



Pan American
Health
Organization



World Health
Organization
Americas Region

Epidemiological Update Dengue and Chikungunya in the Americas Region

20 October 2026

Given the increase in dengue cases observed in some countries of the Andean, Central American, and Caribbean subregions of the Americas Region, as well as the increase in chikungunya cases experienced between late 2025 and 2026, accompanied by the resurgence of chikungunya transmission in countries and territories of the Region where no viral circulation had been recorded for several years, the anticipated intensification of the El Niño phenomenon over the coming months, and the approaching peak season for dengue and chikungunya transmission in South America, the Pan American Health Organization/World Health Organization (PAHO/WHO) urges Member States to maintain and strengthen epidemiological, virological, and entomological surveillance, as well as to strengthen diagnostic capacity, to ensure early detection and timely clinical management of cases, and to consolidate integrated vector management efforts, with the aim of limiting transmission and reducing morbidity and mortality associated with dengue, chikungunya, and other arboviral diseases.

Summary of the dengue situation in the Americas

In the Americas Region, during 2026 as of epidemiological week (EW) 37, 1,692,937 suspected cases of dengue¹ and 523,102 confirmed cases of dengue were reported to the Health Information Platform for the Americas (PLISA) of the Pan American Health Organization (PAHO) (1). Of this total, 3,413 (0.2%) were classified as severe dengue, and there were 571 deaths (case fatality rate [CFR] of 0.034%) (1).

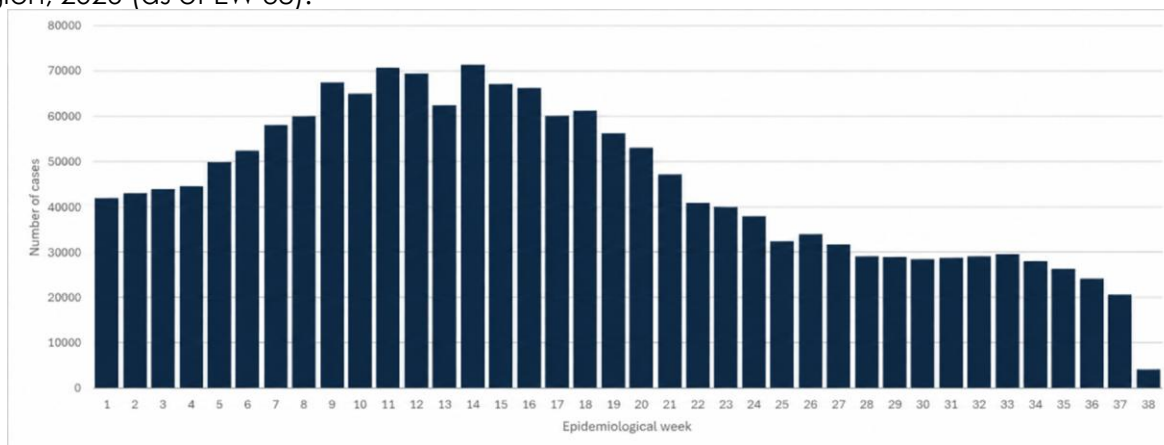
In 2026, the circulation of all four serotypes of the dengue virus was identified in the Americas Region. Brazil, Colombia, Mexico, Panama, and Venezuela reported simultaneous circulation of all four serotypes (DENV-1, DENV-2, DENV-3, and DENV-4). In addition, Costa Rica, Ecuador, Guatemala, Paraguay, and Peru reported simultaneous circulation of DENV-1, DENV-2, and DENV-3, while Cuba reported simultaneous circulation of DENV-2, DENV-3, and DENV-4 (1).

Regarding the trend analysis, a comparison of cases reported through PLISA in 2026 with the numbers in 2025 during the same period show a 58% decrease; a comparison of the 2026 data with the last five-year average, shows a 64% decrease, given that 2024 saw the highest number of dengue cases in the past ten years (n= 13,123,659 cases) (**Figure 1**) (1, 2). However, despite this overall downward trend, specific epidemiological situations are observed in some countries

¹ The number of suspected dengue cases corresponds to the total number of dengue cases, as defined by PLISA (Health Information Platform for the Americas), Arboviral Diseases Portal. Washington, D.C.: PAHO/WHO; 2026 [cited October 13, 2026]. Available from: <https://www.paho.org/en/arbo-portal/dengue-data-and-analysis> (1).

in the Andean², Central American Isthmus and Mexico³, and the Caribbean⁴ subregions, where an increase in the number of cases has been observed in recent epidemiological weeks (1), requiring special attention given the anticipated intensification of the El Niño phenomenon over the coming months, which could, depending on the local context, create conditions favorable for dengue transmission and the simultaneous occurrence of measles outbreaks in several countries of the Americas Region, potentially placing additional strain on health systems.

Figure 1. Distribution of reported dengue cases by epidemiological week (EW) in the Americas Region, 2026 (as of EW 38).



Source: Adapted from the Pan American Health Organization. PLISA Health Information Platform for the Americas, Arboviral Diseases Portal. Washington, D.C.: PAHO/WHO; 2026 [cited 29 September 2026]. Available from: <https://www.paho.org/en/arbo-portal/dengue-data-and-analysis> (1).

The following is a summary of the situation in selected countries in the Andean², Central American Isthmus and Mexico³, and Caribbean⁴ subregions, where an upward trend in the number of dengue cases was observed during the last quarter of 2026, listed in alphabetical order.

In **Colombia**, between EW 1 and 38 of 2026, 83,905 suspected cases of dengue were reported, including 51 deaths. Of the total reported cases, 28,677 were confirmed, representing an incidence rate of 157.12 per 100,000 population and a case fatality rate of 0.177% (1, 3). Of the total reported cases, 1% were severe dengue cases (n= 856 cases). According to information reported by the National Reference Laboratory (NRL) for Virology, all four serotypes of the dengue virus (DENV-1, -2, -3, and -4) continued to circulate nationwide in 2023–2026; however, a marked increase in the proportion of serotype 3 has been observed from the fourth quarter of 2025 to the present, with this serotype being the most dominant (1, 3).

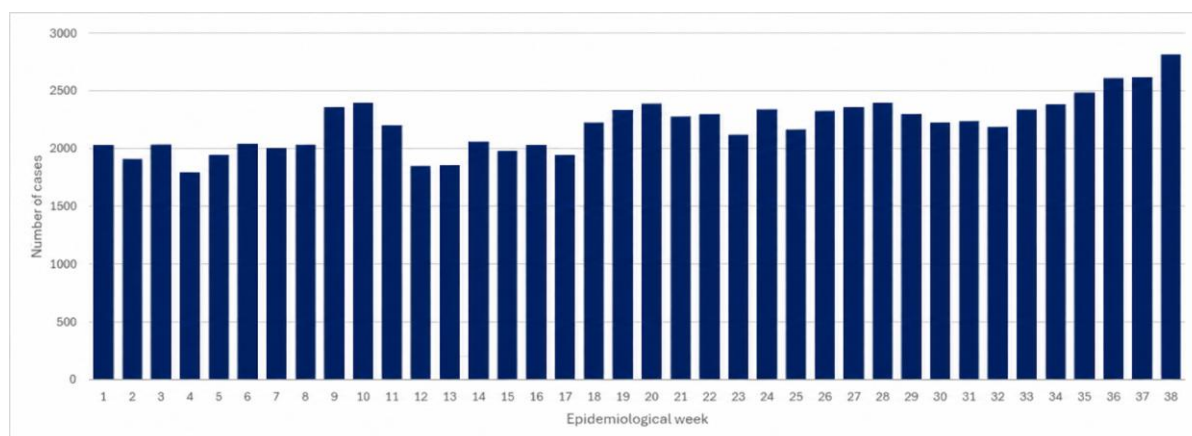
² This subregion includes Bolivia, Colombia, Ecuador, and Peru.

³ <https://www.paho.org/en/arbo-portal/dengue-data-and-analysis> (Ia, Honduras, Nicaragua, Panama, and Mexico).

⁴ It includes the countries and territories belonging to the Latin Caribbean and the non-Latin Caribbean (Anguilla, Antigua and Barbuda, Aruba, the Bahamas, Barbados, Bermuda, Bonaire, the British Virgin Islands, the Cayman Islands, Cuba, Curaçao, the Dominican Republic, Grenada, Guadeloupe, French Guiana, Guyana, Jamaica, Martinique, Montserrat, Puerto Rico, Saint Barthélemy, Saint Kitts and Nevis, Saint Lucia, Saint Martin, Saint Vincent and the Grenadines, Sint Maarten, Suriname, Trinidad and Tobago, Turks and Caicos, and the U.S. Virgin Islands,, according to the divisions described in PLISA—Health Information Platform for the Americas, Dengue Portal. Washington, DC: PAHO; 2025 [cited 13 October 2026]. Available from: <https://www.paho.org/en/arbo-portal/dengue-data-and-analysis> .

In EW 38 of 2026, the number of cases nationwide, as measured by the endemic channel, reached outbreak levels compared to historical trends, with an upward trend observed in recent weeks and a 14% increase in the most recent period analyzed (between EW 34 and EW 37 of 2026) compared to the previous period (between EW 30 and EW 33 of 2026) (**Figure 2**). In 2026, as of EW 38, there was a 19.8% decrease in reported dengue cases nationwide compared with the same period in 2025 (3).

Figure 2. Distribution of reported dengue cases by epidemiological week (EW) in Colombia, 2026 (as of EW 38).

