



ARMED FORCES HEALTH SURVEILLANCE DIVISION

INTEGRATED BIOSURVEILLANCE BRANCH

Health Surveillance Update
19 MAY 2026

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DHA Public Health AFHSD – Integrated Biosurveillance (IB) Branch Health Surveillance Update 13–19 MAY 2026



The IB Health Surveillance Update (HSU) is a weekly report of health events and disease outbreaks monitored by the IB Branch.

Executive Summary

An Ebola virus disease outbreak has been reported in the **Democratic Republic of the Congo** (11 confirmed cases; 336 suspected cases; 88 deaths) and **Uganda** (2 confirmed cases; 1 death). The eighth human infection with avian influenza A(H9N2) in **China** during 2026 has been reported. **Japan** has recorded case increases of Japanese Spotted Fever (37) and severe fever with thrombocytopenia syndrome (29). More than 27k dengue cases have been reported in **Sri Lanka** during 2026, a 43% increase compared to the same period in 2025.

HSU Health Events

Geographic Combatant Command	Country	Event
USNORTHCOM	United States	Tick bite
	United States	Novel influenza A(H1N2v)
	Other events	
USAFRICOM	USAFRICOM	Ebola virus disease
	Other events	
USCENTCOM	Other events	--
USEUCOM	Lithuania	Tick-borne encephalitis
	Other events	
USINDOPACOM	China	Novel influenza A(H5N6)
	China	Novel influenza A(H9N2)
	Japan	Tick-borne illness
	Sri Lanka	Dengue
	Other events	
USSOUTHCOM	Dominican Republic	Leptospirosis
	Venezuela	Chikungunya
	Other events	

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USNORTHCOM Health Events of Interest

United States – Novel influenza A(H1N2v):

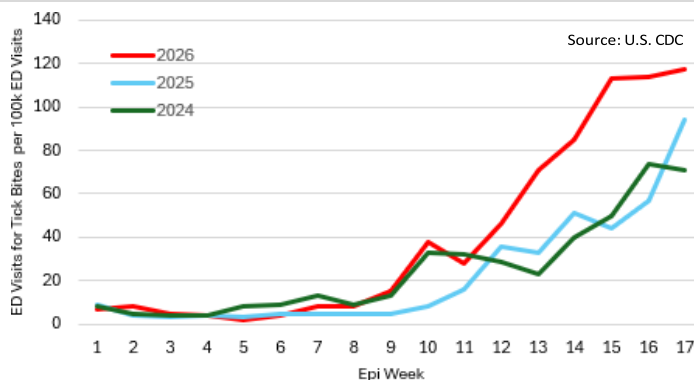
On 02 MAY, the Nebraska Department of Health and Human Services reported a human infection with **swine influenza A(H1N2) variant A(H1N2v) virus** in the United States during 2026, in an individual aged <18 years. The case had onset of respiratory symptoms during the week ending 04 APRIL and sought medical care twice during the following week. In the week ending 18 APRIL, the case sought outpatient care again due to worsening symptoms. The case was not hospitalized and has since recovered. An epidemiological investigation revealed that the case did not have direct or indirect contact with swine. An additional investigation identified one household contact who developed mild respiratory symptoms the same day as the case. No additional influenza A(H1N2v) cases associated with the case have been identified. (CDC)

Influenza A(H1N2) is one of three main influenza A subtypes that have been isolated from swine in the U.S. Human infections with novel swine influenza viruses are generally characterized as mild, with symptoms similar to seasonal influenza. **The U.S. CDC Influenza Risk Assessment Tool (IRAT) has assessed one A(H1N2v) virus from California in 2018, identifying a “Moderate” risk for the virus to significantly impact public health if sustained human-to-human transmission occurs.** Since 2011, a total of 44 human A(H1N2v) infections have been reported to CDC, including 2 in 2025 (Iowa and Vermont), 4 in 2024 (all Pennsylvania), 2 in 2023 (Michigan and Montana), and 5 each in 2022 (Georgia, Ohio, Michigan, Oregon, and Wisconsin) and 2021 (Ohio, and California, Iowa, and Indiana). (U.S. CDC)

U.S. – Tick bite:

On 23 APRIL, the U.S. CDC issued an advisory **regarding an increase in emergency department (ED) visits for tick bites for this time of the year in every region except South Central**, raising concerns about increased exposure to tick-borne diseases. **During APR, weekly ED tick bite visits were at their highest level since 2017, at 104 per 100k visits).** In the week ending 02 MAY (Epidemiological Week [EW] 17), there were 117 ED visits for tick bites per 100k ED visits across the U.S., a 24% increase compared to the 94 visits per 100k in the same period in 2025. See Figure 1 for tick bite ED visit incidence by week since 2024 for EWs 1-17. The Northeast Region has reported the highest incidence (66 ED visits for tick bites per 100k ED visits), followed by the Midwest (48 per 100k), Southeast (23 per 100k), West (18 per 100k), and South Central (7 per 100k) regions. From 04 JAN (EW 1) to 28 FEB (EW 8) there was an average of 5.8 ED visits for tick bites per 100k ED visits before tick bite visits began increasing earlier than usual in spring, surging 680% from the week ending 07 MARCH (15 ED visits for tick bites per 100k ED visits; EW 9) through 02 MAY (117 per 100k; EW 17). Additionally, the actual number of cases is likely higher due to underreporting. (Bloomberg School of Public Health, U.S. CDC)

