NAIIS Weekly Summary: April 2, 2026

Influenza Activity Update – Alicia Budd, MPH, Influenza Division, Centers for Disease Control and Prevention (CDC)

Alicia Budd, MPH, provided CDC data on influenza activity through March 21, 2026.

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Influenza Activity
In addition to laboratory and mortality data reported to the CDC, the agency tracks influenza through the National Healthcare Safety Network's Hospital Respiratory Data and the U.S. Outpatient Influenza-like Illness Surveillance Network. Influenza activity peaked in late December of 2025, followed by a sharp decline, but viral spread persisted for some time before finally decreasing in recent weeks. The decrease is seen across all age groups and most areas of the country, but three U.S. Department of Health and Humans Services (HHS) regions have higher rates than the rest: 1 (New England), 8 (Mountain West), and 10 (Pacific Northwest). For most of the season, influenza type A dominated, but when it began to decline, type B increased. That pattern applies across the country, but the timing of the shift, the extent, and the rise varies. The continued influenza infections in most regions around the country are currently being driven by type B. In HHS regions 9 (Pacific Southwest) and 10, type B influenza started circulating later and remains lower than in other areas of the country.

Influenza Strains
Laboratory analysis shows that H3N2 was the dominant strain this season. Nearly all of the H3N2 specimens belonged to subclade K and were not antigenically similar to the vaccine reference virus. Only about 30% of subclades of the type B Victoria strain were antigenically similar to the vaccine. The 2026–27 vaccine will address new strains of H1N1, H3N2, and type B Victoria.

Comparison with Previous Seasons
Although the peak for this season was earlier than recent seasons, the timing falls within historical norms. Similarly, the peak weekly values fall within historical norms. The peaks are at the high range of normal and higher than last season, but hospital and mortality data were within historical norms and lower than the peaks for the 2024–25 season. Cumulative rates of hospitalization help demonstrate the overall impact; for all ages, cumulative rates so

far are comparatively high but not at record rates. The cumulative hospitalization rates are highest among those 0–4 years old, and their rates are high compared with other seasons. People ages 5–17 years old have the highest-ever cumulative hospitalization rate for this age group this season (to date), although the number is relatively low, as this group usually has the lowest such rates. Compared with the previous 15 years, overall influenza severity for this season is moderate. Severity is measured across three indicators: influenza-like illness treated in outpatient settings, hospitalizations, and mortality. For older adults, influenza-like illness reached high severity, but the other two categories were moderate. For children, influenza-like illness and hospitalization were categorized as severe.

QUESTIONS & ANSWERS

Q: Are the results of home testing for influenza infection captured in CDC data? What is the impact of some of the antigen testing that is going on at home?

Alicia Budd (CDC): This has been the case ever since flu surveillance started. We know we're not catching all the cases. Earlier, we may not have been catching them because no one got tested. Now we're not catching them because people are getting tested, but it's not funneling into one of our surveillance systems. So, I would never look at these systems themselves and say that only this many people have had flu, because we know we're not counting them all, and I expect that that could continue. Sometimes I think comparing values in a particular system from one year to the next may not even necessarily be the best way to do it, because we may be looking at a different denominator in terms of whose tests are getting reported. So, a lot of things to keep in mind, but I think we certainly can track when activity is happening, where it's happening, and I think the models that we have to estimate burden take into account testing practices, and how accurate the tests are, and all those things. I think, to the extent possible, the burden estimates are taking some of this into account.

COVID-19 & RSV Surveillance – Amber Winn, Coronavirus and Other Respiratory Viruses Division, CDC

Amber Winn gave an update on the impact of COVID-19 and RSV in the United States in the 2025–26 season.

COVID-19

CDC captures laboratory data using the National Respiratory and Enteric Virus Surveillance System and hospitalization data from the Respiratory Virus Hospitalization Network. As of March 21, positive tests for COVID-19 infection have been low and stable for several weeks across the country. The XFG variant remains the dominant circulating variant. COVID-19 infections have resulted in the following for the 2025–26 season to date:

- 3.4–10.8 million illnesses
- 680,000–1.9 million outpatient visits
- 110,000–210,000 hospitalizations

- 12,000–37,000 deaths

RSV
The RSV season started later than usual in most regions (compared with prepandemic seasons), with higher-than-usual activity in all HHS regions at the same time. It typically begins around October and peaks from December to January. RSV has likely peaked for this season in five HHS regions but continues to increase in the other five. Severity is not increased compared with other seasons. Compared with the previous five seasons, RSV is higher than normal for this time of year but is projected to decline. Cumulative rates of hospitalization are slightly higher than for the same week last year but are not higher than earlier seasons. The most recent weekly data from mid-February show that severe outcomes from COVID-19 and RSV continue to occur.

