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Measles resurgence in 2026

Best practices for outbreak control
and closing immunization gaps

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ABOUT THIS REPORT

Outbreak Reports from the Global Health Center of the European Society of Medicine (ESMED) review current outbreaks of infectious diseases and set out practical, evidence-based measures for clinicians, immunization programmes and public health authorities.

This report was prepared by Dr. Enrique Chacon-Cruz, a member of the Global Health Center's Immunization Advisory Committee.

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METHODS AND LIMITATIONS

This is a narrative review of WHO and CDC guidance, surveillance data and published studies, not a systematic review. Case counts in Figure 1 are provisional monthly surveillance data reported to WHO for March to August 2026, as published by CDC in October 2026; they are subject to revision. Reporting completeness differs between countries and delays of one to two months are common, so recent counts understate true incidence and are not directly comparable between countries. Coverage figures are WHO/UNICEF estimates (2025 estimates, released July 2026). All sources were accessed on 13 October 2026.

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SUMMARY

Key messages

- 1 Measles is resurging.** An estimated 95,000 people died of measles in 2024, most of them young children, and 57 countries reported large or disruptive outbreaks in 2025.
- 2 Global coverage has stalled.** In 2025, 84% of children received a first dose of measles-containing vaccine and 77% a second dose, far below the 95% needed to stop transmission.
- 3 National averages hide risk.** Outbreaks take hold where unvaccinated people are clustered, even in countries whose national coverage appears high.
- 4 Proven measures interrupt transmission.** Two-dose coverage in every district, targeted catch-up, sensitive surveillance, rapid response with post-exposure prophylaxis, infection control in health-care settings and better access all work together.
- 5 Equity is pivotal.** People who decline vaccination and people whom health systems have never reached are different groups, and each needs a different response.

AT A GLANCE

95,000

estimated measles deaths
worldwide in 2024

84%/77%

global coverage with the
first and second dose in
2025

57

countries with large or
disruptive outbreaks in
2025

59 million

deaths averted by
measles vaccination,
2000–2024

Sources: deaths and deaths averted, WHO measles fact sheet (reference 1); coverage and countries with outbreaks, WHO/UNICEF coverage release of July 2026 (reference 9).

Introduction

Measles is one of the most contagious human infectious diseases and one of the clearest indicators of weakness in national immunization programmes. A safe, highly effective and affordable vaccine has been available for more than six decades, yet measles still causes substantial illness, hospitalization and preventable death worldwide.

The resurgence of measles in 2025 and 2026 is a serious setback for global elimination efforts. WHO estimates that 95,000 people died of measles in 2024, most of them unvaccinated or under-vaccinated children younger than five years. Between 2000 and 2024, measles vaccination averted nearly 59 million deaths.¹

The central challenge, however, goes beyond high national coverage. Elimination requires sustained coverage of at least 95% with both doses of measles-containing vaccine (MCV1 and MCV2), with consistently high protection across districts, communities and population groups. Countries that report high national coverage can still experience major outbreaks when unvaccinated people are clustered, geographically or socially.^{2,3}

