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PUBLIC HEALTH

ARMED FORCES HEALTH SURVEILLANCE DIVISION

INTEGRATED BIOSURVEILLANCE BRANCH

Health Surveillance Update
26 MAY 2026

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DHA Public Health
AFHSD – Integrated Biosurveillance (IB) Branch
Health Surveillance Update
20–26 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

During 2026, the **United States** has reported 737 dengue cases across 26 jurisdictions. Three multistate salmonellosis outbreaks (184 cases, 1 death) have occurred across 31 states in the **U.S.** since 17 JAN, linked to backyard poultry. As of 26 MAY, the **Democratic Republic of the Congo** has reported 105 confirmed Ebola virus disease (EVD) cases (906 suspected, 223 deaths [10 confirmed]) across 3 provinces; **Uganda** has reported 7 confirmed EVD cases (1 confirmed death). The **Kingdom of Saudi Arabia** has reported two Middle East respiratory syndrome case since MARCH. **Latvia** has recorded eight leptospirosis cases through MARCH, a fourfold increase compared to the same period in 2025. **Japan** has reported 479 measles cases during 2026, 4 times higher than the same period in 2025. The **Republic of Korea** has reported >19k carbapenem-resistant Enterobacteriaceae infections during 2026, a 10% increase compared to the same period in 2025.

HSU Health Events

Geographic Combatant Command	Country	Event
USNORTHCOM	*United States	Dengue
	*United States	Salmonellosis
	Other events	
USAFRICOM	USAFRICOM	Ebola virus disease
	Other events	
USCENTCOM	*Kingdom of Saudi Arabia	Middle East respiratory syndrome
	Other events	
USEUCOM	Latvia	Leptospirosis
	Other events	
USINDOPACOM	China	Novel influenza A(H9N2)
	India	Novel influenza A(H5N1)
	*Japan	Measles
	*Japan	Tick-borne illness
	*Republic of Korea	Carbapenem-resistant Enterobacteriaceae
	Sri Lanka	Dengue
	Other events	
USSOUTHCOM	Other events	--

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USNORTHCOM Health Events of Interest

*United States – Dengue:

Through 13 MAY, the U.S. Centers for Disease Control and Prevention (CDC) has reported 737 confirmed **dengue** cases in 26 U.S. jurisdictions during 2026. Of these, 631 cases have been locally acquired, including from Puerto Rico (514 cases) and American Samoa (117). In 2025, a total of 5.3k dengue cases were reported, including locally acquired cases from 3 states in the continental U.S. (Florida [60], California [6], and Arizona [1]) as well as Puerto Rico (3, 365), American Samoa (552), the U.S. Virgin Islands (47), and the Northern Mariana Islands (1).

In 2024, a record-breaking 3.8k dengue cases were recorded in the 50 U.S. states and the District of Columbia, a 359% increase from the annual average of 828 cases recorded from 2010 to 2023. Most of these cases (97%) were associated with travel, with infections most commonly acquired in the Caribbean (including Puerto Rico and U.S. Virgin Islands; 34%), North America (Mexico and the United States; 24%), and Central America (16%); Hispanic or Latino individuals accounted for 58% of all cases. The remaining 3% of cases were locally acquired, from Florida (87), California (18), and Texas (2). Dengue virus (DENV)-3 was the most reported serotype in the United States in 2024, accounting for 55% of the 1.2k cases with known serotypes. (Morbidity and Mortality Weekly Report)

Frequent or continuous dengue virus transmission is limited to six U.S. territories and freely associated states (American Samoa, the Federated States of Micronesia, the Marshall Islands, Palau, Puerto Rico, and U.S. Virgin Islands). Spring and summer travel coincides with peak dengue season in many countries, increasing the risk of imported and locally acquired cases in the United States. As of 18 MAY, the U.S. CDC has issued "Level 1 – Practice Usual Precautions" travel health notices for Bolivia, Colombia, Cook Islands, Guyana, Maldives, Mali, New Caledonia, Samoa, Timor-Leste, Tonga, and Vietnam.

*U.S. – Salmonellosis:

Three multistate **salmonellosis** outbreak have been reported in the United States, linked to backyard poultry, particularly chickens and ducks. As of 14 MAY, 184 (+150 since IB's last report on 12 MAY) cases (28% are children aged <5 years; 53 hospitalizations; 1 death) have been reported across 31 (+18; Figure 1), with most from Kentucky (22), followed by Michigan (21), Wisconsin (17), Ohio (15), and Idaho, Indiana, and Maine (10 each). Symptom onset dates range from 17 JAN to 20 APRIL (Figure 2). **Of the 141 individuals interviewed, 78% reported contact with backyard poultry, and traceback data showed that 87% of the 70 poultry owners acquired poultry since 01 JAN across various locations, including agricultural retail stores.** The outbreaks involve multiple strains, with

Figure 1. Salmonellosis Outbreak Linked to Backyard Poultry, U.S., as of 04 MAY

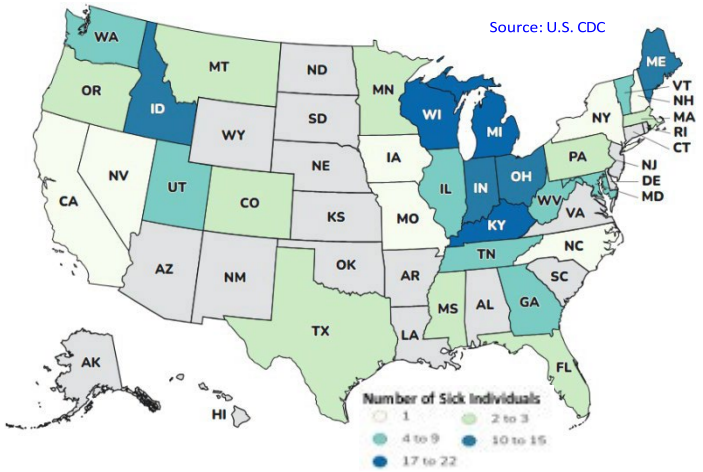
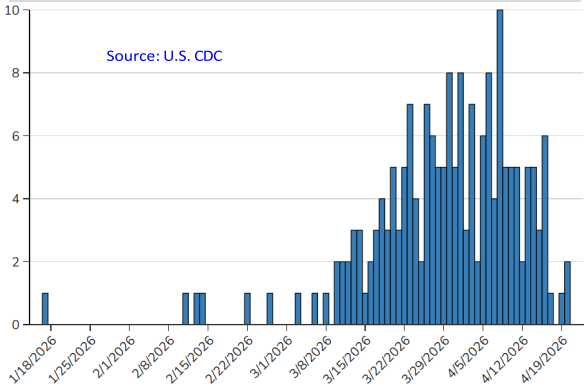


