Epidemiological Alert
Avian Influenza A(H5N1) in the Americas Region

24 November 2026

Although fewer avian influenza A(H5N1) outbreaks has been detected in birds and mammals during 2026 in the Americas, the number of confirmed cases of human infection with avian influenza A(H5) among workers at dairy facilities exceeds the number recorded in 2025. In light of this situation and considering the onset of the period of highest risk for viral spread associated with the seasonal migration of wild birds from the Northern Hemisphere to Latin America and the Caribbean, the Pan American Health Organization/World Health Organization (PAHO/WHO) urges Member States to strengthen their capacities for surveillance, early detection, epidemiological investigation, diagnosis, virological characterization, reporting, and timely response to cases of human infection with avian influenza. It also highlights the importance of strengthening surveillance in animals, prevention and biosecurity measures, and mechanisms for intersectoral coordination at the interface between human and animal health, under the One Health approach.

Global Context

Avian influenza A(H5N1) is a subtype of the influenza virus that infects birds and mammals, including humans in rare cases. Since their emergence in 1996, avian influenza A(H5N1) viruses of the Goose/Guangdong lineage have caused recurrent outbreaks in birds. Beginning in 2020, a variant of these viruses, belonging to clade H5 2.3.4.4b, led to unprecedented mortality among wild and domestic birds in several countries in Africa, Asia, and Europe. In 2021, the virus spread to North America and, in 2022, to Central and South America, affecting birds as well as terrestrial and marine mammals *(1, 2)*.

Avian influenza viruses can be classified into two groups based on their pathogenicity in poultry: low-pathogenic avian influenza (LPAI) and highly pathogenic avian influenza (HPAI) *(3)*. Globally, the World Organization for Animal Health (WOAH) reported that, between October 2025 and September 2026, a total of 7,831 HPAI outbreaks occurred in wild birds across 61 countries and territories, substantially exceeding the 1,926 and 1,076 outbreaks reported during the 2024–2025 and 2023–2024 seasons, respectively *(4)*.

According to global data compiled by the World Health Organization (WHO), between 2003 and 7 October 2026, a total of 1,005 confirmed human cases of avian influenza A(H5N1), including 479 deaths, were reported in 25 countries across all six WHO regions: the African, the Americas, the Eastern Mediterranean, the European, the South-East Asia, and the Western Pacific. In 2026, as of 7 October, 11 cases, including two deaths, were reported in three countries across two WHO regions: Cambodia (n = 6) in the Western Pacific Region, and Bangladesh (n= 4) and India (n= 1) in the South-East Asia Region *(5)*. To date, the available epidemiological, virological, and serological evidence has not demonstrated sustained human-to-human transmission *(6, 7)*.

Suggested citation: Pan American Health Organization/World Health Organization. Epidemiological Alert: Avian Influenza A(H5N1) in the Americas Region, 24 November 2026.

Situation in the Americas Region

In the Americas Region, outbreaks of avian influenza A(H5) in birds and mammals, as well as human cases of infection, have been reported during 2026. An overview of the regional epidemiological situation, including reported outbreaks in animals and human cases, is presented below *(8, 9)*.

Animal outbreaks of Avian Influenza A(H5N1) in the Americas, 2026

Between 1 January and 14 November 2026, 13 countries and territories in the Americas Region reported a total of 616 outbreaks of avian influenza A(H5N1) to the WOAH. Of these, 541 outbreaks involved birds (52 in wild birds and 489 in poultry or domestic birds) and 75 involved mammals (40 in wild mammals and 35 in domestic mammals)[1] . All 13 countries and territories reported outbreaks in birds, while two also reported outbreaks in mammals. **Table 1** presents a summary of the reported outbreaks by country or territory and animal group *(8)*.

Table 1. Outbreaks of avian influenza A(H5N1) in animals reported to WOAH in the Americas Region, by country or territory and animal type, from 1 January to 14 November 2026.

