



Pan American
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Americas Region

Epidemiological Update Avian Influenza A(H5) in the Americas Region

26 August 2026

Global Context

Avian influenza A(H5) is a highly contagious viral disease that primarily affects poultry and wild birds, with the ability to sporadically infect mammalian species, including humans (1, 2). Since 1996, the A/goose/Guangdong/1/96 lineage has caused recurrent outbreaks in bird populations, as well as hundreds of human cases and deaths resulting from exposure to infected animals or contaminated environments (2, 3). Currently, the A(H5N1) subtype and other avian influenza A(H5) viruses have been identified in birds and mammals across multiple geographic regions worldwide (4).

Between 2021 and March 2026, more than 600 species of wild and poultry birds and more than 100 species of mammals have been reported as affected by avian influenza viruses with zoonotic potential, such as A(H5Nx) (5). In May 2026, the Food and Agriculture Organization of the United Nations (FAO), the World Organization for Animal Health (WOAH), and the World Health Organization (WHO) determined that the global public health risk associated with highly pathogenic avian influenza viruses (HPAI)¹ A(H5) belonging to the Gs/Gd lineage remains low (6). Similarly, for people with occupational or frequent exposure, the risk was estimated to be low to moderate. This assessment is based on the fact that most reported human infections result from direct or indirect exposure to infected animals (such as dairy cattle on affected farms, backyard poultry, or slaughtering activities on poultry farms) or contaminated environments (such as live poultry markets or coastal areas with sick marine mammals and birds) (6). The clinical presentation in humans has ranged from mild symptoms to severe and fatal cases. To date, epidemiological, virological, and serological investigations have not demonstrated self-sustaining person-to-person transmission (6).

Globally, from 2025 to July 2026, there was a significant increase in HPAI detections in wild birds compared with the two previous seasons, with the highest concentration observed in Europe (7,379 outbreaks). In the Americas Region, by July 2026, cases of transmission in mammals—specifically in cattle in the United States of America—had been reported (7).

Likewise, on 20 June 2026, the WHO was notified of the first identification of HPAI A(H5N1) in Australia in a wild seabird (*Stercorarius antarcticus*), which represents a significant epidemiological event, as it documents the first detection of HPAI A(H5N1) in a wild bird in Australia (8). Subsequently, on 8 July 2026, the first identification of H5N1 avian influenza in New Zealand was reported in the same species of wild seabird (*Stercorarius antarcticus*), which was also the first detection of H5N1 avian influenza in a wild bird in that country (7).

¹ Generally speaking, the many strains of avian influenza virus can be classified into two categories based on the severity of the disease in poultry: low-pathogenic avian influenza (LPAI) and highly pathogenic avian influenza (HPAI).

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During July 2026, 16 outbreaks were reported in poultry and 72 in non-poultry species (wild birds and mammals) across Africa, the Americas, Asia, Europe, and Oceania. Subsequently, the incidence in poultry showed a downward trend in the Northern Hemisphere, consistent with the disease's usual seasonal pattern (7).

Between 2003 and 7 August 2026, a total of 1,002 laboratory-confirmed cases of human infection with the avian influenza A(H5N1) virus were reported to the WHO in 25 countries, including 479 deaths (case fatality rate: 47.8%). In 2026, to date, nine cases and two deaths were reported: Bangladesh reported three cases, including one death; India reported one case; and Cambodia reported five cases, including one death (9).

Available scientific evidence indicates that the circulating viruses continue to be avian influenza viruses and that sustained person-to-person transmission has not been demonstrated (6). Continued detections in wild bird and mammal species, including their identification in new geographic areas, maintain concerns about possible viral adaptation to mammalian hosts, even though human infections remain sporadic.

Summary of the Situation in 2026 in the Americas Region

Infections in animals with avian influenza A(H5) virus

In 2026, as of 15 July ten countries in the Americas reported 455 outbreaks² of avian influenza A(H5) in animals. Of the total outbreaks, 386 occurred in avian species (35 in wild birds and 351 in poultry or domestic birds) and 69 in mammals (44 in wild mammals and 25 in domestic mammals) (10). The countries that reported outbreaks were Argentina (n= 23), Brazil (n= 5), Canada (n= 21), Chile (n= 42), Colombia (n= 2), Ecuador (n= 1), the United States of America (n= 301), Mexico (n= 3), Peru (n= 49), and Uruguay (n= 8). The largest number of outbreaks occurred in the United States of America, followed by Peru, Chile, Argentina, and Canada (10) (Table 1).

