

Regional Situation Report • No. 14

Measles in the Region of the Americas

22 October 2026 • Next issue: 5 November 2026¹

REPORTING PERIOD: EW 1–41, 2026 (4 January 2026 – 17 October 2026) • 2-week change window: EW 39–40 vs. EW 37–38 ²		
CUMULATIVE — EW 1–41, 2026		
56,753 CONFIRMED CASES	81 DEATHS Case Fatality Rate (CFR) 0.14%	17 COUNTRIES AND TERRITORIES (CUMULATIVE) ³
LAST 2 WEEKS — EW 39–40, 2026		
+643 NEW CONFIRMED CASES ↓ -32% (compared to EW 37–38) ⁴	+4 NEW DEATHS Three new deaths in Guatemala and one new death in the United States of America	6/17 COUNTRIES AND TERRITORIES THAT HAVE REPORTED CASES DURING EW 39–40 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 41 of 2026 (which ended on 17 October 2026), the Region of the Americas reported **56,753** confirmed cases of measles in 17 countries and territories, representing a 4.8-fold increase compared with the same period in 2025. Guatemala (34,535), Mexico (13,691), the United States (4,410), Peru (2,698), and Canada (1,124) account for the vast majority (99.5%) of confirmed cases (**Map 1**). A total of **81** deaths has been reported, including 53 in Guatemala, 23 in Mexico, three in the United States of America, one in Peru and one in Bolivia (1).

During EW 39 and EW 40 of 2026, the Region of the Americas reported **643** new confirmed cases of measles in six countries and territories, representing a 32% decrease compared with the previous two-week period (EW 37–38; 946 new cases, including 259 retrospectively reported since the last Regional Situation Report) (**Figure 1**). Of the 643 new confirmed cases reported during EW 39–40, the United States accounted for 320, followed by Guatemala 211, Peru with 68, Mexico with 39, Canada with three, and Bolivia with two².

Despite declining transmission in some countries of the Americas, with **Rt estimates below 1** (**Table 3**), persistent low-level transmission may continue through sporadic and hard-to-detect chains of infection. This "drop-by-drop" transmission pattern can sustain virus circulation for more than 12 months, delaying outbreak closure and increasing the risk of re-establishment of endemic transmission, which could ultimately jeopardize a country's **measles-free status**.

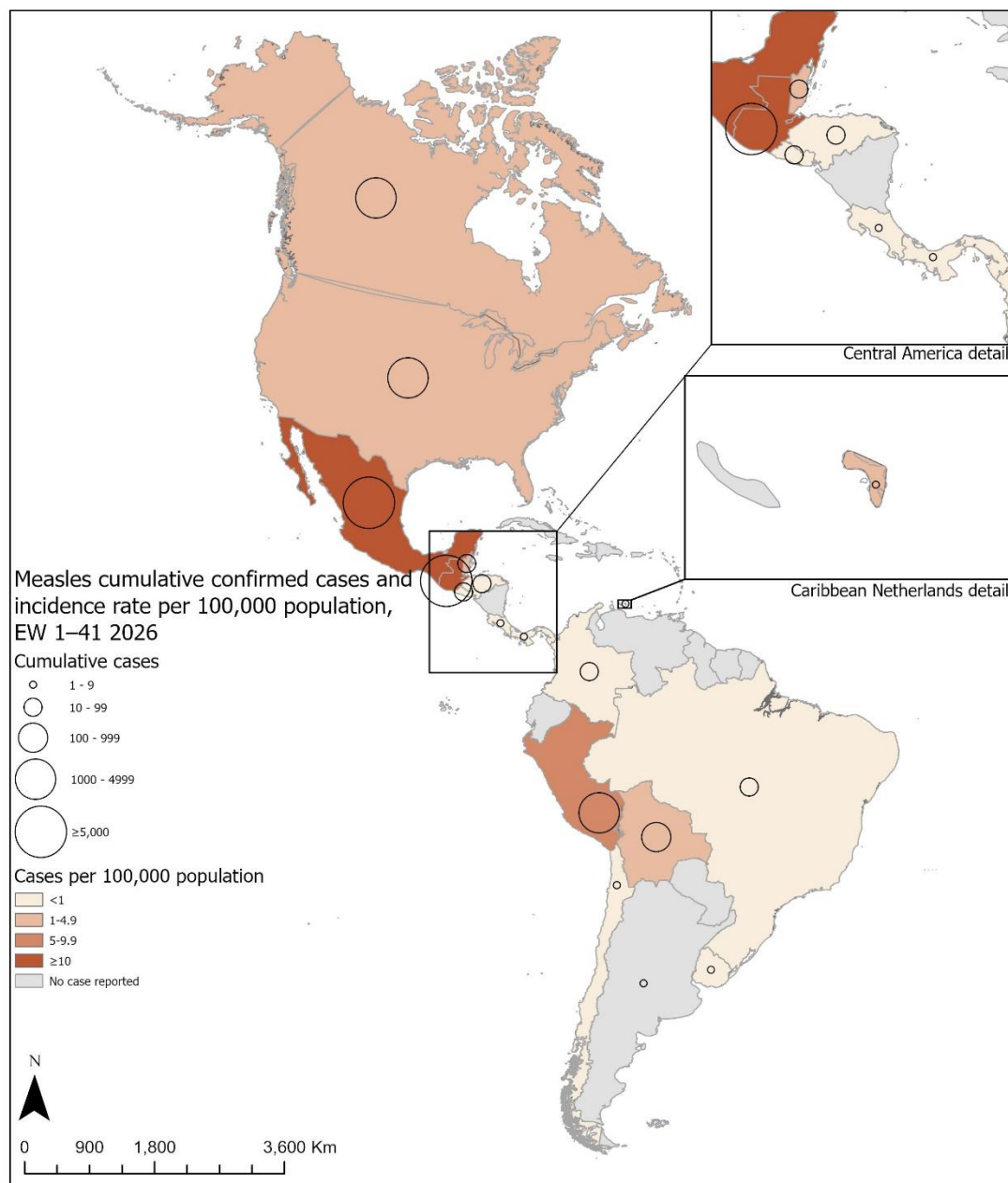
¹ Previous Regional Situation Reports and additional information and resources on measles in the Region of the Americas are available on the PAHO measles webpage: [Measles Multi-Country Outbreak 2026 - PAHO/WHO | Pan American Health Organization](#) (2)

