Epidemiological Alert
Simultaneous circulation of seasonal influenza and respiratory syncytial virus (RSV)
9 January 2026

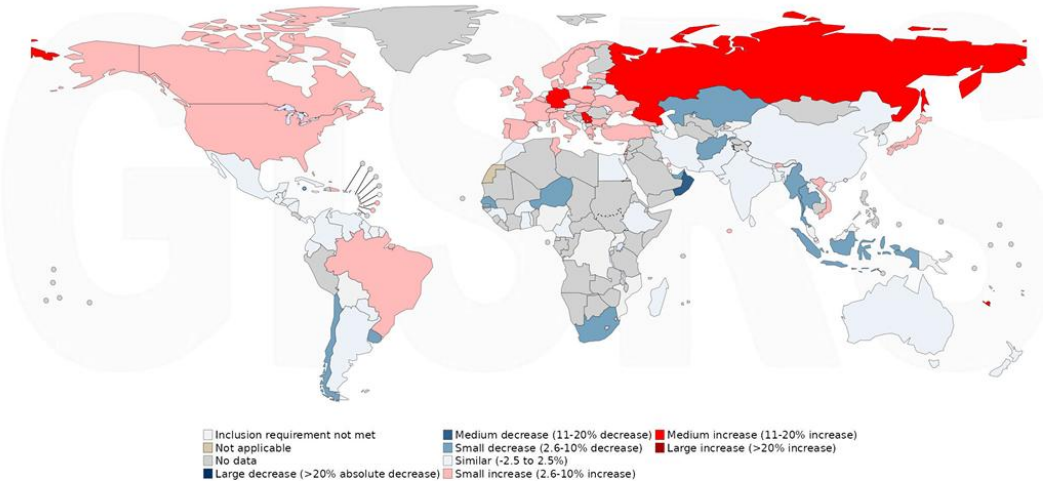
On 4 December 2025, the Pan American Health Organization/World Health Organization (PAHO/WHO) issued an alert regarding the possibility of early or more intense activity of respiratory viruses during the 2025-26 season, as compared to previous years. In this context, and based on the behavior observed to date, PAHO/WHO recommends that Member States remain vigilant in order to adjust their health service preparedness and organizational plans in anticipation of possible concurrent outbreaks of seasonal influenza and respiratory syncytial virus, which could overload their health care system.

Summary of the global situation

Globally, there has been an increase in influenza activity since October 2025. Some countries have reported an early start to the influenza season, and influenza A(H3N2) viruses have been shown to be predominant. This marked increase in influenza activity coincides with the start of the winter season in the Northern Hemisphere (**Figure 1**) *(1, 2)*.

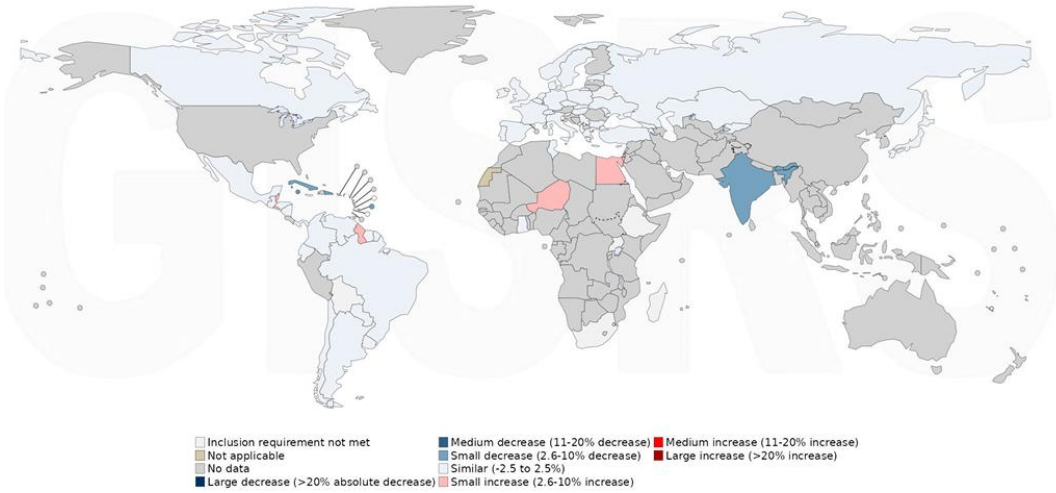
Figure 1. Change in the proportion of samples positive for (a) influenza (b) respiratory syncytial virus (RSV), epidemiological week (EW) 50 of 2025 compared to EW 49 of 2025.

a. Influenza



Suggested citation: Pan American Health Organization/World Health Organization. Epidemiological Alert: Simultaneous circulation of seasonal influenza and respiratory syncytial virus (RSV) – 9 January 2026. Washington, D.C.: PAHO/WHO; 2026.

b. Respiratory syncytial virus (RSV)



Source: Adapted from the World Health Organization. Global Respiratory Virus Activity Weekly Update No. 558. Geneva: WHO; 2025 [cited 8 January 2026]. Available from: https://www.who.int/publications/m/item/global-respiratory-virus-activity--weekly-update-n--558 *(2)*.

Although global activity remains within expected seasonal ranges, some regions have seen early and accelerated increases, with activity levels higher than usual for this time of year *(1, 2)*. Outbreaks of seasonal influenza and other circulating respiratory viruses such as respiratory syncytial virus (RSV) can place significant pressure on health systems *(1, 2)*, especially when increases in cases occur simultaneously or consecutively.

In this context, a summary of the situation in select countries in the Northern and Southern Hemispheres, within and outside the Americas Region, is presented below, including the situation in the European Union, with the aim of illustrating patterns observed in the dynamics of the season and contextualizing regional trends. In the Southern Hemisphere, the influenza season has been prolonged, mainly due to the circulation of influenza A(H3N2), and in the Northern Hemisphere, the early start of the season is of concern, with rapid increases in influenza cases, high incidences of outpatient visits, particularly in the pediatric population, but with levels of severity comparable to previous seasons, with hospitalization burdens concentrated in older adults. Following, a series of preparedness and response considerations are outlined below.

Summary of the situation in the Americas Region

In the Americas Region, influenza positivity remains above 10% in the Northern Hemisphere *(3)*. Influenza A(H3N2) is dominant in most subregions, while A(H1N1)pdm09 is dominant in the Andean subregion specifically. The intensity of activity is heterogeneous, with sustained increases in North America[1] and Central America[2] and levels close to 20% in the Caribbean[3] and Central America *(3)*. Countries such as Barbados, Canada, Ecuador, Guatemala, Nicaragua, Panama, Paraguay, and the United States of America are reporting high influenza circulation. In contrast, RSV circulation remains at low levels with initial signs of an increase in North America *(3)*.

