- Immunize Weekly Summary: September 10, 2026
- Vaccine Integrity Project (VIP): 2026–27 Respiratory Season Evidence Review Summary
- American Medical Association (AMA)/VIP: 2026–27 Respiratory Season Communications Update
- American Academy of Family Physicians (AAFP): 2026–27 Respiratory Season Vaccine Recommendations
- American Academy of Pediatrics (AAP): 2026–27 Respiratory Season Immunization Recommendations
- American College of Obstetricians & Gynecologists (ACOG): 2026–27 Respiratory Season Vaccination Recommendations
- Infectious Diseases Society of America (IDSA): Updating IDSA's Vaccine Guidelines

VIP: 2026–27 Respiratory Season Evidence Review Summary – Angela Ulrich, PhD, MPH, Director of Research and Assistant Professor, Center for Infectious Disease Research and Policy, University of Minnesota, VIP

Angela Ulrich, PhD, MPH, presented key findings of VIP's review of the evidence for the safety and effectiveness of the influenza, COVID-19, and respiratory syncytial virus (RSV) vaccines.

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Influenza Vaccine Conclusions

Recent evidence confirms that influenza vaccines reduce the risk of severe disease, and no new safety concerns have emerged based on post-market surveillance of nearly 10 million people.

- Among adults 65 and older, vaccination reduced the risk of hospitalization by 31%.
- Among adults 50 and older, the newly approved mRNA-1010 vaccine (mFLUSIVA®) was 27% more effective against symptomatic disease than the standard-dose vaccine.
- Across 10 seasons, vaccination during pregnancy reduced the risk of symptomatic disease in infants ages 0–6 months by 44%.

- Across eight seasons, vaccination was associated with an 80% reduction in deaths among children ages 6 months to 17 years and a 77% reduction among children with underlying health conditions that increased the risk of severe disease.

COVID-19 Vaccine Conclusions
Evidence supports that COVID-19 vaccines reduce the risk of hospitalization and mortality for those at high risk of severe disease, including older adults, infants, and pregnant people, and no new safety concerns were identified.

- For adults 65 and older, vaccination cut the risk of hospitalization by 53% last season.
- For immunocompromised adults, vaccination cut the risk of intensive care unit admission or death by 32% to 53%, depending on the condition and other factors.
- Vaccination during pregnancy reduced the risk of emergency department or urgent care visits by 58% and reduced the risk of hospital encounters for infants born subsequently by 36% throughout the first year of life.
- Young children (9 months to 4 years) saw a 76% reduction in pediatric emergency visits.

RSV Vaccine Conclusions
RSV vaccination of older adults and pregnant women, along with infant immunization with monoclonal antibodies (mAbs), substantially reduced severe illness and hospitalization, and no new safety concerns were identified.

- For adults 60 and older, multiple studies showed significant reductions in hospitalization, with vaccine effectiveness ranging from 69% to 83% within the same season.
- Vaccination reduced the risk of RSV by 82% during pregnancy and also reduced the risk of RSV-associated hospitalization among infants born subsequently.
- The infant mAb nirsevimab reduced the risk of hospitalization by 64% to 93% within 6–12 months.

Visit the VIP website for more information about the evidence review, an interactive data tool, and related JAMA publications.

AMA/VIP: 2026–27 Respiratory Season Communications Update – Andrea M. Garcia, JD, MPH, Vice President of Science, Medicine, and Public Health, AMA

Andrea M. Garcia, JD, MPH, gave an update on AMA's role in disseminating the VIP's work and amplifying vaccine recommendations, in coordination with other medical specialty societies.

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In response to stakeholders' requests for consolidated immunization recommendations and resources for patients and health care providers, AMA recently launched SpreadTheFacts.org. Summit partners are welcome to submit resources for consideration, as AMA anticipates posting a second wave of resources. Register here for AMA's clinical webinar on immunizations on September 23.

