NIPAH VIRUS INFECTION - GLOBAL

Date and version of current assessment: 06 March 2026, v1

Date(s) and version(s) of previous assessment(s):

Overall Global risk and confidence

Overall risk
Global
Low

Confidence[1] in available information
Global
Moderate

Risk Statement

This Rapid Risk Assessment (RRA) evaluates the global public health risk posed by Nipah virus (NiV), considering the distinct epidemiological profiles of i) enzootic countries, where recurrent zoonotic spillover and limited human-to-human transmission continue to occur, and ii) non-enzootic regions, where the risk remains primarily associated with infected travellers or importation of infected livestock. The assessment considers the ecological and seasonal drivers of spillover, the constrained efficiency of human-to-human transmission, and the capacity of health and community systems to detect, confirm, and rapidly contain outbreaks. Given that NiV has not demonstrated sustained transmission beyond outbreak settings and no human cases have ever been reported outside Asia, the global risk is largely determined by localized outbreaks in endemic areas and the very low likelihood of onward transmission following importation.

NiV activity remains geographically limited, with human cases occurring primarily in the South-East Asia Region with limited outbreaks in the Western Pacific Region. The epidemiological profile of NiV is characterized by low frequency, localized outbreaks, occurring predominantly in Bangladesh and India, with additional historical events reported in Malaysia, Singapore, and the Philippines. Bangladesh has reported sporadic cases almost annually since 2001, largely associated with consumption of raw date palm sap, following a well-defined seasonal pattern between December and April. India reported its first outbreak in 2001 and has documented near-annual cases in Kerala since 2018 with sporadic cases reported in West Bengal. In 2025, eight laboratory-confirmed cases were detected across Bangladesh (four) and India (four). As of March 2026, three sporadic cases have been reported in the two countries, two in India and one in Bangladesh. Malaysia (1998–1999), Singapore (1999), and the Philippines (2014) experienced outbreaks previously but have not reported any additional NiV events recently.

Although NiV has a high case-fatality ratio (40–75%), transmission remains limited in scale, typically arising from isolated spillover events linked to fruit bats, contaminated fruits or fruit products, or occasionally infected livestock. Human-to-human transmission has been documented, particularly in Bangladesh and India. However, sustained community transmission or multi-country spread has never been observed.

KEY RISK FACTORS

1. Risk to Enzootic Countries

- Sporadic zoonotic spillover events occur due to contact with infected bats or consumption of contaminated fruits or fruit products.
- Serological evidence of NiV circulation beyond affected areas in Bangladesh and India (Kerala and West Bengal), suggest that spillover could potentially occur in other areas where infected bats are present.
- Human-to-human transmission, although documented, is limited to close contacts and has not resulted in widespread community transmission.
- The case-fatality ratio is high; however, the total number of reported cases remains low.
- Health care settings may amplify transmission when infection prevention and control (IPC) measures are insufficient.
- Spillover from other susceptible animal hosts (pigs, horses) cannot be ruled out, nor the risk of importation through infected livestock, though probably very low.

2. Risk to Non-Enzootic Regions (reservoirs may be present; no human cases to date)

- Risk is primarily associated with an infected traveller.
- No human NiV transmission has ever been reported outside affected Asian countries.
- In settings without established animal reservoirs or intermediate hosts, onward transmission following importation is unlikely and would require close, prolonged contact.

[1] Confidence refers to the level of confidence in the data/information or the quality of the evidence available at the time the RRA is conducted. Poor quality information may increase the overall perceived risk due to the incertitude in the assessment.

- Historical spread via movement of infected animals (e.g., pigs exported from Malaysia to Singapore in 1999) demonstrates that animal trade–related spillover is possible, however current evidence suggests that the risk under present animal-health and trade practices is likely very low.

3. Risk to Countries Without Known Bat Reservoirs (reservoirs absent; no human cases)

- Importation via travellers (and, exceptionally, livestock) may occur and while secondary transmission is possible it is unlikely, given the absence of established animal reservoirs and the need for close contact for human-to-human spread.

4. Risk to Travellers

- Travellers to affected areas face a very low but non-zero risk, particularly if they have direct exposure to fruit bats, consume contaminated food products, or come into contact with other infected animals, including pigs or horses.
- Returning infected travellers pose a limited risk of onward transmission due to low NiV transmissibility.

