



Immunize Weekly Summary: September 3, 2026

- Centers for Disease Control and Prevention (CDC)
Influenza Update, 2025–26
- CDC COVID-19 and Respiratory Syncytial Virus (RSV)
Surveillance and Prevention Updates
- Announcements

CDC Influenza Update, 2025–26 – Katie Reinhart, PhD, MPH, Influenza Division, CDC

Katie Reinhart, PhD, MPH, provided data from influenza surveillance systems through August 22, 2026.

[VIEW SLIDES](#)

The 2025–26 influenza season was characterized by two waves—influenza type A (mostly H3N2, subclade K) reached its peak in late December 2025, while type B peaked in March 2026. That trend was reflected across all age groups, but those ages 5–24 years had higher rates of type B, and those ages 65 years and older had the lowest rates of type B. Data through week 20 of 2026 show that nearly all of the type A H1N1 viruses matched the reference vaccine virus, but very few of the type A H3N2 viruses did. About 33% of the type B/Victoria viruses matched the reference virus.

In 2025–26, influenza cases peaked earlier than previous seasons but remains within historic norms. Outpatient influenza-like illness rates remained above the national baseline of 3.1% for 15 consecutive weeks this season. People ages 5–17 years had the highest percentage of emergency department visits for influenza, followed by those ages 4 years and younger. This season saw the third highest cumulative hospitalization rate since the 2010–11 season, with people ages 65 years and older having the highest admissions rates. Mortality rates (based on death certificate data) reached the third highest peak since the 2015–16 season.

So far, 191 pediatric deaths have been reported, and that figure is likely to rise as data are updated. These deaths represent the fourth highest pediatric mortality rate since reporting began in 2004–05, not including the 2009–10 H1N1 influenza pandemic. About 20% of pediatric deaths occurred in children younger than 2 years, and about half occurred in children with an underlying high-risk medical condition. Most of the pediatric deaths took place within one week of the onset of symptoms.

Preliminary estimates classify the 2025–26 season as moderately severe. Through modeling, CDC estimated this season resulted in at least:

- 32 million influenza cases

- 15 million related medical visits
- 390,000 related hospital admissions
- 24,000 influenza deaths

QUESTIONS & ANSWERS

Q: Why was there so much less subtyping last season compared to the previous season?

Katie Reinhart (CDC): I'm not sure there was less subtyping this season compared to last season. Looking at the genetic and antigenic characterization data [on slide 4]—this is preliminary data. They've been continuing to test over the summer months. This data is just through week 20, so I think there's going to be—I don't want to give out a number here—but there will be quite a bit more information coming out when we post our overall final season summary, which should be out sometime this fall. I did look at those numbers, and while the counts increased, what we were seeing overall didn't really change much. It was still mostly H1s that were antigenically similar—same story with subclade K, and same with the B viruses. So there will be more data to come on that.

Q: Do you think the declines in immunization rates contributed to the high hospitalization rates this past season? And the high pediatric incidence rate as well?

Katie Reinhart (CDC): Yeah, it's always hard to draw a one-to-one comparison. We know immunization helps prevent severe illness and hospitalizations, so if we see a decrease in immunizations, it makes sense that that would be one of the reasons we're seeing that—but it's always hard to draw a direct line from one to the other.

L.J. Tan (NAIIS): I think it's interesting—again, it's hard to draw the direct line, but it's interesting that our immunization coverage has continued to drop since COVID, and our pediatric mortality rates have been the highest we've seen since before COVID. So it's curious, even though we're not able to draw the line.

Q: What are you seeing regarding the match for the upcoming season?

Katie Reinhart (CDC): So, all three viruses were updated for the upcoming season, I believe. I haven't looked that closely at the genetic and antigenic information compared to what we'll be seeing in the next vaccine, so, sorry, I can't give a better answer for that.

CDC COVID-19 and RSV Surveillance and Prevention Updates – Fatimah S. Dawood, MD, CAPT, U.S. Public Health Service, Surveillance and Prevention Branch, Coronavirus and Other Respiratory Viruses Division

Fatimah S. Dawood, MD, CAPT, U.S. Public Health Service, summarized COVID-19 and RSV surveillance data and prevention efforts.

COVID-19

Surveillance data going back to 2021–22 indicate that SARS-CoV-2 activity continues to peak regionally in summer and winter, with a higher peak in winter. Overall activity is low

across the United States and has been mostly stable in recent weeks. Some regions are seeing increased activity, consistent with the summer peak, but at a slower rate than previous years. Encouraging vaccination in the fall aligns well with the timing of the winter peak in COVID-19 hospitalization rates. Rates of COVID-19 hospitalization have been declining over time but remain highest among the youngest (<6 months) and oldest (≥ 65 years) age groups. Among adults, chronic conditions increase hospitalization risk. These data underscore the importance of a second dose of COVID-19 vaccine for people ages 65 years and older to prevent hospitalization.

