Chikungunya virus disease, Global

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Overall risk and confidence

Overall risk
Global
Moderate

Confidence in available information
Global
Moderate

Overall Risk statement

This rapid risk assessment aims to assess the overall public health risk posed by chikungunya virus (CHIKV) transmission in 2026 at the global level. It considers the potential risk to human health, the likelihood of geographical spread, limitations in prevention and control capacities, and the influence of regional seasonal patterns that favour *Aedes mosquito* activity, which could drive outbreaks during the 2026 transmission season. Chikungunya virus poses a significant and growing global health risk due to large and widespread regional outbreaks in recent years, lack of specific treatment, limited use of vaccine, and climate- and conveyance-driven mosquito range expansion, with increasing international travel. While mortality remains relatively low, the CHIKV infection can cause prolonged arthritis with disability as well as severe illness in some patients.

In 2025, an overall of 502 264 CHIKV disease cases including 208 335 confirmed cases, and 186 deaths were reported globally from 41 countries and territories, including autochthonous and imported cases in travellers. From 1 January to 31 March 2026, Chikungunya transmission was reported by 18 countries, with the vast majority of cases occurring in the Region of the Americas. From 1 January to 31 March 2026, chikungunya transmission was reported by 18 countries, with the vast majority of cases occurring in the Region of the Americas. Brazil and Bolivia account for 87% of cases in the Region; together with Argentina, Suriname, and Cuba, these five countries represent approximately 99% of reported cases. The European Region reported the second-highest number of cases, predominantly reported from French overseas departments, particularly Mayotte and La Réunion. Global aggregation is limited due to incomplete reporting.

With the rainy season about to begin in many regions in the coming months, cases of CHIKV are expected to rise, as rainfall events create favourable conditions for *Aedes* mosquito breeding and increase the risk of CHIKV transmission, including in previously unaffected areas. Transmission dynamics will also be impacted by the population immunity acquired from outbreaks in recent years. Peak CHIKV transmission months in the respective WHO regions include:

- **Southeast Asia & Western Pacific:** May–October
- **Americas:** May–November (Northern hemisphere)/November–March (Southern hemisphere)
- **Continental Europe:** June–September (main season) (transmission in overseas departments aligns with climatic conditions within their geographic location/proximity)
- **Africa & Eastern Mediterranean:** During/after local rainy seasons (varies by country)

The global public health risk posed by CHIKV transmission is assessed as moderate. This takes into account the widespread transmission and outbreaks across multiple WHO regions in 2025, which continued into early 2026, including in areas with previously low or no transmission. Ongoing transmission in parts of the Indian Ocean region, such as Seychelles, Mauritius and Mayotte demonstrates continued regional activity. The resurgence and emergence of cases in new geographic areas are facilitated by the presence of competent *Aedes* mosquito vectors, limited population immunity, favorable environmental conditions, and increased human mobility coupled with under-performing/disrupted health systems, particularly in fragile, conflict-affected and vulnerable countries- leading to poor control measures.

The uneven distribution of cases across regions complicates the interpretation of a global trend but highlights significant localized transmission. Prevention and control capacities remain challenged by gaps in surveillance, equitable access to quality-assured diagnostics and laboratory confirmation, healthcare infrastructure, and sustained vector surveillance and control management.

*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.