5. Risk Determinants

- Ecological presence of *Pteropodidae* bats in enzootic countries.
- Presence of potential intermediary hosts that could transmit to humans (e.g., pigs, horses).
- Cultural and dietary practices (e.g., consumption of raw date palm sap).
- Exposure in health care settings with inadequate IPC measures.
- Limited awareness among communities and health workers.
- Close, unprotected contact with sick/deceased individuals, including local practice traditions.

6. Response Capacity

- Countries with recurring outbreaks have strengthened their surveillance systems, diagnostics, and clinical management capacity.
- No licensed vaccines or specific antiviral treatments are currently available; however, several vaccine and therapeutics candidates are in development, supported by CEPI and WHO-aligned research priorities.
- Rapid case isolation and contact tracing remain effective measures in preventing wider spread.

7. Confidence in Available Information

Overall confidence is moderate, due to:

- Under-detection of sporadic spillover events in rural areas.
- Ongoing uncertainty about the full geographic distribution of bat reservoirs and potential intermediate hosts.

Based on current evidence, characterized by rare outbreaks, limited human-to-human transmission, no sustained global spread, and improving response capacity, the overall global public health risk posed by NiV is assessed as Low with a Moderate level of confidence in the available information.

This rapid risk assessment will be updated as new epidemiological, clinical, or virological information becomes available.

Risk questions

Risk question	Assessment		Risk	Rationale
	Likelihood	Consequences	Global	
Potential risk for human health?	Unlikely	Moderate	Low	Nipah virus (NiV) poses a serious health risk in affected countries due to its high case-fatality ratio (40–75%) and its ability to cause severe encephalitis and respiratory disease. Although outbreaks are infrequent, zoonotic spillover from fruit bats, combined with documented human-to-human transmission in household and health care settings, continues to cause severe illness and deaths in Bangladesh and India. Health system challenges such as delayed case detection, limited access to intensive supportive care, and gaps in IPC may amplify the impact of outbreaks, especially in rural or resource-constrained settings where clinical recognition and laboratory confirmation may be delayed. In countries and areas without prior experience of an NiV outbreak, case identification may be slower due to low clinical awareness. While overall global risk is low because NiV does not transmit efficiently between humans, severe localized clusters can still occur, underscoring the need for early detection and early supportive care, strong IPC, and community awareness to reduce morbidity and mortality.
Risk of geographical	Very unlikely	Minor	Low	The risk of NiV spreading geographically is low, driven by its reliance on bat-to-human spillover and close-contact human transmission. While fruit bats capable of carrying henipaviruses are widely

spread of the event?				distributed across Asia, and parts of Africa and Oceania, human cases remain confined to Bangladesh, India, Malaysia, Singapore, and the Philippines. Intermediate hosts (e.g., pigs) played a role to human transmission in outbreaks in Malaysia and Singapore (pigs exported from Malaysia). The full extent of virus circulation in intermediate hosts remains poorly understood, and the possibility of exportation of infected animals cannot be ruled out, as evidenced in previous outbreak. In Bangladesh and India, spillover is linked to consumption of contaminated food sources (e.g., raw date palm sap) and close-contact caregiving, with occasional health care associated clusters. These factors create potential for localized spread within affected districts, especially where surveillance or IPC capacity is limited. The potential persistence of NiV in raw date-palm sap, which is increasingly distributed beyond harvesting areas including through social media mediated trade, is poorly characterized. Bangladesh's limited ability to regulate sap circulation suggests that while the risk from such products remains low, it is not zero. International spread is expected to be extremely rare, as transmission requires close, prolonged contact; no sustained community transmission has ever been observed. Even in countries with ecological suitability for bat hosts, no recent outbreaks have been reported. Although NiV currently lacks the capacity for large-scale regional expansion, the risks could increase in settings with health care IPC gaps, or undetected spillover in settings with limited surveillance. Strengthened surveillance and IPC remain essential to prevent spread beyond currently affected areas.
Risk of insufficient control capacities	Very unlikely	Minor	Low	Insufficient NiV control capacities, such as limited surveillance sensitivity, delayed outbreak detection, limited laboratory and testing capacity, and IPC gaps, can hinder rapid containment and increase the risk of severe localized outbreaks. Because NiV transmission depends on zoonotic spillover and close human contact, rapid case identification and strong IPC are essential. In Bangladesh and India, structural challenges in rural areas, such as limited access to diagnostic capacity and under recognition of early cases, can delay outbreak response and increase the likelihood of health care associated transmission. The absence of licensed vaccines or specific antiviral treatments underscores the critical importance of timely supportive care, contact tracing, and community engagement. Outside South Asia, preparedness is uneven, and clinical familiarity with NiV may be low. The non-specific early symptoms of infection with NiV, which resemble many common febrile or neurological illnesses, can make initial diagnosis challenging, further heightening the risk of delayed recognition in settings without prior outbreak experience. A significant outbreak in a previously unaffected setting could strain systems lacking high-containment laboratory facilities or advanced IPC capacity. Without continued investment in surveillance, access to diagnostics and rapid specimen referral pathways, health-worker training, and risk communication, delays in case detection and outbreak response could lead in preventable morbidity and mortality, even though the risk of global spread remains low.