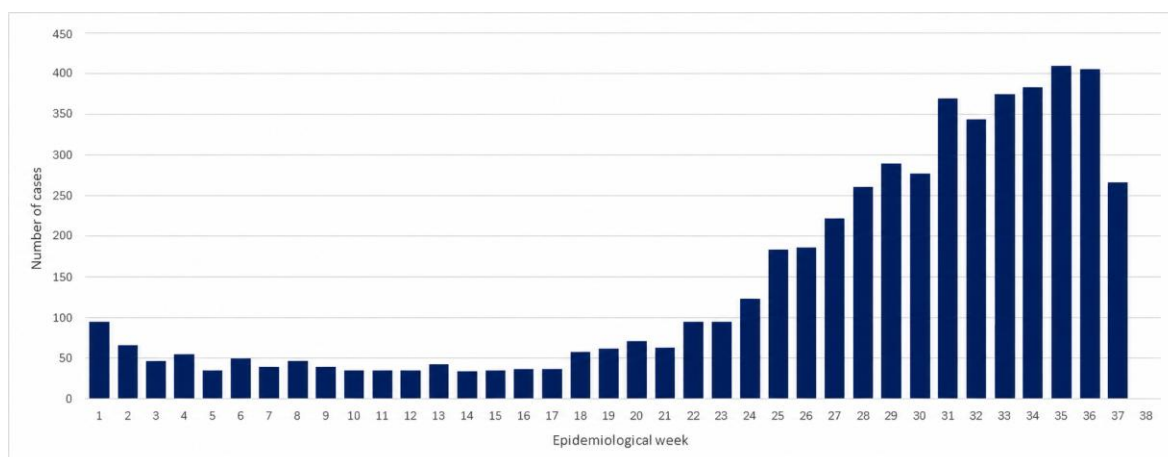


Source: Adapted from the Pan American Health Organization. PLISA Health Information Platform for the Americas, Arboviral Diseases Portal. Washington, D.C.: PAHO/WHO; 2026 [cited 29 September 2026]. Available from: <https://www.paho.org/en/arbo-portal/dengue-data-and-analysis> (1).

In the most recent epidemiological period analyzed (EW 34 to EW 37 of 2026), compared to the previous epidemiological period (EW 30 to EW 33 of 2026), an upward trend of more than 30% was observed in the departments of Antioquia, Atlántico, Caldas, Chocó, Cundinamarca, Guainía, Guaviare, Huila, Putumayo, Quindío, Risaralda, Santander, Sucre, Tolima, Valle del Cauca, and Vichada, as well as the cities of Buenaventura, Cartagena de Indias, and Santiago de Cali; in contrast, a downward trend of more than 30% was observed in the departments of Casanare, La Guajira, Nariño, and Vaupés, while the remaining territorial entities showed stable trends.

In **Costa Rica**, between EW 1 and 37 of 2026, 5,302 suspected cases of dengue were reported. Of the total reported cases, 2,393 were confirmed, representing an incidence rate of 102.47 per 100,000 population, and no deaths were reported. Of the total reported cases, 1.96% were severe dengue cases (n= 104 cases). Three serotypes of the dengue virus (DENV-1, -2, and -3) were identified as circulating, with DENV-3 being the predominant serotype. Regarding the trend in 2026, an increase in the number of reported cases was observed starting in EW 24, which has continued until EW 37 (**Figure 3**). Compared with the same period in 2025, there was a 38.6% increase in the number of reported cases in 2026 (1, 4).

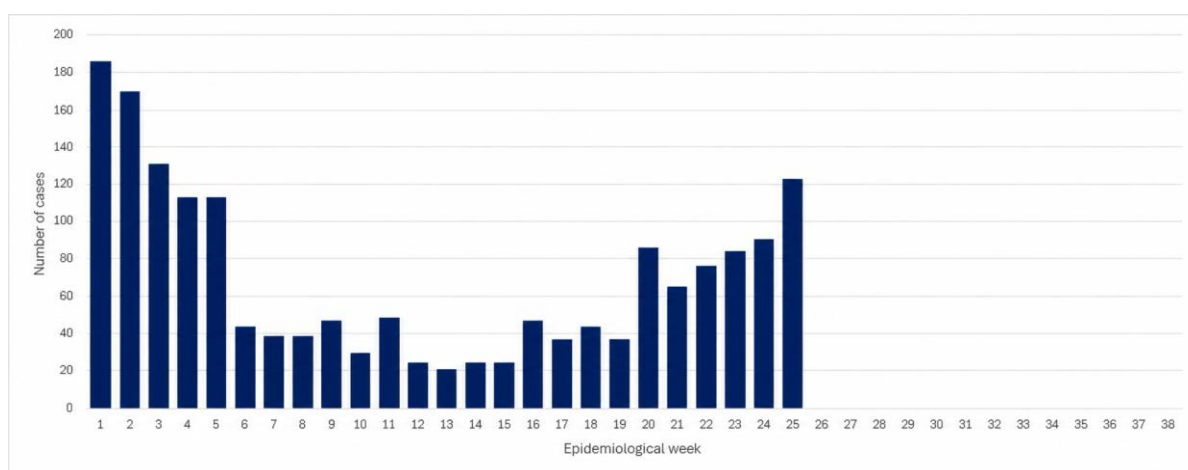
Figure 3. Distribution of reported dengue cases by epidemiological week (EW) in Costa Rica, 2026 (as of EW 37).



Source: Adapted from the Pan American Health Organization. PLISA Health Information Platform for the Americas, Arboviral Diseases Portal. Washington, D.C.: PAHO/WHO; 2026 [cited September 29, 2026]. Available from: <https://www.paho.org/en/arbo-portal/dengue-data-and-analysis> (1).

In **Cuba**, between EW 1 and EW 25 of 2026, 1,746 suspected cases of dengue were reported. Of the total reported cases, 62 were confirmed, with no deaths, representing an incidence rate of 16 per 100,000 population. Cases were reported in ten of the country's provinces. Of the total reported cases, 0.92% were severe dengue cases ($n=16$ cases). Three serotypes of the dengue virus (DENV-2, -3, and -4) were identified as circulating, with DENV-2 being the predominant serotype. Regarding the trend in 2026, after a high number of cases were recorded in EW 1, there was a decline in the number of cases until EW 15; starting in EW 16, there has been an increase in the number of cases, which has continued as of EW 25 (**Figure 4**) (1, 5)

Figure 4. Distribution of reported dengue cases by epidemiological week (EW) in Cuba, 2026 (as of EW 25).

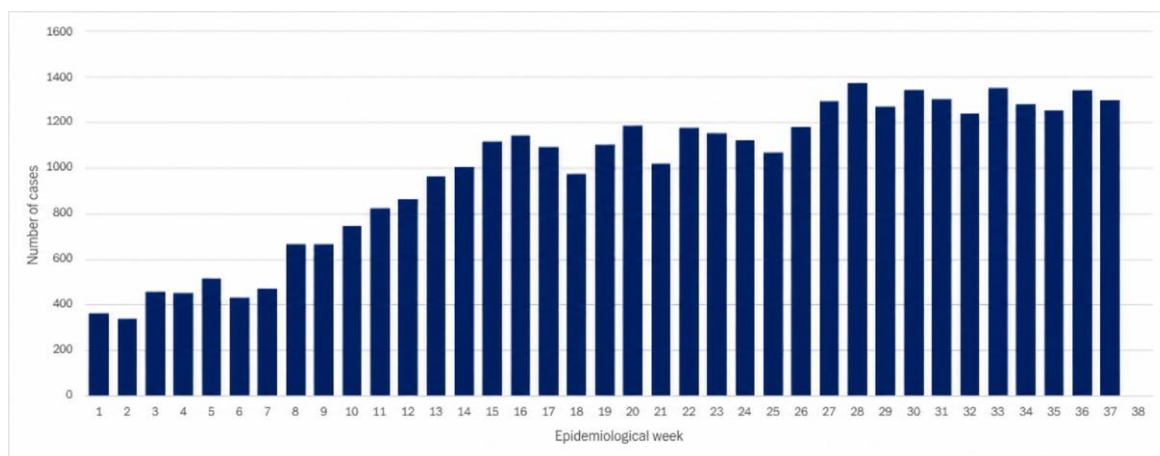


Source: Adapted from Cuba's National Focal Point (NFP) for the International Health Regulations (IHR). Information from an email dated 9 October 2026. Havana; 2026. Unpublished (5).

In **Ecuador**, between EW 1 and 37 of 2026, 35,566 cases of dengue were reported, including 37 deaths. This represents an incidence rate of 192.8 per 100,000 population and a case fatality rate of 0.10%. Cases were reported in all 24 provinces of the country. Of the total reported cases,

0.76% were severe dengue cases (n= 271 cases). Three serotypes of the dengue virus (DENV-1, -2, and -3) were identified, with DENV-3 being the predominant serotype. Regarding the trend in 2026, a gradual increase was observed throughout the year, with a significant number of reported cases between EW 26 and EW 37 (**Figure 5**). Between EW 34 and EW 37, the number of dengue cases remained consistently high, with more than 1,200 cases reported weekly (1, 6).

