



# Epidemiological Alert Seasonal Influenza and Other Respiratory Viruses: Start of the Southern Hemisphere Season

27 April 2026

With the start of the 2026 season of respiratory virus circulation in the Southern Hemisphere, and considering the experience of the 2025–2026 season in the Northern Hemisphere—characterized by the predominance of influenza A(H3N2) virus of the K subclade, with evidence of intense activity concentrated in a short period and moderate effectiveness of the influenza vaccine—the Pan American Health Organization / World Health Organization (PAHO/WHO) urges Member States to strengthen integrated epidemiological and virological surveillance of respiratory viruses, including timely genomic characterization; adjust health service preparedness and organizational plans in anticipation of possible concentrated increases in demand for services due to the circulation of influenza A(H3N2) and the potential co-circulation of respiratory syncytial virus (RSV); and accelerate vaccination against seasonal influenza and RSV in priority groups before the peak of circulation.

## Summary of the global situation

Globally, in the **Northern Hemisphere**—as the winter season comes to a close—influenza activity continues to decline, with a positivity rate of around 10% in temperate and subtropical regions, although some countries are reporting high levels (>20%) (**Figure 1**). While the 2025–2026 influenza season was marked by a predominance of influenza A(H3N2) in the Northern Hemisphere, recent weeks have been characterized by a proportional increase in influenza B, which is common toward the end of the influenza season. In contrast, in the **Southern Hemisphere**, marked by the end of the summer season, an increase in influenza detections is observed, with a predominance of influenza A(H3N2) (**Figure 1** and **Figure 2**) (1).

By 2026, global influenza trends show a predominance of influenza B detections, with a downward trend. In the Northern Hemisphere, the influenza positivity rate was high (>10%) in some countries in North America, East Africa, and in countries in South, East, and Southeast Asia. The positivity rate exceeded 30% in countries in Central America and the Caribbean and Eastern Europe. Likewise, a slight increase in influenza activity was observed in some countries in Central America and the Caribbean and South Asia, as well as in some countries in Central Africa and Central Asia (1).

In the Southern Hemisphere, during EW 14, influenza activity has generally remained low, although an increase in positivity (>10%) was reported in some countries in South America, Eastern and Southern Africa, and Southeast Asia. In South America, only one country reported

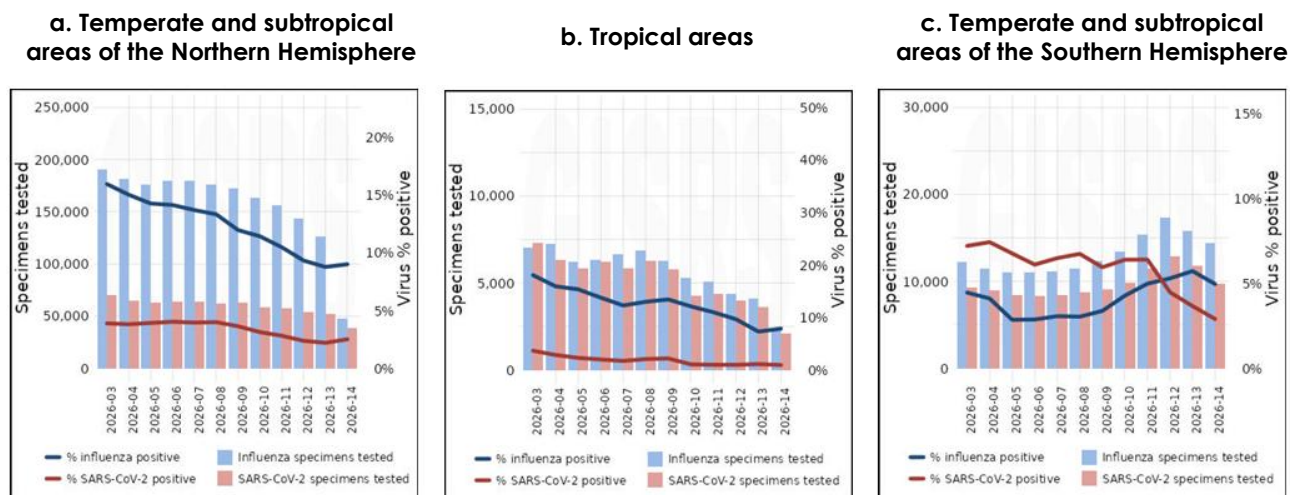
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influenza positivity rates above 30% (1). In areas with high positivity, influenza A(H3N2) predominated, particularly in Central America and the Caribbean, tropical and temperate South America, and East Africa, while influenza A(H1N1)pdm 09 was predominant in Eastern Europe and Southern Africa. Influenza B was predominant in North America, West Africa, and East Asia. Influenza A and B were co-dominant in South and Southeast Asia (1).

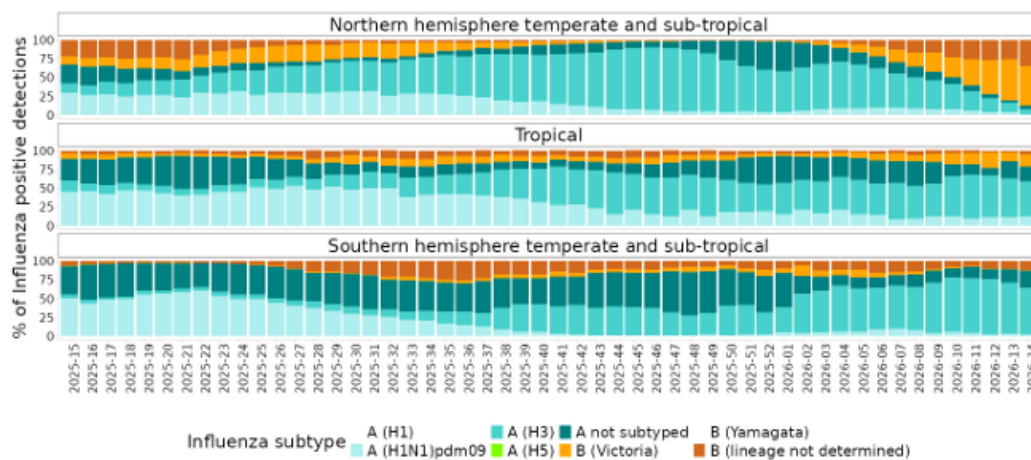
Globally, SARS-CoV-2 positivity remained stable and low (Figure 1). Respiratory syncytial virus (RSV) circulation shows heterogeneous patterns, with low aggregate positivity globally but with pockets of high activity in countries in Central America and the Andean subregion (1).

**Figure 1.** Weekly number of samples tested for influenza and SARS-CoV-2 and global positivity rate, by geographic region (last 12 months).



**Source:** Adapted from the World Health Organization. Global Respiratory Virus Activity: Weekly Update N° 573. Geneva: WHO; 2026. Available from: <https://www.who.int/publications/m/item/global-respiratory-virus-activity-weekly-update-n-573> (1).

**Figure 2.** Weekly distribution of influenza virus types and subtypes by geographic region (last 12 months).



**Source:** Adapted from the World Health Organization. Global Respiratory Virus Activity: Weekly Update N° 573. Geneva: WHO; 2026. Available from: <https://www.who.int/publications/m/item/global-respiratory-virus-activity-weekly-update-n-573> (1).

## Summary of the situation in the Region of the Americas

In the **Northern Hemisphere**, the 2025–2026 influenza season was characterized by an early onset and moderate to high activity, with a predominance of the A(H3N2) virus, mainly from the K subclade. In recent weeks, a transition toward increasing predominance of influenza B has been observed, consistent with the end-of-season pattern, accompanied by an overall downward trend. Concurrently, RSV circulation peaked during the winter months, followed by a sustained decline, although it remains at detectable levels in some North American countries (2, 3).