In addition, AMA is developing a dissemination toolkit to share resources, messaging, and social assets that focus on spreading the facts and linking to the new website. AMA is planning a letter of broad support for the evidence review process and recommendations and will seek signers representing other organizations. Finally, AMA, VIP, and other national medical societies begin a media tour September 22 to amplify the VIP recommendations to the public.

AAFP: 2026–27 Respiratory Season Vaccine Recommendations – Margot Savoy, MD, MPH, FAAFP, Chief Medical Officer, AAFP

Margot Savoy, MD, MPH, FAAFP, described AAFP's guidance development process and their recommendations for nonpregnant, immunocompetent adults and health care professionals.

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AAFP collaborated with VIP on the evidence review, which serves as the basis for its recommendations. In addition to external peer review, AAFP created the Vaccine Evidence Review Council and added external technical review to its multistep process. Its recommendations for nonpregnant, immunocompetent adults 19 and older and health care professionals are described here. There were no major changes to the recommendations. For the 2026–27 season:

- **Influenza vaccination** is recommended annually for this population. This season's vaccine contains new virus strains, so past years' vaccines likely do not offer residual coverage. The new mRNA vaccine is included among the products preferred for those 65 and older, although no particular enhanced product is preferred over others, and vaccination should not be delayed in anticipation of any particular product.
- **COVID-19 vaccination**, updated, continues to be recommended for all adults. Two doses, 6 months apart, are recommended for people 65 and older. No particular product is preferred, although AAFP recommendations may be broader than those of the U.S. Food and Drug Administration, which revised product package insert information last year.
- **RSV vaccination** is recommended for older adults and those with certain risk factors. There are no data to support a recommendation for health care providers unless they have other risk factors.

AAP: 2026–27 Respiratory Season Immunization Recommendations – Sunnah Kim, MS, RN, Senior Director, Pediatric Practice and Health Care Delivery, AAP

Sunnah Kim, MS, RN, outlined updates to AAP's process for developing recommendations and its vaccine recommendations for those 18 and younger.

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AAP engages infectious disease and other experts to review published and unpublished data according to an evidence review framework and develop recommendations, which then go through several rounds of review before publication. For the 2026–27 season:

- **Influenza vaccine** is recommended for all children 6 months and older who do not have medical contraindications. Immunization should occur as soon as possible in the respiratory virus season, and no product is preferable to another.
- **COVID-19 vaccine** is recommended for children ages 6 through 23 months with no medical contraindications. Children 2–18 years old with certain risk factors should be vaccinated, regardless of prior vaccination status. Children who are not at risk but whose parent or guardian desires COVID-19 protection should be offered a single dose. Moderately or severely immunocompromised children 6 months through 18 years may require two or more doses, depending on previous vaccination status.
- **RSV immunization** recommendations for infants younger than 8 months of age born during or entering their first RSV season are the same as the 2025–26 recommendations. For those 8 through 19 months of age entering their second RSV season, vaccination is recommended for those with conditions that pose a higher risk of significant illness.

AAP did not make specific recommendations for RSV vaccination for immunocompromised adolescents but may do so in the future, pending sufficient data. For the upcoming season, see IDSA's recommendation to consider RSV vaccination for immunocompromised adolescents through shared decision-making. Implementation resources, dosing guides, fact sheets, and other resources are available at AAP's website.

ACOG: 2026–27 Respiratory Season Vaccination Recommendations – Kim Fortner, MD, Professor; Program Director, Maternal Fetal Medicine Fellowship; Director, Division of Maternal-Fetal Medicine; Vice Chair, Obstetric

Operations and Quality, Division of Maternal-Fetal Medicine, University of Tennessee Medical Center; ACOG

Kim Fortner, MD, summarized ACOG's recommendations and rationale for immunization among those who are pregnant, were recently pregnant, are considering pregnancy, or are lactating.

