PHF Science

5 November 2026

Overseas emerging respiratory virus intelligence

Influenza A(H5N1) - Situation at a glance

Oceania

Influenza A(H5N1) clade 2.3.4.4b has been **DETECTED** in **THREE** birds in NZ and has been detected in **SEVEN** states and Territories of Australia

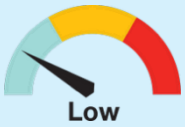
Global

Since the last monthly update on 10 September:

FOUR NEW CASES of influenza A(H5N1) in humans.

Sporadic human detections of different avian and swine influenza viruses continue.

Public health risk assessment - New Zealand



Overall public health risk of **avian influenza A (H5) Clade 2.3.4.4b** to Aotearoa New Zealand is **LOW.**

- **VERY LOW** likelihood of infection,
- Potentially **MODERATE** health impacts of the disease,
- **VERY LOW** likelihood of human-to human transmission; and
- **VERY LOW** likelihood of importation of a human case of influenza A (H5) Clade 2.3.4.4b

World Health Organization

Global public health risk for currently known viruses at the human animal interface, including influenza A(H5N1), remains **LOW**

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Major new content as of **5 November 2026** is highlighted in green. The next scheduled update of this report is on 10 December 2026. Please note that we have changed the format of this report since 6 August 2026 update. Please refer to the 6 August 2026 version available in the *Digital library* for more detail on previously reported cases and detections.

Highly Pathogenic Avian Influenza A(H5)

Human cases of influenza A(H5) reported in 2026 to 10 September 2026 are documented in Table 1.

Table 1 Influenza H5 cases reported during 2026 to date

Report date	Country	Symptom onset	Subtype	Clade	Outcome	Ref
9 February 2026	Bangladesh	21 January 2026	H5N1	2.3.2.1a	Died	[1]
27 March 2026	India	Approximately 19 March 2026	H5N1	2.3.2.1a	Hospitalised	[2]
15 February - 31 March 2026	Cambodia	5 February 2026	H5N1	2.3.2.1e	Not stated	[1]
15 February - 31 March 2026	Cambodia	13 March 2026 (sample collection date)	H5N1	2.3.2.1e	Not stated	[1]
15 February - 31 March 2026	Cambodia	28 March 2026	H5N1	2.3.2.1e	Hospitalised	[1]
23 April 2026	Bangladesh	28 March 2026	H5N1	Not reported	Hospitalised	[2]
22 April 2026	Cambodia	15 April 2026	H5N1	2.3.2.1e	Died	[2]
29 April 2026	China	16 April 2026	H5N6	Not reported	Died	[2]
15 June 2026	Bangladesh	17 May 2026	H5N1	Not reported	Received outpatient healthcare	[3]
11 July 2026	Cambodia	30 June 2026	H5N1	2.3.2.1e	Hospitalised	[4, 5]
30 August 2026	Bangladesh	15 August 2026	H5N1	Not reported	Hospitalised	[6]
2 October to 8 October 2026	Cambodia	24 September	H5N1	Not reported	Hospitalised	[7, 8]
16 October 2026	Yakima County, USA	Not reported	H5N1	Not reported	Isolated at home (no severe illness)	[9]
November 2026	Yakima County, USA	Not reported	H5N1	Not reported	Not reported	[10]

November 2026	Yakima County, USA	Not reported	H5N1	Not reported	Died	[10]

Epidemiology of influenza A(H5N1) clade 2.3.4.4b

Avian influenza A(H5N1) clade 2.3.4.4b emerged in 2020 and has spread widely throughout wild and domesticated birds and some mammal species across Africa, Asia, Europe and the Americas since this time. It was detected in Antarctica in 2023 and a sub-Antarctic Australian territory in 2024. In June 2026, influenza A(H5N1) clade 2.3.4.4b was detected in Australia for the first time, followed by New Zealand in July 2026. As of 8 September 2026, there have been no detections in Pacific Island Countries or Territories.[11]

From 1 January 2026 to 10 August 2026, no human cases of clade 2.3.4.4b avian influenza have been reported to WHO.

Eight human cases of clade 2.3.4.4b were reported in 2025.

New Zealand

As of 4 November 2026, there have been no further detections of H5 high pathogenicity avian influenza in birds in New Zealand.

As of 2 September 2026, New Zealand has three confirmed detections of H5 high pathogenicity avian influenza in birds. The third case was confirmed on 21 August in a northern giant petral found in the Wairarapa. The second case was reported on 17 July 2026, in a kāhu (swamp harrier hawk) in the Wairarapa. The first ever detection of H5 in New Zealand was reported on 15 July 2026 in an ocean-going wild sea bird (brown skua) found on Petone beach, Wellington. There is no evidence of mass mortality in wildlife, no evidence of transmission between wild birds, and no detections in poultry. [12, 13]

