SIDC Health Bulletin

QUARTERLY BULLETIN ON LOCAL & GLOBAL HEALTH NEWS

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What is currently happening?

- COVID-19 has transitioned into an endemic phase globally. The Omicron BA.3.2. has re-emerged.
- Malaysia reported an increase in TB cases in the first quarter of the year compared to the same period last year. Study supports shorter TB preventive therapy. The WHO has updated its support for the use of cost-saving methods and tools for TB.
- Singapore has confirmed that Wolbachia-infected mosquitoes are effective in controlling dengue.
- Sarawak has reported 3 fatal human rabies cases to date.
- The H5N1 zoonotic influenza continues to circulate among animals, with one human case from Cambodia. Human cases of zoonotic H9N2 influenza were reported in China and for the first time in Europe.
- The Nipah virus outbreak in India is over; however, the one in Bangladesh has not. Bangladeshi researchers identified an emerging bat-borne virus, Pteropine orthoreovirus (PRV), that has Nipah virus-like symptoms.
- The Marburg outbreak in Ethiopia has ended.
- The global mpox epidemic continues, though the public health risk is assessed as unchanged.

COVID-19

From January to March 2026, global COVID-19 activity remained low and stable overall, with declining case numbers and no major surges reported across surveillance regions.[1]

New confirmed cases dropped to 38,516 across 80 countries in the one month from 16 February to 15 March, down from the prior 28-day tallies. An estimated 2,940 hospitalisations and 1,254 deaths were reported in 37 countries in the same period. Weekly testing in mid-March totalled 64,397 tests globally, reflecting reduced transmission.[1]

The World Health Organization (WHO) is currently tracking several SARS-CoV-2 variants. The most prevalent variant remains the XFG, which accounted for 45% of all submitted sequences in the week ending 8 March 2026; however, its prevalence has been declining since the previous months. Both NB.1.8.1and BA.3.2 variants under monitoring (VUM) have been increasing in prevalence (31% and 8%, respectively) while LP.8.1 has been de-escalated since February 2026 and is no longer considered a VUM.[1] The current variant of interest (VOI), JN.1—responsible for the multi-country surges in cases in 2025 [2]—seems to be stabilising.[2]

BA.3.2, also known as 'Cicada', a descendant of the early Omicron BA.3 lineage (first detected in South Africa in November 2024), began to rise in late 2025 and spread to 23 countries by early 2026, primarily due to its substantial antibody evasion capabilities.[2–4] However, there has not been a significant rise in COVID-19 cases due to its (re)emergence.[1]

Based on available evidence on XFG, NB.1.8.1 and BA.3.2, the WHO has assessed that they do not pose additional public health risks relative to other currently circulating SARS-CoV-2 variants.[1]

TUBERCULOSIS

Cases ushered in the new year, Malaysia

Tuberculosis (TB) returned to focus again early this year, with reports of 'outbreaks' nationwide. By early February 2026, 10 active clusters were reported, with one in Johor linked to school children.[5]

Kementerian Kesihatan Malaysia (KKM) reported that 2,571 cases were reported in the first week of this year, a 9.8% increase from the same period last year. The number of cases peaked in mid-February, reaching over 3,100, before stabilising by mid-March.[6–10]

Cumulative cases reached 3,161 by epidemiological week 6 (EW6/8 – 14 February 2026), with 755 cases reported in Sabah, followed by Selangor (596) and Sarawak (332). footnote1

KKM emphasises early detection, screening of contacts, treatment adherence and public education to control the disease.

Study supports short treatment

A trial conducted in Brazil indicated that shortened regimens of TB preventive therapy (TPT) are safe and effective in preventing active TB infections.[11–13]

The trial involved 500 participants above 15 years old, without HIV, with recent TB exposure and a positive latent TB infection (TBI) test. They received either one or three months of isoniazid and rifapentine (HP; 1HP or 3HP).

The outcomes were:[11]

- high completion rates for both regimens (89.6% and 84.1%, respectively, for 1HP and 3HP),
- mild or moderate adverse reaction (targeted safety events or treatment discontinuation, 10% - 16%), and
- the regimens were neither superior to the other.

The data generated will help clinicians, public health authorities, and patients to make informed decisions regarding treatment choices.[11–13]

The link to the publication.

