Epidemiological Alert
Seasonal influenza and other respiratory viruses: start of the season, Northern Hemisphere

17 November 2026

With the start of the 2026–2027 respiratory virus circulation season in the Northern Hemisphere, and given the increase in influenza activity observed in several countries in the Americas Region, as well as the high circulation of respiratory syncytial virus (RSV) in some countries in the Northern Hemisphere, 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 increases in demand for services; and accelerate vaccination against seasonal influenza and RSV in priority groups before the peak of circulation, in accordance with current recommendations and prior to periods of increased viral circulation.

Summary of the global situation

Globally, influenza activity is following expected seasonal patterns, characterized by a gradual increase over the past few months in the temperate and subtropical regions of the Northern Hemisphere, where the influenza positivity rate is approaching 10%, and a decline over the past two months in the temperate and subtropical regions of the Southern Hemisphere, where the positivity rate has fallen to around 5% (**Figure 1**) *(1)*.

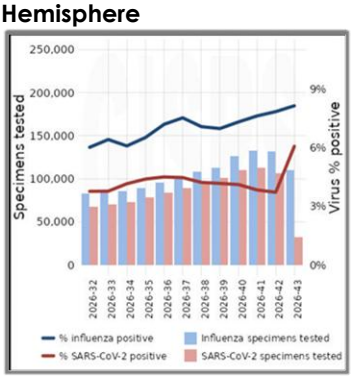
In the Northern Hemisphere, some countries in North America, Central America, and the Caribbean, as well as in Africa, Asia, and Europe, reported influenza positivity rates above 10%. In contrast, in the Southern Hemisphere—particularly in the Southern Cone[1]countries of the Americas Region—a decline in influenza activity has been observed. Although some countries in the Andean[2] subregion of American Region have shown increases during the most recent epidemiological weeks (EW), these trends should be interpreted with caution, given possible delays in the reporting of surveillance data *(1)*.

[1] Brazil and the Southern Cone: Argentina, Brazil, Chile, Paraguay, and Uruguay.
[2] Andean Region: Bolivia (Plurinational State of), Colombia, Ecuador, Peru, and Venezuela (Bolivarian Republic of).

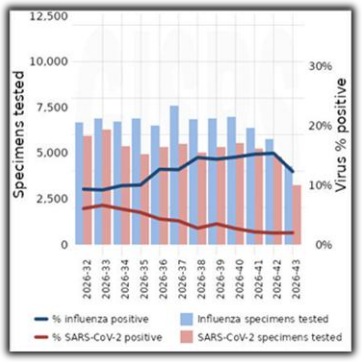
Suggested citation: Pan American Health Organization / World Health Organization. Epidemiological Alert: Seasonal influenza and other respiratory viruses: start of the season, Northern Hemisphere, 17 November 2026. Washington, D.C.: PAHO/WHO; 2026.

Figure 1. Weekly number of samples tested and positivity rates for influenza and SARS-CoV-2 by climate areas[3] worldwide, epidemiological week (EW) 32 to EW 43 of 2026.

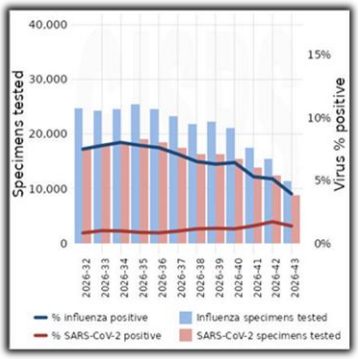
a.Temperate and subtropical areasof the Northern Hemisphere



b. Tropical areas



c. Temperate and subtropical areas of the Southern Hemisphere



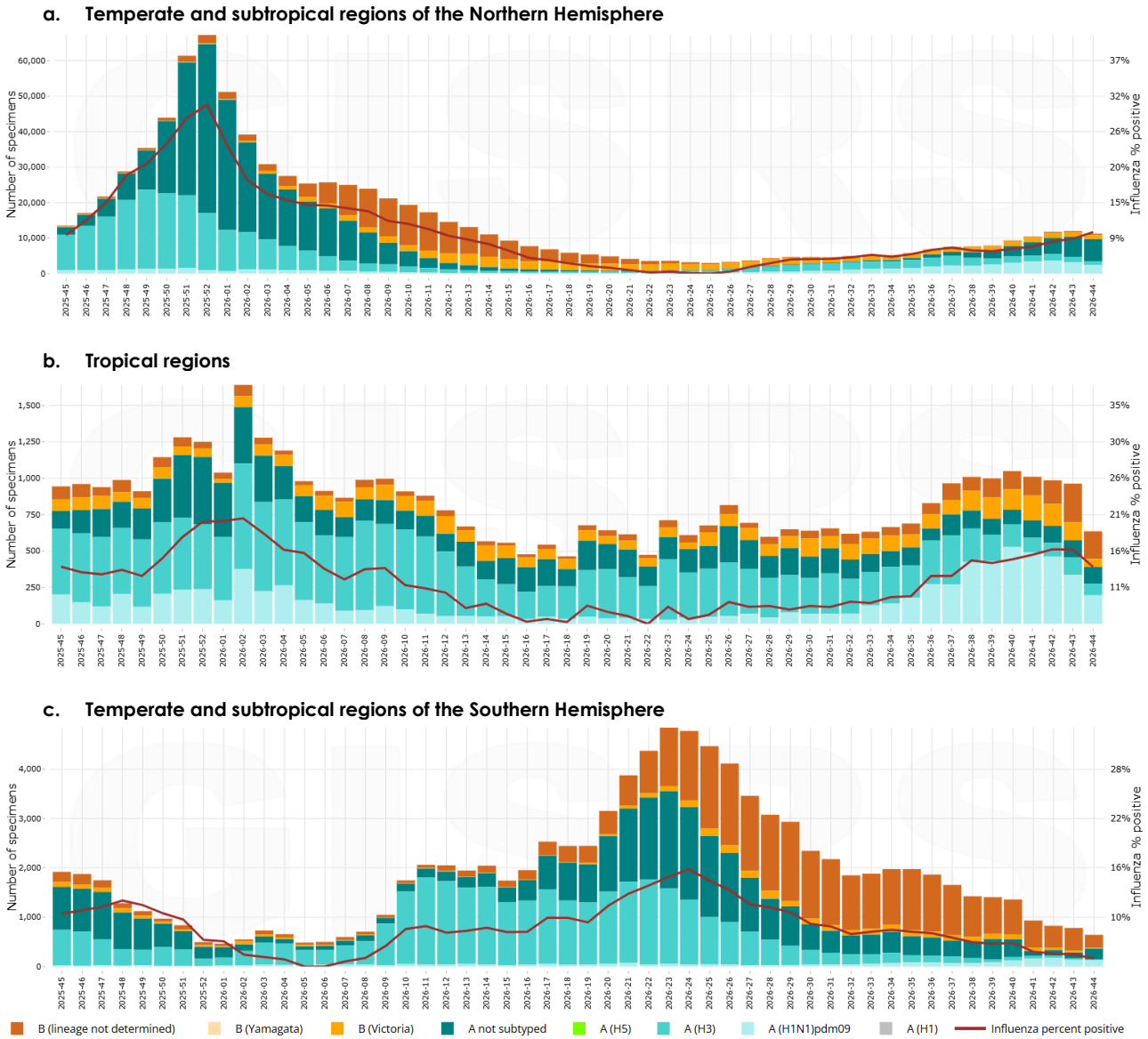
Source: Adapted from the World Health Organization. Global Respiratory Virus Activity Weekly Update No. 602. Geneva: WHO; 2026. Available from: https://www.who.int/publications/m/item/global-respiratory-virus-activity--weekly-update-n--602 *(1)*.

