Pan American Health Organization
World Health Organization
Americas Region

PAHO

Regional Situation Report · No. 15

Measles in the Region of the Americas

5 November 2026 · *Next issue: 19 November 2026*[1]

REPORTING PERIOD: EW 1–43, 2026 (4 January 2026 – 31 October 2026) · 2-week change window: EW 41–42 vs. EW 39–40 [2]

CUMULATIVE — EW 1–43, 2026		
57,666 CONFIRMED CASES	**81** DEATHS Case Fatality Rate (CFR) 0.14%	**17** COUNTRIES AND TERRITORIES (CUMULATIVE) [3]
LAST 2 WEEKS — EW 41–42, 2026		
+547 NEW CONFIRMED CASES ↓ -38% *(compared to EW 39–40)*[4]	**0** NEW DEATHS	**6/17** COUNTRIES AND TERRITORIES THAT HAVE REPORTED CASES DURING EW 41-42 *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 43 of 2026 (which ended on 31 October 2026), the Region of the Americas reported **57,666** confirmed cases of measles in 17 countries and territories, representing a 4.7-fold increase compared with the same period in 2025. Guatemala (34,748), Mexico (13,761), the United States (4,852), Peru (2,862), and Canada (1,126) 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 41 and EW 42 of 2026, the Region of the Americas reported **547** new confirmed cases of measles in six countries and territories, representing a 38% decrease compared with the previous two-week period (EW 39–40; 885 new cases, including 242 retrospectively reported since the last Regional Situation Report) (**Figure 1**). Of the 547 new confirmed cases reported during EW 41–42, the United States accounted for 332, followed by Guatemala 115, Peru with 66, Mexico with 29, Bolivia with four, and Canada with one[2].

Despite declining transmission in some countries of the Americas, as indicated by **effective reproduction number (Rt) estimates below 1 (Table 3)**, persistent low-level transmission may continue, with the potential for renewed increases in cases when the virus reaches clusters of undervaccinated populations. This pattern of sporadic, or "drop-by-drop" transmission can sustain viral circulation for more than 12 months, delaying outbreak closure and increasing the risk of re-establishment of endemic transmission. This could jeopardize a country's **measles-free status** and heighten the risk of infection among vulnerable populations, particularly individuals who cannot be vaccinated due to medical contraindications.