Figure 1. Weekly Incidence of ED Visits for Tick Bites, EWs 1–17, 2024–2026



In the United States, tick season typically peaks during warmer months (APRIL to SEPTEMBER) but exposure can occur year-round. **The current increase in tick activity is being attributed to warmer temperatures due to**

changing climate trends, allowing ticks to become active earlier and remain for longer periods. Multiple tick species are present across the United States, including the blacklegged tick (*Ixodes scapularis*) in the Northeast and Upper Midwest, the western blacklegged tick (*I. pacificus*) along the Pacific Coast, and the lone star tick (*Amblyomma americanum*) expanding in geographic range throughout the eastern and central states. Ticks can transmit a range of pathogens, including *Anaplasma phagocytophilum* (anaplasmosis), *Babesia microti* (babesiosis), *Borrelia burgdorferi* (Lyme disease [LD]), and *Borrelia miyamotoi* (hard tick relapsing fever), as well as viruses such as Powassan virus and tick-borne encephalitis (TBE). Health providers in endemic areas are also reporting concern about alpha-gal syndrome, an allergic condition linked to lone star tick bites that can cause delayed allergic reactions to red meat and, in some cases, severe anaphylaxis. A 2024 study found that across >31 million individuals in the United States, nearly 1 in 10 may experience a tick bite annually. The U.S. CDC recommends that the public use Environmental Protection Agency-registered insect repellents, perform tick checks after outdoor activities, promptly remove attached ticks, and seek medical care if they develop fever, rash, or other compatible symptoms following a tick bite. (U.S. CDC, Healthbeat, Newsweek, *Ticks Tick Borne Dis*)

Other events:

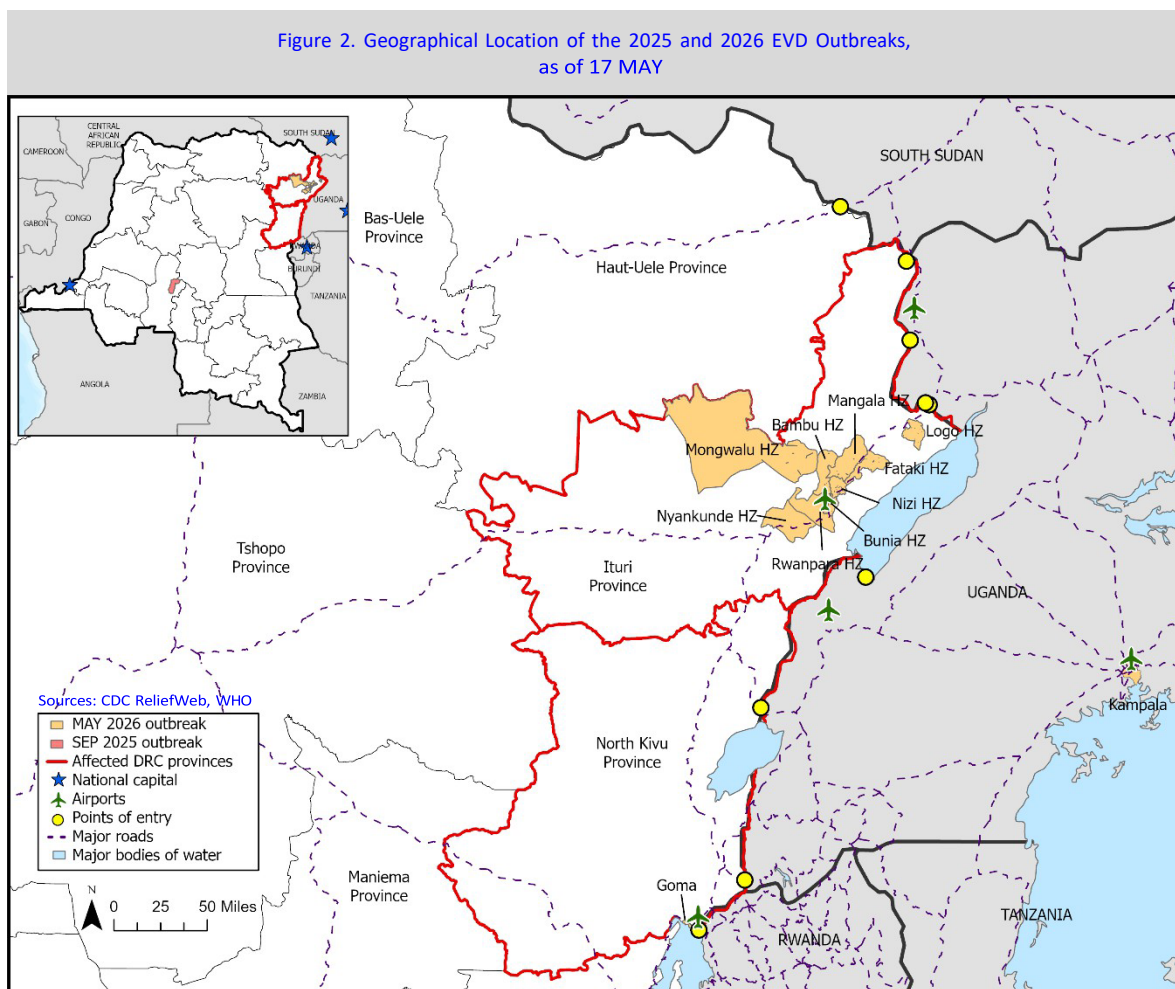
- **GLOBAL**, Study finds R_0 estimate of 2.76 for the MV Hondius cruise ship hantavirus outbreak
- **CANADA**, 601 hepatitis A cases (133 hospitalizations; 3 deaths) in Manitoba Province since APRIL 2025
- **CANADA**, At least 19 confirmed legionellosis cases (19 hospitalizations) in Hamilton, Ontario Province, as of 16 MAY; no source identified
- **MEXICO**, 13 rickettsiosis cases (7 deaths) in Chihuahua State during 2026
- **MEXICO**, 30 human New World screwworm disease cases in Veracruz State during 2026
- **MEXICO**, >440 heat illness cases (13 deaths) due to extreme temperatures during 2026
- **U.S.**, >2.1k tuberculosis cases (279 deaths) in California in 2025; highest annual total since 2013 and nearly double the national average
- **U.S.**, Asian longhorned tick detected on dog in DeKalb County, Alabama, in APRIL
- **U.S.**, Dengue cases increased >350% in 2024 compared to historical average; U.S. CDC travel warnings for 12 countries
- **U.S.**, First mpox clade I case in Connecticut as of 13 MAY; case reports recent travel to western Europe
- **U.S.**, Increase in parvovirus B19 wastewater detection in northern California as of 12 MAY
- **U.S.**, Norovirus wastewater level decreased to “Medium” as of 12 MAY
- **U.S.**, One fatal coccidiomycosis case in California as of 10 MAY
- **U.S.**, Suspected hantavirus infection case in Winnebago County, Illinois, not linked to MV Hondius cruise ship outbreak, as of 12 MAY
- **U.S.**, Suspected locally acquired hantavirus infection case in Ontario County, New York, as of 14 MAY; not linked to MV Hondius cruise ship
- **U.S.**, Two suspected hantavirus infection cases (one symptomatic) linked to the MV Hondius cruise ship at Emory University Hospital in Atlanta, Georgia, and 16 others (1 confirmed) at University of Nebraska Medical Center in Omaha, Nebraska; 18 total passengers returned as of 12 MAY
- **U.S.**, West Nile virus (WNV) wastewater level increased from “Not Detected” to “Low” as of 13 MAY