Risk question	Assessment		Risk	Rationale
	Likelihood	Consequences		
Potential risk for human health?	Likely	Moderate	High	Chikungunya poses a significant risk to human health due to its potential to cause widespread outbreaks that can strain healthcare systems. Some cases can lead to prolonged joint pain, severe illness and death, particularly affecting vulnerable populations. 1. **Epidemiology and global burden (2025-2026):** Chikungunya is a mosquito-borne disease, caused by the chikungunya virus (CHIKV), that is widely distributed in tropical and subtropical regions. It is characterized by sudden fever associated with severe joint pain. Other clinical manifestations include muscle pain, headache, and rash. In some cases, the joint pain can persist for months or years, causing prolonged disability. In 2025, an overall of 502 264 CHIKV disease cases including 208 335 confirmed cases, and 186 deaths were reported globally from 41 countries and territories, including autochthonous and imported cases in travellers. Further, from 1 January to 31 March 2026, CHIKV disease cases have been reported from 18 countries and territories. 2. **Severity, vulnerable populations:** While the overall case fatality rate for chikungunya is low or similar compared to other arbovirus disease, severe illness, complications, and deaths can occur, especially in vulnerable populations such as newborns, young children, pregnant women, elderly individuals, and individuals with pre-existing health conditions including diabetes, hypertension, and cardiovascular diseases. The transmission rate during birth (vertical transmission) is high, approximately 50%. 3. **Health system impact:** Moreover, high attack rates have been documented in recent outbreaks across several countries. Such large outbreaks have the potential to overwhelm health systems, particularly in resource-limited settings, due to high outpatients and hospitalization rates in the acute setting and increased demands for clinical care of those patients with prolonged disease.
Risk of geographical spread of the event?	Likely	Moderate	Moderate	Chikungunya represents a growing global health threat with potential for rapid spread. 1. **Global spread and transmission risk:** While some regions experienced a significant increase in case numbers in 2025 compared to 2024, others reported lower case numbers. This uneven distribution of cases across regions makes it challenging to characterize the situation globally. However, given ongoing outbreaks, the potential for further spread in 2026 remains significant. CHIKV disease can also be introduced into new areas by infected travellers and local transmission may be established if there is the presence of competent *Aedes* mosquito and a susceptible population. The risk is heightened by limited population immunity in previously unaffected areas, favorable environmental conditions for vector breeding, gaps in surveillance, prevention, control and diagnostic capacity, and increased human mobility and trade. 2. **Regional re-emergence of CHIKV (2025 and 2026):** In 2025, a resurgence of CHIKV disease was noted in a number of countries in the Indian Ocean islands and Asia, including some that had not reported substantial case numbers in recent years. Prior to 2025, autochthonous transmission of CHIKV had been reported from 119 countries and territories. A total of 27 countries and territories across six WHO regions have established competent populations of *Aedes aegypti* mosquitoes but have not yet reported autochthonous CHIKV transmission. Additional countries have established populations of *Aedes albopictus* mosquitoes, which can also transmit CHIKV. Between late 2025

				and early 2026 , there has been a sustained increase in chikungunya cases in countries and territories in the Americas, as well as the resumption of autochthonous transmission in areas that had not reported circulation of the virus for several years. This was especially documented in the central-western and southeastern regions of Brazil, southern Bolivia, and in the Guiana Shield area. 3. **Vector expansion and future spread:** The expanding geographic presence of these *Aedes* species (spp) vectors poses a continuous threat of chikungunya introduction and spread in previously unaffected areas. Given the ongoing outbreaks reported globally in 2025, and the outbreaks of chikungunya in quiescent parts of South America in late 2025-early 2026, the potential for further spread in 2026 remains.
Risk of insufficient control capacities	Unlikely	Moderate	Moderate	Chikungunya outbreaks pose multifaceted challenges to healthcare systems, surveillance, and public health response. 1. **Healthcare System burden:** These outbreaks often place a significant burden on healthcare systems due to the number of affected individuals requiring outpatient visits and/or hospitalization. 2. **Surveillance and reporting:** Countries differ in their ability to detect and report chikungunya and other vector-borne diseases, with many outbreaks identified only retrospectively, hindering effective public health responses. 3. **Early detection and clinical management:** The capacity to detect and confirm cases differs between countries. Case management is also hampered by a shortage of health workers in some countries and the lack of standard protocols, particularly in countries also affected by malaria and dengue. Early detection of chikungunya cases, especially in persons at risk for severe disease, adequate diagnostics, and timely access to appropriate medical care, are essential for minimizing clinical complications and reducing mortality. 4. **Access to healthcare:** In some rural and/or hard-to-reach areas, there is a lack of medical facilities and access to intensive care is insufficient for patients with severe conditions requiring adult or neonatal ICU monitoring/management. These further limits people's ability to access timely essential health care. 5. **Vector surveillance and control:** *Aedes* mosquito surveillance and control face major operational and structural challenges in some areas, such as, unplanned urbanization, inadequate water and waste management, limited human and financial resources. Insecticide resistance further hinders effective interventions. Weak integration between entomological and epidemiological surveillance, together with climate variability and population mobility, increases the risk of sustained transmission and virus spread. 6. **Lack of resources and skilled workers:** Other challenges can be stockouts of several essential supplies for prevention and control (insecticide, equipment, PPE), lack of reagents and consumables for laboratory diagnosis, and need for re-training field teams and health workers. The variation in distribution of cases across regions highlights the importance of continued investment in surveillance, preparedness, and response capacities to address evolving regional dynamics.

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 ERF response mechanism (IMS) as urgent public health response is required
☐	Recommend setting up of grading call (funding can be accessed before grading completed)
☐	Immediate support to response, but within limit of CFE (no grading recommended at this point in time)
☐	Rapidly seek further information and repeat RRA (including field risk assessment)
☒	Support Member States to undertake preparedness measures
☒	Continue to closely monitor
☐	No further risk assessment required for this event, return to routine activities

Immediate actions

WHO country offices (WCOs) to:

- Continue supporting public health response.
- Continue supporting national authorities' efforts to strengthen gaps in surveillance, case detection and reporting, laboratory confirmation of cases, case management, infection prevention and control.
- Continue supporting strengthening of community awareness on the ongoing outbreaks as well as prevention measures.
- Continue supporting resource mobilisation for an adequate implementation of response activities.
- Continue supporting the development of vaccine requests for supplementary immunization activities where necessary, according to regional and global recommendations (RITAG, SAGE).