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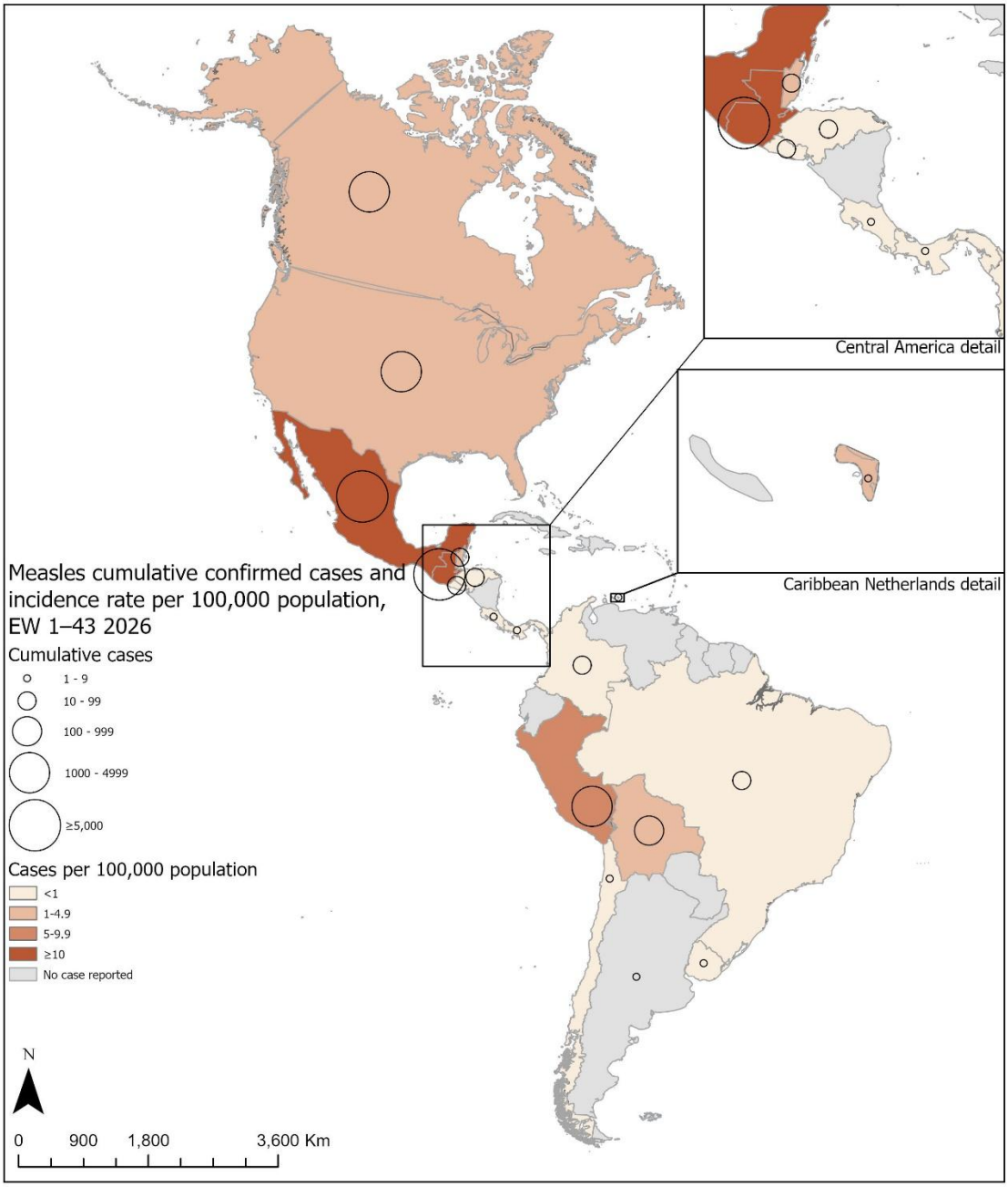
[1] *Previous Regional Situation Reports and additional information and resources on measles in the Region of the Americas are available on the PAHO measles webpage: Measles Multi - Country Outbreak 2026 - PAHO/WHO | Pan American Health Organization (2)*

[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 43, 2026, while the dashboard is updated on a rolling basis as new data becomes available.*

[3] *Since Situation Report No. 14, 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 – EW43, 2026. (n = 57,666)



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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. The 90-day measles outbreak response plan was approved by the Undersecretary for Health Policies and Population Well-being and is expected to undergo further review by the Interinstitutional Working Group and the National Vaccination Council (CONAVA per its acronym in Spanish) before implementation. Technical advisory visits on outbreak control and closure have already begun in Sonora and Jalisco, with Chiapas identified as the next priority state. PAHO also supported the planning of microplanning training for the routine Universal Vaccination Program in four states (Guanajuato, Querétaro, Tlaxcala and Yucatán), including a second planning meeting on 20 October and virtual training sessions on 29–30 October in preparation for in-person training activities scheduled for November 2026.	Continue coordinating with national authorities to support the review and implementation of the approved 90-day measles outbreak response plan, including coordination with the Interinstitutional Working Group and CONAVA. Continue technical advisory visits on outbreak control and closure in priority states, including Chiapas, and support the planned in-person microplanning training activities in Guanajuato, Querétaro, Tlaxcala and Yucatán during November 2026.
Guatemala (4)	PAHO continued to support subnational response through territorial consultants in five priority departments (Quiché, Sololá, Guatemala Sur, Izabal and Quetzaltenango). Support included vaccination campaign activities in Quiché and Sololá, community engagement and vaccination-promotion training, preparations for active case finding in hospitals, and training on outbreak response guidelines in health facilities in Guatemala Sur. In Quetzaltenango, PAHO supported training for 75 medical students and 11 traditional birth attendants, active institutional and community case finding, and follow-up of seven cases through Go.Data. Additional activities included adjustments to campaign targets and vaccine requests, logistics for vaccination brigades in hard-to-reach areas, and intersectoral coordination to mobilize resources and prepare campaigns. Risk communication activities included the development of a Mayan-language leaflet in Quiché and the recruitment of a social communicator to support intersectoral coordination and communication materials. PAHO also supported in-person microplanning workshops for 16 Departmental	Continue supporting vaccination campaign implementation and monitoring in priority health areas, including microplanning, vaccine logistics, mobilization of vaccination brigades, and community engagement. Support preparations for phase 3 of the vaccination campaign and coordination with national authorities to review campaign target populations, duration, and the establishment of an official, validated denominator for monitoring and evaluation. Continue efforts to address identified operational and cold-chain gaps, prioritize vaccination among vulnerable population groups, and establish an official, validated denominator for campaign monitoring and evaluation. Maintain technical support for active institutional and community case finding, case follow-up, and training on outbreak response, clinical management, and IPC.