Figure 2. Symptom Onset of Salmonellosis Cases Linked to Backyard Poultry, U.S., 18 JAN – 20 APRIL



Salmonella Saintpaul being the dominant serotype (133 cases), followed by *S.* Enteritidis (32) and *S.* Mbandaka (19). Out of 65 *S.* Saintpaul cases with exposure information available, 78% reported contact with chickens and 54% reported contact with ducks. *S.* Saintpaul cases have been associated with Pekin ducks, suggesting a strain-specific reservoir or husbandry practice at the hatchery level, which permits targeted investigations. Cases have been traced back to five hatcheries who supply birds to retailers. According to the U.S. CDC, **due to the nature of the illness, the true number of cases linked to the outbreak may be higher than reported because many individuals recover without medical care and are not tested for Salmonellosis.** To minimize the risk of transmission, the U.S. CDC recommends 1) washing hands immediately after contact with backyard poultry, 2) avoiding direct mouth contact with animals or eating and drinking in the same vicinity, 3) supervising children around flocks, 4) handling eggs safely and evaluating for cracks prior to use, and 5) storing supplies such as feed containers and shoes worn in the coop outside houses. Historically, outbreaks linked to backyard poultry have followed the "chick season" cycle. Cases usually start increasing in late spring and peak between JUNE and AUGUST, when juvenile birds mature and shedding remains high in domestic environments. (Biothreats Emergence, Analysis, and Communications Network [BEACON], *Front Public Health*, U.S. CDC)

In 2025, 559 salmonellosis cases (125 hospitalizations; 2 deaths) were reported across 48 U.S. states linked to backyard poultry. Laboratory testing confirmed *Salmonella* Anatum, Cerro, Enteritidis, Indiana, Johannesburg, London, Mbandaka, and Thompson. Of the 385 cases with information about animal contact, 69% reported contact with backyard poultry prior to illness onset. ***S.* Saintpaul ranks as one of the top 10 most frequently detected *Salmonella* serovars in humans and animals globally, accounting for ~1.6% of severe salmonellosis cases.** In the U.S., SSa has caused notable outbreaks in 2008, 2009, and 2013, linked to alfalfa sprouts, contaminated peppers, and cucumbers. Symptoms of salmonellosis typically include diarrhea, fever, and stomach cramps, usually appearing within six hours to six days of exposure; individuals typically recover without treatment within one week. (U.S. CDC, *Genes*)

Other events:

- *__MEXICO__, 14 confirmed New World screwworm disease cases in cattle in Coahuila State; first detection in San Juan de Sabinas Municipality
- *__U.S.__, 17 murine typhus cases (2 deaths) in Louisiana since the start of 2025, majority in Acadiana area, compared to 21 cases total from 2010 to 2024; likely underreported
- *__U.S.__, 77 rattlesnake bite cases (3 deaths) in California during 2026; increase attributed to spring heat wave
- *__U.S.__, California officials warn of mushroom poisoning outbreak (47 cases; 4 deaths) since NOVEMBER 2025; compared to <5 cases reported annually
- *__U.S.__, CDC issues updated guidance for investigating locally acquired malaria
- *__U.S.__, Cluster of *Brucella melitensis* infection cases among adults in Los Angeles County, California, as of 21 MAY, following consumption of unpasteurized cheese from Mexico

- *U.S., First human West Nile virus (WNV) disease case in Texas during 2026 in Harris County as of 19 MAY
- *U.S., First WNV detection during 2026 in dead bird in Fresno County, California; no human infections as of 18 MAY
- *U.S., One confirmed fatal hantavirus infection case in Douglas County, Colorado, as of 16 MAY; unrelated to MV Hondius cruise ship
- *U.S., One confirmed hantavirus infection case in Chelan County, Washington, as of 15 MAY; unrelated to MV Hondius cruise ship
- *U.S., Food and Drug Administration investigating salmonellosis outbreak (16 cases; *S.* Typhimurium) as of 20 MAY; source not yet identified

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). **According to the U.S. CDC, as of 1000 EST on 26 MAY, 105 (+94) confirmed cases (906 suspected; 10 confirmed deaths; 223 suspected deaths) have been reported across at least 12 HZs, including Aru, Bambu, Bunia, Butembo, Goma, Katwa, Kilo, Miti-Murhesa, Mongbwalu, Nizi, Nyankunde, and Rwampara.** (Table 1; data as of 24 MAY at 1300 EST). 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 3 for the geographical location of the current and last EVD outbreak in the DRC. According to the World Health Organization (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**