Influenza A viruses continue to predominate globally, particularly the A(H1N1)pdm09 subtype, which is also the main subtype identified in Europe in recent weeks, according to the European Centre for Disease Prevention and Control (ECDC) *(1, 2)*. However, co-circulation of influenza A(H1N1)pdm09, A(H3N2), and B has been observed in Central America and the Caribbean, as well as in South Asia. In contrast, influenza B circulation predominated in tropical and temperate South America and in West Africa (**Figure 2**)*(1, 3)*.

In recent weeks, the positivity rate for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) remained stable and at low levels in most countries worldwide, although some countries in the Northern Hemisphere reported positivity rates above 10% (**Figure 1**) *(1)*. Regarding respiratory syncytial virus (RSV), positivity rates above 10% were observed in some countries, mainly in tropical and subtropical regions *(1)*.

[3] This refers to the five major thermal zones bounded by the tropics and the polar circles: a tropical or intertropical zone, located between the Tropic of Cancer and the Tropic of Capricorn; two temperate zones, located between the tropics and the polar circles of each hemisphere; and two polar zones, which extend from the polar circles to the poles. This distribution is related to differences in solar radiation received depending on latitude.

Figure 2. Weekly number of positive samples by influenza virus type and subtype and positivity rate by geographic region, EW 45 of 2025 to EW 44 of 2026.



Source: Adapted from the World Health Organization. Influenza Laboratory Surveillance Information Dashboard. Geneva: WHO; 2026 [cited 9 November 2026]. Available from: https://worldhealthorg.shinyapps.io/flunetchart *(3)*.

Summary of the situation in the Americas Region

In North America[4] and Central America[5], a gradual increase in influenza activity has been observed in recent four weeks, with A(H1N1)pdm09 predominating in Canada and the United States of America. In Mexico, although influenza B continues to predominate, an increasing proportion of A(H1N1)pdm09 is being observed. In Central America, influenza A(H1N1)pdm09, A(H3N2), and B are circulating concurrently. The increase has been most pronounced in the

[4] North America: Canada, Mexico, and the United States of America.
[5] Central America: Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua, and Panama.

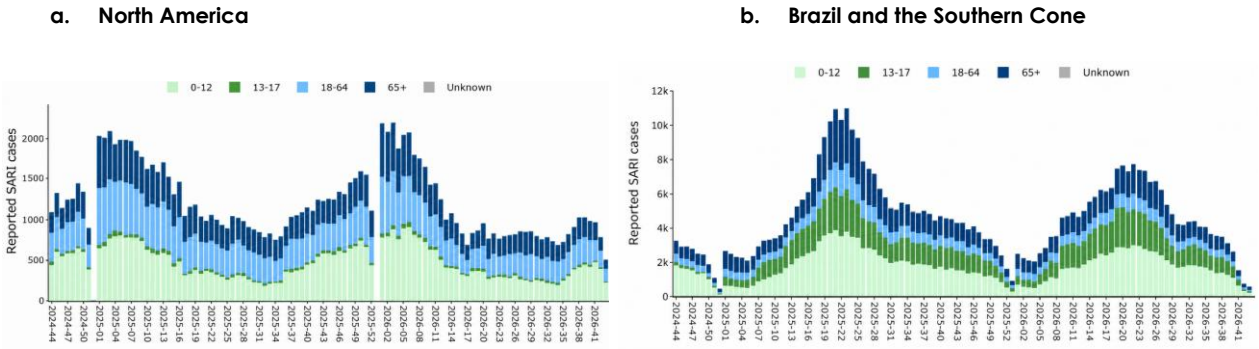
Caribbean subregion[6] , where the positivity rate rose from 4.2% in EW 39 to 27% in EW 42, with co-circulation of influenza A(H1N1)pdm09 and B *(4–6)*.

In the Andean subregion, influenza positivity has remained relatively stable over the past few months, with co-circulation of influenza A(H1N1)pdm09, A(H3N2), and B. In contrast, in Brazil and the Southern Cone[2], influenza activity has declined steadily over the same period, with influenza B predominating toward the end of the season *(4–6)*.

RSV circulation remains high in Central America[5], the Andean subregion[2], and Brazil and the Southern Cone[1], although it is trending downward in all three subregions following a period of high activity. In contrast, SARS-CoV-2 activity remains low in all subregions, with the highest positivity rate in North America[4] (2.5%), where a downward trend is also observed *(4–6)*.

Syndromic surveillance data on severe acute respiratory infection (SARI) show trends consistent with expected seasonal patterns. In North America[4], an increase in reported SARI cases has been observed in recent weeks, while in Brazil and the Southern Cone[1] a sustained decline has been recorded since the peak of the Southern Hemisphere winter season (**Figure 3**) *(4–6)*.

Figure 3. Weekly number of reported cases of severe acute respiratory infection (SARI), by age group, (a) North America and (b) Brazil and the Southern Cone, EW 44 of 2024 to EW 43 of 2026



Source: Adapted from the Pan American Health Organization. Situation Regarding Influenza, SARS-CoV-2, RSV, and Other Respiratory Viruses—Americas Region. Washington, D.C.: PAHO; 2026 [cited 10 November 2026]. Available from: https://dashboards.pahoflu.com/app/respiratory_viruses *(6)*.

Genomic surveillance data show a predominance of clade 6B.1A.5a.2a.1 among influenza A(H1N1)pdm09 viruses characterized in North America during 2026. This pattern contrasts with the previous Northern Hemisphere season, which was characterized by the predominance of influenza A(H3N2), particularly subclade K *(4–6)*. The WHO-recommended composition for the 2026–2027 Northern Hemisphere influenza vaccine includes an A(H1N1)pdm09 component similar to A/Missouri/11/2025, belonging to subclade D.3.1, which has shown good antigenic recognition of circulating viruses from clades 5a.2a and 5a.2a.1 *(7)*.

