Epidemiological Alert Seasonal Influenza and other respiratory viruses in the Southern Hemisphere

1 July 2026

Considering the increase in influenza B activity observed in some countries of the Americas Region, as evidenced by recent increases in detections reported by national surveillance systems, and given that this increase occurs in the context of the onset of the respiratory virus season—characterized by increased transmission of seasonal influenza and the progressive circulation of respiratory syncytial virus (RSV)— particularly in the Southern Hemisphere, the Pan American Health Organization/World Health Organization (PAHO/WHO) urges Member States to strengthen epidemiological and virological surveillance of acute respiratory infections, review response capacity, and reinforce prevention and control strategies targeting high-risk groups. In this context, the co-circulation of influenza and RSV could lead to a significant increase in outpatient visits, hospitalizations, and the demand for pediatric and intensive care beds, placing additional pressure on health services, particularly during periods of peak viral circulation.

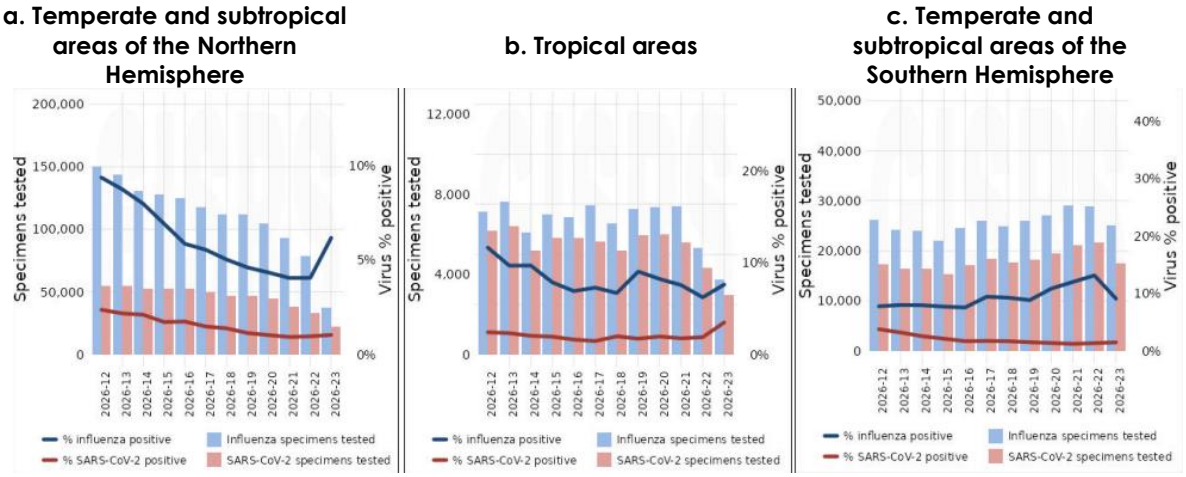
Summary of the Global Situation

Globally, influenza and respiratory syncytial virus (RSV) activity follows the expected seasonal pattern: the Northern Hemisphere is currently in an inter-seasonal period with low viral circulation, while the Southern Hemisphere is in its epidemic season (**Figure 1**) *(1)*. In the Southern Hemisphere, for influenza, following a period characterized by a predominance of influenza A(H3N2), a gradual increase in influenza B is being observed. Similarly, high positivity rates for respiratory syncytial virus (RSV) (11–20%) are being observed in countries in the Southern Hemisphere and subtropics. Since the B/Yamagata lineage has not circulated globally since 2020, the genotyped influenza B viruses belong to the Victoria lineage. During epidemiological week (EW) 23 of 2026, an increase was observed in the proportion of influenza B detections, both ungenotyped and of the Victoria lineage, with the latter being the predominant lineage among influenza B viruses detected globally (**Figure 2**) *(1)*.

For severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), even in 2026, there is no seasonal pattern as clear as that seen for influenza and RSV. In recent weeks, globally, SARS-CoV-2 positivity has remained stable and at low levels (**Figure 1**) *(1)*.

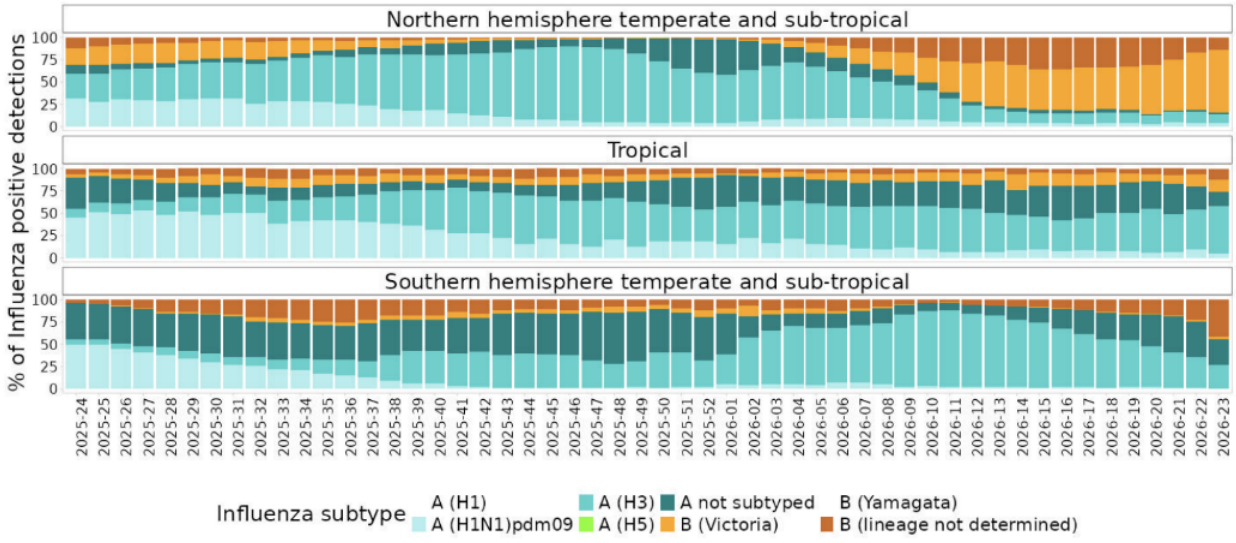
Suggested citation: Pan American Health Organization / World Health Organization. Epidemiological Alert: Seasonal Influenza and other respiratory viruses in the Southern Hemisphere, 1 July 2026. Washington, D.C.: PAHO/WHO; 2026.

Figure 1. Weekly number of samples tested for influenza viruses and SARS-CoV-2 and global positivity rate by geographic areas, EW 12 of 2026 to EW 23 of 2026.



Source: Adapted from the World Health Organization. Global Respiratory Virus Activity: Weekly Update No. 582. Geneva: WHO; 2026. Available from: https://www.who.int/publications/m/item/global-respiratory-virus-activity--weekly-update-n--582 *(1)*.