USAFRICOM Health Events of Interest

USAFRICOM – Ebola virus disease (EVD):

DRC CASE REPORT: On 15 MAY, Africa CDC reported an EVD outbreak in Ituri Province, northeast DRC, primarily from the Mongbwalu and Rwampara health zones (HZ). **As of 18 MAY, 11 confirmed cases (336 suspected; 88 deaths) have been reported across at least 9 HZs, including Bambu, Bunia, Fataki, Logo, Mangala, Mongbwalu, Nizi, Nyankunde, and Rwampara** (Table 1; data last checked 18 MAY at 1300). On 17 MAY, Health Authorities in Goma, North Kivu Province, confirmed an EVD case with a direct epidemiological link to the outbreak in Ituri Province (secondary transmission clusters), leading to a border closure between Goma and Rwanda and further complicating response efforts. The geographic spread represents a critical threat because cities like Bunia and Rwampara feature

dense urban populations, while Mongbwalu hosts a highly transient mining workforce. See Figure 2 for the geographical location of the current and last EVD outbreak in the DRC. According to WHO, a cluster of suspected cases was reported on 05 MAY, and a team was deployed to the province to support DRC health officials in their investigation of the outbreak and collect samples in the field, which initially tested negative for Ebola virus. **On 15 MAY, the National Institute of Biomedical Research in Kinshasa confirmed Bundibugyo virus disease (BVD) in 8 out of 13 samples from Rwampara HZ (5 inconclusive).** As of 15 MAY, 65 contacts (15 high risk) have been identified in the DRC. On 18 MAY, the U.S. CDC reported that an American doctor working with a medical missionary organization in the DRC has tested positive for Ebola virus, and the documented exposure of six additional American nationals stationed at Nyankunde Hospital in Bunia. The American doctor has been evacuated to Germany. The U.S. CDC is supporting interagency partners who are actively coordinating the safe withdrawal of a small number of Americans who have been affected by the outbreak. The first known case from the outbreak was a nurse who developed symptoms on 24 APR, meaning the virus had been spreading undetected for weeks. According to Congolese Health Minister Samuel Roger Kamba, she died in Bunia. Her body was then transported back to her family (where probably there was a traditional burial practice [open-casket funeral]) in Mongbwalu, one of two gold-mining towns where most of the cases have been reported (six to eight deaths per day). Many individuals were likely exposed to the body during the funeral ceremony, which may explain why the virus spread quickly. According to initial sequencing analysis, the outbreak was caused by a new zoonotic spillover (BBC, CBS, CDC, Reuters, ReliefWeb, Virological, YahooNews)



UGANDA CASE REPORT: On 15 MAY, the Uganda MOH confirmed a BVD outbreak involving an imported case from the DRC. The case was an elderly man who was admitted to a private hospital on 11 MAY with severe symptoms and died on 14 MAY; the case was posthumously transferred to the DRC the same day. A clinical sample was collected upon admission and was confirmed as BVD by the Central Emergency Surveillance and Response Support Laboratory

in Wandegaya, Kampala District, on 15 MAY. A second imported case was confirmed on 16 MAY in Kampala District in an individual with recent travel to the DRC; no epidemiological link to the first case was identified and no local transmission has been reported (Table 1). Ugandan public health authorities assert that no localized, autochthonous chains of transmission have been confirmed among the domestic Ugandan populace to date. Both cases were individuals who had traveled across the international border from the highly affected zones in the DRC. (WHO)

ZAMBIA CASE REPORT: The Zambia MOH reported that while the country has not recorded any EVD cases, one individual with symptoms consistent with a hemorrhagic fever was admitted and isolated at a local hospital on 13 MAY. Preliminary rapid tests have been negative for EVD and Marburg virus disease. (Xinhua)

Table 1. 2026 EVD Outbreak Case Counts by Country, as of 18 MAY			
Country	Confirmed Cases	Suspected Cases	Deaths
DRC	11	336	88
Uganda	2	0	1

Source: CDC

BACKGROUND: BVD is a severe and often fatal EVD caused by the Bundibugyo virus; **there is no vaccine for BVD and treatment consists of supportive care.** Historically, BVD has case fatality rates (CFR) ranging from 25 to 50%; the CFR from the past two BVD outbreaks in Uganda (2007) and the DRC (2012) was ~30 – 50%. The incubation period is 2 – 21 days (for Ebola Bundibugyo, the mean incubation period is 6.3 – 7.0 days) and presents with symptoms including abdominal pain, fever, headache, nosebleeds, severe weakness, and vomiting blood, that can progress to gastrointestinal symptoms, organ dysfunction, and in some severe cases hemorrhagic manifestations. A systematic review and meta-analysis report found that the overall pooled mean EVD basic reproduction number (R_0) was 1.95 (95% CI: 1.74 – 2.15), and this varies widely across countries due to the context, population density, socio-behavioral, and environmental factors. The Bundibugyo species has an extremely sparse epidemiological record. It has only been responsible for two previously documented public health emergencies: one in Uganda in 2007 and a subsequent cluster in the DRC in 2012. Due to its infrequent emergence, the fundamental biology and clinical epidemiology of this non-Zaire species are not well characterized in the infectious disease literature. Fruit bats are the natural reservoir. The DRC outbreak was first signaled by reports of unusually high mortality in Mongbwalu HZ, a mining town ~90 km from Bunia, where 55 patients died at the General Referral Hospital between 01 APRIL and 13 MAY; the CFR in the internal medicine ward increased from 9% in APRIL to 31% in MAY. Four healthcare workers were among the deceased. Field investigations across five local facilities identified an additional 45 community deaths, including a single-family cluster in Mongbwalu HZ with 15 deaths over two weeks, 5 of whom died in Bunia; all reportedly presented with fever, headache, and vomiting. Ituri Province is currently managing an ongoing conflict between rival militia groups, exacerbating the humanitarian situation and leaving health facilities overwhelmed or non-functional in parts of the province. Poor road access, remote settlements, and limited health infrastructure are delaying contact tracing efforts and treatment. (Actualite.cd, the BMJ, Daily Sabah, Reuters, *Travel Med Infect Dis*, U.S. CDC, WHO)

