Epidemiological Alert Seasonal Influenza in the Americas Region:

End of the 2025 Season in the Southern Hemisphere
Start of the 2025-26 Season in the Northern Hemisphere

4 December 2025

Given the start of the season of increased circulation of influenza and other respiratory viruses in the northern hemisphere, the Pan American Health Organization/World Health Organization (PAHO/WHO) recommends that Member States adjust their preparedness and organization plans for health services in anticipation of a possible overload of the health system. PAHO/WHO recommends strengthening surveillance for influenza, respiratory syncytial virus (RSV), and SARS-CoV-2, adopting the necessary prevention and control measures against respiratory virus infections, implementing measures to ensure early diagnosis and appropriate clinical management, especially among the population at high risk of severe disease, guarantee vaccination against respiratory viruses, ensuring high vaccination coverage in high-risk groups, and carry out adequate forecasting and organization of health services to ensure strict compliance with infection control and prevention measures, adequate supply of antivirals and personal protective equipment, as well as adequate risk communication to the population and health professionals.

Summary of the situation at the start of the 2025-26 season in the northern hemisphere

According to available respiratory virus surveillance data reported by countries to the World Health Organization (WHO) through epidemiological week (EW) 45, influenza activity was on the rise, with influenza A viruses predominantly detected in all regions (**Figure 1**) *(1)*.

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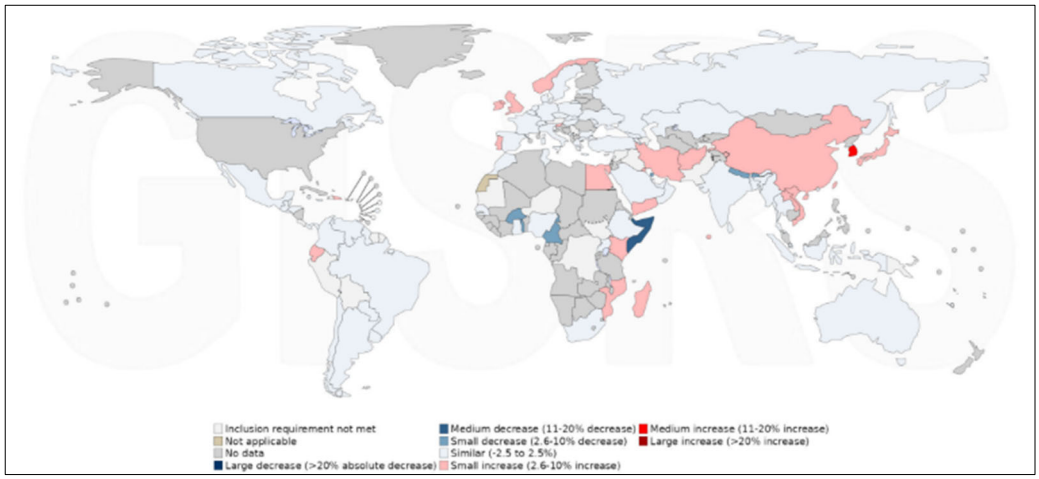
Figure 1. Change in the proportion of influenza-positive samples in EW 45 of 2025 compared to EW 44 of 2025.



Source: World Health Organization. Global Respiratory Virus Activity Weekly Update No. 553. Geneva: WHO; 2025 [cited 20 November 2025]. Available from: https://cdn.who.int/media/docs/default-source/influenza/influenza-updates/2025/202545_who-respiratory-virus-update_553.pdf?sfvrsn=9f6b8c29_3&download=true *(1)*.

In countries in the northern hemisphere of the Americas Region, for EW 45 of 2025, seasonal influenza circulation remained at low levels, with influenza A(H1N1)pdm09 predominating in the countries of the Caribbean[1] and Central America[2] *(2)*. In countries in the North American subregion[3] *(3-5)*, although influenza activity remained at low levels, a sustained increase was observed, mainly due to influenza type A. While influenza A(H1N1)pdm09 detections predominated in Mexico, the United States of America and Canada saw greater circulation of the A(H3N2) subtype, with a progressive increase in detections of influenza A(H3N2) subclade K *(3)*.

In recent months, the circulation of the A(H3N2) subclade K (J.2.4.1) virus has increased rapidly in Europe and several countries in Asia *(6)*. In Europe, influenza activity began earlier than usual, and subclade K accounted for almost half of the sequences reported between May and November 2025 *(6)*. So far, no significant change in clinical severity has been documented. However, seasons dominated by the A(H3N2) subtype are often associated with greater severity, particularly among older individuals *(7)*. Genetic analyses show that subclade K (J.2.4.1) accumulates mutations at key positions in the hemagglutinin gene that differentiate it from the strain included in the 2025–26 vaccine, and early serological studies point to lower antigenic match. However, preliminary data on the vaccine's effectiveness in preventing hospitalizations indicate protection similar to previous seasons (70% to 75% in children; 30% to 40% in adults) *(6–8)*.

