HAWAII STATE DEPARTMENT OF HEALTH
DISEASE OUTBREAK CONTROL DIVISION

Influenza/Respiratory Disease Surveillance Report

Morbidity and Mortality Weekly Report (MMWR)[1]

WEEK 40: SEPTEMBER 28, 2025– OCTOBER 4, 2025

OVERVIEW: The Hawaii State Department of Health (HDOH) monitors influenza and other respiratory pathogens, including COVID-19, throughout the state of Hawaii. Influenza surveillance in the state of Hawaii relies upon selected sentinel health practitioners, the State Laboratories Division (SLD), private laboratories, and the Office of Health Status Monitoring (OHSM). For detailed information concerning influenza, please visit the HDOH Disease Outbreak Control Division (HDOH DOCD) website (*here*). **All data and information are conditional and may change as more reports are received.** The data in this report reflect the 2025-2026 influenza season which began the week ending October 4, 2025 (week 40[1] 2025) and will end the week ending on October 3, 2026 (week 39 2026).

REPORT SNAPSHOT FOR WEEK 40

Surveillance for Influenza-like Illness (ILI)		
Metric	*Value*	*Comment*
Outpatient visits related to influenza-like illness (ILI) from ILINet Sentinel Providers	2.1%	Lower than the previous week. Comparable to the Hawaii's historical baseline and lower than the national baseline. Comparison to national ILI rate is unavailable at this time.
Number of ILI clusters reported to HDOH	0	There have been 0 clusters this season.

Laboratory Surveillance		
Percent of all respiratory specimens positive for influenza this week	2.0%	Lower than the previous week. This number means that many, if not all, of the 98.0% who tested negative for influenza had illness from another respiratory etiology.
Percent of all respiratory specimens positive for influenza this season to date	2.0%	

Surveillance for Severe Outcomes		
Pneumonia, influenza and COVID-19 (PIC) mortality rate		No new report for PIC mortality rates is available this week due to a pause in data updates from the National Vital Statistics System (NVSS).
Number of influenza-associated pediatric deaths reported nationwide		0 influenza-associated pediatric deaths have been reported from Hawaii this season to date.

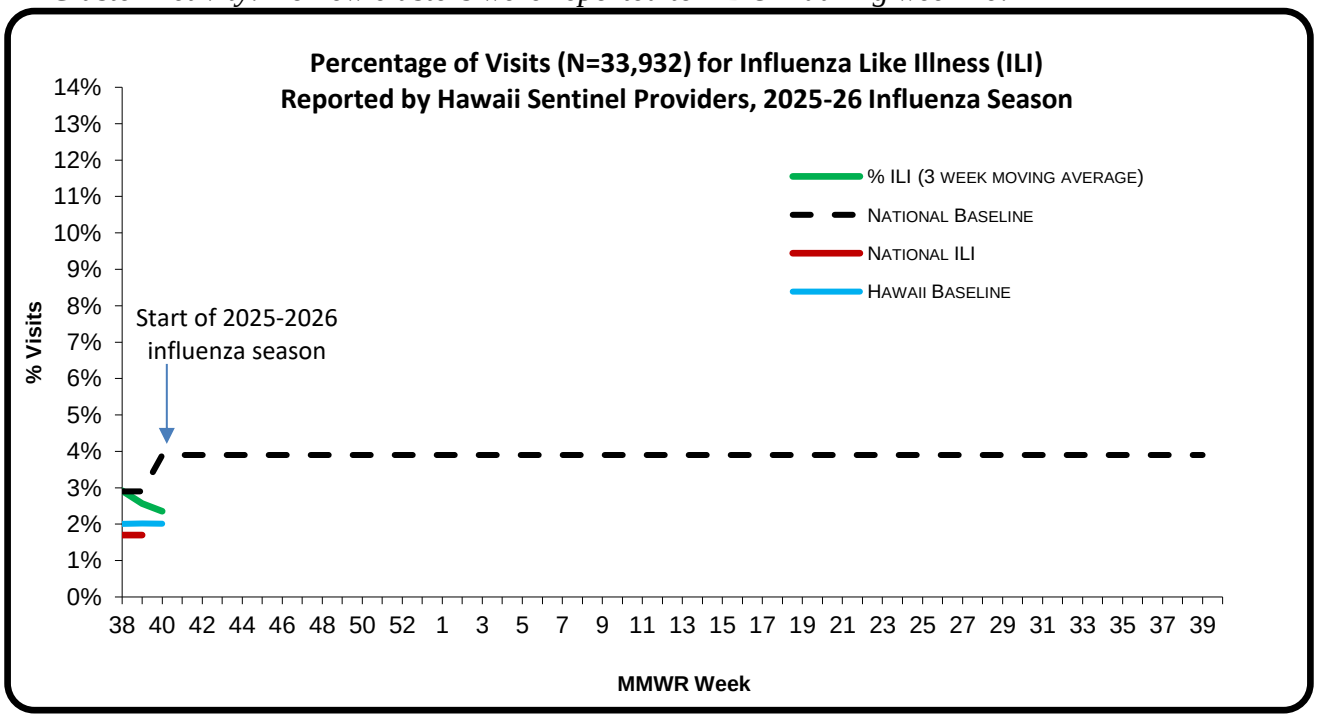
[1] MMWR stands for "Morbidity and Mortality Weekly Report," conventionally used by the Centers for Disease Control and Prevention (CDC). The weeks of a flu season are often referred to by their respective MMWR week. **See appendix 2 for interpretation of MMWR weeks.** Data reported will begin on week 40, the traditional start date of flu season.

INFLUENZA SURVEILLANCE

I. INFLUENZA-LIKE ILLNESS (ILI): HDOH collaborates with recruited doctors and healthcare providers who report the total number of outpatient visits for ILI as well as the total number of patients who complained of symptoms consistent with an ILI. A patient with ILI must have the following: a fever (temperature of 100°F [37.8°C] or greater) AND a cough and/or a sore throat. ILI is based on reported symptoms and not laboratory confirmed tests; thus, ILI may represent other respiratory pathogens and not solely influenza. Further, sentinel providers report these numbers on a weekly basis; therefore, data are preliminary and may change depending on additional reporting. In combination with laboratory testing and other surveillance systems, ILI surveillance helps monitor influenza and other respiratory pathogen activity. For more information concerning ILINet and sentinel requirements, please visit the CDC website (*here*).