DIAGNOSTICS AND MEDICAL COUNTERMEASURES: On 15 MAY, Africa CDC arranged an urgent high-level coordination meeting with officials from the DRC, South Sudan, Uganda, and international partners to strengthen cross-border surveillance, preparedness, and outbreak response measures. Several factors are amplifying transmission risks, including 1) the co-occurrence of a highly mobile mining population in Mongbwalu HZ, 2) dense urban settings and population movement in Bunia and Rwampara HZ, 3) porous borders with Uganda and South Sudan, and 4) significant gaps in infection prevention and control (IPC) and surveillance. Facility assessments in the early response phase documented major IPC deficiencies, with a lack of compliant isolation spaces and organized triages, limited testing kits, and untrained staff for epidemic-prone diseases among the primary concerns. On 15 MAY, WHO released \$500k from the Contingency Fund for Emergencies to support the response; **a public health emergency of international concern has been declared.** Response measures include 1) deployment of rapid response teams, 2) delivery of medical supplies, 3) strengthened surveillance, laboratory confirmation, infection prevention and control assessments, 4) the set-up of safe treatment centers, and 5) community engagement. WHO is also supporting the coordination of the response, case management, and cross-border preparedness. As of 17 MAY, U.S. CDC Country Offices in the DRC and Uganda have been coordinating across the U.S. Government,

MOHs, and international partners to support response operations, including surveillance, laboratory diagnostics, IPC, and other outbreak containment efforts. As of 18 MAY, three EVD treatment centers are scheduled to open in Ituri Province, DRC. **Both the Biofire FilmArray NGDS Warrior and Global Fever Special Pathogens Panels detect the following *Ebolavirus* spp.: Zaire, Reston, Sudan, Tai Forest, and Bundibugyo.** In addition, the Warrior Panel can detect the *Zaire Ebolavirus* variants Mayinga and Makona. The Instructions for Use for each Panel state that results are presumptive and consultation with DoW and local Public Health labs (Warrior Panel) or confirmatory testing with local public health labs or the U.S. CDC (GFSP) is necessary before releasing presumptive results to the ordering physician. Ultimately, the release of presumptive test results to the ordering physician before confirmation testing rests with the clinical laboratory director. In this outbreak, early laboratory testing algorithms incorrectly targeted the more prevalent *Zaire Ebolavirus* strain. This resulted in false-negative test results, which allowed the virus to spread unabated for nearly three weeks. (Actualite.cd, Biothreats Emergence, Analysis, and Communications Network [BEACON], Center for Infectious Disease Research and Policy, Eye Radio, U.S. CDC, WHO, YahooNews)

RISK ASSESSMENTS: Currently licensed vaccines and monoclonal antibody therapies target *Zaire ebolavirus*; medical countermeasures for non-Zaire species (for example, Bundibugyo or Sudan viruses) remain limited, though several investigational vaccines are in clinical trials. The DRC maintains a strategic stockpile of ~ 2k doses of the Ervebo Ebola vaccine. Developed by Merck, Ervebo demonstrated profound efficacy during the 2018 – 2020 Zaire outbreak. However, because its antigen profile is strictly optimized for Zaire, Ervebo provides no cross-protective immunity against Bundibugyo. The vaccine has shown evidence of providing some protection against Bundibugyo in animal studies. According to GIDEON, the last outbreak in Ituri Province occurred from 2018 to 2020, with 535 cases (277 deaths) during the DRC's 10th EVD outbreak and second largest in history (3.4k cases; 3.3k confirmed; 2.2k deaths; CFR: 69%). More recently, in SEPTEMBER 2025, an EVD outbreak was reported in Bulape HZ, Kasai Province (53 confirmed cases; 45 deaths). The last outbreak in Uganda occurred from 29 JAN to 04 MARCH 2025, with 14 *Sudan ebolavirus* disease cases (12 confirmed; 4 deaths). (Actualite.cd, AP News, BEACON, WHO)

TRAVEL ADVISORIES: On 18 MAY, the U.S. CDC upgraded to a “**Level 3 – Reconsider Nonessential Travel**” travel health notice for the BVD outbreak in the DRC, on 15 MAY, issued a “**Level 1 – Practice Usual Precautions**” travel health notice for the BVD outbreak in Uganda. On 17 MAY, the U.S. Department of State issued “**Level 4 - Do Not Travel**” advisories for DRC, South Sudan, and Uganda. On 18 MAY, the U.S. Embassy in Uganda issued a health alert for EVD. On 18 MAY, the U.S. CDC and Department of Homeland Security implemented enhanced travel screenings, entry restrictions, and public health measures to prevent EVD from entering the U.S. amid ongoing outbreaks in east and central Africa. Within 48 hours of the confirmed cases, the U.S. Department of State activated a comprehensive response plan, instantly mobilizing \$13 million in direct foreign assistance. According to WHO, neighboring countries sharing land borders with the DRC are considered at high risk for further spread due to population mobility, trade and travel links, and uncertainty about the transmission chains. To accurately determine the risk to the public in Ituri Province in the DRC and Uganda, a rigorous analysis of the logistical networks and major transportation corridors traversing the outbreak epicenter is mandatory. The intersection of dense population mobility and protracted humanitarian conflict greatly increases the potential for pathogen dissemination. The primary terrestrial artery is Route Nationale 27 (RN27), a 195-kilometer commercial and humanitarian corridor that links Bunia directly to Mahagi, a municipality on the border with Uganda, and connects DRC supply lines to Uganda. See Figure 3 for the main road connections with other provinces and countries from DRC. Bunia Airport has non-stop passenger flights to three destinations: Isiro and Kisangani, DRC, and Entebbe, Uganda. Goma Airport has non-stop passenger flights to three destinations: Beni and Butembo, DRC, and Addis Ababa, Ethiopia. (Bankable, European Centre for Disease Prevention and Control, FlightConnections)

