Avian influenza A H5N1 viruses have caused many, typically severe, human infections since the first human case was reported in 1997. However, no comprehensive epidemiological analysis of global human cases of H5N1 from 1997 to 2015 exists. Moreover, few studies have examined in detail the changing epidemiology of human H5N1 cases in Egypt, especially given the outbreaks since November, 2014, which have the highest number of cases ever reported worldwide in a similar period. Data on individual patients were collated from different sources using a systematic approach to describe the global epidemiology of 907 human H5N1 cases between May, 1997, and April, 2015. The number of affected countries rose between 2003 and 2008, with expansion from east and southeast Asia, then to west Asia and Africa. Most cases (67·2%) occurred from December to March, and the overall case-fatality risk was 483 (53·5%) of 903 cases which varied across geographical regions. Although the incidence in Egypt has increased dramatically since November, 2014, compared with the cases beforehand, there were no significant differences in the fatality risk, history of exposure to poultry, history of patient contact, and time from onset to hospital admission in the recent cases.

Methods

Search strategy and selection criteria

Human H5N1 case data were identified and compiled according to the probable and confirmed case definitions described below. Data on all human H5N1 cases in mainland China were downloaded from the online National Notifiable Infectious Disease Reporting Information System at the Chinese Center for Disease Control and Prevention. To improve understanding of the epidemiology of highly pathogenic avian influenza H5N1 virus, we did a systematic review of individual case data to describe the magnitude and distribution of all human H5N1 cases globally with illness onset between May 1, 1997, and April 30, 2015. We focused on the characteristics of patients, seasonal and geographical patterns, and examined in more detail the epidemiology of human H5N1 cases in Egypt.
Region’s Avian Influenza Weekly Update, the FluTrackers website, and the websites of the ministries of health in individual countries or regions.

We also searched PubMed for related studies using a systematic review approach that followed the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines (figure 1). Articles published from May 1, 1997, to April 30, 2015, were identified with the query "(H5N1[Title] AND PATIENT[Title] OR PATIENTS[Title] OR HUMAN[Title] OR HUMANS[Title] OR PERSON[Title] OR CASE[Title] OR CASES[Title]) AND ("1997/05/01"[Date-Publication]: "2015/04/30"[Date-Publication])". Articles published in English and Chinese were included, and full-text Chinese articles were found by searches of China National Knowledge Infrastructure and Wanfang Data. Relevant articles published between 1997 and 2015 were identified through searches in reports from WHO and ProMed-mail posts. Articles resulting from these searches and relevant references cited in those articles were reviewed.

WHO Disease Outbreak News of the Global Alert and Response updates and WHO statistics on the cumulative number of confirmed human H5N1 cases from November, 2003, to April, 2015, were used to establish a list of human H5N1 cases. All cases from sources other than WHO updates were matched with the initial list (figure 1). New cases, which were not yet officially announced by WHO, were identified with ProMed-mail posts and FluTrackers, and confirmed by the announcements of ministries of health in individual countries or regions. When crucial information was missing, additional information was sought from published literature, ProMed-mail posts and English language news releases from the regional office of WHO and the relevant ministry of health (appendix p 1).

### Case definition

WHO case definition was used to define cases of H5N1 infection. A confirmed case was defined as a human case of influenza A H5N1 virus infection reported by WHO and with laboratory confirmation—ie, a patient with defined clinical signs, epidemiological linkage, and laboratory confirmation by an influenza laboratory accepted by WHO, as specified in WHO case definition. Other reported cases were considered as probable cases if they had exposure to other confirmed patients or to sick or dead poultry, or the H5N1 infection was confirmed by the country or local institutions, but did not meet WHO criteria or was not announced by WHO.

### Data variables and extraction

All probable and confirmed cases with illness onset by April 30, 2015, were included in the analysis. Individual data on cases included age, sex, country, type of diagnosis, year, month and day of onset, date of hospital admission, final outcome (fatal or non-fatal), date of outcome, and potential risk factors (appendix pp 8–9). Information on exposure potentially related to the acquisition of H5N1 infections was collected (panel). Where contradictory information was found for a given variable, WHO and ministry of health data were given priority over journal articles, and journal articles were given priority over other data.