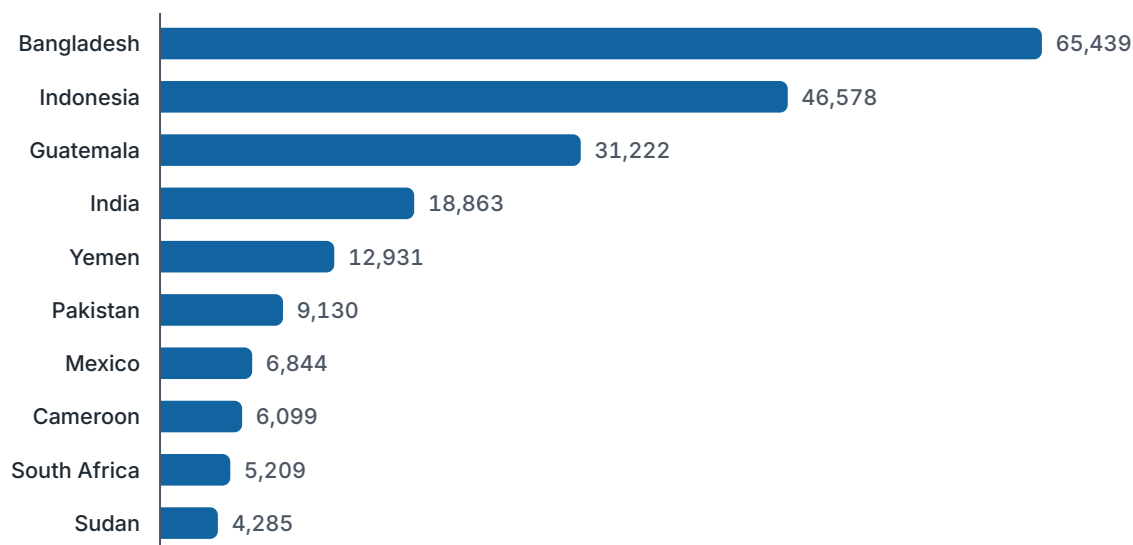
This report reviews the global measles situation in 2026, explains why closing local immunity gaps matters, and sets out the clinical and public health measures needed to interrupt transmission and advance equitable immunization.

1

The global situation in 2026

Provisional surveillance data reported to WHO show substantial measles activity in several regions, including South and South-East Asia, Africa, the Eastern Mediterranean and the Americas.^{4,5} The ten countries that reported the most cases between March and August 2026 are shown in Figure 1.

FIGURE 1

Countries reporting the most measles cases, March to August 2026

Provisional monthly surveillance data reported to WHO as of October 2026, as published by the US Centers for Disease Control and Prevention.⁴ Figures cover March to August 2026, not the full calendar year. They are absolute reported counts, not incidence rates, and completeness of reporting differs between countries.

Bangladesh, which reported the most cases, notified WHO in April 2026 of a nationwide increase affecting 58 of its 64 districts. Most cases were in children younger than five years, and in Dhaka they were concentrated in densely populated informal settlements.⁶

Measles resurgence is not confined to low-income countries. Transmission also affects middle- and high-income settings where immunity gaps have accumulated: in 2025, the United States recorded its first measles deaths in a decade.⁷ WHO notes that provisional data underestimate the true number of infections, because of under-diagnosis, incomplete reporting and reporting delays that often last one to two months.⁵