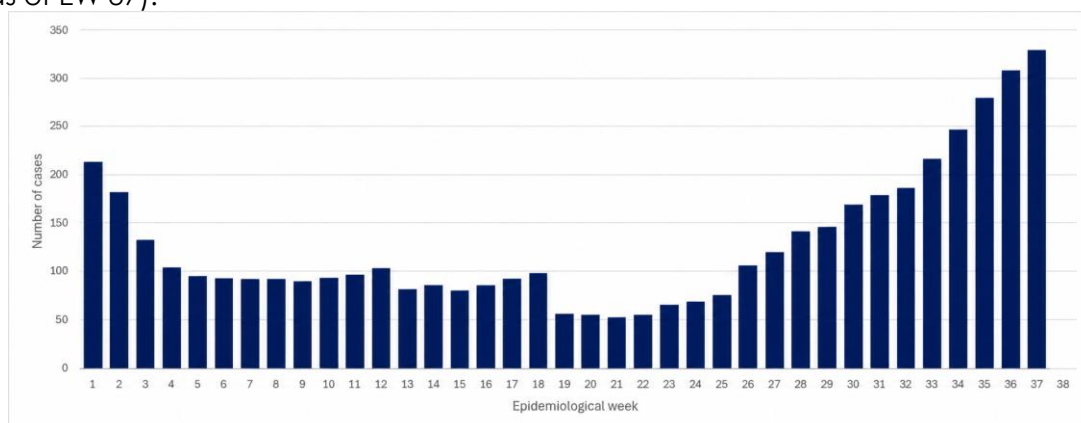
Figure 5. Distribution of reported dengue cases by epidemiological week (EW) in Ecuador, 2026 (as of EW 37).



Source: Adapted from the Pan American Health Organization. PLISA Health Information Platform for the Americas, Arboviral Diseases Portal. Washington, D.C.: PAHO/WHO; 2026 [cited 29 September 2026]. Available from: <https://www.paho.org/en/arbo-portal/dengue-data-and-analysis> (1).

In **El Salvador**, between EW 1 and EW 37 of 2026, 4,786 cases of dengue were reported, of which 48 have been confirmed, including three deaths. This represents an incidence rate of 74.9 cases per 100,000 population and a case fatality rate of 0.062%. Of the total reported cases, 0.1% were severe dengue cases (n= 6 cases). In 2026, only one serotype of the dengue virus (DENV-3) was identified as circulating, unlike in previous years when all four serotypes (DENV-1, -2, -3, and -4) were circulating (1, 7). Regarding the trend in 2026, after a high number of cases were recorded in the first EW of the year, there was a decline in the number of cases through EW 22; starting in EW 25, there was an increase, which has continued through EW 37 (**Figure 6**) (1, 7)

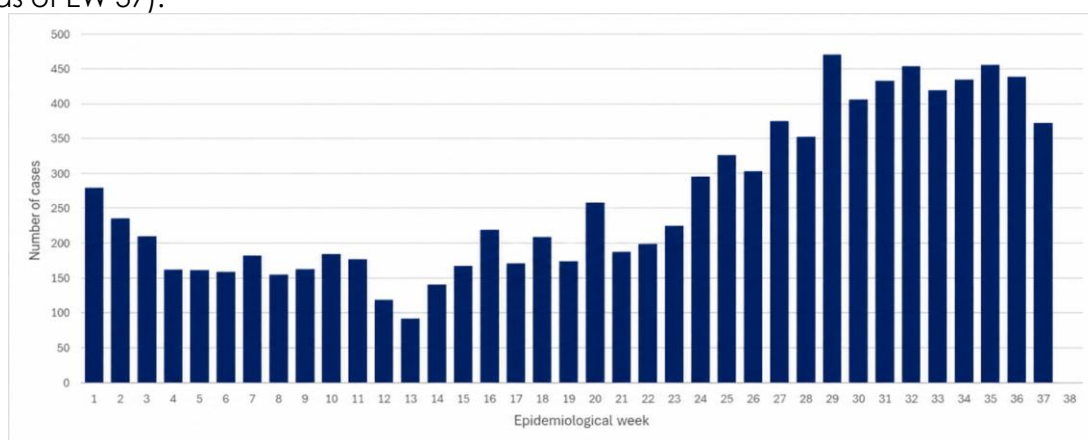
Figure 6. Distribution of reported dengue cases by epidemiological week (EW) in El Salvador, 2026 (as of EW 37).



Source: Adapted from the Pan American Health Organization. PLISA Health Information Platform for the Americas, Arboviral Diseases Portal. Washington, D.C.: PAHO/WHO; 2026 [cited September 29, 2026]. Available from: <https://www.paho.org/en/arbo-portal/dengue-data-and-analysis> (1).

In **Honduras**, between EW 1 and EW 37 of 2026, 9,782 cases of dengue were reported, of which 1,083 have been confirmed, including four deaths. This represents an incidence rate of 96 per 100,000 population and a case fatality rate of 0.04%. Of the total reported cases, 1.64% were severe dengue cases (n= 160 cases). The circulation of two dengue virus serotypes (DENV-1 and DENV-3) was identified, with DENV-3 accounting for 99% of cases. Regarding the trend in 2026, a gradual increase was observed throughout the year, with a significant number of reported cases between EW 24 and EW 37 (**Figure 7**) (1, 8). Between EW 30 and EW 37, reported cases have remained above 400 per week, and the health regions with the highest number of reports continue to be the Central District and Cortés (San Pedro Sula) (1, 8).

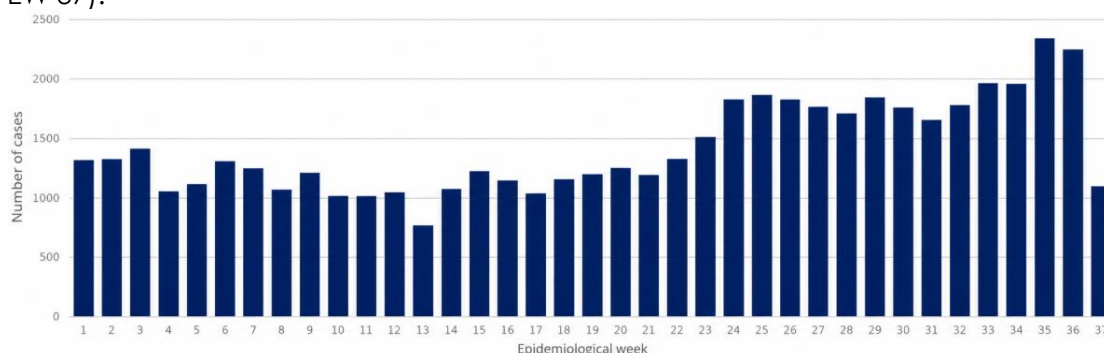
Figure 7. Distribution of reported dengue cases by epidemiological week (EW) in Honduras, 2026 (as of EW 37).



Source: Adapted from the Pan American Health Organization. PLISA Health Information Platform for the Americas, Arboviral Diseases Portal. Washington, D.C.: PAHO/WHO; 2026 [cited September 29, 2026]. Available from: <https://www.paho.org/en/arbo-portal/dengue-data-and-analysis> (1).

In **Mexico**, between EW 1 and EW 37 of 2026, 52,866 probable cases of dengue were reported. Of the total reported cases, 5,859 were laboratory-confirmed, including 26 deaths. The incidence rate of confirmed cases was 4.36 per 100,000 population (1). Of the total confirmed cases, 3.41% were severe dengue cases (n= 200 cases) (1). All four serotypes of the dengue virus were identified as circulating, with a predominance of serotype DENV-3 (1, 9). Regarding the trend in 2026, a stable trend in case reporting was observed through EW 23; however, starting in EW 24, an increase in cases has been observed (**Figure 8**) (1, 9).

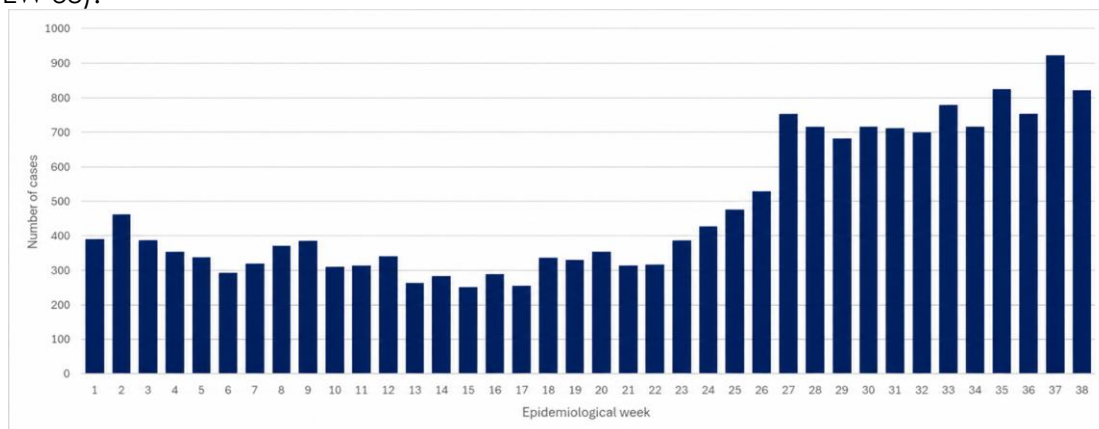
Figure 8. Distribution of reported dengue cases by epidemiological week (EW) in Mexico, 2026 (as of EW 37).



Source: Adapted from the Pan American Health Organization. PLISA Health Information Platform for the Americas, Arboviral Diseases Portal. Washington, D.C.: PAHO/WHO; 2026 [cited September 29, 2026]. Available from <https://www.paho.org/en/arbo-portal/dengue-data-and-analysis> (1).

In **Panama**, between EW 1 and EW 38 of 2026, 11,772 suspected cases of dengue were reported. Of the total reported cases, 9,679 were confirmed, including 20 deaths, representing an incidence rate of 209.3 per 100,000 population and a case fatality rate of 0.2%. Of the total reported cases, 0.58% were severe dengue cases (n= 56 cases) (1, 10). Circulation of all four dengue virus serotypes (DENV-1, -2, -3, and -4) was identified, with DENV-2 and -3 being predominant (1, 10). Regarding the trend in 2026, a slight increase was observed in the first half of the year, with a jump in the number of reported cases between EW 24 and EW 38 (**Figure 9**) (1, 10).