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**Figure 1: Study selection and collection of individual case data**

858 laboratory-confirmed H5N1 cases including 840 reported to WHO since 2003, plus 18 in Hong Kong in 1997

105 cases’ data provided by health agencies
134 in Vietnam
52 in mainland China
9 in Azerbaijan

868 cases after duplicates removed

280 cases’ data from FluTrackers
350 from 2015
60 from 2014
39 from 2013
31 from 2012

164 records identified in other sources
86 WHO reports of Weekly Epidemiological Record
61 ProMED-mail posts
17 WHO reports of genetic characteristics of H5N1 viruses

889 cases after 259 duplicates removed

116 records included in review

350 reports excluded
331 not data of individual case
16 not in English or Chinese
3 duplicates

907 cases included in this study after 251 duplicates removed
858 confirmed cases
49 probable cases

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southern Asia, and Cambodia, Indonesia, and Egypt (appendix p 20). The incidence in Asia remained at low levels in 2013–15, while the number of cases in Egypt has increased in 2014–15. During 1997–2015, 594 (67·2%) of 884 cases were reported between December and March, with a peak in January (20·9%; appendix p 21). However, compared with countries in southeast Asia and north Africa, countries in east Asia and west Asia had fewer cases in the warm or hot season from April to September (8·1% vs 26·2%), and showed earlier peaks (December vs January) and shorter epidemic periods, with cases occurring year-round in southeast Asia and north Africa, but from January to June and October to December in east Asia, and only from December to March in west Asia (appendix p 20, 21).

**Ethical approval**

The National Health and Family Planning Commission of China, the Ministry of Health of Vietnam, and the Ministry of Health of Azerbaijan determined that the collection of data from human cases of avian influenza A H5N1 virus infection was part of the public health investigation of an outbreak and was exempt from institutional review board assessment. All other data from other countries were obtained from publicly available data sources. All data were supplied and analysed in an anonymous format, without access to personal identifying information.

**Results**

907 human cases of H5N1 infection were reported globally between May 1, 1997, and April 30, 2015, of which 94·6% were confirmed cases and 5·4% were probable cases (table 1, figure 2). The number of cases per year varied, with the highest numbers recorded in 2015 (figure 3, appendix p 18, 19). The total number of cases (n=213) in 2014–15 was greater than that recorded from 2010–13 (n=181; appendix p 19), with the highest number of cases recorded in February, 2015, when 55 cases were reported in Egypt and one in China. The overall male-to-female ratio was almost even (1:1·2) from 1997 to 2014, although this pattern was not uniform across regions (table 1). The median age of patients was 19 years (IQR 5–32), and 363 (41·2%) of 881 cases were in children younger than 15 years and 707 (80·3%) of 881 cases were in people younger than 35 years. The incidence in Asia remained at low levels in 2013–15, while the number of cases in Egypt has increased in 2014–15. During 1997–2015, 594 (67·2%) of 884 cases were reported between December and March, with a peak in January (20·9%; appendix p 21). However, compared with countries in southeast Asia and north Africa, countries in east Asia and west Asia had fewer cases in the warm or hot season from April to September (8·1% vs 26·2%), and showed earlier peaks (December vs January) and shorter epidemic periods, with cases occurring year-round in southeast Asia and north Africa, but from January to June and October to December in east Asia, and only from December to March in west Asia (appendix p 20, 21).

**Panel: Definition of exposures to poultry and humans**

**Occupational exposure to live poultry**

Poultry-related exposure at place of work (eg, people involved in the breeding, trafficking, sale, and quarantine of poultry) in the 2 weeks before symptom onset

**Exposure to poultry at live bird markets**

Visit of a wholesale or retail market of live poultry or birds in the 2 weeks before symptom onset

**Exposure to sick or dead poultry**

Direct physical contact with, or proximity to, sick or dead poultry or poultry products (eg, meat) or faeces in the 2 weeks before symptom onset

**Exposure to backyard poultry**

Direct physical contact with, or proximity to poultry raised in the backyard within 2 weeks before symptom onset

**Any exposure to poultry**

Direct or indirect contact with, or proximity to healthy, sick, or dead poultry (including any kind of poultry or birds—eg, chickens, ducks, geese, pet birds, pigeons) in live bird markets, backyards, farms, or neighbourhoods, or consumption of improperly processed poultry products