Country or territory	Wild birds	Domestic birds	Wild mammals	Domestic mammals	Total
Argentina	4	19	—	—	23
Brazil	3	4	—	—	7
Canada	2	34	—	1	37
Chile	10	45	—	—	55
Colombia	—	2	—	—	2
Costa Rica	1	—	—	—	1
Ecuador	1	—	—	—	1
Honduras	7	2	—	—	9
Mexico	2	2	—	—	4
Peru	20	100	—	—	120
Puerto Rico	—	2	—	—	2
United States of America	2	278	40	34	354
Uruguay	—	1	—	—	1
Total	**52**	**489**	**40**	**35**	**616**

Source: Adapted from data published by the World Organization for Animal Health *(8)*.

[1] Please note that the figures presented correspond to the number of outbreaks, each of which may include multiple epidemiologically linked records and updates to the number of reported cases. This methodology may result in lower counts than those presented in previous publications. The figures include only officially verified outbreaks reported to WOAH, in accordance with its reporting standards.

Figure 1 shows the geographic distribution of avian influenza A(H5N1) outbreaks reported to WOAH in the Americas Region during 2026, by type of animal affected, along with reported human cases and the main migratory routes of wild birds. **Figure 2** shows the quarterly geographic distribution of avian influenza A(H5) outbreaks in animals and human cases from January 2025 to 14 November 2026, allowing for a comparison of the spatial distribution of events reported in 2026 in relation to the previous year *(8, 9)*.

Given the continued circulation HPAI viruses in the Americas and the onset of the period of heightened risk associated with the seasonal movement of migratory wild birds from the Northern Hemisphere to Latin America and the Caribbean, the Food and Agriculture Organization of the United Nations (FAO) called for strengthening prevention, surveillance, early detection, and response preparedness measures, particularly in areas along migratory routes, wetlands, lagoons, coastal areas, and other sites where wild birds congregate, as well as in poultry farms located near these environments *(10)*. WOAH also noted that surveillance of wild birds can provide an early warning of virus circulation, even before outbreaks are detected on poultry farms, and emphasized the importance of early detection, timely information sharing, and strengthening biosecurity measures *(11)*.