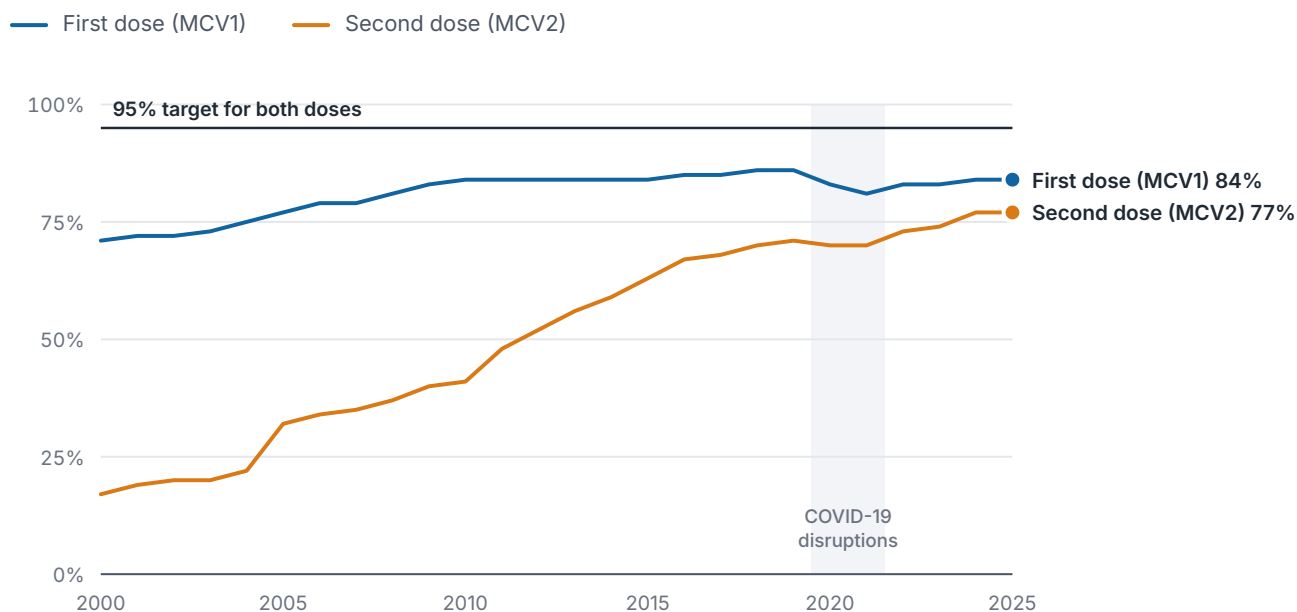
2**The 95% threshold: necessary but not sufficient**

Measles has an exceptionally high basic reproduction number (R_0), often cited as 12 to 18: in a fully susceptible population, each infected person would infect 12 to 18 others on average, although estimates vary by setting.^{1,8} Very high population immunity is therefore needed to interrupt sustained transmission.

WHO recommends at least 95% coverage with both MCV1 and MCV2, ideally in every district and community rather than only at national level.^{2,3} Global coverage remains well below this target (Figure 2). In 2025, 84% of children worldwide received the first dose of measles-containing vaccine, and only 77% the second. An estimated 7.3 million infants who received a first dose of diphtheria, tetanus and pertussis vaccine dropped out before their first measles dose.⁹

FIGURE 2

Global coverage with measles-containing vaccine, 2000–2025



WHO/UNICEF estimates of national immunization coverage (2025 estimates, released July 2026), global indicators extracted from the WHO Global Health Observatory on 13 October 2026.^{9,10}

BOX 1

Why national averages can mislead

A country may report 95–97% coverage nationally while some of its communities have far lower coverage. In a hypothetical country with 96% national coverage, some districts may reach only 65–70%. Such districts can sustain large outbreaks once the virus is introduced, even though the national average appears satisfactory.

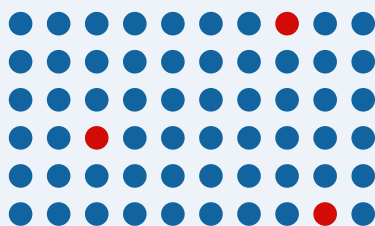
FIGURE 3

Same coverage, different risk: an illustration

● Vaccinated ● Unvaccinated

Dispersed

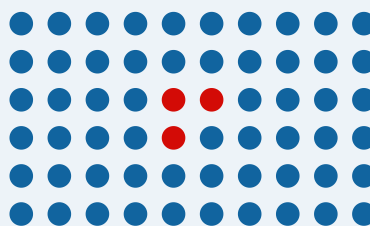
Unvaccinated people are scattered



57 of 60 vaccinated: 95% coverage

Clustered

Unvaccinated people live side by side



57 of 60 vaccinated: 95% coverage

Schematic only; vaccination status is used here as a proxy for immunity. Both populations have the same coverage, but where unvaccinated people are clustered, the virus can pass more easily from one susceptible person to the next.

A modelling study using French surveillance data from 2009 to 2018 found that areas with higher local vaccine coverage had fewer imported cases and a lower risk of local transmission.¹¹ The implication is fundamental: immunization programmes must measure not only how many people are vaccinated, but also where susceptible people are concentrated.