**Exposure to virus through patient contact**

A patient with a history of close contact with a person with confirmed or probable influenza H5N1 virus infection (at any time from the day before symptom onset to death, or during the period that the patient was admitted into hospital) in the 2 weeks before symptom onset

| Type of case | Total (n=907) | East and southeast Asia (n=505) | North Africa (n=363) | Other (n=39) |
|--------------|--------------|-------------------------------|----------------------|-------------|
| Confirmed    | 858 (94.6%)  | 479 (94.9%)                   | 254 (94.5%)          | 25 (64.1%)  |
| Probable     | 49 (5.4%)    | 26 (5.1%)                     | 20 (5.5%)            | 3 (7.7%)    |
| Sex          |              |                               |                      |             |
| Female       | 476 (52.5%)  | 246 (48.7%)                   | 230 (63.5%)          | 17 (43.6%)  |
| Unknown      | 29 (3.2%)    | 21 (4.2%)                     | 6 (1.7%)             | 2 (5.1%)    |
| Age, years   |              |                               |                      |             |
| Median (IQR) | 19 (5–32)    | 19 (5–32)                     | 20 (4–34)            | 15 (5–22)   |

(Table 1 continues on next page)
After exclusion of four cases with unknown outcome (two from Vietnam in 2005 and two from Egypt in 2015), the overall case-fatality risk was 53.3% (483 of 903 cases), with a decrease from 70.7% (275 of 420 cases) in 2003–08 to 43.4% (202 of 465 cases) in 2009–15, and varied across geographical regions, with a case-fatality risk (69.4%, 349 of 503 cases) in east and southeast Asia more than two times that in north Africa (32.1%, 116 cases) and 36% (52 of 183 cases) during November, 2014, to April, 2015 (table 1). The age distribution of patients also differed by outcome, with a median age of 22 years (IQR 12–32) for patients with fatal cases and 10 years (3–30) in patients who recovered (figure 3). Most cases (95.8%, 748 of 781) reported exposure to poultry including 85.7% (439 of 512 patients) exposed to sick or dead poultry, 61.4% (188 of 306 patients) exposed to backyard poultry, 26.4% (82 of 311 patients) exposed to poultry at live bird markets, and 4.7% (15 of 321 patients) occupationally exposed to live poultry. Additionally, 6.2% (49 of 792 patients) reported contact with a patient with H5N1 infection before the onset of illness (table 1, appendix p 10). Time from onset of illness to hospital admission was available for 79.7% (723 of 907 patients) with a median of 4 days (IQR 2–6). Generally, patients who survived were admitted into hospital earlier than patients who died (median 3 days [IQR 1–6] vs 5 days [3–7]; appendix). Additionally, patients in north Africa had a shorter time from onset to hospital admission than patients in east and southeast Asia (3 days [1–6] vs 5 days [3–7]), but the median time from onset to outcome was the same (10 days) between patients in north Africa and cases in east and southeast Asia.

The influenza A H5N1 viruses in human cases have been characterised as clade or subclade 0, 1, 2.1, 2.1.3, and 7 (table 1, 2; appendix p 10). Clade 1 was first reported in Hong Kong in 2003, and then reported in southeast Asia each year from 2003 to 2014, but subclade 2.1 was only reported in Indonesia since 2005, and subclade 2.2 has circulated in Egypt since 2006 with sporadic reporting in Africa and west Asia. Additionally, subclade 2.3 has been reported in east and southeast Asia since 2005.

From March, 2006, to April, 2015, a total of 363 human cases with influenza A H5N1 virus infection were reported in Egypt with 116 deaths (32%; appendix p 23), of which 51% of cases were reported during the 6 months between November, 2014, and April, 2015 (appendix p 15). The male-to-female ratio was not significantly different between cases before November, 2014, and cases in the period from November, 2014, to April, 2015, but of the latter cases, patients had a higher median age (26 years, IQR 4–38) than before November, 2014 (16 years, 3–30), which was also different for both non-fatal and fatal cases (figure 4). However, the case-fatality risk was not significantly different at 36% (64 of 178 cases) before November, 2014, compared with 28.4% (52 of 183 cases) during November, 2014, to April, 2015.

