Global Respiratory Virus Activity
Weekly update for week 13, ending 29 March 2026
Update No. 572

GLOBAL INFLUENZA SURVEILLANCE AND RESPONSE SYSTEM (**GISRS**)

Co-circulation | Influenza | SARS-CoV-2 | RSV | Severity assessment

SUMMARY

Globally, influenza positivity was below 10% in week 13 2026. SARS-CoV-2 activity remained low overall. Influenza predominated and positivity was below 10% in the northern hemisphere temperate and subtropical areas and in tropical areas. In the southern hemisphere temperate and subtropical areas, influenza and SARS-CoV-2 positivity were both low. [Figures 1a, 1b, 1c and 1d] Globally, RSV positivity remained stable and low. Holidays in some regions may have affected surveillance and testing practices in week 13 2026.

❖ **Influenza**

Globally, influenza detections continued to decline in week 13 and influenza B viruses were predominant among influenza detections. [Figure 2]

In the northern hemisphere, influenza percent positivity was elevated (>10%) in single countries in North America, Northern and Eastern Africa and in countries in Northern and Eastern Europe, and Southern, Eastern and South-East Asia. Percent positivity was over 30% in countries in Central America and the Caribbean and in a single country in Western Africa. Small increases in activity were observed in single countries in Central America and the Caribbean, Northern, Western and Eastern Africa. [Figures 3 and 4]

In the southern hemisphere, influenza activity remained low overall although elevated positivity (>10%) was reported in single countries in Temperate and Tropical South America, Southern Africa and South-East Asia. Percent positivity was over 30% in one country in Tropical South America. Small increases were reported in single countries in Temperate South America and Southern Africa. [Figures 3 and 4]

In the zones with elevated positivity, influenza A(H3N2) was predominant in Central America and the Caribbean, Tropical and Temperate South America, Eastern Europe and Southern Asia. Influenza A(H1N1)pdm09 was predominant in Northern Europe and Southern Africa. Influenza B was dominant in North America, Western Africa, Eastern and South-East Asia. [Figures 5 and 6]

❖ **SARS-CoV-2**

Globally, SARS-CoV-2 positivity remained stable and low. A small increase was reported in one country in Central America and the Caribbean. [Figures 7 and 8]

❖ **Respiratory Syncytial Virus (RSV)**

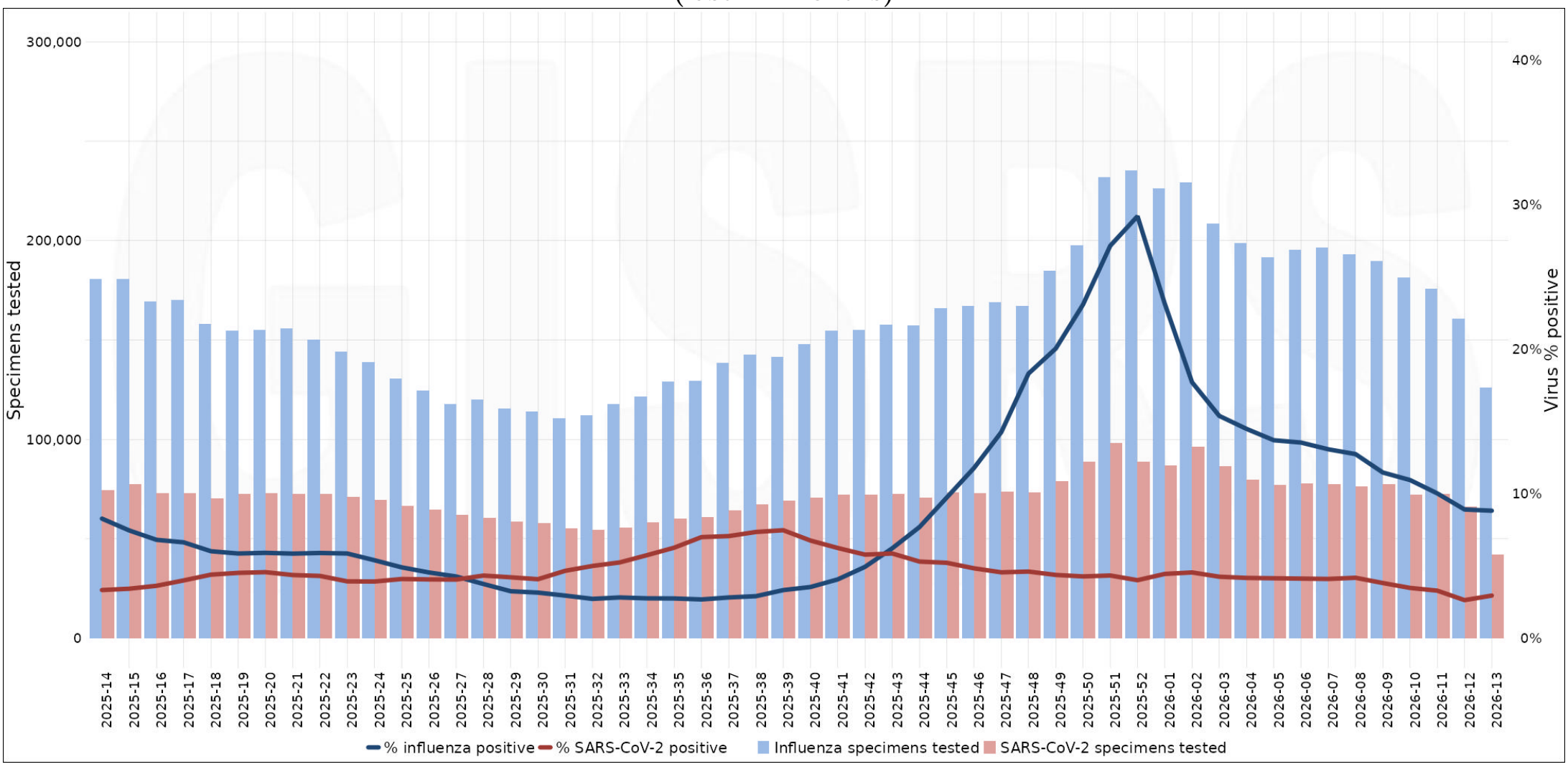
Globally, RSV positivity remained stable and low, with a few countries reporting elevated positivity (>10%) in Tropical South America, Europe and a single country in Northern Africa. Percent positivity was over 30% in a single country in Eastern Africa. Small increases in activity were reported in a few countries in Eastern Europe and a single country in Eastern Africa. [Figures 9 and 10] RSV and influenza activity were both elevated in a few countries in Europe.