In the **Southern Hemisphere**, at the start of the 2026 season, influenza activity remains low, with initial signs of an increase in some countries, with the A(H3N2) virus predominating. This trend is consistent with the gradual onset of the winter season. In this context, RSV circulation is showing a gradual increase in several countries, anticipating its typical seasonal pattern, with a potential impact on the disease burden among young children and other at-risk groups in the coming weeks (2, 3).

In the **tropical areas of the Region**, influenza activity has shown more heterogeneous and sustained circulation, with variable predominance between influenza A(H3N2) and influenza B depending on the country. In these areas, RSV circulation has been more persistent throughout the year, with recent increases in subregions such as the Andean Region and some Central American countries, where it has been associated with an increase in hospitalizations due to severe acute respiratory infections in the pediatric population (2, 3).

SARS-CoV-2 activity remains low in most countries (2, 3).

### Influenza vaccine effectiveness

The 2025–2026 season in the Northern Hemisphere has been dominated by the influenza A(H3N2) virus of subclade K (clade 2a.3a.1, subclade J.2.4.1), which is antigenically distant from the vaccine strain A/District of Columbia/27/2023 (subclade J.2) included in the formulations recommended by the WHO for this season. Despite this antigenic mismatch, interim estimates of vaccine effectiveness (VE) published to date indicate that the vaccine retains clinically significant protection. In Europe, a pooled analysis of nine studies from the I-MOVE/VEBIS network (19 countries in the European Union/European Economic Area; n = 275,785) reported a VE against influenza A, combining outpatient and inpatient settings, of 25% to 45% across all age groups, with higher estimates in children (47% to 72%), comparable to those observed in previous seasons (4).

In the United Kingdom, the UK Health Security Agency (UKHSA) reported a VE of 70–75% against hospitalization in children and 30–40% in adults, and 44% against outpatient illness due to any influenza and 52% specifically against A(H3N2) (5). In Canada, the Sentinel Physicians Network (SPSN) estimated a VE of approximately 40% against medically attended acute respiratory illness associated with A(H3N2), including subclade K, and approximately 30% against A(H1N1)pdm09 (6). In the United States, interim estimates from the CDC (September 2025–February 2026, three surveillance networks) reported a VE of 38–41% against outpatient visits and 41% against hospitalization in children and adolescents, representing a reduction compared to previous seasons but maintaining clinically relevant protection (7).

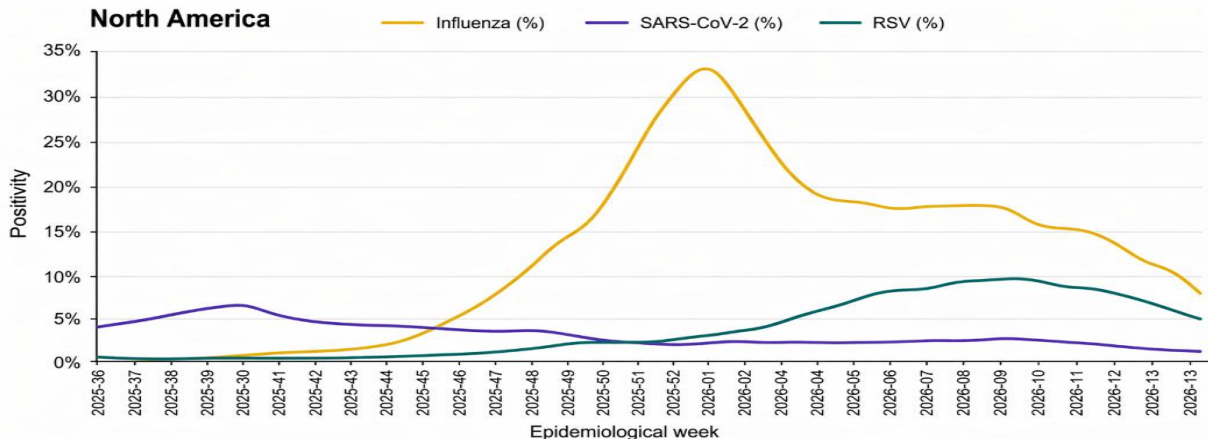
It is important to note that the formulation recommended by the WHO for vaccines in the Southern Hemisphere for the 2026 season includes an update to the A(H3N2) component changing from A/District of Columbia/27/2023 (subclade J.2) to A/Tasmanian/1003/2025 (subclade L.1) (8, 9). This change responds to the antigenic divergence observed between the

currently dominant viruses of subclade K and the previous vaccine strain. Although efficacy data for this new formulation are not yet available, it is expected that the update of the A(H3N2) component will improve the match with circulating viruses and, therefore, the level of protection conferred by the vaccine in the Southern Hemisphere. However, it will be essential to generate early evidence of vaccine effectiveness through REVELAC-i and other surveillance platforms in the Region to confirm this hypothesis and guide public health decisions (8, 9).

### North America Subregion<sup>1</sup>

In the countries of the North American subregion, following the peak reached between weeks 52 and 53 of 2025, a gradual decline in influenza activity was observed, which remained stable between 16% and 17% during weeks 2–7 of 2026, showing a decline in the last four weeks and reaching a positivity rate of 6.5% in EW 13 (Figure 3) (3). In this subregion, a change in the pattern of viral circulation is observed: following an initial period of predominance of influenza A(H3N2), in recent weeks, influenza B (Victoria lineage) has displaced influenza A as the predominant virus, accounting for 86.8% of detections nationwide in Canada at the end of the analyzed period. Regarding RSV circulation, a downward trend has been observed over the past three weeks, reaching a positivity rate of 4.7% in EW 13. SARS-CoV-2 activity continues to trend downward, with a positivity rate of 1.5% in EW 13 (3). Cases of severe acute respiratory infection (SARI) associated with influenza continue to decline, standing at 7% (3).

**Figure 3.** Positive samples and positivity rate by epidemiological week in the North America subregion, from EW 35 of 2025 as of EW 13 of 2026.



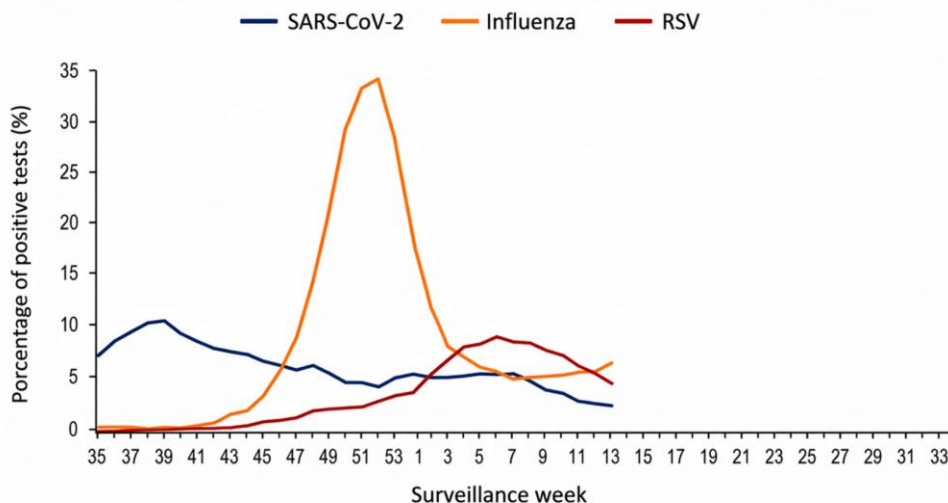
**Source:** Adapted from the Pan American Health Organization. Dashboard on the Situation of Influenza, SARS-CoV-2, RSV, and Other Respiratory Viruses – Region of the Americas. Washington, D.C.: PAHO; 2026 [cited 15 April 2026]. Available from: [https://dashboards.pahoflu.com/app/respiratory\\_viruses/](https://dashboards.pahoflu.com/app/respiratory_viruses/) (3).