### Table 1: Characteristics of patients with H5N1 infection by geographic region, May, 1997, to April, 2015

|                          | Total (n=907) | East and southeast Asia (n=505) | North Africa (n=363) | Other (n=39) |
|--------------------------|--------------|---------------------------------|----------------------|-------------|
| **Final outcome**        |              |                                 |                      |             |
| Death                    | 483 (53.3%)  | 349 (69.1%)                     | 116 (32.0%)          | 18 (46.2%)  |
| Unknown                  | 4 (0.4%)     | 2 (0.4%)                        | 2 (0.6%)             | 0           |
| **Hospital admission**   |              |                                 |                      |             |
| Yes                      | 819 (90.3%)  | 438 (86.7%)                     | 353 (97.2%)          | 28 (71.8%)  |
| Unknown                  | 82 (9.0%)    | 64 (12.7%)                      | 9 (2.5%)             | 9 (23.1%)   |
| **Time delay from onset to hospital admission, days** | | | | |
| Median time (IQR)        | 4 (2–6)      | 5 (3–7)                         | 3 (1–6)              | 2 (1–5)     |
| Unknown                  | 184 (20.3%)  | 121 (24.0%)                     | 46 (12.7%)           | 17 (43.6%)  |
| **Time delay from hospital admission to death or discharge (recovery), days** | | | | |
| Median time (IQR)        | 5 (2–9)      | 4 (2–9)                         | 5 (2–9)              | 5 (3–18)    |
| Unknown                  | 403 (44.4%)  | 166 (32.9%)                     | 219 (60.3%)          | 18 (46.2%)  |
| **Time delay from onset to death or discharge (recovery), days** | | | | |
| Median time (IQR)        | 10 (7–15)    | 10 (7–15)                       | 10 (7–14)            | 9 (7–20)    |
| Unknown                  | 360 (39.7%)  | 124 (24.6%)                     | 221 (60.9%)          | 15 (38.5%)  |
| **Predominant clade or subclade** | | | | |
| 0                        | 18 (2.0%)    | 18 (3.6%)                       | 0                    | 0           |
| 1                        | 193 (21.3%)  | 193 (38.2%)                     | 0                    | 0           |
| 2.1                      | 208 (22.9%)  | 208 (41.2%)                     | 0                    | 0           |
| 2.2                      | 393 (43.0%)  | 363 (100%)                      | 30 (76.9%)           |             |
| 2.3                      | 89 (9.8%)    | 84 (16.6%)                      | 5 (12.8%)            |             |
| 7                        | 2 (0.2%)     | 2 (0.4%)                        | 0                    | 0           |
| Unknown                  | 4 (0.4%)     | 0                               | 4 (10.3%)            | 0           |
| **Exposure history**     |              |                                 |                      |             |
| Any exposure to poultry  |              |                                 |                      |             |
| Exposure                 | 748 (82.5%)  | 382 (75.6%)                     | 339 (93.4%)          | 27 (69.2%)  |
| Unknown                  | 126 (13.9%)  | 94 (18.6%)                      | 24 (6.6%)            | 8 (20.5%)   |
| Occupational exposure to live poultry | | | | |
| Exposure                 | 15 (1.7%)    | 12 (2.4%)                       | 2 (0.6%)             | 1 (2.6%)    |
| Unknown                  | 586 (64.6%)  | 289 (57.2%)                     | 286 (78.8%)          | 11 (28.2%)  |
| Visits to live bird markets | 82 (9.0%) | 68 (13.5%) | 11 (3.0%) | 3 (7.7%) |
| Visits to sick or dead poultry | 596 (65.7%) | 296 (58.6%) | 286 (78.8%) | 14 (35.9%) |
| Exposure to sick or dead poultry | | | | |
| Exposure                 | 439 (48.4%)  | 242 (47.9%)                     | 174 (47.9%)          | 23 (59.0%)  |
| Unknown                  | 395 (43.6%)  | 217 (43.0%)                     | 166 (45.7%)          | 12 (30.8%)  |
| Exposure to backyard poultry | 188 (20.7%) | 113 (22.4%) | 64 (17.6%) | 11 (28.2%) |
| Unknown                  | 601 (66.3%)  | 301 (59.6%)                     | 286 (78.8%)          | 14 (35.9%)  |
| Human case contact       |              |                                 |                      |             |
| Contact                  | 49 (5.4%)    | 35 (6.9%)                       | 3 (0.8%)             | 11 (28.2%)  |
| Unknown                  | 115 (12.7%)  | 86 (17.0%)                      | 21 (5.8%)            | 8 (20.5%)   |