Australia

- **As of 3 November 2026**, there have been 734 confirmed H5 bird flu events in wildlife. These events have been reported in South Australia (341), Victoria (249), New South Wales (78), Tasmania (53), Western Australia (10), Queensland (2), and Other Territories (1). [14]
- **On 28 August**, H5 bird flu was reported in the first land mammal in Australia – a red fox found in Adelaide. To date there have been three detections in red foxes, a second in South Australia, and the first in Victoria.[15, 16] There remain no detections in poultry or in the agricultural production system. The risk to human health remains low.[17]
- **On 23 August,** H5 bird flu was reported in the first mammal in Australia – a long-nosed fur seal in South Australia. [17]

Pacific

The risk of incursion of highly pathogenic avian influenza into the Pacific Island countries and areas has been recently updated.[18] During August 2026:

- entry through seabird and wild birds is assessed as **VERY HIGH risk** and
- entry through poultry trade and human-associated movement is assessed as **LOW risk.**

If introduced into the Pacific Islands countries and areas, the risk is assessed as:

- **HIGH risk** in resident wild bird populations,
- **VERY HIGH risk** in domestic poultry,
- **MODERATE risk** of establishment in wild or domestic mammals,
- **LOW risk** of human exposure under current conditions.

Global updates

Influenza A(H5) has now been detected in birds and/or mammals in all continents.[19]

In the USA during 2026, H5N1 is being detected in wildbirds, commercial flocks, dairy milking cows, and other mammals[20]. Recently, H5N1 has been detected in humans and wastewater:

- **On 29 October 2026**, avian influenza (H5N1) genotype D1 was reported as detected in wastewater at a site in East Kaua'i, Hawai'i**.** This is the first detection of genotype D1.1 in Hawai'i. Human, animal, and environmental contamination cannot be distinguished between in wastewater detections.[21]
- **From 15 October to 3 November 2026**, three human cases of avian influenza (H5N1) have been reported in Yakima County, Washington. All three cases were exposed to infected dairy cattle. One case who had underlying health conditions died. [9, 10] A total of 39 herds have been reported with H5N1 in Yakima County throughout October 2026, two of which were confirmed with clade 2.3.4.4b genotype B3.13.[22, 23]
- Prior to this, the last reported human case of influenza A(H5) in the USA had been in **October 2025**.[24]

Other human cases of avian and swine influenza reported in 2026

Human cases of influenza A(H9N2)

Human cases of influenza A(H9N2) during 2026 to date are recorded in Table 2. Since 2015, 189 human cases of avian influenza A(H9N2) have been reported to WHO in the Western Pacific Region.[25]

Table 2 Influenza A(H9N2) human cases reported during 2026 to date

Report date	Location	Onset date	Case age and sex	
Influenza A(H9N2)				
9 February to 20 March 2026	Guangdong, China	17 January 2026	73-year-old female	[1]
9 February to 20 March 2026	Guangdong, China	20 January 2026	<5-year-old male	[1]
9 February to 20 March 2026	Guangxi, China	5 February 2026	63-year-old male	[1]
21 March 2026	Italy (ex-Senegal)	Mid-January 2026	Adult male	[1]
7 April to 6 May 2026	Guangdong, China	23 February 2026	<5-year-old male	[2]
7 April to 6 May 2026	Yunnan, China	3 March 2026	<5-year-old female	[2]

7 April to 6 May 2026	Jiangxi, China	20 March 2026	<5-year-old male	[2]
7 April to 6 May 2026	Guangxi, China	12 April 2026	<5-year-old male	[2]
7 April to 6 May 2026	Sichuan, China	25 April 2026	<5-year-old female	[2]
13 May to 11 June 2026	Yunnan, China	28 April 2026	< 5-year-old male	[26]
13 May to 11 June 2026	Guangxi, China	4 May 2026	>60-year-old female	[26]
13 May to 11 June 2026	Yunnan, China	17 May 2026	< 5-year-old female	[26]
13 May to 11 June 2026	Guangxi, China	31 May 2026	< 5-year-old male	[26]
12 June to 23 June 2026	Hong Kong Special Administrative Region (SAR)	9 June 2026	< 5-year-old male	[3]
12 June to 23 June 2026	Guangdong, China	12 June 2026	< 5-year-old female	[3]
7 July to 5 August 2026	Jiangsu, China	22 June 2026	< 5-year-old male	[5]
7 July to 5 August 2026	Guangxi, China	26 June 2026	< 5-year-old male	[5]
7 July to 5 August 2026	Guangdong, China	26 June 2026	Adult male	[5]
7 July to 5 August 2026	Jiangsu, China	5 July 2026	Adult female	[5]
7 July to 5 August 2026	Jiangsu, China	6 July 2026	< 5-year-old male	[5]
7 July to 5 August 2026	Gansu, China	11 July 2026	< 5-year-old female	[5]
7 July to 5 August 2026	Yunnan, China	13 Jul 2026	Adult female	[5]
7 July to 5 August 2026	Yunnan, China	28 July 2026	< 5-year-old female	[5]
14 August to 20 August 2026	Anhui, China	3 August 2026	< 5-year-old male	[27]
21 August to 27 August 2026	Beijing, China	15 August 2026	Child	[28]
13 August to 1 September 2026	Guangxi Zhuang Autonomous Region, China	23 August 2026	< 5-year-old	[6]
18 September to 24 September 2026	Henan, China	30 August 2026	< 5-year-old female	[29]
18 September to 24 September 2026	Guangdong, China	7 September 2026	< 5-year-old female	[29]
2 October to 8 October 2026	Henan, China	17 September 2026	Adult	[8]
2 October to 8 October 2026	Guizhou, China	20 September 2026	Child	[8]
16 October to 21 October 2026	Hubei, China	22 September 2026	Child	[30]
16 October to 21 October 2026	Jiangxi, China	16 September 2026	Adult	[30]