WHO Regional Offices (RO) to support WCOs with:

- Advocacy efforts for timely information sharing.
- Regional partners coordination for a coordinated and efficient response.
- Monitoring of chikungunya case trends across the Regions, and in-depth risk analytics to identify high-risk areas and guide targeted interventions.
- Provide technical assistance, as appropriate, to support disease control and outbreak response activities.
- Adapt and contextualize guidance through the Regional Technical Advisory Group (RTAG) for dengue and other arboviruses of public health importance
- Support planning and capacity building to strengthen preparedness and response systems.

WHO HQ will support WCOs and ROs as needed, including:

- Support with vaccine recommendations, once the available evidence for the two available CHIKV vaccines has been reviewed by the chikungunya vaccine working group for the Strategic Advisory Group of Experts in immunization is completed (RITAG, SAGE).
- Support for the procurement of laboratory reagents and specimen collection kits.

Supporting information

Hazard assessment

Chikungunya is an *Aedes*-borne viral disease caused by the CHIKV, an RNA virus in the *alphavirus* genus of the family *Togaviridae*. CHIKV is transmitted by infected female mosquitoes, most commonly *Aedes aegypti* and *Aedes albopictus*, which can also transmit dengue and Zika viruses. These mosquitoes bite primarily during daylight hours and *Aedes aegypti* feeds both indoors and outdoors, whereas *Aedes albopictus* feeds primarily outdoors. They lay eggs in manmade and natural containers with standing water.

When an uninfected mosquito from *Aedes* species feeds on a person who has CHIKV circulating in their bloodstream, the mosquito can ingest the virus. Over a period of about 10 days (range: 7-12 days), the virus replicates into the mosquito and enters its salivary glands. Once this occurs, the mosquito becomes capable of transmitting the virus to a new human host through a subsequent bite. In the newly infected person, the virus begins to replicate and reaches high concentrations in the blood, enabling further transmission to other mosquitos and perpetuating the transmission cycle.

Transmission efficiency by *Aedes albopictus* can be enhanced for certain CHIKV lineages harboring the E1-A226V mutation.

In symptomatic patients, illness onset is typically 4–8 days (range 2–12 days) after the bite of a CHIKV-infected mosquito. Disease is characterized by an abrupt onset of fever, frequently accompanied by severe joint pain. The joint pain is often debilitating and usually lasts for a few days but may be prolonged, lasting for weeks, months or even years. Other common signs and symptoms include joint swelling, muscle pain, headache, nausea, fatigue and rash. Since these symptoms overlap with other diseases, including those with dengue,Zika and malaria, cases can be misdiagnosed. In the absence of significant joint pain, symptoms in infected individuals are usually mild and the infection may go unrecognized. Most patients recover fully from the infection; however, occasional ocular, cardiac, dermatological and neurological disease manifestations can occur. Cases with shock and perforation of small intestines have been reported with CHIKV infections. Patients at extremes of the age spectrum are at higher risk for severe disease. Newborns can be infected during birth from infected mothers or bitten by infected mosquitoes in the weeks after birth. Older people, particularly those with underlying medical conditions, are also at risk. Patients with severe disease require hospitalization because of the risk of organ damage and death. Available evidence suggests that once patients recover, they are likely immune from future chikungunya infections. CHIKV may be detected directly in blood samples collected during the first week of illness using molecular tests such as reverse transcriptase–polymerase chain reaction (RT–PCR), and after the first week of illness using serologic tests to detect immunoglobulin-M (IgM) antibodies produced in response to CHIKV infection.

There is no specific antiviral drug treatment for CHIKV infections. Clinical management includes managing fever and joint pain with anti-pyretic, analgesics, maintaining adequate hydration by consuming sufficient fluids and ensuring general rest. Paracetamol (acetaminophen) is recommended for pain relief and reducing fever until dengue infection is ruled out, as non-steroidal anti-inflammatory drugs (NSAIDs) can increase the risk of bleeding in patients with dengue.

There are currently two chikungunya vaccines that have received regulatory approvals and have been recommended for use in populations at risk in several countries, but the vaccines are not yet widely available nor in widespread use. A working group on chikungunya vaccines has been established from the WHO Strategic Advisory Group of Experts on Immunization (SAGE) to review vaccine trial and post-marketing data for possible recommendations.