Major actions recommended by the risk assessment team

	Action
☐	Refer the event for review by IHR Emergency Committee for consideration as a PHEIC by DG (Art 12, IHR)
☐	Immediate activation of WHO response mechanism as urgent public health response is required
☐	Recommend setting up WHO grading call
☐	Immediate support to response, but no WHO grading recommended at this point in time
☐	Rapidly seek further information and repeat RRA (including field risk assessment)
☒	Support Member State to undertake preparedness measures
☒	Continue to closely monitor
☐	No further risk assessment required for this event, return to routine activities

Supporting information

Hazard assessment

Nipah virus (NiV) is a high-consequence zoonotic pathogen that causes severe acute encephalitis and respiratory illness in humans. It is a member of the *Henipavirus* genus Henipavirus of the *Paramyxoviridae* family. Fruit bats of the *Pteropodidae* family serve as the natural reservoir, typically without showing signs of illness. Human infection occurs through direct contact with infected bats, exposure to contaminated food products, contact with infected animals, or close contact with infectious human cases, especially in household or health care settings.

The incubation period usually ranges from 3 to 14 days, though incubation up to 45 days has been reported in some rare cases. Clinical illness may range from asymptomatic infection to acute respiratory disease or severe encephalitis, which presents as fever, headache, altered mental status, seizures, and rapid progression to coma. Some patients develop severe respiratory symptoms. Relapse or late-onset encephalitis can occur among survivors. NiV infection is associated with a very high case-fatality ratio (40–75%), influenced by the outbreak setting and available clinical care.

Transmission of NiV is driven by ecological interactions involving fruit bats, consumption of contaminated food sources (e.g., raw date palm sap), contact with infected domestic animals (e.g., pigs, horses, dogs, and cats), and close human-to-human contact. Outbreaks have occurred in Malaysia, Singapore, Bangladesh, India, and the Philippines. Although serological evidence of henipavirus exposure has been detected in fruit bats across parts of Africa and Asia, no human NiV cases have been reported outside the Asia–Pacific region.

Diagnosis mostly relies on detecting viral RNA through RT-PCR, identifying recent or past infection using IgM and IgG serology. Isolation of the virus through examining tissues by histopathology or immunohistochemistry in cases that result in death can also be considered for diagnosis provided a maximum containment facility and trained workforce are available. Diagnostic challenges include the requirement for high-containment laboratory facilities if handling non-inactivated samples, the severity of disease, and limited access to testing capacity in some affected areas.

There is no licensed vaccine or specific antiviral treatment for NiV; symptom management is supportive, focusing on maintaining vital organ function and preventing complications. Several candidate vaccines and monoclonal antibody therapeutics are under development but remain investigational. Effective prevention requires early recognition, robust infection IPC practices in health care settings, safe caregiving practices, and community-level risk-reduction measures, including avoidance of contaminated food products.

Exposure assessment

This RRA is focused on cases of NiV infection occurring in Bangladesh and India from 1 January 2025 until 3 March 2026. These cases do not represent widespread transmission but reflect the ongoing pattern of sporadic zoonotic spillover and limited human-to-human transmission in endemic settings.

SOUTH-EAST ASIA REGION

Between 1 January 2025 and 3 March 2026, a total of 11 confirmed cases of NiV infection, including eight deaths, were reported from Bangladesh and India, the two countries where the virus remains enzootic.