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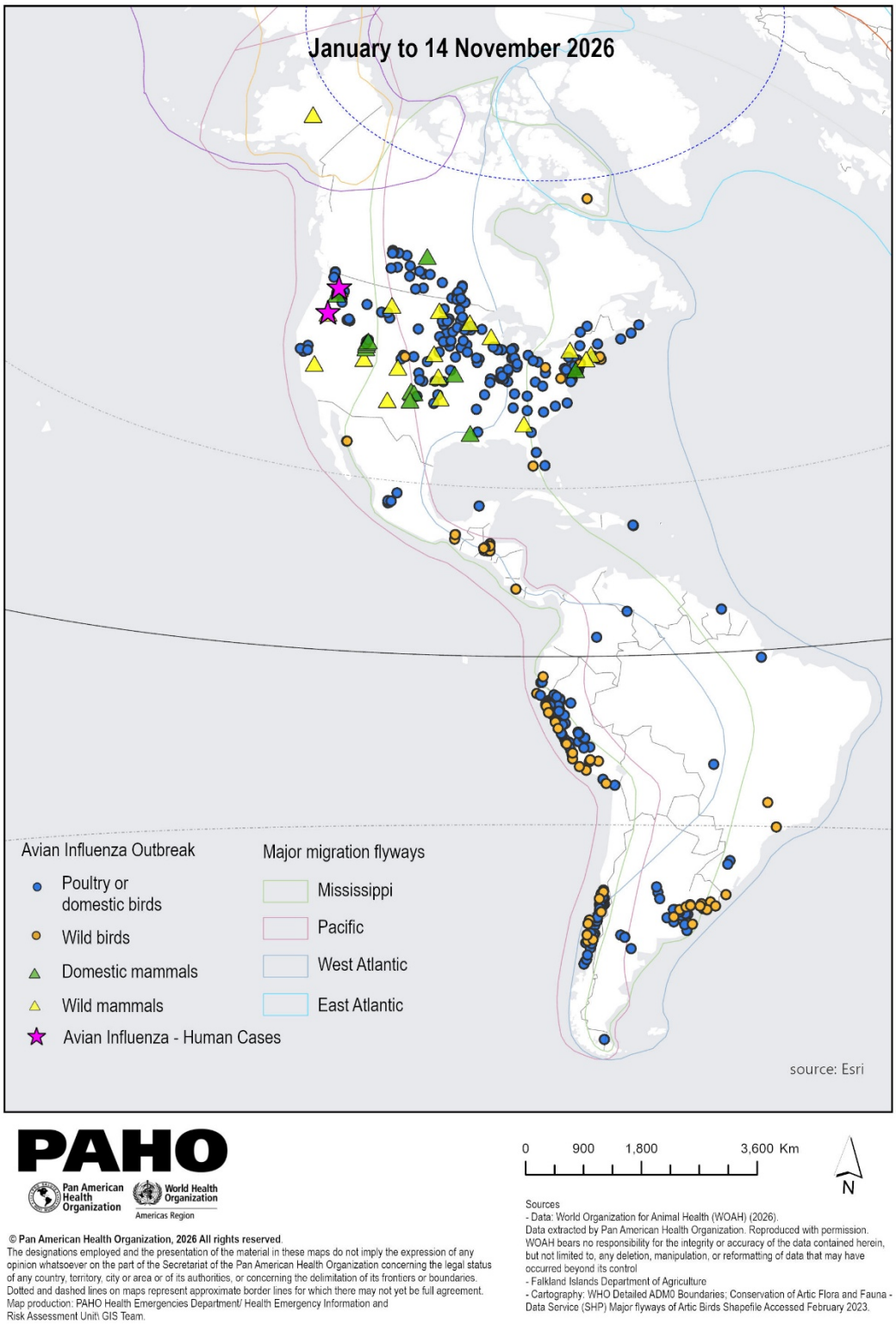
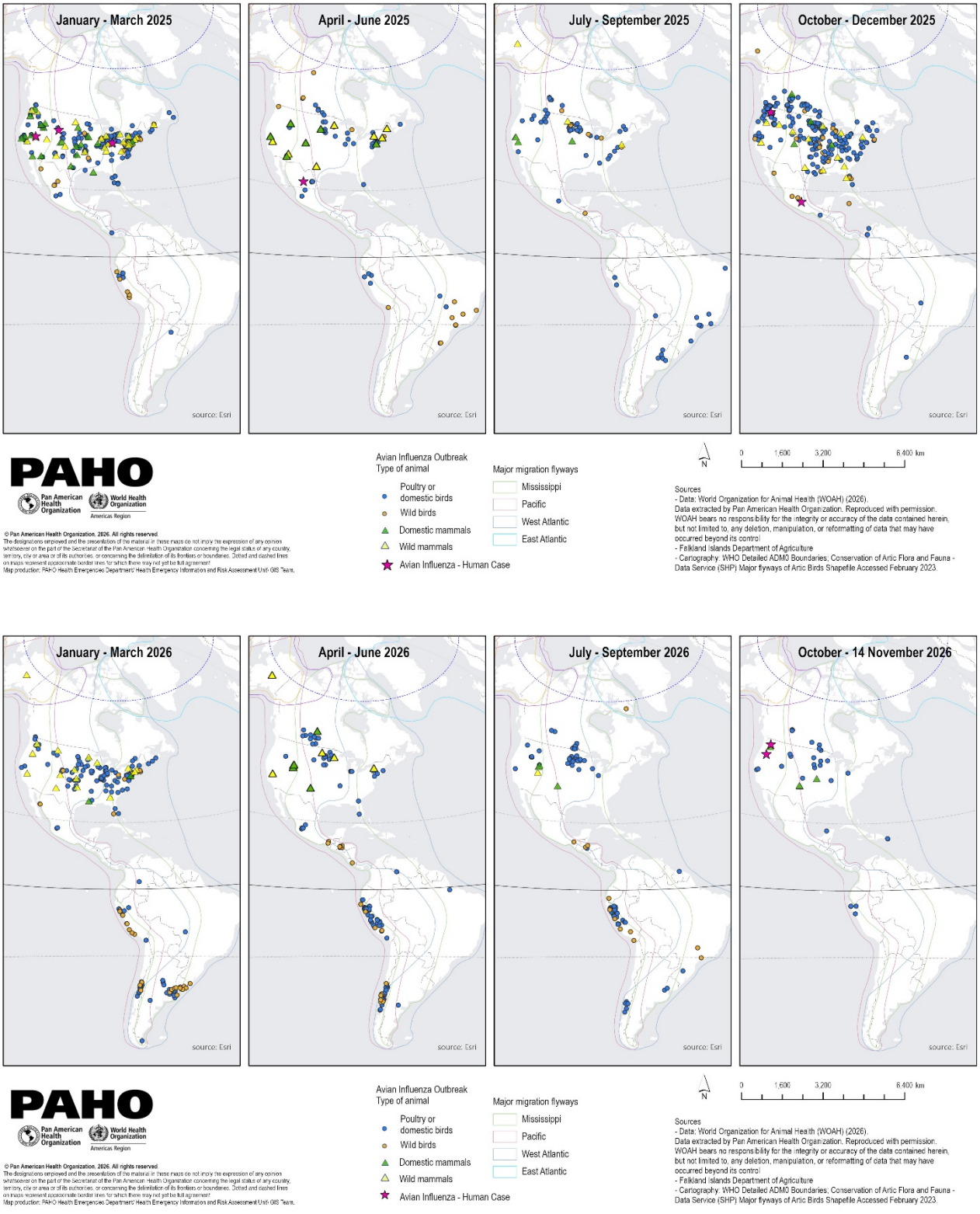
Figure 1. Geographic distribution of animal outbreaks of influenza A(H5N1) reported to WOAH in the Americas, 1 January to 14 November 2026.