Exposure assessment

Globally as of December 2024, autochthonous transmission of CHIKV had been reported from 119 countries and territories across six WHO regions. In addition, 27 countries and territories have evidence of established and competent *Aedes aegypti* and *Aedes albopictus* vector populations but have not yet documented autochthonous CHIKV transmission

From January to 10 December 2025, a total of 502 264 CHIKV disease cases including 208 335 confirmed cases, and 186 deaths were reported globally from 41 countries and territories. While certain WHO regions reported lower case numbers compared to 2024, others experienced marked increases, with some regions experiencing continued transmission. . The region of the Americas reported the highest number of confirmed cases followed by the European Region, with cases predominantly reported from French Overseas Departments in the Indian Ocean, Mayotte and Reunion. Based on available information, the number of suspected and confirmed CHIKV disease cases and deaths reported globally in 2025 are as below.

From January 2026 until 31 March 2026, CHIKV cases have been reported from 18 countries and territories. Global aggregation is limited due to incomplete reporting in some WHO regions.

Region	Context
African region	In 2025, a total of 2314 suspected cases, including 538 confirmed CHIKV disease cases have been reported from these countries: Cameroon, the Democratic Republic of Congo, Kenya, Madagascar, Mauritius, Senegal and Seychelles with Mauritius recording the highest number of cases. In 2026, as of 19 April, a total of 1500 (82 confirmed) cases have been reported from three countries: Madagascar (n=29), Mauritius (n= 1418), and Seychelles (n=53). In Madagascar, a total of 29 laboratory- confirmed cases with zero deaths were reported between 1 January to 14 February 2026. Confirmed cases were mainly reported from Mahajanga (21 cases)

	and Toamasina (7 cases) districts, with one case in Antsirabe. A limited number of travel-related cases were identified in Antananarivo and Antsirabe. In Mauritius, a total of 1418 cases, including 1415 local and three imported cases, have been reported in the country as of 19 April 2026. The current outbreak seems to have an increasing trend, with more cases reported in February when compared to January. The outbreak has been officially reported to WHO through IHR channels. In Seychelles, a total of 53 confirmed cases have been reported between 1 January to 14 February 2026, compared with 37 cases reported in 2025, suggesting intensified transmission during the rainy season and increased vector activity. More than 70 chikungunya cases have been reported among travellers returning from Seychelles to 10 European countries since November 2025, indicating ongoing virus transmission in the archipelago and the wider Indian Ocean region. Among these, three imported cases were recently confirmed in Latvia in individuals who had travelled to Seychelles. These travel-associated infections occur against the backdrop of a resurgence of chikungunya in Seychelles, where laboratory-confirmed cases increased sharply from around 15 December 2025 and peaked in early 2026.
Eastern Mediterranean Region	As of October 2025, a total of 1596 cases, including 67 confirmed CHIKV disease cases have been reported from Pakistan and Somalia**.** In Somalia, the latest outbreak was reported in Sool region, with 488 suspected cases between January and June 2025. Eight out of 10 samples tested were laboratory-confirmed for chikungunya. No further cases were reported in the country since then. In Pakistan, CHIKV disease cases in 2025 have been reported at a rate similar to 2024, with more than 1000 cases reported each year. According to the National Institute of Health, a total of 18 cases have been reported in the country in 2026 as of 22 March 2026. Sindh province reported 16 cases, and Khyber Pakhtunkhwa reported 2 cases. The burden of chikungunya in the WHO Eastern Mediterranean Region is likely underestimated due to surveillance gaps and underreporting. This is coupled with increasing numbers of *Aedes* population in some countries.
European Region	In 2025, France and Italy had reported locally acquired cases of CHIKV disease. France recorded 788 cases distributed across 78 clusters. The onset date of the last reported chikungunya case was 30 October, in Antibes, Provence-Alpes-Côte d'Azur. Italy reported 384 locally acquired cases distributed across six clusters. The onset date of the last reported chikungunya case was 11 November 2025 in Bellaria-Igea Marina. French overseas departments: • La Réunion: as of 10 December 2025, a total of 54 500 confirmed cases of chikungunya including 45 deaths were reported. From 1 January to 27 March 2026, nine imported cases of chikungunya have been reported, mainly returning from Madagascar (five cases) and from Mayotte, Seychelles, and more recently from Thailand. There have been 21 sporadic cases of locally acquired chikungunya reported since the beginning of the year. • Mayotte: as of 12 December 2025, a total of 1261 confirmed cases of chikungunya were reported. Between 1 January to 27 March 2026, a total of 549 confirmed chikungunya cases have been reported. The incidence remains high, indicating ongoing active viral circulation in the territory, although the number of cases decreased in the week of March 16-22 (n=70) when compared with the week before (n=111). Please note that for the European Region, data refer to confirmed cases only.
Region of the Americas	In 2025, 19 countries and one territory in the Americas Region reported a total of 316 401 chikungunya cases to Pan American Health Organization's (PAHO) Health Information Platform for the Americas (PLISA), of which 115 875 were laboratory-confirmed, including 175 deaths. Countries with the higher number of chikungunya cases were: Brazil (253 481 cases, 108 873 laboratory-confirmed, and 125 deaths), Cuba (51 271 cases, 1959 laboratory-confirmed, and 46 deaths), Bolivia (6860 cases, 4696 laboratory-confirmed, and 4 deaths), Argentina (3712 cases and 40 laboratory-confirmed), and Suriname (575 cases and 190 laboratory-confirmed).