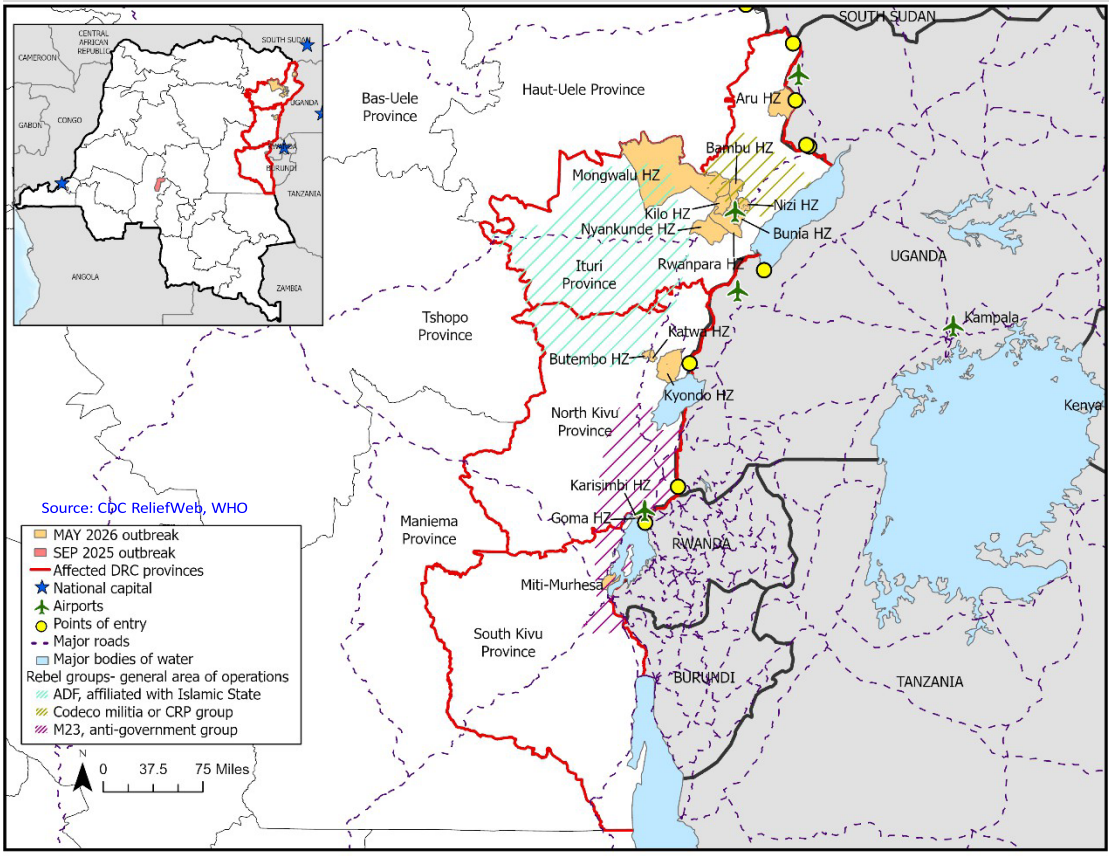
Table 1. 2026 EVD Outbreak Case Counts by Country, as of 24 MAY at 1300 EST

Country	Province	Health Zone	Confirmed Cases	Suspected Cases	Suspected Deaths	Contacts
DRC	Ituri	Aru	1	4	1	0
	Ituri	Bambu	0	6	2	183
	Ituri	Bunia	24	249	48	404
	Ituri	Kilo	1	8	0	0
	Ituri	Mongbwalu	19	339	88	222
	Ituri	Nizi	2	6	2	22
	Ituri	Nyankunde	9	45	11	365
	Ituri	Rwanpala	32	228	69	621
	Ituri	¥	6	0	0	0
	North Kivu	Butembo	1	7	0	22
	North Kivu	Goma	1	0	0	28
	North Kivu	Katwa	4	13	0	99
	North Kivu	Karisimbi	0	0	0	249
	North Kivu	Kyondo	0	0	0	16
	South Kivu	Miti-Murhesa	1	1	0	-
Uganda			7	0	1	0

Sources: CDC, DRC MOH
¥ Samples without a label

(BVD) in eight out of 13 samples from Rwampara HZ (five inconclusive). As of 24 MAY, 2,231 contacts 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. As of 20 MAY, **the six exposed Americans have been evacuated to Germany**, and one American doctor (surgery resident at the University of Kentucky) is being treated at Charite University Hospital in Berlin, where he has received an infusion of monoclonal antibodies. The Charite's isolation unit is the largest of its kind in Germany, and the only one that combines infectious disease treatment with intensive care. This self-contained unit can isolate up to 20 patients, without disrupting normal hospital operations. Another American medical missionary was also exposed while treating patients in the DRC has been evacuated to Bulovka University Hospital in Prague, Czech Republic. On 21 MAY, one confirmed fatal EVD case was reported in Miti-Murhesa HZ, South Kivu Province, DRC, >100 km from the outbreak epicenter and on the outskirts of Bukavu City. The case had travelled from Kisangani City, Tshopo Province, and was buried safely. **One additional suspected EVD case has been reported in South Kivu Province and is currently in isolation pending laboratory results.** These new cases suggest the potential presence of undetected transmission chains and unreported cases in Tshopo Province. Bukavu is a densely populated urban center with a population of ~1.5 million individuals, significantly increasing the risk of further transmission, particularly along the major Bukavu–Goma transport corridor characterized by high population mobility and trade movements. **The DRC national soccer team has relocated its pre-FIFA World Cup training camp to Belgium to isolate for 21 days amid the Ebola outbreak**. The DRC team will play in friendlies against Denmark in Liege, Belgium, on 03 JUNE and Chile in Cadiz, Spain, on 09 JUNE. DRC's opening World Cup game is on 17 JUNE against Portugal in Houston, Texas, U.S., followed by Colombia in Guadalajara, Mexico, on 23 JUNE and Uzbekistan in Atlanta, GA, U.S., on 27 JUNE. The U.S. CDC is supporting interagency partners

Figure 3. Geographical Location of the 2025 and 2026 EVD Outbreaks, as of 24 MAY



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 APRIL, 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. Delayed laboratory confirmation, including transport of samples ~1.7k km to Kinshasa for testing, highlights diagnostic and surveillance shortfalls in conflict-affected areas of Ituri Province, suggesting that the true burden may be underestimated. According to initial sequencing analysis, the outbreak was caused by a new zoonotic spillover followed by sustained human-to-human transmission. Preliminary analysis revealed genetic similarity to Bundibugyo virus strains previously identified in the 2007 (Uganda) and 2012 (DRC) outbreaks. On 19 MAY, researchers from the Imperial College London, United Kingdom, using modeling techniques, estimated that cases could exceed >1k. (ACAPS, BBC, Biothreats Emergence, Analysis, and Communications Network [BEACON], CBS, CIDRAP, DRC MOH, DW, Imperial, New York Times, Reuters, ReliefWeb, TVP World, Virological, YahooNews)