❖ **Severity assessment**

The severity assessments here are reported from countries, areas and territories. Assessments for transmissibility can be reported based on syndromic parameters and/or influenza-specific parameters. In the northern hemisphere temperate and subtropical areas, influenza-specific transmissibility was reported as low in a single country; transmissibility using syndromic data was reported as below seasonal threshold and moderate in single countries. Influenza-specific transmissibility was reported as below seasonal threshold in a single country in the southern hemisphere temperate and subtropical areas and in a single country in the tropical areas. [Figures 11 and 12]

Co-circulation of influenza and SARS-CoV-2

1a) Weekly numbers of influenza and SARS-CoV-2 virus specimens tested and percent positivity at the global level (last 12 months)



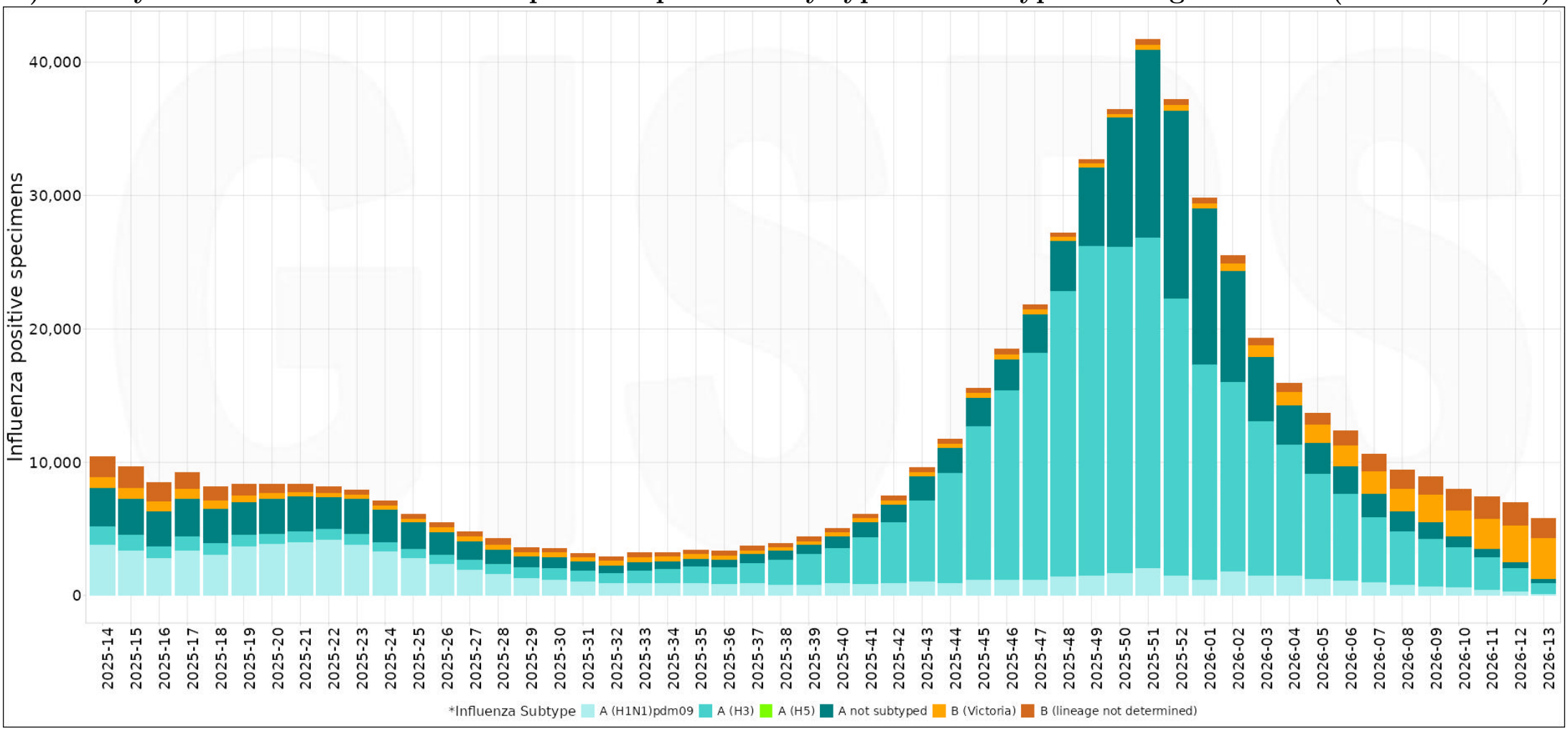
1b) Weekly numbers of influenza and SARS-CoV-2 virus specimens tested and percent positivity in northern hemisphere temperate and subtropical areas