Epidemiological situation by country in the Americas Region

As the 2026–2027 influenza season begins in the Northern Hemisphere, some countries in the Americas Region have reported increases in influenza activity during the most recent epidemiological weeks, with variations in the magnitude of the increases and the types and

[6] Caribbean: Barbados, Belize, Cuba, Dominica, the Dominican Republic, Grenada, Guyana, Haiti, Jamaica, Saint Lucia, Saint Vincent and the Grenadines, and Suriname.

subtypes of circulating viruses. The following is an overview of the epidemiological situation in select countries, taking into account recent trends in viral circulation and other surveillance indicators in the Americas Region, presented in alphabetical order and hemisphere.

Northern Hemisphere

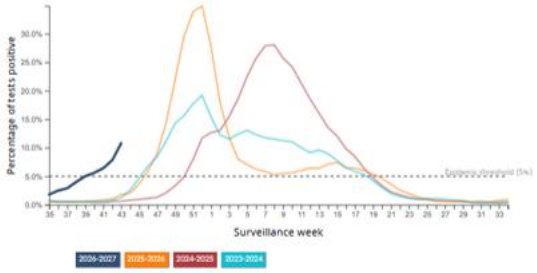
In **Canada,** the increase in influenza circulation began earlier than in previous post-pandemic seasons (2022–2023 through 2025–2026), exceeding the national positivity rate of 5% in early October, EW 40 of 2026. As of EW 43 of 2026, influenza activity has shifted from low to moderate levels, reaching a national positivity rate of 10.8% (**Figure 4**). Unlike the previous season, the predominant subtype is influenza A(H1N1)pdm09 (**Figure 5**). At the same time, SARS-CoV-2 circulation is gradually increasing but remains at low levels and below those observed in previous seasons, with a positivity rate of 5.8% in EW 43 (**Figure 4**) *(8, 9)*.

Hospitalizations associated with respiratory viruses are on the rise, reaching a hospitalization rate of 2.6 per 100,000 population, reflecting increased activity of both influenza and SARS-CoV-2 (**Figure 6**). The hospitalization rate associated with influenza rose to 1.2 per 100,000 population, and the hospitalization rate associated with SARS-CoV-2 rose to 1.3 per 100,000 population in EW 43 (**Figure 7**). However, hospitalization rates remain low and are within the expected range for this time of the season. As respiratory virus activity continues to increase, more hospitalizations are expected to be reported *(8, 9)*.

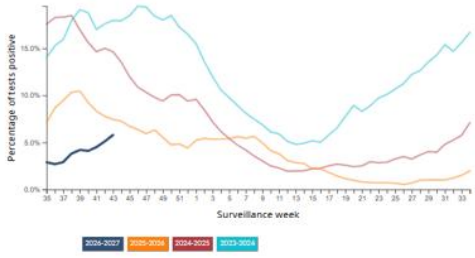
Since 1 September, all A(H1N1) specimens genetically characterized (n= 90) by the Public Health Agency of Canada (PHAC) National Microbiology Laboratory Branch (NMLB) have belonged to the HA subclade D.3.1.1, and all antigenically characterized A(H1N1) viruses (n= 200) have been determined to be antigenically similar to the vaccine component. Limited data are available for the other strains (n= 5); however, all were determined to be antigenically similar to the vaccine component *(8, 9)*.

Figure 4. Percentage of positive tests for (a) influenza and (b) SARS-CoV-2 in Canada, by surveillance week, from the 2023–2024 season through the 2026–2027 season.

a. Influenza

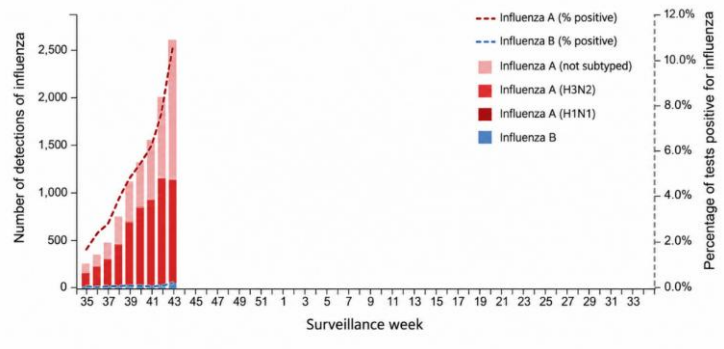


b. SARS-CoV-2



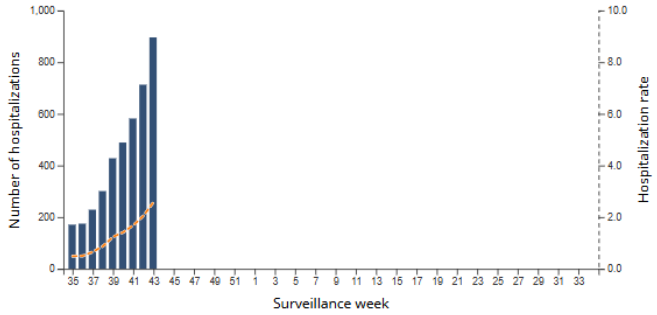
Source: Adapted from Government of Canada. Public Health Agency of Canada (PHAC). Canadian respiratory virus surveillance report. Weekly overview of key trends in the activity of respiratory viruses in Canada. Ottawa: PHAC; 2025 [cited 10 November 2026]. Available from: https://health-infobase.canada.ca/respiratory-virus-surveillance/explore.html *(8)*.

Figure 5. Number of influenza detections and positivity rate by influenza type and subtype in Canada, by surveillance week, 2026–2027 season.



Source: Adapted from Government of Canada. Public Health Agency of Canada (PHAC). Canadian respiratory virus surveillance report. Weekly overview of key trends in the activity of respiratory viruses in Canada. Ottawa: PHAC; 2025 [cited 10 November 2026]. Available from: https://health-infobase.canada.ca/respiratory-virus-surveillance/explore.html *(8)*.

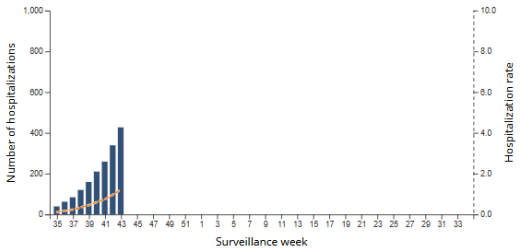
Figure 6. Number of hospitalizations and hospitalization rates (per 100,000 population) associated with respiratory viruses (influenza, COVID-19, and RSV) by epidemiological week, 2026–2027 season.