	Directorates of Integrated Health Services Networks (DDRISS per its acronym in Spanish) in preparation for phase 3 of the vaccination campaign, as well as a central-level workshop for Ministry of Public Health and Social Assistance (MSPAS per its acronym in Spanish) staff on surveillance, outbreak response simulations, microplanning and risk communication. In addition, the first of six virtual training sessions on measles clinical management and infection prevention and control (IPC) were conducted, reaching 358 participants, followed by a second session covering initial assessment, risk stratification, warning signs, vitamin A administration and referral procedures. PAHO also supported the printing and distribution of vaccination certificates in Sololá and participated in a high-level meeting with national health authorities to review vaccination campaign guidelines, vaccine availability, operational capacity and procurement challenges.	Continue supporting risk communication activities and coordination with national authorities to address vaccine procurement constraints.
Bolivia (5)	PAHO continued to support Bolivia's measles outbreak response through active institutional case finding in eight prioritized municipalities across seven departments and outbreak-closure activities in 40 municipalities that have reported no confirmed cases for more than three months, including verification of the nine national closure criteria. Immunization support included deployment of 276 vaccination brigades under the *Cerrando brechas* measles, mumps and rubella (MMR) / measles and rubella (MR) vaccination campaign and the mobilization of 361 health professionals for rapid vaccination monitoring and supervision in eight prioritized municipalities across seven departments. PAHO also supported national monitoring of vaccination coverage and campaign progress through technical help-desk teams and continued reviewing materials for a virtual measles clinical management course.	Continue to support intensified vaccination activities under the *Cerrando brechas* campaign, including the deployment of vaccination brigades, rapid vaccination monitoring, and supervision in eight prioritized municipalities across seven departments through 15 November. Complete active institutional case finding and verification of the nine outbreak-closure criteria in eligible municipalities, with results to be assessed following completion of these activities. Continue providing technical support for monitoring vaccination coverage and campaign progress through national help-desk teams, as well as reviewing the content of the measles clinical management course for the Virtual Campus for Public Health.
Peru (6)	PAHO supported measles preparedness and response activities in Ucayali, including a technical workshop on clinical characteristics, epidemiological surveillance, and events supposedly attributable to vaccination or immunization (ESAVI). Coordination with the Vicariate of Pucallpa included discussions on protecting approximately 3,000 volunteers and other participants during the upcoming papal visit, with vaccination activities agreed upon at the parish level. The Regional Health Directorate committed to engaging hotels and restaurants to strengthen timely notification of suspected cases. The donation of cold-chain equipment to Ucayali was also completed. Additionally, technical visits were conducted in Piura and Trujillo, where recommendations were provided on outbreak response activities and the use of the MMR vaccine for outbreak control.	Support the assessment of measles diagnostic reagents to ensure laboratory testing quality and assist with the analysis and final classification of cases pending from the initial weeks of the outbreak. 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]

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, following the detection of a new imported case from Peru.
- In Guatemala, PAHO continues to support outbreak response activities through the deployment of four national professionals and one international professional across five departments, alongside an ongoing vaccination campaign in four departments.
- In the United States, PAHO continues to monitor ongoing high levels of measles transmission, particularly in northeastern states.
- Brazil, Colombia and Peru are coordinating cross-border immunization activities in border municipalities, scheduled for 7 November 2026.
- In Uruguay, the virtual review and accreditation process for the national measles and rubella laboratory was initiated on 22 October 2026 and is expected to be completed in December 2026.
- In Belize, Costa Rica and El Salvador, PAHO conducted interviews with country delegates as part of the 7-1-7 approach to assess and strengthen capacities for the timely detection, notification and response to public health events.