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

Summary of the situation in the Northern and Southern Hemispheres

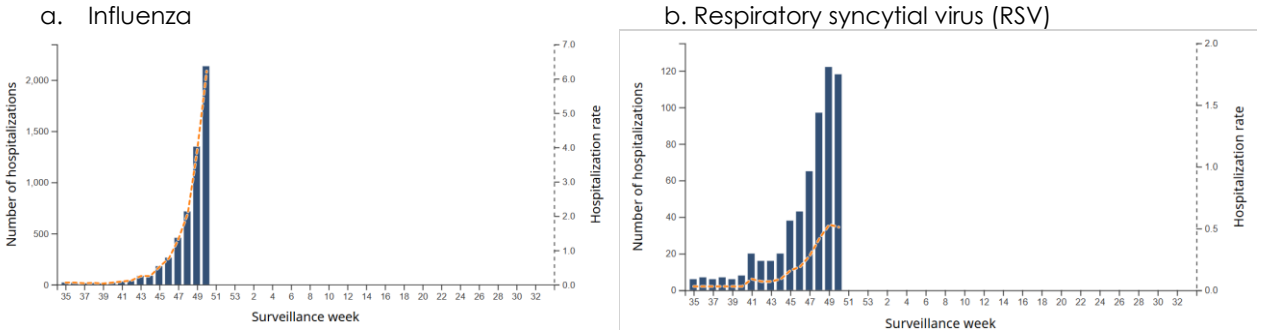
The following sections describe the current situation (2025-2026 season) regarding seasonal influenza and RSV in select countries in the Northern and Southern Hemispheres globally, as well as the situation in the European Union region, presented in alphabetical order.

Northern Hemisphere

In **Canada**, intense influenza transmission has been observed during the 2025-2026 season. By the end of 2025, the national positivity rate reached 32.4% in epidemiological week (EW) 51, which represents a significant increase compared to the 20.2% recorded in EW 49 (**Figure 2**). The predominant subtype is influenza A(H3N2). Among the influenza A(H3N2) viruses sequenced, 89% belonged to subclade K. The analysis of hospitalization rates by age group indicates that the most affected groups are those among 65 years and older and those under 5 years of age (**Figure 3**) *(4)*. In contrast to influenza, RSV presents more moderate behavior, remaining at low levels but with a gradual increase, with a positivity rate between 2.4% and 2.6% (**Figure 2**). The age groups most affected by RSV are among infants under 1 year of age and adults 65 years of age and older (**Figure 4**) *(4)*.

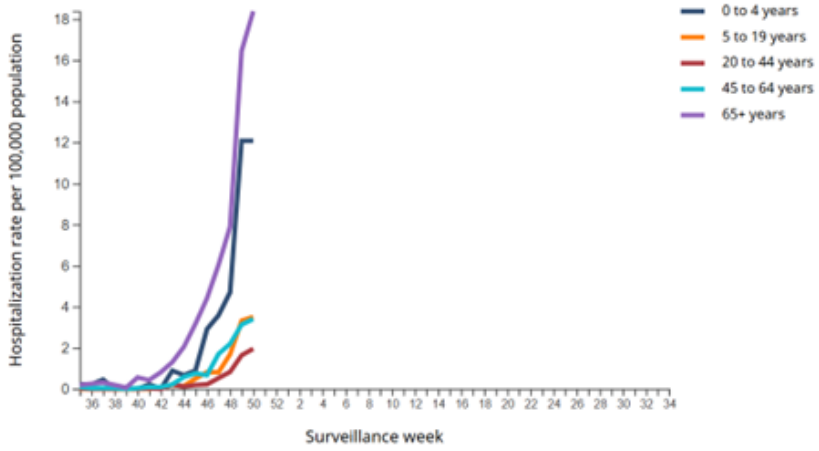
An increasing trend is observed with regard to hospitalizations associated with both influenza and RSV. For influenza, the increase has accelerated, especially in EW 49 and EW 50 of 2025 (**Figure 2**); however, early evidence suggests influenza activity, including hospitalizations, may be approaching its peak. The increase in RSV hospitalizations has been more gradual, and the overall rate remains low (weekly rate of 0.5 hospitalizations per 100,000 population) (**Figure 2**).

Figure 2. Number and crude rate of hospitalizations associated with laboratory-confirmed (a) influenza and (b) RSV cases in Canada, by EW, 2025-2026 season.



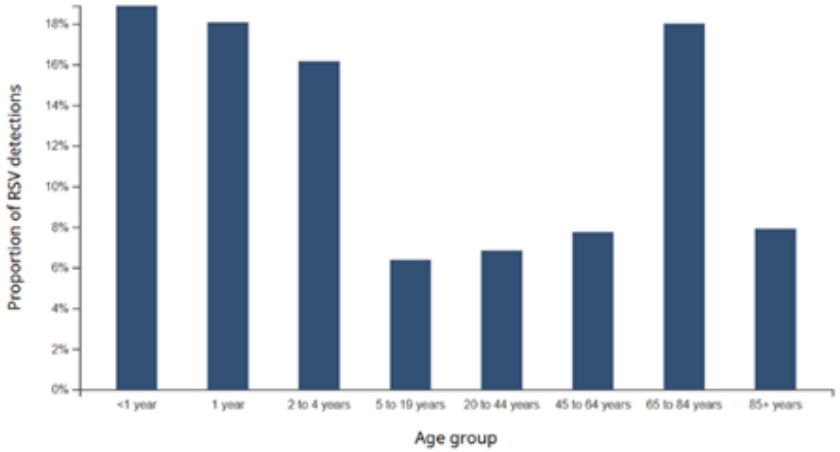
Source: Adapted from Government of Canada. Public Health Agency of Canada. Canadian respiratory virus surveillance report. Weekly overview of key trends in the activity of respiratory viruses in Canada. Ottawa: PHAC; 2025 [cited 3 January 2026]. Available from: https://health-infobase.canada.ca/respiratory-virus-surveillance/explore.html *(4)*.

Figure 3. Weekly crude rates (per 100,000 population) of influenza-associated hospitalizations by age group and epidemiological week.



Source: Adapted from Government of Canada. Public Health Agency of Canada. Canadian respiratory virus surveillance report. Weekly overview of key trends in the activity of respiratory viruses in Canada. Ottawa: PHAC; 2025 [cited 3 January 2026]. Available from: https://health-infobase.canada.ca/respiratory-virus-surveillance/explore.html *(4)*.

Figure 4. Proportion of RSV detections reported in Canada by age group, 2025-2026 season.