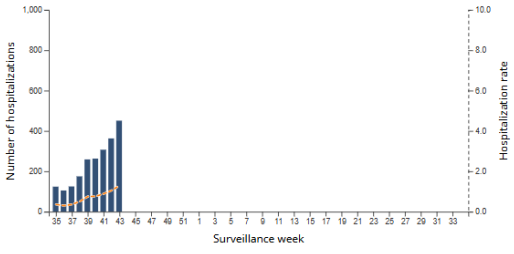
Source: Adapted from Government of Canada. Public Health Agency of Canada (PHAC). Canadian respiratory virus surveillance report. Weekly overview of key trends in the activity of respiratory viruses in Canada. Ottawa: PHAC; 2025 [cited 10 November 2026]. Available from: https://health-infobase.canada.ca/respiratory-virus-surveillance/explore.html *(8)*.

Figure 7. Number of hospitalizations and hospitalization rates (per 100,000 population) associated with (a) influenza and (b) COVID-19 by epidemiological week, 2026–2027 season.

a. Influenza



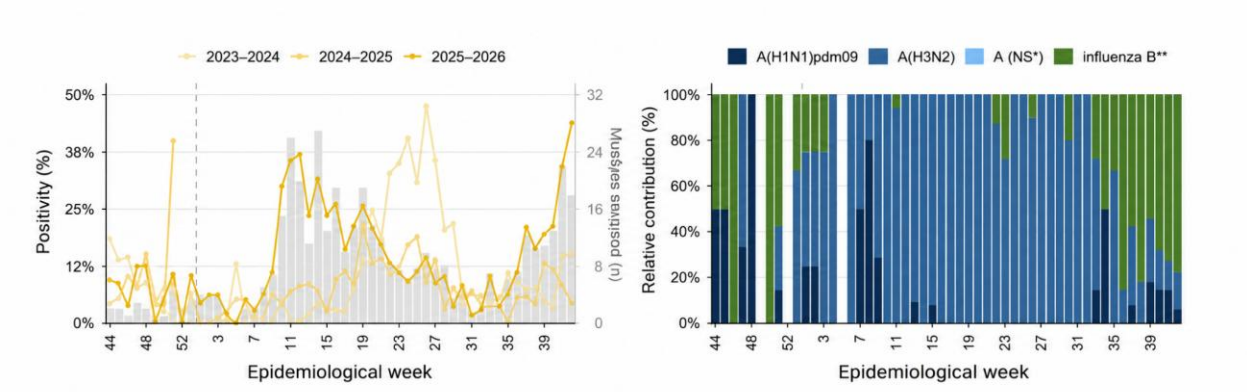
b. SARS-CoV-2



Source: Adapted from Government of Canada. Public Health Agency of Canada. Canadian Respiratory Virus Surveillance Report. Weekly Overview of Key Trends in the Activity of Respiratory Viruses in Canada. Ottawa: PHAC; 2025 [cited 10 November 2026]. Available from: https://health-infobase.canada.ca/respiratory-virus-surveillance/explore.html *(8)*.

In **El Salvador**, in 2026, influenza surveillance has been strengthened compared to previous years, with an increase in the number of samples processed at sentinel sites. As a result of this enhanced surveillance and sampling, influenza circulation was detected, with a sharp increase in activity during the most recent epidemiological weeks, reaching a positivity rate of 44% in EW 42 of 2026. Among the viruses detected, co-circulation of influenza A(H1N1)pdm09, A(H3N2), and B has been observed, with a recent predominance of influenza B (**Figure 8**) *(5, 6)*.

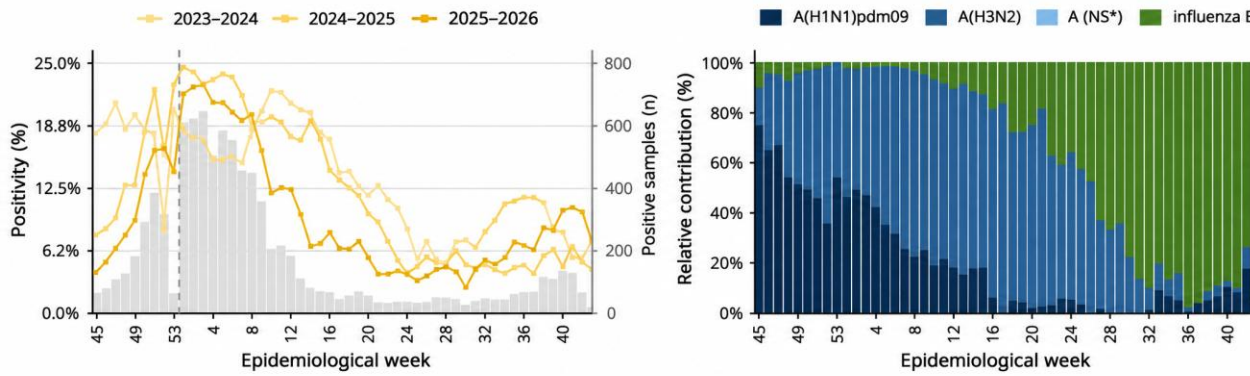
Figure 8. Influenza-positive samples, positivity rate, and weekly distribution of influenza types and subtypes in El Salvador, EW 44 of 2023 to EW 42 of 2026



Source: Adapted from the Pan American Health Organization. Situation of Influenza, SARS-CoV-2, RSV, and Other Respiratory Viruses—Americas Region. Washington, D.C.: PAHO; 2026 [cited 10 November 2026]. Available from: https://www.paho.org/en/influenza-situation-report *(6)*.

In **Mexico**, a gradual increase in influenza activity has been observed during the most recent epidemiological weeks, with a positivity rate higher than that recorded during the same period in the two previous seasons, reaching 10.5% in EW 42 of 2026. Among the typed viruses, influenza B predominates, although an increasing proportion of influenza A(H1N1)pdm09 detections is observed (**Figure 9**) *(5, 6)*.