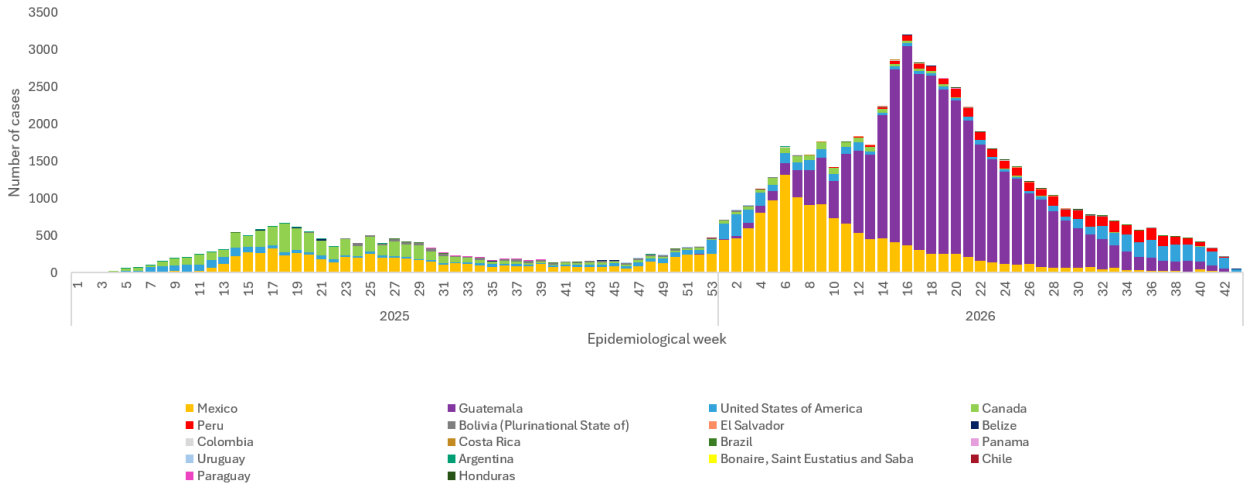
Risk & Crisis Communication and Community Engagement

- PAHO is promoting the Strategic Response and Donor Appeal document through social media to increase visibility of the regional measles response and support resource mobilization efforts. Available from: https://www.linkedin.com/posts/pan-american-health-organization_el-sarampi%C3%B3n-ha-resurgido-en-las-am%C3%A9ricas-activity-7520847715954511872-h6yB (8)
- Communication materials prepared for the upcoming visit of Pope Leo XIV to Argentina, Uruguay and Peru from 6 to 17 November 2026, including social media content to promote measles prevention and raise awareness of transmission risks associated with mass gatherings.
- PAHO has updated its recommendations for travelers to strengthen measles prevention and preparedness in the context of international travel and upcoming mass gatherings. Available from: https://www.paho.org/es/documentos/recomendaciones-salud-para-viajeros-peregrinos-noviembre-2026 (9)
- PAHO is coordinating with counterparts in Bolivia, Mexico and the United States to align communication strategies and messaging related to the conclusions of the Regional Monitoring and Re-verification Commission for Measles and Rubella Elimination.

[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.*

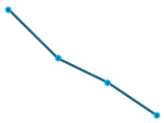
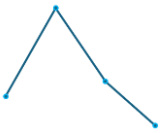
Epidemiological Situation

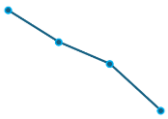
Figure 1. Epidemiological curve of confirmed measles cases in the Region of the Americas, by country and epidemiological week (EW), from EW 1 of 2025 to EW 43 of 2026



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 43 of 2026

Country	New cases reported through EW 41-42	Cases in 2026 (up to EW 43) (*1*)	Deaths in 2026 (up to EW 43) (*1*)	Observed trend (EW 39-42)**	Response scenario (10)****	Epidemiological notes
Guatemala*	+115	34,748	53	↓ declining 	Scenario C – Community transmission	As of EW 43, transmission has been reported in all the 22 departments. The overall downward trend continues at the national level since the observed peak during EW 16-18; at the departmental level, the highest incidence rates continue to be observed in Izabal (402.5 cases per 100,000 inhabitants), followed by Central Guatemala (332.4 per 100,000 inhabitants) and Sololá (309.3 per 100,000 inhabitants). Individuals aged 15 to 39 years accounted for 62% of confirmed cases, with those aged 20 to 29 years representing the most affected age group. Infants under one year remain particularly vulnerable, with a case fatality rate of 0.55%, compared with 0.15% in the general population of confirmed cases. Overall, 67.6% of confirmed cases had no documented history of vaccination. The most recent case was reported in EW 43 of 2026.
Mexico*	+29	13,761	23	- 	Scenario C – Community transmission	Transmission continues to show an overall declining trend, although cases are still being reported in several states. Most cases in 2026 are concentrated in three states: Jalisco, with 7,290 cumulative cases in 2026; Mexico City, with 1,033 cases; and Chiapas, with 993 cases. Infants under one year remain the most affected in terms of incidence, with 102 cases per 100,000 inhabitants. The most recent case was recorded in EW 42 of 2026.