² Please note that the current figures represent the number of outbreaks, which may include multiple linked epidemiological records and updates to the number of reported cases for each outbreak. This may result in lower counts than those reported in previous publications. These figures reflect only officially verified outbreaks reported to OMSA, ensuring accuracy according to OMSA standards.

Table 1. Outbreaks of avian influenza A(H5) in birds and mammals in the Americas Region in 2026, as of 15 July 2026

Country	Total out-breaks	Outbreaks in wild birds	Outbreaks in poultry or domestic birds	Outbreaks in wild mammals	Outbreaks in domestic mammals
Argentina	23	4	19	0	0
Brazil	5	2	3	0	0
Canada	21	2	18	0	1
Chile	42	10	32	0	0
Colombia	2	0	2	0	0
Ecuador	1	1	0	0	0
Mexico	3	2	1	0	0
Peru	49	0	49	0	0
Uruguay	8	8	0	0	0
United States of America	301	6	227	44	24
Total	455	35	351	44	25

Source: Adapted from the World Organization for Animal Health (9).

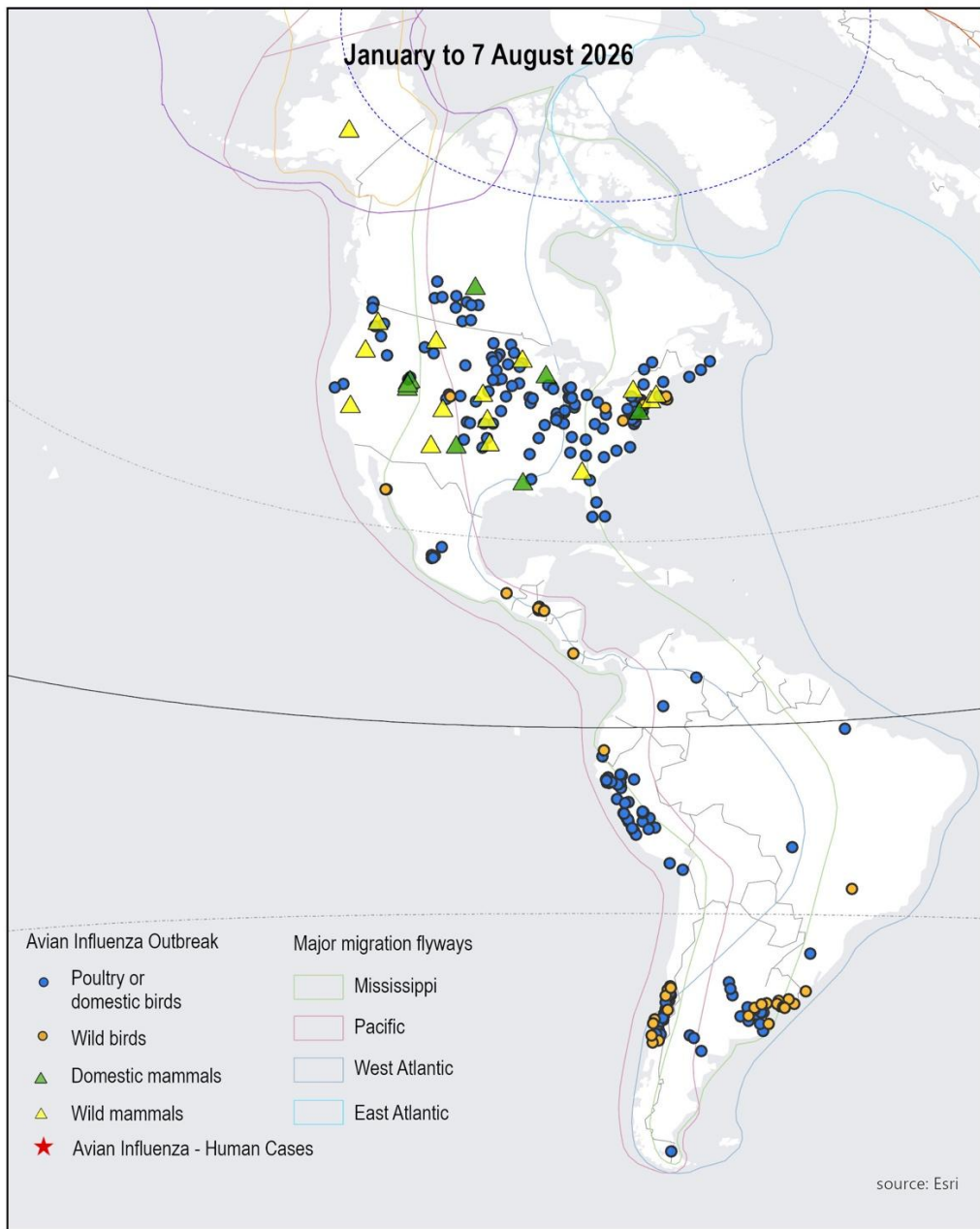
The total of 455 outbreaks of avian influenza A(H5) in animals represents a 25.7% decrease compared with the 612 outbreaks recorded during the same period in 2025. The reduction was observed in both birds (7.2%, from 416 to 386 outbreaks) and mammals (64.8%, from 196 to 69), with the decline being more pronounced in the latter group (10).