RSV vaccination is currently recommended for adults age 50 years and older with underlying medical conditions and for all adults age 75 years and older. RSV vaccination is also recommended for infants, either via maternal prenatal vaccination or monoclonal antibodies. Both options for RSV prevention in infants and young children are highly effective in preventing RSV hospitalization and other severe outcomes. Data from the 2024–25 RSV season indicate that RSV hospitalization rates fell by up to half with the increasing uptake of these products.

Public health authorities may modify recommendations at the jurisdiction level, including extending the recommended timeframe for vaccination to account for the unusual persistence of RSV this year beyond March. About 20 state, local, and tribal public health entities have revised their recommendations to extend RSV prevention. CDC is working to raise awareness about the flexibility of recommendations and the implications of the later start to the RSV season. It suggests local public health entities monitor local activity and consider proactive communication with local immunization providers as needed. CDC's Respiratory Illness Data Channel has useful resources for planning.

QUESTIONS & ANSWERS
Q: Is there any potential truth to the speculation by some virologists that COVID-19 may actually diminish and potentially vanish?
Amber Winn (CDC): It's a great question. It's something that I think we all are continuing to anticipate. We have seen that second peak continue to decline more and more, and that was speculated just a few years ago—that those two peaks would eventually become one. But I think the jury's still out. There are a lot of theories going on about what we will see, so we'll stay tuned. But we certainly saw a more muted peak this year compared to the previous ones.

Influenza, COVID-19, and RSV Vaccination Coverage Update – Carla Black, PhD, Immunization Services Division, National Center for Immunization and Respiratory Diseases, CDC

Carla Black, PhD, described vaccine coverage for influenza, COVID-19, and RSV for the past three respiratory virus seasons.

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CDC determines vaccine coverage rates based on the National Immunization Surveys, the Behavioral Risk Factors Surveillance System, and, for pregnant people, the Vaccine Safety Datalink. The survey categorizes vaccine uptake according to receipt, intent to receive, or refusal of vaccine. The RespVaxView web page provides data for COVID-19, influenza, and RSV.

Influenza Vaccination

- Coverage rates are around 46%, similar to the past two seasons, but lower than prepandemic rates. For the past 3 years, around 33–35% have said they will definitely not get the vaccine.
- Demographic data (including race, ethnicity, geography, and income level) show that Hispanic people have lower rates of coverage but also lower rates of hesitancy/refusal and a larger proportion of people who fall into the "moveable middle"—that is, people who might respond to interventions or improved access.
- Vaccination rates among children and pregnant people have decreased dramatically since the COVID-19 pandemic; rates have been stable for the past three seasons but are not rebounding to prepandemic numbers.
- White and Black children are less likely to be vaccinated than Hispanic and multiracial children; parents of rural children report more hesitancy/refusal compared with urban parents.

COVID Vaccination

- Vaccination rates declined about 5% compared with last season, and the proportion of people refusing the vaccine has increased.
- Adults ages 65 years and over had the biggest drop in vaccination rates and the largest increase in refusal.
- Vaccination rates among children decreased about 3% compared with last season, and refusals of childhood vaccination have increased over the past three seasons.
- Vaccination rates among pregnant people have changed little and remain consistently low.

RSV Vaccination

The recommendation for adults changed this year to start earlier for older people with high-risk conditions. The vaccine has been available for about 3 years.

- About 43% of adults 75 years and older and about 33% of adults ages 50–74 with high-risk conditions have been vaccinated.
- The percentage of people who refuse RSV vaccine is smaller than for other vaccines, and the moveable middle is fairly large.
- People living above the poverty level are much more likely to be vaccinated than those living below the poverty level.
- For older adults at high risk, rural and White people have lower coverage rates and higher rates of hesitancy/refusal.
- About 65% of infants are protected against RSV through either maternal vaccination or monoclonal antibodies, similar to last season.
- Maternal vaccination rates are higher this season than last season, but the vaccine was not available in all places early in the RSV season.

QUESTIONS & ANSWERS

Q: Is there enough granularity in the survey data to see whether those who are refusing COVID vaccines are still getting flu vaccines? In other words, the folks who have said they are definitely not getting a COVID vaccine, which is almost 50%—are they just resistant to COVID? Because there's a lot of speculation right now, especially as we talk about combination vaccines and coadministration of vaccines, about COVID hesitancy dragging down flu vaccine coverage rates.

Carla Black (CDC): Oh, yeah, we could look at that. I have not, but that would be an interesting thing to look at.

Announcements

- Registration is open for the 2026 National Adult and Influenza Immunization Summit, May 19-21, 2026, at the Crowne Plaza Atlanta Perimeter at Ravinia, 4355 Ashford Dunwoody Rd, Atlanta, GA 30346 (https://www.izsummitpartners.org/2026-naiis/).
- Registrants are encouraged to book a hotel room using this link by April 23: https://book.passkey.com/event/51059389/owner/55306/home