Figure 2. Weekly distribution of influenza virus types and subtypes globally by geographic areas, EW 24 of 2025 to EW 23 of 2026.



Source: Adapted from the World Health Organization. Global Respiratory Virus Activity: Weekly Update No. 582. Geneva: WHO; 2026. Available from: https://www.who.int/publications/m/item/global-respiratory-virus-activity--weekly-update-n--582 *(1)*.

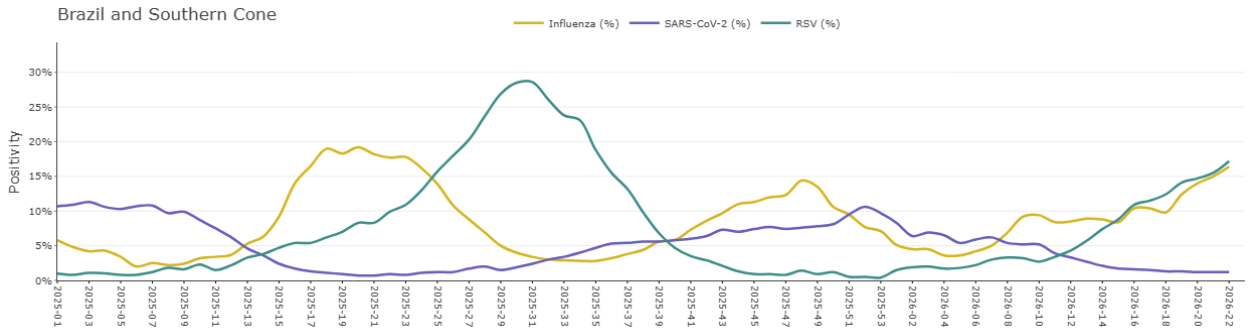
Summary of the Situation in the Americas Region

In North America[1], in 2026 and as of EW 23, influenza and RSV activity have declined to inter-seasonal levels, with positivity rates of 1.3% and 0.4%, respectively. In the Caribbean[2], circulation of both viruses remains low, with positivity rates of 5.1% for influenza and 0.4% for RSV. Meanwhile, in Central America[3], influenza activity continues to decline, with influenza A(H3N2) predominating, although at moderate levels of circulation with an 8.8% positivity rate, while RSV continues to rise, reaching an 8.1% positivity rate *(2, 3)*.

In the Andean subregion[4] , influenza activity remains at low levels, with a positivity rate of 5.5%, and influenza A(H3N2) is the predominant virus. In contrast, since early 2026, a sustained increase in RSV activity has been observed, driven primarily by increased circulation in Peru and Ecuador. This increase has been reflected in a higher proportion of severe acute respiratory infection (SARI) cases associated with RSV in the Andean subregion *(2, 3)*.

In the Southern Hemisphere, the subregion comprising Brazil and the Southern Cone[5] is at the start of the southern winter season, showing a sustained increase in influenza activity, with a positivity rate reaching 16.4% in EW 22 of 2026 *(2, 3)*. Similarly, RSV follows this seasonal trend and continues to rise, reaching a positivity rate of 17.2% in EW 22, consistent with the expected seasonal pattern for this time of year (**Figure 3**) *(2, 3)*.

Figure 3. Percentage of positive results by epidemiological week (EW) in the subregion of Brazil and the Southern Cone, EW 1 of 2025 to EW 22 of 2026.

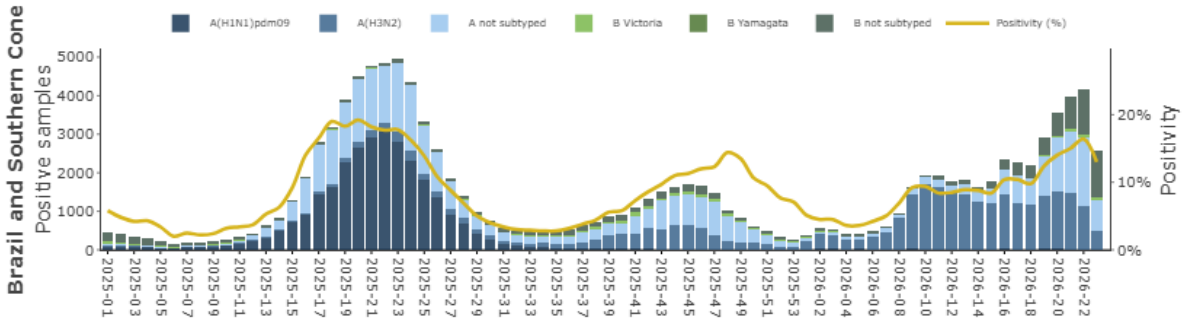


Source: Adapted from the Pan American Health Organization. Dashboard - Influenza, SARS-CoV-2, RSV, and other respiratory viruses situation - Region of the Americas. Washington, D.C.: PAHO; 2026 [cited 17 June 2026]. Available from: https://dashboards.pahoflu.com/app/respiratory_viruses/ *(3)*.

Although influenza A remains the predominant virus in the subregion (77% of influenza samples), an increase in the co-circulation of influenza B has been observed in recent weeks, driven primarily by its increased circulation in Brazil and Chile (**Figure 4**). Among the subtyped influenza A samples, 99% were A(H3N2), which remains the predominant subtype in this subregion *(3)*.

[1] Canada, Mexico, and the United States of America.
[2] Barbados, Belize, the Cayman Islands, Cuba, Dominica, the Dominican Republic, French Guiana, Grenada, Guyana, Haiti, Jamaica, Saint Lucia, Saint Vincent and the Grenadines, and Suriname.
[3] Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua, and Panama.
[4] Bolivia (Plurinational State of), Colombia, Ecuador, Peru, and Venezuela (Bolivarian Republic of).
[5] Argentina, Brazil, Chile, Paraguay, and Uruguay.

Figure 4. Influenza-positive samples by subtype and by epidemiological week (EW) in the subregion of Brazil and the Southern Cone, EW 1 of 2025 to EW 23 of 2026.