For **week 40** of the current influenza season:

- ***2.1**% (season to date: **2.1**%) of the outpatient visits recorded by Hawaii sentinel providers were for ILI.*
- *ILI visits were comparable to the historical baseline in Hawaii[2,3] (i.e., inside the 95% confidence interval).*
- *Hawaii's ILI outpatient visits were lower than the national baseline (**3.1%**)[4] (i.e., outside the 95% confidence interval). Comparison to national ILI rate is unavailable at this time.*
- *ILI activity level: Low[5]*
- *Geographic Spread: Sporadic Activity[6].*
- *ILI Cluster Activity: No new clusters were reported to HDOH during week 40.*



[2] The Hawaii historical baseline (%ILI) is the average of 3-week moving averages over the preceding 10 flu seasons of historical data (2015-2016, 2016-2017, 2017-2018, 2018-2019, 2019-2020, 2020-2021, 2021-2022, 2022-2023, 2023-2024 and 2024-2025).

[3] This value is based upon comparison of actual outpatient ILI with the historical baseline, which only captures outpatient ILI. The chart above represents a 3-week moving average and not the actual ILI by week.

[4] The National Baseline is calculated by CDC as the mean percentage of visits for ILI during weeks 21–39 with two standard deviations. Because of large variability in regional ILI, comparison of the national baseline with local ILI may not be appropriate. It is provided in this report because no meaningful regional baselines are available for comparison. The national baseline combines all data reported by states to CDC, including ILI in outpatient, ER, urgent care, and inpatient settings.

[5] There are 10 activity levels classified as minimal (levels 1-3), low (levels 4-5), moderate (levels 6-7), and high (levels 8-10).

[6] The influenza activity reported by state and territorial epidemiologists indicates geographic spread of influenza viruses but does not measure the severity of influenza activity. Sporadic: no clusters reported to HDOH, Local: one or more clusters reported in one county, Regional: clusters reported two to three counties, Widespread: clusters reported in all counties. Hawaii does not report No Activity, as flu circulates year-round in Hawaii.

II. LABORATORY SURVEILLANCE: State Laboratories Division (SLD; the HDOH public health laboratory) and Hawaii's major private laboratories (DLS, CLH) report results of RT-PCR, which can be considered confirmatory (SLD may perform viral culture on select specimens). Specimens meeting priority criteria[7] are forwarded to SLD for sub-typing. Additionally, specimens meeting case definition from requesting sentinel providers are sent directly to SLD for sub-typing. Due to resource constraints, not all submitted specimens undergo sub-typing. Sub-typing at the commercial laboratories is only conducted on a case-by-case basis. The majority of specimens testing positive by rapid antigen testing or RT-PCR at the commercial laboratories do not meet criteria and are not subtyped. For more information on influenza tests and types, please visit the CDC website (*here*).

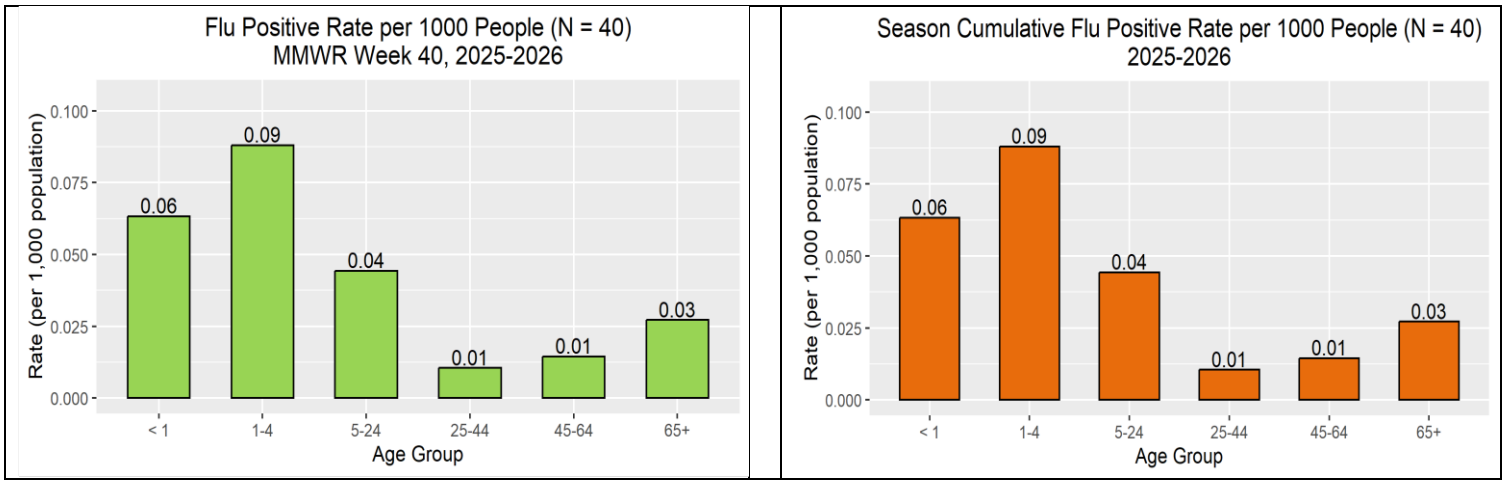
A. INFLUENZA:

- The following reflects laboratory findings for week 40 of the 2025–26 influenza season:
  - *A total of **2,028** specimens have been tested statewide for influenza viruses (positive: 40 [**2.0%**]). (Season to date: **2,028** tested (**2.0%** positive])*
    - *969 (47.8%) were screened only by rapid antigen tests with no confirmatory testing.*
    - *1,059 (52.2%) underwent confirmatory testing (either RT-PCR or viral culture).*
    - *1,988 (98.0%) were negative.*

Influenza type	*Current week 40 (%)*	*Season to date (%)*[8]
Influenza A (H1)[9]	*1 (2.5)*	*1 (2.5)*
Influenza A (H3)	*0 (0.0)*	*0 (0.0)*
Influenza A no subtyping	*35 (87.5)*	*35 (87.5)*
Influenza B (Yamagata)	*0 (0.0)*	*0 (0.0)*
Influenza B (Victoria)	*0 (0.0)*	*0 (0.0)*
Influenza B no genotyping	*4 (10.0)*	*4 (10.0)*