[1] *Data incomplete; no public data available up to 30 March 2026.*

Tuberculosis diagnosis update from the World Health Organization (WHO)

The World Health Organization (WHO), for the first time, issued recommendations on new near-point-of-care (NPOC) molecular tests for the diagnosis of tuberculosis (TB); easy-to-collect tongue swab samples to simplify and expand access to testing; and a cost-saving sputum pooling strategy to increase testing efficiency for TB and rifampicin-resistant TB.[14,15]

The agency endorses NPOC nucleic acid amplification tests (NAATs) on sputum or tongue swabs for initial detection of TB and rifampicin resistance, especially where resources are limited. Tongue swabs are suitable for adults and adolescents who are unable to produce sputum and can be self-collected with guidance. Sputum pooling with low-complexity automated NAATs (LC-aNAATs) saves costs and speeds results in high-burden settings.[15,16]

These updates stem from 2025 evidence reviews, including cost-effectiveness models showing NPOC-NAATs as highly cost-effective versus smear microscopy and cheaper than LC-aNAATs. They boost equity, acceptability, and feasibility, enabling earlier diagnosis at lower programme costs. Their implementation targets gaps in testing access for pulmonary TB.[14]

The consolidated guidelines on TB, *Module 3: Diagnosis, 2nd Edition*, are being updated and will be published soon.

Find out more at this link.

DENGUE

Bacterial infection in mosquitoes cuts dengue infection

Singapore's National Environmental Agency (NEA) details the outcome of a major clinical trial on 'Project Wolbachia', which involved the release of *Aedes aegypti* mosquitoes infected with Wolbachia bacteria to suppress dengue transmission.[17,18]

It reports results from a large-scale, multi-year intervention in Singapore, comparing Wolbachia-treated areas against controls. The method leverages Wolbachia's natural ability to block dengue, Zika, chikungunya, and yellow fever viruses in mosquitoes without killing them, achieving sustained population replacement.

The trial found that Wolbachia deployment reduced dengue cases by over 70% in treated zones, with no rebound after years of monitoring, marking it as a safe, sustainable alternative to chemical insecticides. The NEA highlighted these outcomes as a public health breakthrough, now expanding regionally.[19]

Click the link for the full publication.

RABIES

Sarawak human cases

In 2026, up to mid-March, three human rabies deaths were reported amid the ongoing outbreak since 2017; these brought the cumulative total to 93 cases.[20–22]

As of EW10/2026 (week ending 8 March), a total of 4,623 animal bite cases were reported in Sarawak, with an average of 462 cases recorded each week. The health authorities have announced a shift in transmission patterns in the state as the number of animal bite cases from cats is rising. Of the total, 62% involved bites or scratches from cats, followed by dog bites (37%), while the remaining (1.3%) involved bites from other animals.[21,22]

AVIAN / ZOONOTIC INFLUENZA

Global avian and zoonotic influenza activity in 2026 through March remained widespread, though primarily confined to animal populations, with clade 2.3.4.4b of the influenza A(H5N1) virus driving most outbreaks in birds, poultry, and some mammals. However, no sustained human-to-human transmission has been observed.[23]

From late February to 26 March, the Food and Agriculture Organization (FAO) reported 1,479 new highly pathogenic avian influenza (HPAI) events across 42 countries/territories, mainly H5N1 (1,251 events), affecting poultry, wild birds, and species like swans and ducks in regions including Europe (Belgium, Lithuania), Asia (China, South Korea), and the Americas (Argentina, Canada, Chile). Europe alone saw 2,514 influenza A(H5) detections in domestic (406) and wild (2,108) birds from December 2025 to late February 2026 across 32 countries.[23,24]

Human H5N1 cases in Q1 2026 (January–March) remained sparse globally, with Cambodia reporting the only confirmed cases amid ongoing sporadic zoonotic transmissions. China reported two human cases of low pathogenicity avian influenza A (LPAI) H9N2 and an H10N3 in February.[25] Italy confirmed Europe's first case of human H9N2 on 25 March 2026.[26] To date, 90% of human H9N2 cases have been reported in China, with several more in Cambodia, Vietnam and India. Cases have also been detected in Africa.[27–30]

NIPAH VIRUS

India, outbreak ended

India experienced a Nipah virus (NiV) outbreak in West Bengal in late 2025 to early 2026 – the third in the state since 2001. Two laboratory-confirmed cases among healthcare workers at a private hospital in Barasat were reported, with no community transmission detected. The situation was declared contained by late January 2026.[31]

Cases emerged in December 2025 and were confirmed by the National Virology Institute in mid-January. The authorities had deployed mobile BSL-3 labs together with enhanced

surveillance (contact tracing, infection prevention control [IPC], and airport screenings) to address the outbreak. All prior 2025 cases were fatal, underscoring persistent high lethality and surveillance needs.[31]

Bangladesh, ongoing

Bangladesh reported its first NiV case in early February 2026 in Rajshahi. The fatal adult case was linked to the consumption of raw date palm sap sometime between 5th and 20th January. She did not have any travel history. At the time of publication, all 35 contact persons are being monitored and have tested negative for the virus.[32]

Efforts include surveillance by the Institute of Epidemiology, Disease Control and Research (IECDR),[33] contact tracing, public awareness campaigns against contaminated sap, and palm tree barriers.

