

Regional Situation Report • No. 13

Measles in the Region of the Americas

8 October 2026 • Next issue: 22 October 2026¹

REPORTING PERIOD: EW 1–39, 2026 (4 January 2026 – 3 October 2026) • 2-week change window: EW 37–38 vs. EW 35–36 ²		
CUMULATIVE — EW 1–39, 2026		
55,792 CONFIRMED CASES	77 DEATHS Case Fatality Rate (CFR) 0.14%	17 COUNTRIES AND TERRITORIES (CUMULATIVE) ³
LAST 2 WEEKS — EW 37–38, 2026		
+687 NEW CONFIRMED CASES ↓ -35% (compared to EW 35–36) ⁴	+9 NEW DEATHS <i>Five new deaths in Guatemala, two new deaths in the United States of America, one new death in Mexico and one new death in Peru</i>	7/17 COUNTRIES AND TERRITORIES THAT HAVE REPORTED CASES <i>Bolivia (Plurinational State of), Brazil, Canada, Guatemala, Mexico, Peru and the United States of America</i>

Summary of the Situation

Between epidemiological week (EW) 1 and EW 39 of 2026 (which ended on 3 October 2026), the Region of the Americas reported **55,792** confirmed cases of measles in 17 countries and territories, representing a 4.8-fold increase compared with the same period in 2025. Guatemala (34,355), Mexico (13,595), the United States (3,887), Peru (2,553), and Canada (1,121) account for the vast majority (99.5%) of confirmed cases (**Map 1**). A total of **77** deaths has been reported, including 50 in Guatemala, 23 in Mexico, 2 in the United States of America, one in Peru and one in Bolivia (1). Notably, the deaths reported in the United States of America and Peru are the first deaths reported by these countries in 2026.

During EW 37 and EW 38 of 2026, the Region of the Americas reported **687** new confirmed cases of measles in seven countries and territories, representing a 35% decrease compared with the previous two-week period (EW 35–36; 1,059 new cases, including 350 retrospectively reported since the last Regional Situation Report) (**Figure 1**). Of the 687 new confirmed cases reported during EW 37–38, the United States accounted for 293, followed by Guatemala 200, Peru with 155, Mexico with 34, and Bolivia with 3, while Canada and Brazil reported one case each².

Despite declining transmission in some countries of the Americas, with **Rt estimates below 1**, 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**.