For the Americas Region, this situation highlights the importance of closely monitoring the evolution of the virus, maintaining high vaccination coverage, and preparing for possible early or more intense activity during the 2025–26 season. It is essential that the population, especially older adults and those with risk factors, receive the influenza vaccine to protect themselves individually and avoid overburdening health services, especially from hospitalization.

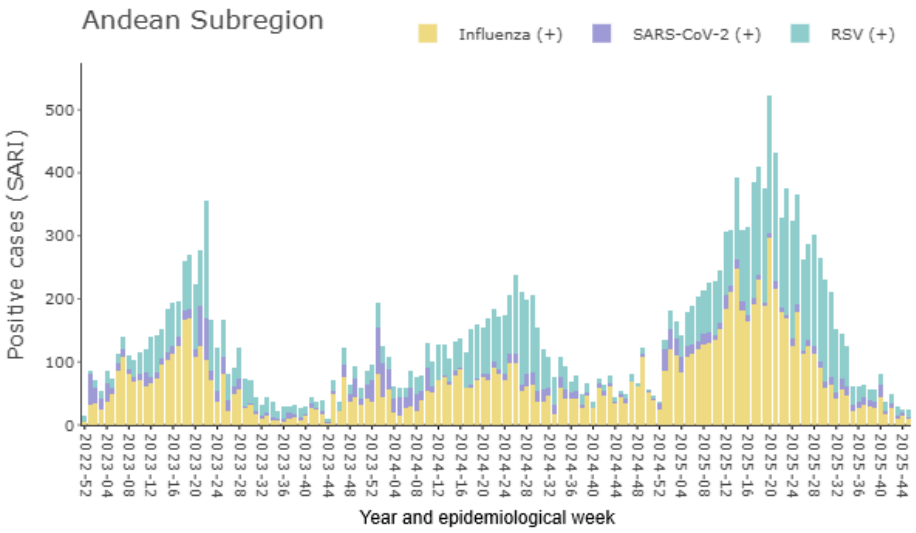
[1] Caribbean: Barbados, Belize, Cuba, Dominica, Dominican Republic, Grenada, Guyana, Haiti, Jamaica, Saint Lucia, Saint Vincent and the Grenadines, and Suriname.
[2] Central America: Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua, and Panama.
[3] North American subregion: Canada, Mexico, and the United States.

Summary of the situation at the end of the 2025 season in the southern hemisphere:

Syndromic surveillance data

In 2025, as of EW 45, there was a 29% increase in cases of severe acute respiratory infection (SARI) and a 5% increase in cases of influenza-like illness (ILI) compared to the same period in 2024[4] (**Figures 2-5**). In 2025, when data were disaggregated by virus type, 19% of SARI cases were found to be associated with Respiratory Syncytial Virus (RSV), 13% with influenza virus, and 4% with SARS-CoV-2. Among the SARI cases reported in 2025, the age distribution varied by identified virus, with 46% of hospitalized RSV cases detected in children under 6 months of age and 41% of hospitalized influenza cases detected in adults aged 65 years and older *(2)*.

Figure 2. SARI cases by virus type, Andean subregion[5] , 2023-2025



Source: Adapted from the Pan American Health Organization. Influenza, SARS-CoV-2, RSV, and other Respiratory Viruses Situation Dashboard – Americas Region. Washington, D.C.: PAHO; 2025 [cited 20 November 2025]. Available from: https://dashboards.pahoflu.com/app/respiratory_viruses/.

[4] The data should be interpreted with caution, as the number of reporting units between countries may change from season to season, in addition to experiencing variations in data reporting from week to week.

[5] Andean subregión: Bolivia (Plurinational State of), Colombia, Ecuador, Peru, and Venezuela (Bolivarian Republic of).

Figure 3. SARI cases by virus type, Brazil and Southern Cone subregion[6] , 2023-2025