1c) Weekly numbers of influenza and SARS-CoV-2 virus specimens tested and percent positivity in tropical areas

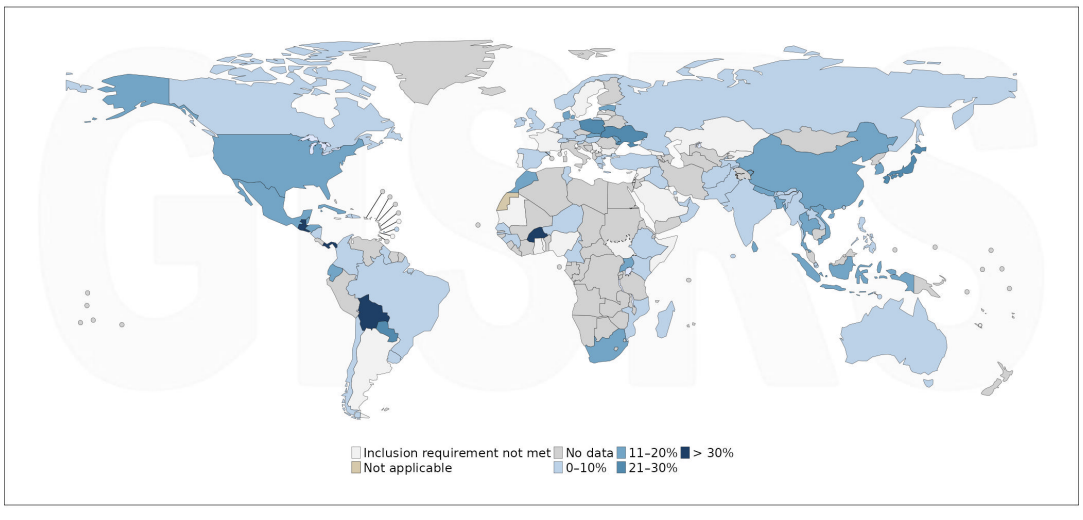
1d) Weekly numbers of influenza and SARS-CoV-2 virus specimens tested and percent positivity in southern hemisphere temperate and subtropical areas

Influenza

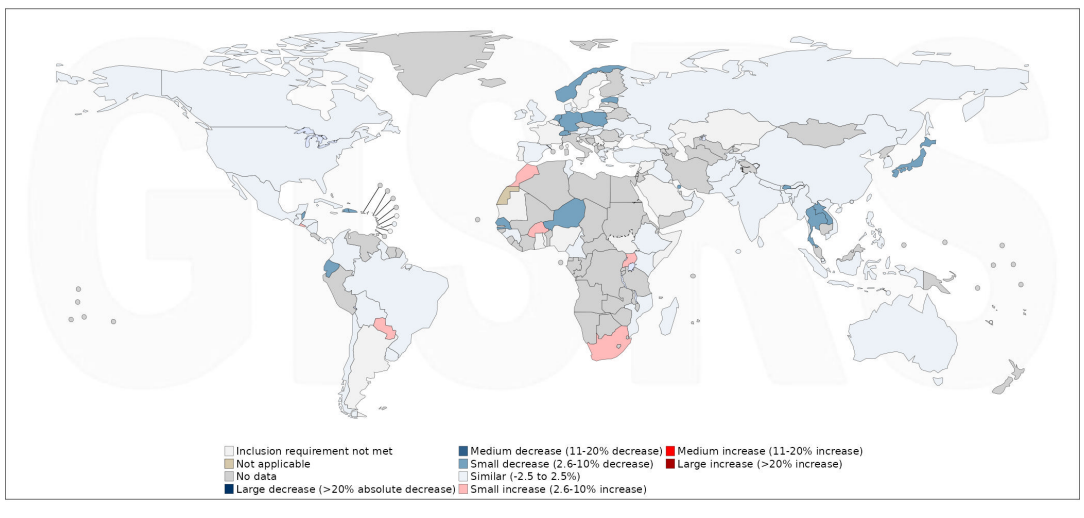
2) Weekly numbers of influenza virus positive specimens by type and subtype at the global level (last 12 months)



