador	0	56	0	Sporadic imports	Scenario A – No current transmission / risk of importation	The last case was reported in EW 30 of 2026.
Brazil	0	24	0	Sporadic imports	Scenario A – No current transmission / risk of importation	The last case was reported in EW 27 of 2026.
Honduras	0	15	0	Sporadic imports	Scenario A – No current transmission / risk of importation	The last case was reported in EW 31 of 2026.
Colombia	0	14	0	Sporadic imports	Scenario A – No current transmission / risk of importation	The last case was reported in EW 27 of 2026.
Belize	0	12	0	Sporadic imports	Scenario A – No current transmission / risk of importation	The most recent case was reported in EW 27 of 2026.

Country	New cases reported through EW 33-34	Cases in 2026 (up to EW 35) (*1*)	Deaths in 2026 (up to EW 35) (*1*)	Trend (EW 31-34)**	Response scenario (7)****	Epidemiological notes
Panama	0	9	0	Sporadic imports	Scenario A – No current transmission / risk of importation	The last case was reported in EW 23 of 2026.
Costa Rica	0	5	0	Sporadic imports	Scenario A – No current transmission / risk of importation	The last case was reported in EW 15 of 2026.
Others (≤5 cases) * **	—	See dashboard (*1*)	See dashboard (*1*)	—		—

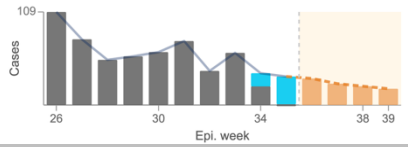
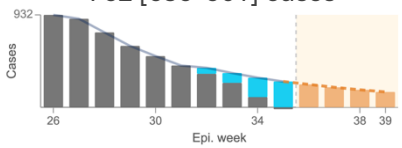
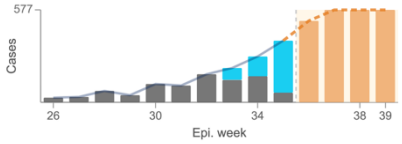
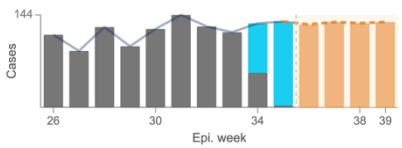
**Countries with active outbreaks: Measles cases have been reported over a period of 12 weeks or more. **The most recent epidemiological week (EW) was excluded from the observed counts to account for delays in reporting. ***Argentina, Bonaire, St. Eustatius, and Saba; Chile; and Uruguay. See the Pan American Health Organization/World Health Organization (PAHO/WHO) measles dashboard: https://tinyurl.com/3xtcjv84 (1)*

*****Response scenarios are defined according to the current pattern of measles transmission: Scenario A refers to settings with no confirmed cases and a risk of importation; Scenario B to limited confirmed cases with identifiable transmission chains; and Scenario C to confirmed cases occurring across multiple geographic areas with multiple identifiable or unidentifiable transmission chains, consistent with community transmission. Response actions are cumulative: Scenario B includes the actions under Scenario A, while Scenario C includes the actions under Scenarios A and B, with additional or intensified measures as needed. (7)*

To supplement the case summary above, this section presents model-based estimates of transmission dynamics for countries with sustained outbreaks and sufficient data (***Table 2***). 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 EW 35 of 2026

Country	R_t (95% CrI)[1] Effective reproduction number	Based on the model [2]	4-week forecast (EW 36–38) Median [95% PrI][3]	Model interpretation
Mexico	0.73 [0.63–0.85]	↓ *declining*	~97 [56–150] cases	R_t is below 1, with the uncertainty interval remaining entirely below

Country	R_t (95% CrI)[1] Effective reproduction number	Based on the model [2]	4-week forecast (EW 36–38) Median [95% PrI][3]	Model interpretation
				1 — the model suggests declining transmission.
Guatemala	0.75 [0.71 – 0.79]	↓ *declining*	~762 [636–901] cases 	R_t is estimated to be 0.75, remaining below the epidemic threshold. This indicates declining transmission, and projections suggest that the downward trend will continue.
United States	1.81 [1.70 – 1.92]	↑ *on the rise*	~3,296 [2,867–3,769] cases 	R_t is estimated to be 1.81. 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	1.01 [0.92 – 1.10]	*~stable*	~526 [411–657] cases 	R_t is estimated to be 1.01. The estimate is close to 1, with the uncertainty interval spanning values below and above 1, indicating broadly stable transmission in the most recent period. Continued monitoring is recommended to assess whether transmission

Country	R_t (95% CrI)[1] Effective reproduction number	Based on the model [2]	4-week forecast (EW 36–38) Median [95% PrI][3]	Model interpretation
				shifts toward a clearer increasing or decreasing trend.
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 (9).

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 (10). 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 per its acronym in Spanish) (March 16, 2026)—may affect the interpretation of trends in each country and are noted in the country appendix.

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