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Vaccination during pregnancy prevents maternal morbidity and mortality and pregnancy complications, reduces outbreaks of vaccine-preventable diseases, and protects newborns. ACOG continues to strongly recommend annual influenza and COVID-19 vaccination as well as maternal RSV vaccination during pregnancy. Resources and information about the 2026 maternal immunization schedule are available on ACOG's website.

COVID-19 Maternal Immunization

The COVID-19 vaccine has been shown to be safe and effective for preventing severe illness and complications during pregnancy, with no differences in safety or immunogenicity between pregnant and nonpregnant adults. Despite initial concerns to the contrary, miscarriage rates are lower in vaccinated pregnant people, and some data suggest vaccination protects against preterm birth. Vaccination reduces maternal infection and hospitalization, as well as infant hospitalization and need for ventilation. Data show that pregnant and postpartum people remain at higher risk of severe disease and hospitalization than nonpregnant people of reproductive age. A single dose is recommended for anyone vaccinated before September 1, 2026; for others, and for immunocompromised people, recommendations may include a second dose.

RSV Prevention

RSV can be prevented by maternal vaccination in the late third trimester or by administering mAbs to infants. Data show that both approaches substantially reduced the risk of infection and hospitalization in infants. Initial concerns about the safety of maternal vaccination have not borne out. ACOG recommends that pregnant people receive RSV vaccine between September 1 and March 1. Additional doses are not recommended for future pregnancies. Alternatively, infants born from October 1 through March 31 can receive a single dose of mAb. The timeline for vaccination recognizes that RSV season is starting sooner and continuing longer.

Influenza Vaccine

A wealth of data demonstrate that pregnant people are at significantly higher risk than nonpregnant people for serious complications from seasonal and pandemic influenza. Vaccination decreases the risk of complications, hospitalization, and preterm birth, improving maternal, neonatal, and obstetric outcomes. ACOG continues to recommend annual vaccination, ideally given from September through October, in any pregnancy trimester. The vaccine is not associated with increased risk of adverse pregnancy outcomes.

Vaccine Coverage
Influenza and COVID-19 vaccination rates among pregnant patients have been declining since 2020. RSV vaccination rates appear to be increasing. ACOG offers resources and clinical tools for obstetric care providers that emphasize the following:

- Engage patients in vaccine counseling early and frequently.
- Affirm the long-term maternal and infant benefits of immunization on health outcomes and health equity.
- Provide strong recommendations for vaccination during pregnancy.

ACOG also encourages clinicians to stock and administer recommended vaccines and provides information on reimbursement to support such practices.

IDSA: Updating IDSA's Vaccine Guidelines – Jon Heald, MA, Senior Director of Clinical Policy, IDSA

Jon Heald, MA, presented the process IDSA used to develop guidelines and its recommendations for vaccines for immunocompromised children and adults.

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IDSA worked with VIP to define and assess the evidence for its upcoming respiratory season vaccine recommendations, published here. For the 2026–27 respiratory virus season:

- **COVID-19 vaccine** is recommended for adults and children with compromised immunity. Household members and close contacts should also be up to date on COVID-19 vaccination.
- **Influenza vaccine** is recommended for adults and children with compromised immunity. High-dose or adjuvanted vaccines provide more robust immune response, which may be of particular importance in immunocompromised patients. Household members and close contacts should be up to date with influenza vaccination. Live-attenuated influenza vaccines are contraindicated for immunocompromised hosts and should be avoided in close contacts of severely immunosuppressed individuals.
- **RSV vaccine** is recommended for adolescents and adults with compromised immunity. While data are limited for immunocompromised adolescents, the benefits outweigh the risks. Administration should be guided by shared decision-making.

The IDSA guidelines also address considerations specifically for solid organ transplant patients.

QUESTIONS & ANSWERS
Q: Regarding AAFP's decision on the mRNA vaccine, mFLUSIVA: what was your process, what data did you look at, and how did you come to that recommendation?