Source: Adapted from data published by the World Organization for Animal Health *(8)*.

Figure 2. Quarterly geographical distribution of avian influenza A(H5N1) outbreaks in animals reported to WOAH and human cases of influenza A(H5) in the Americas Region, 2025-2026.



Source: Adapted from data published by the World Organization for Animal Health and data published by the Pan American Health Organization *(8)*.

Human infections with avian influenza A(H5) virus in the Americas, 2022–2026

Between January 2022 and 14 November 2026, 82 human infections with avian influenza A(H5) viruses were reported in five countries of the Region of the Americas (Canada, Chile, Ecuador, Mexico, and the United States of America): 78 were caused by influenza A(H5N1), two by influenza A(H5N2), one by influenza A(H5)with undetermined NA, and one by influenza A(H5N5) viruses *(1, 9, 15)*. During October and 14 November 2026, four confirmed human cases of avian influenza A(H5) virus infection were reported in the United States of America: three in the state of Washington, including one fatal case, and one case in Oregon. These were all epidemiologically linked to exposure to dairy cattle infected with influenza A(H5N1). With the confirmation of the case in Oregon, the cumulative number of human infections with avian influenza A(H5) viruses detected in the United States of America since April 2022 increased to 76 *(12-16)*.

The three cases reported in the state of Washington in 2026 occurred in adults who worked at dairy farms where highly pathogenic avian influenza (HPAI) A(H5N1) virus had been detected in cattle. Two developed mild illness, including ocular and upper respiratory symptoms, and did not require hospitalization, while the third developed severe respiratory illness, was hospitalized, and died on 1 November 2026. Further testing identified avian influenza A(H5N1) virus in all cases. Genetic sequencing identified all cases resulted from clade 2.3.4.4b, genotype B3.13 virus infections with high genetic similarity to viruses detected in dairy cattle in the state of Washington *(13–16)*. According to USDA, genetic analysis indicated that the detections were consistent with introduction of the virus from Idaho, likely through cattle movement (16)

The case reported in Oregon occurred in an adult, a dairy farm worker in Oregon with occupational exposure to dairy cattle infected with influenza A(H5N1), who developed conjunctivitis on 10 November 2026. The patient was not hospitalized, received oseltamivir, and was recovering. Influenza A(H5) virus infection was confirmed by the United States Centers for Disease Control and Prevention on 18 November from the patient's conjunctival specimen; genetic sequencing identified the virus as clade 2.3.4.4b, genotype B3.13 with high genetic similarity to the virus detected in dairy cattle in the state of Oregon. This was the second human case of influenza A(H5) virus infection identified in Oregon and the first associated with exposure to dairy cattle; the previous case was associated with exposure to infected poultry. As of 18 November 2026, no person-to-person transmission of avian influenza A(H5) virus had been identified in the United States of America *(9, 15)*

Figure 3 shows reported human cases of avian influenza A(H5) in the Americas Region by epidemiological week, country, and virus subtype, from 2022 to 14 November 2026. **Figure 4** shows the geographic distribution of reported human cases of avian influenza A(H5) in the Americas Region at the subnational level, including the main migratory routes of wild birds as a geographical reference *(1, 5, 9, 17)*.

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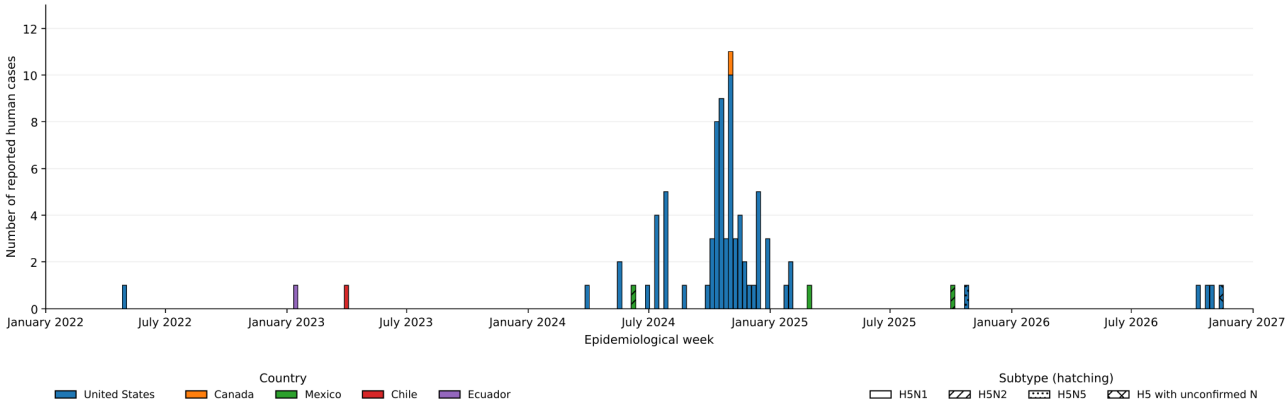
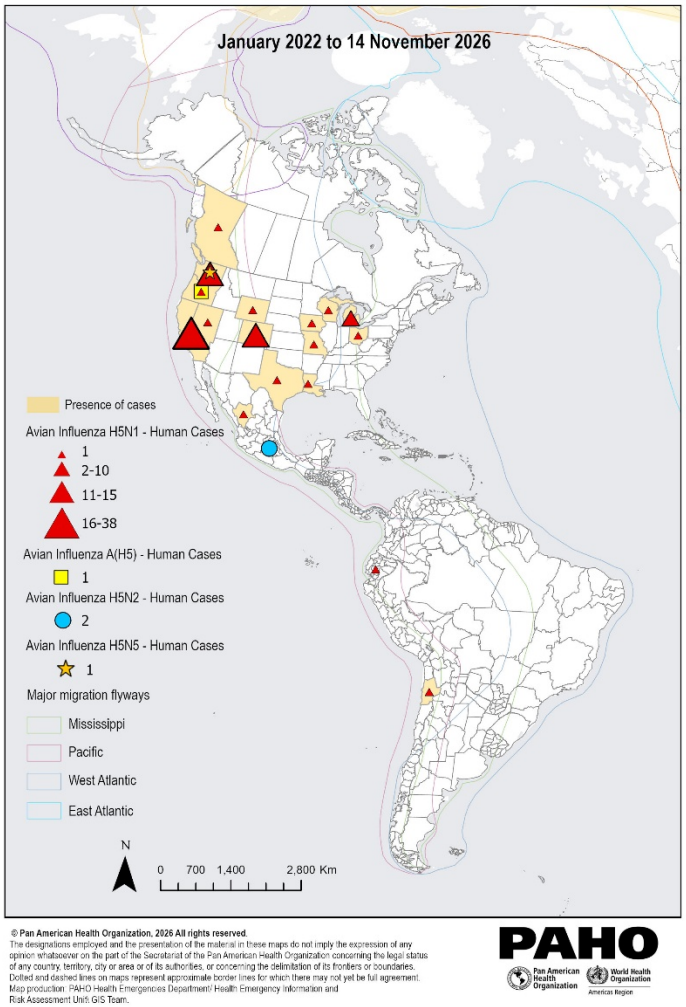
Figure 3. Human cases of avian influenza A(H5) in the Americas Region, by epidemiological week, country, and virus subtype, 2022–2026, up to 14 November 2026.