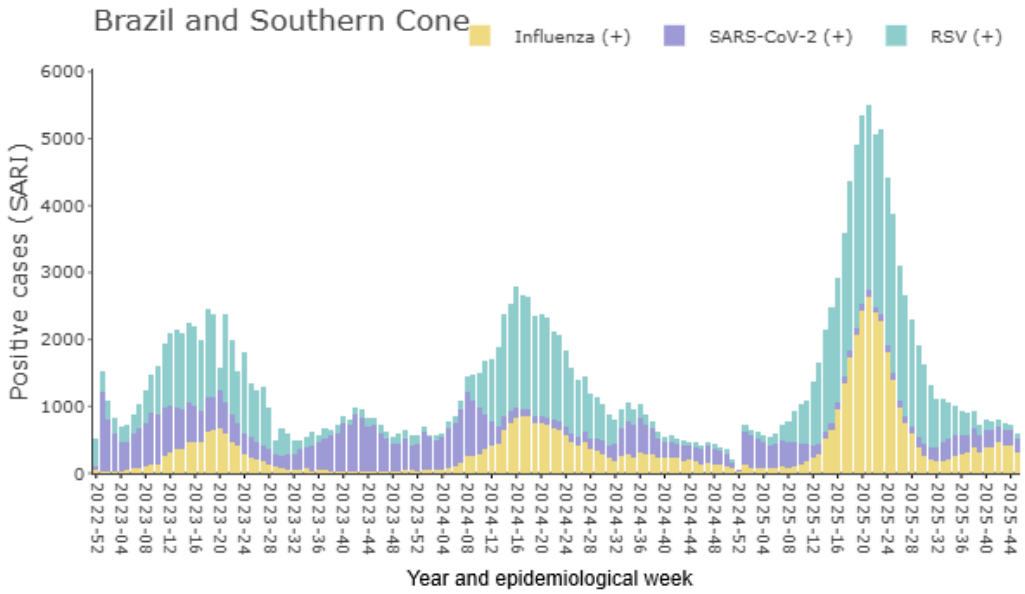


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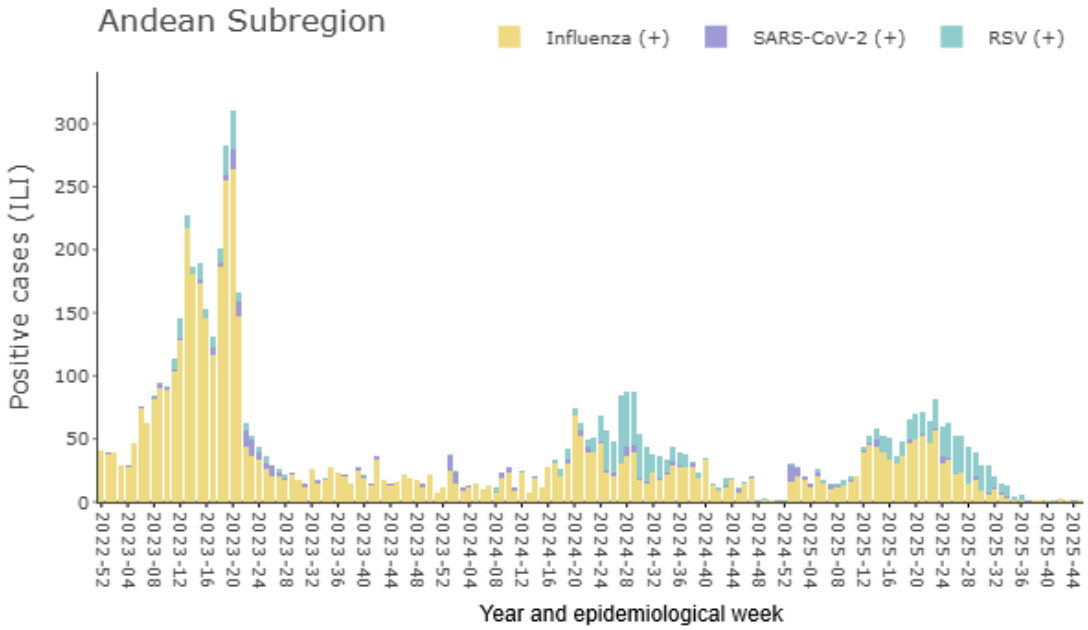
Figure 4. ILI cases by virus type, Andean subregion[5], 2023-2025



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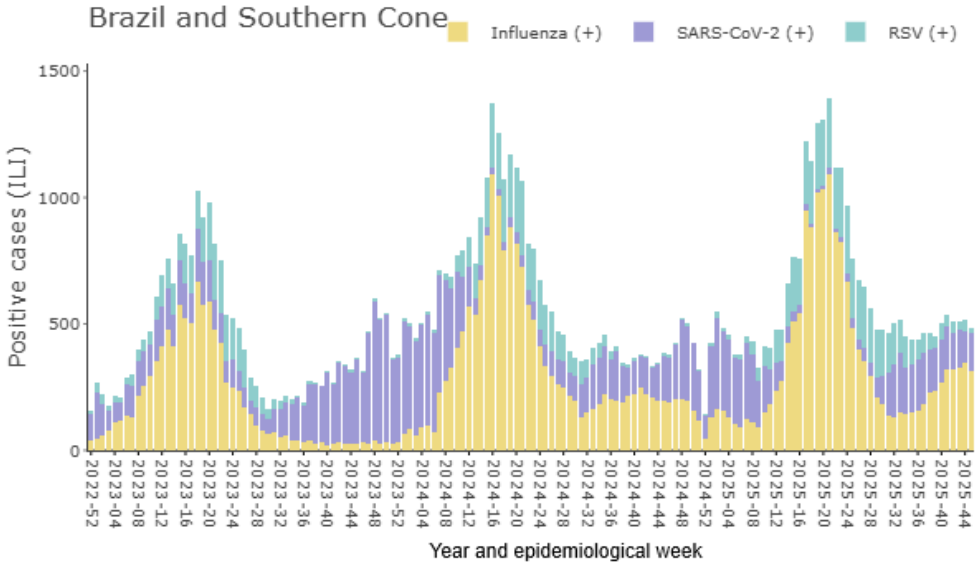
[6] Brazil and Southern Cone subregion: Argentina, Brazil, Chile, Paraguay, and Uruguay.