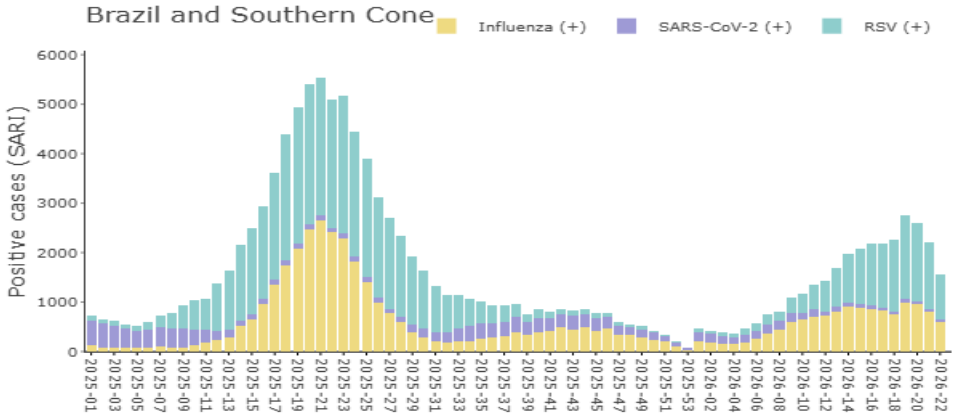


Source: Adapted from the Pan American Health Organization. Dashboard - Influenza, SARS-CoV-2, RSV, and other respiratory viruses situation - Region of the Americas. Washington, D.C.: PAHO; 2026 [cited 23 June 2026]. Available from: https://dashboards.pahoflu.com/app/respiratory_viruses/ *(3)*.

Indicators for influenza-like illness (ILI) and SARI show an upward trend, consistent with expected patterns for this time of year (**Figure 5** and **Figure 6**). However, in recent weeks, Chile has seen an increase in the number of ILI cases observed in the country that exceeds expected values *(2, 3)*.

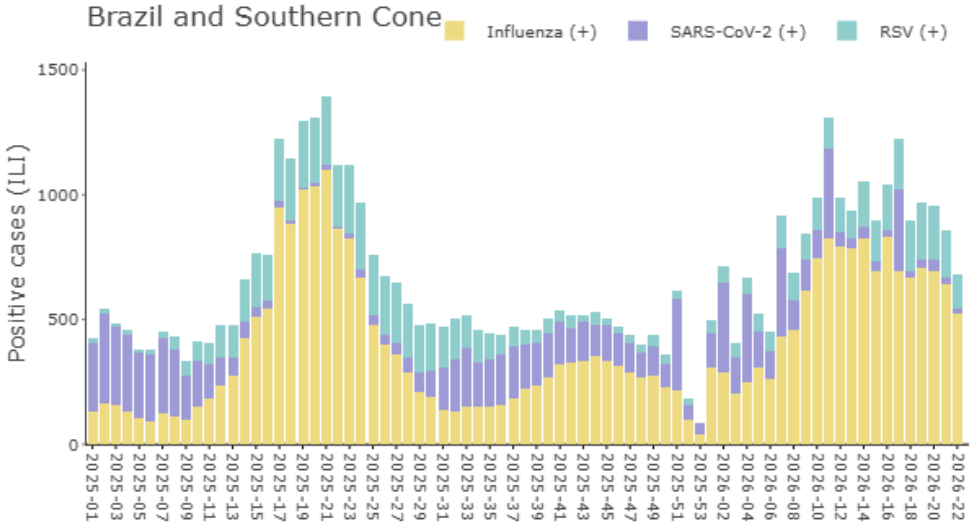
Meanwhile, SARS-CoV-2 circulation remains at low and stable levels throughout the Americas.

Figure 5. Positive cases of SARI caused by respiratory viruses by epidemiological week, in the subregion of Brazil and the Southern Cone, EW 1 of 2025 to EW 22 of 2026.



Source: Adapted from the Pan American Health Organization. Dashboard - Influenza, SARS-CoV-2, RSV, and other respiratory viruses situation - Region of the Americas. Washington, D.C.: PAHO; 2026 [cited June 17, 2026]. Available from: https://dashboards.pahoflu.com/app/respiratory_viruses/ *(3)*.

Figure 6. Positive cases of influenza-like-illness (ILI) caused by respiratory viruses by epidemiological week, Brazil and Southern Cone subregion, EW 1 of 2025 to EW 22 of 2026.

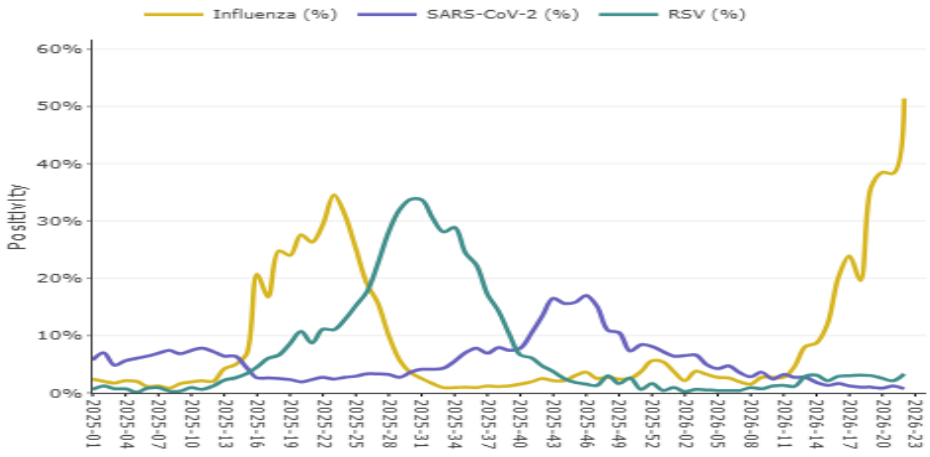


Source: Adapted from the Pan American Health Organization. Dashboard - Influenza, SARS-CoV-2, RSV, and other respiratory viruses situation - Region of the Americas. Washington, D.C.: PAHO; 2026 [cited 23 June 2026]. Available from: https://dashboards.pahoflu.com/app/respiratory_viruses/ *(3)*.

The following is an analysis of selected countries in the Southern Hemisphere, listed in alphabetical order.

In **Argentina**, influenza detections remained stable through EW 9 of 2026; starting in EW 10, there was an increase in both the number of cases and the positivity rate for this virus, with a predominance of influenza A, primarily subtype A(H3N2). Detections currently peak in EW 21 and EW 22, exceeding 1,500 weekly cases and a positivity rate above 40% (**Figure 7**) *(3, 4)*.

Figure 7. Positivity rate by respiratory virus and epidemiological week in Argentina, EW 1 of 2025 to EW 23 of 2026.