Between January and August 2026, animal outbreak activity was concentrated in North America, with lower levels of activity reported in South America. These findings confirm the continued circulation of the virus in animal populations and its implications for public health (10) **(Figure 1)**.

According to a regional alert issued by the FAO in April 2026, avian influenza A(H5N1) activity in Latin America and the Caribbean showed renewed expansion during late 2025 and the first months of 2026, with detections in wild birds and outbreaks in backyard and commercial poultry in several countries. The FAO noted that the sustained circulation of the virus in wild bird populations, particularly along migratory routes, continues to represent a major mechanism for its geographic spread and for the introduction or reintroduction of the virus into domestic bird populations. It also emphasized that direct or indirect contact between wild birds and poultry constitutes one of the main risk factors for the introduction of highly pathogenic avian influenza into poultry operations (11).

In 2026, the United States of America had the highest number of avian influenza A(H5) outbreaks, with 233 outbreaks in birds and 68 in mammals, followed by Peru with 49 outbreaks in birds and Chile with 42 outbreaks in birds (10).

Figure 1. Cases of avian influenza A(H5) in the Americas from January as of 7 August 2026.



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Map production: PAHO Health Emergencies Department/ Health Emergency Information and Risk Assessment Unit GIS Team.

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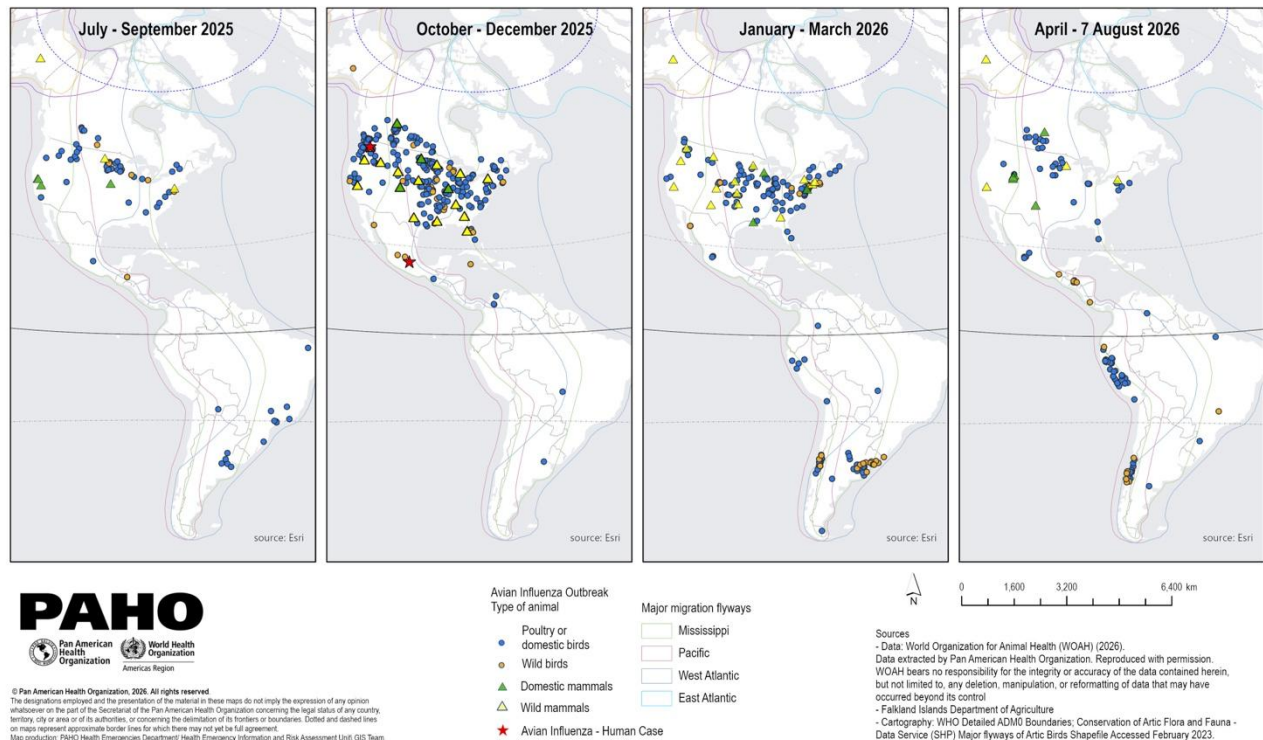
Sources
- Data: World Organization for Animal Health (WOAH) (2026).
Data extracted by Pan American Health Organization. Reproduced with permission. WOAH bears no responsibility for the integrity or accuracy of the data contained herein, but not limited to, any deletion, manipulation, or reformatting of data that may have occurred beyond its control.
- Falkland Islands Department of Agriculture
- Cartography: WHO Detailed ADM0 Boundaries; Conservation of Arctic Flora and Fauna - Data Service (SHP) Major flyways of Arctic Birds Shapefile Accessed February 2023.