Figure 5. ILI cases by virus type, Brazil and Southern Cone subregion[6], 2023-2025



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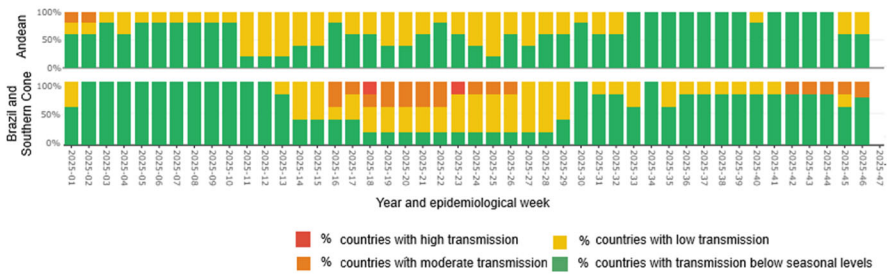
Virological surveillance data

Seasonal influenza

During the 2025 southern hemisphere season in the Americas Region, influenza transmission levels exceeded the seasonal threshold in mid-March. Circulation was dominated by influenza A(H1N1)pdm09 and reached a peak positivity rate of 19% in EW 20 *(2)* (**Figure 6**). Subsequently, activity declined to low levels until EW 35, when an increase in influenza A(H3N2) circulation was observed, especially in Brazil and Chile *(2)*. As of EW 45, Chile continues to experience moderate levels of influenza A(H3N2) transmission, without any association with greater severity or increased outpatient visits. As of 4 November 2025, subclade K had not been detected in South America *(2)*.

Figure 6. Seasonal influenza transmission levels, Andean Subregions and Brazil and the Southern Cone, 2025.



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Respiratory Syncytial Virus (RSV)

RSV activity began early, toward the end of January in the southern hemisphere of the Americas and peaked in late July with a 30% positivity rate, higher than the rates observed in 2023 and 2024 (**Figures 7 and 8**) *(2)*. Argentina, Paraguay, Peru, and Uruguay maintained high levels of RSV until mid-September *(2)*. Currently, circulation is at inter-seasonal levels in the Andean subregion, Brazil, and the Southern Cone *(2)*.

Figure 7. RSV-positive samples and positivity rate, Andean subregion[5], 2023-2025.