	From 1 January 2026 until 20 April 2026, a total of 75 840 cases including 25 830 laboratory confirmed cases and 26 deaths have been reported in 19 countries from the region of the Americas. Brazil accounts for 42 979 cases (15 579 laboratory-confirmed) and 16 deaths, followed by Bolivia (with 23145) cases (7817 laboratory –confirmed) and 7 deaths. Together both these countries account for 87% of the total cases reported in the region. Cases have also been reported from: Argentina (n=5506), Suriname (n=2579), Cuba (n=1457), French Guiana (n=104), Mexico (n=15), Colombia (n=11), Costa Rica (n=9), Paraguay (n=9), Peru (n=5), Guatemala (n=8), El Salvador (n=5), Guyana (n=2), Honduras (n=1), Panama (n=1) Santa Lucia (n=1) and United States of America (n=1). The increase of chikungunya cases in Cuba in 2025 occurred after 9 years without the circulation of the virus. In Suriname, the increase of cases started in December 2025, after 5 years without cases reported.
South- East Asia Region	In 2025, over 300 72 confirmed CHIKV disease cases have been reported in the WHO South-East Asia region, with most cases reported from Bangladesh, followed by India, Thailand, and Sri Lanka. In India, between 1 January and 31 December 2025, a total of 213 016 suspected cases and 9177 confirmed cases were reported. The states reporting the highest number of confirmed cases were Maharashtra (3444), Karnataka (1096), and Tamil Nadu (580). In Bangladesh, the Institute of Epidemiology, Disease Control and Research reported a total of 19 490 suspected CHIKV disease cases in Dhaka city between 1 January and 31 December 2025, confirmed by RT-PCR or ICT method. Cases have been reported from both Dhaka North and South City Corporations, as well as from Chattogram, Gazipur, and Narayanganj, reflecting widespread urban transmission In Sri Lanka, a total of 151 confirmed CHIKV disease cases were reported from sentinel sites in Colombo, Gampaha and Kandy between 1 January 2025 and the second week of March 2025. According to the Epidemiology Unit situation report of the Ministry of Health dated 31 December 2025, a clear seasonal pattern of chikungunya was observed in 2025, with low transmission initially. A sharp peak occurred in June–July, followed by a gradual decline and a resurgence toward the end of the year, reflecting the country's monsoon pattern. Early in 2025, cases were mainly reported from Colombo, Gampaha and Kandy, while later in the year, a higher proportion of cases were reported from Jaffna, resulting in the observed cumulative distribution pattern across districts. The majority of reported cases (56%) were among females, with 36% in the 41–60 age group. In Thailand, a total of 1405 chikungunya cases were reported between 1 January and 31 December 2025 with 874 cases being females and 531 cases being male. Compared to the same period in 2024, the number of reported cases in 2025 is approximately double, increasing from 722 cases in 2024. No deaths were reported. The age distribution of cases is as follows: 0-4 years 25 (1.8%), 5-14 years 123 (8.8%), 15-24 years 105 (7.5%), 25-34 years 197 (14.0%), 35-44 years 255 (18.1%), 45-54 years 228 (16.2%), 55-64 years 243 (17.3%), ≥ 65 years 229 (16.3%). The northern region—particularly Chiang Mai, which lies along Thailand's border corridor with Myanmar and in proximity to Laos—is reporting the highest prevalence. Chiang Mai has reported 484 cumulative cases, with an incidence of 29.7 per 100 000 population, which is the highest among all provinces.
Western Pacific Region	In China (excluding China, Hong Kong SAR; China, Macao SAR; and Taiwan, China), as of 4 December 2025, a total of 29 497 locally confirmed cases has been reported, mainly in Guangdong (25 826), followed by Guangxi Zhuang Autonomous Region (2 198), Sichuan (358), Chongqing (296), Fujian Province (243), and Hunan (146), while other provinces such as Hainan and Jiangxi also reported a few local cases. Up to now, all reported cases have been mild, with no severe cases or deaths. China's national and provincial health authorities have implemented response efforts, including enhanced surveillance, early detection, clinical management, reinforced vector control, and community engagement activities.