Country	New cases reported through EW 41-42	Cases in 2026 (up to EW 43) (*1*)	Deaths in 2026 (up to EW 43) (*1*)	Observed trend (EW 39-42)**	Response scenario (10)****	Epidemiological notes
United States*	+332	4,852	3	↓ declining [6] 	Scenario C – Community transmission	In 2026, the highest numbers of confirmed cases have been reported in Pennsylvania (1,411), South Carolina (670), Utah (535), and Wisconsin (323). Cases have been reported across 47 jurisdictions, with 96% associated with outbreaks. Children and adolescents aged 5-19 years and adults aged 20 years and older each account for 41% of cases, followed by children under five years (17%). Overall, 96% of cases occurred among individuals who were unvaccinated or whose vaccination status was unknown. The most recent case was reported in EW 43 of 2026.
Peru*	+66	2,862	1	↓ declining[7] 	Scenario C – Community transmission	As of EW 43, transmission has been concentrated primarily in southern Peru, particularly in the departments of Puno (1,500) and Arequipa (531), with cases also reported in Madre de Dios (253), Loreto (190), Lima (118), and Cusco (110). The most recent case was recorded in EW 43 of 2026.
Canada*	+1	1,126	0	Droplet transmission with sporadic cases that are part of the same outbreak	Scenario B – Identifiable transmission chains	The last case associated with the multijurisdictional measles outbreak that started in New Brunswick in October 2024 was reported in August 2026. Since then, nine additional imported cases have been reported. The most recent case was recorded in EW 41 of 2026.
Bolivia*	+4	125	1	Droplet transmission with sporadic cases that are part of the same outbreak	Scenario B – Identifiable transmission chains	Transmission is still active in Santa Cruz and La Paz Departments. The last case was reported in EW 42 of 2026.

[6] *The recent decline observed in the United States should be interpreted with caution. Case counts for the most recent epidemio logical 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.*

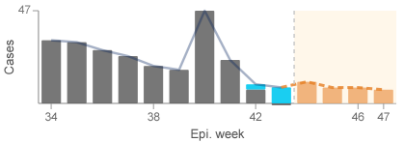
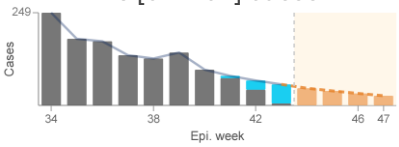
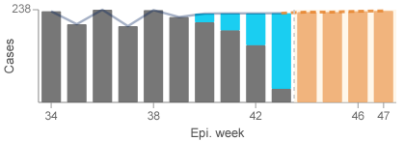
Country	New cases reported through EW 41-42	Cases in 2026 (up to EW 43) (*1*)	Deaths in 2026 (up to EW 43) (*1*)	Observed trend (EW 39-42)**	Response scenario (10)****	Epidemiological notes
Brazil	0	65	0	Sporadic imports	Scenario A – No current transmission / risk of importation	New outbreaks in Amazonas and Acre States have been reported, related to imported cases from Peru. The last case was reported in EW 40 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.
Belize	0	19	0	Sporadic imports	Scenario A – No current transmission / risk of importation	The most recent case was reported in EW 43 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.
Honduras	0	15	0	Sporadic imports	Scenario A – No current transmission / risk of importation	The last 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*)	—		—

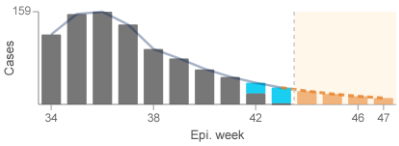
**Countries with active outbreaks: Measles cases have been reported over a period of 12 weeks or more. **The most recent epidemiological week (EW) was excluded from the observed counts to account for delays in reporting. ***Argentina, Bonaire, St. Eustatius, and Saba; Chile; and Uruguay. See the Pan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