Note: Two of the cases reported in Mexico involve avian influenza A(H5N2), and one in the United States involves avian influenza A(H5N5).

Source: Adapted from data published by the World Organization for Animal Health (10) and the Pan American Health Organization (12).

During the period from July 2025 to August 2026, avian influenza exhibited patterns related to the seasonal movements of migratory birds. Between July and September 2025, localized outbreaks occurred in North America. Transmission peaked between October and December 2025, spreading most widely across central and eastern North America along the Mississippi and Atlantic routes, affecting wild birds, poultry, and mammals, with human cases also reported. Between January and March 2026, activity declined in the north and shifted to the southern part of the continent, with an increase in outbreaks in South America. Finally, between April and August 2026, activity decreased in parts of North America, while localized outbreaks persisted along the Pacific coast and in the Southern Cone (10, 11) (**Figure 2**).

Figure 2. History of animal outbreaks of influenza A(H5N1) reported to the WOA and human cases of influenza A(H5) between July 2025 and 7 August 2026 in the Americas.



Source: Adapted from data published by the World Organization for Animal Health (9) and the Pan American Health Organization (12).

Human infections with avian influenza A(H5) virus

In 2026, through epidemiological week (EW) 32, no human cases of avian influenza A(H5) were reported in the Americas Region (12).

Between 2022 and 2025, 75 human infections with avian influenza A(H5) virus were reported in five countries in the Americas Region (Canada, Chile, Ecuador, Mexico, and the United States): 72 were due to influenza A(H5N1), two to influenza A(H5N2), and one to influenza A(H5N5). The most recent case of influenza A(H5) in the Region was reported in November 2025. Additional information on the characterization of human cases identified in the Americas Region is available in the epidemiological update on avian influenza A(H5N1) published by PAHO/WHO on March 11, 2026 (12, 13).

Recommendations for Member States

PAHO/WHO, together with the Food and Agriculture Organization of the United Nations (FAO) and the World Organization for Animal Health (WOAH), urges Member States to work in a coordinated and intersectoral manner to ensure prevention in animal and human populations, detection, and timely reporting to global authorities, and to strengthen the monitoring and characterization of circulating viruses in order to prevent transmission within and to new species and, consequently, reduce the risk of human infections associated with exposure to infected animals (6, 13).

Available virological and epidemiological data indicate that influenza A(H5) viruses remain avian influenza viruses, with no evidence of established adaptation to mammals or sustained human-to-human transmission. However, as long as these viruses persist in wild and domestic birds and mammals, additional human infections are expected, especially among people with direct exposure to infected animals and contaminated environments. There is no evidence that influenza A(H5) or other avian influenza viruses are transmitted through the consumption of properly prepared and thoroughly cooked poultry or eggs. The FAO, WHO, and WOAH recommend the consumption of pasteurized milk to minimize potential health risks associated with raw or unpasteurized milk (6, 13).

WOAH has issued specific recommendations regarding the avian influenza situation in birds and mammals. These recommendations advise countries to maintain enhanced surveillance for the disease in domestic and wild animal species, implement biosecurity and prevention measures at animal production sites, and ensure timely reporting of outbreaks in bird and mammal species (8).