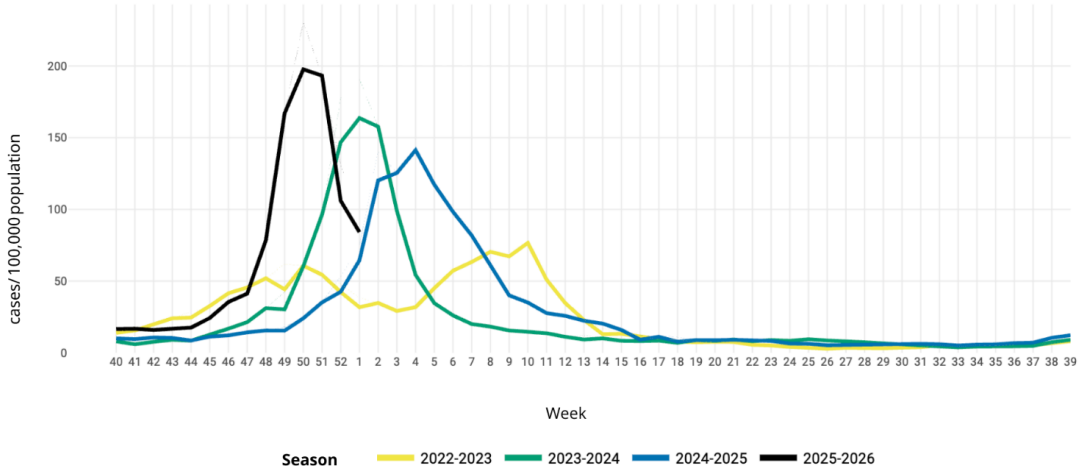


Source: Adapted from Government of Canada. Public Health Agency of Canada. Canadian respiratory virus surveillance report. Weekly overview of key trends in the activity of respiratory viruses in Canada. Ottawa: PHAC; 2025 [cited 3 January 2026]. Available from: https://health-infobase.canada.ca/respiratory-virus-surveillance/explore.html *(4)*.

In **Spain**, during the 2025–2026 influenza season, as of 8 January 2025, the early circulation of influenza was dominated by subtype A(H3N2), with an influenza-like illness rate (in primary care) that exceeded the epidemic threshold earlier than expected, reaching a peak higher than the previous three seasons (**Figure 5**) *(5)*. The estimated rate of hospitalizations for influenza followed a similar trend, reaching levels higher than those of the 2022–23 and 2024–25 seasons but lower than those of the 2023–24 season (**Figure 6**) *(5)*. Finally, as of week[4] (W)1 of 2026, the observed mortality had not exceeded expectations (**Figure 7**) *(5)*.

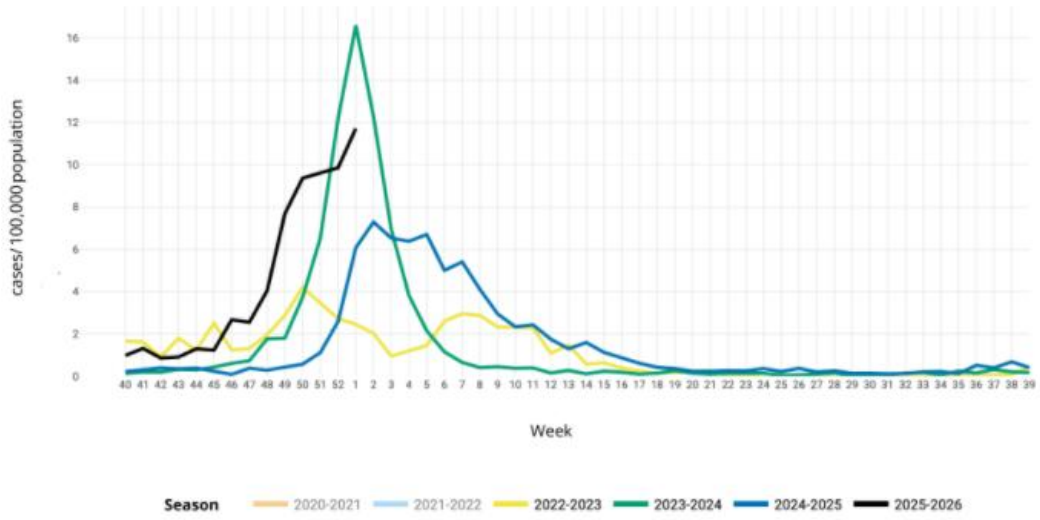
[4] Refers to the week number according to the International Organization for Standardization (ISO) standard ISO 8601.

Figure 5. Influenza-like illness rates in the 2022-23 to 2025-26 seasons in Spain. SiVIRA, week 1 of 2026.



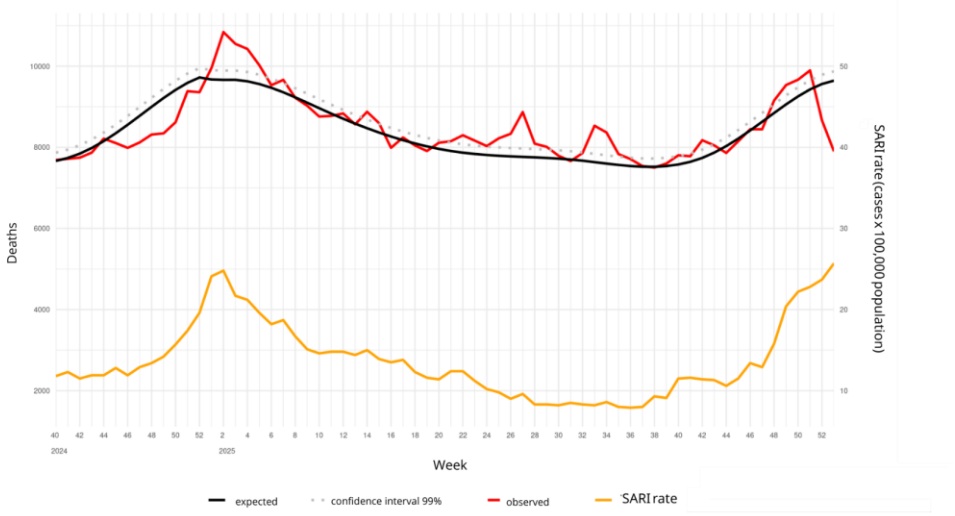
Source: Adapted from the Carlos III Health Institute. Surveillance of acute respiratory infection: influenza, COVID-19, and RSV. Week 1/2026 (29 December to 4 January 2026). Madrid: ISCIII; 2026 [cited 8 January 2026]. Available from: https://docsivira.isciii.es/Informe_semanal_SiVIRA_202601.html *(5)*.

Figure 6. Estimated hospitalization rate for influenza in the 2020-21 to 2025-26 seasons in Spain. SiVIRA, week 1 of 2026.



Source: Adapted from the Carlos III Health Institute. Surveillance of acute respiratory infection: influenza, COVID-19, and RSV. Week 1/2026 (29 December to 4 January 2026). Madrid: ISCIII; 2026 [cited 8 January 2026]. Available from: https://docsivira.isciii.es/Informe_semanal_SiVIRA_202601.html *(5)*.

Figure 7. Observed and expected all-cause mortality in the last three seasons in Spain. SiVIRA, week 1 of 2026.