In **Canada**, the **2025–2026** season was characterized by an early onset and a period of high influenza activity, with a positivity rate peaking at nearly 35% in mid-December, driven primarily by the circulation of influenza A(H3N2), predominantly of the K subclade (Figure 4 and Figure 5). Subsequently, activity showed a sustained decline, with a relative increase in influenza B toward the end of the season, especially among school-aged children. RSV activity began later than in previous seasons, peaking in February with moderate positivity rates for (~8%) and primarily affecting children under five years of age; although less intense than in recent years,

<sup>1</sup> North America: Canada, the United States, and Mexico.

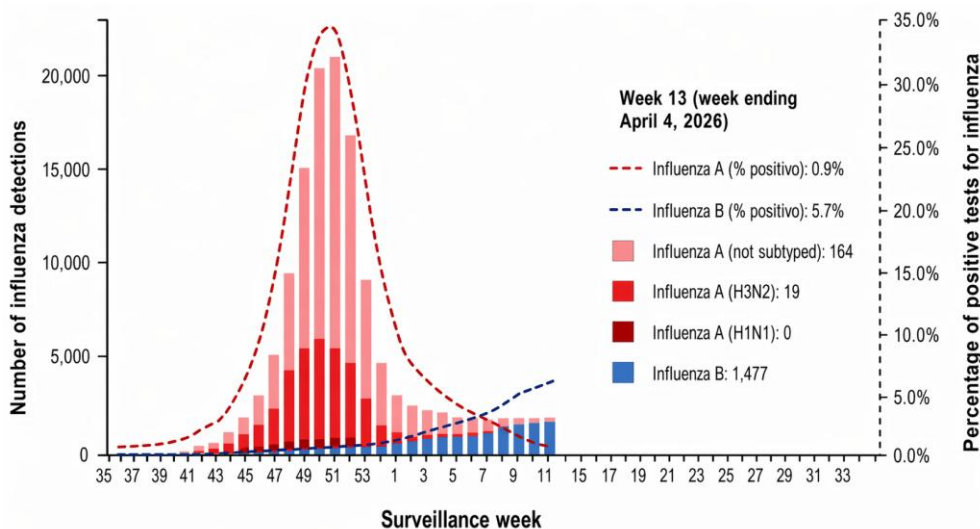
the period of circulation was longer. In recent weeks, influenza, RSV, and SARS-CoV-2 activity has continued to decline and remains at low levels (10).

**Figure 4.** Percentage of positive tests for influenza, SARS-CoV-2, and respiratory syncytial virus in Canada by surveillance week, 2025–2026.



**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; 2026 [cited 15 April 2026]. Available from: <https://health-infobase.canada.ca/respiratory-virus-surveillance/explore.html> (10).

**Figure 5.** Number of reported influenza cases and percentage of positive tests in Canada, by type, subtype, and reporting week, 2025–2026.



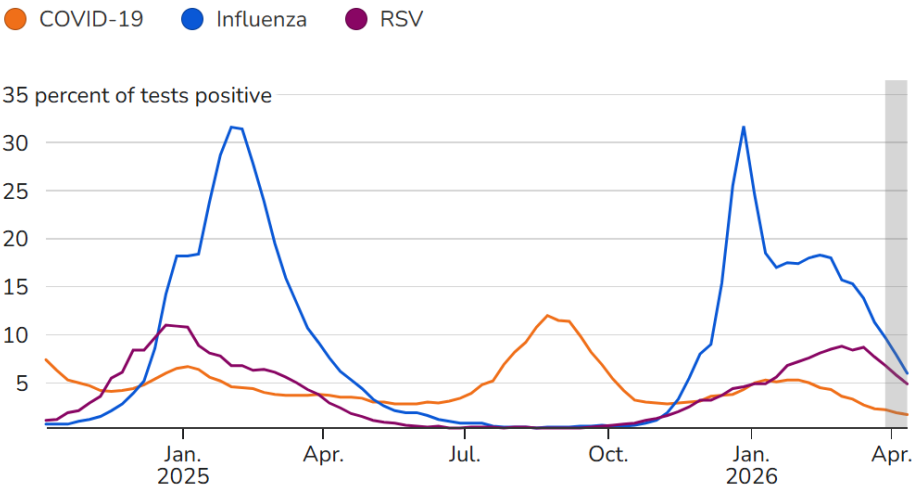
**Source:** Adapted from Government of Canada. Public Health Agency of Canada. Canadian respiratory virus surveillance report. Weekly overview of key trends in the activity of respiratory viruses in Canada. Ottawa: PHAC; 2026 [cited 15 April 2026]. Available from: <https://health-infobase.canada.ca/respiratory-virus-surveillance/explore.html> (10).

In the **United States of America**, the 2025–2026 season was characterized by an early onset and high influenza activity, with a positivity rate exceeding 30% by late December, driven primarily by the circulation of influenza A(H3N2), predominantly of the K subclade (**Figure 6**).

Subsequently, a sustained decline in activity was observed, accompanied by a relative increase in influenza B toward the end of the season, with regional variations in its intensity. The cumulative rate of influenza-associated hospitalizations was the third highest since the 2010–2011 season, with the highest rate for the 2025–2026 season recorded in EW 53 of 2025 (12.6 hospitalizations per 100,000 population) (Figure 7) (11–13). Children under 18 years of age have the second-highest cumulative hospitalization rate for that age group since the 2010–2011 season (11).

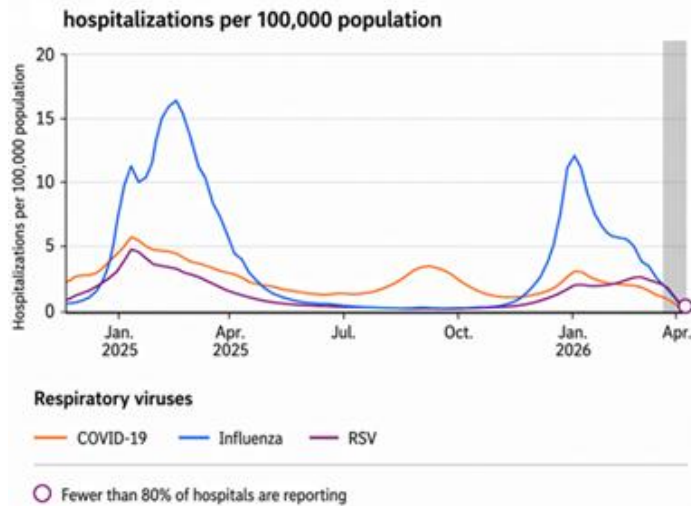
RSV activity showed a gradual increase starting in the fall, peaking in late winter with moderate positivity rates (around 8–9%), primarily affecting young children, followed by a decline in recent weeks. Concurrently, SARS-CoV-2 circulation remained low and declining for most of the period (3).

**Figure 6.** Hospitalization rates reported by hospitals in the United States, by respiratory virus, 2025–2026.



**Source:** Adapted from the U.S. Centers for Disease Control and Prevention. Respiratory Virus Activity Levels. Atlanta: CDC; 2026 [cited 15 April 2026]. Available from: <https://www.cdc.gov/respiratory-viruses/data/activity-levels.html> (12).

**Figure 7.** Hospitalization rates reported by hospitals in the United States, by respiratory virus, 2025–2026.

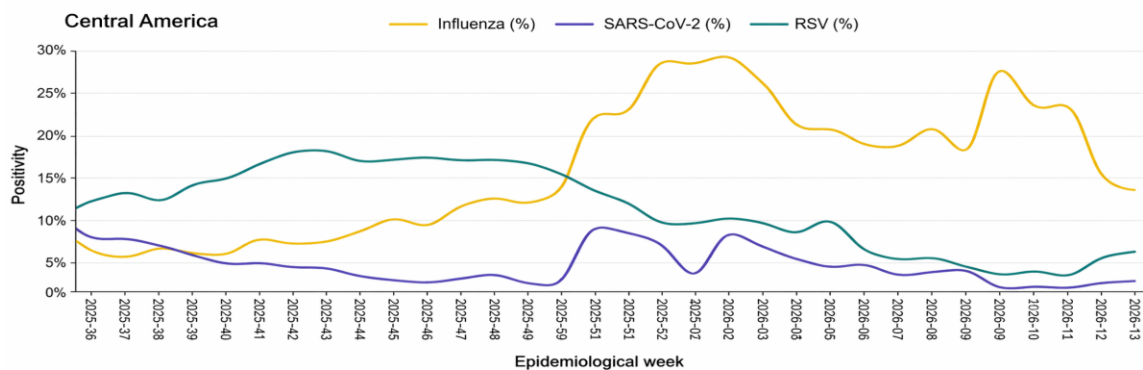


**Source:** Adapted from the U.S. Centers for Disease Control and Prevention. Severe Viral Respiratory Illness. Atlanta: CDC; 2026 [cited 15 April 2026]. Available from: <https://www.cdc.gov/respiratory-viruses/data/illness-severity.html> (13).