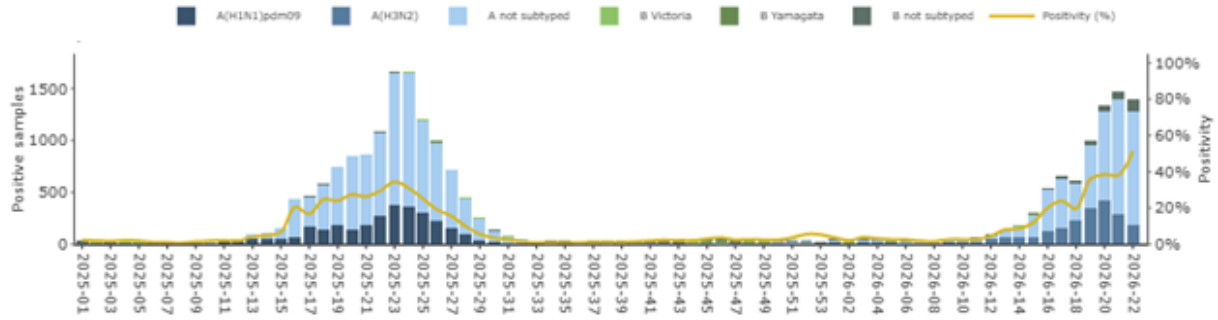


Source: Adapted from the Pan American Health Organization. Dashboard - Influenza, SARS-CoV-2, RSV, and other respiratory viruses situation - Region of the Americas. Washington, D.C.: PAHO; 2026 [cited 23 June 2026]. Available from: https://dashboards.pahoflu.com/app/respiratory_viruses/ *(3)*.

In the surveillance of clinical events, cases of ILI have shown an increase since EW 10 of 2026. Between EW 14 and as of EW 20, ILI cases have ranged between alert and outbreak levels, with fluctuations from week to week *(4)*.

Between EW 19 and EW 22 of 2026, 5,191 cases of influenza were detected, of which 94% were influenza A. Of the influenza A samples that were subtyped, 99% were influenza A(H3N2). For influenza B, 287 positive samples were recorded, and 100% of the subtyped samples were identified as belonging to the Victoria lineage. RSV has been detected sporadically in 2026; as of EW 22, 923 positive RSV samples were reported among 47,427 samples tested (**Figure 8**) *(3)*.

Figure 8. Positive influenza samples by subtype and by EW in Argentina, EW 1 of 2025 to EW 22 of 2026.

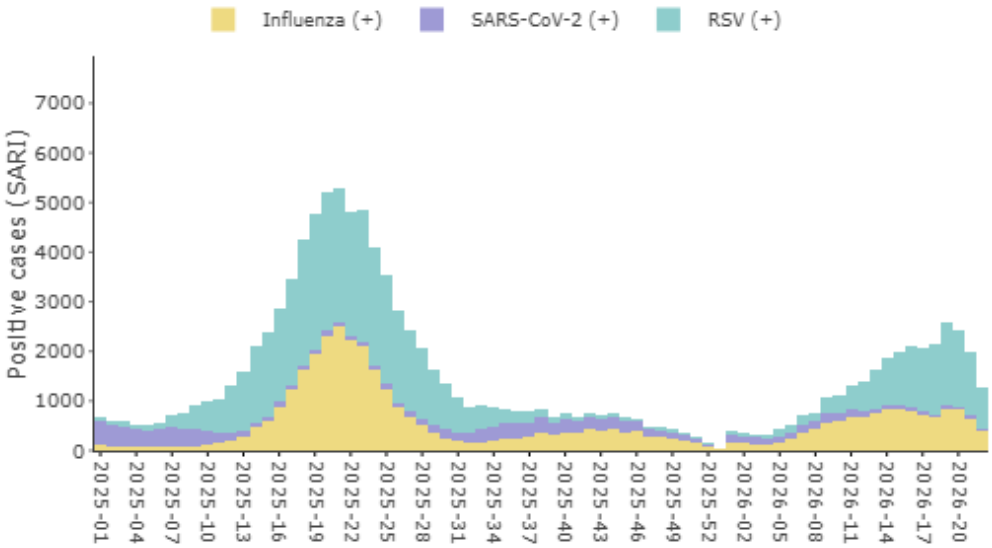


Source: Adapted from the Pan American Health Organization. Dashboard - Influenza, SARS-CoV-2, RSV, and other respiratory viruses situation - Region of the Americas. Washington, D.C.: PAHO; 2026 [cited 23 June 2026]. Available from: https://dashboards.pahoflu.com/app/respiratory_viruses/ *(3)*.

In **Brazil**, between EW 5 and EW 19 of 2026, an upward trend has been observed in both ILI cases and SARI cases (**Figure 9** and **Figure 10**). This trend is consistent with the seasonal pattern observed in previous years. Levels of ILI remain similar to those recorded in previous seasons, while SARI activity is below the levels observed during the same period of the previous year *(5, 6)*.

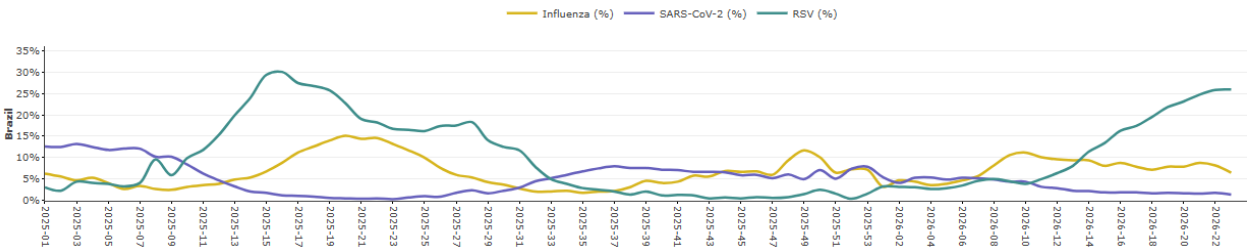
The observed increase in SARI cases is associated with a rise in RSV-related hospitalizations and the co-circulation of influenza A and influenza B *(5)*. However, RSV-associated SARI activity remains within the expected seasonal ranges. On the other hand, SARI cases admitted to intensive care units (ICUs) and SARI-related deaths remain at levels similar to or lower than those observed during the previous year, suggesting that, despite the seasonal increase in respiratory activity, there has not yet been an increase in severity beyond expected levels *(5, 6)*.

Figure 9. Reported cases of influenza, SARS-CoV-2, and RSV by EW in Brazil, EW 1 of 2025 to EW 22 of 2026.



Source: Adapted from the Pan American Health Organization. Dashboard - Influenza, SARS-CoV-2, RSV, and other respiratory viruses situation - Region of the Americas.. Washington, D.C.: PAHO; 2026 [cited 23 June 2026]. Available from: https://dashboards.pahoflu.com/app/respiratory_viruses/ *(3)*.

Figure 10. Percentage of positive test results for respiratory viruses by epidemiological week (EW) in Brazil, between EW 1 of 2025 and as of EW 22 of 2026.