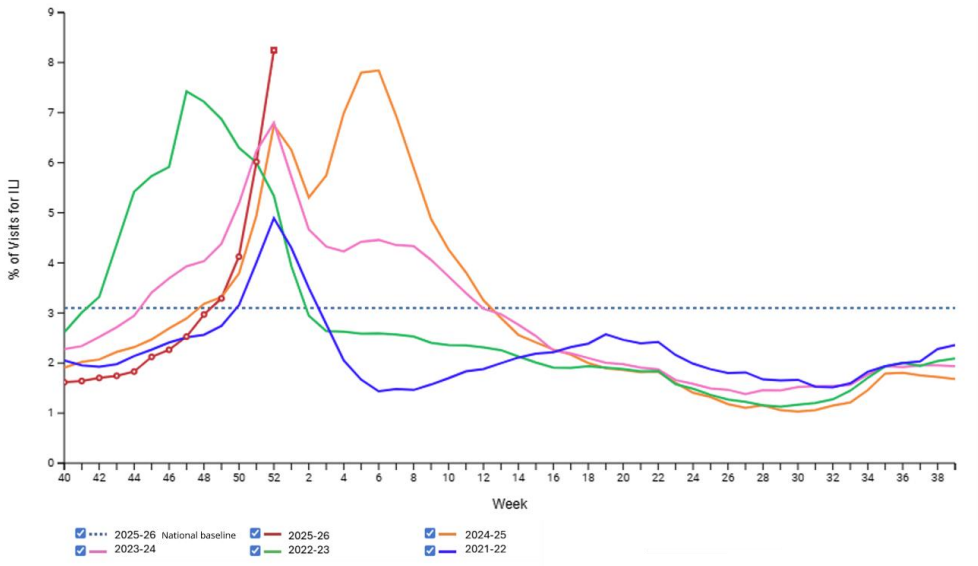


Source: Adapted from the Carlos III Health Institute. Surveillance of acute respiratory infection: influenza, COVID-19, and RSV. Week 1/2026 (29 December to 4 January 2026). Madrid: ISCIII; 2026 [cited 8 January 2026]. Available from: https://docsivira.isciii.es/Informe_semanal_SiVIRA_202601.html *(5)*.

In the **United States of America**, as of EW 45 of 2025, there has been a progressive increase in cases of influenza and other respiratory viruses, which is consistent with activity during the winter season (**Figure 8** and **Figure 9**) *(6-8)*. As of EW 52 of 2025, influenza-like illness (ILI) is considered very high in 32 jurisdictions, including New York City and Puerto Rico, and the states of Alabama, Alaska, Arkansas, Colorado, Connecticut, Florida, Georgia, Idaho, Indiana, Kansas, Kentucky, Louisiana, Maine, Massachusetts, Michigan, Minnesota, Missouri, Nebraska, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Rhode Island, South Carolina, Tennessee, Texas, and Virginia, as per the information available from the United States Centers for Disease Control and Prevention (US CDC) *(7)*. RSV activity is elevated in many areas of the country (**Figure 10**) *(6)*.

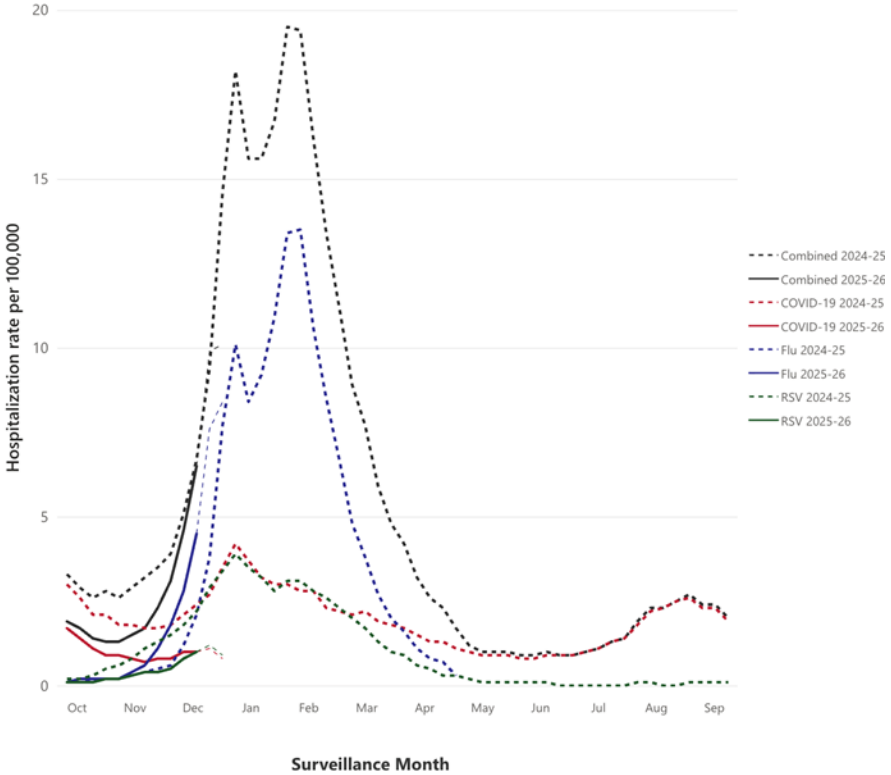
Hospital surveillance data indicate elevated and increasing influenza-associated hospitalization rates, with higher rates among adults aged 65 years and older, and a gradual increase in RSV-associated hospitalization rates, particularly among children under five years of age (**Figure 11**) *(6, 7)*. RSV hospitalization rates observed through 2 January 2026, remain below the peaks recorded during the 2024–2025 season (**Figure 9**) *(9)*.

Figure 8. Percentage of outpatient visits for respiratory illness reported by the Influenza-like Illness (ILI) Surveillance Network in outpatient settings in the United States (ILINet).



Source: Adapted from the US Centers for Disease Control and Prevention. Weekly US Influenza Surveillance Report: Key Updates for Week 52, ending 27 December 2025. Atlanta: CDC; 2025 [cited 6 January 2026]. Available from: https://www.cdc.gov/fluview/surveillance/2025-week-52.html *(6)*.

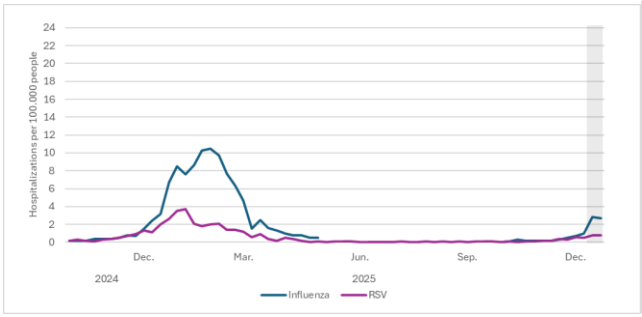
Figure 9. Weekly hospitalization rates associated with COVID-19, influenza, and RSV during the 2024-25 and 2025-26 seasons, United States.



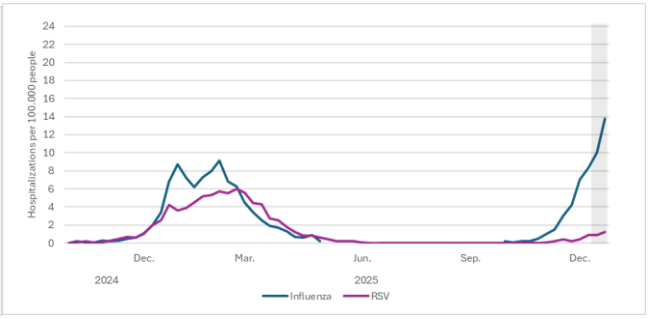
Source: Adapted from the US Centers for Disease Control and Prevention. Respiratory Virus Hospitalization Surveillance Network (RESP-NET). Atlanta: CDC; 2025 [cited 2 January 2026]. Available from: https://www.cdc.gov/resp-net/dashboard/ *(8)*.

