What Happened to All the Human Bird Flu Cases?

The end of the CDC's emergency H5N1 flu response shows the challenges of disease surveillance in vulnerable groups.

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From the outset of the Trump administration, bird flu, or H5N1 avian influenza, has flown rather conspicuously — and in fact quite mysteriously — under the radar. So much so that [on July 7], the Centers for Disease Control and Prevention announced the end of its emergency response to bird flu, citing the lack of reported human cases. Updates, previously issued weekly, will now arrive monthly. But something isn't adding up.

At the end of 2024, infections in the United States were surging. From Ohio to California, and in a swath of intervening states, diagnoses were being made in growing numbers of farmworkers who came into contact with infected cattle and poultry.

Most suffered a mild spectrum of symptoms — low grade fevers, muscle aches, inflammation in their eyes. As cases swelled, an older man in Louisiana fell critically ill. He would eventually become the first person in the U.S. to succumb to the virus since initial human cases were reported to the World Health Organization in 1997. We seemed then, for a moment, to be at a tipping point: bound to unleash something both larger and deadlier than we could foreseeably contain, and destined to dust off the cobwebs of a life grimly lived, again, under a pandemic.

And yet, none of that came to pass. Instead, since February, the CDC, which still monitors infections in humans, has not recorded a single new case in the U.S. The count remains the same — stuck firmly at 70.

Rationalizing the lull in infections has been puzzling. Researchers have tied wild birds, the virus's largest reservoir, and their spring and fall migrations to periods of greater spread of contagion. Cuts to staff who monitored the virus, at the U.S. Department of Agriculture and the Center for Veterinary Medicine, might also be playing a role.

But these ideas dismiss the deeper and more fundamental problem around our present grasp of bird flu. As an infectious diseases physician who works primarily with immigrant populations, my perspective often sits at the nexus between the people a novel disease affects and the

apparatuses that exist to control it. Lately, the actions of each arm of that equation, no longer motivated by the ethos of a collective concern, are fractured by individual ambitions and epitomize our faltering response.

Cases, in all likelihood, are being missed, in part because detecting infections is simply challenging. Foremost, it requires the ability to recognize an infected person. But this, as we've seen, is not always achieved. A number of bovine veterinarians, for example, were found earlier this year to harbor antibodies to the virus — a signature of infection — though none had influenza-like symptoms to suggest they'd been infected.

Surveillance, therefore, is largely — and imperfectly — built around those who are exposed and symptomatic. It's a system that also exposes the vulnerable contexts in which a person may have gotten infected.

In vulnerable groups, this makes a willingness to be tested all the more fraught. According to the Center for Migration Studies, 45% of the agricultural workforce in the U.S. comprised undocumented persons in 2022. And according to USDA data from 2020 to 2022, an additional 19% don't hold U.S. citizenship. Nearly 80% of American milk is supplied from dairies that employ immigrant labor. Consider a foreign-born dairy hand perplexed by redness in his eyes and a sore throat. He faces a dilemma: After ICE raids like "Operation Return to Sender" targeted farmworkers in California this winter, is getting to the root of his symptoms worth falling into an anti-immigrant governmental maw?

"I can't argue with anyone who would be risking getting shipped to a Salvadoran gulag for reporting an exposure or seeking testing," Angela Rasmussen, a virologist at the University of Saskatchewan, told the Associated Press in May.

For anyone in this situation, the personal calculus simply does not add up. And so, outreach programs and protective measures have not been sought; infections, if they happen, fester undetected. Lacking granular data from those that might be affected, we are without the empirical information we would typically use to form broader understandings, draw conclusions, and map out predictions.

Indeed, while this political climate has caused the vulnerable to shrink from the public conscience, the dearth of cases doesn't seem to be a concern for the government brass handling bird flu, who placed their priorities and interests above those of the widely accepted consensuses of scientists, virologists, and public health officials.

In March, this was evident when Health and Human Services Secretary Robert F. Kennedy Jr. proposed allowing H5N1 to sweep through poultry flocks unabated, part of an unorthodox effort to gain insight into how surviving birds could become naturally immune to the virus. The scientific community balked at the danger of such an experiment, but the proposal garnered the support of Agriculture Secretary Brooke Rollins. She suggested in a February interview that farmers would be willing to try this on as a "pilot."

Animal studies in this realm have already been conducted in controlled settings. And our understanding of H5N1 — which has plagued humankind for almost 30 years — and the immune responses it elicits is fairly robust. But that didn't dissuade the current administration from pressing for a redundant mandate.

Instead, Mehmet Oz, administrator for the Centers for Medicare and Medicaid Services, went so far as to offer refuge on his personal 900-acre ranch in Okeechobee, Florida, to about 400 ostriches that the Canadian Food Inspection Agency had ordered to be culled. This was after dozens of the birds in a British Columbia farm's flock had come into contact with and died from H5N1.

Kennedy, in a post on X, displayed a copy of a letter to the president of the CFIA explaining that studying the ostriches would "help us understand how to better protect human and animal populations and perhaps lead to the development of new vaccines and therapeutics."

Soon after, likely as part of Kennedy's vendetta against the technology, the HHS canceled a Biden-administration contract with Moderna to develop an mRNA-based vaccine (akin to the one successfully deployed against COVID-19) for bird flu.

Bird flu is far from a passing peril. It has been detected in almost 1,100 cattle herds across the U.S. In Brazil, the world's largest exporter of chickens, the first outbreak on a commercial poultry farm was confirmed in May while the country was also investigating about a dozen others. And in Mexico, a 3-year-old girl died from respiratory complications related to the virus. She was the country's first confirmed human case and was infected by the same D1.1 variant that precipitated severe illnesses in the man in Louisiana and a teenager in British Columbia.

Because infections are still largely constrained to animals and the marginalized people who work with them, bird flu has the distinction of being both omnipresent and barely visible. The way in which one country approaches it will, invariably, have rippling effects in others.

As the focus shifts to the economics of maintaining stocks of chickens and rebalancing the price of eggs, incentives for the testing of farmworkers remain inadequate, and protections among those who are foreign-born are, at best, dubious. From bench to barn, earnest collaborations with scientists and experts are also being undermined.

Public health is a delicate concept. To uphold it involves a complex interplay between forces large and, more importantly, small. We can predict the risk of a bird flu pandemic from a single mutation in the virus's genetic code. An individual, we must also realize, can upend things all the same.

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