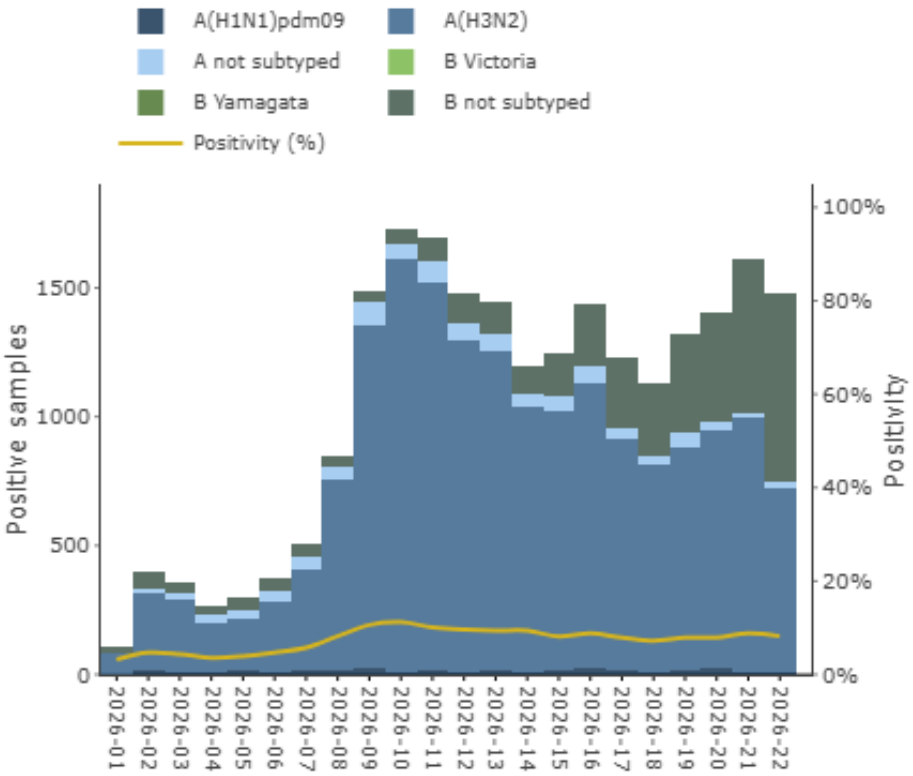
Source: Adapted from the Pan American Health Organization. Dashboard - Influenza, SARS-CoV-2, RSV, and other respiratory viruses situation - Region of the Americas. Washington, D.C.: PAHO; 2026 [cited 23 June 2026]. Available from: https://dashboards.pahoflu.com/app/respiratory_viruses/ *(3)*.

In Brazil, per SARI surveillance, 35,540 hospitalized cases were reported in 2026 as of EW 21, with respiratory viruses identified. In the last four weeks (EW 19 to EW 22), 63% of positive influenza samples were influenza A and 37% were influenza B. Influenza A(H3N2) was the predominant subtype, accounting for 98% of subtyped influenza A samples (**Figure 11**) *(5)*. This year, an increase in the number of samples testing positive for rhinovirus has been observed, associated with an increase in the number of samples analyzed during 2026 (**Figure 12**) *(3)*.

Notably in Brazil, since February 2025, laboratories in the federal units of the Brazil respiratory virus surveillance network have routinely diagnosed three additional respiratory viruses of public health importance (adenovirus, rhinovirus, and metapneumovirus), in addition to influenza A and B viruses, SARS-CoV-2, and RSV. This reflects a high degree of consistency in the monitoring and identification of these respiratory viruses, which contributes to epidemiological analyses of the circulation of respiratory viruses of public health importance in the country *(7)*.

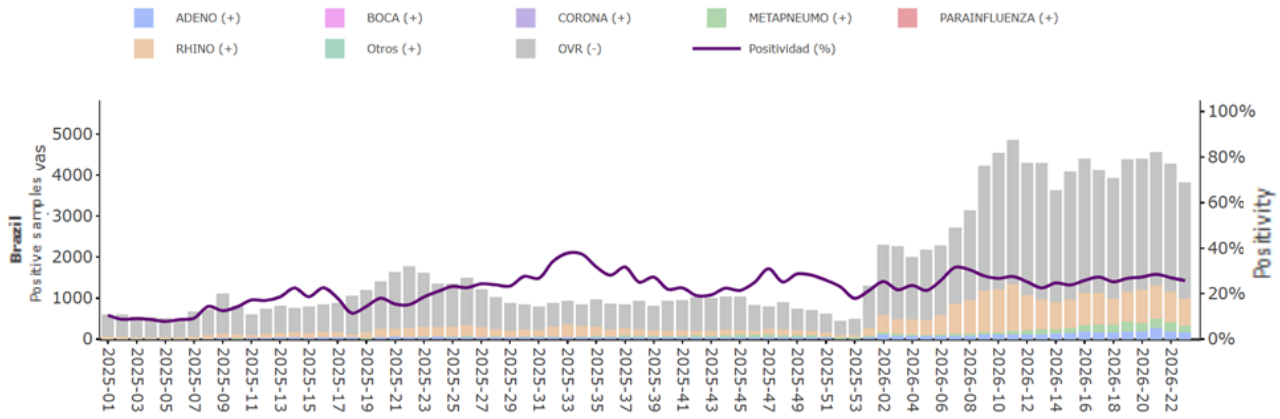
SARI cases caused by RSV continue to rise in most states in the North (Acre, Amapá, Pará, and Roraima), the Northeast (Alagoas, Bahia, Ceará, Maranhão, Piauí, Rio Grande do Norte, and Sergipe), the Southeast (Minas Gerais, Rio de Janeiro, and São Paulo), and the South (Paraná, Santa Catarina, and Rio Grande do Sul) *(5, 6)*. Rhinovirus has also contributed to the increase in cases of SARI, especially among children and adolescents, in some states in the Northeast (Alagoas, Ceará, Paraíba, Piauí, and Sergipe), the Southeast (Minas Gerais, Rio de Janeiro), and the South (Santa Catarina and Rio Grande do Sul), as well as in the state of Goiás *(5)*. Hospitalizations due to influenza A are decreasing or have stabilized at low incidence levels across much of the country, although they continue to rise throughout the South, as well as in some states in the Southeast and North *(5, 6)*.

Figure 11. Positive samples, positivity rate, and viral characteristics of circulating influenza by epidemiological week (EW) in Brazil, EW 1 of 2026 to EW 22 of 2026.



Source: Adapted from the Pan American Health Organization. Dashboard - Influenza, SARS-CoV-2, RSV, and other respiratory viruses situation - Region of the Americas. Washington, D.C.: PAHO; 2026 [cited 17 June 2026]. Available from: https://dashboards.pahoflu.com/app/respiratory_viruses/ *(3)*.

Figure 12. Positive and negative samples, positivity rate, and viral characteristics of other circulating respiratory viruses by epidemiological week (EW) in Brazil, EW 1 of 2025 to EW 22 of 2026.



Note: OVR: Other Respiratory Viruses.