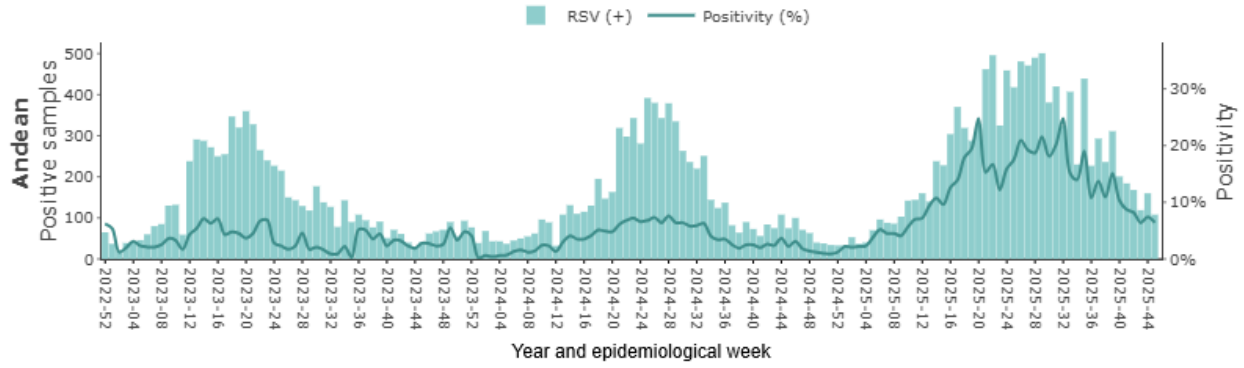

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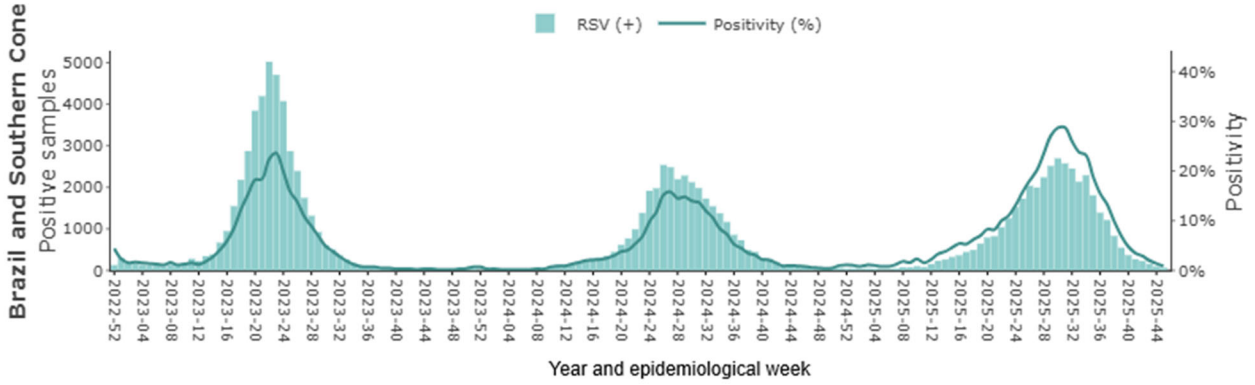
Figure 8. RSV-positive samples and positivity rate, Brazil and Southern Cone subregion[6], 2023-2025.



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SARS-CoV-2

Although SARS-CoV-2 does not yet show a clear seasonal pattern, during 2025, it was detected most frequently in the months of January to March, prior to the seasonal influenza and RSV season. Genomic surveillance data indicate that the XFG variant entered the region in April

and, to date, remains the predominant variant in the southern hemisphere (**Figures 9 and 10**). There is no evidence of increased severity associated with this variant.

Figure 9. SARS-CoV-2 positive samples and positivity rate, Andean subregion[5], 2023–2025.

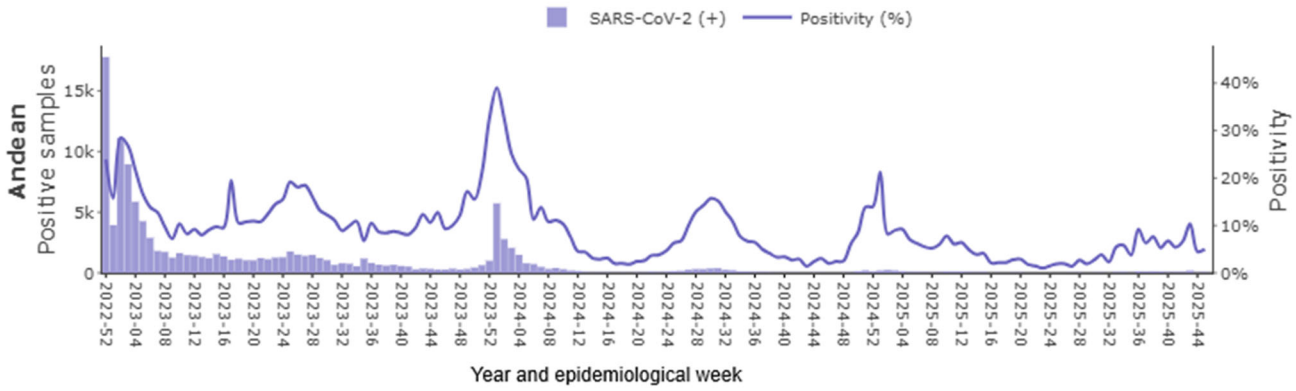

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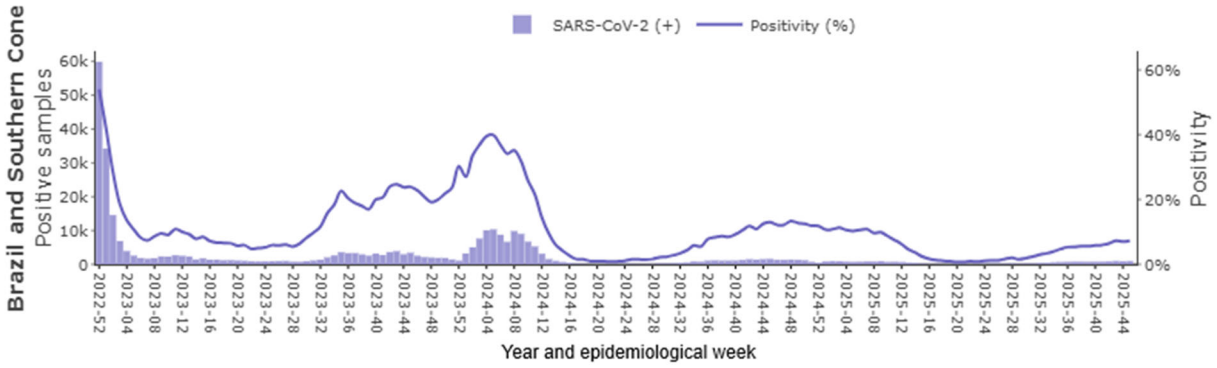
Figure 10. SARS-CoV-2 positive samples and positivity rate, Brazil and Southern Cone subregion[6], 2023-2025.



