

Regional Situation Report • No. 12

Measles in the Region of the Americas

24 September 2026 • Next issue: 8 October 2026

REPORTING PERIOD: EW 1–37, 2026 (4 January 2026 – 19 September 2026) • 2-week change window: EW 35–36 vs. EW 33–34 ¹		
CUMULATIVE — EW 1–37, 2026		
53,957 CONFIRMED CASES	68 DEATHS Case Fatality Rate (CFR) 0.13%	17 COUNTRIES AND TERRITORIES (CUMULATIVE) ²
LAST 2 WEEKS — EW 35–36, 2026		
+709 NEW CONFIRMED CASES ↓ -43% (compared to EW 33–34) ³	+7 NEW DEATHS <i>Four new deaths in Guatemala and three new deaths in Mexico</i>	7/17 COUNTRIES AND TERRITORIES THAT HAVE REPORTED CASES <i>Bolivia (Plurinational State of), Canada, Colombia, Guatemala, Mexico, Peru and the United States of America</i>

Summary of the Situation

Between epidemiological week (EW) 1 and EW 37 of 2026 (which ended on 19 September 2026), the Region of the Americas reported **53,957** confirmed cases of measles in 17 countries and territories, representing a 3.8-fold increase compared with the same period in 2025. Guatemala (33,866), Mexico (12,943), the United States (3,471), Peru (2,292), and Canada (1,120) account for the vast majority (99.5%) of confirmed cases (**Map 1**). A total of **68** deaths have been reported, including 45 in Guatemala, 22 in Mexico, and one in Bolivia (1).

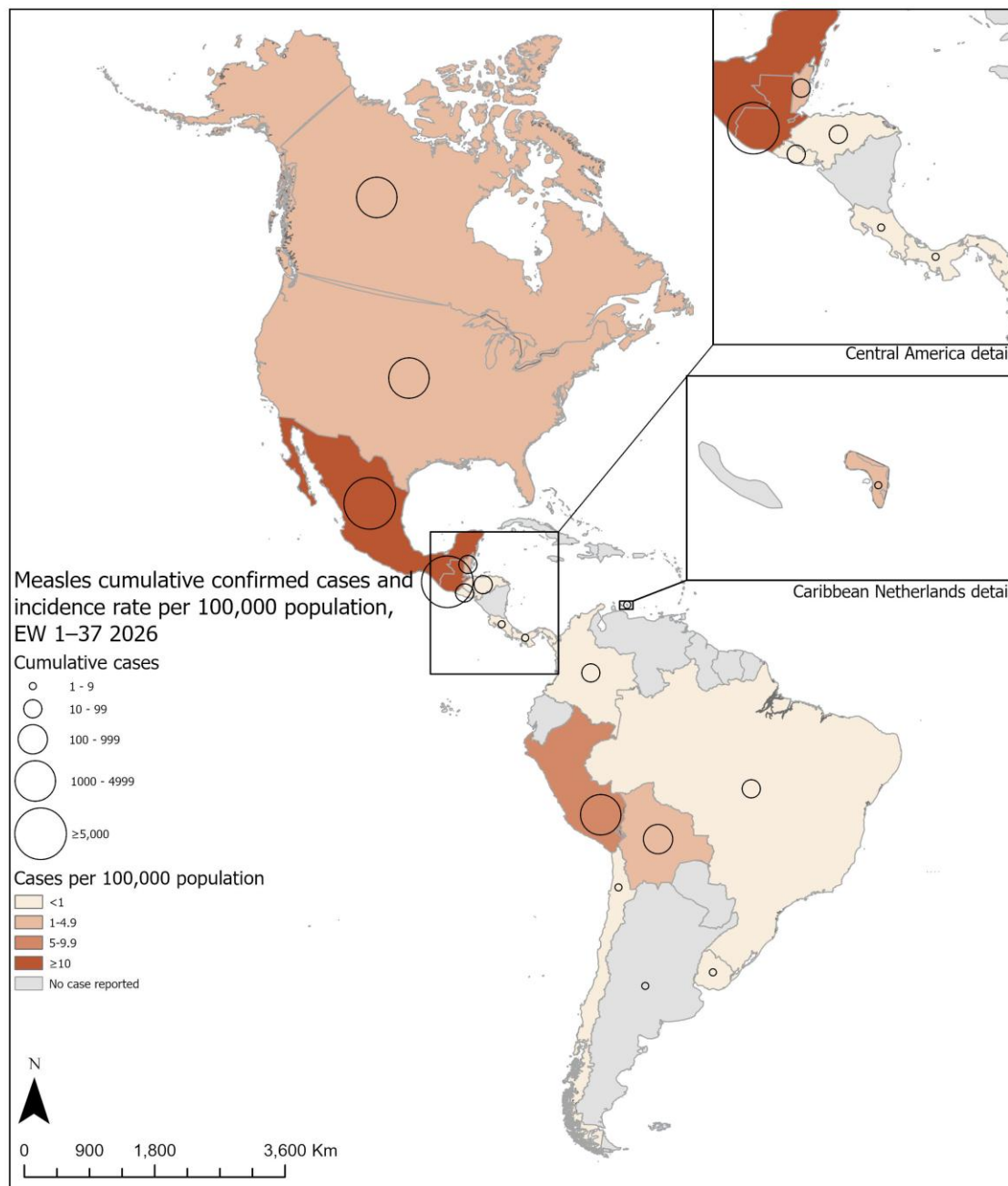
During EW 35 and EW 36 of 2026, the Region of the Americas reported **709** new confirmed cases of measles in seven countries and territories, representing a 43% decrease compared with the previous two-week period (EW 33–34; 1,244 new cases, of which 333 were retrospectively accounted for since the last regional situation report was published) (**Figure 1**). Of the 709 new confirmed cases reported during EW 35–36, the United States accounted for 290, followed by Peru with 190, Guatemala with 176, Mexico with 46, and Bolivia with 5, while Canada and Colombia reported one case each².