² 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 41, 2026, while the dashboard is updated on a rolling basis as new data becomes available.

³ Since Situation Report No. 13, no other country has reported any new cases of measles in 2026.

⁴ 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 – EW41, 2026. (n = 56,753)



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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 (3)	PAHO continued supporting Mexico's measles outbreak response through technical assistance to priority states and coordination with national authorities. In Durango, virtual technical assistance was provided to the Rapid Response Team (ERRA per its acronym in Spanish) to assess outbreak dynamics, align intervention strategies, and strengthen the integration of Active Community Search (BAC per its acronym in Spanish) with intensive vaccination activities. This combined approach aims to improve early case detection, reduce surveillance gaps, and interrupt transmission through timely vaccination of contacts and household members. In Chihuahua, the state most affected by the outbreak and the location of the index case, technical support focused on strengthening Rapid Vaccination Monitoring (MRV per its acronym in Spanish). Training covered the planning, implementation, and analysis of MRV to assess vaccination coverage and support the documentation required for outbreak closure.	Continue coordinating with ERRA to validate a 90-day measles outbreak response plan. Planned activities include strengthening ERRA capacities through targeted training and provide technical support to Chiapas in response to increasing cases and its high-risk border with Guatemala.
Guatemala (4)	PAHO continued providing technical support through territorial consultants in Quiché, Sololá, Guatemala Sur, Izabal and Quetzaltenango. PAHO also supported preparation of in-person microplanning workshops for the remaining 16 Departmental Directorates of Integrated Health Services Networks (DDRIS per its acronym in Spanish) as part of phase 3 of the vaccination campaign, deployment of central-level teams for campaign monitoring in Quiché and Sololá, transportation of vaccination brigades in Izabal, and identification of a cold-chain gap in Quiché. Risk communication materials were distributed to Quiché, Sololá, Quetzaltenango and Izabal. In addition, PAHO, together with the Ministry of Public Health and Social Assistance (MSPAS per its acronym in Spanish), established a joint October 2026–April 2027 response roadmap covering immunization, surveillance, communication, clinical management and infection prevention and control (IPC), with indicators to monitor implementation and results.	Continue technical support to priority health areas for vaccination campaign implementation and monitoring, microplanning, rapid vaccination monitoring, vaccine logistics, community engagement and preparation of phase 3. PAHO will also support implementation of the MSPAS–PAHO joint roadmap, address identified cold-chain and operational gaps, and support establishment of a validated denominator for campaign monitoring and prioritization of vaccination among vulnerable groups.