Bangladesh

Bangladesh reported its first case of NiV infection in 2001. Since then, human infections have been reported almost every year, with a total of 348 documented cases of NiV infection, including 250 deaths, corresponding to an overall case-fatality ratio of 72%. Since 2016, an average of approximately 4.5 cases have been reported per year. NiV infections in Bangladesh are typically associated with consumption of raw date palm sap and reported between December and April with only one case reported outside the usual seasonal period (August 2025).

In 2025, Bangladesh reported four confirmed fatal NiV cases, all temporally unrelated and detected across three divisions (Barisal, Dhaka, and Rajshahi), with no epidemiological links between them. One case in August 2025 occurred outside the usual seasonal period. On 3 February 2026, one additional confirmed fatal case was detected in Naogaon District, Rajshahi Division, in a woman aged 40–50 years who had repeatedly consumed raw date palm sap, a known exposure risk in Bangladesh. No further cases have been detected.

India

Since the first outbreak in 2001, India has recorded 104 cases, including 73 deaths, corresponding to case-fatality ratio of 70.1%. Since 2018, India has reported cases almost annually, averaging approximately 1.9 cases per year since 2019.

In 2025, four confirmed NiV cases, including two deaths, were reported from Malappuram and Palakkad districts in Kerala State, marking the first reported outbreak in Palakkad. On 26 January 2026, India notified WHO of two laboratory-confirmed cases in West Bengal, both in health care workers from the same hospital in Barasat (North 24 Parganas district). One case died. No additional cases have been detected. This event represents the third NiV outbreak reported in West Bengal and reflects the ongoing pattern of sporadic spillover events, associated with bat-contaminated food, environmental exposure or health care associated exposure. Despite recurring outbreaks, no sustained chains of transmission were identified, and each cluster has remained localized.

WHO AFRICAN REGION, REGION OF THE AMERICAS, EASTERN MEDITERRANEAN REGION, EUROPEAN REGION, AND WESTERN PACIFIC REGION

Across the WHO African Region, the Region of the Americas, the Eastern Mediterranean Region, the European Region, and the Western Pacific Region, no confirmed human NiV cases or imported infections were reported during the review period. Although ecological studies have identified henipavirus antibodies in fruit bat populations and domestic animals in parts of Asia, Africa, and multiple countries in the Western Pacific Region, no human NiV infections have ever been detected in these regions, and similarly, no countries in the other Regions, except South-East Asia, have reported any confirmed cases. Surveillance mechanisms in these regions have not identified travel-related introductions despite international connectivity with South Asia, and all documented NiV cases between 2025 and early 2026 occurred exclusively within Bangladesh and India, with no evidence of spread. WHO continues to assess the risk of international spread as low, supported by the virus's limited capacity for sustained human-to-human transmission and rapid containment of recent events.

Context assessment

NiV remains a recurrent zoonotic threat in parts of South Asia, driven by a convergence of ecological pressures, changing human–bat interfaces, and persistent vulnerabilities in health-system capacity. Bangladesh and India continue to report annual or periodic spillover events, including four fatal cases in Bangladesh in 2025; four cases, including two deaths in Kerala (India) in 2025: two confirmed cases in West Bengal (India) in January 2026; and one fatal spillover case in Bangladesh in February 2026. Despite these events, all outbreaks remained small, localized, and rapidly contained, with no onward international transmission.

Social:

Risk of NiV infection is shaped by behavioral and cultural practices, particularly the harvesting and consumption of raw date palm sap, a well-established route of spillover in Bangladesh and linked to recent fatal cases. Sporadic spillover occurs in settings where people are exposed to bat habitats or contaminated food sources, particularly in peri-urban and rural areas. Health care associated exposure illustrates vulnerability in close-contact caregiving. Communities with limited access to health services or lower awareness of NiV infection exposure risks and symptoms often experience delays in treatment seeking, increasing the likelihood of severe outcomes and household-level transmission.