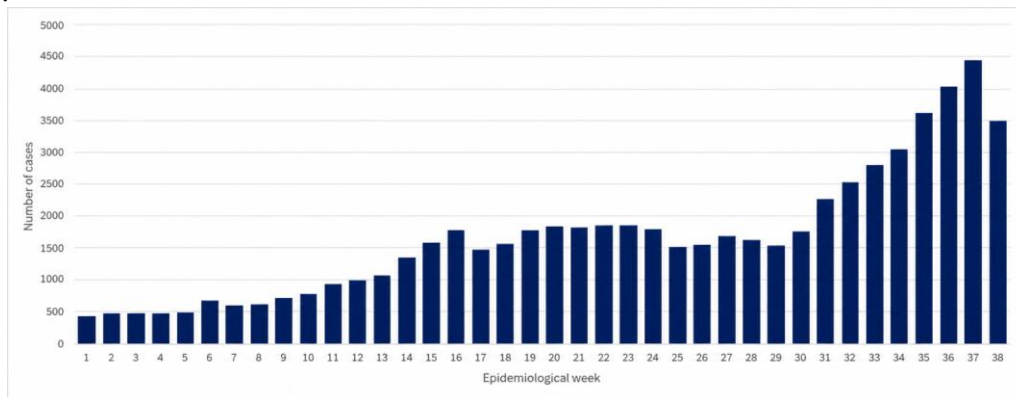
Figure 9. Distribution of reported dengue cases by epidemiological week (EW) in Panama, 2026 (as of EW 38).



Source: Adapted from the Pan American Health Organization. PLISA Health Information Platform for the Americas, Arboviral Diseases Portal. Washington, D.C.: PAHO/WHO; 2026 [cited September 29, 2026]. Available from: <https://www.paho.org/en/arbo-portal/dengue-data-and-analysis> (1).

In **Peru**, between EW 1 and EW 38 of 2026, 63,407 cases of dengue were reported. Of the total reported cases, 49,650 were confirmed, including 71 deaths, corresponding to an incidence rate of 183.02 per 100,000 population and a case fatality rate of 0.11%. Of the total reported cases, 0.41% were severe dengue cases (n= 259 cases). Three serotypes of the dengue virus (DENV-1, -2, and -3) were identified in circulation, with DENV-3 being the predominant serotype (1, 11). As of EW 38 of 2026, the number of reported cases exceeded the total recorded as of EW 38 of 2025 by 100%. Likewise, cases of severe dengue increased by 55%, rising from 167 in 2025 to 259 in 2026, while the number of deaths increased by 39% compared with the total recorded as of EW 38 of 2025. Regarding the trend observed in 2026, an upward trend in the number of reported cases has been observed since EW 10 of 2026 (**Figure 10**) (11, 12). The increase in dengue cases is primarily associated with rising ambient temperatures and increased rainfall due to the El Niño phenomenon, which create favorable conditions for the vector (12).

Figure 10. Distribution of reported dengue cases by epidemiological week (EW) in Peru, 2026 (as of EW 38).



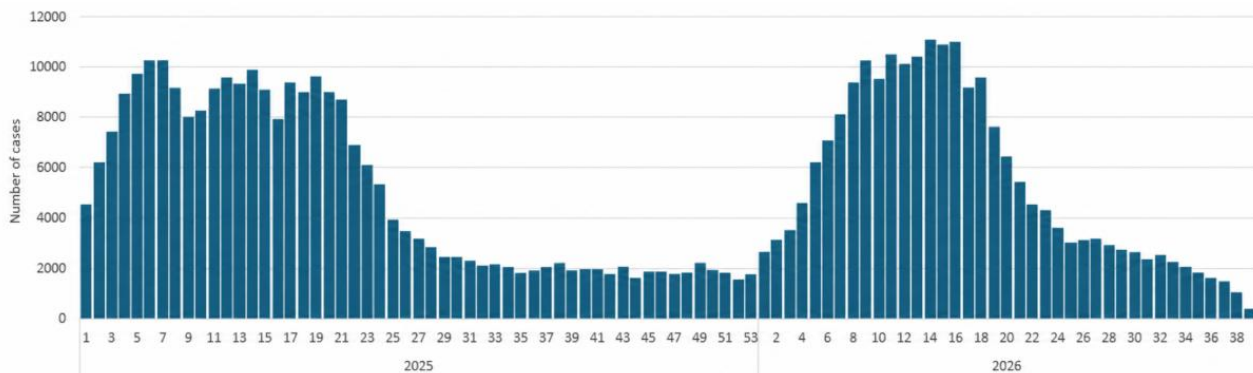
Source: Adapted from the Peruvian Ministry of Health. Centro Nacional de Epidemiología, Prevención y Control de Enfermedades. Sala situacional de enfermedades metaxénicas. Lima: MINSA; 2026 [cited 6 October 2026]. Available from: https://app7.dge.gob.pe/maps2/shiny_metaxenicas_web/ (12).

Summary of the chikungunya situation in the Americas

Between late 2025 and 2026, there has been an increase in chikungunya cases in several countries and territories in the Americas Region, as well as the resurgence of indigenous transmission in countries and territories that had not reported viral circulation for several years (13, 14). During this period, high levels of chikungunya virus transmission have been documented in all provinces of Cuba, the central-western and southeastern regions of Brazil, and southern Bolivia, as well as the reappearance of cases in the Guiana Shield region and in Central American countries (1, 15).

Between EW 1 and EW 38 of 2026, a total of 213,919 suspected cases of chikungunya were reported, including 78,481 confirmed cases (**Figure 11**) and 88 deaths, with a case fatality rate of 0.041%, in 20 countries and territories of the Americas Region (1). Although this figure is lower than that observed during the same period in 2025, transmission shows a greater potential for expansion into new areas where *Aedes aegypti* mosquitoes are present, the occurrence of outbreaks outside of historical seasons, longer transmission periods, and an increase in more severe clinical forms (16).

Figure 11. Distribution of reported chikungunya cases by year and epidemiological week (EW) in the Americas Region, 2025–2026 (as of EW 39).

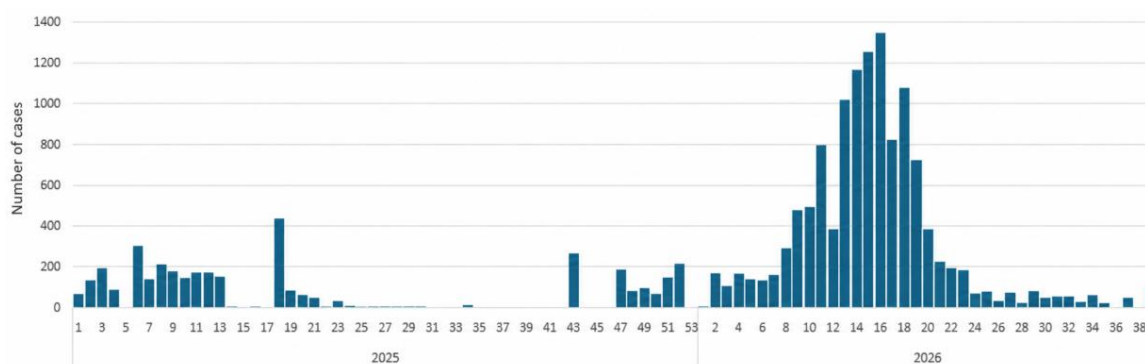


Source: Adapted from the Pan American Health Organization. PLISA Health Information Platform for the Americas, Arboviral Diseases Portal. Washington, D.C.: PAHO/WHO; 2026 [cited 13 October 2026]. Available from: <https://www.paho.org/en/arbo-portal/dengue-data-and-analysis> (1).

The following is a summary of the epidemiological situation of chikungunya in select countries of the Region, which reported the highest number of cases between late 2025 and 2026, listed in alphabetical order.

In **Argentina**, from 2025 as of EW 53, 3,712 suspected cases of chikungunya were reported, including 38 laboratory-confirmed cases. In 2026, as of EW 38, 12,383 suspected cases were reported, of which 3,803 were laboratory-confirmed, including two deaths. The provinces with the highest number of cases were Salta (n= 4,543 suspected cases, including 1,730 confirmed cases), Tucumán (n= 3,487 suspected cases, including 673 confirmed cases), Jujuy (n= 1,192 suspected cases, including 206 confirmed cases), Córdoba (n= 1,315 suspected cases, including 37 confirmed cases), Santiago del Estero (n= 532 suspected cases, including 229 confirmed cases), and Catamarca (n= 263 suspected cases, including 21 confirmed cases). The highest number of reported cases occurred in EW 16, followed by a subsequent decline in transmission (**Figure 12**) (17, 18).

Figure 12. Distribution of chikungunya cases by year and epidemiological week (EW) in Argentina, 2025–2026 (through EW 39).