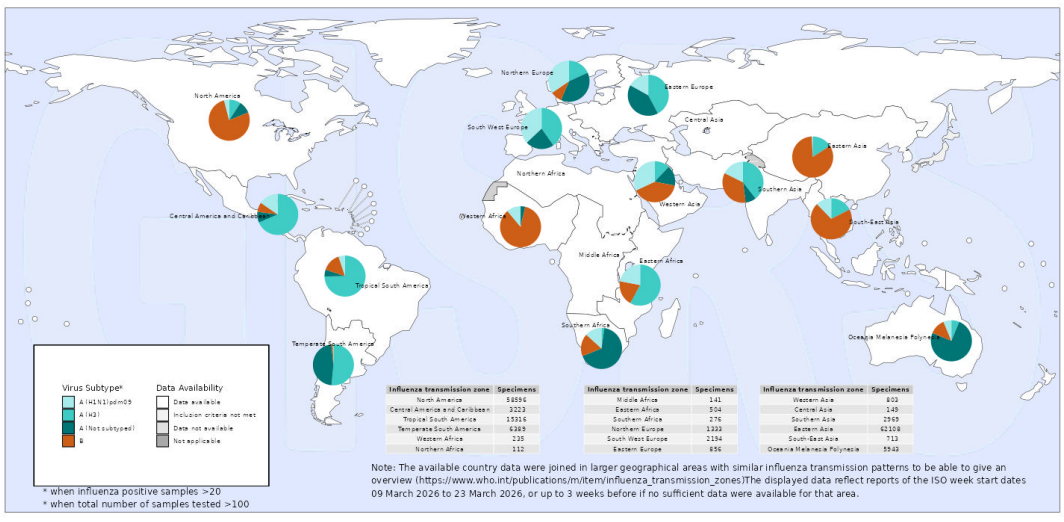
3) Proportions of specimens that tested positive for influenza (year-week: 2026-13)



4) Change in proportions of specimens that tested positive for influenza (year-week: 2026-13)



5) Proportions of influenza virus types and subtypes by influenza transmission zones (year-week: 2026-13)

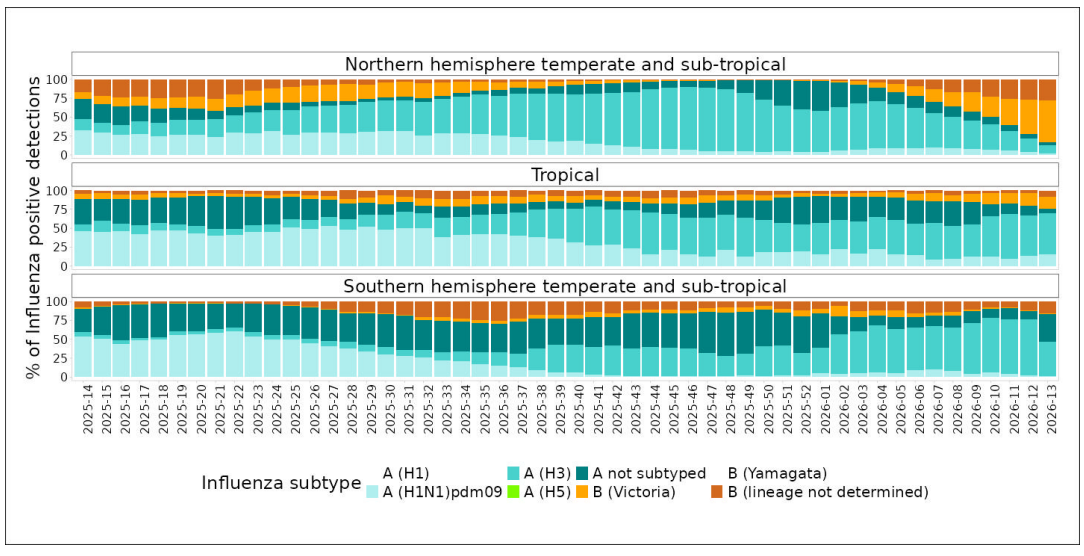


Influenza transmission zone	Specimens
North America	58596
Central America and Caribbean	3223
Tropical South America	15316
Temperate South America	6365
Western Africa	235
Northern Africa	112