Other events:

- **GLOBAL**, 11 hantavirus infection cases (9 confirmed; 2 suspected; 3 deaths) linked to MV Hondius cruise ship, as of 12 MAY
- **GLOBAL**, Study finds R_0 estimate of 2.76 for the MV Hondius cruise ship hantavirus outbreak
- **DRC**, >6.3k cholera cases (128 deaths) across 6 provinces during MAY; 15% increase compared to APR
- **MAYOTTE**, 156 malaria cases during 2026, as of 12 MAY
- **MAURITIUS**, CDC issues “**Level 2 – Practice Enhanced Precautions**” travel health notice for chikungunya in Mauritius on 14 MAY

- **NIGERIA**, 754 confirmed Lassa fever cases (190 deaths; CFR: 25%) through 02 MAY, surpassing previous 2019 peak CFR of 23% and 2020-2023 average of 18.9%
- **SIERRA LEONE**, 41 measles cases across 8 districts through APR, outbreak declared on 13 MAY
- **TUNISIA**, >100 food-borne disease cases linked to single restaurant in Nabeul, Nabeul Governorate, as of 12 MAY; salmonellosis suspected

USCENTCOM Health Events of Interest

Other events:

- **GAZA STRIP**, Hundreds of cartons of specialized pesticides for rodent control transferred into country to counter rat infestations amongst displaced individuals
- **IRAN**, Increased infectious disease risk and water-borne disease due to U.S.-Israeli conflict since 28 FEBRUARY
- **IRAQ**, 48 Crimean-Congo hemorrhagic fever (CCHF) cases (4 deaths) in Dhi Qar Governorate during 2026; 15 cases (1 death) in past week
- **PAKISTAN**, 353 dengue cases (54 confirmed) in Khyber Pakhtunkhwa Province during 2026
- **PAKISTAN**, 406 malaria cases in Landi Kotal Town, Khyber Pakhtunkhwa Province, since APRIL

USEUCOM Health Events of Interest

Lithuania – Tick-borne encephalitis (TBE):

On 11 MAY, Lithuania's National Public Health Center (NVSC) issued a warning to the public regarding substantially elevated tick activity in the country linked to an unusually mild winter and warm spring. **Health officials have observed the emergence of ticks about two to three weeks earlier than usual this year**, with warm and humid conditions creating a hospitable environment for population growth, resulting in high concentrations of ticks in forested areas, parks, and even urban green spaces. **Concomitantly, there has been a sharp increase in TBE cases, with incidence far exceeding the national average in Vilnius (southeast Lithuania; "Very High" risk of TBE according to the NVSC) and Kaunas (south-central; "High" risk of TBE and LD) counties, which contain the two most populated cities in the country; other risk areas include Panevėžys (northeast Lithuania; "Medium" risk of TBE) and Šiauliai (north-central; "Medium" risk of LD) counties.** Officials have cautioned residents and visitors engaging in outdoor activities in parks or forests to take immediate precautions, including 1) wearing light-colored clothing so ticks are more visible, tucking pant legs into socks, and wearing shirts with sleeves that are tight around the wrists, 2) using tick repellents such as DEET, picaridin, or IR3535, 3) completing thorough body checks after spending time outdoors, and 4) avoiding consumption of unpasteurized goat or cow milk. TBE vaccination is also strongly recommended and is offered by the state at no charge for residents aged 50 to 80 years. (Infoerdve)

Lithuania is among the countries with the highest TBE incidence in Europe. The primary vector of TBE in the country is *Ixodes ricinus* ticks. A 2024 study found TBE virus in 0.4% of 7.2k *I. ricinus* and 0.4% of 1.7k *Dermacentor reticulatus* ticks collected from locations throughout Lithuania from 2017 to 2019; all belonged to the European subtype, which is endemic in parts of central, eastern, and northern Europe. The CFR for this subtype ranges from 0.5 to 2%, and ≤10% of cases develop severe neurological sequelae. TBE incidence has been increasing in Europe for several years, including expansion of the geographical range to the northwest. This is likely due to improvements in awareness and diagnostic practices, changes in human behavior, and ecological and environmental factors. (*Infect Dis Now, Parasit Vectors, PLoS One*)

Other events:

- **GLOBAL**, 11 hantavirus infection cases (9 confirmed; 2 suspected; 3 deaths) linked to MV Hondius cruise ship, as of 12 MAY
- **GLOBAL**, Study finds R_0 estimate of 2.76 for the MV Hondius cruise ship hantavirus outbreak

- **ALBANIA**, 125 new HIV cases in 2025, through OCTOBER; highest since 2016
- **BELGIUM**, ~100 mpox cases during 2026; cases three times higher in APRIL than previous months
- **ESTONIA**, 152 norovirus infection and 85 rotavirus disease cases in APRIL, compared to 88 and 39 during same period, respectively
- **FRANCE**, 50 GI illness cases (1 death) among cruise ship passengers in Bordeaux, southwestern France, as of 13 MAY
- **FRANCE**, One fatal human infection with avian paramyxovirus type 1 as of 28 APRIL; suspected contact with bird droppings in forest
- **GERMANY**, Four hantavirus infection contacts being monitored in Frankfurt, Hesse State, after returning from MV Hondius cruise ship as of 11 MAY
- **ITALY**, One WNV disease case in Oristano Province as of 13 MAY
- **LATVIA**, 156 rotavirus disease cases in MARCH, more than three times the same period in 2025 (46)
- **LATVIA**, Three tularemia cases during 2026 through MARCH, compared to one during same period in 2025
- **MOLDOVA**, Eight Q fever cases since 16 APR; no epidemiological link identified between cases
- **NETHERLANDS**, 12 hospital staff members in quarantine after mishandling blood and urine of hantavirus infection case, as of 13 MAY; hospital officials state infection risk “Very Low”
- **RUSSIA**, First CCHF case in Rostov Region during 2026
- **SLOVENIA**, Study finds 93.4% tick-borne encephalitis vaccine effectiveness after three-dose series completion
- **SPAIN**, 445 measles cases (110 confirmed; 10 imported) during 2026
- **UNITED KINGDOM**, Three meningitis cases (one death) in Reading, England, as of 14 MAY
- **UKRAINE**, 63 hemorrhagic fever with renal syndrome cases through MARCH; 0 during same period in 2025