### Central America Subregion<sup>2</sup>

In the Central America subregion, influenza activity during the first weeks of 2026 has varied, with positivity rates ranging from 13% to 30.4% (3). Following high values at the start of the period (30.4% in EW 1), a gradual decline was observed through EW 6 (17.9%). Subsequently, a new increase was recorded, with a peak positivity rate in EW 9 (28.5%); however, the downward trend resumed in the following weeks (**Figure 8**) (3).

**Figure 8.** Positive samples and percentage of positivity by epidemiological week in the Central America subregion, between EW 35 of 2025 and as of EW 13 of 2026.



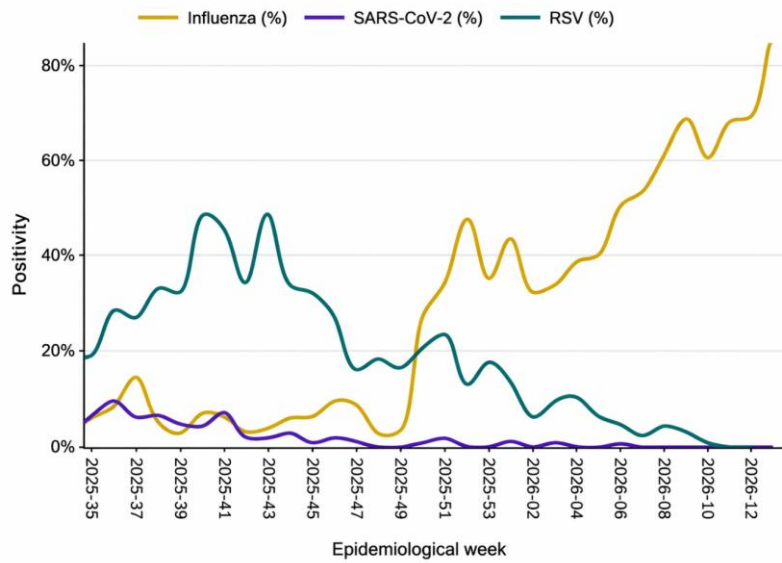
**Source:** Adapted from the Pan American Health Organization. Dashboard on the Situation of Influenza, SARS-CoV-2, RSV, and Other Respiratory Viruses—Region of the Americas. Washington, D.C.: PAHO; 2026 [cited 15 April 2026]. Available from: [https://dashboards.pahoflu.com/app/respiratory\\_viruses/](https://dashboards.pahoflu.com/app/respiratory_viruses/) (3).

In **Guatemala**, during the last eight weeks of 2026, influenza positivity showed an upward trend, with values ranging from 38.3% (EW 4) to 100% (EW 13), an increase that should be interpreted

<sup>2</sup> Central America: Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua, and Panama.

with caution, as it is likely influenced by a reduction in testing volume, which could overestimate the intensity of transmission (**Figure 9**). In the last four weeks, positivity remained at 64.2%. Cases are primarily associated with the circulation of influenza A(H3N2) and A(H1N1)pdm09 (3). Compared to other respiratory viruses, influenza has been the predominant virus in cases of severe acute respiratory infections (SARI). The most affected groups are children aged 0 to 12 years (3).

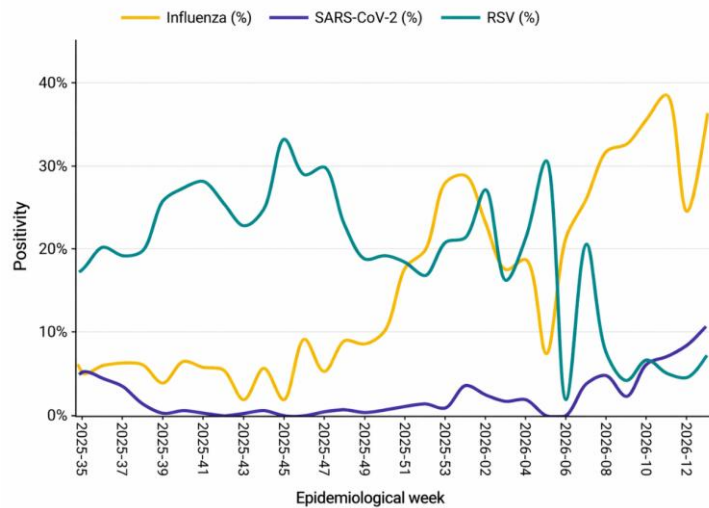
**Figure 9.** Positive samples and positivity rate by epidemiological week, Guatemala, between EW 35 of 2025 and as of EW 13 of 2026.



**Source:** Adapted from the Pan American Health Organization. Dashboard on the Situation of Influenza, SARS-CoV-2, RSV, and Other Respiratory Viruses—Region of the Americas. Washington, D.C.: PAHO; 2026 [cited 15 April 2026]. Available from: [https://dashboards.paho.org/app/respiratory\\_viruses/](https://dashboards.paho.org/app/respiratory_viruses/) (3).

In **Panama**, during the first weeks of 2026, a change in the circulation pattern of respiratory viruses was observed. At the beginning of the period, between EW 1 and EW 4, co-circulation of influenza and RSV was evident, with relatively high positivity rates for both viruses. In particular, RSV reached its highest level in EW 5 (30.6%), becoming the predominant virus at that time. Starting in EW 6, a marked decline in RSV positivity was observed, accompanied by a sustained increase in influenza activity, which became the predominant virus from EW 7 onward, peaking at 38.5% in EW 11 and remaining at high levels in EW 13 (36.6%) (**Figure 10**). Meanwhile, SARS-CoV-2 positivity remained low for most of the period. Regarding case severity, hospitalizations for severe acute respiratory infections (SARIs) associated with influenza have predominated, followed by those related to RSV (2).

**Figure 10.** Positive samples and positivity rate by epidemiological week, Panama, Between EW 35 of 2025 and as of EW 13 of 2026.

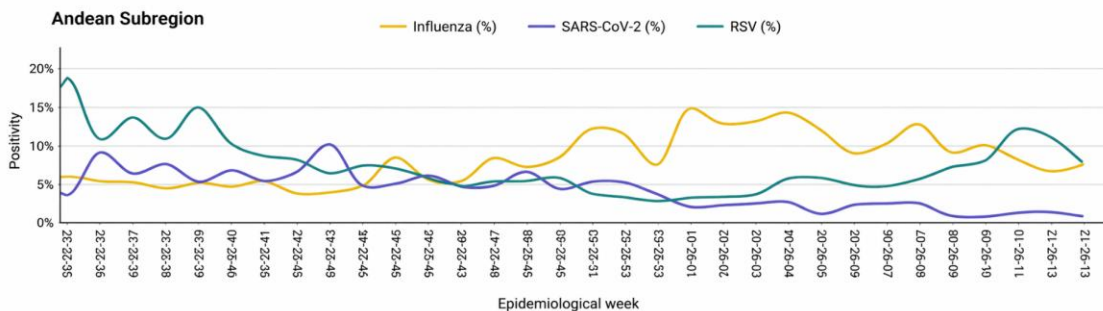


**Source:** Adapted from the Pan American Health Organization. Dashboard on the Situation of Influenza, SARS-CoV-2, RSV, and Other Respiratory Viruses—Region of the Americas. Washington, D.C.: PAHO; 2026 [cited 15 April 2026]. Available from: [https://dashboards.pahoflu.com/app/respiratory\\_viruses/](https://dashboards.pahoflu.com/app/respiratory_viruses/) (3).