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Preliminary results on the effectiveness of the influenza vaccine in the 2025 season in the southern hemisphere of the Americas Region

Interim results measuring seasonal influenza vaccine effectiveness (VE) during the 2025 season provide important information on the degree of protection that the vaccine confers on the population. A study conducted between March and July 2025 in eight countries in the southern hemisphere, including five countries in Latin America (Argentina, Brazil, Chile, Paraguay, and Uruguay), estimated an effectiveness of 41.6% (95% confidence interval [CI]: 36.7, 46.0) in preventing hospitalization associated with influenza A(H1N1)pdm09, 37.2% (95%CI: 29.7, 43.9) against influenza A(H3N2), and influenza virus type B 77.6% (95%CI: 70.0, 83.3) *(9)*. The findings

provide essential information to health authorities in the northern hemisphere in preparation for the 2025/2026 season, given that the composition of the vaccine used in the 2025/2026 season in the northern hemisphere is the same as that used in the 2025 season in the southern hemisphere.

Virological characterization of seasonal influenza viruses for the 2025 season and vaccine composition for the southern hemisphere in 2026

Genetic and antigenic analyses identified that the A(H1N1)pdm09 viruses detected during the surveillance period had HA genes belonging to clades 5a.2a and 5a.2a.1, with a sustained shift toward subclade D.3.1, while the A(H3N2) viruses were mainly grouped in clade 2a.3a.1, subclade J.2, with diversification towards subclades J.2.1, J.2.2, J.2.3, J.2.4, and J.2.5, including subclade K (J.2.4.1) evaluated in serological studies *(10)*. These genetic groups showed different levels of recognition by vaccine strain antisera and a reduced human serological response to recent variants *(10)*. Influenza B viruses belonged exclusively to the B/Victoria lineage and showed adequate antigenic match with current vaccine strains *(10)*. Based on these findings, in September 2025, the WHO Advisory Committee on Influenza Vaccine Composition recommended the following updated trivalent composition of the vaccine for the southern hemisphere in 2026, for both egg-based and cell culture, recombinant protein, or nucleic acid platforms *(10)*:

Vaccines produced in embryonated eggs containing:

- An A/Missouri/11/2025 (H1N1)pdm09-like virus;
- An A/Singapore/GP20238/2024 (H3N2)-like virus; and
- A B/Austria/1359417/2021 (B/Victoria lineage)-like virus.

Cell culture-, recombinant protein-, or nucleic acid-based vaccines containing:

- An A/Missouri/11/2025 (H1N1)pdm09-like virus;
- An A/Sydney/1359/2024 (H3N2)-like virus; and
- A B/Austria/1359417/2021 (B/Victoria lineage)-like virus.

Due to the continued absence of detection of **B/Yamagata** lineage viruses globally since March 2020, the WHO Advisory Committee on Influenza Vaccine Composition has recommended the exclusion of this antigen from the vaccine composition since 2023 *(10)*.

Serological studies using hemagglutination inhibition tests with circulating influenza A(H3N2) viruses indicate that neutralizing antibodies generated by the H3N2 vaccine strain (A/Singapore/GP20238/2024) would react against subclade K (J.2.4.1) *(10)*.

Recommendations for Member States

The following is a summary of the main recommendations for surveillance, clinical management and prophylaxis, risk communication, and vaccination.

Surveillance

The Pan American Health Organization/World Health Organization (PAHO/WHO) recommends that Member States integrate surveillance for influenza, RSV, SARS-CoV-2, and other respiratory viruses into existing national platforms and report surveillance data weekly through PAHO/WHO's FluNET and FluID platforms. It is also important to continue sending samples for sequencing in

order to monitor and identify clades/subclades potentially associated with increased transmissibility or pathogenicity.

Member States are recommended to continue strengthening sentinel surveillance of ILIs and prioritize sentinel surveillance of SARIs, complementing it with other surveillance strategies to monitor epidemiological changes and viral circulation trends in order to assess transmission patterns, clinical severity, and impact on the health system and society, and to identify groups at risk of developing associated respiratory complications *(11, 12)*.