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 37, 2026, while the dashboard is updated on a rolling basis as new data become available.

² Since Situation Report No. 11, 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 – EW37, 2026. (n = 53,957)



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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)	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 strengthening national and subnational outbreak response activities. Training was initiated for four subnational consultants, supported by preparation of an intensive training package, while arrangements continued for international technical support in outbreak response, microplanning, and vaccination campaign implementation. A health-area prioritization matrix based on active transmission, mortality, and the 2025 PAHO risk score was developed and presented to the Ministry of Health, together with a proposal to apply the 7-1-7 methodology for early review of outbreak response. Surveillance and vaccination microplanning activities were expanded in Totonicapán. PAHO also supported vaccination campaign planning through situation and risk analysis, strengthened ESAVI (Events Supposedly Attributable to Vaccination or Immunization) surveillance through technical support to the interprogrammatic mechanism and delivery of national guidance and SOPs, and supported the National Verification Commission and preparation of the annual certification report on measles, rubella and congenital	Continue supporting implementation of priority outbreak-response interventions in health areas identified through the prioritization analysis, including subnational technical support, vaccination planning and microplanning, ESAVI surveillance, and community engagement. PAHO will also support resource mobilization and efforts to address operational constraints affecting vaccine and supply procurement and implementation of vaccination and communication activities, while strengthening coordination with implementing partners, including Jhpiego, SE-COMISCA, and CDC.

	rubella syndrome elimination. Go.Data digitization products and a user manual were delivered to the Ministry of Health. Risk communication and community engagement activities advanced through work with community leaders and traditional birth attendants in Quiché, development and validation of documentary materials, and distribution of promotional materials to priority health areas.	
Bolivia (4)	PAHO continued supporting outbreak-response and verification activities. The Regional Commission for Reverification of the Elimination of Measles, Rubella and Congenital Rubella Syndrome completed its visit, including review of the measles situation in Santa Cruz, La Paz and at national level, and findings and recommendations were presented to the Minister of Health. Work also advanced on the case-closure and documentation process, with verification of the completeness and consistency of information in the centralized documentary repository and establishment of a work schedule with departmental epidemiological surveillance teams to ensure completeness, integrity and consistency of case files.	Continue follow-up on recommendations from the Reverification Commission and implementation of 7-1-7 action plans in Santa Cruz and La Paz, including continued strengthening of case documentation and repository quality. Continue advocacy with the education sector, particularly universities, to facilitate vaccination access and promote vaccination requirements for health-related students participating in clinical practice. PAHO will also continue supporting risk communication activities in the context of limited resources and administrative constraints affecting implementation.
Peru (5)	PAHO continued supporting outbreak-response activities and preparations for the 7-1-7 early response review and follow-up assessment of outbreak-control measures with national and regional teams in Puno and Arequipa. Technical support also included coordination of an immunization training for Integrated Health Networks Directorates (DIRIS per its acronym in Spanish) in Lima Centro.	Continue supporting implementation and monitoring of outbreak-control measures, including follow-up to the 7-1-7 review and Reverification Commission recommendations. Strengthen local teams for timely case identification and control actions, and continue advocacy to address insufficient resources for vaccine procurement and monitoring by national and regional surveillance, laboratory, and immunization teams. Support more targeted risk communication on measles risk and the importance of vaccination.