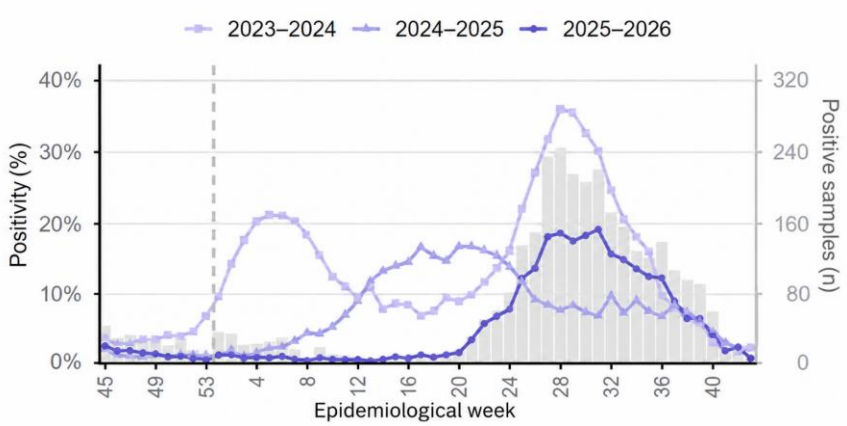
Figure 9. Influenza-positive samples, positivity rate, and weekly distribution of influenza types and subtypes in Mexico, EW 45 of 2023 to EW 43 of 2026



Source: Adapted from the Pan American Health Organization. Situation of Influenza, SARS-CoV-2, RSV, and Other Respiratory Viruses—Americas Region. Washington, D.C.: PAHO; 2026 [cited 10 November 2026]. Available from: https://www.paho.org/en/influenza-situation-report *(6)*.

Meanwhile, SARS-CoV-2 activity has shown a downward trend (2.4% positivity in EW 42 of 2026), after reaching a peak in circulation in EW 31, while RSV circulation shows an upward trend in the last weeks (**Figure 10**) *(5, 6)*.

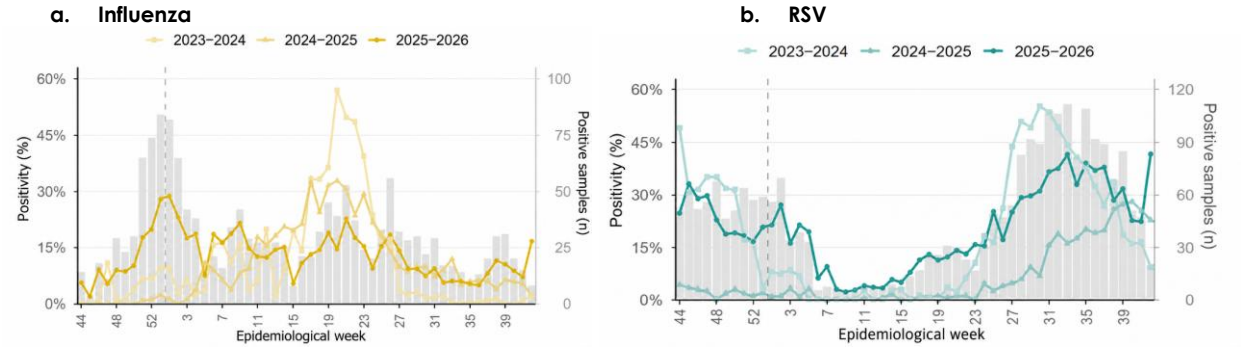
Figure 10. Positive samples and positivity rates for SARS-CoV-2 in Mexico, EW 44 of 2023 to EW 43 of 2026.



Source: Adapted from the Pan American Health Organization. Situation of Influenza, SARS-CoV-2, RSV, and Other Respiratory Viruses—Americas Region. Washington, D.C.: PAHO; 2026 [cited 10 November 2026]. Available from: https://www.paho.org/en/influenza-situation-report *(6)*.

In **Panama**, the influenza positivity rate has remained stable in recent weeks, reaching 7.4% in EW 41 of 2026, with influenza B predominating among the detected viruses. Meanwhile, the circulation of respiratory syncytial virus (RSV) has remained high in recent months, although it has shown a downward trend in recent weeks, reaching a positivity rate of 22.5% in EW 41. The SARS-CoV-2 positivity rate remained low, at 2.6% (**Figure 11**) *(3, 4)*. Data are presented as of EW 41 due to a reduction in the number of processed samples and possible reporting delays for EW 42 *(5, 6)*.

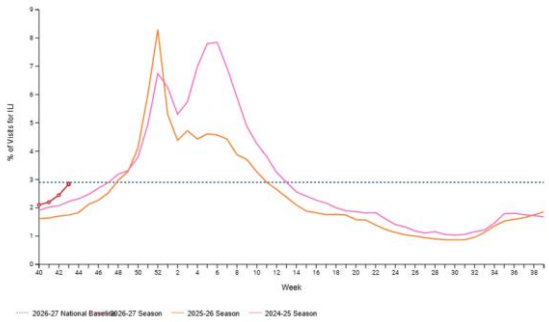
Figure 11. Positive samples and positivity rates for (a) influenza and (b) RSV in Panama, EW 44 of 2023 to EW 42 of 2026



Source: Adapted from the Pan American Health Organization. Situation of Influenza, SARS-CoV-2, RSV, and Other Respiratory Viruses—Americas Region. Washington, D.C.: PAHO; 2026 [cited 10 November 2026]. Available from: https://www.paho.org/en/influenza-situation-report *(6)*.

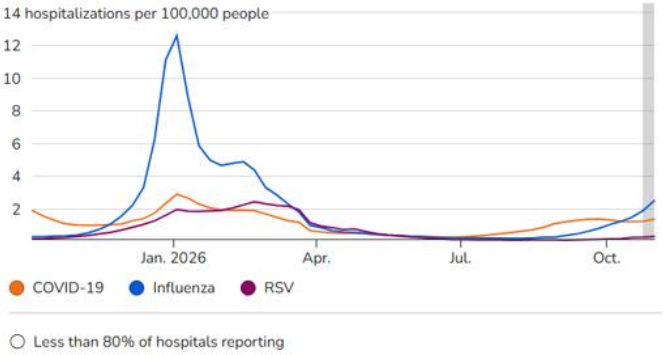
In the **United States**, as of EW 43 of 2026, there has been a gradual increase in cases of influenza, RSV, and other respiratory viruses, consistent with the activity expected at the start of the winter season; however, the level of activity is higher than is typically observed in the United States (**Figure 12**) *(10–12)*. According to available information from the United States Centers for Disease Control and Prevention (U.S. CDC) *(7),* Influenza-Like Illness (ILI) activity is considered high in two states: Louisiana and South Carolina. (**Figure 12**) *(10–12)*. Hospital surveillance data show a gradual increase in influenza-associated hospitalization rates (**Figure 13**) *(10–12)*. Influenza positivity has shown a gradual increase, rising from 7.6% in EW 42 to 9.1% in EW 43, with influenza A(H1N1)pdm09 predominating (**Figure 14**) *(10–12)*.

Figure 12. Percentage of outpatient visits for respiratory illnesses reported by the Influenza-Like Illness Surveillance Network (ILINet) among outpatients in the United States, 2024-25, 2025-26, and 2026-27 seasons.