Bangladesh regularly has small NiV outbreaks, with cases reported at different times of the year, though most tend to occur between December and April, corresponding with the harvesting and consumption of date palm sap.[32]

The World Health Organization (WHO) assessment and advice

The case fatality ratio (CFR) in outbreaks across Bangladesh, India, Malaysia, and Singapore ranges from 40% to 75%, depending on local capabilities for early detection and clinical management. There are currently no licensed medicines or vaccines specific for NiV infection.[31,32]

Public health education messages should focus on:

- Reducing the risk of bat-to-human transmission
- Reducing the risk of human-to-human transmission
- Controlling infection in health care settings

Based on the available information, the WHO does not recommend any travel and/or trade restrictions.

The WHO assesses the overall public health risk posed by NiV at the Indian sub-national level and in Bangladesh to be moderate, taking into consideration the unavailability of specific drugs or vaccines for NiV infection and the difficulty of early diagnosis. For neighbouring countries, the public health risk posed by the virus at the regional level is low. There have been no reports of cross-border transmission, and the current outbreak remains geographically limited. Nevertheless, the risk of disease occurrence persists due to the shared ecological corridor of fruit bats and the history of human cases previously reported in the region. Both India and Bangladesh have demonstrated strong capacity and experience in managing past NiV outbreaks. [31,32]

The WHO assesses the public health risk posed by NiV at the global level to be low, as there has been no confirmed spread of cases outside India, Bangladesh, the Philippines, Malaysia and Singapore.[31,32]

For more information, please proceed to any of the links below:

- Nipah Fact Sheets (WHO)
- Nipah Virus Infection (WHO)
- Nipah Virus Outbreak (WHO)

Emerging bat virus

Bangladeshi researchers have identified an emerging bat-borne virus, Pteropine orthoreovirus (PRV), while investigating archived throat swabs from five patients initially suspected of NiV infection between December 2022 and March 2023.[34–36]

The patients, detected via a multi-agency NiV surveillance (IEDCR and Research and the International Centre for Diarrheal Disease Research, icddr,b) in Bangladesh and the US Centres for Disease Control and Prevention, CDC), presented with NiV-like symptoms (fever, encephalitis, respiratory issues, disorientation, abnormal gait, and breathing difficulties - one paediatric case had convulsions). Polymerase chain reaction (PCR) tests ruled out NiV. However, sequencing confirmed PRV, which was cultured from three samples. The outcomes varied between patients: two fully recovered, two had lingering symptoms, and one died in 2024 from neurological decline.[34]

PRV, related to Nelson Bay virus (with prior human cases in Malaysia), circulates silently alongside NiV from fruit bats, likely via raw date palm sap. Testing for PRV in NiV-like illnesses is urged to address the under-detection of bat zoonoses.[35]

MARBURG

Ethiopia, end of the first outbreak

The World Health Organisation (WHO) declared the November 2025 Ethiopian Marburg virus disease (MVD) outbreak over on 26 January 2026. A total of 19 cases were reported. Of these, 14 were confirmed, with 9 deaths, and a further 5 probable cases, which resulted in deaths. The case fatality rate, CFR, was 64.3%.[37]

The first known case developed symptoms on 23 October 2025. The announcement of suspected viral haemorrhagic fever (VHF) was made on 12 November 2025, and laboratory confirmation of MVD was made two days later. Over 800 contacts were screened, with two consecutive rounds of disease-free periods completed before the outbreak was declared over. This was the first time the disease was reported in the country.[38]

Globally, 19 outbreaks have previously been reported, with the most recent in the Republic of Tanzania from January to March 2025.[37]

MPOX

The global mpox situation up to March 2026 reflects an ongoing multi-country outbreak that began in 2022, with over 179,612 confirmed cases reported across 145 countries and territories by late January 2026. The Americas accounted for approximately 41% of cases, Africa 36.2%, and Europe 17.8%, with a total of 160 deaths in the Americas alone through early 2026.[39,40]