### Andean Subregion<sup>3</sup>

In the Andean subregion, influenza activity during the first weeks of 2026 remained stable at a positivity rate of 12% to 15% through EW 4, with influenza A predominating. Subsequently, a downward trend was observed, with activity remaining at low levels in EW 13 (7.5%). These data suggest a decrease in influenza activity accompanied by a relative increase in RSV circulation in recent weeks (**Figure 11**).

**Figure 11.** Positive samples and positivity rate by epidemiological week in the Andean subregion, from Between EW 35 of 2025 and as of EW 13 of 2026.



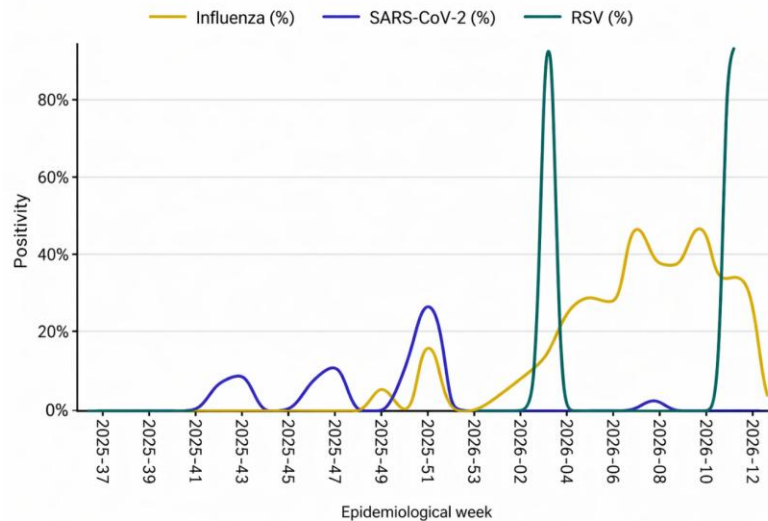
**Source:** Adapted from the Pan American Health Organization. Dashboard on the Situation of Influenza, SARS-CoV-2, RSV, and Other Respiratory Viruses—Region of the Americas. Washington, D.C.: PAHO; 2026 [cited 15 April 2026]. Available from: [https://dashboards.pahoflu.com/app/respiratory\\_viruses/](https://dashboards.pahoflu.com/app/respiratory_viruses/) (3).

In **Bolivia (Plurinational State of)**, during the first weeks of 2026, influenza positivity showed an upward trend starting in EW 5, reaching a peak of 44.6% in EW 7. Subsequently, a decline in positivity was observed starting in EW 11. In the last four weeks, influenza positivity stood at 37.1%. Regarding respiratory syncytial virus (RSV), high positivity rates were recorded in recent weeks,

<sup>3</sup> Andean: Bolivia (Plurinational State of), Colombia, Ecuador, Peru, and Venezuela (Bolivarian Republic of).

reaching 100% between EW 5 and EW 13, values that may be influenced by a low number of samples analyzed. This pattern was also previously observed in EW 3 and has persisted since EW 32 of 2025. Regarding virological characterization, influenza A(H1N1)pdm09 predominates (65.1%). Furthermore, among cases of severe acute respiratory infections (SARI), the most affected age group is children aged 0 to 12 years (42.5%) (**Figure 12**) (3).

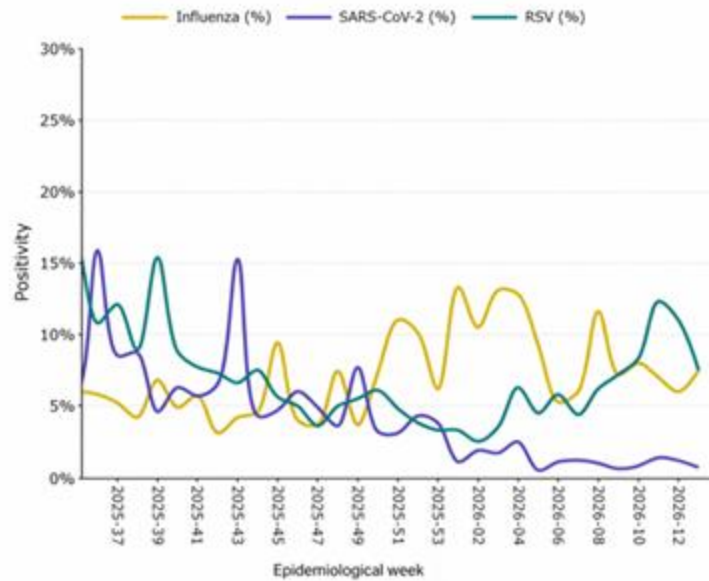
**Figure 12.** Positive samples and percentage of positivity by epidemiological week, Bolivia, Between EW 35 of 2025 and as of EW 13 of 2026.



**Source:** Adapted from the Pan American Health Organization. Dashboard on the Situation of Influenza, SARS-CoV-2, RSV, and Other Respiratory Viruses—Region of the Americas. Washington, D.C.: PAHO; 2026 [cited 15 April 2026]. Available from: [https://dashboards.pahoflu.com/app/respiratory\\_viruses/](https://dashboards.pahoflu.com/app/respiratory_viruses/) (3).

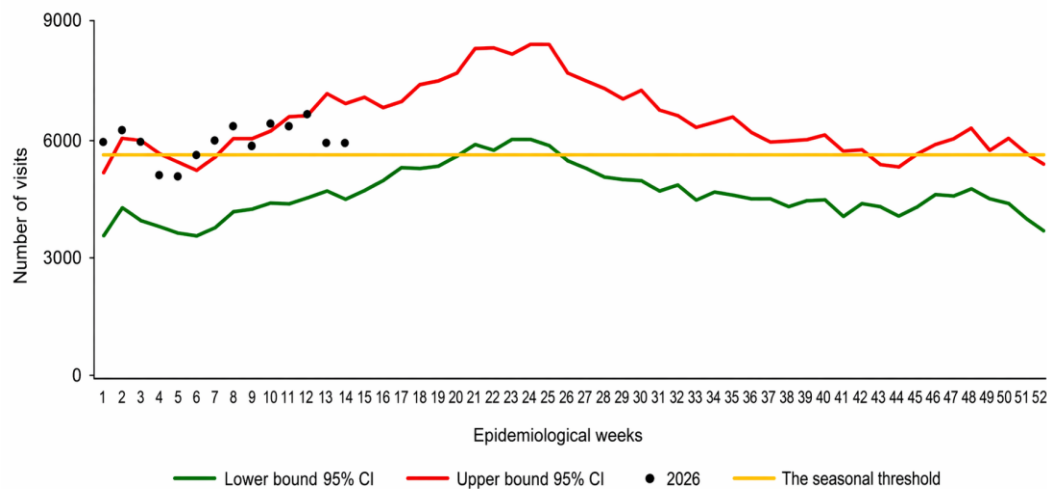
In **Colombia**, during the last four EW of 2026, an increase in RSV positivity was observed, with signs of stabilization in the most recent weeks. With regard to cases of acute respiratory infections, RSV also predominated; the most affected age group was children aged 0 to 12 years, followed by those aged 13 to 17 years (14). On the other hand, hospitalizations for acute respiratory infections (ARI) in general wards showed a sustained upward trend between EW 1 and EW 12, remaining near or above the upper limit of the endemic range; however, a decline was observed in EW 13 and EW 14, although figures remained above the seasonal threshold (**Figure 14**). This trend was most evident among people over 60 years of age, whose hospitalizations remained above the upper limit for several recent weeks. Regarding viral circulation, during the last period analyzed, the presence of multiple respiratory viruses was evident, including RSV, enterovirus, rhinovirus, adenovirus, parainfluenza, and influenza B. Likewise, a general increase in positivity was observed, particularly associated with metapneumovirus, while other viruses remained at stable levels (3).