3 Best practices for prevention and outbreak control

A

Achieve and sustain high two-dose coverage

Routine immunization programmes should give priority to timely administration of MCV1 and MCV2 according to national schedules, and systematically identify children who have missed either dose. Vaccination status should be checked at every appropriate health-care contact, including primary care visits, hospital encounters, school health assessments and community outreach. Catch-up vaccination should be offered routinely to eligible children, adolescents and adults without adequate evidence of immunity.^{2,3}

B

Find and close clusters of unvaccinated people

Identifying where susceptibility accumulates is one of the most important priorities. Where reliable data exist, national programmes should routinely analyse coverage at district, municipal, school and community level. Particular attention should be given to zero-dose children (those who have received no routine vaccines, usually measured as no first dose of diphtheria, tetanus and pertussis vaccine), migrant and displaced populations, geographically isolated communities and groups that face persistent barriers to health care. Targeted vaccination campaigns should complement, not replace, strong routine immunization services.^{3,12}

C

Strengthen clinical, epidemiological and molecular surveillance

Surveillance must be sensitive enough to detect suspected cases promptly, including in areas previously free of measles. Good practice includes rapid case notification, appropriate serological testing, molecular confirmation by reverse transcription polymerase chain reaction (RT-PCR) and genomic characterization of the virus where indicated, including genotyping and, where available, sequencing. Molecular surveillance is particularly valuable for tracing chains of transmission, investigating imported cases and documenting elimination. Close collaboration between clinicians, laboratories, epidemiologists and immunization programmes is essential.^{13,14}

D

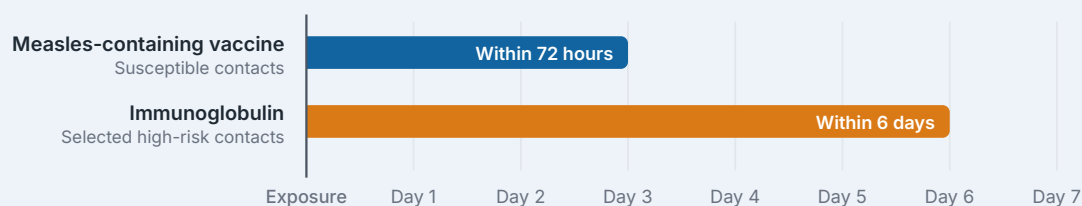
Respond rapidly and offer post-exposure prophylaxis

Every suspected case should trigger immediate public health action, without waiting unnecessarily for laboratory confirmation. Key measures include airborne isolation, rapid identification of contacts, assessment of their immunity and appropriate post-exposure prophylaxis (Box 2). Outbreak response vaccination should be tailored to local epidemiology, the age distribution of cases and the immunity gaps that have accumulated.^{13,15}

Clinical management of cases is outside the scope of this report and should follow WHO and national guidance. There is no specific antiviral treatment for measles: care focuses on supportive treatment and on preventing and managing complications such as pneumonia, diarrhoea and dehydration. WHO recommends two doses of vitamin A for all children younger than five years with suspected measles, given immediately on diagnosis and repeated the next day.¹

BOX 2

Post-exposure prophylaxis at a glance



For susceptible contacts without contraindications, measles-containing vaccine given within 72 hours of exposure may provide protection. Immunoglobulin given within six days may be indicated for high-risk contacts, including susceptible infants and pregnant people without evidence of measles immunity, in line with national guidelines. Under ACIP guidance, severely immunocompromised patients who are exposed should receive intravenous immunoglobulin regardless of their vaccination status, because vaccination may not have protected them.^{13,15}

E

Prevent transmission in health-care settings

Health-care facilities can amplify transmission when cases are not recognized and isolated promptly. All health workers should have documented evidence of measles immunity, and facilities should maintain clear protocols for airborne precautions, triage, management of exposures and occupational health follow-up. Suspected cases should be separated from other patients immediately, particularly from infants, pregnant people and immunocompromised patients.^{13,15}