Figure 10. Weekly hospitalization rates associated with influenza and RSV per 100,000 population according to RESP-NET, by select states (a-h), United States, 2024-2025 and 2025-2026 seasons.

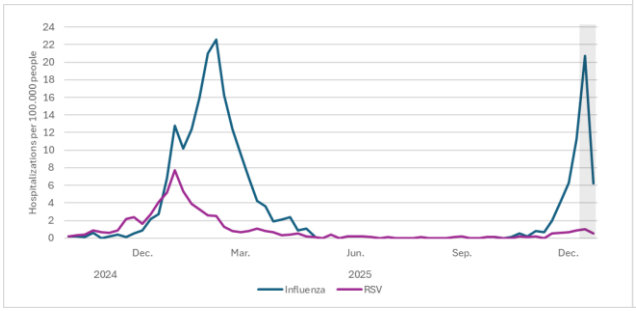
a. California



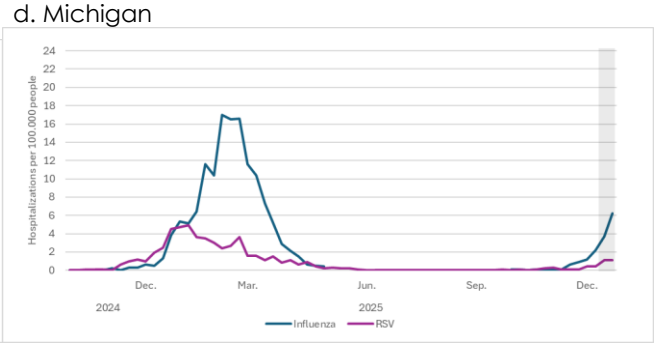
b. Colorado



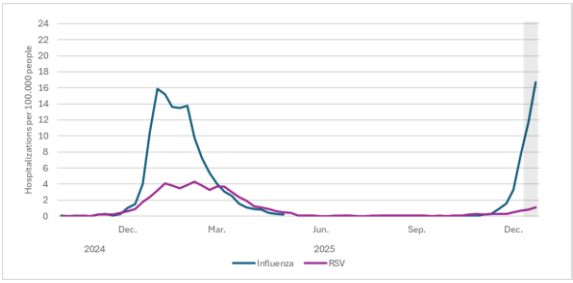
c. Connecticut



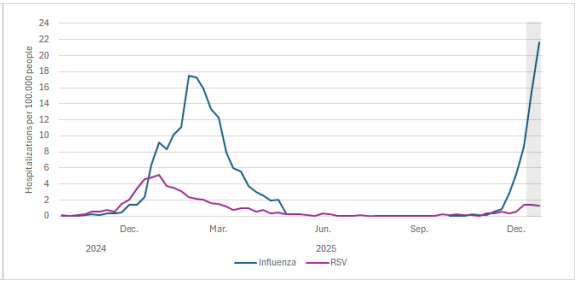
d. Michigan



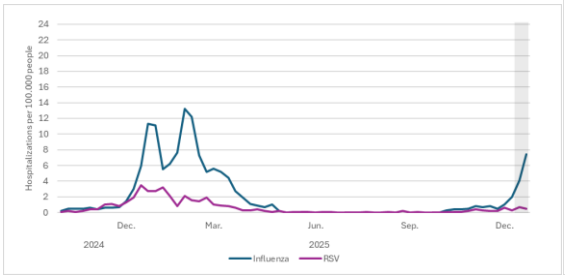
e. Minnesota



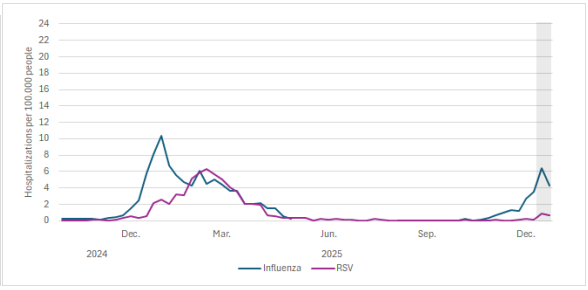
f. New York



g. Tennessee



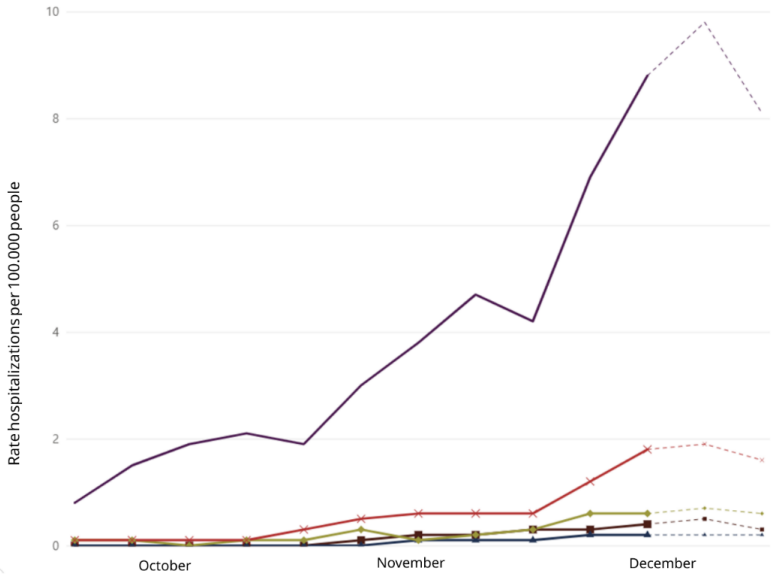
h. Utah



Note: Gray bars for the 2025-26 season indicate possible delays in reporting for the last few weeks. RESP-NET data are preliminary and subject to change as more data becomes available.

Source: Adapted from the US Centers for Disease Control and Prevention. Severe Viral Respiratory Illness. Atlanta: CDC; 2026 [cited 7 January 2026]. Available from: https://www.cdc.gov/respiratory-viruses/data/illness-severity.html *(10)*.

Figure 11. Weekly hospitalization rates associated with respiratory syncytial virus (RSV), by age group, United States, 2025-2026 seasons.

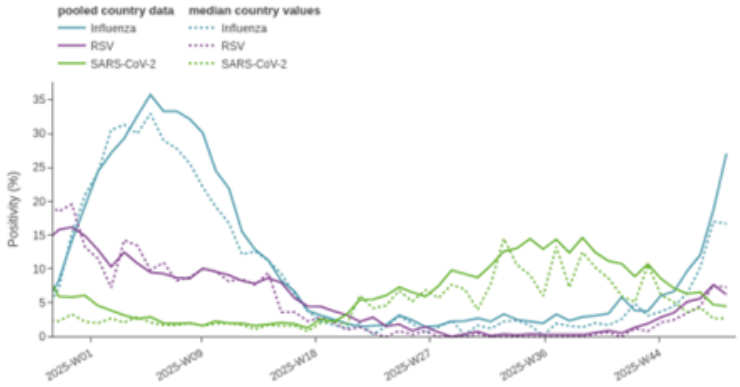


Source: Adapted from the Centers for Disease Control and Prevention. Respiratory Syncytial Virus (RSV) Hospitalization Surveillance Network (RSV-NET). Atlanta: CDC; 2025 [cited 6 January 2026]. Available from: https://www.cdc.gov/rsv/php/surveillance/rsv-net.html *(9)*.