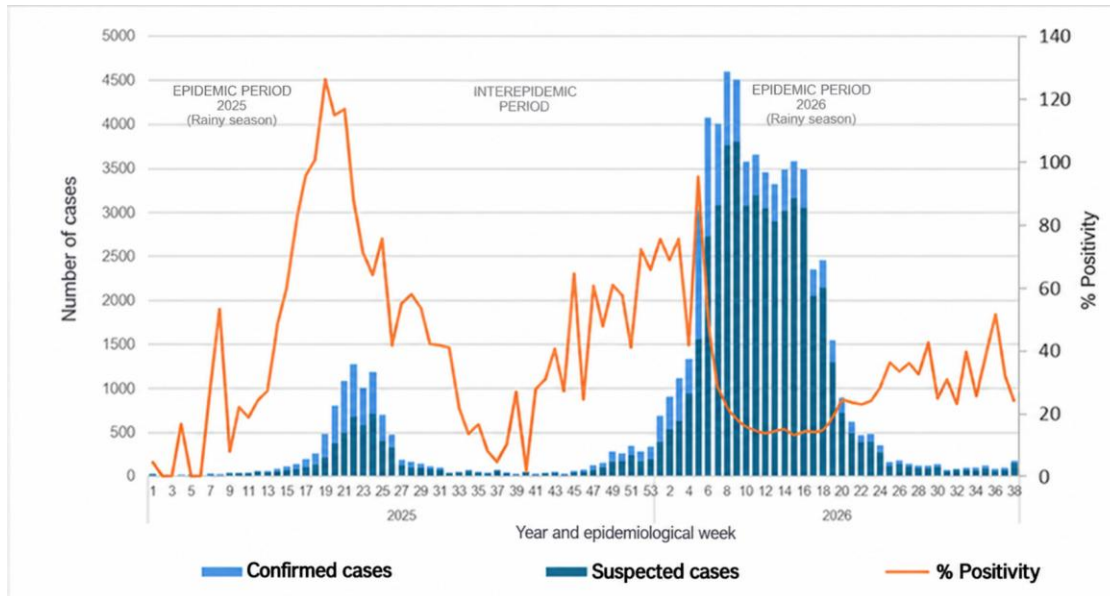
Source: Adapted from the Pan American Health Organization. PLISA Health Information Platform for the Americas, Arboviral Diseases Portal. Washington, D.C.: PAHO/WHO; 2026 [cited 13 October 2026]. Available from: <https://www.paho.org/en/arbo-portal/dengue-data-and-analysis> (1).

In **Bolivia**, in 2025, there was continuous transmission of the chikungunya virus from the beginning of the year, with 6,860 suspected cases reported, including 4,697 laboratory-confirmed cases and four deaths. In 2026, as of EW 38, 48,079 cases were reported, including 11,749 confirmed cases and 45 deaths. Regarding the trend, 2026 began with a significant increase in cases in the first few weeks, with the highest number reported in EW 9 at 3,823 cases (**Figure 13**).

The reporting of confirmed chikungunya cases in 2026 shows an epidemic pattern, beginning with 296 cases in EW 1, followed by a sharp rise from 395 cases in EW 4 to 1,483 cases in EW 5. From that point on, a sustained decline in the epidemic curve was observed, reaching 415 confirmed cases in EW 12, and entering a period of decline beginning in EW 17 (**Figure 13**) (19).

Regarding the positivity rate, high values were observed at the beginning of the year: 75.5% in EW 1, 69.1% in EW 2, and 75.4% in EW 3. The highest value was reported in EW 5, at 95.1%, indicating that a very high proportion of the processed samples tested positive for chikungunya. In EW 38, the positivity rate dropped to 1.3%, the lowest for this period (**Figure 13**) (19).

Figure 13. Distribution of suspected and confirmed cases of chikungunya by year and epidemiological week (EW) in Bolivia, 2025–2026 (as of EW 38).

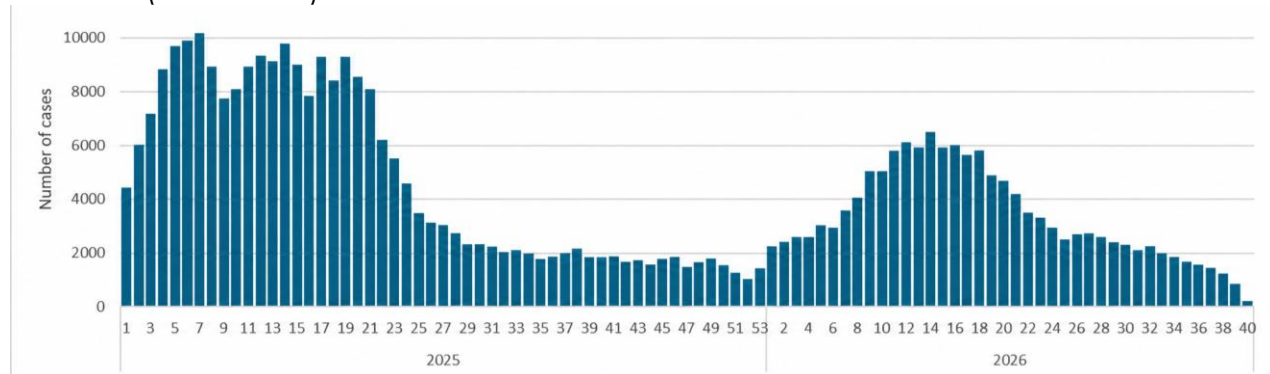


Source: Adapted from the International Health Regulations (IHR) National Focal Point (NFP) of the Plurinational State of Bolivia. Information provided via email on 15 October 2026. La Paz; 2026. Unpublished (19).

In 2026, chikungunya cases were reported in all nine departments of the country, with the highest number reported in Santa Cruz ($n = 33,972$ suspected cases, including 5,989 confirmed cases and 45 deaths), followed by Tarija ($n = 7,131$ suspected cases, including 1,541 confirmed cases), Cochabamba ($n = 2,685$ suspected cases, including 1,279 confirmed cases), and Chuquisaca ($n = 1,521$ suspected cases, including 852 confirmed cases). Circulation of the East, Central, and Southern Africa (ECSA) genotype of chikungunya virus (CHIKV) has been documented in Bolivia; however, the E1-A226V mutation has not been identified (19).

In **Brazil**, between EW 1 and EW 53 of 2025, 253,753 suspected cases of chikungunya were reported, of which 108,975 were confirmed, including 130 deaths. In 2026, as of EW 40, 135,962 suspected cases were reported, of which 56,759 were confirmed, including 58 deaths (**Figure 14**) (1,20). The cases reported in 2026 represent a 41,6% decrease compared with those reported during the same week in 2025 ($n = 232,719$ cases). Although the risk of chikungunya transmission in Brazil in 2026 shows a decrease compared with the same period in 2025, the persistence of a considerable number of cases across the 26 states and the Federal District indicates that transmission remains active and that the risk persists. In Brazil, the circulation of the ECSA genotype without the E1-A226V mutation has been documented (14, 21).

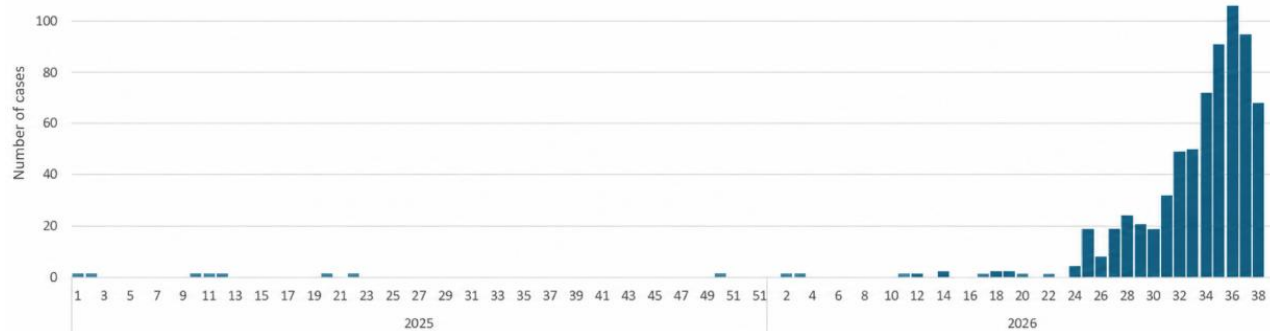
Figure 14. Distribution of chikungunya cases by year and epidemiological week (EW) in Brazil, 2025–2026 (as of EW 40).



Source: Adapted from the International Health Regulations (IHR) National Focal Point (NFP) of Brazil. Information provided via email on 16 October 2026. Brasília 2026. Unpublished (20)

In **Costa Rica**, in 2025, as of EW 53, eight suspected cases of chikungunya were reported, with no laboratory-confirmed cases. In contrast, in 2026, as of EW 38, 690 suspected cases were reported, of these 539 were laboratory-confirmed cases (**Figure 15**) (1, 4). The distribution by province is: Guanacaste (n= 404 cases), Alajuela (n= 132 cases), San José (n= 94 cases), Puntarenas (n= 29 cases), Heredia (n= 21 cases), Cartago (n= 8 cases), and Limón (n= 2 cases) (4).

Figure 15. Distribution of chikungunya cases by year and epidemiological week (EW) in Costa Rica, 2025–2026 (as of EW 38).



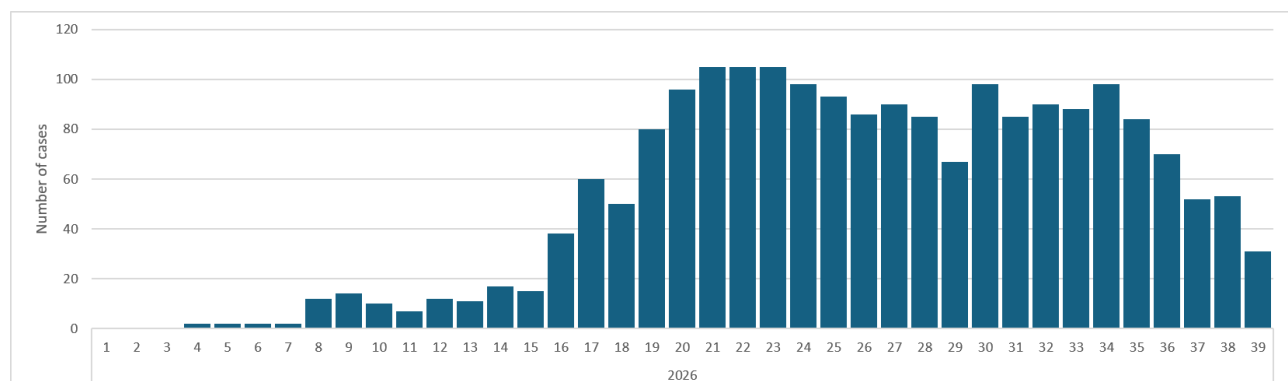
Source: Adapted from the Pan American Health Organization. PLISA Health Information Platform for the Americas, Arboviral Diseases Portal. Washington, D.C.: PAHO/WHO; 2026 [cited 13 October 2026]. Available from: <https://www.paho.org/en/arbo-portal/dengue-data-and-analysis> (1).