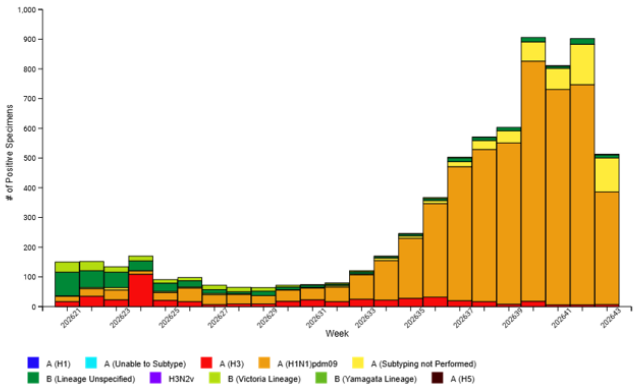
Source: Adapted from the United States Centers for Disease Control and Prevention). Weekly U.S. Influenza Surveillance Report: Key Updates for Week 43, ending October 31, 2026. Atlanta: CDC; 2025 [cited 6 November 2026]. Available from: https://www.cdc.gov/fluview/surveillance/2026-week-43.html#cdc_data_surveillance_section_4-outpatient-and-emergency-department-illness-surveillance *(10)*

Figure 13. Weekly hospitalization rates associated with COVID-19, influenza, and RSV in the Unites States, 2025–26 and 2026–27 seasons.



Source: Adapted from the United States Centers for Disease Control and Prevention (U.S. CDC). Respiratory Virus Hospitalization Surveillance Network (RESP-NET). Atlanta: CDC; 2026 [cited 6 November 2026]. Available from: https://www.cdc.gov/resp-net/dashboard/ *(11)*

Figure 14. Positive influenza test results reported to the U.S. CDC by public health laboratories in the United States, 2026–27 season.

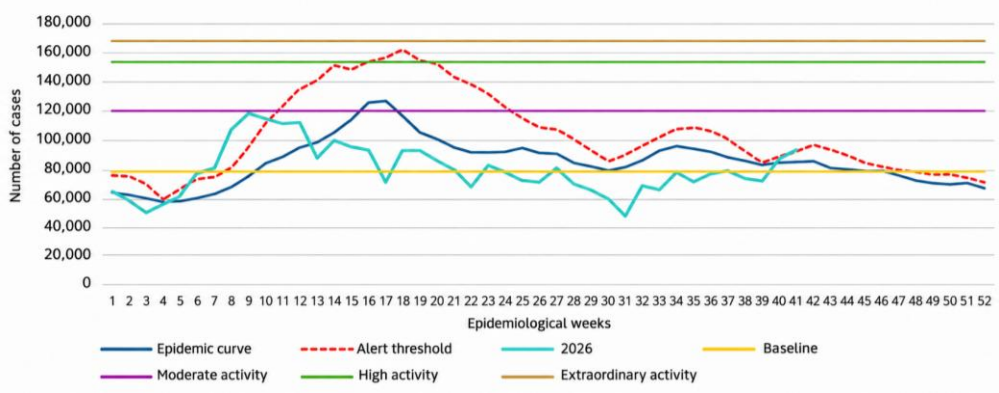


Source: Adapted from the United States Centers for Disease Control and Prevention (U.S. CDC). Weekly U.S. Influenza Surveillance Report: Key Updates for Week 43, ending October 31, 2026. Atlanta: CDC; 2025 [cited 6 November 2026]. Available from: https://www.cdc.gov/fluview/surveillance/2026-week-43.html#cdc_data_surveillance_section_4-outpatient-and-emergency-department-illness-surveillance *(10)*.

Southern Hemisphere

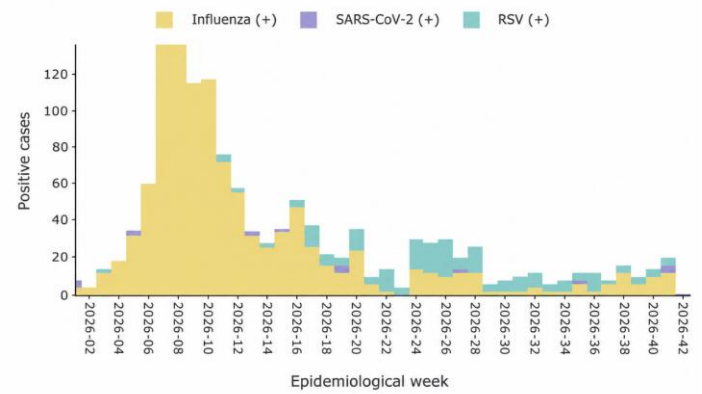
In **Bolivia,** between EW 41 and EW 42, an increase in cases of acute respiratory infections was observed, reaching the alert threshold above the epidemic threshold (**Figure 15**). Regarding influenza activity between EW 39 and EW 42, a positivity rate of 20.3% was observed, with a predominance of the B Victoria subtype (**Figure 16**). Regarding the circulation of SARS-CoV-2, the positivity rate reached 3.6% *(4, 13, 14)*.

Figure 15. Epidemic curve for acute respiratory infection, Bolivia, EW 1 to EW 41 of 2026**.**



Source: Adapted from the Ministerio de Salud y Deportes de Bolivia. Boletín epidemiológico: semana epidemiológica n.° 41, del 11 al 17 de octubre de 2026. La Paz: Ministry of Health and Sports; 2026. Available from: https://www.minsalud.gob.bo/component/jdownloads/send/71-boletines-epidemiologicos-semanal/1060-boletin-epidemiologico-semana-epidemiologica-no-41?Itemid=465 *(13)*.

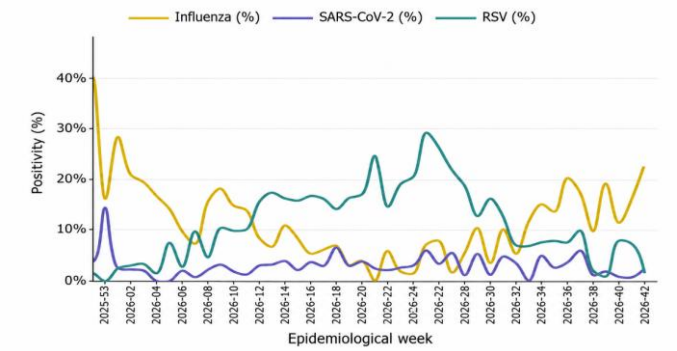
Figure 16. Positive cases of acute respiratory infections (ARI) caused by respiratory viruses by epidemiological week in Bolivia, between EW 1 and EW 42 of 2026.