1. AGE DISTRIBUTION

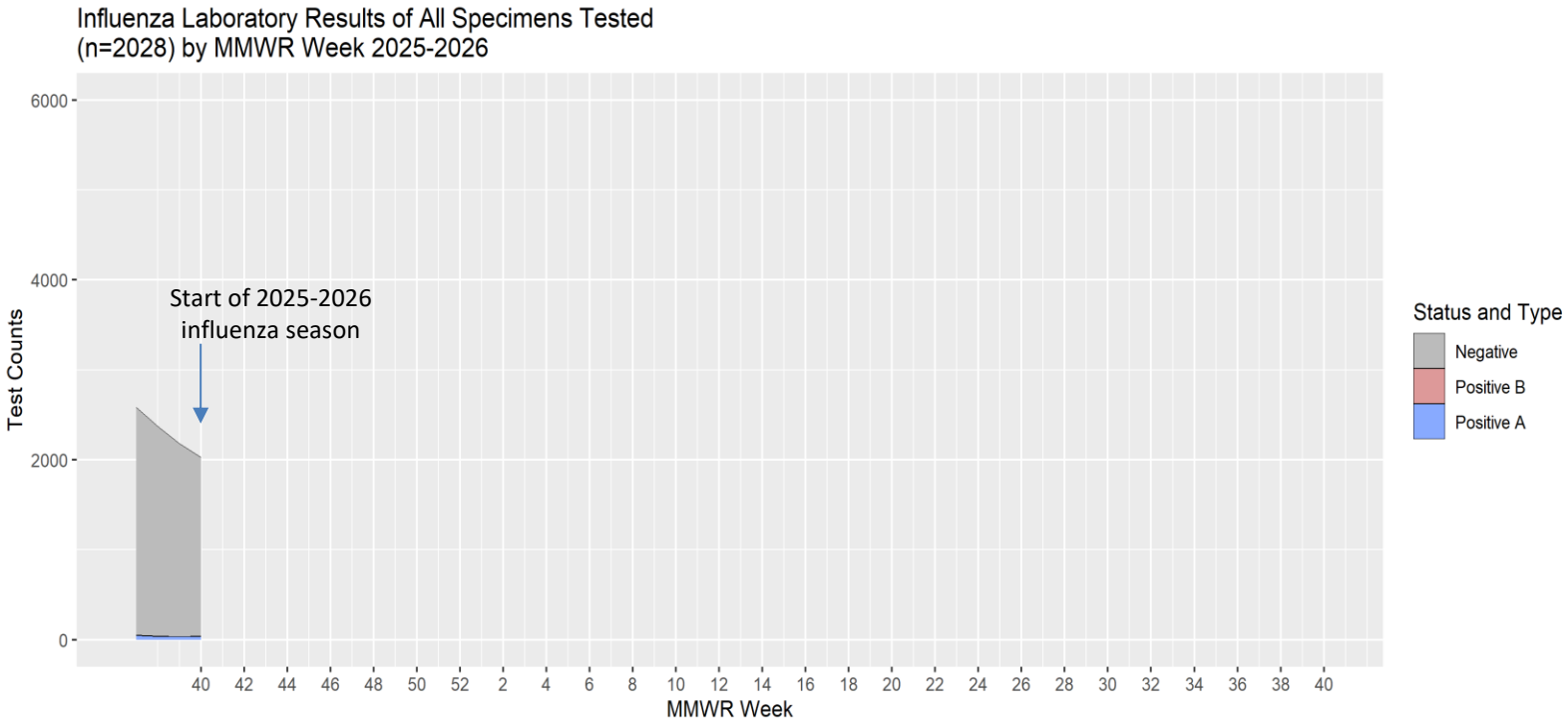
The charts below indicate the population-based rates of positive influenza cases in Hawaii by age group during the 2025–26 influenza season.[10]

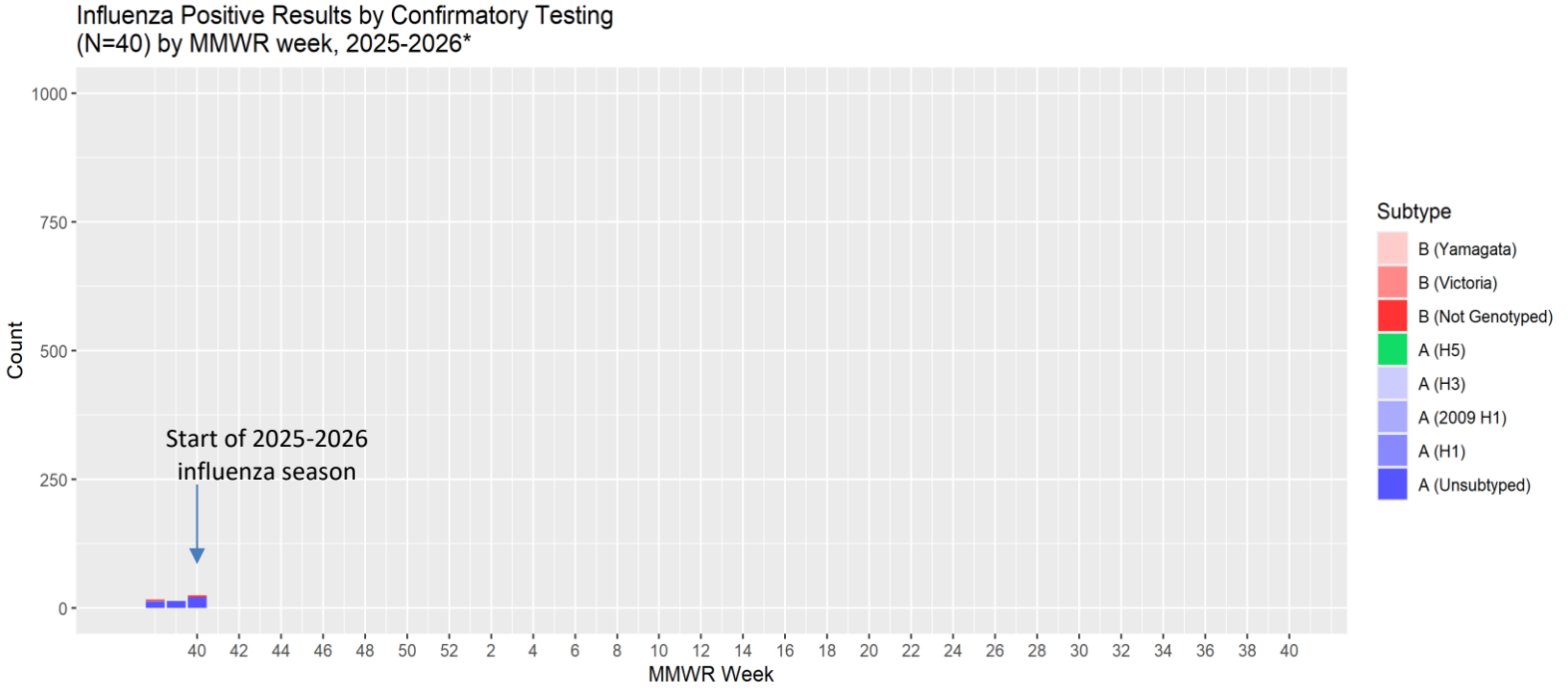


[7] Priority criteria include: hospitalized patients with acute respiratory distress syndrome [ARDS] or x-ray confirmed pneumonia; travelers with international travel history within 10 days of onset; specimens submitted by sentinel providers; specimens collected from healthcare workers, pregnant women, or women up to 6 weeks' post-partum; those with underlying medical conditions; and patients presenting with unusual or severe manifestations of influenza infection.
[8] Influenza coding were updated to reflect a more accurate count.
[9] All influenza A H1 viruses detected this season have been 2009 H1N1.
[10] This represents an estimate of population-based rates based on available data.