F

Communicate well and remove barriers to access

Vaccination programmes must combine evidence-based communication with practical improvements in access. Health professionals remain essential sources of trusted information. Vaccine hesitancy, however, should not be treated as the sole explanation for under-immunization: transport difficulties, poverty, migration, limited access to health care, service disruptions and missed opportunities for vaccination can matter just as much. Effective interventions combine culturally appropriate communication, convenient services and sustained engagement with communities.^{3,12}

4

Health equity: no community left behind

Measles outbreaks often expose wider structural inequalities in health systems. Children living in poverty, displaced people, migrants, residents of conflict-affected areas and communities with limited access to routine health care are disproportionately likely to remain unvaccinated.

WHO recognizes measles outbreaks as an indicator of weaknesses in immunization programmes and primary health care.³ An equitable elimination strategy must therefore identify underserved communities, remove financial and administrative barriers, expand mobile and outreach vaccination, secure the supply of vaccines and monitor disparities in coverage.

A child who has never been offered a vaccine presents a different challenge from a child whose family has declined it. Both need attention, but the responses must differ.

Public health authorities should therefore distinguish between people who decline vaccination and people who remain unvaccinated because health systems have failed to reach them.

5 Practical indicators for national immunization programmes

The indicators in Table 1 can help programmes track whether population immunity is high everywhere, not only on average, and whether outbreaks are detected and controlled quickly.

TABLE 1

Recommended indicators and objectives

Indicator	Recommended objective
COVERAGE	
MCV1 coverage	At least 95%, nationally and in every district
MCV2 coverage	At least 95%, nationally and in every district
Zero-dose children	Identify and reach them, and progressively reduce their number
Geographic immunity gaps	Identify and close clusters of susceptible people
Missed opportunities for vaccination	Assess routinely and keep to a minimum
SURVEILLANCE AND RESPONSE	
Surveillance sensitivity	Detect and investigate suspected cases promptly
Laboratory and molecular surveillance	Confirm cases and characterize virus strains
Outbreak response	Investigate immediately and implement control measures rapidly
Health-worker immunity	Document immunity and close identified gaps
EQUITY	
Equity of coverage	Monitor coverage by geography, socioeconomic status and barriers to access

Compiled by the author from WHO guidance.^{2,3,13}

6 Conclusions

The global resurgence of measles in 2026 shows that an effective vaccine, and even apparently satisfactory national coverage, cannot by themselves guarantee protection against outbreaks.

For measles, 95% coverage is not merely a statistical target. It must translate into consistently high immunity across communities, districts and countries. When susceptible people accumulate in geographically or socially clustered populations, decades of progress towards elimination can be undone.

Strong routine immunization, timely catch-up vaccination, sensitive epidemiological and molecular surveillance, rapid outbreak response and equitable access to vaccination must remain central priorities. Elimination requires moving beyond national averages to a precise understanding of where immunity is lacking, and why.

Measles will not be eliminated simply when countries reach 95% coverage nationally. It will be eliminated only when sustained high coverage is matched by finding and protecting the communities that have been systematically left behind.

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About this report

Measles is resurging worldwide, and national averages hide the risk: outbreaks take hold where unvaccinated people are clustered. This Outbreak Report reviews the situation in 2026 and sets out the measures that interrupt transmission, from two-dose coverage in every district and targeted catch-up to sensitive surveillance, rapid response and better access to vaccination.

The Global Health Center is the public health policy division of the European Society of Medicine. Its advisory committees of clinicians and researchers provide evidence-based guidance to policymakers, health professionals and the public on the most pressing challenges in global health. This report was prepared by the Immunization Advisory Committee.

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- Front cover: a cluster of unvaccinated people
- Back cover: the same people, protected