Influenza transmission zone	Specimens
Middle Africa	141
Eastern Africa	504
Southern Africa	276
Northern Europe	1222
South West Europe	2194
Eastern Europe	656

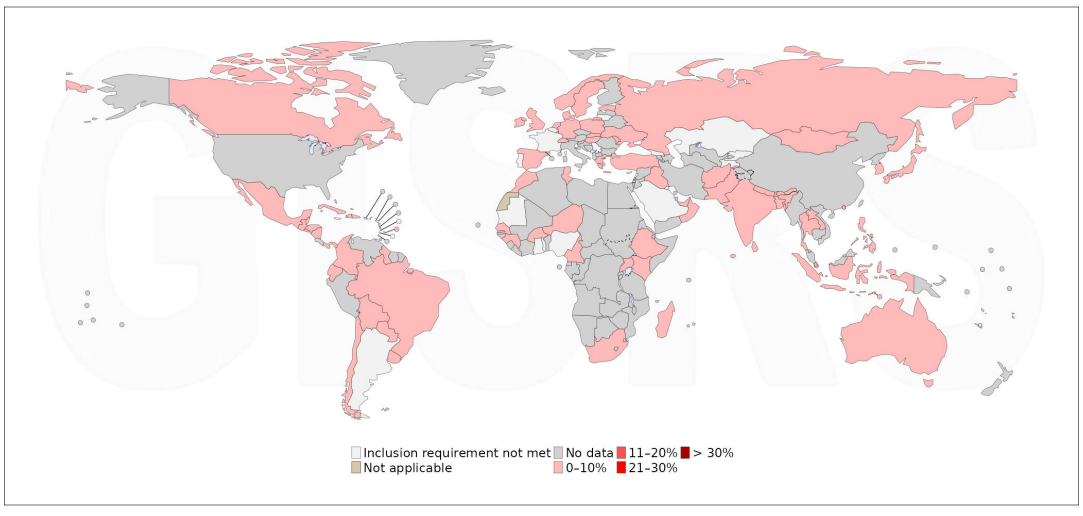
Influenza transmission zone	Specimens
Western Asia	803
Central Asia	149
Southern Asia	2363
Eastern Asia	62108
South-East Asia	713
Oceania Melanesia Polynesia	5943

6) Weekly distribution of influenza virus types and subtypes by geographic zone (last 12 months)

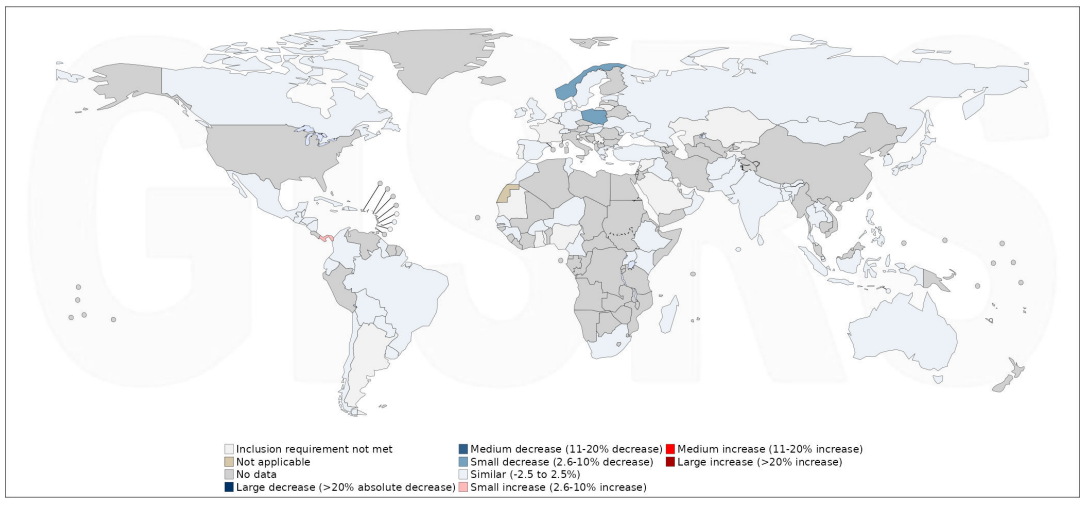


SARS-CoV-2

7) Proportions of specimens that tested positive for SARS-CoV-2 (year-week: 2026-13)