USINDOPACOM Health Events of Interest

China – Novel influenza A(H5N6):

On 08 MAY, WHO reported one fatal human infection with avian influenza A(H5N6) in Chongqing Municipality during 2026. The case was a 55-year-old female with symptom onset beginning 16 APRIL. On 23 APRIL, the case was hospitalized with severe pneumonia and subsequently died on 03 MAY. The case had previously purchased, slaughtered, and consumed poultry. Samples collected from a cutting board tested positive for influenza A(H5). Contact tracing was conducted and all close contacts tested negative and developed no symptoms. (WHO)

U.S. CDC considers A(H5N6) a “highly pathogenic avian influenza” (HPAI). WHO reported 93 total confirmed human infection with A(H5N6) cases (58 deaths; CFR:62%) in the Western Pacific Region since 2014. No influenza A(H5N6) cases were reported in 2025; however, three were reported in 2024 and six in 2023. U.S. CDC’s Influenza Risk Assessment Tool has assessed one HPAI A(H5N6) virus [A/Sichuan/06681/2021], identifying a “**Moderate**” risk of the virus having a significant public health impact if sustained human-to-human transmission occurs. (Avian Flu Diary, Canada.ca)

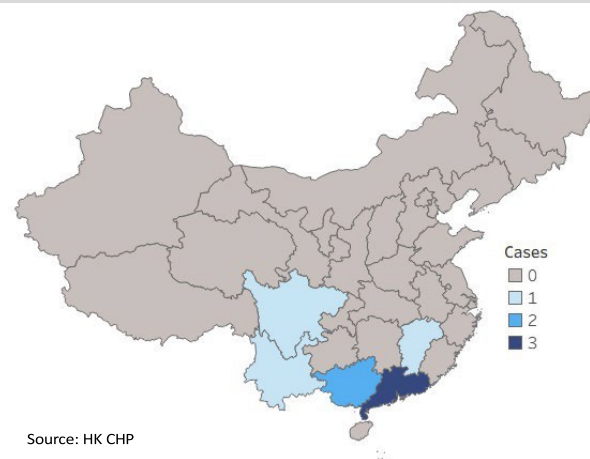
China – Novel influenza A(H9N2):

As of 15 MAY, eight (+1) human infections with avian influenza A(H9N2) have been reported in China during 2026. The most recent case is a female child from Sichuan Province with symptom onset of fever on 25 APRIL. The case was not hospitalized and clinical symptoms had resolved. The case had a history of exposure to a live poultry market prior to symptom onset. Close contacts living in the same household all tested negative for influenza. This is the first avian influenza A(H9N2) case in Sichuan Province during 2026; two cases were reported in 2025. (Hong Kong Centre for Health Protection [HK CHP], WHO)

During 2026, cases have been reported in Guangdong (three), Guangxi (two), and Jiangxi, Sichuan, and Yunnan (one each) provinces (Figure 3). A total of 161 (+1) A(H9N2) infections have been reported in China since 2015. U.S. CDC considers A(H9) a “low pathogenic avian influenza” (LPAI). LPAI A(H9N2) infections have been reported sporadically

in >100 individuals since 1998 from Bangladesh, Cambodia, China, Egypt, Ghana, Hong Kong, India, Oman, Pakistan, and Senegal. Most cases have occurred in children and have caused mild upper respiratory tract illness; however, lower respiratory tract diseases, including pneumonia and respiratory failure, have also been documented. (HK CHP, U.S. CDC, WHO)

Figure 3. 2026 Human Novel Influenza A(H9N2) Infections, China, as of 15 MAY



Japan – Tick-borne illness:

Through 03 MAY, the Japan Institute for Health Security (JIHS) reported **37 Japanese spotted fever (JSF) and 29 SFTS cases during 2026, compared to 32 and 17 cases, respectively, during the same period in 2025**. JSF cases have been reported in 18 prefectures, with the highest totals in Mie and Miyazaki (5 each), Ehime and Nagasaki (4 each), and Hiroshima, Kochi, Osaka, Saga, and Wakayama (2 each). Eleven cases were reported in the week ending 03 MAY, 30% of the 2026 total. In 2025, 674 JSF cases were reported in Japan, 33% higher than the total in 2024 (505) and 2023 (501). Cases were detected in 35 prefectures in 2025, with Mie reporting the most cases (86), followed by Hiroshima (64), and Chiba and Shimane (61 each).

SFTS cases have primarily been reported in southern prefectures, with cases in 19 out of 47 prefectures during 2026; Oita reported the highest total (4), followed by Saga and Shizuoka (3 each), and Nagasaki, Tokushima, and Yamaguchi (2 each). In the week ending 03 MAY, 11 SFTS cases were reported, 38% of total 2026 cases. In 2025, 191 SFTS cases were reported, compared 120 in 2024, and 133 in 2023; SFTS cases in 2025 were 43% higher than the previous high of 133 cases in 2023. In 2025, SFTS cases were reported primarily in western Japan; however, cases were reported in eastern prefectures for the first time, including Hokkaido, Ibaraki, Kanagawa, and Tochigi. This suggests both a geographic expansion into new prefectures beyond the traditional endemic regions in central and western Japan and growing ecological suitability. **Officials from JIHS have attributed the increase to intensifying transmission dynamics exacerbated by ecological factors, including 1) climate-related changes in tick habitat suitability, 2) geographically expanding tick populations, and 3) increased human-tick contact via outdoor recreational activities.** (BEACON, JIHS)