Regionally, Africa saw sustained clade I and Ib transmission, with de-escalation of its continental emergency by late January 2026. New clade Ib cases emerged in places such as Madagascar (495 cases by January), Comoros, Czechia, and Nepal. The Americas reported 172 cases in 8 countries early in 2026, while Europe had 25,975 cases across 29 EU/EEA countries since the outbreak started. The US noted 15 clade I cases by March, mostly travel-related.[39–43]

The WHO's latest update (26 March 2026, number 64), which covered global data to 28 February, and Africa to 15 March, reported recombinant clade Ib/IIb strains in the UK and India.[39] The Indian case involved a 40-year-old male from Kerala with no travel history, presenting mpox symptoms in early January. Sequencing revealed recombination likely occurring since at least September 2025. A similar UK case from December 2025 involved a traveller from an endemic African country, also showing Ib/IIb genomic mix; no onward transmission occurred in either instance.[39,44]

The WHO urges sustained mpox surveillance, rapid International Health Regulations (IHR) notifications for unusual events, and genomic sequencing of at least 10% of cases in outbreak settings. Guidance covers ongoing clades Ib/IIb transmission in key populations and Ia/IIa zoonotic spread. The WHO supports diagnostics and vaccines via allocation mechanisms, and rapid test evaluations amid moderate risk in affected regions.[44]

The public health risk of the mpox recombinant strain (clades Ib/IIb) is assessed as unchanged from prior strains: moderate for high-risk groups like men-having sex with-men (MSM) with multiple partners or sex workers, and low for the general population.[44,45]

IMPLICATION FOR SARAWAK BASED ON THE VIEWS OF SIDC

As with the other SARS-CoV-2 variants, the highly mutated Omicron BA.3.2 sublineage has been tracked by a network of virologists through global genomic surveillance systems. While early and ongoing assessments indicate that BA.3.2 exhibits antibody escape characteristics, it may be less efficient at infecting cells. More importantly, there is no current evidence that this variant is associated with increased disease severity or sustained growth in population-level transmission. Its emergence reinforces the importance of sustained vigilance, including monitoring the virus, maintaining readiness in the healthcare and public health systems, and clear, evidence-based communication to the public.[4]

The public should continue to follow established public health guidance, which means staying up to date with recommended COVID-19 vaccinations, practising good hygiene when having respiratory episodes, and seeking testing and medical advice if having symptoms.

TB comprises a spectrum of disease. It spreads through the air when an infected person coughs or sneezes. It spreads the fastest when there are many people in the same place at the same time (high-density settings). A person infected can:[46,47]

- develop the disease, with typical TB symptoms;
- remain infected with no disease and not infective (cannot spread the disease, latent TB infection); or
- develop asymptomatic disease where they may be mildly contagious, though feeling well and do not show typical TB symptoms.

Latent infection can develop into active TB infection years later after exposure to the bacteria, very much like a ticking bomb waiting to explode.

The asymptomatic version of the disease can contribute to the persistence of TB in the population. It is difficult to identify, and it can be the cause of TB being under-reported, which could be the case for Sarawak and Malaysia.

Both present a challenge to the National Strategic Plan to End TB.

The Sarawak TB Elimination Programme (STEP) began in 2024. It is a collaboration between the Sarawak Infectious Disease Centre (SIDC) and the Sarawak Tuberculosis and Leprosy Control Branch at the Sarawak Health Department (Jabatan Kesihatan Negeri Sarawak, JKNS). It aims to address TB by targeting latent TB infection—defuse the bomb before it explodes. While the results of this initiative are yet to show, both agencies are positive that this collaborative effort should, in time, prove itself.

The threat of asymptomatic TB, however, remains a challenge to the public and the public healthcare system.[47] The combined use of the current screening test method and imaging, as well as microbiological testing, can be the way forward to address this problem.[48]

Bats are a natural reservoir of numerous known and novel zoonotic viruses, including rabies, NiV, Hendra, Marburg, and severe acute respiratory syndrome (SARS) viruses. The PRV is classified under the genus Orthoreovirus, family Reoviridae, which includes Nelson Bay virus (NBV), identified in Australia in 1968. The zoonotic potential of NBV was confirmed in 2006, when a human case occurred in Melaka, Malaysia.[35]

These viruses may already be circulating silently in Sarawak. It is time to look for them.

Dengue continues to be a public health challenge in Sarawak. With the emergence of insecticide resistance, the chemicals currently in use may be rendered useless in the near future.[49] The use of microbes such as *Bacillus thuringiensis israelensis* (Bti), seen as a success when it was implemented in Sibu,[50] should be expanded to other locations in the state. Furthermore, it would be worth considering the implementation of a pilot test for the use of Wolbachia-infected mosquitoes in our environment.

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