Member States are encouraged to use the tools and initiatives developed by PAHO to support timely risk assessment and evidence-based decision-making, including the regional panel on avian influenza A(H5N1)³, which consolidates information from multiple official sources, and the periodic conduct of intersectoral risk assessments (IRA) for highly pathogenic avian influenza (14).

Recommendations for Strengthening Surveillance at the Human-Animal Interface

PAHO/WHO urges Member States to strengthen surveillance for avian influenza in both animals and humans through a multisectoral approach, ensuring the timely detection of cases to monitor potential changes in the virus's epidemiology (15, 16). Epidemiological surveillance of avian influenza A(H5N1) should be strengthened among populations at higher risk of exposure, including agricultural workers, veterinarians, health care workers, and laboratory personnel, as well as individuals who have had contact with infected animals or with contaminated environments and materials, regardless of the use of PPE or travel history. These individuals should be monitored from the time of initial exposure through 14 days after the last known exposure (16). During this period, they should be monitored for the onset of fever or fever-like symptoms, cough, sore throat, runny nose, shortness of breath, conjunctivitis, fatigue, headache, muscle aches, and neurological signs (15, 16). Furthermore, the absence of fever does not rule out a possible infection (16).

³ The PAHO Regional Avian Influenza Panel A(H5N1) is Available fromfrom: <https://shiny.paho-phe.org/h5n1/>

It is also recommended to monitor clusters of acute respiratory infections of unknown origin (IRAG) or cases with atypical symptoms in family, workplace, or social settings. The implementation of surveillance in healthcare facilities and at-risk populations, along with reporting and response protocols, is essential. It is recommended to strengthen awareness and training among health care workers for the early detection of individuals with possible exposure to avian influenza, particularly in areas where zoonotic outbreaks have been confirmed, as well as to actively monitor exposed individuals to ensure immediate reporting of suspected cases, thereby guaranteeing a rapid and coordinated response involving all sectors (15, 16).

Human specimens must be collected by trained personnel, in accordance with biosafety guidelines and using personal protective equipment (PPE) appropriate for respiratory viruses (16). Upon identification of a suspected human case of avian influenza A(H5N1), a respiratory specimen should be collected and, if conjunctivitis is present, a conjunctival specimen should also be collected and sent to the National Influenza Center (CNI) or the National Reference Laboratory (LNR) for analysis (17, 18). In patients with severe respiratory illness, particularly when upper respiratory tract sample results are negative and a high clinical and epidemiological suspicion persists, it is recommended to consider collecting lower respiratory tract samples, when clinically feasible, to increase the likelihood of viral detection. The initiation of antiviral treatment should not be delayed while awaiting laboratory test results in patients with suspected avian influenza A(H5N1) infection (16, 19). For more information, refer to the publications on respiratory specimen collection and the laboratory diagnostic algorithm for specimens from patients with suspected avian influenza A(H5) (17, 18).

A suspected or confirmed case of human infection with avian influenza A(H5), in accordance with Annex 2 of the International Health Regulations (IHR), must be reported immediately to the WHO Regional Focal Point for the IHR through the International Health Regulations (IHR) National Focal Point (NFP) via the official IHR channel. The report must include available epidemiological and virological findings. It is recommended that Ministries of Health establish intersectoral communication protocols to notify animal health and environmental authorities of any suspected or confirmed human cases (16, 20).

PAHO/WHO emphasizes the need for coordinated surveillance among the human, animal, and environmental health sectors, with clear responsibilities regarding wildlife, common definitions of suspected cases, and established workflows for reporting and sample submission. It also suggests using tools that facilitate rapid reporting from the field and strengthening communication with farmers and producers to improve early detection. For domestic animals, risk-based actions are recommended, including awareness campaigns on poultry farming, information sharing across sectors, updated risk maps, and surveillance of highly and low pathogenic subtypes, along with specific strategies for pigs and dairy cattle, such as sampling milk tanks in priority areas based on risk (20). Furthermore, the evolving situation underscores the need to strengthen risk mitigation strategies across various production settings. Close collaboration with backyard and small-scale poultry producers is essential to raise community awareness of risks related to HPAI, promote timely reporting of unusual events consistent with avian influenza, and reinforce practical biosecurity measures. In poultry establishments and backyard production units, it is recommended to reduce direct and indirect contact with wild birds, protect water and feed sources from contamination, prevent wild birds from accessing production areas, reduce standing water that may attract them, and maintain adequate feed storage and rodent control measures (11, 20). These efforts are essential to safeguard animal health and reduce potential spillover risks to public health.