In **Cuba**, in 2025, the chikungunya virus resurged after nine years without any reported cases. The virus was first detected in EW 26 of 2025 and as of EW 53 of 2025, transmission had been confirmed in 15 provinces and 147 municipalities, with 51,217 suspected cases, including 1,959 confirmed cases and 46 deaths (1, 14). Severe cases were documented, including neurological complications (encephalitis, Guillain-Barré syndrome, meningoencephalitis), cardiovascular manifestations (acute myocarditis, decompensation of preexisting conditions, pulmonary thromboembolism), and perinatal or neonatal transmission (1, 15).

In 2026, as of EW 26, 2,716 cases have been reported, including 254 confirmed cases and six deaths (1). Circulation of the ECSA lineage has been identified, with no detection of the E1-A226V mutation associated with increased infectivity in *Ae. albopictus* (15).

In **French Guiana**, chikungunya virus transmission resumed in 2026⁵ following eleven years without any cases. In EW 4 of 2026, the first four autochthonous cases were confirmed in the western part of the region, near the border with Suriname, in Saint-Laurent-du-Maroni (n= 3 cases) and Kourou (n= 1 case) (22-24). By EW 39, 2,017 confirmed cases had been reported, and four deaths with positive reverse transcription polymerase chain reaction (RT-PCR) for chikungunya: two without a link with the disease, one indirectly linked and one directly linked to chikungunya (**Figure 16**) (1, 22). Sequencing of the first locally acquired cases revealed high genetic similarity among them and a close relationship to recent sequences from Ecuador and Brazil (1, 22). The causative strain is the East, Central, and Southern African (ECSA) strain, which lacks the vector-adaptive E1-A226V mutation (1, 23,24).

Figure 16. Distribution of reported chikungunya cases by year and epidemiological week in French Guiana, 2026 (as of EW 39).



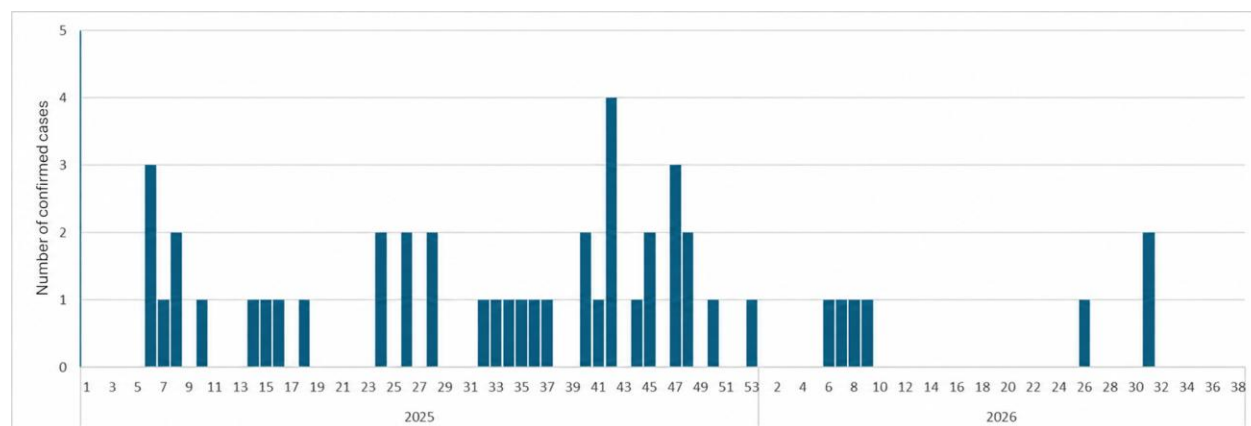
Source: Adapted from the Pan American Health Organization. PLISA Health Information Platform for the Americas, Arboviral Diseases Portal. Washington, D.C.: PAHO/WHO; 2026 [cited 13 October 2026]. Available from: <https://www.paho.org/en/arbo-portal/dengue-data-and-analysis> (1).

In **Guyana**, in 2025, following eight years without local transmission of chikungunya, six laboratory-confirmed locally acquired cases were reported. The cases occurred between EW 42 and EW 52. In 2026, as of EW 37, two confirmed cases have been reported, both in EW 8 (1, 25).

In **Panama**, 40 cases of chikungunya were confirmed in 2025 as of EW 53. In 2026, as of EW 38, seven confirmed cases have been reported, one of which is an imported case (**Figure 17**) (1, 10).

⁵ Last outbreak occurred in 2014-2015 in French Guiana (22)

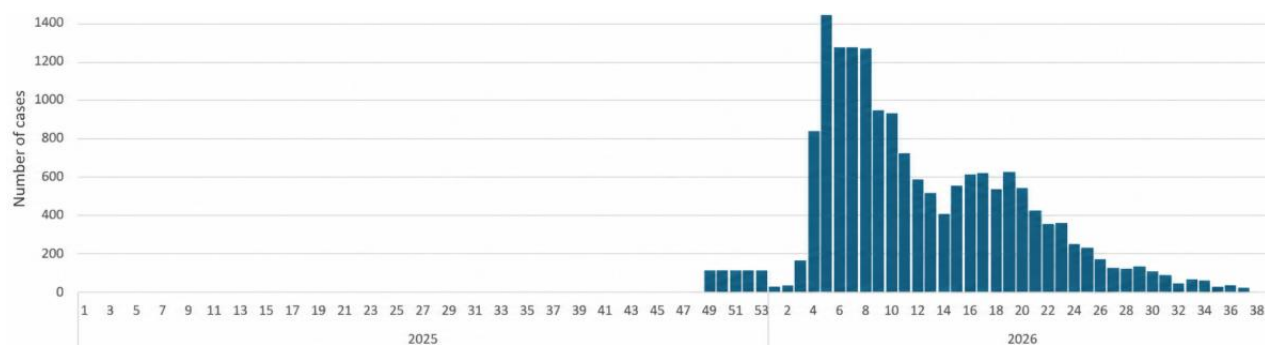
Figure 17. Distribution of confirmed chikungunya cases by year and epidemiological week (EW) in Panama, 2025–2026 (as of EW 38).



Source: Adapted from the Panamanian Ministry of Health, General Directorate of Public Health, National Department of Epidemiology. Boletín epidemiológico semanal: semana 38, del 20 al 26 de septiembre de 2026. Panama: MINSA; 2026. Available from: https://www.minsa.gob.pa/sites/default/files/2026-10/BOLETIN%20EPIDEMIOLOGICO%20SEMANAL%20%2038_0.pdf (26).

In **Suriname**, in EW 49 of 2025, an increase in cases of undifferentiated fever was observed, which coincided with what would be expected seasonally for influenza or dengue. In EW 51 of 2025, after nine years without any reported transmission of the chikungunya virus, the first suspected cases of chikungunya were reported. In EW 2 of 2026, four cases were laboratory-confirmed. In 2026, as of EW 38, 16,623 suspected cases have been reported, of which 4,883 were laboratory-confirmed (**Figure 18**) (1, 27).

Figure 18. Distribution of reported chikungunya cases by year and epidemiological week (EW) in Suriname, 2025–2026 (as of EW 38).



Source: Adapted from the Pan American Health Organization. PLISA Health Information Platform for the Americas, Arboviral Diseases Portal. Washington, D.C.: PAHO/WHO; 2026 [cited 13 October 2026]. Available from: <https://www.paho.org/en/arbo-portal/dengue-data-and-analysis> (1).

Guidance for National Authorities

Given the increase in cases of dengue and chikungunya observed in some countries of the Region, the anticipated intensification of the El Niño phenomenon over the coming months, and the approaching peak season for dengue and chikungunya circulation in South America, the Pan American Health Organization reminds Member States that the same guidance published in the Epidemiological Update of 10 June 2020, on dengue and other arboviral diseases remains in effect, available from: <https://www.paho.org/en/documents/epidemiological-update-dengue-and-other-arboviruses-10-june-2020> (28), which are summarized below:

Integrated Surveillance

PAHO/WHO encourages the continuation of epidemiological surveillance and the reporting of suspected and confirmed cases of dengue, chikungunya, and Zika.

Since clusters of cases are common for these diseases (dengue, chikungunya, and Zika), efforts should be made to analyze the spatial distribution of cases to enable a rapid local response in the most affected areas. Information on hotspots for the three diseases should be used to guide intensive vector control.

Sentinel entomological surveillance will help assess changes in the risk of vector-borne diseases and the impact of vector control measures.

Case Management

Chikungunya. CHIKV disease can cause a wide range of clinical manifestations, although it is primarily characterized by the onset of fever associated with arthritis or arthralgia. Joint pain is often severe and debilitating. Other common manifestations include headache, muscle pain, rash, and itching.

The duration of symptoms ranges from a few days to several months, thus defining the different phases of the disease: acute, post-acute, and chronic, each with specific care requirements. The acute phase lasts up to two weeks, the post-acute phase extends from the third week to the third month, and the chronic phase begins in the fourth month and can last for years (27). In most patients in the chronic phase, a significant deterioration in quality of life is observed in the first few years following chikungunya infection. Consequently, it is recommended that the clinical capabilities of health care personnel at all levels be strengthened to address all phases of the disease.

