



Immunize Weekly Summary: October 8, 2026 Legislative Policy Update

- Respiratory Virus Vaccination Coverage, 2025–26 Season: Centers for Disease Control and Prevention (CDC)
- Adult and Maternal Vaccination in the United States: IQVIA

Respiratory Virus Vaccination Coverage, 2025–26 Season – Carla Black, PhD, Lead, Influenza and Adult Coverage Assessment Team, Surveillance and Epidemiology Branch, CDC

Carla Black, PhD, summarized key findings on vaccine coverage from the most recent respiratory virus season, drawing on various CDC surveys.

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Drawing on the National Immunization Survey – Fall Respiratory Virus Module, Behavioral Risk Factor Surveillance System, Pregnant Women Internet Panel Survey, Health Care Personnel Internet Panel Survey, and Omnibus Survey, CDC assessed trends in vaccination coverage by age, race, ethnicity, income level, and geographic location.

Overall Population

- Influenza vaccination among adults (42%) and children (52%) was similar or slightly higher in 2025–26 compared with the previous season, but remains below pre-pandemic coverage.
 - Those living in urban and suburban areas are much more likely to be vaccinated than those in rural areas, especially children.
- COVID-19 vaccination coverage has decreased since the previous season and hesitancy has increased, especially among those age 65 years and older.
 - Coverage among children remains low, and hesitancy has increased.
- Respiratory syncytial virus (RSV) vaccination coverage is about 43% for adults age 75 years and older and about 33% for adults ages 50–74 years with high-risk conditions.
 - Coverage is lowest among those with no insurance and those with low income.

- Black and Hispanic people have lower coverage rates than people of other races or ethnicities but also express less vaccine hesitancy than White people.
- In adults age 74 and younger, those in urban and suburban areas are more likely to be vaccinated than those in rural areas.

Special Populations

- Influenza vaccination coverage among pregnant women was about 50% in 2025–26, similar to the previous season, but remains below the 2020–21 season.
 - Tetanus, diphtheria, and pertussis (Tdap) coverage among pregnant women was 45% in 2025–26, generally consistent with previous seasons.
 - Tdap and influenza vaccination coverage among pregnant women are both about 10 percentage points below peak pre-pandemic coverage.
- Influenza vaccination coverage among health care personnel (HCP) was about 74% overall.
 - Coverage remains highest among HCP working in hospitals (84%), but coverage in hospitals is about 10 percentage points lower than peak coverage.
 - Coverage is lowest among HCP in long-term care settings and lower than previous seasons (62%).
- Overall COVID-19 vaccination coverage is about 35% for all HCP and about 29% for pregnant women. In both populations, coverage decreased slightly compared with the prior season.

Intent to Vaccinate

- Data on intent to vaccinate suggest that influenza and COVID-19 vaccine coverage will be similar to last season, or possibly slightly lower for COVID-19.
- RSV vaccination coverage is not expected to increase meaningfully.
- The most common concerns about vaccination differed by vaccine:
 - Influenza: Not worried about getting sick
 - COVID-19: Concern about serious side effects
 - RSV: Lack of information about the vaccine or no provider recommendation

In all surveys, a portion of respondents say they will probably get vaccinated or are unsure. CDC refers to them as the “movable middle”—that is, people who might get vaccinated if vaccines were more accessible, for example. CDC anticipates posting new data for the current season starting at the end of November on its [RespVaxView website](#).

QUESTIONS & ANSWERS

Q: In the past, CDC used to look at the HCP breakdown by profession. Are you seeing differences in that at all? Because those numbers are obviously going down.

Carla Black (CDC): Yeah, we do look at that. That report will come out soonish, I hope. We definitely see differences by profession. I don’t know the numbers off the top of my head, and I don’t think it’s changed much in past years. It’s always highest among doctors,

pharmacists, nurse practitioners, physician assistants, and nurses, and usually lowest among assistants and aides and non-clinical personnel.

Q: Because of the declines you report in hospitals, are we seeing a decline in the number of hospitals that have vaccination as a condition of employment?