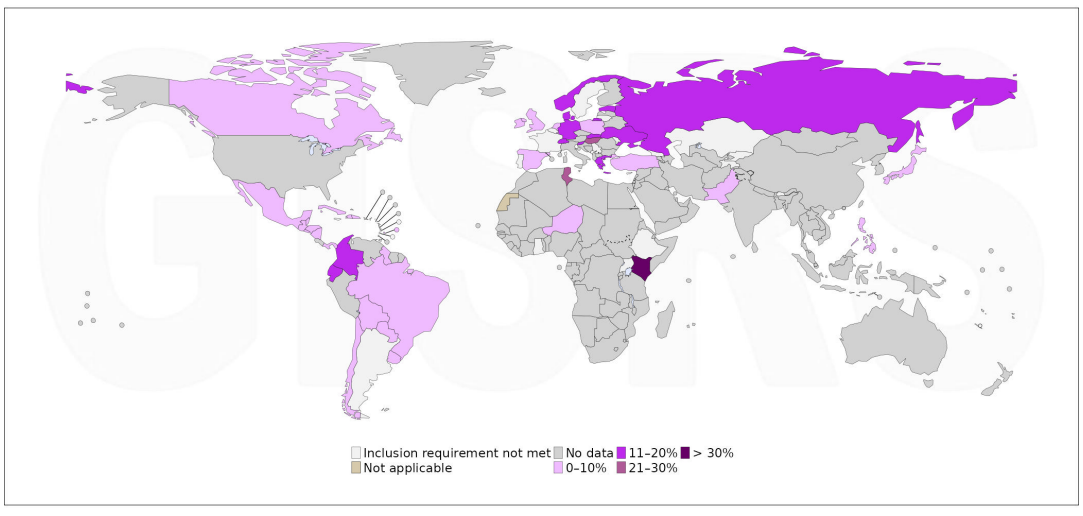


8) Change in proportions of specimens that tested positive for SARS-CoV-2 (year-week: 2026-13)

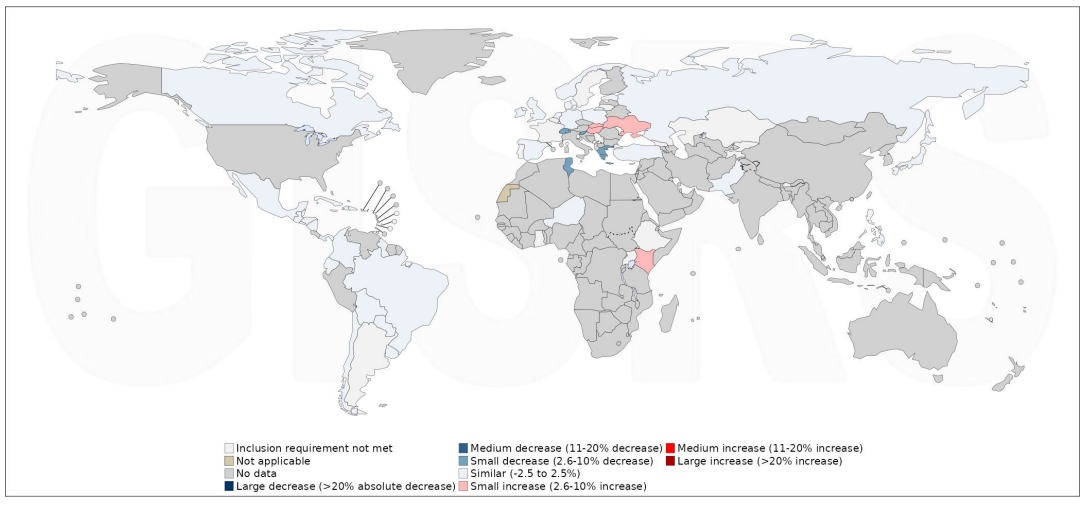


Respiratory syncytial virus

9) Proportions of specimens that tested positive for RSV (year-week: 2026-13)