*****Response scenarios are defined according to the current pattern of measles transmission: Scenario A refers to settings with no confirmed cases and a risk of importation; Scenario B to limited confirmed cases with identifiable transmission chains; and Scenario C to confirmed cases occurring across multiple geographic areas with multiple identifiable or unidentifiable transmission chains, consistent with community transmission. Response actions are cumulative: Scenario B includes the actions under Scenario A, while Scenario C includes the actions under Scenarios A and B, with additional or intensified measures as needed. (10)*

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 43 of 2026

Country	R_t (95% CrI)[1] Effective reproduction number	Based on the model [2]	4-week forecast (EW 44–47) Median [95% PrI][3]	Model interpretation
Mexico	**0.84 [0.68–1.03]**	*~stable*	~34 [12–68] cases 	R_t is estimated at 0.84. The interval includes 1, suggesting relatively stable transmission. The model projects low case counts over the next four weeks.
Guatemala	**0.66 [0.59–0.74]**	*↓ declining*	~143 [92–202] cases 	R_t is estimated to be 0.66, remaining below the epidemic threshold. This indicates declining transmission, and projections suggest that the downward trend will continue.
United States	**1.01 [0.95–1.08]**	*~stable*	~933 [777–1,105] cases 	R_t is estimated to be 1.01. The interval includes 1, consistent with a plateau at the national level. The national aggregate combined a declining outbreak in Pennsylvania with recent growth in other states. However, the most recent two weeks have been substantially delay-adjusted so this

Country	R_t (95% CrI)[1] Effective reproduction number	Based on the model [2]	4-week forecast (EW 44–47) Median [95% PrI][3]	Model interpretation
				estimate should be read with caution.
Canada	—[4]	—[4]	—[4]	No modeling was performed—see footnote 4.
Peru	**0.58 [0.5–0.67]**	↓ *declining*	~66 [33–105] cases 	R_t is estimated at 0.58, with the uncertainty interval remaining entirely below 1, indicating declining transmission at the national level. The model projects a continued decrease in cases over the next four weeks.
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 (11). 95% CrI = 95% credibility interval. See Technical Notes.

[2] Trend classified based on the full 95% credibility interval (CrI) of R_t: increasing (lower limit > 1), decreasing (upper limit < 1), or uncertain (the interval includes 1).

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

[4] Canada 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 (Rt).

Case data. Weekly counts of confirmed measles cases were obtained from national surveillance systems that report to the Pan American Health Organization/World Health Organization (PAHO/WHO).

Immediate forecast. To account for reporting delays inherent in passive surveillance, an immediate forecast model was applied to estimate the actual incidence for the most recent epidemiological weeks. Depending on the length of the available training period, either a negative generalized linear binomial model (6–14 weeks) or a generalized additive model with penalized splines (≥15 weeks) was fitted to the historical reporting pattern and used to project the expected final case count for incomplete weeks, with 95% credibility intervals. Thresholds were established based on an internal assessment of model stability, in accordance with general guidelines on data-adaptive short-term forecasting (12).

Effective reproduction number (Rt). Rt was estimated using the EpiEstim method (11), 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 (13). The serial interval was treated as fixed; this simplification slightly underestimates the uncertainty of Rt but does not affect the qualitative trend classifications presented. The credibility intervals for Rt are calculated based on the point estimate of the immediate forecast and, therefore, do not formally propagate the uncertainty of that forecast. The classification of trends was based on the full 95% credibility interval of Rt: **increasing** (lower bound > 1), **decreasing** (upper bound < 1), or **uncertain** (the interval includes 1).

Short-term forecasts. Four-week projections were generated using a renewal model that simulated 10,000 stochastic Poisson trajectories anchored to the estimated Rt. The results are expressed as the median and 95% prediction interval.

Limitations. The estimates depend on the completeness and timeliness of national-level reports, as well as on the assumed serial interval. Country-specific changes in surveillance—including the expanded case definition adopted by Guatemala in Protocol V3 of the Ministry of Public Health and Social Assistance (MSPAS per its acronym in Spanish) (March 16, 2026)—may affect the interpretation of trends in each country and are noted in the country appendix.

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