With regard to the countries of the **European Union/European Economic Area (EU/EEA)**, the European Centre for Disease Prevention and Control (ECDC) reported that, during the last weeks of 2025, a high number of patients attending primary care services with symptoms of respiratory diseases was observed in the 21 countries that have reported data (Austria, Belgium, Croatia, Czechia, Denmark, Estonia, Finland, France, Greece, Hungary, Iceland, Ireland, Lithuania, Luxembourg, Malta, Norway, the Netherlands, Poland, Romania, Slovenia, and Spain). The circulation of the influenza virus continues to increase, with influenza A being predominant in all countries and the A(H3N2) virus being the main driver of the increase in cases in recent weeks (**Figure 12**). This increased circulation has been observed mainly among children aged 5 to 14 years *(11)*. An increase in hospitalizations is being observed in some countries, affecting all age groups, but mainly adults aged 65 years and older *(11)*.

In contrast, RSV circulation shows a slower increase from low levels. Although overall circulation remains below that observed in the same period in the previous four seasons, hospital data indicate an increase in RSV-associated admissions in some countries, mainly among children under five years of age *(11)*.

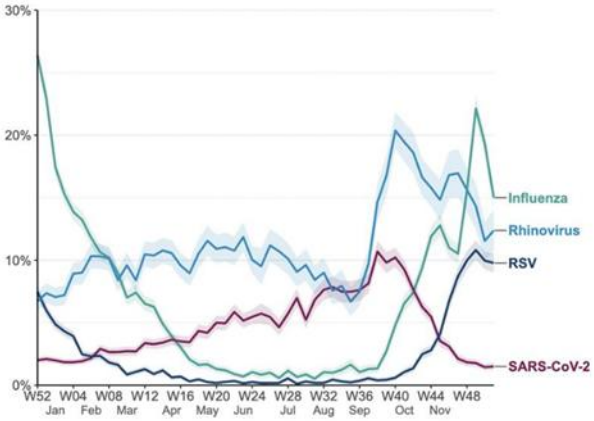
Figure 12. Severe acute respiratory infection (SARI) virological surveillance in hospitals: weekly positivity of tests week[4] (W) 50 of 2025.



Source: Adapted from European Centre for Disease Prevention and Control . Weekly Communicable Disease Threats Report, Week 51, December 13–19. Solna: ECDC; 2025. Available from: https://www.ecdc.europa.eu/sites/default/files/documents/communicable-disease-threats-report-week-51-2025.pdf *(11)*.

In **England**, the United Kingdom Health Security Agency (UKHSA) reported that, for the 2025-2026 season, influenza circulation and influenza hospitalizations increased early and rapidly. From week[4] (W) 42 of 2025, an abrupt increase in influenza-associated hospitalizations was observed, with the weekly hospital admission rate reaching a maximum of 10.2 per 100,000 population in W49; medium levels based on the moving epidemic method. As of 24 December 2025, during the 2025-2026 season, the maximum positivity rate in sentinel laboratories was observed for W50 at 22.1% and had declined to 15.0% in W51. RSV circulation during the last four weeks of 2025 shows a slight decrease, with a slower increase compared to other respiratory viruses (**Figure 13**)**.** However, for W51, a positivity rate of 9.8% was observed, with a predominant impact among children under five years of age (**Figure 14**) *(12)***.** Hospital surveillance data show an increase in RSV-associated admissions, with the overall weekly RSV hospital admission rate increasing to 4.07 per 100,000 population compared to 3.63 per 100,000 population in the previous week *(12)*.

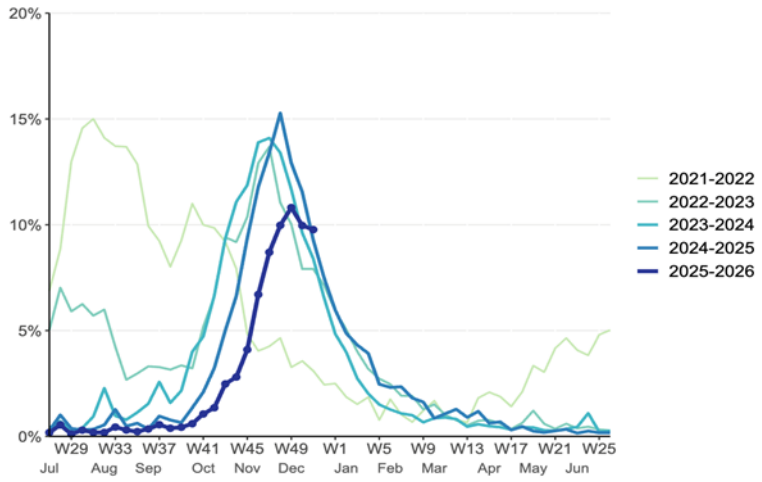
Figure 13. Weekly percentage of positive tests for influenza, SARS-CoV-2, RSV, and rhinovirus in England from W1 to W51 in 2025*



*Shadows represent 95% confidence intervals

Source: Adapted from UK Health Security Agency. Respiratory DataMart sentinel laboratory network, England. National Influenza and COVID-19 Surveillance Report, 2025–2026 Season, Week 52. London: UKHSA; 2025 [cited 2 January 2026]. Available from: https://www.gov.uk/government/statistics/national-flu-and-covid-19-surveillance-reports-2025-to-2026-season/national-flu-and-covid-19-surveillance-report-24-december-2025-week-52 *(12)*.

Figure 14. RSV positivity in England during the 2021-22 to 2025-26 season



Source: Adapted from UK Health Security Agency. Respiratory DataMart sentinel laboratory network, England National Influenza and COVID-19 Surveillance Report, 2025–2026 Season, Week 52. London: UKHSA; 2025 [cited 2 January 2026]. Available from: https://www.gov.uk/government/statistics/national-flu-and-covid-19-surveillance-reports-2025-to-2026-season/national-flu-and-covid-19-surveillance-report-24-december-2025-week-52 *(12)*.