SOUTH SUDAN CASE REPORT: On 19 MAY, South Sudan reported one suspected EVD case in Yambio County, Western Equatoria State, which borders Haut-Uele Province, DRC. The case was announced on 18 MAY when a patient was positive for Ebola in preliminary tests. Further test results of the samples are pending confirmation at the central laboratory of Public Health South Sudan. Additionally, samples have been sent to other countries for testing. Surveillance and preparedness measures have been intensified, particularly in areas near the border with the DRC. As of 22 MAY, WHO has investigated and disproved rumors of a suspected EVD case in Yambio County. (Infobae, Relief Web)

UGANDA CASE REPORT: As of 26 MAY, seven confirmed EVD cases (one confirmed death) have been reported in Uganda; five cases are epidemiologically linked to the first two confirmed cases. 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 Wandegeya, 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. On May 21, the second Congolese national recorded two consecutive negative test results from blood samples taken at least 48 hours apart. 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. As of 19 MAY, >100 individuals, including health workers, have been isolated and are under monitoring following close contact with first case; none have tested positive. On 20 MAY, three suspected EVD cases were reported at Mubende Regional Referral Hospital; samples from the suspected cases in Hoima, Kukuube, and Msindi districts have tested negative. All hospital entry points have been temporarily closed, except one which is being used for strict screening of all attendants, patients, and staff upon entering. On 23 MAY, three additional confirmed EVD cases were reported in Uganda, including a driver who transported the country's first confirmed patient, and a health care worker exposed while caring for the patient. Both cases are receiving treatment. The fifth case was a female from the DRC who entered Uganda with milk abdominal symptoms and later travelled to Arua, close to the border, to Entebbe before seeking care in Kampala. The case initially improved and returned to the DRC before testing positive for EVD in a follow-up. All close contacts linked to the confirmed cases are being closely monitored. On 25 MAY, the sixth and seventh confirmed EVD cases were reported in Uganda; both are healthcare workers and have been admitted and receiving care in a private health facility in Kampala. On 25 MAY, two aid workers returning from Uganda were transferred to Milan's Sacco hospital in Italy, and tested negative for EVD. (24 Italy, All Africa, Aljazeera, U.S. CDC, Monitor, NTV Reuters, WHO, X)

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. On 20 MAY, Zambia activated health screening measures at all entry points bordering the DRC. (Lusaka Times, Xinhua)

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**. On 22 MAY, the Diagnostics Advisory Committee produced a list of real-time PCT tests for BVD that have either received regulatory approval or have been validated and are currently in use in the ongoing outbreak response. 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 (GI) 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 5 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, Africa CDC, the BMJ, Daily Sabah, Reuters, *Travel Med Infect Dis*, U.S. CDC, WHO)

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 SEP 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 MAR 2025, with 14 *Sudan ebolavirus* disease cases (12 confirmed; 4 deaths). (WHO)

DIAGNOSTICS AND MEDICAL COUNTERMEASURES: On 19 MAY, U.S. CDC issued a Health Alert Network advisory for Ebola virus disease outbreak in the DRC and Uganda. 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 infection prevention and control (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. Safe burial is an essential part of the response; however, friends and family

members have perpetrated violence against an isolation center when prevented from taking a body for burial. As of 19 MAY, the Bunia-Mongbwalu road axis (86 km) is currently operational, with an estimated travel time of two hours; however, access is weakened by the collapse of the main bridge at Iga Barrière, just north of Bunia. Additionally, air access to Mongbwalu is highly constrained. The airstrip is unusable, and the former helicopter landing site is no longer operational. A new helipad has been identified and cleared for use by authorities. On 19 MAY, the United States announced funding for up to 50 treatment clinics, and associated frontline costs are being established in EVD-affected regions of the DRC and Uganda. On 19 MAY, UNICEF in Bunia received 16 tons of relief supplies, including disinfectants, personal protective equipment, purification tablets, soaps, and water tanks. As of 20 MAY, an additional $3.4 million was approved from the WHO Contingency Fund for Emergencies. More than 40 international experts were deployed to support outbreak response activities and ~12 tons of personal protective equipment and outbreak response materials were transported from Kinshasa, DRC, and Nairobi, Kenya. Health officials in Walikale Territory, North Kivu Province, implemented enhanced screening and community awareness measures at checkpoints and border access points connected to Ituri Province. As of 21 MAY, Uganda has suspended flights, border transports, and weekly markets in high-risk districts, and has implemented enhanced screening, testing, and treatment capacity along the border with the 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 DoD and local Public Health labs (Warrior Panel) or confirmatory testing with local public health labs or the U.S. CDC (GFSPP) 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. On 21 MAY, the Pan American Health Organization released an epidemiological alert due to the outbreak, sharing guidance to support its member states in laboratory preparedness, IPC measures, and clinical management. (Actualite.cd, AllAfrica, BBC, BEACON, Center for Infectious Disease Research and Policy, Eye Radio, Reflector, Relief Web, U.S. CDC, U.S. Department of State, WHO, YahooNews)

The identification of a non-Zaire Ebola strain is operationally critical, as 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 approximately 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. As of 20 MAY, there are two potential vaccine candidates against the Bundibugyo virus. One candidate will not be available for six to nine months, and the second, developed by Oxford University using the same platform as AstraZeneca's COVID-19 injections, could be available in two to three months; however, it is uncertain due to limited data from animal efficacy tests. (AP News, BBC, BEACON, The Guardian)