Data are presented as n (%) of patients unless otherwise indicated. East and southeast Asia (505 cases): Indonesia (205), Vietnam (134), Cambodia (58), mainland China (52), Thailand (27), Hong Kong (23), Laos (2), and Myanmar (1). North Africa (363): Egypt (53). Other (39): Turkey (12), Azerbaijan (9), Bangladesh (7), Pakistan (4), Iraq (3), Nigeria (2), Djibouti (1), and Canada (1). Data on H5N1 clade or subclade were based on the reports from WHO website or scientific literature, and the known geographic distribution of the viruses. Not all cases were laboratory confirmed and reported with clade results, so we presumed that the case in each area was infected by the reported predominant clade or subclade of H5N1 in the same period and area. The clade or subclade in each area were clade 0 in Hong Kong in 1997; clade 1 in Vietnam, Cambodia, Thailand, and Hong Kong; subclade 2.1 mainly in Indonesia; subclade 2.2 in Egypt, Turkey, Azerbaijan, Bangladesh, Iraq, Nigeria, and Djibouti; subclade 2.3 in Vietnam, Bangladesh, Laos, Canada, and Myanmar; and clade 7 in mainland China. Clade data were unavailable for four cases in Pakistan in 2007.
Figure 2: Geographic distribution of human cases of H5N1 infection by outcome, May, 1997, to April, 2015 (n=907)
Data for China include cases reported by mainland China (52 cases) and Hong Kong, China (23 cases). In the pie charts, the blue sectors show the proportion of non-fatal cases, the red fatal cases, and the green unresolved cases. The numbers beneath the country names show numbers of cases: fatal/non-fatal/unresolved.

Figure 3: Epidemic curve of human cases of H5N1 infection by region, May, 1997, to April, 2015
(A) H5N1 human cases reported worldwide (884 cases). (B) East and southeast Asian countries (484 cases) were Indonesia (187), Vietnam (134), Cambodia (58), mainland China (52), Thailand (27), Hong Kong (23), Laos (2), and Myanmar (1). (C) North African countries (363 cases) were Egypt (363). Month of illness was unknown in 23 cases (21 cases in Indonesia in 2009 and two cases in Turkey in 2006) and were excluded from this epidemic curve.
(appendix p 15). For fatal cases, the median time and IQR (5 days, 3–6) for onset to hospital admission was the same from March, 2006, to October, 2014, and November, 2014, to April, 2015, but the time was different for non-fatal cases before November, 2014 (1 day, 1–3), and in November, 2014, to April, 2015, (4 days, 2–6). Most cases reported a history of poultry exposure—96·1% before November, 2014, and 90·8% in November, 2014, to April, 2015.

Discussion

In this Review, a global dataset spanning 18 years was systematically collated to investigate changes in the epidemiological characteristics of human H5N1 cases, and we focused on Egypt, given its unique situation of increasing incidence since November, 2014.\(^{20,37,46}\) Our findings suggest that the geographical extent of human H5N1 cases has expanded from east Asia to southeast Asia, then to west Asia and north Africa in 2003–09, which could be related to global spread of the virus via bird migration.\(^{61–63}\) The bird migration network was shown to better reflect the observed viral gene sequence data than other networks (eg, poultry trade networks) and contributes to seasonal H5N1 epidemics in local regions.\(^{3,5,7}\) Additionally, previous evidence showed Siberia as a major hub for the spread of the virus via

![Figure 4: Age distribution of human cases with H5N1 infection by gender, geographic regions, and outcome, May, 1997, to April, 2015](image-url)
There is a significant increase in the range of virus spread and outbreaks among birds, with the migration patterns of wild birds and the activity of the virus in winter or cooler seasons. Investigators with the migration patterns of wild birds and the activity of the virus in winter or cooler seasons, and also overlapped with increased poultry outbreaks and H5N1 transmission during cold and dry conditions, and also overlapped with human seasonal influenza epidemics. 