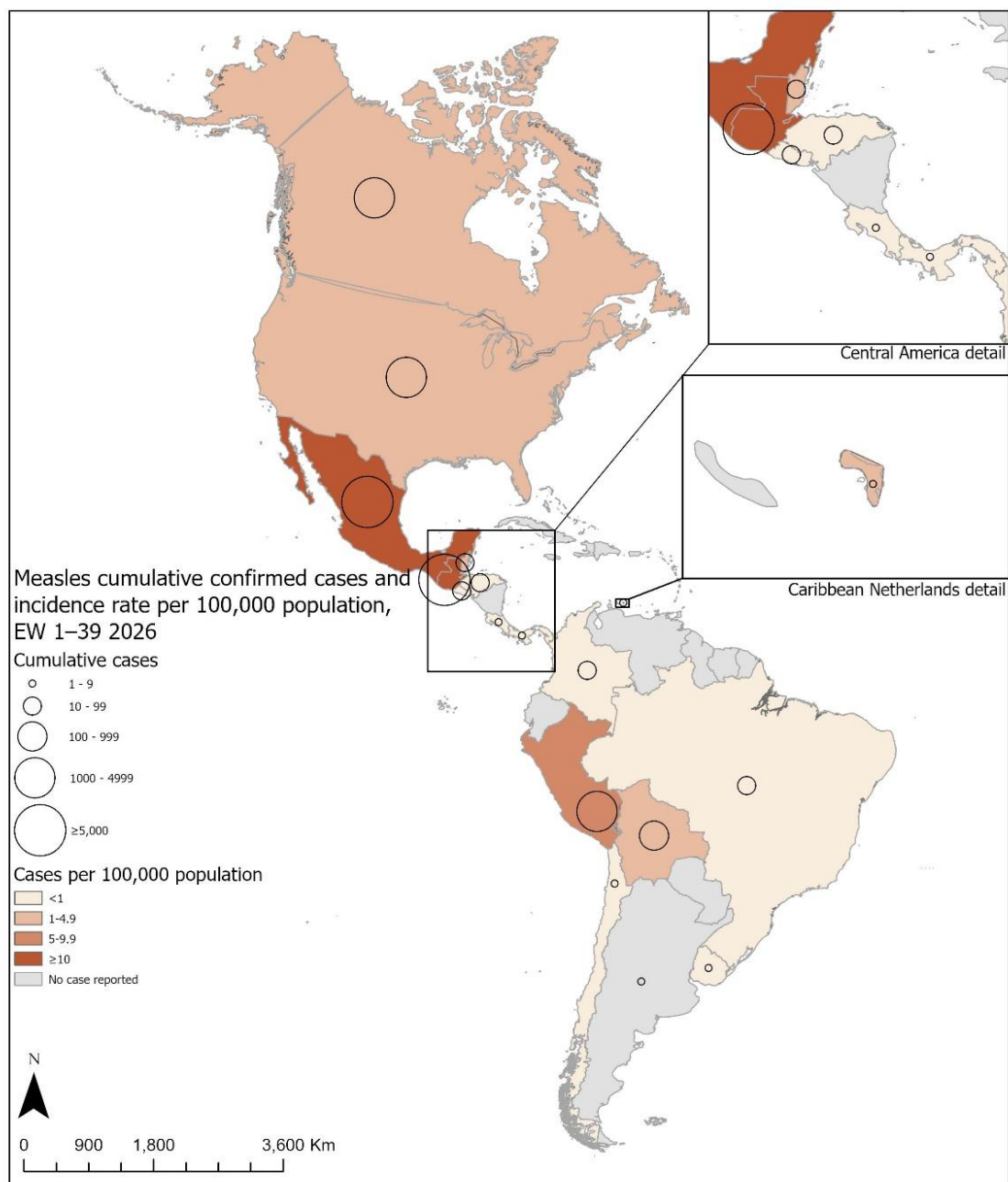
¹ Previous Regional Situation Reports and additional information and resources on measles in the Region of the Americas are available on the PAHO measles webpage: [Measles Multi-Country Outbreak 2026 - PAHO/WHO | Pan American Health Organization](#) (2)

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 39, 2026, while the dashboard is updated on a rolling basis as new data becomes available.

³ Since Situation Report No. 12, 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 – EW39, 2026. (n = 55,792)



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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 to support Mexico's measles outbreak response, with particular attention to Zacatecas, where on-site technical assistance was provided following an increase in mortality associated with the outbreak, which has resulted in 385 confirmed cases and six deaths. Support also included an assessment of compliance with the standard requiring epidemiological investigation of suspected cases within 48 hours of notification. Technical assistance focused on strengthening contact tracing and accelerating measles-rubella (MR) and measles-mumps-rubella (MMR) vaccination activities among the most affected age groups, particularly children aged 1–4 years and adults aged 25–29 years. PAHO also provided technical guidance on the application of Regional Verification Commission (RVC) outbreak closure criteria, supporting the transition from active outbreak containment toward stabilization and eventual closure.	Continue supporting the final classification of cases under investigation, with particular attention to cases reported during the most recent epidemiological weeks. Support will also focus on the review and approval of the 90-day measles outbreak control and closure plan and on validating the schedule for inter-institutional technical support visits to priority states. PAHO will continue providing targeted technical assistance to strengthen surveillance, contact tracing, vaccination activities, and outbreak response, while supporting follow-up of vaccination coverage and the identification of immunity gaps among populations at higher risk of sustained transmission. Technical guidance will also continue on the application of RVC criteria to support progress toward stabilization and outbreak closure.
Guatemala (4)	PAHO continued to support Guatemala's national and subnational measles response. This included deploying technical staff and training four subnational consultants for priority departments and presenting a health-area prioritization matrix to the Ministry of Health with a proposal for an early 7-1-7 review. On immunization, PAHO supported campaign planning and surveillance of events supposedly attributable to vaccination or immunization (ESAVI). Through the PAHO Revolving Fund, it supported the procurement of 3 million MR vaccine doses and approximately 1.74 million MMR vaccine doses for routine immunization and campaign activities. PAHO also supported Guatemala's annual report on the elimination of measles, rubella, and congenital rubella syndrome, delivered Go.Data digitization products, and continued work on clinical management and infection prevention and control (IPC) training and community engagement.	Continue technical support to priority departments, focusing on vaccination campaign implementation and monitoring, including dose availability relative to target populations, along with preparedness and response assessment. PAHO will also continue to support surveillance, clinical management, risk communication and community engagement, and will help address funding and operational challenges.