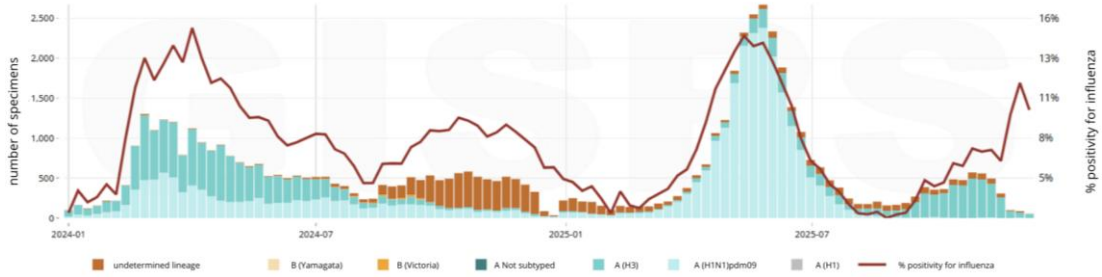
Southern Hemisphere

In **Brazil**, the 2025 influenza season showed a bimodal pattern, with a first increase in activity between EWs 12 and 22, followed by a sustained decline and a second spike around EW 39 (**Figure 15**) *(13)*. Circulation was most attributable to influenza A, with A(H1N1)pdm09 predominating the first period of peak activity and A(H3N2) contributing more during the late rebound *(13)*. In syndromic surveillance of severe acute respiratory infection (SARI), the highest number of influenza-positive cases was concentrated in the first period of peak activity, while the end-of-year rebound was of lesser magnitude *(3)*. Overall, the season was characterized by the predominance of influenza A, with no consistent signs of increased severity at the national level. As for RSV, circulation lasted slightly longer than usual, with activity levels higher than in the previous season, contributing to sustained demand for care for respiratory infections (**Figure 16**) *(3)*.

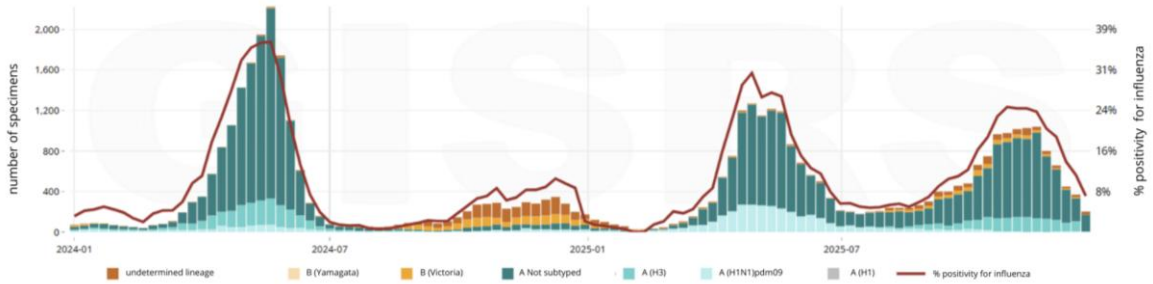
In **Chile**, the 2025 influenza season showed a bimodal pattern, with influenza A predominating throughout the year *(***Figure 15**) *(12)*. Influenza activity began earlier than in previous seasons, with a first peak around week 18, in which influenza A(H1N1)pdm09 predominated *(12)*. Toward the last third of the year, a seasonal uptick was observed with an increase in cases of acute respiratory infections (ARI), consistent with an increase in the circulation of influenza A(H3N2), followed by a gradual decline in the following weeks *(12)*. People aged 65 years and older accounted for 42.1% of reported cases of IRAG, with no signs of increased severity or unusual increase in severe outcomes during the season. With regard to RSV, a higher number of cases and higher positivity were recorded than in 2024 (**Figure 16**) *(3)*.

Figure 15. Virus detection by subtype/lineage reported to FluNet in (a) Brazil and (b) Chile from 1 January 2024 to 22 December 2025.

a. Brazil



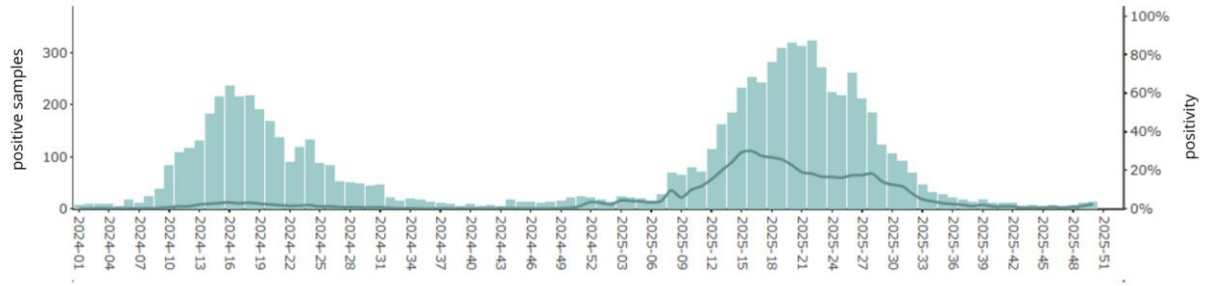
b. Chile



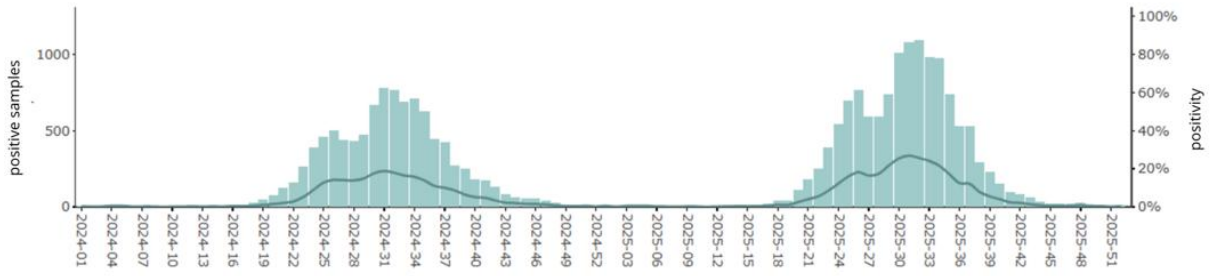
Source: Adapted from World Health Organization. Influenza Laboratory Surveillance Information - Flunet. Geneva: WHO; 2026 [cited 6 January 2026]. Available from: https://worldhealthorg.shinyapps.io/flunetchart/ *(13)*.

Figure 16. Positive samples and percentage of positivity per EW for RSV in (a) Brazil and (b) Chile, as of EW 51 of 2025.

a. Brazil



b. Chile



Source: Adapted from the Pan American Health Organization. Influenza, SARS-CoV-2, RSV, and other respiratory viruses situation dashboard – Region of the Americas. Washington, D.C.: PAHO; 2025 [cited 7 January 2026]. Available from: https://dashboards.pahoflu.com/app/respiratory_viruses/ *(3)*.

Effectiveness of the influenza vaccine

Studies on the effectiveness of the influenza vaccine conducted in Europe and the United Kingdom during the 2025-2026 season, where influenza A(H3N2) subclade K is predominant, indicate that the vaccine confers protection against hospitalization (70 to 75% in children; 30 to 40% in adults) and outpatient illness (44% for any influenza and 52% for influenza A(H3N2) *(14, 15)*. Interim results on vaccine effectiveness during the 2025-2026 season show that the vaccine confers protection against influenza-associated illness and that high vaccination coverage should therefore be achieved in priority groups.