Source: Adapted from data published by the Pan American Health Organization *(17)*.

Figure 4. Human cases of avian influenza A(H5) in the Americas Region, 2022–2026, through November 14, 2026.



Source: Adapted from data published by the Pan American Health Organization *(17)*.

Recommendations for Member States

The Pan American Health Organization/World Health Organization (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 timely notification 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 *(7, 18)*.

Available virological and epidemiological data indicate that influenza A(H5) viruses continue to remain avian influenza viruses, with no evidence of established adaptation to mammals or sustained human-to-human transmission. However, while these viruses persist in wild and domestic birds and mammals, additional human infections are anticipated, particularly among individuals 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 related to raw/unpasteurized milk *(6, 7)*.

Specific recommendations regarding the avian influenza situation in birds and mammals have been issued by WOAH. These recommendations advise countries to maintain intensified surveillance for the disease in domestic and wild animal species. These recommendations also advise implementing biosecurity and preventive measures in animal production sites and urge the timely reporting of outbreaks in bird and mammal species *(3, 11)*.

Member States are encouraged to make use of the tools and initiatives developed by PAHO to support timely risk assessment and evidence-informed decision-making, including the regional avian influenza A(H5N1) dashboard, which consolidates information from multiple official sources.[2]

In this context, Member States are urged to strengthen their participation in the Intersectoral Commission for the Prevention and Control of Zoonotic Influenza in the Americas (CIPCIZA) and consolidate national coordination mechanisms that bring together the human health, animal health, and environmental sectors. Coordinated by PAHO, CIPCIZA serves as a regional technical platform to facilitate the timely exchange of information, harmonize technical approaches, and formulate practical recommendations on surveillance, risk assessment, laboratory capacity, genomic surveillance, biosecurity, preparedness, and response, under the One Health approach *(18)*.

Member States are also encouraged to consider the use of the Intersectoral Risk Assessment (EVIR, for its Spanish acronym) tool, developed by PAHO's Pan American Center for Foot-and-Mouth Disease and Veterinary Public Health (PANAFTOSA/SPV) and coordinated within the framework of CIPCIZA. Through participatory workshops and structured qualitative analysis, the EVIR tool enables the identification of potential routes of virus introduction and spread, the mapping of critical points and intersectoral risk flows, the assessment of existing capacities, the definition of the roles and responsibilities across participating sectors, the identification of technical and information gaps, and the prioritization of actions to strengthen surveillance, preparedness, and response to zoonotic avian influenza *(19)*.