RISK ASSESSMENTS: On 22 MAY, **WHO reassessed the overall public health risk posed by the current outbreak as "Very High" at the national level, "High" for Uganda, "High" at the regional level, and "Low" at the global level.** On 21 MAY, ECDC assessed the risk to the general population in Europe from the current Ebola outbreak to be "Very Low." On 23 MAY, Africa CDC listed 10 countries "at risk" in the current outbreak, including Angola, Burundi, the Central African Republic, the Republic of Congo, Ethiopia, Kenya, Rwanda, South Sudan, Tanzania, and Zambia. (AA)

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, and 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. As of 21 MAY, U.S. citizens, nationals, and permanent residents who have been in the DRC, Uganda, or South Sudan within 21 days are being redirected to Washington-Dulles International Airport, Virginia (starting 20 MAY), Hartsfield-Jackson Atlanta International Airport, Georgia (starting 22 MAY), and George Bush Intercontinental Airport, Texas (starting 26 MAY) upon their return to the United States for enhanced screening. On 22 MAY, Uganda announced temporary suspension of flights to and from the DRC. 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. On 23 MAY, the DRC suspended all flights to and from Bunia until further notice, except for humanitarian, health, and emergency operations authorized by the aeronautical and health authorities. Goma Airport has non-stop passenger flights to three destinations: Beni and Butembo, DRC, and Addis Ababa, Ethiopia. (Bankable, BEACON, CDC, European Centre for Disease Prevention and Control [ECDC], FlightConnections, Independent)

Other events:

- **ANGOLA**, Surge in cholera (3,146 cases; 62 deaths) during 2026 across 18 provinces
- ***DRC**, >2.3k bacterial meningitis cases (151 deaths) during 2026 across 4 provinces
- **MADAGASCAR**, >2.7k mpox cases (1.6k confirmed; 6 deaths) since DEC 2025
- **MALAWI**, Rift Valley fever outbreak among animals (81 cases) in the Thumbwe Extension Planning Area; no human cases as of 17 MAY
- **MAURITIUS**, >3.3k chikungunya cases since 30 MAR, primarily in densely populated urban areas
- **NIGERIA**, >1.5k suspected cholera cases (21 deaths) across 142 settlements as of 17 MAY
- ***SENEGAL**, 60 confirmed dengue and 101 measles cases during 2026
- **SOMALIA**, 1,206 cholera cases (35 confirmed; no deaths) during 2026
- ***TUNISIA**, 31st country to eliminate trachoma as of 14 MAY
- **USAFRICOM**, 2026 study finds Africa accounts for disproportionate antimicrobial resistance burden globally

USCENTCOM Health Events of Interest

*Kingdom of Saudi Arabia (KSA) – Middle East respiratory syndrome (MERS):

As of 25 MAY, **WHO Eastern Mediterranean Region Office (EMRO) reported two MERS cases in the KSA during 2026.** The first case occurred on 15 MAR in a male who was not a healthcare worker and survived. On 19 APRIL, WHO reported a second MERS case in a male who was not a healthcare worker and died. Since 2012, 2,225 MERS cases (868 deaths; CFR: 39%) have been reported from the KSA. See Table 2 for MERS cases by year from 2020 to MARCH 2026. In 2025, cases were reported from Eastern, Hail, Makkah, Najran, and Riyadh regions. See Figure 4 for maps of confirmed MERS cases in the KSA from 2020 to 2025 with probable region of infection and route of exposure. (WHO)

The epidemiological outlook for Middle East respiratory syndrome coronavirus (MERS-CoV) in the KSA is characterized by continued endemic circulation in dromedary camels, leading to sporadic zoonotic spillovers and occasional, highly localized healthcare-associated clusters. (WHO)

Figure 4. MERS Cases in the KSA by Year and Probable Region of Infection, 2020 to 2025

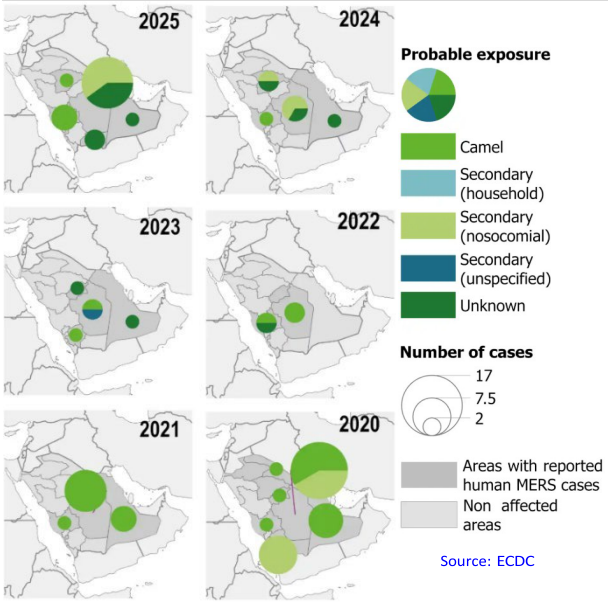


Table 2. KSA MERS Cases, 2020–2026*

Year	Cases
2026*	2
2025	17
2024	8
2023	5
2022	5
2021	18
2020	59

*Through MAR; Source: WHO

Other events:

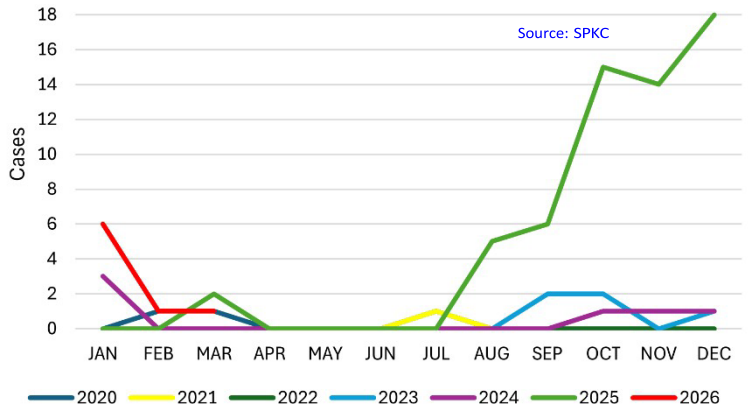
- **AFGHANISTAN**, 152 Crimean-Congo hemorrhagic (CCHF) fever cases (6 deaths) in APRIL; 141% increase compared to MAR (63 cases)
- ***IRAQ**, First CCHF case in Nineveh Province during 2026; 16 cases nationwide as of 19 MAY
- **ISRAEL**, Seven tick-borne relapsing fever hospitalizations among Israeli soldiers returning from southern combat operations in Lebanon as of 18 MAY
- **KAZAKHSTAN**, >2k tick bite cases have sought medical care since early-MARCH in Almaty; 11% increase from same period in 2025
- **KAZAKHSTAN**, Five brucellosis cases in East Kazakhstan Region during 2026; 66% increase compared to same period in 2025
- **YEMEN**, 9.7k measles cases in 2026 through APRIL; monthly cases increasing since FEBRUARY

USEUCOM Health Events of Interest

Latvia – Leptospirosis:

Through MARCH, eight leptospirosis cases have been reported in Latvia, a four-fold increase compared to the same period in 2025 (two cases). The majority of 2026 cases were reported in JANUARY (six), with one each in FEBRUARY and MARCH. In 2025, 60 leptospirosis cases (at least 3 deaths) were reported, a 20-fold increase compared to the previous five-year average (3 cases). Cases began to increase with humid weather in AUGUST 2025, when 5 cases were reported, to a peak of 18 in DECEMBER 2025; cases usually increase during the cold season, when rodents migrate into human homes and agricultural buildings. However, 2025 saw an abnormal increase that carried into 2026. See Figure 5 for a graph of leptospirosis cases in Latvia by month from 2020 to 2026. (Grani, Latvia Disease Prevention and Control Centre [SPKC], Latvian Public Media)

Figure 5. Leptospirosis Cases in Latvia by Month, JANUARY 2020 to MARCH 2026



Leptospirosis is caused by *Leptospira* bacteria and transmitted via water and soil contaminated with urine or body fluids from infected animals such as cats, cattle, dogs, and rodents. Bior, the Scientific Institute of Food Safety, Animal Health, and Environment, conducts monitoring of rodent populations in Latvia and tested mice, rats, and water voles for leptospirosis. The monitoring program found that 34% (44 of 129) of the rodents studied tested positive for leptospirosis. In 2025, human cases were reported in Augsdaugava, Bauska, Cesis, Jelgava, Kuldīga, Ogre, Riga, Ropaži, Salaspils, Sigulda, and Valmiera regions. **The 2025 outbreak was likely caused in part by Latvia's unusually wet summer**, with severe flooding in agricultural areas from MAY to JUNE. The rainy summer may have supported the survival of *Leptospira* bacteria in the environment, enhancing enzootic transmission within rodent reservoirs and increasing the risk of transmission to humans. Historically, the Baltic countries reported fluctuating and relatively low incidences of leptospirosis compared to other European regions. However, **recent data indicates shifting transmission dynamics driven by ecological changes.** (Baltijas Balss, DOAJ, ECDC, Grani, *Radioelectronic and Computer Systems.*, U.S. CDC)

Other events:

- *__GERMANY__, >1.2k shigellosis cases during 2026, a 40% increase compared to the same period in 2025
- *__GERMANY__, Six Borna disease cases during 2026, compared to one during the same period in 2025; first ever in Mecklenburg-Vorpommern State
- __ITALY__, Highly pathogenic avian influenza vaccination pilot targeting turkey launches as of 20 MAY
- __NORWAY__, First avian influenza A(H5N5) detection in polar bear in Europe on Svalbard Islands
- __ROMANIA__, One confirmed hantavirus infection case in Arad County as of 17 MAY; no recent travel history
- __United Kingdom__, >1.1k Lyme disease cases in England in 2025; 20% increase compared to 2024
- __USEUCOM__, Increasing multi- and extensively drug-resistant shigellosis cases; >2.3k since 2023

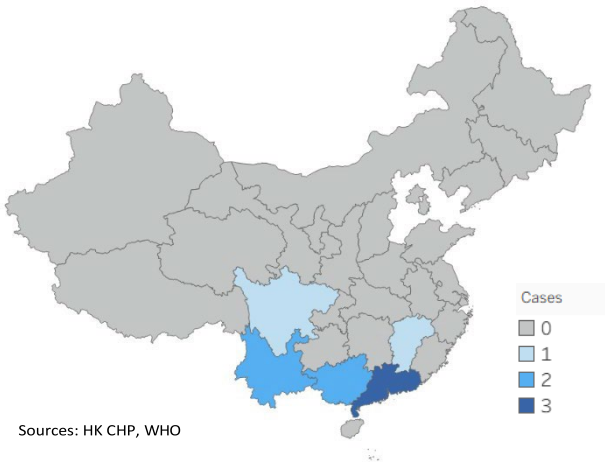
USINDOPACOM Health Events of Interest

China – Novel influenza A(H9N2):

As of 19 MAY, nine (+1) human infections with **avian influenza A(H9N2)** have been reported in China during 2026. **From 15 to 21 MAY, China notified WHO of one additional human A(H9N2) infection.** The case is a male child from Yunnan Province with no known underlying conditions and had symptom onset of cough, fever, and vomiting on 28 APRIL. The case was hospitalized with pneumonia on 29 APRIL and was discharged. An epidemiological investigation revealed the case had exposure to poultry. All close contacts tested negative for influenza. From 08 to 14 MAY, China reported to WHO one additional human A(H9N2) infection (the eight reported case), diagnosed in APRIL. The case is a female child from Sichuan Province with symptom onset of fever on 25 APRIL. The case's clinical symptoms self-resolved. The case had a history of exposure to a live poultry market prior to symptom onset. Close contacts were identified and 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, and Yunnan (two each), Jiangxi, and Sichuan, (one each) provinces (Figure 6). Since 2015, a total of 162 (+1) A(H9N2) infections have been reported in China, suggesting an endemic circulation of A(H9N2) in Chinese poultry ecosystems. 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. (U.S. CDC, WHO)