Source: Adapted from the Pan American Health Organization. Dashboard on the Situation of Influenza, SARS-CoV-2, RSV, and Other Respiratory Viruses—Americas Region. Washington, D.C.: PAHO; 2026 [cited November 6, 2026]. Available from: https://dashboards.pahoflu.com/app/respiratory_viruses/

In **Ecuador**, influenza activity reached a positivity rate of 23.5% in EW 42, with a predominance of influenza B (55.7% of samples typed during EPs 39–42) and co-circulation of A(H3N2) (**Figure 17**). The positivity rates for RSV and SARS-CoV-2 remained relatively low, at 1.7% and 2.5%, respectively *(4, 6,15)*.

Figure 17. Positivity rates for influenza, SARS-CoV-2, and RSV by epidemiological week in Ecuador, between EW 1 and EW 42 of 2026.



Source: Adapted from the Pan American Health Organization. Dashboard on the Situation of Influenza, SARS-CoV-2, RSV, and Other Respiratory Viruses—Americas Region. Washington, D.C.: PAHO; 2026 [cited November 6, 2026]. Available from: https://dashboards.pahoflu.com/app/respiratory_viruses/.

Genomic Surveillance of Influenza and Respiratory Viruses

Recent genomic surveillance data from the start of the 2026–2027 season in the Northern Hemisphere show a marked predominance of clade 5a.2a.1, subclade D.3.1.1, among circulating influenza A(H1N1)pdm09 viruses. Similarly, genomic surveillance data from the Americas Region available on the PAHO/RESVIGEN dashboard show a predominance of sequences from clade 5a.2a.1 among influenza A(H1) viruses characterized during the last epidemiological weeks of 2026 *(6)*. This subclade accounts for 99.8% of the genetically characterized A(H1N1)pdm09 viruses *(10)*. Among A(H3N2) viruses, subclade K predominated, accounting for more than 95% of the viruses in the region. The vaccine composition recommended by the WHO for the 2026–2027 season in the Northern Hemisphere includes an A(H1N1)pdm09 component similar to A/Missouri/11/2025, belonging to subclade D.3.1, and an A(H3N2) component similar to A/Darwin/1454/2025, belonging to subclade K *(16)*.

The results of antigenic characterization indicate that the vaccine reference viruses adequately recognize most circulating viruses, although antigenic differences have been identified in some A(H1N1)pdm09 viruses *(17)*. In this context, genomic surveillance findings should be interpreted in conjunction with antigenic characterization results to assess the relevance of the identified genetic changes and their potential impact on the match between circulating viruses and vaccine components.

Variants of influenza A(H3N2) and A(H1N1) with antigenic changes—including mutations associated with antigenic escape (particularly in the K subclade)—have recently been identified, highlighting the impact of the ongoing evolution of influenza viruses. Although the available evidence indicates that current seasonal vaccines continue to provide good protection, especially against severe disease, the ongoing monitoring and updating of vaccine strains remains a significant challenge.

Regarding SARS-CoV-2, genomic surveillance data show a higher proportion of the XFG variant among the available sequences, followed by other lineages descended from Omicron *(18, 19)*. Meanwhile, for respiratory syncytial virus (RSV), an increase in circulation is observed in some countries in the Northern Hemisphere, although the available genomic information does not allow for the identification of the predominance of specific genotypes or lineages *(20, 21)*.

These findings reinforce the importance of maintaining integrated genomic and antigenic surveillance of respiratory viruses in order to monitor their evolution, identify genetic and antigenic changes relevant to public health, and contribute to the ongoing evaluation of prevention and immunization strategies. In this context, PAHO/WHO, through the PAHOGen and RESVIGEN networks, supports countries in strengthening their capacities for genomic sequencing and analysis, as well as the timely sharing of data to support integrated surveillance and public health decision-making. Likewise, PAHO encourages countries to continue routine submissions of influenza viruses to WHO Collaborating Centers.

Recommendations for Member States

Based on the available information, an early onset and increased activity of the influenza A(H1N1)pdm09 subtype have been observed in some countries in the Northern Hemisphere. This could lead to an increase in the number of medical visits and hospitalizations, as has been seen in seasons when influenza A(H1N1)pdm09 was predominant, which could place greater demand on health services. Although this trend corresponds to an expected seasonal pattern—given the onset of the season of peak circulation in the Northern Hemisphere, it reinforces the need to maintain close epidemiological and virological surveillance and strengthen prevention and preparedness measures.

The Pan American Health Organization / World Health Organization (PAHO/WHO) urges Member States to continue strengthening key actions for surveillance, clinical management and prophylaxis, infection prevention and control, risk communication, and vaccination. Below is a summary of the main recommendations issued in the 4 December 2025, 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 *(22)*, which remain in effect.

Surveillance

PAHO/WHO recommends Member States integrate surveillance of influenza, RSV, SARS-CoV-2, and other respiratory viruses into existing national platforms, in accordance with the regional technical guidelines for an integrated approach to routine surveillance of respiratory viruses, and report surveillance data weekly through the PAHO/WHO FluNET and FluID platforms, ensuring their timeliness, quality, and completeness. It is also important to continue sequencing influenza viruses to monitor and identify mutations that may be associated with increased transmissibility or pathogenicity. It is recommended that sequences be uploaded to the GISAID database as soon as possible to facilitate regional and global monitoring. In countries with the capacity to sequence respiratory syncytial virus (RSV), it is recommended to sequence 46 samples per year and deposit the sequences in GISAID *(23)*.

Member States are recommended to continue strengthening sentinel surveillance of influenza-like illness (ILI) and to prioritize sentinel surveillance of severe acute respiratory infection (SARI), complementing it with other surveillance strategies to monitor epidemiological changes and viral circulation trends in order to assess transmission patterns, clinical severity, and impact on the health system and society, and to identify groups at greater risk of developing associated respiratory complications *(24, 25)*.

As a complement to indicator-based surveillance, PAHO/WHO recommends that Member States implement event-based surveillance, for the early detection of signs that may pose a risk to public health. Event-based surveillance is the organized and rapid capture of information on events that may pose a potential risk to public health. The information may come from rumors and/or other ad hoc reports transmitted 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 *(26, 27)*.

Unusual respiratory events should be investigated immediately and reported to PAHO/WHO in accordance with the International Health Regulations (IHR) *(27)*. Unusual events include cases of acute respiratory illness with presentation or atypical clinical progression; acute respiratory infection associated with exposure to sick or dead animals or detected in travelers from areas prone to the emergence of new influenza viruses; cases of SARI in health care workers who are treating severe respiratory cases of unknown etiology; or clusters of unusual respiratory illnesses, including those that occur outside the usual season.