Margot Savoy (AAFP): Thank you, it's a great question. The reason I said it's somewhat controversial is that typically when we discuss immunization recommendations, the data is

pretty clear and people are usually unanimous, but this was one where there was a lot of discussion and it wasn't unanimous in the end — people made a decision, but it was closer than usual.

Ultimately, we don't use GRADE in our guidance documents, but we always do a version of it — we have a modified GRADE process and evidence-to-recommendation process — but we don't necessarily have to be beholden to GRADE if it's guidance versus a clinical practice guideline. For us, immunization recommendations are guidance, not a guideline, so people have the opportunity to consider things outside of the strict GRADE process — that's sort of where the hair got split here.

When we review the data with a strict GRADE/evidence-to-recommendation process, in general, the mRNA vaccine does do better compared to standard-dose vaccine in the 50-and-older group. Where the data is lacking — and we think it's coming next year — is around whether 65-and-older data was strong enough to suggest it should be preferential. If we graded that, it would be low evidence, so it would have been a very conditional recommendation.

The thing that tipped the group toward adding it to the list is that when we were working on language noting it's considered an enhanced vaccine, we didn't think its safety profile was enough of an issue to be a problem for people receiving it. Would we create more confusion for people if that's the vaccine available to them, and we wanted them to get standard vaccine instead if that's what's available at their pharmacy or site? So the decision was made to include it on the list, while recognizing we don't think all four vaccines on the list are equal — even the previous three weren't at parity. We'll use this coming year to look for data to support keeping it there; if the data isn't there, we'll remove it next year when we update the guidance.

At the same time, we'll think about whether to split things out further, since we may have enough data to go back and look at the others. Is there a true difference in which ones you'd want people to get over standard dose, and should there be a three-tiered recommendation instead of two-tiered? That requires more data, which we didn't have this time. That's the work for this coming year. It's a great question, thank you for asking.

L.J Tan (NAIIS): Dr. Savoy, that's a great answer too, because what you just walked through is what would typically happen in an ACIP [Advisory Committee on Immunization Practices] working group followed by an ACIP meeting — the rationale behind that discussion. I wish there were more ways to get this kind of discussion process out for people to see, because it highlights how you came to your decision.

Q: Did VIP review any long COVID related studies and the impact of COVID-19 vaccine on preventing long COVID?

Angela Ulrich (VIP): Sure, good question. We did review studies for the long COVID outcome — we identified three studies. I'd encourage you to look at our data tool and click

through to each of the three studies to review them yourself. You can find details of the specific studies that assessed these outcomes using our online tool and entering "PASC" into the search box: https://vaxintegrity.cidrap.umn.edu/2026-27-respiratory-season.

Q: What was the evidence rationale for reverting to two doses of NUVAXOVID® for vaccine-naive recipients when that stopped being recommended last season by CDC [Centers for Disease Control and Prevention] due to a priming dose no longer being necessary as a result of high levels of population priming through prior infection? Last season, Nuvaxovid was recommended and administered as a single dose for all age-eligible recipients regardless of vaccination history (except if immunocompromised). AAP now recommends only one dose. Could you explain ACOG's decision on that?

Kim Fortner (ACOG): Thank you so much for the question; it is certainly open for discussion. Our recommendations were presented last night in a separate webinar, where we reiterated some of the changes. Currently, ours does recommend at this point that NUVAXOVID be administered as a two-dose series as the primary series, rather than the one-dose update — but I'll take that discussion point back to our group.

Q: Can you provide more information about the discussion to recommend a COVID-19 vaccine for children 2–18 without an identified risk group, if the parent or guardian requests vaccination?

Sunnah Kim (AAP): Yes — thank you for the question. Just a reminder, this isn't a new recommendation; it's the same one AAP issued last year. Our committee and subject matter experts felt that the data on hospitalization rates in the 2-to-18 age group didn't justify a universal recommendation for that age group. That said, there's recognition that every family's situation is different, and there could certainly be people living with other family members who are at high risk for severe illness, etc.