	In China, Hong Kong SAR, a total of 82 confirmed cases have been reported. Of these, 11 cases were classified as local. As of 10 March 2026, 2 imported cases have been reported. The Centre for Health Protection (CHP) of the Department of Health continues to implement various prevention and control measures in collaboration with government departments and relevant organizations, aiming to minimize the public health impact of the disease in affected areas. In Indonesia, as of 31 July 2025, a total of 3608 confirmed CHIKV disease cases across 19 provinces have been reported, compared to 1399 confirmed cases reported during the same period in 2024. No chikungunya-related deaths have been recorded to date. The risk of future increases persists, particularly during the transition from the rainy to the dry season, with heightened concern in the most populous and frequently visited provinces: West Java, Central Java, East Java, and Banten. The Ministry of Health of Indonesia has strengthened detection and reporting through its Early Warning Alert and Response System (EWARS) and has implemented response measures in high-risk areas. In Malaysia, a total of 74 CHIKV disease cases have been reported in 2025. No chikungunya-related deaths have been recorded. Case investigation, integrated vector management, community engagement, and multisectoral collaboration efforts were implemented. All outbreaks were successfully contained within two weeks of detection, indicating an effective public health response and outbreak management. In the Philippines, as of 23 August 2025, a total of 653 CHIKV disease cases have been reported, a 78% decrease from 3009 cases reported in the same period in 2024. Cases ranged from 1 to 87 years old, with a median age of 33. Females accounted for 66% of cases (432 out of 653). There was one death reported (CFR: 0.15%). Local health authorities have investigated areas with clustering of cases to determine risk factors and implement vector control activities. In Singapore, 33 cases of CHIKV disease cases have been reported in 2025, compared to 14 cases reported in 2024. The majority of the cases were individuals with recent travel to chikungunya-affected areas. No chikungunya-related deaths and no sustained local transmission have been reported. As of 28 March 2026, 5 cases have been reported. The Communicable Diseases Agency of the country will continue to coordinate closely with agencies working on vector control as part of the overall public health response. Please note that for the Western Pacific region, data refers to confirmed cases only and only countries with local transmission are included.

Context assessment

Chikungunya is a disease caused by the CHIKV, an *Aedes*-borne arbovirus that is widely distributed in tropical and subtropical regions. While the overall fatality rate is low, severe disease can occur, especially in vulnerable populations such as infants, pregnant women, the elderly, and those with underlying medical conditions.

As seen in recent seasons, CHIKV can be introduced into new geographic areas through travellers carrying the virus, leading to local transmission where competent mosquito vectors, a susceptible population, and favorable environmental conditions are present.

In early 2026, several WHO regions reported continued or renewed chikungunya transmission, including areas that had previously experienced limited or no recent activity. This reflects the persistence of ecological and social determinants that enable rapid spread once the virus is introduced.

Factors associated with increased CHIKV transmission include:

- expansion of *Aedes* mosquito habitats, facilitated by climate change, increased temperatures, altered rainfall patterns, and extreme weather events. These changes continue to broaden the geographic suitability for *Aedes aegypti* and *Aedes albopictus*, increasing the risk of transmission in areas previously unaffected.
- broader geographic range of *Aedes* mosquitoes associated with transport of mosquito life stages in goods and vessels;
- unplanned urbanization and poor water and waste management contributing to vector reproduction, persistent transmission cycles and supporting sustained urban transmission cycles;

- weak integration between entomological and epidemiological surveillance, limited or inconsistent vector control capacity, including insufficient coverage and poor integration with water, sanitation and hygiene (WASH) challenges in maintaining long-term interventions, and rising insecticide resistance in several settings;
- political instability and humanitarian crises in some countries, such as those in parts of the Eastern Mediterranean and African Regions, which disrupt surveillance, healthcare delivery, laboratory capacity, and outbreak response operations; and lead to massive population movement;
- viral mutations linked to adaptation to *Aedes albopictus* mosquitoes, including E1-A226V, documented during the 2025 transmission and continuing into early 2026;
- increased travel to and from endemic regions introducing cases into areas with established populations of competent mosquito vectors and favorable environmental conditions.

The public health impact of the outbreaks depends on several factors, including the ability to detect chikungunya transmission, overall capacities for a coordinated public health response and clinical management, and the proportion of the population immunologically susceptible to CHIKV infection (i.e., people not previously infected with CHIKV). Young children, elderly individuals, and those with pre-existing medical conditions such as diabetes, hypertension, and cardiovascular diseases are at higher risk of developing severe disease. Additionally, people living in areas with high mosquito populations and inadequate vector control measures are at greater risk of being infected.