**Figure 13.** Positive samples and positivity rate by epidemiological week in Colombia, between EW 35 of 2025 and as of EW 12 of 2026.



**Source:** Adapted from the Pan American Health Organization. Dashboard on the Situation of Influenza, SARS-CoV-2, RSV, and Other Respiratory Viruses—Region of the Americas. Washington, D.C.: PAHO; 2026 [cited 15 April 2026]. Available from: [https://dashboards.pahoflu.com/app/respiratory\\_viruses/](https://dashboards.pahoflu.com/app/respiratory_viruses/) (3).

**Figure 14.** Endemic trend of hospitalizations for severe acute respiratory infection in general wards, Colombia, between EW 1 and EW 14 of 2026.



**Source:** Adapted from the Instituto Nacional de Salud. Boletín Epidemiológico Semanal- Año 21. Semana Epidemiológica 14. Bogotá: INS; 2026. Available from: [https://www.ins.gov.co/buscador-eventos/BoletinEpidemiologico/2026\\_Boletin\\_epidemiologico\\_semana\\_14.pdf](https://www.ins.gov.co/buscador-eventos/BoletinEpidemiologico/2026_Boletin_epidemiologico_semana_14.pdf) (14).

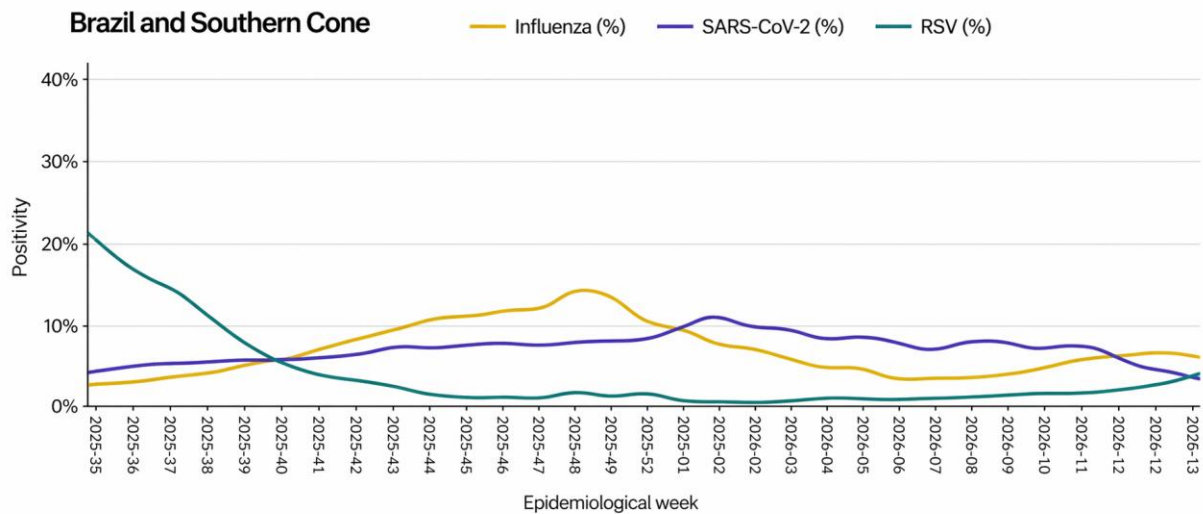
### Brazil and Southern Cone Subregion<sup>4</sup>

In Brazil and the Southern Cone, influenza activity remained below 6% during the first eight weeks of 2026, with slight increases beginning in EW 9, reaching a positivity rate of 5.9% in EW 13 (**Figure 15**) (2, 3). There is a clear predominance of influenza A(H3N2), with high circulation intensity and a lower proportion of unsubtype viruses compared to other subregions, suggesting a more

<sup>4</sup> Brazil and the Southern Cone: Argentina, Brazil, Chile, Paraguay, and Uruguay.

defined transmission dynamic dominated by this subtype (2, 3). Considering that the recent season in the Northern Hemisphere was characterized by the predominance of influenza A(H3N2) of the K clade, associated with intense activity and concentrated peaks of transmission; the recent detection of this clade's in countries of the subregion suggests the possible continuation of similar patterns, although its impact will depend on local dynamics and the evolution of viral circulation. Regarding RSV circulation, although its circulation is considered low, a gradual upward trend is observed, reaching a positivity rate of 3.9% in EW 13. SARS-CoV-2 shows a downward trend, with a positivity rate of 3.2%. Cases of influenza-like illness (ILI) and SARI in the Brazil and Southern Cone subregion are mainly associated with influenza, for which a slight upward trend is observed (2, 3).

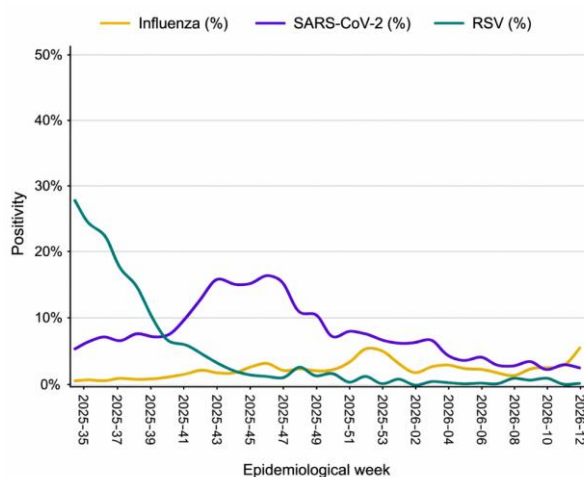
**Figure 15.** Positive samples and positivity rate by epidemiological week in the Brazil and Southern Cone subregion, Between EW 35 of 2025 and as of EW 13 of 2026.



**Source:** Adapted from the Pan American Health Organization. Dashboard on the Situation of Influenza, SARS-CoV-2, RSV, and Other Respiratory Viruses—Region of the Americas. Washington, D.C.: PAHO; 2026 [cited 15 April 2026]. Available from: [https://dashboards.pahoflu.com/app/respiratory\\_viruses/](https://dashboards.pahoflu.com/app/respiratory_viruses/) (3).

In **Argentina**, influenza activity has shown a slight upward trend over the past four weeks, reaching a positivity rate of 6.2% in EW 12 (**Figure 16**). RSV activity remains low, reaching a positivity rate of 0.5%, and SARS-CoV-2 activity shows a low and stable trend with a positivity rate of 2.9%, with no significant changes in the last two months (3).

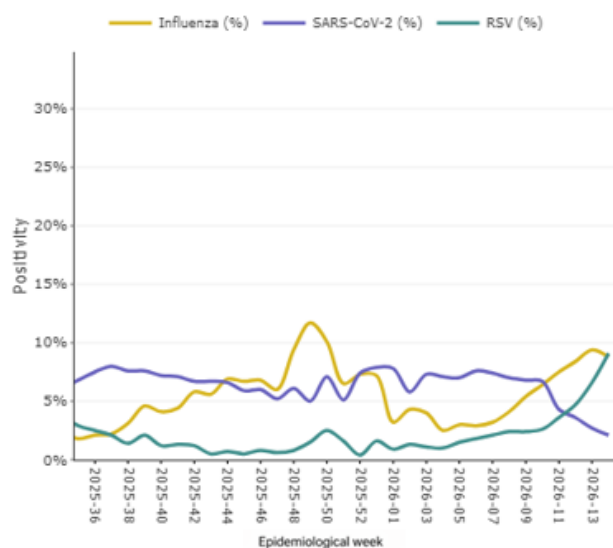
**Figure 16.** Positive samples and positivity rate by epidemiological week in Argentina, between EW 35 of 2025 and as of EW 12 of 2026.