CDC relies on genomic surveillance data to identify circulating variants as the COVID-19 virus evolves. The JN.1 variant emerged in 2024, and its descendant, the XFG variant, has been the most common circulating virus since August 2025. The SW.2 sublineage of XFG is currently the most common lineage in the United States and appears to be increasing the most rapidly. A federal advisory committee recommended that the 2026–27 COVID-19 vaccines include the JN.1-lineage XFG variant, which should protect against severe COVID-19 disease caused by currently circulating variants in the United States. CDC’s COVID-19 burden estimates are available [online](#).

RSV

RSV activity began, peaked, and ended later than usual in the 2025–26 season. The timing of onset of RSV varies regionally across the United States, typically starting earliest in the Southeast and latest in the central and northwestern states. RSV activity is currently low in most of the United States. CDC recognizes that the timing of onset affects decisions about administering infant RSV prevention products. Therefore, its recommendations include flexibility for jurisdictional public health authorities to modify timing to address atypical RSV activity in their areas. For more details on RSV, see:

- [Use of Clesrovimab for Prevention of Severe Respiratory Syncytial Virus–Associated Lower Respiratory Tract Infections in Infants: Recommendations of the Advisory Committee on Immunization Practices — United States, 2025](#)
- [RSV Immunization Guidance for Infants and Young Children](#)
- [RSV Vaccine Guidance for Pregnant Women](#)
- [Preliminary Estimates of RSV Burden](#)

Other CDC Respiratory Illness Resources

- [Respiratory Illnesses Data Channel](#), updated on Fridays by noon
- [NREVSS Dashboard](#)
- [Respiratory Virus Hospitalization Surveillance Network \(RESP-NET\) Interactive Dashboard](#)

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QUESTIONS & ANSWERS

Q: Can jurisdictional public health authorities revise guidance for RSV prevention for both maternal vaccination and infant monoclonal antibodies based on local epidemiology?

Fatimah Dawood (CDC): Yes, there is flexibility to revise both, on a standing basis, because we know there is regional variation in the timing of RSV circulation, as well as during atypical seasons.

Q: Regarding RSV and monoclonals specifically. One of the challenges we've seen in the use of monoclonals has been tricky—missing kids who were born before the season and must come back in, especially if their 6-month visit falls in September and they don't normally come back until their 9-month visit. Are there strategies being recommended, or does the flexibility CDC has built into the window permit a clinic—without checking with public health authorities for permission—to make a judgment call that this little one who's in for their 6-month visit in September should get a monoclonal now, because there's concern they won't be back until they're no longer age-eligible? So I was wondering a bit more about how the recommendations define the flexibility around that October 1 start date, so we can more effectively communicate that to clinicians, beyond the parts about what public health authorities may recommend locally.

Fatimah Dawood (CDC): The way the recommendations are framed around the flexibilities—there are specific instances where clinicians can use clinical judgment to give a prevention product outside of the recommended window. For example, an infant who may be traveling to an area with high RSV circulation before the recommended seasonal administration window for that area—in those sorts of one-off instances, there's flexibility for clinician decision-making.

But in terms of systematic modification of timing, the recommendations really emphasize that that should be done by jurisdictional public health authorities. Part of that thinking is around equity—about half of prevention products are provided through VFC [Vaccines for Children], and we want to make sure there's equitable distribution.

Q: The delayed peak for RSV in recent seasons is intriguing. Could this be in part due to the availability of RSV interventions early in the season?

Fatimah Dawood: It is intriguing. In short, we don't know. If you talk to 10 epidemiologists, you might hear 10 different perspectives. One thing we did notice last season is that other parts of the world also saw a delayed RSV season—in Europe, they saw similar patterns to what we saw here in the U.S. And of course many European countries are using prevention products, but there's variability, so it's hard to make a direct causal link. We need to see what happens in future seasons, and we'll continue to monitor.

Announcements

- Weekly meetings resume as of Thursday, September 3.
- The Vaccine Integrity Project and the American Medical Association published their independent evidence [review](#) of respiratory virus immunizations. Their [press release](#) includes links to current recommendations and other resources.
- Several professional medical associations also published their 2026–27 fall respiratory viral vaccination recommendations:
 - AAP: [Respiratory Virus Immunization Guidance for 2026-27](#)
 - AAFP: [Fall Immunization Recommendations to Protect Patients and Communities](#)
 - ACOG: [2026-27 Respiratory Virus Season Immunization Recommendations for Pregnant and Postpartum Individuals](#)
 - IDSA: [IDSA recommends respiratory vaccines for people with weakened immune systems](#)
- On September 1, CDC published [interim clinical considerations for the use of seasonal influenza vaccines in the United States](#).