2. LABORATORY TESTING

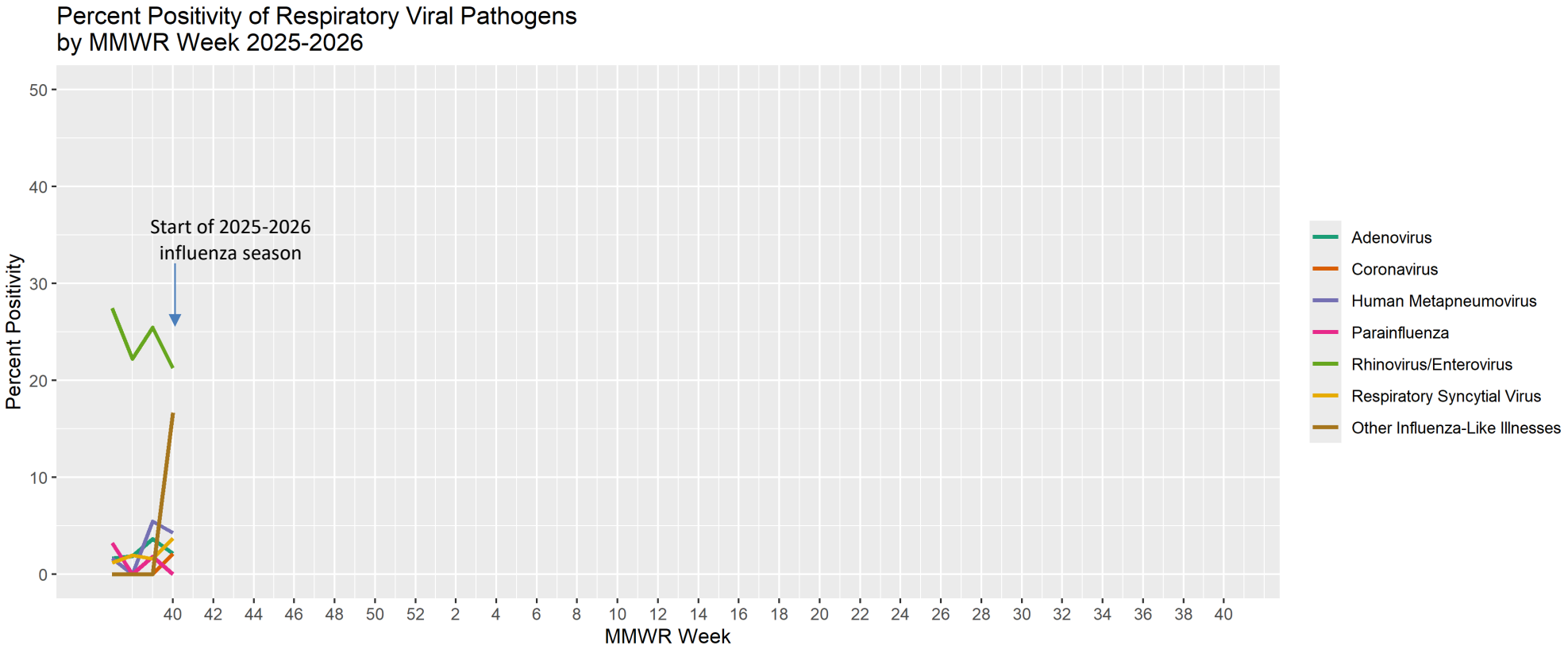
The charts below show the laboratory results of all specimens tested for influenza by MMWR week during the 2025–2026 influenza season as well as the type and subtype of positive results for influenza. Again, sub-typing is only performed on selected specimens tested by confirmatory tests (i.e., RT-PCR or viral culture).





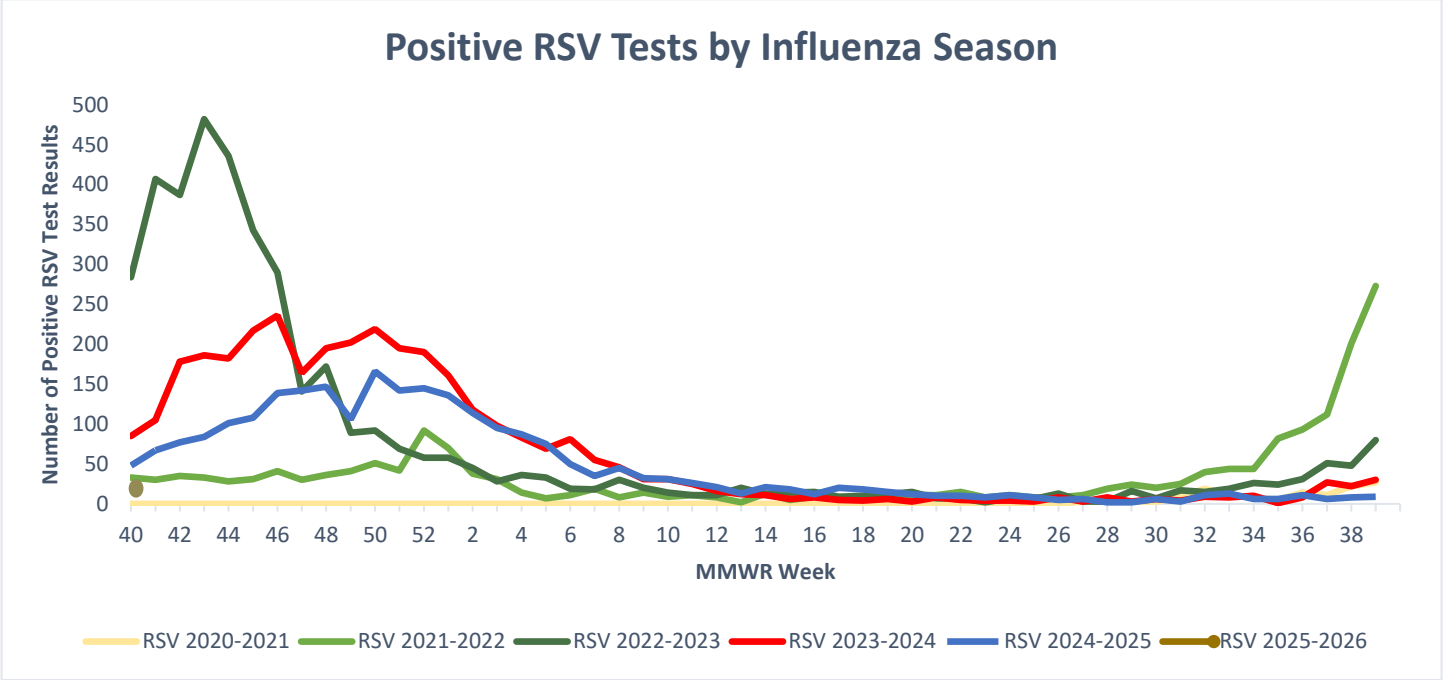
** A total of 1,059 specimens underwent confirmatory testing but not all positive influenza specimens receive confirmatory testing that are circulating in Hawaii.*