Figure 6. 2026 Human Novel Influenza A(H9N2) Infections, China, as of 19 MAY



India – Novel influenza A(H5N1):

As of 18 MAY, an **avian influenza A(H5N1)** outbreak is active on over a dozen poultry farms in Navapur Sub-District, Nandurbar District, Maharashtra State. The outbreak was detected following the sudden spike in poultry deaths on 12 and 13 APRIL. **On 02 and 03 MAY, two veterinary workers developed mild influenza-like symptoms, including body aches, fever, runny nose, and sore throat, following active participation in culling activities. Both were hospitalized as a precaution and discharged on 08 MAY after recovery.** Culling operations have removed ~400k birds and >2.1 million eggs across 13 farms <1km of the identified epicenters. Additionally, 25 response teams have been deployed. Health officials in Maharashtra State have ordered reverse transcription polymerase chain reaction (RT-PCR) testing for all personnel involved in culling and containment operations; rapid influenza diagnostic tests were conducted on each suspected case. Samples from eight poultry workers will be sent to the National Institute of

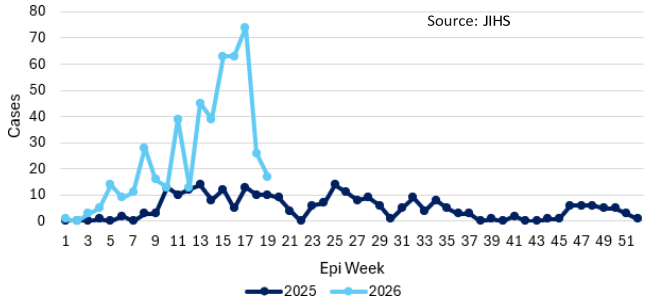
Virology for testing. Samples from the affected farms have been sent to the National Institute of High Security Animal Diseases (NIHSAD) laboratory in Bhopal for confirmation. In APRIL, an additional avian influenza A(H5N1) outbreak was reported in Tumakuru District, Karnataka State. Over 40 dead wild peacocks were identified between 16 and 24 APRIL. Six individuals who had contact with infected birds received treatment and were placed in home quarantine, along with 26 forest officials who had contact with peacock carcasses. **The detection of A(H5N1) in birds in both Karnataka and Maharashtra states suggests broad regional circulation, likely driven by wild bird movements.** (BEACON)

The last reported influenza A(H5N1) case in India was in APRIL 2025 in Andhra Pradesh State, who subsequently died. Since 2003, 1k human A(H5N1) infections (479 deaths) have been reported worldwide from 25 countries. As of 19 MAY, avian influenza A(H5N1) outbreaks in animals have been reported across India during 2026, with major outbreaks in Bihar, Karnataka, and Maharashtra states; however, none have been reported in West Bengal State during 2026. (*Emerg Infect Dis*, Sahyadri Hospitals, WHO)

*Japan – Measles:

Through 10 MAY, the Japan Institute for Health Security (JIHS) has reported 479 measles cases (+243 since IB's last update on 28 APRIL) during 2026, four times higher than the same period in 2025 (116 cases). **Additionally, cases have already increased 80% over the post-COVID-19 pandemic yearly high reported in 2025 (265 cases).** Most cases have been reported in Tokyo Prefecture (49%), followed by Kanagawa (9%), Saitama (8%), Kagoshima (7%), and Chiba (6%) prefectures. New cases peaked in the week beginning 26 APRIL and saw a sharp decline in the following week (Figure 7). In the most recent week (beginning 04 MAY), Tokyo Prefecture reported the most cases (44%), followed by Kanagawa and Saitama (17% each), Chiba (11%), and Aichi and Ibaraki (6% each) prefectures.

Figure 7. Measles Cases by EpiWeek, Japan,
01 JANUARY 2025 – 10 MAY 2026



In 2015, Japan was certified as being free of locally acquired measles cases, but measles continues to be introduced via imported cases. As of 30 APRIL, ~74% of cases were locally acquired, following imported infections from countries such as Indonesia and New Zealand. High population density and dense public transit networks in urban have facilitated rapid secondary transmission. JIHS has urged overseas travelers to exercise caution and check their vaccination records when traveling to regions where measles is prevalent. As of 08 APRIL, surveillance identified genotype B3 as the dominant strain (63% of cases), which is down from 79% through 11 MARCH. Strain D8 cases have increased from 21% of cases through 11 MARCH to 37% through 08 APRIL. Only genotypes B3 and D8 have been circulating globally since 2021. As of mid-APRIL, about a quarter of cases (24%) are aged 10 to 19 years and 28% are in their 20s. **As of 08 APRIL, only 32% of cases of an age to be fully vaccinated were known to have received two doses of vaccine.** On 17 APRIL, the Japanese Society for Vaccinology issued a document recommending that children be vaccinated against measles. (BEACON, The Japan Times, JIHS, Mainichi, NHK One, NHK World Japan, *Vaccines*)

*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 (four each), and Hiroshima, Kochi, Osaka, Saga, and Wakayama (two 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)