Bolivia (5)	PAHO continued to support Bolivia's measles outbreak response, strengthening vaccination and surveillance in priority municipalities. With the national immunization program, an intensification phase is planned from mid-October to mid-November, including mobile vaccination teams, active case finding, rapid vaccination monitoring, and campaign supervision. Coverage monitoring continues through national help-desk and technical support teams, alongside ongoing 7-1-7 follow-up in priority departments.	Continue to support campaign implementation and coverage monitoring in priority municipalities, with attention to areas below national targets, and to strengthen efforts to interrupt transmission in Santa Cruz. PAHO will also continue follow-up on RVC recommendations and 7-1-7 action plans, including case documentation quality; advocacy with universities to facilitate vaccination of health-sciences students in clinical practice; and risk communication activities, despite resource and administrative constraints.
Peru (6)	PAHO continued to support Peru's measles outbreak response, with a focus on Loreto. Following a measles-related death in an adolescent, PAHO supported national and regional immunization teams in reviewing the epidemiological situation and adjusting the intervention plan. Advocacy continued for the procurement of additional MR vaccine.	Continue to support measles control measures in Loreto and other areas with ongoing transmission, including vaccination intensification, coverage improvement, and follow-up on the joint intervention plan, alongside vaccine procurement and risk communication. Preparedness will also account for the planned papal visit in November, given the expected large-scale domestic and international population movement.

PAHO Response by Strategic Pillars (7)⁵

Coordination

- Meetings with potential donors, presenting the response strategy and donor appeal to support countries' response capacity to the Measles outbreaks in the Americas. Available from: <https://iris.paho.org/items/0350b900-ec67-45aa-a813-5c05c861fb94>

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.
- In Bolivia and Peru, the 7-1-7 assessments and RVC field visits have been finalized. In Bolivia, findings were recently discussed with the Minister of Health, while in Peru a communication summarizing the findings and recommendations is being prepared for national authorities.
- In Mexico, the updated 90-day plan for measles outbreak control and elimination has been finalized, with PAHO continuing to provide technical support for its implementation and related field activities.

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.

- In Guatemala, financial resources have been provided to support measles outbreak response activities, with additional resources mobilized through CDC.
- At the subregional level in South America, PAHO is supporting preparedness for mass gatherings associated with the upcoming visit of Pope Leo XIV, including plans to convene a subregional webinar.
- PAHO continued supporting laboratory-based surveillance and genomic monitoring across the Region. In Peru, a working session was held with the National Laboratory to support the reporting of measles sequences to the WHO Measles Nucleotide Surveillance (MeaNS) database.
- PAHO also coordinated with the national reference laboratories in Mexico (InDRE) and Brazil (Fiocruz) to review and correct epidemiological week information associated with selected sequences reported to MeaNS, improving the consistency and quality of regional molecular surveillance data.