**Source:** Adapted from the Pan American Health Organization. Dashboard on the Situation of Influenza, SARS-CoV-2, RSV, and Other Respiratory Viruses—Region of the Americas. Washington, D.C.: PAHO; 2026 [cited 15 April 2026]. Available from: [https://dashboards.pahoflu.com/app/respiratory\\_viruses/](https://dashboards.pahoflu.com/app/respiratory_viruses/) (3).

In **Brazil**, during the first quarter of 2026, influenza activity remained below 5%, showing a slight increase in activity between EW 7 and EW 11 when it reached a positivity rate of 7.4% (**Figure 17**) (3). The predominant subtype has been influenza A(H3N2), with a slight increase in influenza B (3). As for RSV, there has been a slight progressive increase, with a positivity rate of 4.2% over the last four weeks, reaching 6.3% in EW 12. SARS-CoV-2 activity shows a downward trend, with a positivity rate of 2.8% (3).

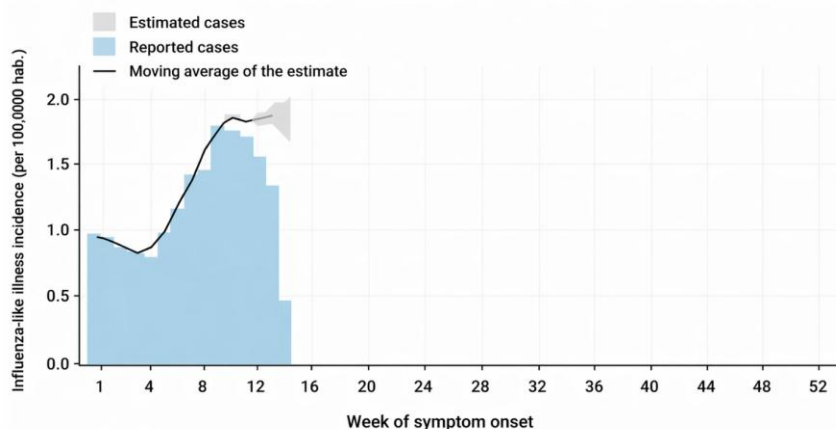
**Figure 17.** Positive samples and positivity rate by epidemiological week in Brazil, between EW 35 of 2025 and as of EW 12 of 2026.



**Source:** Adapted from the Pan American Health Organization. Dashboard on the Situation of Influenza, SARS-CoV-2, RSV, and Other Respiratory Viruses—Region of the Americas. Washington, D.C.: PAHO; 2026 [cited 15 April 2026]. Available from: [https://dashboards.pahoflu.com/app/respiratory\\_viruses/](https://dashboards.pahoflu.com/app/respiratory_viruses/) (3).

Nationwide, cases of severe acute respiratory infection (SARI) show signs of a stabilizing trend. However, there has been a nationwide increase in SARI cases among children under two years of age, driven by a rise in RSV-related hospitalizations (**Figure 18**) (15). Cases of ARVI associated with influenza A continue to decline in many states in the Northeast, as well as in Pará and Rio de Janeiro. However, they continue to rise in much of the Central-South region and in some states in the Northeast, and have begun to increase again in some regions of the North. In the last 4 epidemiological weeks, the proportion of positive cases was 32.2% for influenza A, 2.4% for influenza B, 26.3% for respiratory syncytial virus, 33% for rhinovirus, and 5.5% for SARS-CoV-2 (COVID-19) (15).

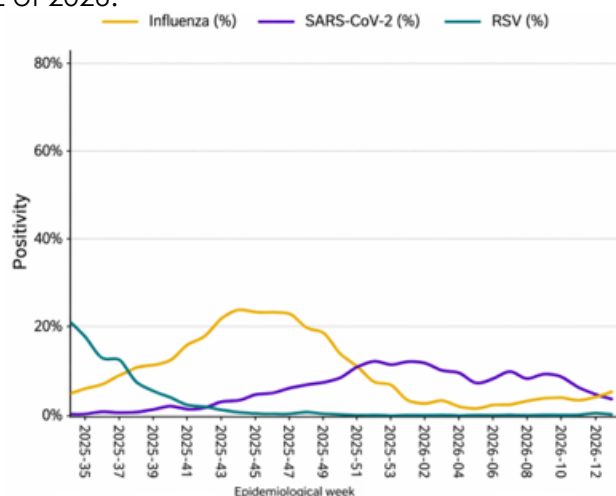
**Figure 18.** Weekly incidence of severe acute respiratory syndrome (SARS) in Brazil in 2026, through EW 14.



**Source:** Adapted from the Instituto de Comunicação e Informação Científica e Tecnológica em Saúde - ICICT/Fiocruz. Resumo do Boletim InfoGripe -- Semana Epidemiológica (SE) 14 2026. Rio de Janeiro: FIOCRUZ; 2026. Available from: [https://agencia.fiocruz.br/sites/agencia.fiocruz.br/files/Resumo\\_InfoGripe\\_2026\\_14\\_0.pdf](https://agencia.fiocruz.br/sites/agencia.fiocruz.br/files/Resumo_InfoGripe_2026_14_0.pdf). (15).

In **Chile**, influenza circulation remains low with a slight increase over the past four weeks, reaching a positivity rate of 5.3% in EW 13 (**Figure 19**). RSV activity remains stable at low levels, reaching a positivity rate of 0.4%, and SARS-CoV-2 continues to be the predominant virus during the first part of the year, showing a downward trend starting in EW 11 and with a positivity rate of 3.8% in EW 13 (3).

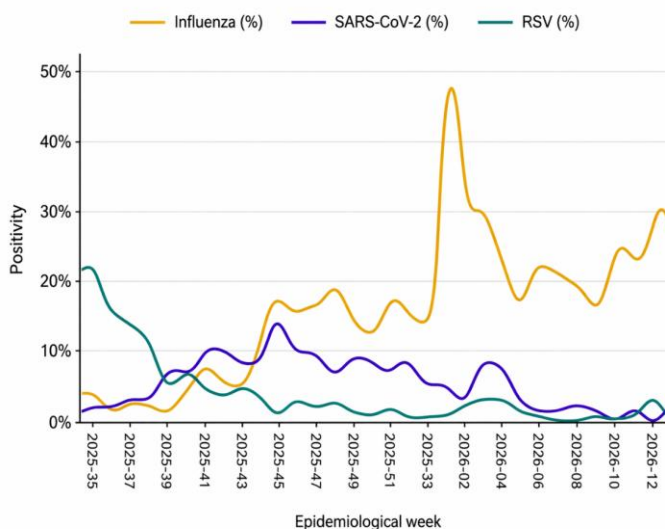
**Figure 19.** Positive samples and positivity rate by epidemiological week in Chile, between EW 35 of 2025 and as of EW 12 of 2026.



**Source:** Adapted from the Pan American Health Organization. Dashboard on the Situation of Influenza, SARS-CoV-2, RSV, and Other Respiratory Viruses—Region of the Americas. Washington, D.C.: PAHO; 2026 [cited 15 April 2026]. Available from: [https://dashboards.pahoflu.com/app/respiratory\\_viruses/](https://dashboards.pahoflu.com/app/respiratory_viruses/) (3).

In **Paraguay**, during the first quarter of 2026, influenza activity remained high, peaking for the first time in EW1 of 2026 when it reached a positivity rate of 47.6%, then showed a downward trend until EW 5, with a positivity rate of 17.1%, and subsequently showed an upward trend, with a positivity rate of 26% over the last four weeks (**Figure 20**) (3). The predominant subtype has been influenza A(H3N2) (3). As for RSV, it remains at low levels with a slight recent increase and a positivity rate of 1% over the last four weeks. SARS-CoV-2 activity shows low circulation with a positivity rate of 0.4% over the last four weeks (3).

**Figure 20.** Positive samples and positivity rate by epidemiological week in Paraguay, between EW 35 of 2025 and as of EW 12 of 2026.