B. OTHER RESPIRATORY PATHOGENS: The major clinical and commercial laboratories throughout the state of Hawaii have the testing capacity for non-influenza respiratory pathogens and report these to HDOH. However, such testing is performed as needed and when sufficient resources are available because of the high costs associated with respiratory panel tests. **Therefore, available data represent only the presence of circulating pathogens and cannot be used to determine specific trends**.

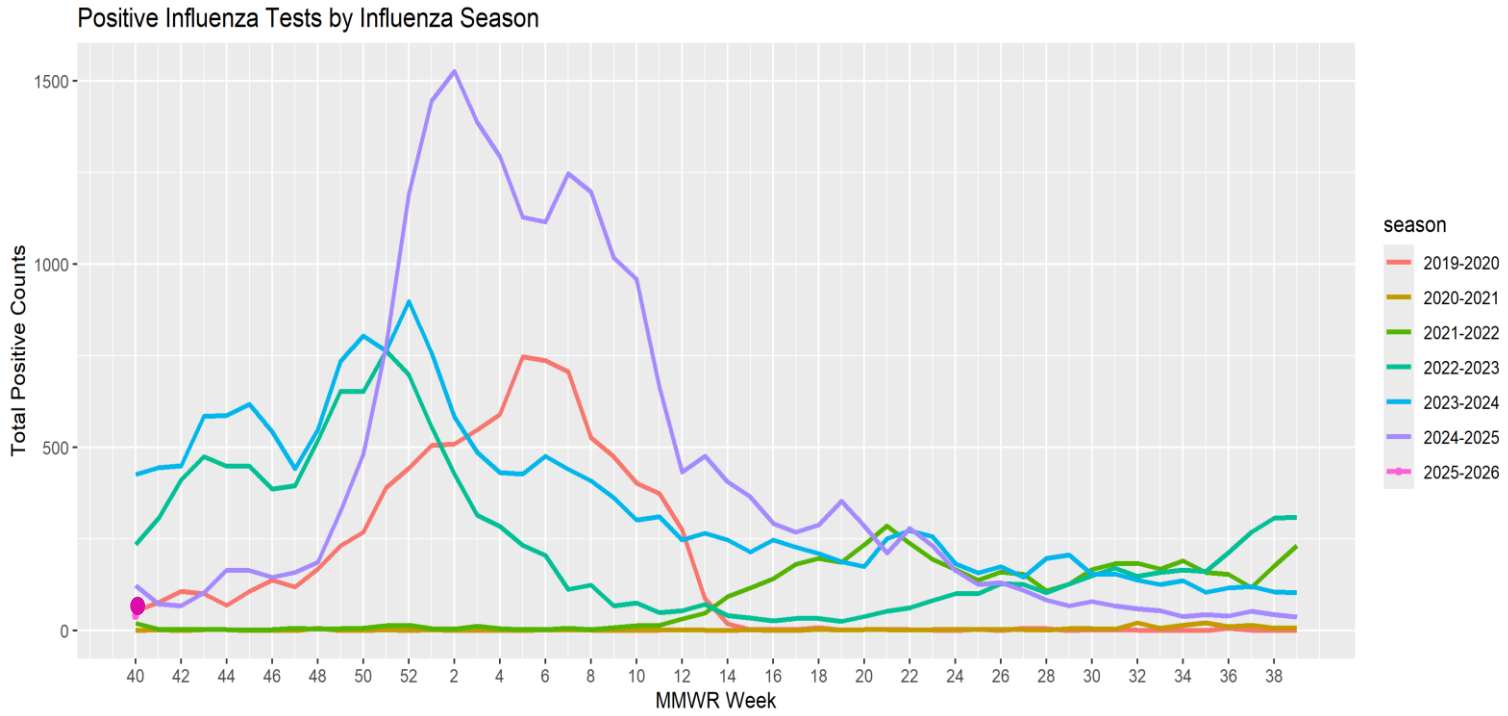


* *The coronavirus presented on this table does not indicate Severe Acute Respiratory Coronavirus-2 (i.e., COVID-19).*

RESPIRATORY SYNCYTIAL VIRUS (RSV) POSITIVE TEST RESULTS BY INFLUENZA SEASON: RSV case appears to have increased earlier than past seasons in the 2025-2026 season. Of note, significantly more tests for RSV are being performed than in pre-COVID-19 seasons.



INFLUENZA POSITIVE TEST RESULTS BY INFLUENZA SEASON: Influenza cases appear to have increased earlier than past seasons in the 2023-2024 season, but it is not yet known whether case numbers will reach a peak similar to pre-COVID-19 seasons.



C. COVID-19 SENTINEL SURVEILLANCE: Due to the low volume of samples currently available through the influenza surveillance system, the COVID-19 sentinel surveillance data may not be accurately portraying COVID-19 activity in our communities. Reporting of the COVID-19 Sentinel Surveillance data will be paused while HODH re-evaluates the program to ensure that the reported data are accurate and representative.

HDOH is continuing to monitor COVID-19 activity throughout the state. To learn more, please visit the Hawaii's COVID-19 data website (*here*). For more information on surveillance of COVID-19 activity in the United States please visit the CDC COVIDView website (*here*).