Bolivia (5)	PAHO continued to support Bolivia's measles outbreak response through coordination with departmental teams on vaccination, rapid vaccination monitoring (MRV per its acronym in Spanish), active institutional and community case finding (BAI/BAC per its acronym in Spanish), supervision, and microplanning for 2027. Technical workshops strengthened MRV implementation across health networks, municipalities, and health facilities. PAHO also supported active institutional case finding in 8 prioritized municipalities across 7 departments and outbreak-closure activities in 40 municipalities, including verification of the nine national closure criteria. Immunization support included deployment of 276 vaccination brigades for the <i>Cerrando brechas</i> campaign through 15 November and mobilization of 361 health professionals for MRV and supervision.	Continue to support intensified vaccination activities, including deployment of vaccination brigades, rapid vaccination monitoring, supervision and coverage monitoring in the prioritized municipalities. Continue to support active surveillance and verification of outbreak-closure criteria, particularly in areas with ongoing transmission risk. PAHO will also continue support for monitoring campaign progress through national help-desk teams, review of the measles clinical management course, and advocacy with the education sector, particularly universities, to facilitate access to vaccination and strengthen vaccination-related policies and regulations in faculties offering health-related programs.
Peru (6)	PAHO continued supporting Peru's measles response, including a joint Centers for Disease Control and Prevention (CDC)–PAHO mission planned for Puno and advocacy with national authorities and partners to strengthen the response. In Loreto, PAHO supported financing for vaccination brigades in San Pablo and the recruitment of a monitor to follow up and analyze vaccination activities. Technical support also focused on responding to continued transmission. PAHO additionally supported preparedness for large gatherings planned for October and November, including the procession of the Lord of Miracles and the visit of Pope Leo XIV, and continued advocacy to advance the shipment of measles-rubella (MR) vaccines planned for 2027 to support vaccination of persons older than 11 years.	Continue supporting measles response activities in Puno, Loreto and other affected areas, including vaccination brigades, monitoring and analysis of vaccination activities, and follow-up with national authorities and partners. PAHO will also continue supporting preparedness for upcoming mass gatherings, advocate for timely availability of additional MR vaccine, and support efforts to increase measles vaccination coverage and respond to ongoing transmission.

PAHO Response by Strategic Pillars (7)⁵

Coordination

- Publication of the Spanish version of the Response strategy and donor appeal. Measles outbreaks in the Americas. Available from: <https://iris.paho.org/items/46fa68c7-419c-4de8-8c64-9181b5e1e478> (8)

Collaborative Surveillance

- In Bolivia, PAHO continues to support the active measles outbreak response in La Paz and Santa Cruz, including surveillance and field response activities.
- In Mexico, the updated 90-day plan for measles outbreak control and elimination is being finalized. PAHO is supporting the mobilization of rapid response teams and field activities in priority areas, including Chiapas, Durango, Jalisco, Quintana Roo and Zacatecas.
- In Peru, PAHO is supporting preparedness activities associated with the upcoming visit of Pope Leo XIV, while also providing field support to vaccination activities in Loreto department.
- At the subregional level in South America, PAHO is supporting preparedness for mass gatherings associated with the upcoming visit of Pope Leo XIV, including coordination activities carried out on Wednesday 14 October.
- In the Dominican Republic, PAHO supported a measles and rubella response workshop with more than 70 participants from epidemiological surveillance, laboratory and immunization teams. The workshop aimed to strengthen preparedness and prevention capacities in a country that has not reported confirmed measles cases for several years but remains at elevated risk due to high international travel and tourism volumes.

Clinical management

- In Guatemala, PAHO is supporting a virtual training cycle and didactic adaptation on clinical response and IPC during the measles outbreak. The six-session series, delivered weekly, targets health personnel from the MSPAS, including the DDRISS, health centers and hospitals, as well as the Guatemalan Social Security Institute (IGSS per its acronym in Spanish) and private-sector health professionals. The sessions include participation from national experts, the National Commission for Verification of Measles Elimination, the Guatemalan Association of Infectious Diseases, and PAHO.