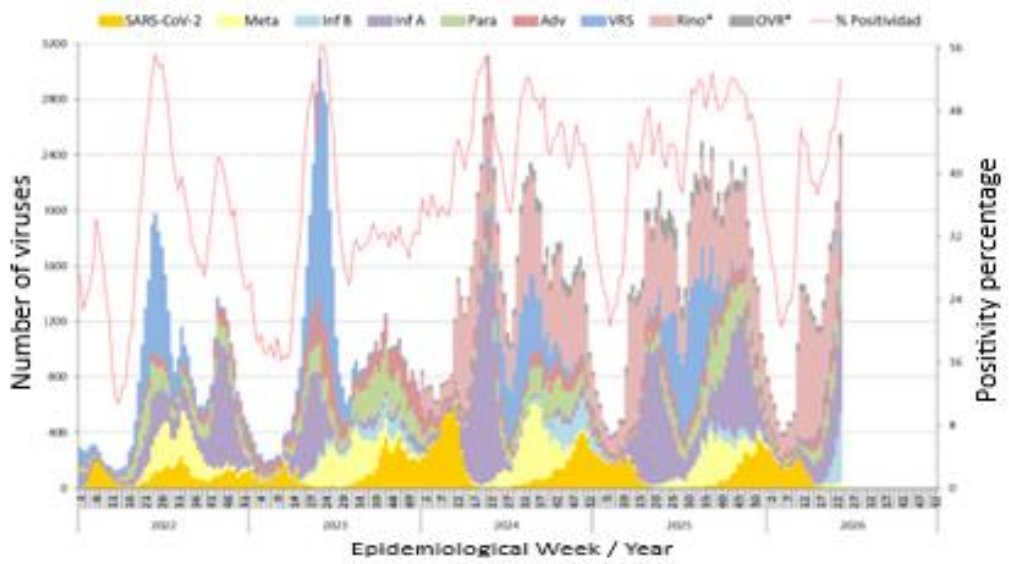
Source: Adapted from the Pan American Health Organization. Dashboard - Influenza, SARS-CoV-2, RSV, and other respiratory viruses situation - Region of the Americas. Washington, D.C.: PAHO; 2026 [cited 23 June 2026]. Available from: https://dashboards.pahoflu.com/app/respiratory_viruses/ *(3)*.

In Brazil, with regard to genomic surveillance of the influenza virus, in 2026, 691 sequences were registered on the GISAID platform, performed by the National Network of Public Health Laboratories, corresponding to samples from influenza cases collected between EW 1 and EW 16 of 2026. Five circulating clades were identified, associated with the subtypes Influenza A(H1N1)pdm09, Influenza A(H3N2), and Influenza B, of which subclade K (3C.2a1b.2a.2a.3a.1K) of Influenza A(H3N2) predominated, identified in 72% of the sequences from that period *(3)*.

In **Chile**, influenza activity has shown a sustained increase since EW 5 of 2026, reaching high levels of activity in the EW 22, with a positivity rate of 25%. Influenza A is the predominant circulating strain, accounting for 67% of influenza-positive samples, although there has been an increase in the circulation of influenza B in recent weeks (EW 19 through EW 22). The overall positivity rate for other respiratory viruses has continued to rise since EW 5 *(3, 8, 9)*.

It is important to note that, although influenza A remains the predominant type, an acute increase in the proportion of influenza B detections has been observed in recent weeks. For EW 22 of 2026, influenza B accounted for 33% of influenza detections, a proportion higher than that observed during the same period in recent seasons (1%–9%). Meanwhile, RSV has been rising consistently since EW 17, although with a low positivity rate (3%), while SARS-CoV-2 remains at low levels (**Figure 13**) *(8, 9)*.

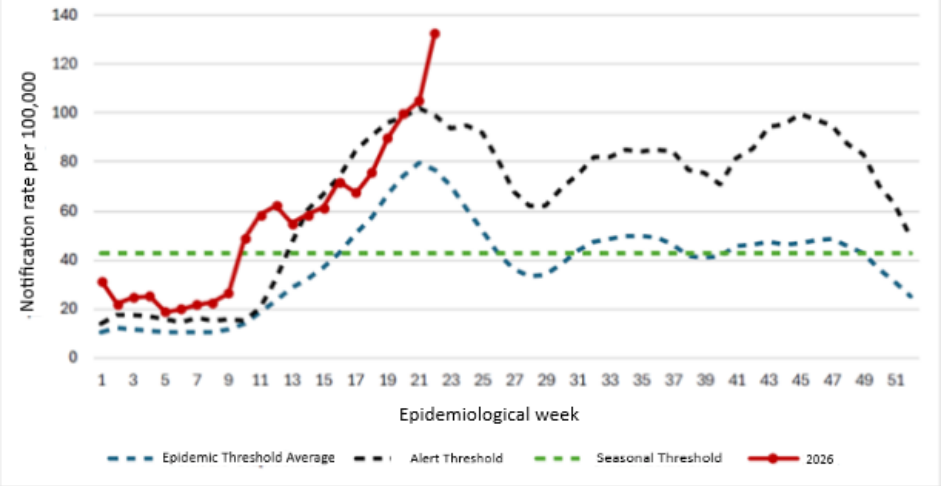
Figure 13. Seasonal threshold, average epidemic curve, alert threshold, and ILI notification rate* by epidemiological week. Chile, EW 1 of 2023 to EW 22 of 2026.



Source: Instituto de Salud Pública de Chile. Informe de Circulación de Virus Respiratorios. Semana epidemiológica 23 del 2026. Santiago: ISP; 2026. Available from https://www.ispch.gob.cl/virusrespiratorios/ *(8)*