Clinical management

- Through the Measles Outbreak Incident Management Support Team (IMST), PAHO published the document *Manejo clínico y medidas de prevención y control para la infección por sarampión* (Clinical management and prevention and control measures for measles infection), currently available in Spanish. Developed with experts from the Region, the guidance provides health professionals with practical recommendations for the clinical management of measles cases and for infection prevention and control (IPC) in health services, with the aim of reducing complications and limiting transmission. An English version is forthcoming. Available from: <https://iris.paho.org/items/4e81cc3d-a209-466a-8031-0c59c41729b6>

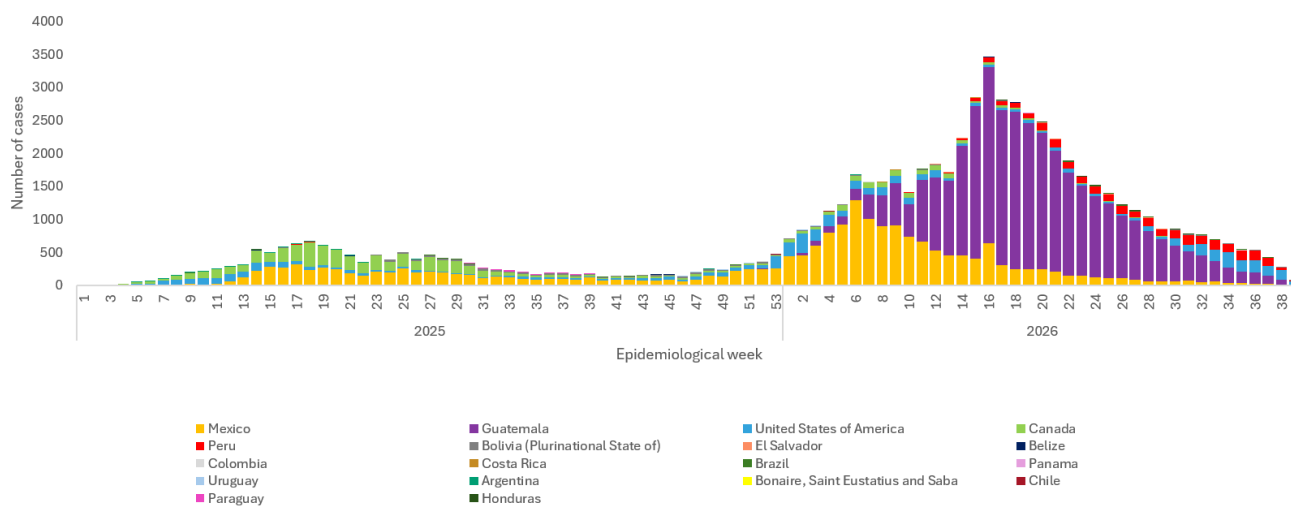
Immunization and Vaccination Operations

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

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.
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	• Work is underway to update the microplanning tool for vaccination campaigns and outbreak response.
Chile	• A social communication plan is being developed to support follow-up vaccination activities targeting selected populations.

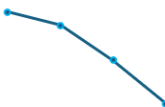
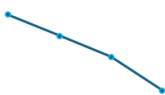
Epidemiological Situation

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 39 of 2026

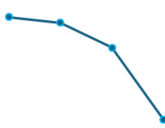


The table below summarizes the epidemiological situation in countries that have reported confirmed cases of measles.

Table 2. Measles cases in the Region of the Americas by country, as of EW 39 of 2026

Country	New cases reported through EW 37-38	Cases in 2026 (up to EW 39) (1)	Deaths in 2026 (up to EW 39) (1)	Observed trend (EW 35-38)**	Response scenario (8)****	Epidemiological notes
Guatemala*	+200	34,355	50	↓ declining 	Scenario C – Community transmission	As of EW 39, 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 (400.4 cases per 100,000 inhabitants), followed by Central Guatemala (328.6 per 100,000 inhabitants) and Sololá (306.7 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. 67.6% of cases had no history of vaccination. The most recent case was reported in EW 39 of 2026.
Mexico*	+34	13,595	23	↓ declining 	Scenario C – Community transmission	Most cases in 2026 are concentrated in three states: Jalisco, with 7,274 cumulative cases in 2026; Mexico City, with 1,033 cases; and Chiapas, with 920 cases. The most recent case was recorded in EW 38 of 2026.
United States*	+293	3,887	2	↓ declining ⁶ 	Scenario C – Community transmission	In 2026, the highest number of cases has been reported in Pennsylvania (963), South Carolina (670), Utah (535), Wisconsin (207), Texas (192), Virginia (178), Florida (148), Ohio (144), and Arizona (110). The first two measles-related deaths reported in the United States in 2026 were also notified during this period. The most recent case was reported in EW 39 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 1.4 [95% CrI 1.33–1.48]). See Table 3.