Immunization and Vaccination Operations

- Vaccination response activities continued across affected and priority countries, including implementation of vaccination campaigns, preparation of microplanning activities, and updating of tools to support routine immunization and outbreak response. Recent progress is summarized below:

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

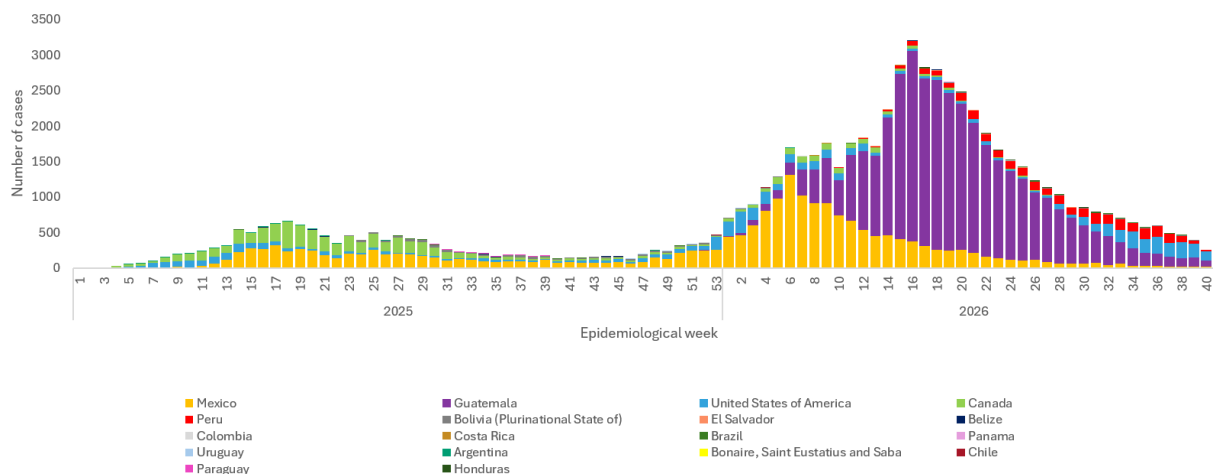
Country	Vaccination response progress
Guatemala	• A vaccination campaign is underway in four programmatic areas: Quiché, Chiquimula, Sololá, and Izabal. • A request for 500,000 vaccine doses has been submitted. • Additional programmatic areas are being prepared to progressively expand the campaign.
Mexico	• Preparations are underway for microplanning training covering campaign activities planned for 2027 and routine immunization in states that have reported no measles virus circulation for more than 20 weeks.
Colombia	• Microplanning tools are being updated to support routine preventive vaccination and the 2027 vaccination campaign.
Brazil	• PAHO met with the national immunization program team to support updates to the microplanning tool for vaccination campaigns and outbreak response, including demonstration of the revised tool.
Chile	• PAHO is supporting development of a social communication plan for the selective follow-up vaccination campaign.

Risk & Crisis Communication and Community Engagement

- Two media interview requests on the regional measles situation were received during the reporting period, from Al Jazeera and Bloomberg.
- PAHO disseminated a communication highlighting the very high risk of measles spread associated with large religious gatherings and other mass gatherings in the Americas, with recommendations intended to support preparedness for the visit of Pope Leo XIV as well as other large-scale events, including concerts and mass gatherings in affected countries such as Peru. Available from: <https://www.paho.org/en/news/9-10-2026-paho-assesses-risk-measles-spread-very-high-ahead-religious-mass-gatherings-americas> (9)
- Communication materials specifically addressing measles prevention during mass gatherings are under development, including a social media carousel to promote key preventive messages for participants and the general public.
- In coordination with relevant PAHO technical teams, measles-specific recommendations for travelers and mass gatherings are also being prepared to support risk communication and preparedness ahead of upcoming events.
- PAHO also disseminated information on the meeting of the Regional Monitoring and Re-verification Commission for Measles and Rubella Elimination. Available from: <https://www.paho.org/en/news/14-10-2026-measles-and-rubella-elimination-regional-monitoring-and-re-verification-commission> (1)

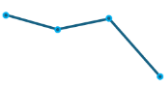
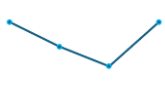
Epidemiological Situation

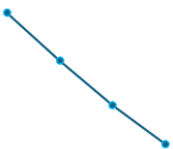
Figure 1. Epidemiological curve of confirmed measles cases in the Region of the Americas, by country and epidemiological week (EW), from EW 1 of 2025 to EW 41 of 2026