In some areas, there is a lack of medical facilities with limited geographical access, making it difficult for people to access basic health care. Other challenges can be stockouts of several essential supplies for prevention and control, lack of reagents and consumables for laboratory diagnosis, turnover and severe shortage of human resources for health particularly in fragile, conflict-affected and vulnerable countries and need for re-training field teams and health workers. *Aedes* mosquito surveillance and control also face operational and structural limitations, including unplanned urbanization, inadequate water and waste management, resource constraints, and insecticide resistance. Weak integration between entomological and epidemiological surveillance, combined with climate variability and population mobility, further increases the risk of sustained transmission and geographic spread of the virus.

Although regional trends vary, early 2026 data indicate that several WHO regions continue, as during 2025, to experience sustained or increasing transmission in localized areas, including re-emergence in settings that had not reported cases for several years. This complicates global situational interpretation but highlights conditions conducive to continued spread. Limited population immunity, favourable climatic patterns leading into the 2026 transmission season, and increasing mobility all contribute to an elevated risk of further expansion.

Strengthening early warning systems, enhancing integrated vector management, and reinforcing community engagement remain essential to reduce transmission risk. Sustained collaboration across sectors, including environmental management, water and sanitation, and urban planning, is required to address the underlying conditions that permit recurrent outbreaks. Effective public health strategies such as vector surveillance and control, and risk communication and community engagement are crucial in reducing the risk infection for susceptible individuals and preventing outbreaks.

WHO is supporting Member States in strengthening preparedness and response to arbovirus epidemics and pandemics, in alignment with the pillars of the Global Arbovirus Initiative, the Global Strategic Preparedness, Readiness and Response Plan, and the 5Cs of WHO's global architecture for Strengthening health emergency prevention, preparedness, response and resilience (HEPR).

Capacities and vulnerabilities related to the chikungunya outbreak response in the affected countries

Capacities	Vulnerabilities
Coordination & Leadership • Some countries provide up-to-date and timely situation reports. • National and regional coordination mechanisms—including incident management systems and multisectoral response plans have been activated, developed or under development in some affected countries. • Continuous capacity development has been supported through webinars, workshops, and virtual collaboration	**Coordination & Leadership** • Political instability and frequent turnover among decision-makers, coupled with weak multisectoral coordination between health and WASH sectors, contribute to a fragmented response. • Multiple emergencies in some countries may saturate response structures and health systems.

spaces, facilitating knowledge sharing through Community of Practice, peer learning, and sustained technical cooperation among Member States. • Due to chikungunya outbreaks, some countries have requested guidance to support public health policy decision-making. • All regional actions are aligned with WHO's global frameworks, ensuring strategic coherence, standardization of approaches, and reinforcement of global and regional preparedness and response architecture for arboviral diseases.	
Resource mobilization • Emergency procurement procedures established during prior outbreaks can be leveraged to fast-track acquisition of supplies.	**Resource mobilization** • All affected countries are experiencing acute funding gaps that are impeding rapid implementation of outbreak response measures. • Delays in mobilizing and disbursing emergency resources further compound response challenges.
Surveillance • Integrated epidemiological, laboratory, entomological, and clinical surveillance systems have been strengthened. Several regions have also advanced data integration for arboviruses and introduced/strengthened genomic surveillance. • Virtual cooperation spaces have been created in the Region of the Americas as a collaborative surveillance initiative between PAHO/WHO and Member States that allow the automated generation of different epidemiological analyses, situation rooms, and epidemiological bulletins, strengthening epidemiological surveillance of arboviruses, including chikungunya.	**Surveillance** • Enhanced surveillance and epidemiologic investigations are essential to more accurately determine the incidence and trends of CHIKV infection. Countries vary in their capacity to detect and report chikungunya and other vector-borne diseases, and outbreaks are often reported retrospectively, meaning real-time epidemiological data necessary for public health response is lacking. • Current surveillance systems often prioritize dengue over other *Aedes*-borne arboviruses, leading to frequent clinical misdiagnosis and misreporting of CHIKV as dengue. • Strengthening early detection and multisource surveillance capacity will support rapid risk assessment to guide targeted response measures such as risk communication and vector control strategies. Ongoing, close monitoring of the regional situation is also critical, along with active cross-border coordination and information sharing, given the potential for transmission in neighbouring countries.
Laboratory • Many of the affected countries have the capacity (human resources, equipment) to test and confirm cases. • Case confirmation protocols are in place. • RT-PCR capacity has been acquired in recent years across many regions. • Laboratory systems are part of integrated surveillance efforts.	**Laboratory** • Although many countries have acquired the capacity to perform RT-PCR testing in recent years, the availability of reagents for chikungunya testing is limited, costs may be prohibitive. • Serology is generally cheaper and more accessible but, in some regions, serological tests can cross-react with other alphaviruses and produce false positive test results. • Access to reliable diagnostics may be uneven, especially in low-resource settings • Stockouts and logistical challenges can disrupt testing and reporting.
Clinical management	**Clinical management**