PAHO Response by Strategic Pillars (6)⁴

Collaborative Surveillance

- The retrospective regional assessment of measles outbreaks reported during 2025–2026 using the adapted 7-1-7 methodology continues to advance, integrating timeliness indicators, qualitative findings, and country validation.
- Assessments and Regional Verification Commission (RVC) visits have been completed in Mexico, Bolivia, and Peru, and findings are being consolidated for the regional analysis and follow-up.
- In Peru, the measles outbreak was discussed during a meeting between the PAHO/WHO Representative (PWR) and the Minister of Health. Preparedness efforts are also being strengthened ahead of major mass gatherings, including the Señor de los Milagros festivities in October and the visit of Pope Leo XIV in November, which could increase the risk of measles transmission.
- PAHO continued providing technical support to strengthen laboratory-based surveillance and diagnostic capacities across the Region. In Costa Rica, technical support was provided to optimize national capacity for measles virus sequencing using the Sanger method.
- PAHO coordinated with the MeaNS2 (WHO Global Measles and Rubella Laboratory Network: Measles Virus Nucleotide Surveillance) curators to align the platform's epidemiological week calculations with the methodology used by countries in the Region.

Immunization and Vaccination Operations

- Vaccination response activities continued in affected countries, including implementation and monitoring of vaccination strategies among priority populations. Recent progress in Guatemala, Mexico, and Peru is summarized below:

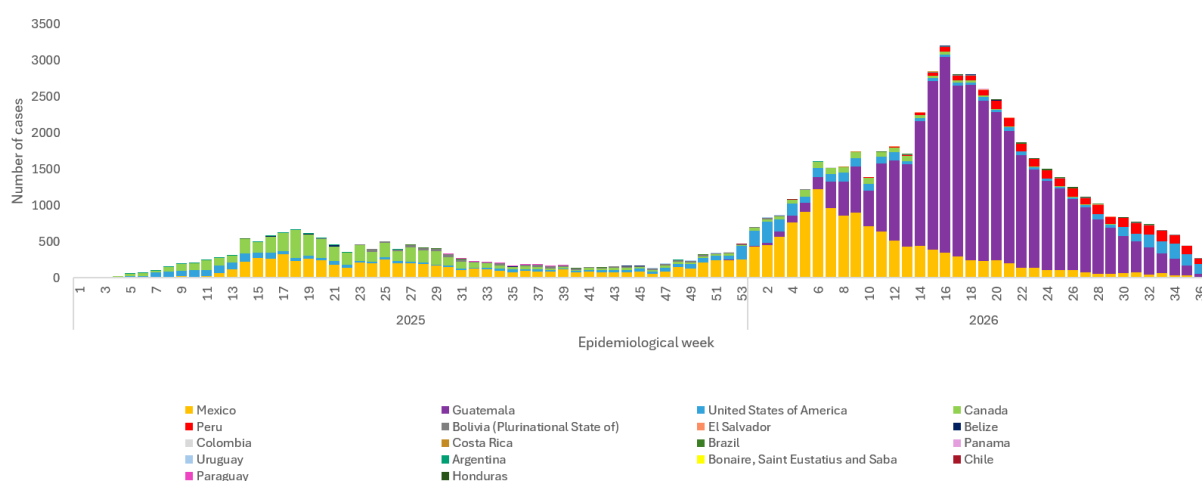
Country	Vaccination response progress
Guatemala	• A vaccination campaign is underway in four programmatic areas: Quiché, Chiquimula, Sololá, and Izabal. • Other departments are developing outbreak response plans to guide vaccination activities.
Mexico	• Microplanning activities have been initiated in states that have reported no measles cases for more than 20 weeks.
Peru	• Vaccination activities continued across priority populations.

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.

- In Puno, none of the 12 evaluated areas achieved the established target (95% CI: 30%–82%).
- Reported coverage included 82% in El Collao, 62% in San Román, and 43% in Sandía.

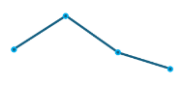
Epidemiological Situation

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 37 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 37 of 2026

Country	New cases reported through EW 35-36	Cases in 2026 (up to EW 37) (1)	Deaths in 2026 (up to EW 37) (1)	Trend (EW 33-36)**	Response scenario (7)****	Epidemiological notes
Guatemala*	+176	33,866	45	↓ declining 	Scenario C – Community transmission	As of EW 37, transmission has been reported in all 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 36 of 2026.
Mexico*	+46	12,943	22	↓ declining 	Scenario C – Community transmission	Most cases in 2026 are concentrated in three states: Jalisco, with 6,839 cumulative cases in 2026; Mexico City, with 1,033 cases; and Chiapas, with 877 cases. The most recent case was recorded in EW 36 of 2026.
United States*	+290	3,471	0	↓ declining 	Scenario C – Community transmission	In 2026, the highest number of cases has been reported in Pennsylvania (745), South Carolina (670), Utah (527), Texas (192), Virginia (178), Wisconsin (158), Florida (147), Ohio (124), and Arizona (110). The most recent case was reported in EW 37 of 2026.