As a complement to indicator-based surveillance, PAHO/WHO recommends that Member States implement event-based surveillance. Event-based surveillance is the organized and rapid capture of information on events that may pose a potential risk to public health. The information may come from rumors and/or other ad hoc reports transmitted through formal routine information systems (pre-established routine information systems) or informal, non-pre-established systems (i.e., the media, direct communication from health workers, or non-governmental organizations). Event-based surveillance is a functional component of the early warning and response mechanism *(13, 14)*.

Unusual respiratory events should be investigated immediately and reported to PAHO/WHO in accordance with the International Health Regulations *(14)*. Unusual events include cases of acute respiratory illness with atypical clinical progression; acute respiratory infection associated with exposure to sick animals or observed in travelers from areas prone to the emergence of new influenza viruses; cases of SARI in health care workers who are medically treating severe respiratory cases of unknown etiology; or clusters of influenza viral infections outside the typical season of circulation.

As part of routine indicator-based surveillance, and for etiological confirmation of unusual cases, nasopharyngeal and oropharyngeal samples (or bronchial washings in severe cases) should be obtained for respiratory virus detection. Laboratory testing of the most severe cases should always be prioritized, especially those admitted to ICUs and fatal cases (deaths), in which respiratory tract tissue samples should also be taken (if possible). All biosafety measures for respiratory pathogens should be taken. Technical guidelines and diagnostic algorithms from the National Influenza Center or the national reference laboratory responsible for laboratory surveillance should be followed. The recommended testing algorithms for influenza, RSV, and SARS-CoV-2 are available on the PAHO/WHO website at: https://www.paho.org/en/documents/influenza-and-sars-cov-2-integrated-surveillance-laboratory-testing-algorithm *(15)*.

According to WHO guidelines, positive influenza samples from severe cases or cases with unusual respiratory clinical presentations should be sent to the PAHO/WHO Collaborating Center (CC) in the United States, the Centers for Disease Control and Prevention (CDC) in Atlanta, for further characterization *(16)*. Influenza A samples for which the virus subtype cannot be determined (those positive for Influenza A but where the PCR for subtyping is negative or inconclusive) should also be sent immediately to the PAHO/WHO CC at the US CDC *(16)*.

Positive influenza samples from animals should be sent to the PAHO/WHO CC at St. Jude Hospital in Memphis, Tennessee, in the United States, for further characterization.

Clinical management and prophylaxis

PAHO/WHO recommends that Member States update their treatment guidelines based on the updated WHO guidelines *(17-19)*. The recommendations for the clinical management of patients with severe respiratory disease indicated in the epidemiological alerts and PAHO/WHO

updates on influenza remain in effect *(20)*. Groups at highest risk for complications related to influenza infection include children younger than two years of age; adults older than 65 years of age; pregnant or postpartum women; people with underlying clinical morbidity (e.g., chronic lung disease, asthma, cardiovascular disease, chronic kidney disease, chronic liver disease, diabetes mellitus, neurological conditions such as central nervous system injuries and cognitive developmental delay); people with immunosuppression (e.g., HIV/AIDS or due to medications); and people with morbid obesity (body mass index greater than 40)*(17)*. Recommendations on antiviral and antibiotic treatment according to clinical presentation are found in **Tables 1-4** *(19)*.

Table 1. Recommendations for treatment of non-severe influenza.

Medication	**Recommendation**
Baloxavir (high risk of progression to severe disease)	Conditional recommendation in favor
Baloxavir (low risk of progression to severe disease)	Conditional recommendation against
Laninamivir	Conditional recommendation against
Oseltamivir	Unqualified recommendation against
Peramivir	Conditional recommendation against
Zanamivir	Unreserved recommendation against
Favipiravir	Unreserved recommendation against
Umifenovir	Conditional recommendation against
Antibiotics	Unreserved recommendation against in low probability of bacterial coinfection

Source: World Health Organization. Clinical practice guidelines for influenza. Geneva: WHO; 2024. Available from: https://www.who.int/publications/i/item/9789240097759 .

Table 2. Recommendations for the treatment of severe influenza.

Medication	**Recommendation**
Oseltamivir	Conditional recommendation in favor
Peramivir	Conditional recommendation against
Zanamivir	Conditional recommendation against

Source: World Health Organization. Clinical practice guidelines for influenza. Geneva: WHO; 2024. Available from: https://www.who.int/publications/i/item/9789240097759.

Table 3. Recommendations for complementary treatment in severe influenza.