JSF is a spotted fever group rickettsiosis caused by *Rickettsia japonica*. The disease is spread via the bite of infected mites and ticks. *R. japonica* in Japan is primarily transmitted by *Haemaphysalis cornigera*, *H. formosensis*, and *H. hystricis* ticks. JSF cases have been increasing, and case totals have been >300 since 2017. JSF has been primarily found in southern and western Japan, but cases have been spreading to additional regions. **Recent environmental changes, including climate change and globalization, have contributed to the expansion of ticks into new geographical areas.** According to GIDEON, Japan averaged 408 JSF cases from 2019 to 2021; 486 JSF cases were reported in 2021, 420 in 2020, and 318 in 2019. (*Emerg Infect Dis*, Heliyon)

SFTS virus is primarily transmitted via the bite of infected ticks, predominantly *H. longicornis* ticks. In Japan, several other tick species, including *H. flava*, *H. formosensis*, *H. hystricis*, *H. kitaokai*, and *H. megaspinosus*, carry the SFTS virus genome or are implicated as potential vectors. Peak transmission typically occurs in the warmer spring and

summer months, coinciding with the seasonal life cycle of the vectors and increased outdoor activity. SFTS was first detected in Japan in 2013 (40 cases), and its incidence has since increased. According to GIDEON, Japan averaged 102 SFTS cases from 2020 to 2022. Although rare, person-to-person transmission can also occur via exposure to the blood or respiratory secretions of an infected individual. The first domestic human-to-human transmission in Japan was reported on 20 MARCH 2024 in an emergency department physician who cared for a 90-year-old male patient. The physician had performed an initial physical examination without gloves and later removed the patient's indwelling central venous catheter post-mortem while wearing a surgical mask, gown, and gloves, but no eye protection. In JUNE 2025, nosocomial SFTS transmission was documented in a cluster of cases in the Republic of Korea, highlighting the importance of prevention and control measures. (BEACON, CDC, *Emerg Infect Dis*, Flu Trackers, National Centre for Infectious Diseases)

Sri Lanka – Dengue:

As of 11 MAY 2026, Sri Lanka's National Dengue Control Unit has reported **27,754 (+21k since IB's last report on 10 FEB)** dengue cases (**14 deaths**) during 2026, a **43%** increase compared to the same period in 2025 (**19k cases**). Cases have been reported across all 25 districts, with the highest number of cases in the Western Province, while Galle, Kalutara, Kandy, Matara, and Ratnapura districts have also reported a significant number of cases during 2026. As of 02 MAY, a high number of cases were also reported in Colombo and Gampaha districts. The cluster of cases in these districts highlights ongoing vulnerability in densely populated urban regions due to frequent human movement and limited vector control. Additionally, Colombo is a major international transportation hub, with direct flights from cities worldwide (for example, Australia, Singapore, the United Kingdom), increasing disease transmission risk to other regions, domestically and internationally. The increasing number of cases indicates sustained high transmission intensity. As of 15 MAY, Sri Lanka has been experiencing flooding and severe weather in the Central, Northern, North-Western, Sabaragamuwa, and Western provinces, as well as Anuradhapura, Galle, and Matara districts. Health officials indicate that mosquito breeding has increased particularly around schools, workplaces, religious institutions, and government and private institutions compared to households. Improper waste disposal was identified as a key contributing factor to dengue transmission. Early detection and appropriate supportive care remain the primary interventions for reducing mortality due to lack of specific antiviral treatments and limited vaccine accessibility in the country. (BEACON, EPID, Lankaweb, Outbreak News Today, Relief Web)

Despite dengue cases remaining below the 2017 epidemic peak (>186k cases) in Sri Lanka, there has been an increasing trend in incidence, with 2018, 2019, 2022, and 2025 each recording >50k cases. As of 12 MAY, the U.S. CDC identified Sri Lanka with "frequent or continuous" dengue risk. A 2024 study revealed that all four dengue serotypes co-circulated from 2000 to 2020; however, a shift in predominant serotype is observed annually and by region. On 11 JUNE 2025, Sri Lanka's Red Cross Society launched the first simplified early action protocol for dengue to provide support across five high-risk districts, including Colombo, Gampaha, Jaffna, Kalutara, and Kandy. Currently, the dengue vaccine is not included in Sri Lanka's National Immunization Program; however, the country has participated in clinical trials of the tetravalent live-attenuated dengue vaccine TAK-003 (Qdenga). (BEACON, CDC, IJID Regions, Outbreak News Today)

Other events:

- **GLOBAL**, 11 hantavirus infection cases (9 confirmed; 2 suspected; 3 deaths) linked to MV Hondius cruise ship, as of 12 MAY
- **GLOBAL**, Study finds R_0 estimate of 2.76 for the MV Hondius cruise ship hantavirus outbreak
- **BANGLADESH**, 55k measles cases (>400 deaths) in past 2 months
- **CHINA**, 279 dengue cases during 2026 through MARCH, compared to 138 during same period in 2025
- **FEDERATED STATES OF MICRONESIA**, Ongoing GI illness in Chuuk State following typhoon Sinlaku as of 12 MAY; one cholera case (non-epidemic strain) identified on 23 APRIL
- **HONG KONG**, First rat hepatitis E virus infection during 2026 on 05 MAY
- **JAPAN**, 627 enterohemorrhagic *E. coli* infection, 69 hepatitis A, and 28 shigellosis cases during 2026, compared 419, 47, and 16 during same period in 2025, respectively
- **MACAU**, 38% mosquito breeding container index in APRIL, leading to increased dengue risk; 153% increase compared to same period in 2025