III. PNEUMONIA, INFLUENZA, AND COVID-19 (PIC) RELATED MORTALITY:

P&I mortality surveillance is collected by CDC through the National Center for Health Statistics (NCHS) using death certificate data. Each week the HDOH OHSM reports specific data from Honolulu to the CDC. CDC collects the following information by age group: the total number of deaths, total deaths from pneumonia, and total deaths related to influenza. Due to the ongoing COVID-19 pandemic, CDC included total deaths from COVID-19 by age group to the death data. Previous studies had suggested that P&I is a good indicator of influenza-related deaths; however, data has shown that pneumonia deaths associated with influenza is now being impacted by COVID-19 related pneumonia. Due to this, CDC had added COVID-19 deaths into P&I to create the PIC (pneumonia, influenza, and/or COVID-19) classification.

To standardize Hawaii's influenza surveillance with CDC influenza surveillance guidelines, PIC deaths will be reported in lieu of P&I. Hawaii's baseline will begin to include PIC deaths starting from 2019-2020 flu season.

On October 1, 2025, certain federal government activities have ceased due to a lack of appropriated funding. The National Vital Statistic System (NVSS) surveillance datasets and reports had been paused temporarily, including those used to evaluate pneumonia, influenza, and COVID-19 deaths. HDOH PIC mortality data will not be published in the Influenza/Respiratory Disease Surveillance Report for week 40. Data updates are expected to resume following the conclusion of the government shutdown.

INFLUENZA-ASSOCIATED PEDIATRIC DEATHS[11]:

- No new influenza-associated pediatric death was reported to Hawaii. There have been zero influenza-associated pediatric deaths reported in Hawaii during the 2025–2026 season.
- Nationally, no new influenza-associated pediatric deaths were reported to CDC during week 40. (2025-2026 season total: 0).

IV. INFLUENZA WATCH: As part of a comprehensive influenza surveillance system and to prevent the spread of contagious respiratory diseases in humans, it is important to monitor all circulating influenza types. Several animal-origin influenza A subtypes are currently of interest: influenza A variant virus (H3N2v, H1N2v, and H1N1v) and Avian flu (H5N1 and H7N9). These types of influenza viruses may cause zoonotic (animal-associated) disease and are a public health concern.

A. VARIANT VIRUSES:

Influenza viruses that normally circulate in pigs are called "variant" viruses when they are found in people. These viruses were first identified in U.S. pigs in 2010. In 2011, 12 cases of H3N2v infection were detected in the United States. In 2012, 309 such cases (resulting in 16 hospitalizations and one death) across 12 states were detected, including one Hawaii case who recovered. Illness associated with H3N2v infection has been mostly mild with symptoms similar to those of seasonal flu. However, serious illness, resulting in hospitalization and death, has occurred in some cases. Most of these infections have been associated with prolonged exposure to pigs at agricultural fairs or similar settings. Limited human-to-human spread of this virus has been detected in the past, but no sustained community spread of H3N2v has been identified. More information regarding H3N2v, H1N1v, and H1N2v viruses may be found on the CDC website (*here*) and (*here*).

- *No variant or novel influenza infections have been reported to HDOH during the 2025-2026 influenza season.*
- *No new human infection with novel influenza A virus, H1N1v (0), H3N2v (0), and H1N2v (0), have been reported during the 2025-2026 influenza season.*

AVIAN (OR BIRD) INFLUENZA: These types of influenza viruses cause zoonotic (animal-associated) disease of public health concern and are therefore monitored globally by the WHO. Most avian influenza viruses do not cause disease in humans and are generally not easily transmissible between person to person, but a few subtypes may cross the species barrier and cause disease in humans. Avian influenza viruses may be of various subtypes, including H5N1, H5N2, H5N8, H7N3, H7N7, H7N8, H7N9, and H9N2. On January 15th, 2016, the USDA and APHIS reported detection of HPAI H7N8 in a commercial turkey flock in Indiana. There have been no associated human infections. This is the first detection of HPAI H7N8 in wild bird surveillance in the United States. More information, the risk assessment and recommendations for HPAI H7N8 can be found (here). The WHO, CDC, and other public health agencies have also been monitoring influenza H7N9, which represents a public health concern because of its high pandemic potential. Although H7N9 has not been detected in the United States, it remains a global concern given continuing epidemics in endemic countries. Since 2013, a total of 1,568 laboratory-confirmed cases of human infection with H7N9 viruses, including at least 613 deaths, have been reported to WHO. More information on H7N9 virus infections can be found (here). For more information regarding avian influenza, please visit the CDC (*here*) or the WHO (*here*) websites. WHO reports total number of cases and deaths related to laboratory-confirmed avian influenza viruses and posts current avian influenza case counts (*here*), which were last updated on **May 27, 2025**..

[11] Influenza-associated deaths are considered pediatric in persons aged less than 18 years. It was made a nationally notifiable condition in October, 2004. All pediatric influenza-associated deaths are laboratory confirmed.

V. INFLUENZA Vaccine: Annual influenza vaccination is recommended for all persons aged 6 months and older and is the most effective way to reduce the risk of getting sick with seasonal flu and spreading it to others. Influenza vaccination can reduce illnesses, visits to the doctor, influenza-related hospitalizations, and missed work and school days. Influenza vaccines become available by the end of October. It takes at least two weeks after vaccination to confer immunity against influenza virus infection. More information regarding influenza vaccination can be found (*here*).

A. Composition of the 2025–2026 Influenza Vaccine**:**

The composition of the 2025–2026 influenza vaccine has been updated to better match circulating influenza viruses. The Advisory Committee on Immunization Practices (ACIP) has recommended that the 2025-2026 influenza trivalent vaccine contain an influenza A/Victoria/4897/2022 (H1N1) pdm09-like virus, influenza A/Croatia/10136RV/2023 (H3N2)-like virus, and influenza B/Austria/1359417/2021 (B/Victoria lineage)-like virus. United States cell culture–based inactivated (ccIIV4) and recombinant (RIV4) influenza vaccines will contain HA derived from an influenza A/Wisconsin/67/2022 (H1N1) pdm09-like virus, an A/District of Columbia/27/2023 (H3N2)-like virus, an influenza B/Austria/1359417/2021 (B/Victoria lineage)-like virus. These vaccine recommendations were based on several factors, including global influenza virologic and epidemiologic surveillance, genetic and antigenic characterization, human serology studies, antiviral susceptibility, and the availability of candidate influenza viruses.

APPENDIX 1: ADDITIONAL INFORMATION

For more information regarding local and national influenza surveillance programs, visit the following sites.