So our guidance was written to still provide a pathway for those who want to receive a COVID vaccine to be able to get one. That's why the language is the way it is. Overall, vaccination rates in the pediatric population, especially in this age group, are really low, and for pediatricians in the field, some of these conversations have been extremely challenging. But ultimately the vaccine is safe, and our experts felt that those who wanted it should be able to receive it.

L.J Tan (NAIIS): Again, these are the things that would come up in an ACIP meeting, and it's a shame we don't have that venue right now, and thanks for the explanation.

Q: Last year AAFP made recommendations for immunocompromised individuals recommending two doses [of COVID-19 vaccine], and IDSA has this year moved to saying one dose for immunocompromised. How did IDSA arrive at that?

Jon Heald (IDSA): We're recommending vaccination, and we have a remark under the recommendation that a second booster dose — that's the language we've used, and we're

working to potentially refine it — may extend protection. We're providing that as a remark so clinicians are aware. Really, what the panel has discussed is that immunocompromised patients' immune response can be highly variable, and when they can get vaccinated may depend on things like what treatments they're undergoing. So we've included a remark to note that a second dose can extend protection, allowing clinicians to make that decision. We're not settling on a single dose — our recommendation is vaccination generally, with that remark noting a second dose is still a potentially good option. It sounds like this is something I can take back to our panel, and we can provide additional clarity in our guideline.

Q: What about the self-attestation language in the IDSA document that says if you self-identify as immunocompromised, you're eligible for COVID-19 vaccination? In the past, people who've traditionally identified as immunocompromised [were] people with diabetes, cardiovascular disease, COPD [chronic obstructive pulmonary disease], etc., and they've been asked to self-identify and get two doses. But your recommendation has very clear subgroups you recommend for two doses. Can you speak to that a bit?

Jon Heald (IDSA): Our guidelines focus on some very specific subgroups. We've outlined those at the top, in the introduction, and in the table itself. Some groups that may have traditionally been covered under "immunocompromised," like COPD patients or transplant recipients, we did not include in our recommendations — those are covered by other groups. So I don't know that I have a good answer to your question. I'll take that back to the panel and see if I can get some clarity.

Q: Since IDSA said they didn't consider these previously identified immunocompromised groups — people with cardiovascular disease, diabetes, COPD — who were recommended last year for two COVID-19 vaccine doses, is that something AAFP addressed this year?

Margot Savoy (AAFP): I don't think we re-discussed it in this current update — I'd have to go back and check our schedule to tell you whether it changed. I don't think our schedule actually changed from still recommending two doses; I think it says something like, "You can consider two doses in people at high risk," but I'd have to look at the exact language, because this was a challenging space for us — similar to the other issue we discussed.

There are groups of people we think have higher risk of hospitalization or mortality, but we don't necessarily have strong studies showing you need two doses versus one — nobody's done that randomized controlled trial. So you're trying to figure out who would actually need and benefit from that, which is difficult. It's similar to the 65-and-older two-dose situation. When we didn't do the second dose, we saw reinfections and spikes in the second half of the season, so we said, "Do it." We don't have a study showing we no longer need to do it, but we also don't have a great study showing we should — so you're using clinical judgment to decide what makes sense for the patient. The spacing for a second COVID dose is generally always 6 months or more. I don't know that we have data that would change that either. I just saw the other question pop up [in the chat].

L.J Tan (NAIIS): Thank you, Dr. Savoy. Perhaps that's something we can follow up on offline with both AAFP and IDSA, because it sounds like this population that was messaged last year as high-risk for two doses is now left hanging: people with diabetes, COPD, cardiovascular disease — unless we refer back to AAFP's guidance from last year. So maybe this is something we need to talk through so we can have a good, consistent message for that population.