Carla Black (CDC): You know, I'll come back to you with that answer. I know for COVID that's definitely true, and I know the percent of hospitals and other facilities that offer on-site vaccination for COVID has decreased a lot. I'm not sure if that's true for flu or not, so let me get back to you on that.

Q: Do the health care professional vaccine data distinguish between professionals serving in rural areas versus urban areas?

Carla Black (CDC): They do, and like everything else, it is lower in the rural areas, though I don't think the differences are as large as in the general population. We are planning a report on that. It won't be in the *Morbidity and Mortality Weekly Report* this year; I think we're going to submit it to a journal and try for a preprint, so it will be out soon. Maybe in the next few weeks, those data will be published.

Adult and Maternal Vaccination in the United States – Nandini Selvam, PhD, MPH, Vice President & General Manager, IQVIA Government Solutions, Inc.

Nandini Selvam, PhD, MPH, described vaccine coverage findings from patient claims and retail sales data.

Drawing on patient-level data from public and private insurers as well as retail pharmacy sales data, IQVIA analyzed trends and gaps in vaccine uptake (see the table).

Table: IQVIA Summary of Vaccination Trends*

Vaccine / Population	Current Momentum	Leading Segments	Gaps and Opportunities
Influenza	Uptake declined in MAT Jul'26	Adults 65+ continue to lead	Lower uptake among Black and Hispanic populations and some privately insured and higher-income groups

Shingles	Relatively stable, with modest improvement among ages 50–64	Adults 65+; rural populations outperform urban	Mature market, but continued opportunity to expand coverage among younger eligible adults
Pneumococcal	Ages 50–64 remain elevated following recent gains; 65+ continues a gradual decline	Adults 65+; rural populations	Follow the 50–64 trend after expanded eligibility and address declines among older adults
RSV, older adults	Uptake is lower than the prior season	Adults 75+; rural populations	Opportunity to improve uptake among younger eligible adults and publicly insured populations
RSV, maternal	Uptake improved across all maternal age groups	Women ages 35–49; urban and privately insured populations	Persistent gaps among Black, publicly insured, rural, and lower-income women
Tdap, maternal	Modest increase in MAT Jul'26	Privately insured women	Gaps remain by insurance, race, geography, and income
COVID-19	Uptake continues to decline across all age groups	Seniors and higher-income populations	Broad re-engagement is needed; rural uptake now slightly exceeds urban uptake

*MAT, moving annual total; RSV, respiratory syncytial virus; Tdap, tetanus, diphtheria, and pertussis
Source: IQVIA, Adult & Maternal Vaccination in the US (see link to slides above).

Cumulative Coverage

Annual vaccination rates show momentum and trends, but cumulative vaccination rates describe accumulated protection over time. For shingles vaccine, cumulative coverage is rising, particularly among those age 65 and older, but it is lower for people ages 50–59. People are not necessarily getting vaccinated for shingles when they become eligible. For pneumococcal vaccine, cumulative coverage increased thanks to expanded eligibility for people age 50 years and older, demonstrating the impact of new guidelines.

Because RSV vaccination is a one-time event, cumulative coverage is a more important index than annual vaccination rates. Through July 2026, the highest uptake was among those age 75 and older, followed by those ages 60–74.

Retail Data

Supply chain data gathered through September 11, 2026, are highly representative of outpatient pharmacy practices across the country and show COVID-19 vaccine uptake much higher than previous seasons at the same time of year, which might be related to availability

or possibly to new guidelines. There is also an encouraging increase in early influenza vaccination. Shingles, RSV, pneumococcal, and Tdap vaccine rates are lower than previous seasons.

Influenza vaccine uptake began earlier this season than previous seasons, starting in July rather than mid-August. Tdap and shingles vaccination rates are not tied to seasonal trends but do tend to be paired with other vaccines. Pneumococcal and RSV vaccine rates are lower than usual.

Policy Implications

The findings suggest that expanding recommendations alone is not enough: vaccination rates depend on effectively reaching those who are eligible. Efforts should focus on closing persistent gaps among populations with lower uptake. Maintaining cumulative progress protects existing gains. Timely data on coverage and administration can identify emerging gaps to address.