Centers for Disease Control and Prevention	General Influenza National ILI and P&I Data Vaccine Virus Selection CDC Web Tool for Respiratory Viruses
Flu.gov	General Influenza Information
HDOH Flu and Pneumonia	General Influenza Surveillance Avian Influenza Respiratory Virus Dashboard To find out more information or join the sentinel physician program, email the Influenza Surveillance Coordinator
World Health Organization	General Global and Local Influenza Avian Influenza

APPENDIX 2: MMWR WEEK DATES

Please refer to the table below to interpret data presented by MMWR week. Week 40 is considered the traditional start for the flu season for the Northern Hemisphere.

MMWR WEEK	2022	2023	2024	2025	2026
1	1/8/2022	1/7/2023	1/6/2024	1/4/2025	1/10/2026
2	1/15/2022	1/14/2023	1/13/2024	1/11/2025	1/17/2026
3	1/22/2022	1/21/2023	1/20/2024	1/18/2025	1/24/2026
4	1/29/2022	1/28/2023	1/27/2024	1/25/2025	1/31/2026
5	2/5/2022	2/4/2023	2/3/2024	2/1/2025	2/7/2026
6	2/12/2022	2/11/2023	2/10/2024	2/8/2025	2/14/2026
7	2/19/2022	2/18/2023	2/17/2024	2/15/2025	2/21/2026
8	2/26/2022	2/25/2023	2/24/2024	2/22/2025	2/28/2026
9	3/5/2022	3/4/2023	3/2/2024	3/1/2025	3/7/2026
10	3/12/2022	3/11/2023	3/9/2024	3/8/2025	3/14/2026
11	3/19/2022	3/18/2023	3/16/2024	3/15/2025	3/21/2026
12	3/26/2022	3/25/2023	3/23/2024	3/22/2025	3/28/2026
13	4/2/2022	4/1/2023	3/30/2024	3/29/2025	4/4/2026
14	4/9/2022	4/8/2023	4/6/2024	4/5/2025	4/11/2026
15	4/16/2022	4/15/2023	4/13/2024	4/12/2025	4/18/2026
16	4/23/2022	4/22/2023	4/20/2024	4/19/2025	4/25/2026
17	4/30/2022	4/29/2023	4/27/2024	4/26/2025	5/2/2026
18	5/7/2022	5/6/2023	5/4/2024	5/3/2025	5/9/2026
19	5/14/2022	5/13/2023	5/11/2024	5/10/2025	5/16/2026
20	5/21/2022	5/20/2023	5/18/2024	5/17/2025	5/23/2026
21	5/28/2022	5/27/2023	5/25/2024	5/24/2025	5/30/2026
22	6/4/2022	6/3/2023	6/1/2024	5/31/2025	6/6/2026
23	6/11/2022	6/10/2023	6/8/2024	6/7/2025	6/13/2026
24	6/18/2022	6/17/2023	6/15/2024	6/14/2025	6/20/2026
25	6/25/2022	6/24/2023	6/22/2024	6/21/2025	6/27/2026
26	7/2/2022	7/1/2023	6/29/2024	6/28/2025	7/4/2026
27	7/9/2022	7/8/2023	7/6/2024	7/5/2025	7/11/2026
28	7/16/2022	7/15/2023	7/13/2024	7/12/2025	7/18/2026
29	7/23/2022	7/22/2023	7/20/2024	7/19/2025	7/25/2026
30	7/30/2022	7/29/2023	7/27/2024	7/26/2025	8/1/2026
31	8/6/2022	8/5/2023	8/3/2024	8/2/2025	8/8/2026
32	8/13/2022	8/12/2023	8/10/2024	8/9/2025	8/15/2026
33	8/20/2022	8/19/2023	8/17/2024	8/16/2025	8/22/2026
34	8/27/2022	8/26/2023	8/24/2024	8/23/2025	8/29/2026
35	9/3/2022	9/2/2023	8/31/2024	8/30/2025	9/5/2026
36	9/10/2022	9/9/2023	9/7/2024	9/6/2025	9/12/2026
37	9/17/2022	9/16/2023	9/14/2024	9/13/2025	9/19/2026
38	9/24/2022	9/23/2023	9/21/2024	9/20/2025	9/26/2026
39	10/1/2022	9/30/2023	9/28/2024	9/27/2025	10/3/2026
40	10/8/2022	10/7/2023	10/5/2024	10/4/2025	10/10/2026
41	10/15/2022	10/14/2023	10/12/2024	10/11/2025	10/17/2026
42	10/22/2022	10/21/2023	10/19/2024	10/18/2025	10/24/2026
43	10/29/2022	10/28/2023	10/26/2024	10/25/2025	10/31/2026
44	11/5/2022	11/4/2023	11/2/2024	11/1/2025	11/7/2026
45	11/12/2022	11/11/2023	11/9/2024	11/8/2025	11/14/2026
46	11/19/2022	11/18/2023	11/16/2024	11/15/2025	11/21/2026
47	11/26/2022	11/25/2023	11/23/2024	11/22/2025	11/28/2026
48	12/3/2022	12/2/2023	11/30/2024	11/29/2025	12/5/2026
49	12/10/2022	12/9/2023	12/7/2024	12/6/2025	12/12/2026
50	12/17/2022	12/16/2023	12/14/2024	12/13/2025	12/19/2026
51	12/24/2022	12/23/2023	12/21/2024	12/20/2025	12/26/2026
52	12/31/2022	12/30/2023	12/28/2024	12/27/2025	
53				01/03/2026	

HAWAII STATE DEPARTMENT OF HEALTH
DISEASE OUTBREAK CONTROL DIVISION

Influenza/Respiratory Disease Surveillance Report

Morbidity and Mortality Weekly Report (MMWR)[1]

WEEK 41: OCTOBER 5, 2025– OCTOBER 11, 2025

OVERVIEW: The Hawaii State Department of Health (HDOH) monitors influenza and other respiratory pathogens, including COVID-19, throughout the state of Hawaii. Influenza surveillance in the state of Hawaii relies upon selected sentinel health practitioners, the State Laboratories Division (SLD), private laboratories, and the Office of Health Status Monitoring (OHSM). For detailed information concerning influenza, please visit the HDOH Disease Outbreak Control Division (HDOH DOCD) website (*here*). **All data and information are conditional and may change as more reports are received.** The data in this report reflect the 2025-2026 influenza season which began the week ending October 4, 2025 (week 40[1] 2025) and will end the week ending on October 3, 2026 (week 39 2026).