- Implement continuing education programs for health professionals on the diagnostic suspicion and clinical management of chikungunya cases, as well as other arboviral diseases prevalent in the Region, particularly dengue and Zika.
- Strengthen competencies at the various levels of care for the prevention and treatment of sequelae of the chronic phase of chikungunya.
- Adapt the “Guidelines for the clinical diagnosis and treatment of dengue, chikungunya, and Zika” (29) to the national and subnational levels.

- Offer training workshops for public and private health personnel on the organization of health services, including outbreak response.

Likewise, pregnant women, children under one year of age, older adults, and people with comorbidities (hypertension, chronic kidney disease, diabetes, obesity, heart disease, among others) should be advised to seek immediate care at the nearest health facility at the first suspicion of chikungunya infection, given their increased risk of developing severe symptoms or complications from this disease. Furthermore, any newborn whose mother had suspected or confirmed chikungunya within 15 days prior to delivery must be hospitalized due to the risk of vertical transmission.

It is important to note that chikungunya disease can be fatal during the acute phase, particularly in this group of patients (pregnant women, children under one year of age, older adults, and people with comorbidities). Severe manifestations include shock, meningoencephalitis, and Guillain-Barré syndrome (30-32). CHIKV infection can exacerbate underlying conditions in people with comorbidities, thereby increasing the risk of severe illness and death in this population group (30).

Dengue. Measures to ensure the appropriate clinical management of suspected dengue cases must be a priority.

Capacities at the primary health care level must be strengthened to prevent progression to severe forms of dengue and dengue-related deaths. To achieve this, health care workers must make an early clinical diagnosis and recognize warning signs of dengue (such as intense and persistent abdominal pain or tenderness, persistent vomiting, clinical signs of fluid accumulation, mucosal bleeding, lethargy, restlessness, liver enlargement >2 cm below the costal margin, and a progressive increase in hematocrit) in order to initiate appropriate management in accordance with the recommendations published in PAHO's clinical guidelines. In cases where dengue is suspected, health care workers should provide clear guidance to patients and/or families on monitoring warning signs and seeking immediate medical care if they occur. These measures will also help reduce the number of patients who must be referred to hospitals, thereby preventing the overcrowding of these facilities and intensive care units.

At the same time, all secondary- and tertiary-level hospitals must be prepared to manage dengue cases with warning signs and severe dengue cases.

Further information on the clinical management of dengue cases is available in the Guidelines for the clinical diagnosis and treatment of dengue, chikungunya, and Zika (29), in the Tool for the diagnosis and care of patients with suspected arboviral diseases (33)—both published by PAHO—and in the Guidelines for the management of severe dengue in intensive care units (34).

PAHO reiterates the recommendations for technical teams responsible for malaria control, which also apply to personnel involved in the care of arbovirus infections, available from: <https://iris.paho.org/items/8f20b9fe-b892-400f-9ad2-c6d454a81e6f> (35).

Adapting health care services

In light of the increased incidence of dengue and chikungunya in the Region, Member States are urged to adapt their health services to provide a timely and appropriate response to the population at all levels of care.

- Organize screening, patient flow, and clinical care and hospitalization areas in each institution, across the various levels of care.
- Reorganize health services during outbreaks or epidemics at the various levels of patient care.
- Strengthening patient care networks for the clinical diagnosis, management, and follow-up of patients with suspected dengue, chikungunya, or Zika, as well as for their referral and counter-referral.

Laboratory confirmation

It is important to note that the initial diagnosis of CHIKV or DENV infection is clinical, and a well-founded suspicion can guide the confirmation protocol. Laboratory results should be interpreted in conjunction with clinical information and the epidemiological context, for surveillance purposes rather than for clinical decision-making.

Chikungunya. Clinical suspicion of CHIKV infection can be confirmed in the laboratory using virological techniques, primarily molecular detection via PCR. The ideal sample for detection is serum collected during the acute phase of infection, preferably within the first 5 days after symptom onset. However, because CHIKV typically presents with more prolonged viremia, a sample taken up to day 8 after symptom onset may be useful for molecular confirmation (36).

There are different algorithms for the molecular detection of CHIKV, depending on the epidemiological and clinical context. Thus, in the event of a clinical suspicion consistent with CHIKV infection, it is recommended to begin with a specific PCR test, where a positive result confirms the infection; if the result is negative, testing can proceed sequentially with the detection of other arboviruses, primarily dengue virus (DENV) and Zika virus (ZIKV), or other pathogens considered in the differential diagnosis (**Figure 19**) (36).

Conversely, when the clinical suspicion is unclear and nonspecific symptoms may be consistent with other arboviruses (or even other pathogens), or in the context of syndromic surveillance, a multiplex amplification protocol that allows for the simultaneous detection of at least 3 of the most likely endemic arboviruses (DENV, CHIKV, and ZIKV) may be more efficient (**Figure 19**) (36).

In fatal cases, it is recommended to collect tissue samples, primarily from the liver and spleen, for molecular detection. These samples are also useful for histopathological analysis to support the diagnosis and better characterize the case (36).

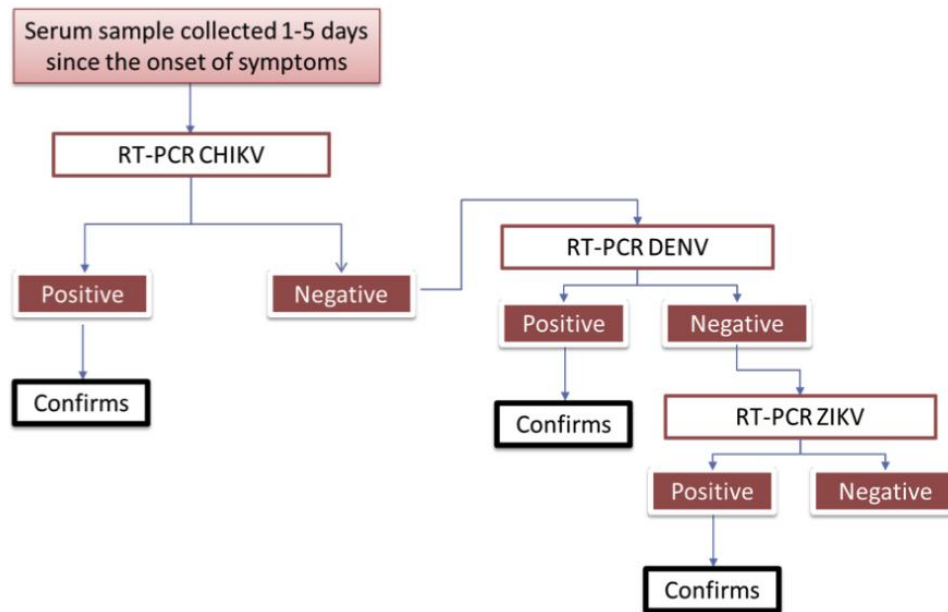
Serological confirmation of CHIKV infection is only possible when paired samples collected at least one week apart (acute phase and convalescent phase) are processed. Seroconversion (negative IgM in the initial sample and positive in the second sample, as determined by ELISA or neutralization) or at least a 4-fold increase in antibody titer (using a quantitative method) can confirm the diagnosis. However, it is important to note that serological assays are susceptible to cross-reactions, especially with other alphaviruses, including Mayaro. Furthermore, a positive result in a single sample is not considered confirmatory, since, in addition to the possibility of cross-reaction, IgM may remain detectable for several months or even years after infection; therefore, a positive result may reflect a past infection (36).

In cases with neurological manifestations (e.g., meningoencephalitis), molecular and serological testing can be performed on cerebrospinal fluid (CSF) samples. However, this sample should be collected only when clinically indicated and not for the specific purpose of identifying

the causative agent. While a positive result on a molecular test of CSF confirms infection, a negative result does not rule it out (36).

Finally, given the initial clinical similarity between chikungunya and measles, and considering the risk that the latter poses to the Region, it is recommended to include measles in the differential diagnosis (37).

Figure 19. Sequential algorithm for virological testing in suspected cases of chikungunya



Source: Pan American Health Organization. Recommendations for the Detection and Laboratory Diagnosis of Arbovirus Infections in the Americas Region. Washington, D.C.: PAHO; 2022. Available from: <https://iris.paho.org/handle/10665.2/56321> (36).

Dengue. Laboratory confirmation of dengue infection is based on virological tests (RT-PCR, detection of NS1 antigen by ELISA, and in some cases viral isolation in culture for further characterization) and serological tests (detection of IgM). However, for case confirmation, priority should be given to virological tests that demonstrate the presence of the whole virus, its genetic material, or its proteins. Virological tests for dengue are performed on serum samples collected during the first 5 days after symptom onset (acute phase) (**Figure 20**).

On the other hand, serological tests based on IgM detection must be interpreted with caution, taking into account the duration for which antibodies circulate in the blood after infection, as well as the possibility of cross-reaction with other flaviviruses (including Zika, yellow fever, and others) and nonspecific detection. Thus, a single IgM result in a patient indicates only exposure to the virus, and such cases are defined as probable cases of dengue. A second sample collected at least one week later, processed in parallel with the first and using a quantitative serological assay (such as PRNT) capable of demonstrating seroconversion or an increase in antibody titer, may be useful for clarifying the diagnosis (**Figure 21**).