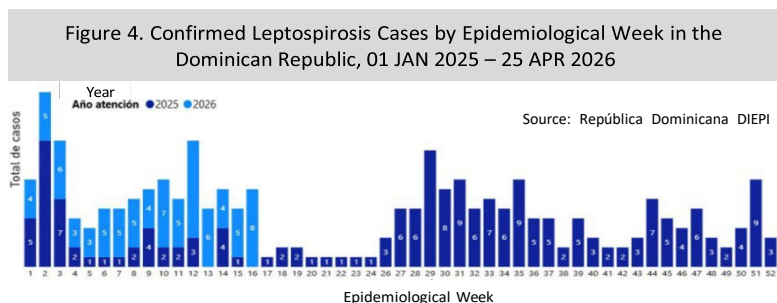
- **MALAYSIA**, Three suspected leptospirosis cases among visitors to Ulu Bendul Recreational Park in Kuala Pilah, Negri Sembilan State, as of 12 MAY; park closed until 17 MAY
- **MONGOLIA**, Seven meningococcal disease cases (three deaths) in northern and western regions as of 06 APRIL
- **NEW CALEDONIA**, Increasing dengue cases (>1.5k) during 2026; driven by local transmission
- **SRI LANKA**, 45 – 50 suspected meningitis cases (5 confirmed enterovirus meningitis) over a two- to three-week period, as of 12 MAY; primarily among adolescents aged 14 – 15 years
- **TAIWAN**, 59 dengue cases during 2026
- **UZBEKISTAN**, 174 meningitis cases (168 among children aged <14 years) from JANUARY – MARCH
- **WALLIS AND FUTUNA**, 14 locally acquired dengue cases on Futuna since 22 APRIL

USSOUTHCOM Health Events of Interest

Dominican Republic (DR) – Leptospirosis:

As of 25 APR, the DR's Ministry of Public Health reported 140 leptospirosis cases (85 confirmed; five deaths) during 2026, a 77% increase in confirmed cases compared to the same period in 2025 (48 cases; Figure 4). The cumulative incidence rate in suspected cases is 4.13 per 100k individuals. Cases have been reported across 25 provinces during 2026, with most cases from Santo Domingo Province (17 suspected cases; 11 confirmed), followed by Santiago (13; 9), Espaillat (10; 10), Monte Cristo (10; 2), Peravia (10; 7), and La Vega (9; 6) provinces. Health officials are attributing the increase in cases to persistent, erratic rainfall and flooding, particularly affecting Duarte, Espaillat, the National District, Puerto Plata, Samaná, San Jaun, Santo Domingo, and Valverde provinces. Health officials issued an urgent public health warning, emphasizing the importance of avoiding stagnant water, improving household hygiene, controlling rodents, and seeking immediate medical attention for symptoms such as headache, high fever, jaundice, muscle pain, and vomiting. **The impacted provinces include both densely populated urban areas and agricultural regions, suggesting that exposure pathways encompass urban flooding and occupational risks in rural settings. The current 2026 trajectory suggests the potential for a higher annual total if environmental conditions remain favorable for transmission.** (BEACON, República Dominicana Dirección de Epidemiología [DIEPI])

The first leptospirosis outbreak (~2.3k cases) in the DR was reported from NOVEMBER to DECEMBER 2007 and was linked to Tropical Storm Noel. Since then, the country has experienced recurring outbreaks following tropical storms and hurricanes, and 305 total cases were reported in 2021, 334 in 2022, 585 in 2023, 578 in 2024, and 549 in 2025. The true burden of disease is unknown due to limited diagnostic capacity and under-reporting. (*Int J Infect Dis*, *PLoS Negl Trop Dis*, República Dominicana Dirección de Epidemiología)



Venezuela – Chikungunya:

Through 11 APRIL, 21 chikungunya cases (3 confirmed) have been reported in Venezuela during 2026. Suspected cases have been reported in Aragua State (17) and Capital District (4). All three confirmed cases have been reported from Libertador Municipality, Capital District, in Sucre (two) and San Agustín (one) parishes. Suspected cases during 2026 represent a 17% increase compared to the same period in 2025 (18). There was one confirmed case in 2025, in Ayacucho Parish, Sucre Municipality, Sucre State, but it occurred towards the end of the year (from EW 49, ending 06 DEC 2025). No deaths due to chikungunya have been reported in 2025 or during 2026. (Venezuela MOH)

The first official imported chikungunya case in Venezuela was reported in JUNE 2014, with local transmission quickly following in JULY 2014. Phylogenetic characterization of early locally acquired cases confirmed presence of the Asian genotype. Chikungunya has been considered endemic in Venezuela since 2014, but the country had not released official data since the same year. Venezuela also had not reported chikungunya cases to PAHO since EW 21 2023 (ending 27 MAY 2023), when 173 cases (12 confirmed) were reported for the year. There were 189 cases (3 confirmed) in 2022, 57 (0) in 2021, 67 (2) in 2020, 180 (9) in 2019, and 295 (11) in 2018. (*Acta Trop*, eldiario, *Emerg Infect Dis*)

Other events:

- **GLOBAL**, 11 hantavirus infection cases (9 confirmed; 2 suspected; 3 deaths) linked to MV Hondius cruise ship, as of 12 MAY
- **GLOBAL**, Study finds R_0 estimate of 2.76 for the MV Hondius cruise ship hantavirus outbreak
- **ARGENTINA**, 172 meningitis cases during 2025, exceeding median for last three years (152)
- **ARGENTINA**, 22k dengue cases (54 confirmed) since 27 JULY 2025; circulation is currently “Low” nationwide
- **ARGENTINA**, Two confirmed St. Louis encephalitis cases since 27 JULY 2025 in Buenos Aires Province
- **BOLIVIA**, >11k confirmed chikungunya cases (35 deaths) in Santa Cruz Department during 2026
- **BOLIVIA**, >45k dengue cases (1 death) as of 25 APRIL, surpassing 2025 total (>38k)
- **BRAZIL**, >8.2k dengue cases (>1k confirmed; 1 death) in Londrina Municipality, Paraná State, during 2026
- **BRAZIL**, Nine yellow fever cases in São Paulo State during 2026
- **CUBA**, Country denies hepatitis A outbreak despite 18 cases in Matanzas and 30 – 40 cases daily in Camagüey in APRIL
- **CHILE**, 24 dengue cases (22 locally acquired) in Rapa Nui as of 13 MAY
- **GUATEMALA**, >13k measles cases (>6k confirmed; 10 deaths) since 09 JAN
- **PERU**, Health emergency declared due to increase in pertussis and other respiratory illness cases in Loreto Department on 13 MAY