Given that sentinel surveillance has limited sensitivity for the early detection of human avian influenza infections, it is recommended to follow the PAHO/WHO guidelines for early detection: expand surveillance to include individuals at higher risk of exposure (poultry and dairy farm workers, animal outbreak response personnel); systematically investigate a history of exposure to birds or mammals in cases of ILI, SARI, and conjunctivitis; strengthen the capacity of health facilities to identify signs, collect specimens, and properly use personal protective equipment; promptly report suspected or confirmed cases; and coordinate investigation and risk assessment with the animal health sector, under the One Health approach.

As part of routine indicator-based surveillance, and for etiological confirmation of unusual cases, nasopharyngeal and oropharyngeal samples (or bronchoalveolar washings in severe cases) should be obtained for respiratory virus detection. Laboratory testing of the most severe cases should always be prioritized, especially those admitted to intensive care units (ICUs) and fatal cases, in which respiratory tract tissue samples should also be taken (if possible). All biosafety measures for respiratory pathogens should be taken. Technical guidelines and diagnostic algorithms from the National Influenza Center or the national reference laboratory responsible for laboratory surveillance should be followed. The recommended testing algorithms for influenza, RSV, and SARS-CoV-2 are available on the PAHO/WHO website at: https://www.paho.org/en/documents/influenza-and-sars-cov-2-integrated-surveillance-laboratory-testing-algorithm *(28)*.

According to WHO guidelines, representative samples for influenza selected according to the criteria recommended by PAHO and WHO should be sent to a WHO Collaborating Center (CC) for additional genomic and antigenic characterization *(28, 29)*. Influenza A samples for which the virus subtype cannot be determined, being a true unsubtypable sample (those positive for Influenza A but where RT-PCR for subtyping is negative or inconclusive), should also be sent immediately to a PAHO/WHO CC *(26)*. For further guidance and verification of a true unsubtyped sample, please contact the PAHO laboratory response team prior to sending to a WHO CC (laboratoryresponse@paho.org).

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

Clinical management and prophylaxis

PAHO/WHO recommends Member States update their treatment guidelines based on the updated WHO guidelines *(30-32)*. The recommendations for the clinical management of patients with severe respiratory illness indicated in the epidemiological alerts and PAHO/WHO updates on influenza remain in effect *(33)*. Recommendations on antiviral and antibiotic treatment according to clinical presentation are found in **Tables 1-4** *(32)*.

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

Medication	Recommendation
Baloxavir (high risk of progression to severe disease)	Conditional recommendation in favor
Baloxavir (low risk of progression to severe disease)	Conditional recommendation against
Laninamivir	Conditional recommendation against
Oseltamivir	Unqualified recommendation against
Peramivir	Conditional recommendation against
Zanamivir	Unreserved recommendation against
Favipiravir	Unreserved recommendation against
Umifenovir	Conditional recommendation against
Antibiotics	No reservations against recommendation in cases of low probability of bacterial coinfection

Source: World Health Organization. Clinical practice guidelines for influenza. Geneva: WHO; 2024. Available from: https://www.who.int/publications/i/item/9789240097759 *(32)*.

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 *(32)*.

Table 3. Recommendations for complementary treatment in severe influenza.

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

Source: World Health Organization. Clinical practice guidelines for influenza. Geneva: WHO; 2024. Available from: https://www.who.int/publications/i/item/9789240097759 *(32)*.

Table 4. Recommendations for prevention in exposed individuals without infection.

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

Source: World Health Organization. Clinical practice guidelines for influenza. Geneva: WHO; 2024. Available from: https://www.who.int/publications/i/item/9789240097759 *(32)*.

Infection prevention and control

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

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

Healthcare and support staff are advised to carry out an appropriate risk assessment to determine whether additional personal protective equipment (e.g., eye protection, FFP2 or N95 respirators, gowns, gloves) is necessary when caring for patients *(33)*.

Following is a summary of the levels of infection prevention and control (IPC) required in routine healthcare activities (excluding those techniques that generate aerosols) (**Table 5**) *(34)*.

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

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

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

Source: Adapted from the World Health Organization. Study protocol for non-seasonal influenza and other emerging acute respiratory conditions. Geneva: WHO; 2018. Available from: https://www.who.int/publications/i/item/WHO-WHE-IHM-GIP-2018.2 *(35)*.

Risk communication

Seasonal influenza is an acute viral infection that spreads easily from person to person. Seasonal influenza viruses circulate worldwide and can affect anyone in any age group *(36, 37)*. Influenza vaccination before the start of seasonal virus circulation remains the best preventive measure against severe influenza *(38)*.

The public should be informed that the main mode of transmission of influenza is interpersonal contact. Handwashing is the most efficient way to reduce transmission. Knowledge of "respiratory etiquette" also helps prevent transmission *(39)*.

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

To take advantage of the knowledge that most of the public has acquired about the prevention of respiratory diseases—in the wake of the COVID-19 pandemic—and to avoid confusion and ensure effective communication, Member States should consider developing risk communication strategies and campaigns that integrate prevention messages for respiratory viruses. The integration of communication to promote vaccination against COVID-19 and influenza is also recommended.

Vaccination

Immunization is an essential strategy for preventing severe illness associated with seasonal influenza, COVID-19, and RSV, including hospitalizations and deaths. PAHO/WHO recommends vaccination of influenza in groups at high risk of severe illness, older adults, people with underlying conditions, children between 6 and 59 months of age, and pregnant women. Vaccination is also recommended for people at high risk of exposure to the virus and subsequent transmission, such as healthcare workers. *(39, 40)*. The Strategic Advisory Group of Experts on Immunization (SAGE) recommends COVID-19 vaccination for groups at high risk of severe disease, including older adults, immunocompromised individuals, people with underlying medical conditions, pregnant women, and healthcare workers *(41)*.

There are currently two strategies available for the prevention of severe RSV disease in infants and newborns: administration of vaccine during pregnancy (RSVPreF vaccine) and administration of long-acting monoclonal antibodies (nirsevimab and clesrovimab) to newborns and infants. Both strategies have been shown to be effective and have a favorable safety profile for both pregnant women and newborns. PAHO and WHO recommend that countries introduce these products for the prevention of RSV disease and death in newborns *(42-44)*.

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 *(45)*. 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 *(46, 47)*. 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 *(45, 48, 49)*. In randomized clinical trials and post-authorization studies, these vaccines have been shown to be effective in reducing the risk of developing severe RSV-associated disease.

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

Non-pharmacological public health measures in the population

Nonpharmacological public health measures that are effective in limiting the transmission of respiratory viruses complement the response to respiratory outbreaks. 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. *(50)*.

For more details, see the guidelines: Non-pharmaceutical public health measures to mitigate the risk and impact of epidemic and pandemic influenza *(50)* and the manual Guidance for the implementation of non-pharmaceutical public health measures in vulnerable population groups in the context of COVID-19 *(51)*.

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