QUESTIONS & ANSWERS

Q: Why does IQVIA separate the shingles and pneumococcal vaccine data by 65-plus in some cases and 50-plus in others?

Nandini Selvam (IQVIA): It's basically how this data is broken out when we do these quick looks, so it's not reflective of what IQVIA's take is on the recommendations. It's done for ease, in the way I need to pull this together for these types of settings, where I can still keep the data recent and still show the flow. If this were a more detailed study that we pulled together, then we'd start to pull that apart and assess it.

Q: RSV is a one-time vaccine, so cumulative counts are actually more significant, but at the very beginning you also talked about this season being higher than the prior season. Does that mean you've accounted for the cumulative, for people who've already been vaccinated?

Nandini Selvam (IQVIA): The way we look at that one—and that's why I gave that asterisk up front, to say it's not technically annual—what we're doing is people age into it annually, and so that first one is showing you, amongst the eligible population, who went out this last year and received that vaccine. That's why those numbers look very different: we're looking at just the eligible, so if somebody's already been vaccinated, they don't count in that denominator, and when someone ages in, that denominator does go up. That's only talking about the behavioral dynamics year over year, as it relates to when we look at the other things on an annual basis.

Q: Are there data that break down maternal vaccination in the retail pharmacy versus the medical clinic setting—pregnant people getting vaccinated in retail pharmacy settings?

Nandini Selvam (IQVIA): No. That's actually a limitation of the data, because it's supply chain data that we're using for this purpose—that's not what it was meant for. There are some surrogate ways around it if we really wanted to look at it. We could say what proportion of the women in that age group are pregnant using our administrative claims data, and make some guesses along those lines—but no, it doesn't.

Q: It's interesting that vaccination, in this case influenza, is starting to pick up earlier compared to last year, given the confusion—no Advisory Committee on Immunization Practices [recommendations], the lack of CDC activation. The thought was that uptake would be slower. Any thoughts on why it's earlier? That's obviously caveated by the fact that even though it started earlier, the volume is lower.

Nandini Selvam (IQVIA): I don't know—I think it's a conversation to be had. I wonder if the confusion has led to some issues. I think there was also some concern around coverage, and what will be reimbursed, not reimbursed. We saw a little bit of this with COVID before the guidelines changed as well—we saw people getting COVID shots earlier—so I wonder if that's a little bit of it. But I haven't parsed it. I think it's certainly a conversation we should be having, and I wonder if one of Carla's next surveys will actually reflect this a little bit as well.

Carla Black (CDC): Yeah, maybe we can figure out a way to ask about that. I don't know off the top of my head why vaccination would be starting earlier. ... It is interesting, because I said during my presentation to take these with a grain of salt—we did have a lot of people say they're already vaccinated for flu, and I just assumed they're still thinking about last season, because it's still hot in the summer and people don't think about flu season already starting like we do. But maybe it's true.

Nandini Selvam (IQVIA): This is showing up in July, which is very unusual. If I go back even 3 or 4 years—because that's how long we've been doing some of these presentations for you—this is early by all measures.

Q: And there was speculation ... that maybe it's because the flu vaccine was available earlier this summer, but I don't think that's the case here.

Carla Black (CDC): For COVID, the Food and Drug Administration's approval of the vaccines and the shipping happened almost exactly the same day this season as last season. For flu, they pretty much always start shipping July 1. So I don't really know.

Q: CDC survey and Omnibus data—are you publishing that again?

Carla Black (CDC): I saw the question about notifying someone when things come out, and I can. On the RespVaxView link at the end of my slides, there will be the in-season coverage. There's actually data from some of the Omnibus [surveys] there, like the data on motivators and concerns about vaccination, which we publish monthly during the season. The rest of the

Omnibus data comes out in publications and such. There will be a publication about the HCP data coming out soon, but yes, I can notify you when things of interest come out.

Announcements

- Immunize.org offers all the available vaccine locator tools in one place on its Vaccine Information website (<https://www.vaccineinformation.org/vaccine-basics/vaccine-finder/>).