Technological:

Surveillance and access to diagnostic capacity remain uneven across affected regions. In the NiV infection events of 2025–2026, laboratory confirmation required advanced reference laboratory support (e.g., the National Institute of Virology in India), and a mobile high-containment laboratory was deployed to handle samples. Bangladesh and India have strengthened surveillance systems since their earlier outbreaks, however, low index of suspicion at frontline facilities and delays in recognizing compatible clinical syndromes continue to hinder timely detection in both countries. In both countries, limitations in IPC-related infrastructure including inadequate ventilation systems, constrained personal protective equipment (PPE) supplies, and limited biosafety capacity remain important technological challenges and have contributed to health care associated infections during previous outbreaks. No approved therapeutics or vaccines exist for NiV infection, reflecting a broader technological and research gap that limits clinical options and outbreak response capacities.

Economic:

Under-resourced health systems face challenges in maintaining sufficient critical-care capacity, laboratory reagents, PPE, and trained IPC staff. Economic constraints can delay sample transport, contact-tracing operations, and community engagement activities. In many affected districts, livelihoods depend on agriculture, seasonal sap harvesting, and small-scale farming activities that bring communities into close contact with bat habitats. These economic drivers increase exposure risk and limit households' ability to avoid high-risk practices without targeted support.

Environmental:

NiV ecology is tightly linked to fruit bat behavior, habitat distribution, and seasonal food availability. Outbreaks in Bangladesh and eastern part of India commonly occur between December and April, corresponding with date palm sap harvesting season, as seen in the 2026 fatal case. Deforestation, agricultural expansion, and human settlement near bat habitats increase the risk of spillover. Climate variations affecting fruiting patterns or bat stress may influence viral shedding dynamics, potentially increasing the frequency or intensity of spillover events.

Political:

Most affected countries demonstrate strong political commitment to NiV preparedness; however, variability in subnational capacity continues to influence response speed and outbreak control. Effective cross-border collaboration between the affected countries is essential, given the geographic proximity of repeated outbreaks in Bangladesh and Indian state of West Bengal. Public-health responses rely on rapid coordination, including

contact tracing, IPC reinforcement, community messaging, and laboratory mobilization. There is a need for sustained political will to maintain preparedness even in periods without cases.

Overall, the burden of NiV infection continues to fall disproportionately on rural, marginalized, and geographically remote populations in Bangladesh and India. Limited diagnostic access, delayed recognition of symptoms, and centralized care models contribute to higher mortality risks. Although outbreaks remain small and contained, seasonal spillover patterns, human–bat interface pressures, and health-system weaknesses create persistent vulnerability. Nevertheless, given the low efficiency of human-to-human transmission and the successful containment of recent clusters with all contacts testing negative, the risk of broader regional or international spread remains low. Continued investments in surveillance, IPC, access to diagnostics, and community engagement are critical to preventing severe outcomes and maintaining early outbreak control.

Capacities and Vulnerabilities by WHO Region

WHO Region	Key Capacities	Key Vulnerabilities
Africa	• Strengthening zoonotic and One Health surveillance systems and risk assessments, integrating animal–human interfaces. • Increasing laboratory capacity detection and referral capacity for high threat pathogens in select countries. • Existing experience with managing viral hemorrhagic fevers may support readiness.	• No human NiV cases reported, but henipavirus antibodies detected in bats, indicating ecological suitability. • Limited capacity for safe sample handling and validated inactivation procedures required for NiV confirmation remains a challenge in some settings. Full maximum-containment infrastructure is not needed; countries already able to confirm other high-consequence pathogens (e.g., Ebola, Lassa) generally have the capability to detect NiV provided adequate reagents; biosafety practices are in place. • Potential delays in detecting possible rare, imported cases due to low clinical familiarity.
Americas	• Strong regional laboratory networks and pathogen surveillance platforms. • Established mechanisms for rapid outbreak verification.	• No cases detected, and clinical awareness with NiV may be limited. • Potential diagnostic delays for rare encephalitis cases with atypical presentation. • Challenges with differential diagnosis with neurotropic arboviruses circulating in the Region.
Eastern Mediterranean	• Established surveillance systems for imported high consequence pathogens.	• No NiV activity documented; clinician awareness of NiV may be limited. • Conflict-affected areas may have weakened detection and response capacity.
Europe	• Strong One Health surveillance systems and high laboratory diagnostic capability for special pathogens. • Robust IHR core capacities, including event-based surveillance, for managing imported emerging diseases.	• No historical cases, creating a very low baseline clinical familiarity. • Potential for delayed recognition of rare, travel-related encephalitis cases.
South-East Asia	• Most experienced region, with established NiV surveillance and laboratory diagnostic capacities in	• Endemic region with recurring spillover events, especially linked to consumption of raw date palm sap.