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 41 of 2026

Country	New cases reported through EW 39-40	Cases in 2026 (up to EW 41) (1)	Deaths in 2026 (up to EW 41) (1)	Observed trend (EW 37-40)**	Response scenario (11)****	Epidemiological notes
Guatemala*	+211	34,535	53	↓ declining 	Scenario C – Community transmission	As of EW 41, transmission has been reported in all the 22 departments. The overall downward trend continues at the national level; at the departmental level, the highest incidence rates continue to be observed in Izabal (400.6 cases per 100,000 inhabitants), followed by Central Guatemala (330.6 per 100,000 inhabitants) and Sololá (306.9 per 100,000 inhabitants). Of all confirmed measles cases, 62% 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. The case fatality rate in this age group is 0.55% (approximately 6 deaths per 1,000 confirmed cases), compared with 0.15% (approximately 1 death per 1,000 confirmed cases) in the general population. 67.6% of cases had no history of vaccination. The most recent case was reported in EW 40 of 2026.
Mexico*	+39	13,691	23		Scenario C – Community transmission	Most cases in 2026 are concentrated in three states: Jalisco, with 7,289 cumulative cases in 2026; Mexico City, with 1,033 cases; and Chiapas, with 951 cases. The most recent case was recorded in EW 40 of 2026.

Country	New cases reported through EW 39-40	Cases in 2026 (up to EW 41) (1)	Deaths in 2026 (up to EW 41) (1)	Observed trend (EW 37-40)**	Response scenario (11)****	Epidemiological notes
United States*	+320	4,410	3	↓ declining ⁶ 	Scenario C – Community transmission	In 2026, the highest number of cases has been reported in Pennsylvania (1,237), South Carolina (670), Utah (535), Wisconsin (256), Texas (192), Virginia (178), Kentucky (167), Ohio (160), and Florida (148). A third measles-related death was newly reported during this reporting period. The most recent case was reported in EW 41 of 2026.
Peru*	+68	2,698	1	↓ declining ⁷ 	Scenario C – Community transmission	The most recent case was recorded in EW 40 of 2026.
Canada*	+3	1,124	0	Droplet transmission with sporadic cases that are part of the same outbreak	Scenario C – Community transmission	For the year 2026 through EW 41, the highest number of cases has been reported in Manitoba (680) and Alberta (311); followed by British Columbia (50), Ontario (35), and Quebec (32). The most affected age group remains those aged 5 to 17 (41%). The most recent case was recorded in EW 40 of 2026.
Bolivia*	+2	120	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 39 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.

⁶ The recent decline observed in the United States should be interpreted with caution. Case counts for the most recent epidemiological weeks are likely incomplete due to reporting delays. Once these delays are accounted for, model estimates indicate increasing transmission (R_t 1.49 [95% CrI 1.42–1.57]). See Table 3.

⁷ The recent decline observed in Peru should be interpreted with caution. Case counts for the most recent epidemiological weeks may be incomplete due to expected reporting delays. Once these delays are accounted for, model estimates suggest broadly stable transmission ($R_t \approx 1.06$, uncertainty interval including 1). See Table 3.

Country	New cases reported through EW 39-40	Cases in 2026 (up to EW 41) (1)	Deaths in 2026 (up to EW 41) (1)	Observed trend (EW 37-40)**	Response scenario (11)****	Epidemiological notes
Brazil	0	52	0	Sporadic imports	Scenario A – No current transmission / risk of importation	The last case was reported in EW 38 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	16	0	Sporadic imports	Scenario A – No current transmission / risk of importation	The last case was reported in EW 38 of 2026.
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. (11)

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 41 of 2026

Country	R_t (95% CrI) ¹ Effective reproduction number	Based on the model ²	4-week forecast (EW 42–45) Median [95% PrI] ³	Model interpretation
Mexico	0.78 [0.62–0.98]	↓ declining	~49 [20–88] cases	R_t is below 1, with the uncertainty interval remaining entirely below 1 — the model suggests declining transmission.
Guatemala	0.7 [0.63–0.77]	↓ declining	~189 [129–258] cases	R_t is estimated to be 0.7, remaining below the epidemic threshold. This indicates declining transmission, and projections suggest that the downward trend will continue.
United States	1.49 [1.42–1.57]	↑ on the rise	~3,480 [3,104–3,897] cases	R_t is estimated to be 1.49. 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 42–45) Median [95% PrI] ³	Model interpretation
				now showing a sustained decline.
Peru	1.06 [0.98–1.15]	~stable	~704 [567–858] cases	R_t is estimated to be 1.06. 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 (12). 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 (13).

Effective reproduction number (R_t). R_t was estimated using the EpiEstim method (12), 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 (14). 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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