Recommendations for Member States

Based on the available information, there has been an early onset and intense activity of influenza in several countries in the northern hemisphere, with a predominance of subtype A(H3N2), which could put sustained pressure on health services. Although the dynamics correspond to an expected seasonal pattern, select countries are reporting high levels compared to recent seasons, reinforcing the need to maintain close epidemiological and virological surveillance and strengthen prevention and preparedness measures.

RSV circulation is also showing a gradual increase in different countries, with a health impact mainly on children under five and adults over 65 years of age. In scenarios with co-circulation of influenza and RSV, pressure on health services could increase, highlighting the importance of integrated monitoring of both viruses.

In light of this situation, the Pan American Health Organization/World Health Organization (PAHO/WHO) urges Member States to continue strengthening key actions for surveillance, clinical management and prophylaxis, infection prevention and control, risk communication, and vaccination. Below is a summary of the main recommendations issued in the Epidemiological Alert on 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 on 4 December 2025 *(16)*, which remain in effect.

Surveillance

PAHO/WHO recommends Member States integrate surveillance of influenza, RSV, SARS-CoV-2, and other respiratory viruses into existing national platforms and report surveillance data weekly through the PAHO/WHO FluNET and FluID platforms. It is also important to continue sequencing influenza viruses to monitor and identify clades/subclades potentially associated with increased transmissibility or pathogenicity.

Member States are recommended to continue strengthening sentinel surveillance of influenza-like illness (ILI) and to prioritize sentinel surveillance of severe acute respiratory infection (SARI), 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 *(17, 18)*.

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 *(19, 20)*.

Unusual respiratory events should be investigated immediately and reported to PAHO/WHO in accordance with the International Health Regulations (IHR) *(20)*. 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 IRAG in health care workers who are treating severe respiratory cases of unknown etiology; or clusters of influenza virus 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 intensive care units (ICUs) and fatal cases, 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 *(21)*.

According to WHO guidelines, representative samples for influenza selected according to the criteria recommended by PAHO and WHO should be sent to a WHO Collaborating Center (CC) for additional genomic and antigenic characterization *(21, 22)*. Influenza A samples for which the virus subtype cannot be determined, being a true unsubtypable sample (those positive for Influenza A but where RT-PCR for subtyping is negative or inconclusive), should also be sent immediately to a PAHO/WHO CC *(19)*. For further guidance and verification of a true unsubtyped sample, please contact the PAHO laboratory response team prior to sending to a WHO CC (laboratoryresponse@paho.org).

Samples that test positive for zoonotic influenza of animal origin, after meeting all veterinary requirements, should be sent to the PAHO/WHO CC at St. Jude Hospital in Memphis, Tennessee, in the United States, for genomic and antigenic characterization.

Clinical management and prophylaxis

PAHO/WHO recommends Member States update their treatment guidelines based on the updated WHO guidelines *(23-25)*. The recommendations for the clinical management of patients with severe respiratory illness indicated in the epidemiological alerts and PAHO/WHO updates on influenza remain in effect *(26)*. Recommendations on antiviral and antibiotic treatment according to clinical presentation are found in **Tables 1-4** *(25)*.

Table 1. Recommendations for the 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	No reservations against recommendation in cases of 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 *(25)*.

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 *(25)*.

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 *(25)*.

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 *(25)*.

Prevention and control of infection

PAHO/WHO recommends strengthening hand hygiene measures, cough etiquette, and the use of masks by people who have symptoms or have tested positive for influenza viruses, as these measures can reduce the transmission of these viruses.

Given the potential risk of outbreaks of healthcare-associated infections caused by respiratory viruses, it is recommended that standard precautions be strengthened and droplet precautions be used when caring for patients with suspected or confirmed respiratory virus infection or when obtaining, transporting, and testing laboratory specimens from suspected patients. This includes the appropriate placement (isolation) of suspected or confirmed cases and the use of surgical masks by patients with respiratory symptoms and by healthcare and nursing staff caring for patients with suspected or confirmed influenza.

Healthcare and support staff are advised to carry out an appropriate risk assessment to determine whether additional personal protective equipment (e.g., eye protection, FFP2 or N95 respirators, gowns, gloves) is necessary when caring for patients *(26)*.

Following is a summary of the levels of IPC required in routine healthcare activities (excluding those techniques that generate aerosols) (**Table 5**) *(27)*.

Table 5. Precautions required in routine care of patients with respiratory conditions.

Level of infection prevention during routine patient care (excluding aerosol-generating procedures)	No pathogen identified, no risk factor for ARI of potential concern (e.g. influenza-like illness without risk factor for ARI of potential concern)	Bacterial ARI, including plague	Other ARI viruses (e.g. parainfluenza RSV, adenovirus)	Influenza virus with sustained human-to-human transmission (e.g. seasonal influenza, pandemic influenza)	New influenza virus with no sustained human-to-human transmission (e.g. avian influenza)	SARS, MERS-CoV SARS-CoV	Novel respiratory infection (route of transmission unknown)
Standard precautions	✓	✓	✓	✓	✓	✓	✓
Droplet precautions	✓	—	✓	✓	✓	✓	—
Contact precautions	—	—	✓	—	✓	✓	✓
Airborne precautions	—	—	—	—	—	—	✓

ARI, acute respiratory infection; MERS-CoV, Middle East respiratory syndrome coronavirus; RSV, respiratory syncytial virus; SARS, severe acute respiratory syndrome SARS-CoV, Severe acute respiratory syndrome coronavirus 2.

Source: Adapted from the World Health Organization. Study protocol for non-seasonal influenza and other emerging acute respiratory conditions. Geneva: WHO; 2018. Available from: https://www.who.int/publications/i/item/WHO-WHE-IHM-GIP-2018.2 *(28)*.

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 *(29, 30)*. Influenza vaccination before the start of seasonal virus circulation remains the best preventive measure against severe influenza *(31)*.

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 *(30)*.

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 most 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 severe illness associated with seasonal influenza, COVID-19, and RSV, including associated hospitalizations and deaths. PAHO/WHO recommends vaccination of groups at particular risk for severe influenza, including older adults, people with underlying conditions, children between 6 and 59 months of age, and pregnant women. Healthcare workers are at increased risk of exposure to and transmission of influenza and SARS-CoV-2 viruses and should therefore also be prioritized *(32, 33)*. It is recommended that the same high-risk priority groups (with the exception of children younger than 59 months) receive booster doses of COVID-19 vaccine 6 to 12 months after the 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 *(34)*.

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 *(35-37)*.

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 *(35)*. 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 *(39, 40)*. Both the RSVpreF vaccine and long-acting monoclonal antibodies have been approved and are being used in several countries in the Americas.

In addition, 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. *(38, 41, 42)*. In randomized clinical trials and post-authorization studies, these vaccines have been shown to be effective in reducing the risk of developing severe RSV-associated disease.

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 *(43)*.

For more details, see the guidelines: Non-pharmaceutical public health measures to mitigate the risk and impact of epidemic and pandemic influenza *(43)* and the manual Guidance for the implementation of non-pharmaceutical public health measures in vulnerable population groups in the context of COVID-19 *(44)*.

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