Country	New cases reported through EW 37-38	Cases in 2026 (up to EW 39) (1)	Deaths in 2026 (up to EW 39) (1)	Observed trend (EW 35-38)**	Response scenario (8)****	Epidemiological notes
Peru*	+155	2,553	1	↓ declining ⁷ 	Scenario C – Community transmission	The first measles-related death in Peru was reported in a 16-year-old unvaccinated male from the community of Alto Monte, San Pablo district, Mariscal Ramón Castilla Province, Loreto Department. The patient developed symptoms on 3 September and died on 13 September 2026. The most recent case was recorded in EW 39 of 2026.
Canada*	+1	1,121	0	Droplet transmission with sporadic cases that are part of the same outbreak	Scenario C – Community transmission	For the year 2026 through EW 39, the highest number of cases has been reported in Manitoba (680) and Alberta (311); followed by British Columbia (50), 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 38 of 2026.
Bolivia*	+3	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.
Brazil	+1	39	0	Sporadic imports	Scenario A – No current transmission / risk of importation	The last case was reported in EW 37 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.

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.

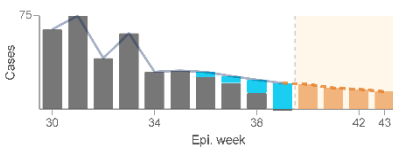
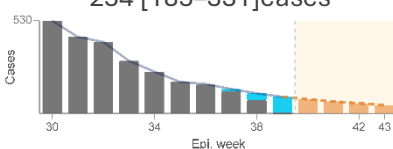
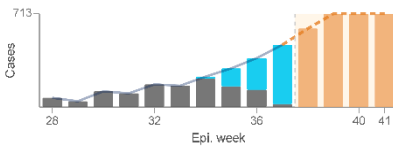
Country	New cases reported through EW 37-38	Cases in 2026 (up to EW 39) (1)	Deaths in 2026 (up to EW 39) (1)	Observed trend (EW 35-38)**	Response scenario (8)****	Epidemiological notes
Colombia	0	15	0	Sporadic imports	Scenario A – No current transmission / risk of importation	The last case was reported in EW 35 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)	—		—

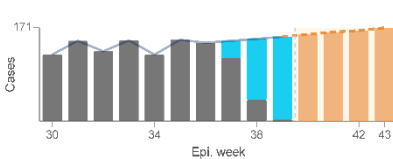
*Countries with active outbreaks: Measles cases have been reported over a period of 12 weeks or more. **The most recent epidemiological week (EW) was excluded from the observed counts to account for delays in reporting. ***Argentina, Bonaire, St. Eustatius, and Saba; Chile; and Uruguay. See the Pan American 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. (8)

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 39 of 2026

Country	R_t (95% CrI) ¹ Effective reproduction number	Based on the model ²	4-week forecast (EW 40–43) Median [95% PrI] ³	Model interpretation
Mexico	0.81 [0.66–0.98]	↓ declining	~67 [33–115] cases 	R_t is below 1, with the uncertainty interval remaining entirely below 1 — the model suggests declining transmission.
Guatemala	0.68 [0.63–0.74]	↓ declining	~254 [185–331] cases 	R_t is estimated to be 0.68, remaining below the epidemic threshold. This indicates declining transmission, and projections suggest that the downward trend will continue.
United States	1.4 [1.33–1.48]	↑ on the rise	~2,480 [2,172–2,812] cases 	R_t is estimated to be 1.4. 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 40–43) Median [95% PrI] ³	Model interpretation
				now showing a sustained decline.
Peru	1.06 [0.97–1.14]	~stable	~659 [528–808] 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 (9). 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 (10).

Effective reproduction number (R_t). R_t was estimated using the EpiEstim method (9), 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 (11). 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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