**Source:** Adapted from the Pan American Health Organization. Dashboard on the Situation of Influenza, SARS-CoV-2, RSV, and Other Respiratory Viruses—Region of the Americas. Washington, D.C.: PAHO; 2026 [cited 15 April 2026]. Available from: [https://dashboards.pahoflu.com/app/respiratory\\_viruses/](https://dashboards.pahoflu.com/app/respiratory_viruses/) (3).

## Recommendations for Member States

The 2025–2026 season in the Northern Hemisphere within the Region of the Americas was characterized by: (i) the predominance of influenza A(H3N2) virus of clade 2a.3a.1, with subclade K (J.2.4.1) as the dominant lineage at the regional level; (ii) evidence of reduced antigenic reactivity of circulating viruses against the reference vaccine strains for the season, but with vaccine effectiveness similar to previous years; (iii) in some countries, such as Canada, transmission activity that reached extraordinary levels but was concentrated over a short period (approximately 4 to 6 weeks), with a cumulative burden of hospitalizations, ICU admissions, and mortality comparable to or lower than in previous seasons; and (iv) a recent shift toward influenza B as the predominant virus in North America in recent weeks. These observations suggest that countries in the Southern Hemisphere should prepare not only for a season of potentially high intensity, but particularly for peaks in hospital demand concentrated over short periods, which could test the response capacity of health services.

Regarding RSV, available data from the Region show heterogeneous patterns of circulation, with clusters of high positivity in some countries despite low aggregate subregional levels. The clinical impact is concentrated, as expected, in children under five years of age—particularly those under two years of age—and in adults over 65 years of age.

The scenarios of co-circulation of influenza, RSV, and SARS-CoV-2 observed in previous seasons, and consistent with recent trends in Brazil, confirm the importance of integrated surveillance of respiratory viruses and advance planning for pediatric and geriatric hospital services.

Considering 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. The following is a summary of the main recommendations issued in the Epidemiological Alert on Seasonal Influenza in the Region of the Americas: 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 that Member States integrate surveillance of 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 sequencing influenza viruses to monitor and identify clades/subclades potentially associated with increased transmissibility or pathogenicity.

Member States are encouraged to continue strengthening sentinel surveillance of influenza-like illness (ILI) and to prioritize sentinel surveillance of severe acute respiratory infections (SARI), complementing it with other surveillance strategies to monitor epidemiological changes and viral circulation trends in order to assess transmission patterns, clinical severity, and the impact on the health system and society, and to identify groups at risk of developing associated respiratory complications (17, 18).

To complement indicator-based surveillance, PAHO/WHO recommends that Member States implement event-based surveillance. Event-based surveillance is the organized and rapid collection 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).

Respiratory events that are unusual 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 ARI among health care workers who are 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 lavage, in severe cases) should be collected for the detection of respiratory viruses. Laboratory testing should always be prioritized for the most severe cases, especially those admitted to intensive care units (ICUs) and fatal cases, in which it is also recommended to collect respiratory tract tissue samples (if possible). All biosafety measures for respiratory pathogens must be followed. Technical guidelines and diagnostic algorithms from the National Influenza Center or the national reference laboratory responsible for laboratory surveillance must be followed. The recommended testing algorithms for influenza, RSV, and SARS-CoV-2 are available on the PAHO/WHO website from: <https://www.paho.org/en/documents/influenza-and-sars-cov-2-integrated-surveillance-laboratory-testing-algorithm> (21).

In accordance with WHO guidelines, representative influenza samples 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—i.e., true non-subtypable samples (those positive for influenza A but where RT-PCR for subtyping is negative or inconclusive)—must also be sent immediately to a PAHO/WHO CC (19). For further guidance and verification of a true non-subtypable sample, contact the PAHO laboratory response team before sending it to a WHO CC ([laboratoryresponse@paho.org](mailto:laboratoryresponse@paho.org)).

To minimize the likelihood of an unsubtyped or inconclusive sample, it is important that laboratories use version 4 (V4) of the CDC influenza subtyping kit, which is available from International Reagent Resources (IRR). This kit change is important given recent developments in the influenza virus, particularly the predominance of influenza A(H3N2) subclade K, whose mutations in the HA gene have reduced the detection sensitivity of the CDC Influenza Subtyping Kit Version 3 (V3).

Samples 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 that 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 outlined in PAHO/WHO epidemiological alerts and influenza updates remain in effect (6). Recommendations regarding antiviral and antibiotic treatment based on clinical presentation are provided in **Tables 1–4** (25).

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

Medication	Recommendation
Baloxavir (high risk of progression to severe illness)	Conditional recommendation in favor
Baloxavir (low risk of progression to severe illness)	Conditional recommendation against
Laninamivir	Conditional recommendation against
Oseltamivir	Unqualified recommendation against
Peramivir	Conditional recommendation against
Zanamivir	Unqualified recommendation against
Favipiravir	Unqualified recommendation against
Umifenovir	Conditional recommendation against
Antibiotics	Unqualified recommendation against use 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 adjunctive treatment in severe influenza.

Intervention	Recommendation
Macrolides	Conditional recommendation against use in the absence of 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 for extremely high risk
Laninamivir	Conditional recommendation against use unless at extremely high risk
Oseltamivir	Conditional recommendation in favor for extremely high risk
Zanamivir	Conditional recommendation against use unless risk is extremely high

**Source:** World Health Organization. Clinical practice guidelines for influenza. Geneva: WHO; 2024. Available from: <https://www.who.int/publications/i/item/9789240097759> (25).

## Infection prevention and control

PAHO/WHO recommends strengthening hand hygiene measures, cough etiquette, and the use of masks by individuals 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 healthcare-associated outbreaks of respiratory virus infections, it is recommended to strengthen standard precautions and use droplet precautions when caring for patients with suspected or confirmed respiratory virus infections or when collecting, transporting, and testing laboratory specimens from suspected cases. This includes the appropriate placement (isolation) of suspected or confirmed cases and the use of surgical masks by the patient presenting with respiratory symptoms and by healthcare and support staff caring for the patient with suspected or confirmed influenza.

It is recommended that healthcare and support staff conduct 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).

The following is a summary of the required levels of personal protective equipment (PPE) for routine healthcare activities (excluding procedures 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. Protocol for the investigation of 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 of any age group (29, 30). Influenza vaccination before the onset of seasonal virus circulation remains the best preventive measure against severe influenza (31).

The public should be informed that the primary mode of influenza transmission is person-to-person contact. Handwashing is the most effective way to reduce transmission. Knowledge of “respiratory etiquette” also helps prevent transmission (30).

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

To capitalize on the knowledge the general public has gained about preventing respiratory illnesses—as a result of the COVID-19 pandemic—and to avoid confusion and ensure effective

communication, Member States should consider developing risk communication strategies and campaigns that incorporate prevention messages for respiratory viruses. It is also recommended to integrate communication efforts to promote vaccination against COVID-19 and influenza.

## Vaccination

Immunization is an important strategy for preventing severe illness associated with seasonal influenza, COVID-19, and RSV, including related 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. Healthcare workers are at increased risk of exposure to and transmission of the influenza virus and SARS-CoV-2 and, therefore, should also be prioritized (32, 33). It is recommended that the same high-risk priority groups (with the exception of children under 59 months of age) 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 aged 6 months and older receive at least one dose of the 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 to prevent 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 (34). 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 region.

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. (38, 41, 42). In randomized clinical trials and post-authorization studies, these vaccines demonstrated their efficacy in reducing the risk of developing severe RSV-associated disease.

Currently, several vaccines and long-acting monoclonal antibodies for the prevention of RSV disease are in the clinical research phase, in addition to significant progress in understanding the immune response to RSV.

## Non-pharmacological public health measures in the population

As recently demonstrated during the COVID-19 pandemic, non-pharmacological 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, mask use, 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 Guidelines for the implementation of non-pharmacological public health measures in vulnerable population groups in the context of COVID-19 (43).

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## Other useful links

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