Ensuring the availability and sustainability of the laboratory diagnostic capabilities needed for the timely confirmation or exclusion of suspected animal cases is essential. These capabilities must include molecular techniques, sequencing, and, where appropriate, serological testing; be firmly established at the national level; and be supported, when necessary, through intersectoral collaboration and with the diagnostic services of FAO and WOA reference laboratories (11, 20).

The sustained circulation of the A(H5N1) virus in wild bird populations also creates opportunities for reassortment with other avian influenza viruses. Such events have been documented in South America, including a virus identified in Argentina in February 2025 with genomic segments derived from Eurasian, South American, and North American lineages. These findings demonstrate that A(H5N1) viruses not only continue to be introduced and spread geographically but can also evolve locally through reassortment events (21).

In addition, PAHO/WHO recommends strengthening intersectoral genomic surveillance and sequencing the complete genome of detected viruses. The analysis should include the timely identification of potential reassortments among circulating viral strains, such as those already documented in the Region (6, 11, 21) and in other parts of the world (22), as well as markers associated with adaptation to mammals, virulence, and antiviral susceptibility (6, 23). Coordinated analysis across the human, animal, and environmental sectors enables the identification of epidemiological links, the timely detection of changes in risk, the assessment of their potential public health implications, and the guidance of the response to zoonotic influenza events. Influenza viruses with pandemic potential, including those of animal origin, should be promptly shared with a WHO collaborating center for characterization, which is essential for assessing zoonotic risk and supporting the development of vaccine candidate viruses (23, 24). Furthermore, the sequences obtained and their essential metadata should be promptly deposited in publicly accessible databases (23).

Additional recommendations for strengthening intersectoral collaboration in surveillance, laboratory testing, intersectoral risk assessment, and genomic surveillance are available in the reports of the Technical Working Groups of the Commission for the Prevention and Control of Zoonotic Influenza in the Americas (CIPCIZA) (20, 25).

Clinical Management

When infections caused by avian influenza A(H5) are suspected, PAHO/WHO recommends conducting an initial triage of patients, implementing infection prevention and control precautions, classifying patients according to the severity of their condition, and ensuring timely hospital care and management of complications (19, 25).

Regarding antiviral treatment and prevention among people exposed to zoonotic influenza viruses, PAHO/WHO recommends the following (19):

- Antiviral treatment of patients with severe influenza (including infection with novel influenza A associated with high mortality or an unknown risk of severe disease):
 - conditional recommendation for the use of oseltamivir in treatment,
 - conditional recommendation against the use of peramivir,
 - conditional recommendation against the use of zanamivir.

- Antiviral treatment for patients with non-severe influenza:
 - Conditional recommendation for the use of baloxavir in patients with non-severe influenza and a high risk of progression to severe illness.

People exposed to a zoonotic influenza virus associated with high mortality or an unknown risk of severe illness:

- For asymptomatic individuals exposed to zoonotic influenza viruses associated with high mortality in humans or with an unknown risk of causing severe illness within the previous two days, administration of baloxavir, laninamivir, oseltamivir, and zanamivir is recommended (conditional recommendation).

Operational Infection Prevention and Control (IPC) Measures in Healthcare and Agricultural Settings

In response to an outbreak of avian influenza A(H5), it is essential to implement robust infection prevention and control (IPC) measures in healthcare settings. This includes reinforcing standard precautions to reduce the transmission of pathogens. Droplet precautions should be applied for patients with respiratory symptoms (26). In addition, based on the risk assessment, airborne precautions should be implemented during procedures that generate aerosols, using appropriate PPE to protect healthcare workers. These measures should be applied from the moment the patient enters the healthcare facility; therefore, early triage is essential (18, 27, 28).

Another group at risk of infection includes those directly or indirectly exposed to infected birds or other animals—whether domestic, wild, or captive—such as workers involved in animal handling, slaughter, or the cleaning and disinfection of affected farms. Therefore, it is recommended to implement good agricultural practices and strict hygiene protocols, and to use appropriate PPE to prevent zoonotic transmission (6, 27, 29). These measures include training on the correct use of PPE, respirator fit testing, and proper disposal or disinfection procedures (27, 29). In December 2025, the WHO published updated guidance on the use of authorized human vaccines against influenza A(H5) during inter pandemic and emergence periods, intended to support national decision-making and the identification of potential target groups based on exposure risk (30).

Detailed information on other key recommendations for Member States—including intersectoral coordination and response, as well as prevention, vaccination, and risk communication measures—can be found in the epidemiological update published by PAHO/WHO on 24 January 2025 (31).

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Useful Links

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