23 October to 29 October 2026	Liaoning, China	20 September 2026	Child	[25]
23 October to 29 October 2026	Guangxi, China	13 October 2026	Child	[25]

Human cases of other influenza A subtypes

Human cases of influenza A(H1N1)v, A(H1N2)v, A(H3N2), A(H7N7), and A(H10N3) that have been reported during 2026 (to 10 September) are summarised in table 3.

Table 3 Other influenza subtypes reported during 2026 to date

Report date	Location	Onset date	Case age and sex	
Influenza A(H1N1)v				
February 2026	Catalonia, Spain	Not reported	Not reported	[31]
20 March 2026	Yunnan, China	30 January 2026	Child	[1]
2 May 2026	Nebraska, USA	Early April 2026	<18 years	[2]
30 September 2026	Santa Catarina, Brazil	16 July 2026	Adult woman	[32]
Influenza A(H1N2)v				
3 February 2026	Yunnan, China	20 January 2026	Child	[1]
14 August 2026	Ionia County, USA	August 2026	<18	[33]
21 August 2026	Ionia County, USA	August 2026	<18	[33]
August 2026	Michigan, USA	Week of 15 August 2026	<18	[6]
August 2026	Michigan, USA	Week of 15 August 2026	<18	[6]
Influenza A(H3N2)				
26 January 2026	Brazil	1 September 2025	Male child	[1]
25 June 2026	Brazil	12 June 2026	Child	[3]
Influenza A(H7N7)				
3 April 2026	Taiwan	20 March 2026	Male adult >70 years	[34]
Influenza A(H9N2)				

21 March 2026	Italy (linked to Senegal)	Mid-January 2026	Adult male	[1]
Influenza A(H10N3)				
9 February 2026	Guangdong, China	29 December 2025	34-year-old male	[1]

International risk assessment for influenza at the human-animal interface

As of 31 March 2026, the WHO advises that the overall public health risk from currently known influenza viruses at the human-animal interface remains low. Sustained human to human transmission of these viruses is currently considered unlikely; however, infections with viruses of animal origin are not unexpected at the human-animal interface wherever these viruses circulate in animals.[1] Consistent with this, the joint FAO/WHO/WOAH assessment on influenza A(H5) virus (updated on 18 May 2026, based on data as of 1 March 2026), concludes that the global public health risk remains low. The risk for occupationally or frequently exposed individuals (e.g., those in contact with backyard poultry) is assessed as low to moderate, depending on the effectiveness of risk mitigation, hygiene measures in place, and the local avian influenza epidemiological situation. While additional human infections among exposed populations are likely to occur, the overall public health impact at the global level remains minor [19]

Situational awareness: Global response limitations

Surveillance and response capacity for emerging viruses is likely to be affected by reduced funding for global health security and One Health programmes led by international organisations such as WHO and FAO as well as national agencies overseas.[35-37]

Middle East respiratory syndrome coronavirus (MERS-CoV)

- **Between 1 January and 5 October 2026**, eight laboratory-confirmed MERS-CoV cases have been reported in the Kingdom of Saudi Arabia. The cases were reported across six locations and appear to be sporadic zoonotic spillover infections (not a single outbreak cluster).[38]
- **As of 11 June 2026**, a total of 2,637 laboratory-confirmed human cases has been reported to WHO, with the majority from countries in the Arabian Peninsula. The estimated crude case fatality ratio is approximately 37%. The risk of further introduction and subsequent spread of MERS-CoV clade B strains in camel populations in the Nile Basin is MINOR. The risk of introduction and subsequent spread of MERS-CoV clade B strains from camel populations in the Nile Basin to other camel populations across bordering countries in Africa is MINOR. Once MERS-CoV clade B is introduced in camel populations in the Nile Basin

countries, the risk of spillover to humans who are exposed to Infected camels or their products is HIGH.[39]

- As of 29 January 2026, the WHO's risk assessment remains moderate at the global and regional levels. The WHO considered that the exportation of cases from the Arabian Peninsula to France in December 2025 and the healthcare-associated clusters reported by Saudi Arabia during 2024-2025, demonstrates the ongoing risk of international spread to non-endemic countries and reflect the persistent circulation of MERS-CoV in the Middle East.[40] The WHO expects additional cases of MERS-CoV to be reported from the Middle East and/or other countries where MERS-CoV is circulating in dromedaries.
- In March 2026, early evidence suggests the first documented transmission of MERS-CoV from camels to occupationally exposed individual in Somalia. This signifies a documented spillover event that warrants monitoring.[41]
- To date, evidence from both molecular and serologic testing of reported cases indicates that human-to-human transmission of MERS-CoV remains limited. [42]

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