[2] The PAHO regional avian influenza A(H5N1) dashboard is available from: https://shiny.paho-phe.org/h5n1/

Recommendations for strengthening surveillance at the human-animal interface

PAHO/WHO encourages Member States to strengthen surveillance in both animals and humans through an intersectoral approach, ensuring timely detection of cases to monitor possible changes in the epidemiology of the virus. Epidemiological surveillance of avian influenza A(H5N1) should be strengthened in populations at higher risk of exposure, including agricultural workers, veterinarians, health-care workers, and laboratory personnel, through the timely identification of signals and the exchange of relevant information across sectors. These signals include respiratory disease, conjunctivitis, or encephalitis in people with recent exposure to infected animals, as well as cases of severe acute respiratory infection (SARI) or pneumonia in travelers from areas with detected avian influenza A(H5) *(20, 21)*.

Monitoring clusters of SARI or cases with atypical symptoms in family, work, or social settings is also recommended. The implementation of surveillance in health facilities and at-risk populations, with notification and response protocols, is essential. Upon detection of avian influenza outbreaks in animals, it is recommended to identify and actively monitor potentially exposed individuals, particularly those involved in handling infected animals, including poultry and dairy farm workers. This monitoring should facilitate the early detection of symptoms compatible with avian influenza, clinical evaluation and specimen collection, as appropriate, as well as timely reporting and implementation of prevention and control measures *(20, 21)*.

Human samples should be collected by trained personnel in accordance with all biosafety standards, including the use of appropriate personal protective equipment (PPE) for respiratory viruses. Upon identifying suspected human cases of avian influenza A(H5N1), a respiratory specimen (and a conjunctival swab if the patient presents conjunctivitis) should be taken and sent to the National Influenza Centers (NICs) or National Reference Laboratories (NRLs) for analysis. For more information, refer to the publications on respiratory specimen collection[3] and the laboratory testing algorithm[4] for samples from patients with suspected avian influenza A(H5) *(22, 23)*.

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 immediately notified to the WHO IHR Regional Contact Point via the IHR National Focal Point using the official IHR channel. The report should include available epidemiological and virological findings. It is recommended that Ministries of Health establish intersectoral communication protocols to notify agricultural and environmental authorities of any suspected or confirmed human cases *(21, 24)*.

In areas along major wild bird migration routes, particularly in wetlands, lagoons, coastal areas, and other sites where wild birds congregate, it is recommended to strengthen surveillance for unusual morbidity and mortality in birds and ensure timely specimen collection. Alerts regarding such events should be shared promptly between the animal health and public health sectors to guide the strengthening of surveillance and biosecurity measures on poultry farms and in backyard flocks in high-risk areas *(7)*.

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[3] Infographic - Respiratory sample collection for zoonotic influenza diagnosis (Influenza A/H5 and other zoonotic influenza viruses). Washington, D.C.: PAHO/WHO; 2024. Available from: https://www.paho.org/en/documents/infographic-respiratory-sample-collection-zoonotic-influenza-diagnosis-influenza-ah5-and.

[4] Laboratory diagnostic algorithm for the detection of suspected cases of influenza A/H5. Washington, D.C.: PAHO/WHO; 2022. Available at:https://www.paho.org/es/documentos/muestras-pacientes-sospechosos-influenza-ah5-algoritmo-pruebas-laboratorio https://www.paho.org/en/documents/laboratory-diagnostic-algorithm-detection-suspected-cases-influenza-ah5.