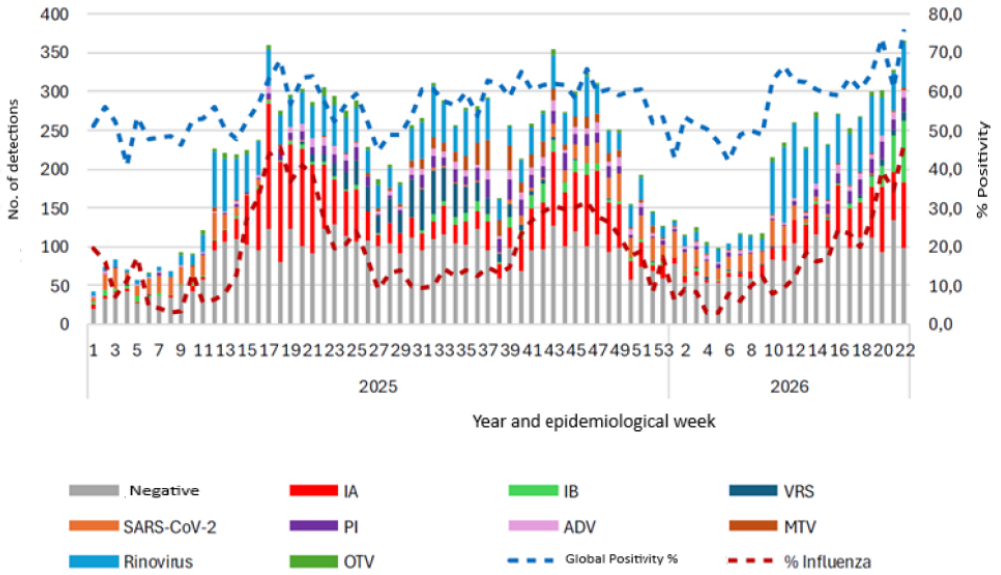
Regarding the trend in ILI, 2,150 ILI cases were reported, corresponding to a notification rate of 132.8 cases per 100,000 population in EW 22. This exceeded the seasonal threshold, was above the average of the epidemic curve, and represented a 26% increase compared to the previous week (**Figure 14**). According to the analysis by regions, the region with the highest notification rate was Magallanes, with 310.5 cases per 100,000 population, followed by Valparaíso, with 293.4 cases per 100,000 population. The positivity rate for ILI cases during this same epidemiological week was 75.6%; the predominant virus was influenza A, with a positivity rate of 23.8%, followed by influenza B at 22.4% (**Figure 15**). Meanwhile, SARI cases are below both the seasonal threshold and the average of the epidemic curve at 4.4%, showing a pattern consistent with seasonal expectations. This suggests that the increase in respiratory activity observed in outpatient settings has not translated into an increase in severity beyond expected levels *(9)*.

Figure 14. Seasonal threshold, average of the epidemic curve, alert threshold, and ARI notification rate* by epidemiological week (EW) in Chile. EW 1 to EW 22 of 2026.



Source: Adapted from the Ministerio de Salud de Chile. Informe Epidemiológico Se 22/2026. Vigilancia Centinela ETI e IRAG Influenza y otras Enfermedades Respiratorias Agudas Chile 09 de junio 2026. Santiago: MS; 2026. Available from: https://epi.minsal.cl/wp-content/uploads/2026/06/EPIDEMIOLOGICO_N_22_2026_VIGILANCIA_CENTINELA_ETI_IRAG_DE_INFLUENZA_Y_OTROS_VIRUS_RESPIRATORIOS.pdf *(9)*.

Figure 15. Distribution of identified respiratory viruses and positivity rates in ARI surveillance by epidemiological week in Chile. EW 1 of 2025 to EW 22 of 2026.

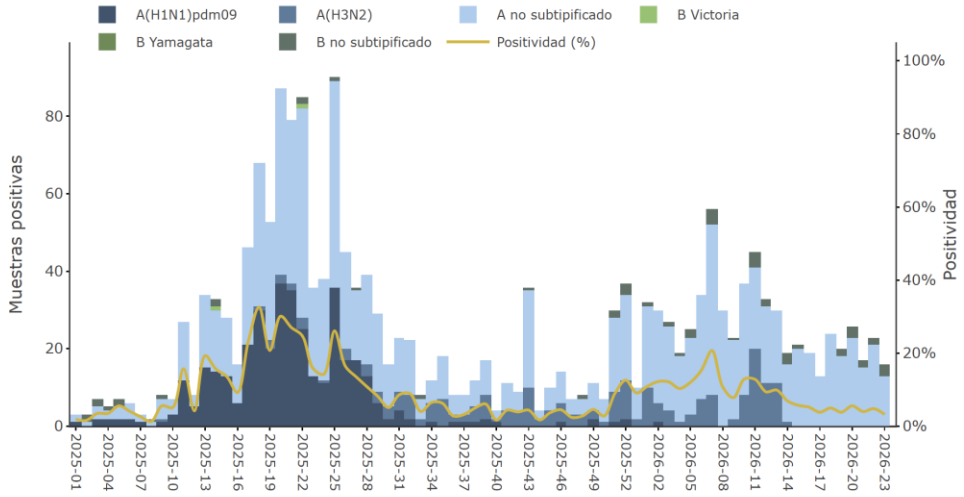


Note: IA: Influenza A; IB: Influenza B; RSV: Respiratory Syncytial Virus; SARS-CoV-2: Coronavirus type 2 causing severe acute respiratory syndrome; PI: Parainfluenza virus; ADV: Adenovirus; MTV: Metapneumovirus; and OTV: Other Respiratory Viruses.

Source: Adapted from the Ministerio de Salud de Chile. Informe Epidemiológico Se 22/2026. Vigilancia Centinela ETI e IRAG Influenza y otras Enfermedades Respiratorias Agudas Chile 9 de junio 2026. Santiago: MS; 2026. Available from: https://epi.minsal.cl/wp-content/uploads/2026/06/EPIDEMIOLOGICO_N_22_2026_VIGILANCIA_CENTINELA_ETI_IRAG_DE_INFLUENZA_Y_OTROS_VIRUS_RESPIRATORIOS.pdf *(9)*.

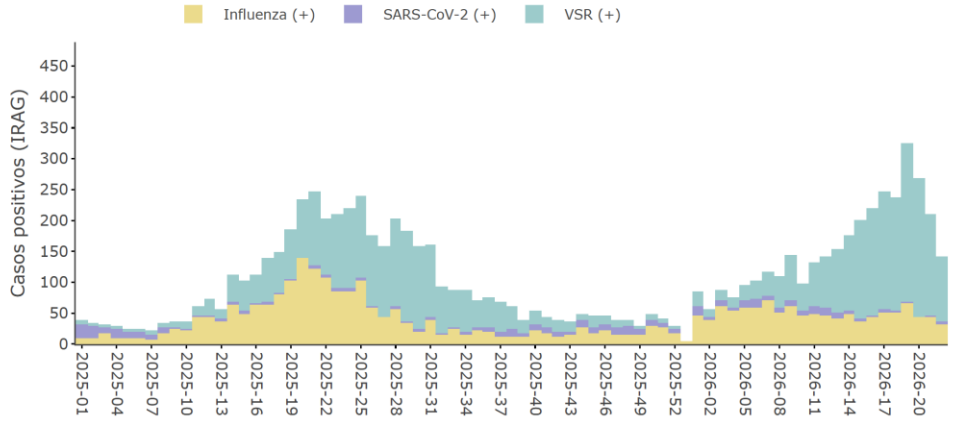
In **Peru**, influenza circulation has remained relatively stable over the past few weeks, with a positivity rate of 5.8% in EW 22 of 2026, with a predominance of influenza A strain (91%) (**Figure 16**). In contrast, RSV activity has shown a sustained increase since EW 4 of 2026, reaching a positivity rate of 58.5% in EW 20. This increase has contributed significantly to the respiratory activity observed in the country and to the rise in SARI cases associated with RSV, with the 0–12 age group being the most affected, accounting for 54% of SARI cases so far in 2026 (**Figure 17**) *(3)*. However, the proportion of SARI cases admitted to the ICU or SARI deaths remains within the expected ranges for this time of year, with no evidence of an increase in severity beyond the levels typically observed for the season.