• WHO and Member States have strengthened clinical capacities through the dissemination and implementation of standardized guidelines, health worker training, and the establishment of clinical expert networks, with the aim of improving diagnosis and case management. • The Region of the Americas has guidelines and other technical document for the case definition, clinical diagnosis and treatment of dengue, chikungunya, and Zika, supporting a comprehensive approach to these diseases in the context of simultaneous circulation. • The Region of the Americas has an international technical group of experts on arboviral diseases that supports technical cooperation activities in the countries. In addition, a regional network of experts in arboviral disease has been created (RECA), and 12 countries has already created their national networks supporting clinical training at subnational level.	• In some areas, limited medical facilities and geographical access, combined with shortages of essential supplies, lack of standard cases management protocols and guidelines, Lack of trained personnel particularly at sub-national levels and the need to retrain field teams and health workers, hinder the delivery of basic healthcare and the effective surveillance and reporting of cases. • Underestimation of clinical burden due to underreporting of severe chikungunya. • In some affected countries, there is weak integration of case notification between private health providers and national surveillance systems. • Epidemics of chikungunya can overwhelm health systems, exceeding the capacity for space and response in hospitalization and intensive care units. Many countries lack the infrastructure and resources to adequately respond to a situation of high patient demand caused by this disease.
Vaccination • Laboratory systems in many affected countries are equipped to support vaccine-related surveillance and monitoring. • WHO and Member States have enhanced monitoring and vaccine readiness, given that two chikungunya vaccines have now received regulatory approval and/or been recommended for use in at-risk populations in several countries by national/regional authorities. • WHO's global strategies can guide coherence and implementation of potential vaccination efforts in future • WHO and external advisors are evaluating vaccine trial and post-marketing data to inform future recommendations for broader use. • Countries introducing new vaccines, should aways strengthen their vaccine safety surveillance and implement plans to generate evidence to contribute to other countries decision making.	**Vaccination** • Although two vaccines have received regulatory approval, they are not yet in widespread use. • WHO and expert advisors are still reviewing vaccine trial and post-marketing data in the context of global chikungunya epidemiology and has initiated a process to evaluate potential use scenarios and the optimal use of vaccines, aiming to maximize public health impact while awaiting clinical effectiveness data—to support recommendations in endemic countries. This may delay implementation. • Shortages of prevention and control materials may also impact vaccine logistics and availability. Field teams and health workers may require updated training to support vaccination efforts effectively including to manage vaccine hesitancy.
Vector Control • Intensive adult mosquitoes control and larval source reduction activities are underway in some countries. • Community mobilization is being supported through local structures. • Countries have implemented a mix of evidence-based vector control interventions, including environmental management, larviciding, fogging, and innovative technologies such as drone-assisted spraying, complemented by monitoring of insecticide resistance. • In the Americas: ○ Strengthened the capacity of Member States to monitor insecticide resistance and viral detection in mosquitoes.	**Vector Control** • Insecticide resistance in *Aedes* mosquitoes reduces the effectiveness of chemical control methods. • Limited community involvement hampers source reduction and personal protection efforts. • Weak surveillance systems delay detection and response to outbreaks. • Unplanned urbanization and poor sanitation create widespread mosquito breeding sites. • Fragmented and underfunded programs lead to inconsistent and unsustainable control measures. • Climate change expands mosquito habitats and prolongs breeding seasons.

○ A new operational model for *Aedes* control has been developed and is being implemented. ○ WHO has supported Member States in strengthening capacities for the adoption and use of innovative *Aedes aegypti* surveillance and control technologies, including the implementation of biological and genetic methods such as the use of Wolbachia and the sterile insect technique, as well as the application of lethal traps, residual insecticide treatments at target sites, and new insecticide formulations. ○ Support for strengthening the entomological surveillance of member states through virtual collaboration spaces, enabling an integrated analysis of entomological and epidemiological data.	
Risk communication & community engagement • Public awareness and behavioural change campaigns have been implemented in some countries, emphasizing personal protection, household vector control, and early care-seeking. • Risk communication has been strengthened through multiple channels, including media, community health workers, and social platforms. • Many countries have strong community networks and community health workers capable of engaging households and rapid mobilization.	**Risk communication & community engagement** • Globally, public awareness of chikungunya transmission and prevention is increasing but inconsistent. Regions with active outbreaks tend to have higher awareness, while newly affected areas often lack sufficient knowledge, resulting in poor adherence to recommended actions such as eliminating mosquito breeding sites and using personal protection. Strengthening community participation and improving targeted risk communication are essential to enhance outbreak control and reduce disease transmission.

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