For domestic animals, risk-based measures tailored to the production setting are recommended, particularly on poultry farms located near these sites. These include raising awareness among producers, updating risk maps, ensuring immediate reporting of unusual events consistent with avian influenza, and strengthening biosecurity measures. For pigs and dairy cattle, specific surveillance strategies should be considered, including for dairy cattle, milk sampling from bulk tanks at facilities prioritized according to risk. Collaboration with backyard and small-scale poultry producers should promote early detection and minimize direct or indirect contact between domestic and wild birds, thereby reducing the risk of virus introduction into domestic bird populations and subsequent human exposure *(10, 11, 18)*.

Ensuring sufficient laboratory diagnostic capacity is also essential to allow the timely confirmation or exclusion of suspected animal cases through a combination of molecular techniques, including sequencing, and serological assays. This capacity should be firmly established at the national level and supported, when necessary, through intersectoral collaboration and with the diagnostic services of WOAH regional reference laboratories *(11, 18)*. To strengthen intersectoral genomic surveillance, it is recommended to analyze the genomes of influenza A(H5) viruses detected in animals to identify mutations associated with mammalian adaptation or with changes in susceptibility to antiviral drugs *(6, 7)*.

Additionally, PAHO/WHO recommends strengthening intersectoral genomic surveillance to detect potential reassortment events among circulating viral strains in a timely manner, such as those already documented in the region *(7, 18)* and in other parts of the world *(7)*. Coordinated analysis between the human, animal, and environmental sectors allows for the interpretation of these events, the anticipation of changes in risk, and the guidance of timely actions and a rapid response to zoonotic influenza events.

Clinical Management

When infections caused by avian influenza A(H5) are suspected, PAHO/WHO recommends conducting an initial triage of patients, applying infection prevention and control (IPC) precautions, classifying patients according to the severity of their condition, and ensuring timely hospital care and management of complications *(2, 25)*.

With regard to antiviral treatment and prevention among persons exposed to zoonotic influenza virus, PAHO/WHO recommends the following *(25):*

- Antiviral treatment of patients with severe influenza (including infection with new influenza A associated with high mortality or 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 high risk of progression to severe illness.

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

- for asymptomatic persons exposed to zoonotic influenza viruses associated with high mortality in humans or those with an unknown risk of causing severe disease, illness in the previous two days, administration of one of the following antivirals is recommended: baloxavir, laninamivir, oseltamivir, and zanamivir (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 within healthcare settings. This includes reinforcing standard precautions, which aim to reduce the transmission of pathogens. Droplet transmission precautions should be applied for patients with respiratory symptoms. Additionally, based on risk assessment, airborne transmission precautions should be implemented during aerosol-generating procedures, using appropriate PPE to prevent transmission to healthcare workers. These measures should be in place when the patient enters the facility, making early triage critical *(26, 27)*.

The other group of people 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 that good agricultural practices and strict hygiene protocols be implemented, and that appropriate PPE be used to prevent zoonotic transmission *(27, 28)*. These include training on the correct use of PPE, respirator fit testing, and proper disposal or disinfection procedures *(28)*. There are currently several A(H5) influenza vaccines authorized for use in humans during the interpandemic period for the prevention of severe disease in people at high risk of infection. It is also recommended to reinforce seasonal influenza vaccination for individuals at risk of occupational or frequent exposure to birds or other potentially infected animals. Although seasonal influenza vaccination does not protect against avian influenza A(H5), it may reduce the likelihood of coinfection with seasonal and avian influenza viruses and should complement other measures, including the appropriate use of PPE. WHO recommends that countries consider seasonal influenza vaccination for individuals at increased risk of exposure, particularly in occupational settings, taking into account the epidemiological context and national public health priorities *(29, 30)*.

Detailed information on other key recommendations for Member States, including intersectoral coordination and response, as well as prevention measures and risk communication, can be found in the epidemiological update published by PAHO/WHO on 24 January 2025, Available from: https://www.paho.org/en/documents/epidemiological-update-avian-influenza-ah5n1-americas-region-24-january-2025 *(30)*.

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Useful Links

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