Intervention	Recommendation
Macrolides	Conditional recommendation against without bacterial coinfection
Plasma	Conditional recommendation against
mTOR inhibitors	Conditional recommendation against
Corticosteroids	Conditional recommendation against

Source: World Health Organization. Clinical practice guidelines for influenza. Geneva: WHO; 2024. Available from: https://www.who.int/publications/i/item/9789240097759.

Table 4. Recommendations for prevention in exposed individuals without infection

Medication	Recommendation
Baloxavir	Conditional recommendation in favor in extremely high risk
Laninamavir	Conditional recommendation against without extremely high risk
Oseltamivir	Conditional recommendation in favor at extremely high risk
Zanamavir	Conditional recommendation against without extremely high risk

Source: World Health Organization. Clinical practice guidelines for influenza. Geneva: WHO; 2024. Available from: https://www.who.int/publications/i/item/9789240097759.

Risk communication

Seasonal influenza is an acute viral infection that spreads easily from person to person. Seasonal influenza viruses circulate worldwide and can affect anyone in any age group *(21, 22)*. Influenza vaccination before the start of seasonal virus circulation remains the best preventive measure against severe influenza *(23)*.

The public should be informed that the main mode of transmission of influenza is interpersonal contact. Handwashing is the most efficient way to reduce transmission. Knowledge of "respiratory etiquette" also helps prevent transmission *(22)*.

People with fever should avoid going to workplaces or public places until their fever subsides. Similarly, school-aged children with respiratory symptoms, fever, or both should stay home and not go to school.

To take advantage of the knowledge that the majority of the public has acquired about the prevention of respiratory diseases—in the wake of the COVID-19 pandemic—and to avoid confusion and ensure effective communication, Member States should consider developing risk communication strategies and campaigns that integrate prevention messages for respiratory

viruses. The integration of communication to promote vaccination against COVID-19 and influenza is also recommended.

Vaccination

Immunization is an important strategy for preventing serious illness associated with seasonal influenza, COVID-19, and RSV, including associated hospitalizations and deaths.

PAHO/WHO recommends vaccination for groups at particular risk of severe influenza, including older adults, people with underlying conditions, children aged 6 to 59 months, and pregnant women. Health workers are at increased risk of exposure to and transmission of influenza and SARS-CoV-2 viruses and should therefore also be prioritized *(24, 25)*. PAHO/WHO recommends that the same high-risk priority groups (with the exception of children younger than 59 months) receive COVID-19 vaccine booster doses 6 to 12 months after their last dose. Finally, the Strategic Advisory Group of Experts on Immunization (SAGE) recommends that all individuals 6 months of age and older receive at least one dose of COVID-19 vaccine if they have never received one *(26)*.

There are currently two strategies available for the prevention of severe RSV disease in infants and newborns: administration of vaccine during pregnancy (RSVPreF vaccine) and administration of long-acting monoclonal antibodies (nirsevimab and clesrovimab) to newborns and infants. Both strategies have been shown to be effective and have a favorable safety profile for both pregnant women and newborns. PAHO and WHO recommend that countries introduce these products for the prevention of RSV disease and death in newborns *(27-29)*.

The RSVPreF vaccine (Abrysvo®, Pfizer) is a bivalent vaccine administered to pregnant women in the third trimester to protect their babies through transplacental transfer of antibodies *(30)*. Long-acting monoclonal antibodies (nirsevimab (Beyfortus®, Sanofi) and clesrovimab, (Enflonsia®, Merck)) are recombinant antibodies with an extended half-life that are administered as a single dose to newborns and children at high risk of severe disease *(31, 32)*. Both the RSVpreF vaccine and long-acting monoclonal antibodies have been approved and are being used in several countries in the Americas.

Additionally, there are three vaccines approved for the prevention of RSV disease in adults with comorbidities and in older adults: Abrysvo®, Pfizer; Arexvy®, GSK; and mRESVIA®, Moderna. *(30, 33, 34)*. In randomized clinical trials and post-authorization studies, these vaccines have been shown to be effective in reducing the risk of developing severe disease associated with RSV.

Several vaccines and long-acting monoclonal antibodies for the prevention of RSV disease are currently in clinical research, and significant progress has been made in understanding the immune response to RSV.

Non-pharmacological public health measures in the population

As recently evidenced during the COVID-19 pandemic, non-pharmaceutical public health measures complement the response to respiratory events. Along with immunization against respiratory viruses, personal measures such as hand hygiene, physical distancing, respiratory etiquette, wearing masks, and staying home when sick should be implemented, as they are effective in limiting the transmission of respiratory viruses *(35)*.

For more details, see the guidelines: Non-pharmaceutical public health measures for mitigating the risk and impact of epidemic and pandemic influenza *(35)*, and the manual: Guidance for the implementation of non-pharmaceutical public health measures in vulnerable population groups in the context of COVID-19 *(36)*.

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