Figure 16. Positive samples, positivity rate, and viral characteristics of circulating influenza by epidemiological week in Peru, EW 1 of 2025 to EW 23 of 2026.



Source: Adapted from the Pan American Health Organization. Dashboard - Influenza, SARS-CoV-2, RSV, and other respiratory viruses situation - Region of the Americas. Washington, D.C.: PAHO; 2026 [cited 23 June 2026]. Available from: https://dashboards.pahoflu.com/app/respiratory_viruses/ *(3)*.

Figure 17. Positive SARI cases by respiratory viruses and epidemiological week in Peru, EW 1 of 2025 to EW 22 of 2026.



Source: Adapted from the Pan American Health Organization. Dashboard - Influenza, SARS-CoV-2, RSV, and other respiratory viruses situation - Region of the Americas. Washington, D.C.: PAHO; 2026 [cited 23 June 2026]. Available from: https://dashboards.pahoflu.com/app/respiratory_viruses/ *(3)*.

Recommendations for Member States

During the 2026 season in the Southern Hemisphere, some countries—such as Brazil and Chile—have seen a sudden increase in influenza-like illness (ILI), accompanied by increased respiratory syncytial virus (RSV) activity and a rise in influenza B. This observed trend may be replicated in other countries of the Southern Cone and the Andean subregion, 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. The clinical impact is concentrated, as expected, among children under five years of age—particularly those under two—and adults over 65 years of age.

Scenarios of co-circulation of influenza A and influenza B underscore the importance of integrated surveillance of respiratory viruses and advance planning for hospital services.

Given this situation, the Pan American Health Organization / World Health Organization (PAHO/WHO) urges Member States to continue strengthening key measures for surveillance, clinical management and prophylaxis, infection prevention and control, risk communication, and vaccination. Following is a summary of the main recommendations issued in the 4 December 2025 PAHO/WHO 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 *(10)*, 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 not only circulating viruses and identify clades and subclades, but also to generate genomic data for influenza vaccine composition meetings and to detect viruses with epidemic or pandemic potential, such as variants, reassortments, or mutations potentially associated with increased transmissibility, pathogenicity, or antiviral resistance.

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 *(11, 12)*.

To complement indicator-based surveillance, PAHO/WHO recommends that Member States implement event-based surveillance (EBS). 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 *(13, 14)*.

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

As part of routine indicator-based surveillance (IBS), and for the etiological confirmation of unusual cases, nasopharyngeal and oropharyngeal specimens (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 *(15)*.

According to WHO guidelines, representative influenza samples selected in accordance with the criteria recommended by PAHO and WHO should be sent to a WHO Collaborating Center (CC) for further genomic and antigenic characterization *(15, 16)*. Influenza A samples for which the virus subtype cannot be determined—that is, true unsubtyped samples (those positive for influenza A but for which RT-PCR for subtyping is negative or inconclusive)—should also be sent immediately to a PAHO/WHO CC *(13)*. For further guidance and verification of a true non-subtypable sample, please contact the PAHO laboratory response team before sending the sample to a WHO CC (laboratoryresponse@paho.org).

To minimize the possibility of a non-subtyped or inconclusive sample, it is important that laboratories use version 4 (V4) of the U.S. Centers for Disease Control and Prevention (CDC) influenza subtyping kit, which is available through International Reagent Resources (IRR). This change in kit 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 Reference Center at St. Jude Hospital in Memphis, Tennessee, in the United States, for genomic and antigenic characterization. Laboratories must contact the PAHO laboratory response team prior to shipment to the WHO Reference Center at St. Jude Hospital (laboratoryresponse@paho.org

Clinical Management and Prophylaxis

PAHO/WHO recommends that Member States update their treatment guidelines based on the updated WHO guidelines *(17–19)*. The recommendations for the clinical management of patients with severe respiratory illness outlined in PAHO/WHO epidemiological alerts and updates on influenza remain in effect *(20)*. The recommendations on antiviral and antibiotic treatment based on clinical presentation are provided in **Tables 1–4** *(19)*.

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 *(19)*.

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 *(19)*.

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 *(19)*.

Table 4. Prevention recommendations for exposed individuals without infection

Medication	Recommendation
Baloxavir	Conditional recommendation in favor for those at 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 the 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 *(19)*.

Prevention and Control of Infection

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 implement droplet precautions when caring for patients with suspected or confirmed respiratory virus infections or when collecting, transporting, and testing laboratory specimens from patients suspected of being infected. 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 support staff caring for patients 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 (PPE) is necessary (e.g., eye protection, FFP2 or N95 respirators, gowns, gloves) when caring for patients *(20)*.

The following is a summary of the levels of personal protective equipment (PPE) required for routine healthcare activities (excluding aerosol-generating procedures) (**Table 5**) *(21, 22)*.

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 *(22)*.

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 *(23, 24)*. Influenza vaccination before the onset of seasonal virus circulation remains the best preventive measure against severe influenza *(25)*.

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 *(24)*.

People with a fever should avoid going to work or public places until their 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 that the general public has gained about the prevention of respiratory diseases—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 medical 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 *(26, 27)*. 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 *(28)*.

There are currently two strategies available for preventing severe RSV disease in infants and newborns: administration of a vaccine during pregnancy (the 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 to 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 *(29–32)*.

The RSVpreF vaccine (Abrysvo®, Pfizer) is a bivalent vaccine administered to pregnant women in the third trimester to protect their babies through transplacental transfer of antibodies *(30)*. Long-acting monoclonal antibodies (nirsevimab (Beyfortus®, Sanofi) and clesrovimab (Enflonsia®, Merck)) are recombinant antibodies with an extended half-life that are administered as a single dose to newborns and children at high risk of severe disease *(33, 34)*. 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. *(32, 35, 36)*. In randomized clinical trials and post-approval 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 clinical development, and significant progress has been made in understanding the immune response to RSV.

Non-pharmacological public health measures in the general population

As recently demonstrated during the COVID-19 pandemic, non-pharmacological public health measures complement the response to respiratory illnesses. Along with immunization against respiratory viruses, personal measures such as hand hygiene, physical distancing, respiratory etiquette, mask-wearing, and staying home when sick should be implemented, as they are effective in limiting the transmission of respiratory viruses *(37)*.

For more details, see the following guides: Nonpharmaceutical Public Health Measures to Mitigate the Risk and Impact of Epidemic and Pandemic Influenza *(37)* and the handbook Guidance on the Implementation of Nonpharmacological Public Health Measures for Vulnerable Population Groups in the Context of COVID-19 *(38)*.

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