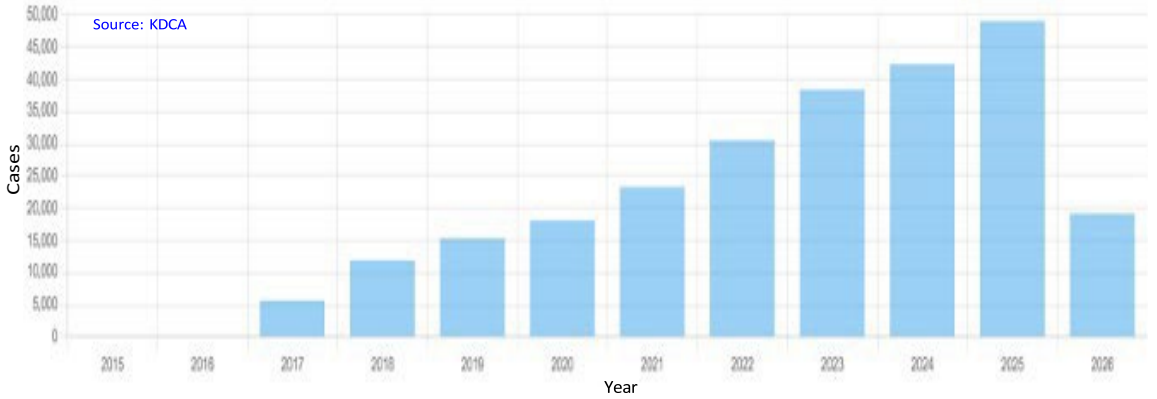
JSF is a spotted fever group rickettsiosis caused by *Rickettsia japonica.* The disease is spread via the bite of infected mites and ticks. *R. japonica* in Japan is primarily transmitted by *Haemaphysalis cornigera, H. formosensis,* and *H. hystricis* ticks. JSF cases have been increasing, and case 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 2021486 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. megaspinosa*, 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 JUN 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)

*Republic of Korea (ROK) – Carbapenem-resistant Enterobacteriaceae (CRE) infection:

As of 21 MAY, the Korea Disease Control and Prevention Agency (KDCA) has reported 19,585 **CRE** infection cases during 2026, a 12% increase compared to the same period in 2025 (17,417). Gyeonggi has reported the most cases (28%), followed by Seoul (25%), Incheon (8%), Busan (7%), and Gyeongnam (5%). **Cases have been increasing consistently since 2017, with an average increase of 28% annually** (Figure 8)**.** Furthermore, the number of CRE infection-related deaths increased nearly four-fold from 2018 (143) to 2023 (663), and the number of cases in long-term care hospitals increased more than four times from 2019 (1.1k) to 2023 (5.8k). In 2023, the most common CRE bacteria detected were *Klebsiella pneumoniae* (72%) and *Escherichia coli* (14%). **Infections caused by CRE are linked to the ROK's unique medical environment. The ROK ranks second among Organisation for Economic Co-operation and Development (OECD) countries in antibiotic use, often prescribing them even for common colds**; infection risk increases with antibiotic overuse, and once infected, existing antibiotics become ineffective. Additionally, >86% of cases in the ROK are among individuals aged ≥60 years, a population that is both highly vulnerable to the infection, and at an increased risk of exposure due to frequent visits to healthcare facilities. Frequent patient transfers between acute and long-term care facilities aid in the spread of resistant strains. In response to the increasing cases, the KDCA is preparing the Third National Antimicrobial Resistance Management Plan for 2026 to 2030. (BEACON, *Infect Chemother*, Chosun, Korea Herald, *Public Health Weekly Report*)

Figure 8. CRE Infection Cases in the ROK by Year, as of 20 MAY



CRE bacteria, including *E. coli* and *K. pneumoniae*, are resistant to one or more carbapenem antibiotics, making them difficult to treat. These bacteria can cause bloodstream infections, meningitis, pneumonia, urinary tract infections, and wound infections. Patients in healthcare settings are at the highest risk for CRE infections, especially if they require devices such as ventilators, urinary catheters, or intravenous catheters, are taking antibiotic courses, or have weakened immune systems. Nosocomial transmission is primarily driven by person-to-person contact and via contaminated medical equipment and devices. Additionally, there have been reports of spread between humans and animals and within animal reservoirs. (U.S. CDC)

Sri Lanka – Dengue:

As of 11 MAY 2026, **Sri Lanka's National Dengue Control Unit has reported 27,754 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 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:

- *__AUSTRALIA__, First *Aedes albopictus* mosquito detection in north Queensland State; vector not currently established in country
- *__AUSTRALIA__, First Japanese encephalitis virus detection in central Queensland State as of 22 APRIL; three human cases in state during 2026
- *__AUSTRALIA__, Two fatal Murray Valley encephalitis cases in Alice Springs, Northern Territory APRIL to MAY 2026
- __INDIA__, 11 GI illness cases in West Godavari District, Andhra Pradesh State, since 13 MAY; linked to flour
- __INDIA__, Dengue cases increasing ahead of monsoon season as of 20 MAY
- __INDONESIA__, 11 confirmed leptospirosis cases (1 death) in Tulungagung Regency, East Java Province, during 2026
- __INDONESIA__, 23 confirmed hemorrhagic fever with renal syndrome cases (256 suspected) across 6 provinces caused by Seoul virus from JANUARY 2024 to 20 MAY; 5 confirmed during 2026
- __SINGAPORE__, ~13k COVID-19 cases through 16 MAY
- __TAIWAN__, Country's first confirmed mpox clade Ib case as of 20 MAY in traveler returned from Thailand
- __THAILAND__, 1,074 mpox cases (16 deaths) since JULY 2022; clade Ib expanding, with 6 cases during 2026
- __TIMOR-LESTE__, One confirmed meningococcal disease case as of 14 MAY

USSOUTHCOM Health Events of Interest

Other events:

- __ANTIGUA AND BARBUDA__, Two confirmed malaria cases as of 21 MAY
- *__BRAZIL__, FEBRUARY 2026 study finds Sabiá virus circulating and mutating in country for 142 years; four fatal cases from São Paulo State since 1990
- __COSTA RICA__, Seven chikungunya cases (two locally acquired) during 2026
- __EL SALVADOR__, >111k GI illness cases (5.6k hospitalizations) during 2026; 18% among children aged 1 – 4 years
- __FRENCH GUIANA__, 338 confirmed chikungunya cases since 01 FEB
- __PERU__, 346 measles cases (231 confirmed) in Puno Department since 01 APRIL; health emergency declared

- **USSOUTHCOM**, U.S. CDC issues "Level 1 – Practice Usual Precautions" travel notice for Andes virus (hantavirus infection) in South America as of 20 MAY; risk for most travelers remains "Extremely Low"