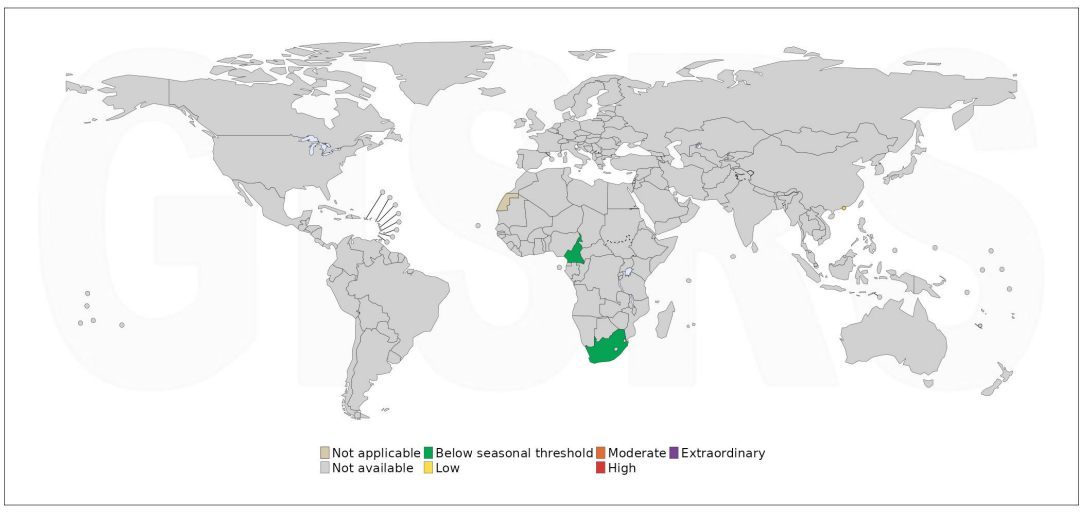


10) Change in proportions of specimens that tested positive for RSV (year-week: 2026-13)

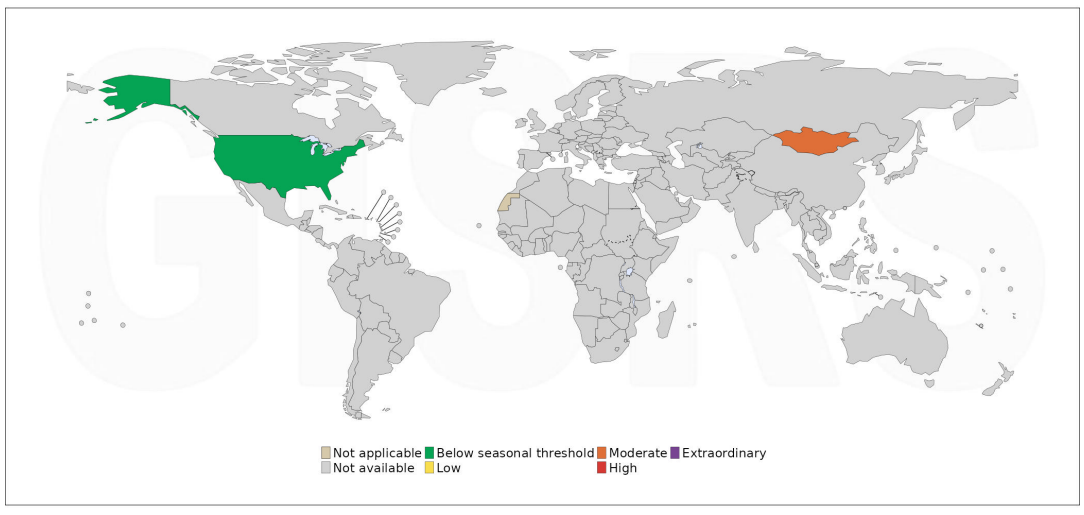


Severity assessment

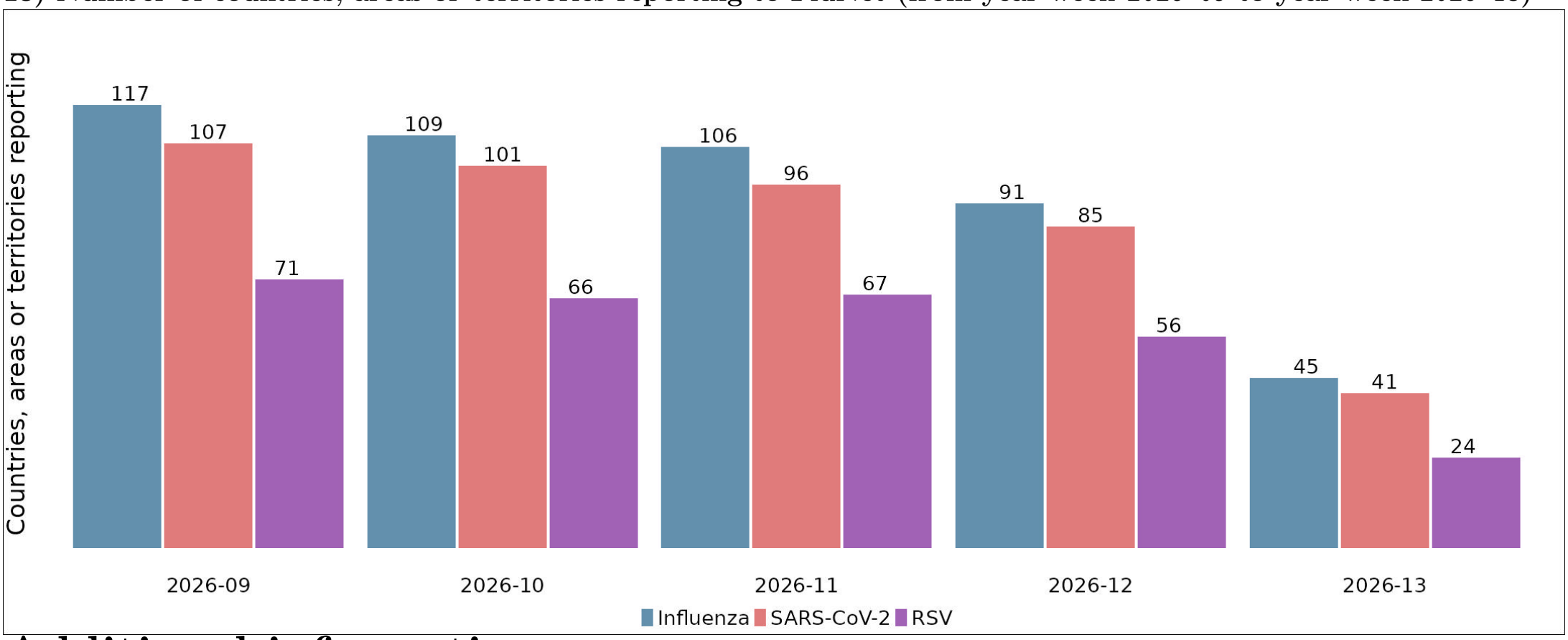
11) Influenza specific transmissibility (year-week: 2026-13)