Although most human populations are thought to have little or no immunity to influenza A H5N1 viruses, most patients examined in this study were children and younger adults, and these age groups were also more likely to recover, whereas the fatality risk was higher in adults, which might be related to the immunological reaction of the virus in different age groups. Consistent with previous reports, the cases in which time from onset of illness to hospital admission was 3 days or more were more likely to be fatal than those admitted to hospital within 3 days of onset with an odds ratios (OR) of 3·6 (95% CI 2·5–5·1), which might be because of the early administration of antiviral treatment, or selection bias where the patients admitted to hospital later after onset were more likely to be severe. Compared with Indonesia, Vietnam, Cambodia, mainland China, and Thailand, the lower case-fatality risk in Egypt might be attributed to a less virulent virus clade, less severe clinical disease, and earlier identification, earlier hospital admission, and early treatment with oseltamivir for H5N1 cases. However, the case-fatality risk might be underestimated because various government entities or reports might not have identified or updated data on which cases had died at the time we collated data. Not all cases were laboratory confirmed and reported with clade results, so we presumed that the patient was infected by the reported clade or subclade of H5N1 in the same period and area. Clade data were unavailable for four cases in Pakistan in 2007, and four cases with unknown outcome (two in Vietnam in 2005 and two in Egypt in 2015) were also excluded.

### Table 2: Clade or subclade and fatality of human case with H5N1 infection, May, 1997, to April, 2015

| Clade or subclade | First identified, year | Locations identified | Case-fatality risk |
|-------------------|------------------------|---------------------|-------------------|
| Clade 0 | 1997 | Hong Kong | 33% (6/18) |
| Clade 1 | 2003 | Hong Kong, Vietnam, Cambodia, and Thailand | 59% (112/191) |
| Subclade 2.1 | 2005 | Indonesia | 85% (176/208) |
| Subclade 2.2 | 2005 | Turkey, Egypt, Azerbaijan, Djibouti, Iraq, Nigeria, and Bangladesh | 33% (130/391) |
| Subclade 2.3 | 2005 | Mainland China, Laos, Myanmar, Vietnam, Hong Kong, Bangladesh, and Canada | 62% (55/89) |
| Clade 7 | 2003 | Mainland China | 100% (2/2) |

Data on H5N1 clade or subclade of human cases were based on the reports from WHO website or scientific literature, and the known geographic distribution of the viruses. Not all cases were laboratory confirmed and reported with clade results, so we presumed that the patient was infected by the reported clade or subclade of H5N1 in the same period and area. Clade data were unavailable for four cases in Pakistan in 2007, and four cases with unknown outcome (two in Vietnam in 2005 and two in Egypt in 2015) were also excluded.

Influenza H5N1 viruses have evolved from the 1996 progenitor strain and now comprise at least ten clades, through a complexity of genetic changes, which have infected domestic poultry and wild birds in many countries. In this study, four clades (0, 1, 2, and 7) and three subclades (2.1, 2.2, and 2.3) of H5N1 strains have infected humans, all of which have been reported in human cases before 2006. Compared with clade 0, the cases with clade 1, and subclades 2.1 and 2.3 were more likely to result in death with a crude OR of 2·8 (95% CI 1·1–6·6), 11·0 (3·5–37·8), and 3·2 (1·0–11·4), respectively (appendix p 10). However, the risk of death between cases with clade 0 and subclade 2.1 was not significantly different (OR 1·0, 95% CI 0·3–3·3). Based on the available information, the virus clades isolated from human beings were the same as the clades circulating in local poultry. From late 2003 to mid-2005, most H5N1 infections in humans were caused by clade 1 strains in southeast Asia (ie, Vietnam, Thailand, and Cambodia).