WHO Region	Key Capacities	Key Vulnerabilities
	Bangladesh and India. • Rapid mobilization of capacities demonstrated in previous outbreaks. • Increasing One Health collaboration and seasonal surveillance aligned with sap harvesting periods.	• IPC gaps in some facilities contribute to risk of health care associated transmission (e.g., Kerala 2018). • Limited availability of advanced critical care in rural districts.
Western Pacific	• History of successful NiV outbreak control (Malaysia and Singapore in 1998–1999). • Strong public health laboratory networks and emergency response infrastructure.	• No recent NiV cases**,** with risk largely tied to bat reservoir distribution. • Potential for delayed recognition if an imported case occurs, especially in settings without routine encephalitis surveillance. • Limited capacity of critical care and IPC in some Member States overlaps with the reservoir distribution.

WHO Immediate actions:

WHO to continue supporting:

- Sustain global monitoring of NiV epidemiology, spillover patterns, and emerging risk factors, including surveillance of human cases, animal reservoirs together with World Organisation for Animal Health (WOAH) and Food and Agriculture Organization of the United Nations (FAO), and high-risk exposure pathways.
- Develop and regularly update global technical guidance on surveillance, laboratory diagnostics, case investigation, clinical management, and IPC, and provide technical support to countries to implement and strengthen these capacities in both community and health care settings.
- Strengthen collaboration and information-sharing with partners at global, regional, and national levels to ensure timely detection and management of any exported or unusual NiV events.
- Support countries in maintaining access to essential medical and IPC supplies, such as PPE and core laboratory reagents, and, where relevant, facilitate surge access to trained critical-care personnel or teams rather than equipment alone, recognising that safe use of advanced critical-care technologies depends on available staffing and existing health-system capacity. In addition, support countries in sustaining robust biorisk-management practices, including safe specimen handling, inactivation, and laboratory biosafety procedures required for NiV and other high-consequence pathogens.
- Coordinate supply and logistics management with partners to ensure timely delivery of required medical and non-medical items during investigation and response operations.
- Ensure WHO Country Offices, Regional Offices, and Headquarters continue to guide and support operational response, including outbreak investigation teams, risk communication, community engagement, and cross-sectoral One Health coordination.
- Continue to drive and catalyze research and development of therapeutics, diagnostics, and vaccines for NiV infection.

Proposed Actions by WHO Region

WHO Region	Proposed Actions
Africa	**WHO to continue supporting:** • Integrate NiV as a rare differential diagnosis within existing surveillance for acute encephalitis and severe respiratory illness, ensuring countries can identify and rapidly verify any suspected cases. • Support safe specimen collection, packaging, and referral to external reference laboratories for confirmatory NiV testing using existing high-consequence pathogen procedures. • Maintain core IPC practices in health care facilities to prevent nosocomial transmission of severe viral infections, including NiV infection. • Ensure points of entry are prepared to recognize and report travellers presenting with unexplained encephalitis, using standard all-hazards border health procedures. • Support access to essential PPE, IPC supplies, and basic laboratory consumables used across high consequence pathogen responses. • Provide targeted clinical guidance for managing severe encephalitis potentially compatible with NiV infection, using existing critical care capacity rather than new pathogen-specific structures.
Americas	**WHO to continue supporting:** • Integrate NiV as a rare imported-case differential within existing surveillance for acute encephalitis and severe respiratory illness, ensuring countries can rapidly identify and verify suspected cases through established laboratory referral networks. • Support safe specimen collection, packaging, and referral for NiV testing using existing high-consequence pathogen workflows. • Provide targeted clinical and public-health advisories (e.g., for clinicians and points-of-entry staff) focused on travel-linked encephalitis. • Ensure that existing multisectoral emergency coordination and all-hazards preparedness systems can accommodate investigation and management of a very rare NiV-compatible event without requiring additional NiV-specific preparedness measures.
Eastern Mediterranean	**WHO to continue supporting:** • Integrate NiV as a rare differential diagnosis within existing all-hazards surveillance systems for acute encephalitis and severe respiratory illness, ensuring rapid identification and verification of any suspected imported case through established reporting pathways. • Support safe specimen collection, packaging, and referral to external reference laboratories for confirmatory NiV testing using existing high-consequence pathogen procedures. • Provide targeted traveller health guidance within routine zoonotic-disease communications, without introducing NiV-specific campaigns. • Ensure that existing multisectoral emergency coordination mechanisms can accommodate a rare NiV-compatible event, without requiring additional NiV specific preparedness structures.
Europe	**WHO to continue supporting:** • Integrate NiV as a rare imported case consideration within existing surveillance for acute encephalitis and severe respiratory disease, ensuring rapid clinical and laboratory verification pathways are available through established high-consequence pathogen networks. • Support safe specimen collection, packaging, and referral for suspected imported cases, using current protocols for high-risk pathogens. • Provide targeted technical advisories for clinicians and public-health authorities, focused on travel-linked encephalitis risk, while avoiding broader NiV specific community risk communication and community engagement (RCCE) activities. • Provide targeted guidance to public health laboratory personnel regarding available testing technologies, data interpretation and reporting, and biosafety and biosecurity during lab operations. • Ensure that existing multisectoral emergency preparedness and response systems can accommodate the investigation and management of a very rare NiV compatible event without requiring additional NiV-specific preparedness measures.