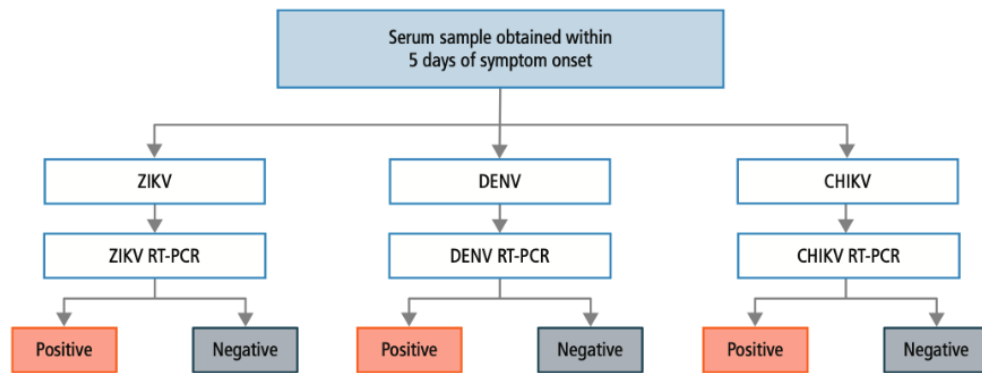
It is important to have a clear laboratory algorithm that enables early detection. While multiplex PCR methods are useful when there is no clear clinical suspicion, in cases of dengue that meet the established definitions and where the clinical presentation is consistent, it is recommended to prioritize protocols for specific (*single-plex*) detection of the virus (37).

In fatal cases, tissue samples (liver, spleen, kidney) should be collected for both the detection of genetic material (RT-PCR) and for histopathological and immunohistochemical analysis. Taking biopsies from a patient with suspected dengue is strictly contraindicated.

On the other hand, the use of immunochromatographic or rapid tests (NS1 and/or antibodies) is not recommended, as their low sensitivity can lead to false-negative results; their use should be limited to community-based studies under established protocols, but under no circumstances should they be used to rule out infection or to guide medical management.

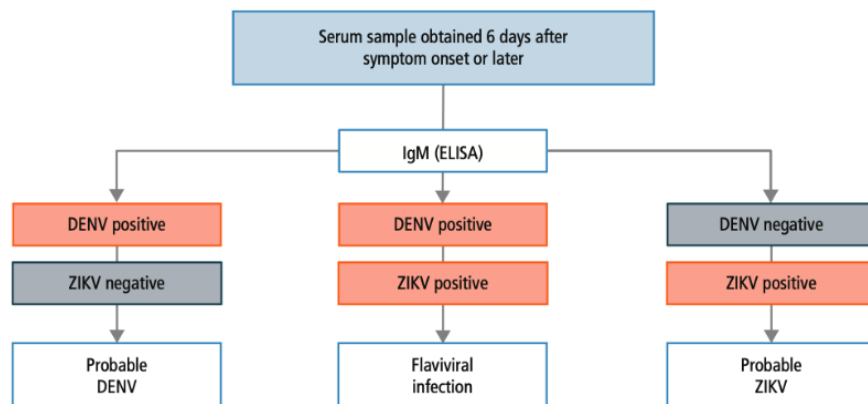
Since laboratory services are a key component of epidemiological and virological surveillance of dengue, timely detection and characterization of appropriate samples must be maintained. To the extent possible and depending on each laboratory's capacity, it is recommended that samples be collected from 100% of severe and fatal dengue cases, while only a proportion (10–30% or a maximum number of samples based on installed capacity) of cases without warning signs will be necessary for surveillance.

Figure 20. Algorithm for virological testing in suspected cases of dengue, chikungunya, and Zika.



Source: PAHO/WHO. Recommendations for the detection and laboratory diagnosis of arbovirus infections in the Americas Region. August 29, 2022. Available from: <https://iris.paho.org/items/9b154948-6dc9-4cf0-8808-3fbe72ca95bd>

Figure 21. Algorithm for serological testing in suspected cases of dengue and Zika.



Source: PAHO/WHO. Recommendations for the detection and laboratory diagnosis of arbovirus infections in the Americas Region. August 29, 2022. Available at: <https://iris.paho.org/items/9b154948-6dc9-4cf0-8808-3fbc72ca95bd>.

Aedes prevention and control measures

PAHO/WHO urges Member States to make effective use of available resources to prevent and/or control vector infestations in affected areas and in health care facilities. This will be achieved through the implementation of integrated vector control strategies in emergencies, which include the following processes:

- Selection of control methods based on knowledge of the vector's biology, disease transmission, and morbidity.
- Use of multiple interventions, often in combination and in a synergistic manner.
- Collaboration between the health sector and public and private sectors involved in environmental management whose work contributes to vector reduction.
- Active participation of individuals, families, and other key partners (education, finance, tourism, water and sanitation, and others) in prevention and control activities.
- Strengthening the legal framework to enable an integrated and intersectoral approach.

Given the high infestation rate of *Aedes aegypti* and the presence of *Aedes albopictus* in the region, it is recommended that prevention and control measures be aimed at reducing vector density and have the support and active participation of the local population. The prevention and control measures to be implemented by national and local authorities should include the following:

- Strengthen environmental management efforts, primarily the elimination of vector breeding sites in homes, surrounding areas, and common areas (parks, schools, cemeteries, etc.).
- Reorganize solid waste collection services to support efforts to eliminate breeding sites in areas with the highest transmission rates and, if necessary, plan intensive actions in specific areas where regular trash collection has been interrupted or where additional collections are needed.
- Implement measures to control (38) breeding sites through the use of physical, biological, and/or chemical methods, actively involving individuals, families, and the community.
- Identify high-risk areas for transmission (risk stratification) (39) and prioritize those with high concentrations of people (schools, transportation hubs, hospitals, health centers, etc.). In these facilities, the presence of the mosquito must be eliminated within a radius of at least 400 meters. It is important to pay special attention to health facilities to ensure they are free of the vector and its breeding sites and do not become sources of viral transmission.
- In areas where active transmission is detected, it is recommended to implement measures aimed at eliminating infected adult mosquitoes (primarily through the use of insecticides) in order to halt and interrupt transmission. This action is of an exceptional nature and is effective only when carried out by properly trained personnel in accordance with internationally accepted technical guidelines, and when performed concurrently with the other proposed actions. The primary measure to interrupt transmission when it is occurring intensively is the elimination of adult mosquitoes infected

with the dengue virus (active transmission) through indoor spraying using handheld equipment or space spraying using heavy-duty vehicle-mounted equipment, combined with the destruction and/or control of vector breeding sites inside and around homes (40).

- An effective method of adult control that can be used, given available operational capabilities, is indoor residual spraying, which should be applied selectively to the resting sites of *Aedes aegypti*, taking care not to contaminate food, containers for storing drinking water, or those used for cooking. This intervention in treated areas is effective for up to four months and can be used in shelters, homes, health facilities, schools, and other settings. For more information, consult the PAHO Manual for the Application of Indoor Residual Spraying in Urban Areas for the Control of *Aedes aegypti* (39) and the document *Control of Aedes aegypti in the Context of Simultaneous COVID-19 Transmission* (42).
- Carefully select the insecticide to be used (following PAHO recommendations), its formulation, and be aware of the susceptibility of *Aedes* populations to that insecticide (43).
- Ensure the proper functioning and maintenance of spraying equipment. Secure strategic supplies, such as insecticides (larvicides and adulticides), personal protective equipment, spare parts for spraying equipment, and fuel, among others.
- Intensify oversight (quality control and coverage) of fieldwork performed by operators, including both indoor spraying with handheld equipment and space spraying with heavy-duty vehicle-mounted equipment, ensuring compliance with personal protective measures.

Personal prevention measures

Patients infected with the dengue, chikungunya, and/or Zika viruses serve as a reservoir of infection for others, both in their homes and in the community. It is necessary to inform patients, their families, and the affected community about the risk of transmission and ways to prevent spread by reducing the vector population and contact between the vector and people.

To minimize vector-patient contact, the following is recommended:

- The patient should rest under mosquito nets, whether or not they are treated with insecticide.
- Sick individuals, as well as other household members, should wear long sleeves to cover their limbs.
- Repellents containing DEET, IR3535, or Icaridin may be applied to exposed skin or clothing, and their use must strictly follow the instructions on the product label. Install wire mesh or mosquito netting on doors and windows.

Community communication and engagement

It is recommended to establish and implement a rapid communication action plan focused on:

- Measures to prevent the formation of vector breeding sites and to eliminate them to prevent transmission, and
- Information on the symptoms and warning signs of dengue when the country's epidemiological situation warrants it—such as an increase in cases or deaths from dengue.

It is recommended to target the following as primary audiences: individuals, communities, neighborhood committees, municipalities, and the public and private sectors, with messages about measures to prevent the formation of vector breeding sites and eliminate them to prevent the transmission of arboviruses.

Target audiences:

- Individuals, communities, neighborhood committees, municipalities, and the public and private sectors: messages on measures to prevent the formation of vector breeding sites and their elimination to prevent the transmission of dengue and other arboviruses. Additionally, information on warning signs of dengue to seek immediate medical attention.
- Healthcare workers (including nurses, doctors, and primary care and hospital staff) and vector control program technicians: information on dengue symptoms and warning signs that are present or on the rise in the country.

Every effort should be made to gain community support for dengue prevention.

Simple Information, Education, and Communication (IEC) materials can be disseminated through various media channels (including social media or closed-circuit television in primary care health facilities).

The public and household members should be encouraged to eliminate mosquito breeding sites, both inside and around the home. This is a shared responsibility: the family, the community, and the public and private sectors.

Highly productive mosquito breeding sites, such as water storage containers (drums, elevated tanks, clay pots, etc.), should be targeted with preventive measures to stop vector breeding. Other breeding sites, such as roof gutters and other water-retaining containers, should also be cleaned periodically.

Both healthcare personnel and affected communities should be encouraged to learn about the symptoms of dengue, as well as its warning signs, and how to respond when these symptoms appear.

Collaboration with local teams is encouraged, as they know how to make this information more effective; in many cases, national campaigns and messages are not as effective as local initiatives (38).

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