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Although the highly pathogenic H5N1 strains can be expected to continue evolving over time, preliminary laboratory investigation has not detected major genetic changes in the viruses isolated from the patients or animals in 2014–15 compared with previously circulating isolates in the same regions,53,54 and the genetic diversity of the influenza H5N1 virus decreased substantially between 1996 and 2011 in China, presumably under strong selective pressure associated with vaccination in poultry.55 However, other influenza A H5 virus subtypes, such as H5N2, H5N3, H5N6, and H5N8, have been detected in birds in Europe, North America, and Asia, and no human cases of infection have been reported so far, with the exception of three human cases of influenza A H5N6 virus infection detected in China in 2014–15.55–57 However, the co-circulation of influenza A viruses in human reservoirs and animal reservoirs can provide opportunities for these viruses to reassort and acquire genetic characteristics that facilitate sustained human-to-human transmission—a necessary trait of pandemic viruses.1,2,3

Vaccines and antivirals are the most effective approaches to prevent influenza virus infection and treat illness, respectively.4,5,6,8-14 Vaccination of poultry has been implemented in many of the affected countries to control H5N1 in poultry, especially in those locations where influenza H5N1 viruses have become enzootic in poultry and wild birds.45–47 27 H5N1 candidate vaccine viruses for human beings are available and a new candidate vaccine is in preparation to protect against the circulating H5 clade 2.2.1.2 of viruses in Egypt.48 The first adjuvant vaccine for the prevention of influenza H5N1 virus was approved by the US Food and Drug Administration in November, 2013, and this vaccine is being stockpiled for pandemic preparedness by the US Government.90 Additionally, the antiviral drug oseltamivir can reduce the severity of illness and mortality when started soon after symptom onset and appears to benefit all age groups. Prompt diagnosis and early therapeutic intervention should therefore be considered for all H5N1 cases,49–51,52 though antiviral resistance continues to receive attention and continued monitoring is needed.92 The availability of antivirals and vaccines in the event of an H5N1 pandemic should be considered in advance.93

There are some limitations to this study. First, the data used were collated from different sources. The data quality might be influenced by key steps in public health surveillance or reports including case definitions, reporting methods, availability of health care and laboratory diagnostics, under-reporting, and the completeness and accuracy of data reported or announced by different countries or organisations. Compared with the areas in which many cases were seen in this study, some countries with few or no cases reported might be attributed to the low availability and capability of public health services, serological testing, and surveillance. Second, detailed data on case characteristics and clinical management were unavailable to assess the association between clinical manifestation, treatment, and outcome, and this study did not include the cases with subclinical H5N1 infection, which have been occasionally reported.70,94–96 Third, the findings might be affected by missing data on exposure, outcome, and hospital admission, and the misclassification of cases with presumed clade or subclade. Additionally, this study only included data sources in English or Chinese, which might neglect data on cases reported in other languages, including announcements or reports from Egypt.

In this Review, the high-risk areas, population groups, and seasonality of human highly pathogenic avian influenza H5N1 virus infections have been systematically reviewed, providing evidence for the planning of prevention and control. The geographical distribution of countries with human H5N1 infections has expanded, especially between 2003 and 2008, with variations in outcome, demography, seasonality, and the clade or subclade of viruses across the region. The incidence of human infections increased dramatically in Egypt from November, 2014, to April, 2015, but remained at a low level in other regions, and the case-fatality risk in Egypt has not significantly changed. However, since avian influenza A H5N1 viruses present a continuous threat to human populations, echoing the recommendations of WHO and other organisations on influenza at the human–animal interface,49,53,97–99 sustained efforts and close collaboration between the animal health sectors and public health sectors at community, national, and international levels to monitor the dynamics in human beings, poultry, and wild birds, and to conduct early clinical management is needed. Downstream research should focus on the development of vaccines and antivirals, explore the driving factors behind the epidemic, and assess the potential for future pandemics.

Contributors

HY designed and supervised the study. SLi and YQ designed the study, collected data, finalised the analysis, wrote the manuscript, and interpreted the findings. XR did analysis and mapped the case geographic distribution. SLi, TKT, LF, HJ, ZP, JZ, and QL did the literature search, data collection, and data analysis. BJC, NAW, MG, PW, PWH, JJF, GFG, and AJT interpreted the findings and commented on and revised drafts of the manuscript. All authors read and approved the final manuscript.

Declaration of interests

BJC has received research funding from MedImmune and Sanofi Pasteur, and is a consultant for Crucell NV. SLi, YQ, BJC, XR, NAW, MG, TKT, PW, LF, HJ, ZP, JZ, QL, SLi, PWH, JJF, GFG, AJT, and HY declare no competing interests.

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