WHO Region	Proposed Actions
South-East Asia	**WHO to continue supporting:** • Strengthen AES (acute encephalitis syndrome) and ARDS (acute respiratory distress syndrome) and spillover surveillance in endemic areas to detect NiV compatible encephalitis clusters and enable rapid identification and verification of suspected cases. • Strengthen referral testing services across the region. • Support outbreak investigation, contact tracing, and IPC reinforcement in districts with recurrent or seasonal spillover risk, including areas linked to raw date palm sap exposure and health care-linked outbreaks. • Promote long-term follow-up and documentation of clinical, neurological, and psychological sequelae among NiV survivors, and support countries in developing guidance for survivor monitoring and care. • Reinforce community education and targeted RCCE on known local risk factors such as preventing bat contamination of food products and the consumption of raw date palm sap in Bangladesh and high-risk areas of India. • Assist countries in surge readiness for clinical management and safe specimen handling by strengthening trained personnel capacity and ensuring access to high-consequence pathogen testing through regional referral networks. • Support global research and development efforts for NiV countermeasures, including candidate vaccines, monoclonal antibodies, and antiviral therapeutics. • Support One Health coordination between human, animal, and environmental sectors to guide risk assessments, particularly during high-risk seasons, and to promote safe agricultural or food-collection practices in areas where *Pteropus* bats are endemic. • Monitor findings from studies involving bats and other animals investigating proof of NiV circulation, to inform risk analysis and public health actions. • Maintain regional and cross-border information-sharing on NiV infection.
Western Pacific	**WHO to continue supporting:** • Strengthen clinical event-based surveillance by increasing frontline clinical suspicion for NiV as a rare differential diagnosis in cases of acute encephalitis or severe respiratory illness with relevant exposure history and ensure rapid verification of any suspected case in countries with historical outbreaks. • Provide technical guidance to public health laboratories on NiV testing including data management and biosafety and biosecurity measures, and available testing kits. • Provide technical guidance on safe specimen collection, packaging, and referral for NiV testing through established regional and international high-containment laboratory networks, without requiring new NiV-specific diagnostic capacity, where these capacities do not exist. • Strengthen localized preparedness in areas where *Pteropus* bats are endemic and where past spillover events occurred (e.g., Malaysia 1998–1999, Philippines 2014), focusing on early detection and IPC readiness. • Provide comprehensive, evidence-based information on the NiV to support the development of national guidelines for Member States. • Provide targeted technical RCCE on known local risk factors and provide Information, Education, and Communication (IEC) materials. • Maintain baseline supply readiness (e.g., PPE, specimen-transport materials, outbreak-investigation kits) used for multiple high-consequence pathogen responses. • Support One Health coordination among human, animal, and environment sectors to guide risk assessments, interpret signals of unusual animal illness, and promote evidence-based risk-reduction measures at the human-animal-environment interface. • Provide targeted, risk-based traveller health advisories for countries with frequent travel to and from enzootic areas, emphasizing the very low overall risk and focusing on avoidance of high-risk exposures (e.g., contact with bats or consumption of raw/contaminated food products) and the importance of seeking care if symptoms develop after travel to affected areas.

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