12) Syndromic transmissibility (year-week: 2026-13)



13) Number of countries, areas or territories reporting to FluNet (from year-week 2026-09 to year-week 2026-13)



Additional information

Data and methods
The data presented in this report originates from virologic surveillance conducted by countries, areas, and territories (CATs) and submitted to WHO FluNet through participation or collaboration with the Global Influenza Surveillance and Response System (GISRS). These CATs employ diverse methodologies to monitor respiratory virus activity, which may result in variations between this report and other surveillance summaries published elsewhere.

This report includes virologic data from both **sentinel surveillance and other systematically conducted surveillance**. Due to differences in surveillance strategies, direct comparisons of percent positivity between CATs should be interpreted with caution. The data source used for each CAT was decided jointly corresponding with WHO Regional Offices and the respective reporting entity. The completeness of data reporting to FluNet changes over time and countries may revise data reported for previous weeks.

To assess trends, the proportion of specimens tested positive for influenza or SARS-CoV-2 was smoothed over a 3-weeks period. This analysis includes only countries that tested 10 or more specimens in at least two of the three weeks. Weekly changes in the smoothed positivity rate for each virus were calculated as absolute differences from the previous week. These absolute changes were categorized and visualized in the proportion change maps. Analyses stratified by source of surveillance are available through RespiMart.

The influenza transmission zones map is based on data aggregated over a 3-weeks period, moving backward from the current week until a minimum threshold of 100 tested samples is reached within each influenza transmission zone. Pie charts are displayed on the map only if the total percent positivity in a influenza transmission zones map is 20% or higher. All trend analyses are based on ISO 8601 calendar week numbering.

Activity summaries are organized by geographical groupings of CATs. These groupings are intended solely for geographic reference and do not imply uniformity in respiratory virus transmission patterns within each group. It is important to note that specimens tested for influenza, SARS-CoV-2, and RSV may not originate from the same sample sources within surveillance systems.

Severity assessments:
The severity assessments here are reported from countries, areas and territories. WHO's Pandemic influenza severity assessment (PISA): a WHO guide to assess the severity of influenza in seasonal epidemics and pandemics, 2nd ed outlines the methods for which countries, areas and territories can derive these severity assessments. Assessments for transmissibility can be reported based on syndromic parameters and/or influenza-specific parameters.

Countries, areas and territories may not provide assessments year-round. The assessments may be revised over time if there is retrospective/delayed reporting or updating of previously reported data. These assessments are made in the context of historical data from the country making the assessment and thus are not comparable between countries. Assessments may differ between countries, areas and territories because differences may exist in the circulating seasonal influenza viruses, the timing of the outbreaks or epidemics, the populations and surveillance systems and the underlying data and methods used to assess severity.

The quality and consistency of influenza surveillance data are influenced by changes in health seeking behaviours, routines in sentinel and non-sentinel sites, national testing priorities and capacities, and public health and social measures implementation. Differences between information products published by WHO, national public health authorities and other sources are to be expected and must be interpreted carefully.

More severity assessment information and outputs can be found here.

Suggested citation: Global respiratory virus activity: weekly update No 572 (week 2026-13). Geneva: World Health Organization; 2026; Licence: CC BY-NC-SA 3.0 IGO.

Additional surveillance outputs:
WHO Influenza Surveillance Outputs
Contact: fluupdate@who.int or Click here to subscribe to the mailing list.

Summary was generated by the WHO Global Influenza Programme based on data last updated in RespiMart on April 07 2026 06:28:02 AM UTC