Country	New cases reported through EW 35-36	Cases in 2026 (up to EW 37) (1)	Deaths in 2026 (up to EW 37) (1)	Trend (EW 33-36)**	Response scenario (7)****	Epidemiological notes
Peru*	+190	2,292	0	↓ declining 	Scenario C – Community transmission	The most recent case was recorded in EW 37 of 2026.
Canada*	+1	1,120	0	Droplet transmission with sporadic cases that are part of the same outbreak	Scenario C – Community transmission	For the year 2026 through EW 37, the highest number of cases has been reported in Manitoba (680) and Alberta (311); followed by British Columbia (49), Ontario (33), and Quebec (31). The most affected age group remains those aged 5 to 17 (41%). The most recent case was recorded in EW 36 of 2026.
Bolivia*	+5	115	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 36 of 2026.
El Salvador	0	58	0	Sporadic imports	Scenario A – No current transmission / risk of importation	The last case was reported in EW 30 of 2026.
Brazil	0	28	0	Sporadic imports	Scenario A – No current transmission / risk of importation	The last case was reported in EW 32 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	+1	15	0	Sporadic imports	Scenario A – No current transmission / risk of importation	The last case was reported in EW 35 of 2026.

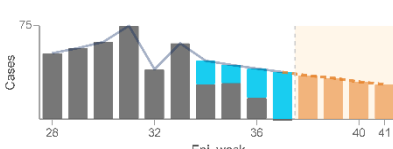
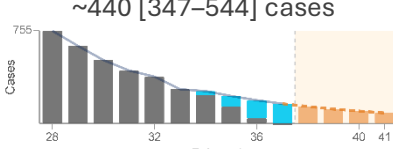
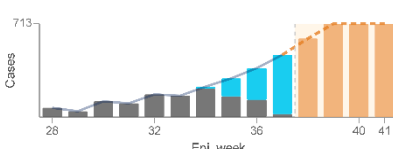
Country	New cases reported through EW 35-36	Cases in 2026 (up to EW 37) (1)	Deaths in 2026 (up to EW 37) (1)	Trend (EW 33-36)**	Response scenario (7)****	Epidemiological notes
Belize	0	15	0	Sporadic imports	Scenario A – No current transmission / risk of importation	The most recent case was reported in EW 31 of 2026.
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)	—		—

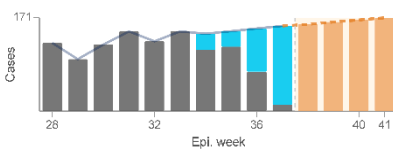
Countries with active outbreaks: Measles cases have been reported over a period of 12 weeks or more. **The most recent epidemiological week (EW) was excluded from the observed counts to account for delays in reporting. *Argentina, Bonaire, St. Eustatius, and Saba; Chile; and Uruguay. See the Pan American Health Organization/World Health Organization (PAHO/WHO) measles dashboard: <https://tinyurl.com/3xtciv84> (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 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 EW 37 of 2026

Country	R_t (95% CrI) ¹ Effective reproduction number	Based on the model ²	4-week forecast (EW 38–41) Median [95% PrI] ³	Model interpretation
Mexico	0.85 [0.73–0.98]	↓ declining	~126 [76–188] cases 	R_t is below 1, with the uncertainty interval remaining entirely below 1 — the model suggests declining transmission.
Guatemala	0.71 [0.66 – 0.76]	↓ declining	~440 [347–544] cases 	R_t is estimated to be 0.71, remaining below the epidemic threshold. This indicates declining transmission, and projections suggest that the downward trend will continue.
United States	1.64 [1.55 – 1.73]	↑ on the rise	~3,550 [3,143–4,011] cases 	R_t is estimated to be 1.64. 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

Country	R_t (95% CrI) ¹ Effective reproduction number	Based on the model ²	4-week forecast (EW 38–41) Median [95% PrI] ³	Model interpretation
				now showing a sustained decline.
Peru	1.05 [0.97 – 1.14]	~stable	~660 [528–810] cases 	R_t is estimated to be 1.05. 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 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.

²Trend 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).

³Median of the 4-week projection and 95% prediction interval (PrI) for projected new cases during epidemiological weeks (EW) 38–41, conditional on the currently estimated R_t .

⁴Canada and Bolivia: 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 (9).

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 (10). 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 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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