REPORT SNAPSHOT FOR WEEK 41

Surveillance for Influenza-like Illness (ILI)		
Metric	*Value*	*Comment*
Outpatient visits related to influenza-like illness (ILI) from ILINet Sentinel Providers	2.2%	Higher than the previous week. Comparable to the Hawaii's historical baseline and comparable to the national baseline. Comparison to national ILI rate is unavailable at this time.
Number of ILI clusters reported to HDOH	0	There have been 0 clusters this season.

Laboratory Surveillance		
Percent of all respiratory specimens positive for influenza this week	3.6%	Higher than the previous week. This number means that many, if not all, of the 96.4% who tested negative for influenza had illness from another respiratory etiology.
Percent of all respiratory specimens positive for influenza this season to date	2.8%	

Surveillance for Severe Outcomes		
Pneumonia, influenza and COVID-19 (PIC) mortality rate		No new report for PIC mortality rates is available this week due to a pause in data updates from the National Vital Statistics System (NVSS).
Number of influenza-associated pediatric deaths reported nationwide		0 influenza-associated pediatric deaths have been reported from Hawaii this season to date.

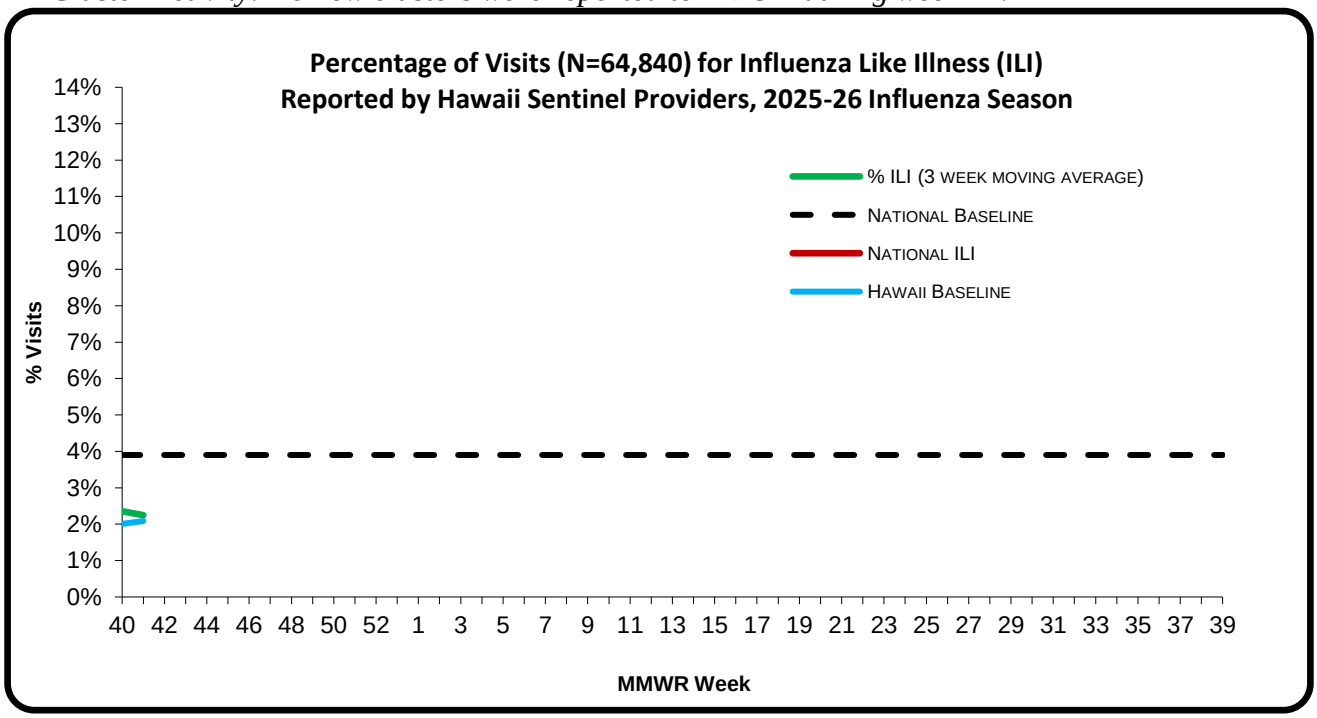
[1] MMWR stands for "Morbidity and Mortality Weekly Report," conventionally used by the Centers for Disease Control and Prevention (CDC). The weeks of a flu season are often referred to by their respective MMWR week. **See appendix 2 for interpretation of MMWR weeks.** Data reported will begin on week 40, the traditional start date of flu season.

INFLUENZA SURVEILLANCE

I. INFLUENZA-LIKE ILLNESS (ILI): HDOH collaborates with recruited doctors and healthcare providers who report the total number of outpatient visits for ILI as well as the total number of patients who complained of symptoms consistent with an ILI. A patient with ILI must have the following: a fever (temperature of 100°F [37.8°C] or greater) AND a cough and/or a sore throat. ILI is based on reported symptoms and not laboratory confirmed tests; thus, ILI may represent other respiratory pathogens and not solely influenza. Further, sentinel providers report these numbers on a weekly basis; therefore, data are preliminary and may change depending on additional reporting. In combination with laboratory testing and other surveillance systems, ILI surveillance helps monitor influenza and other respiratory pathogen activity. For more information concerning ILINet and sentinel requirements, please visit the CDC website (*here*).

For **week 41** of the current influenza season:

- ***2.2%** (season to date: **2.2%**) of the outpatient visits recorded by Hawaii sentinel providers were for ILI.*
- *ILI visits were comparable to the historical baseline in Hawaii[2,3] (i.e., inside the 95% confidence interval).*
- *Hawaii's ILI outpatient visits were comparable to the national baseline (**3.1%**)[4] (i.e., inside the 95% confidence interval). Comparison to national ILI rate is unavailable at this time.*
- *ILI activity level: Low[5]*
- *Geographic Spread: Sporadic Activity[6].*
- *ILI Cluster Activity: No new clusters were reported to HDOH during week 41.*



[2] The Hawaii historical baseline (%ILI) is the average of 3-week moving averages over the preceding 10 flu seasons of historical data (2015-2016, 2016-2017, 2017-2018, 2018-2019, 2019-2020, 2020-2021, 2021-2022, 2022-2023, 2023-2024 and 2024-2025).

[3] This value is based upon comparison of actual outpatient ILI with the historical baseline, which only captures outpatient ILI. The chart above represents a 3-week moving average and not the actual ILI by week.

[4] The National Baseline is calculated by CDC as the mean percentage of visits for ILI during weeks 21–39 with two standard deviations. Because of large variability in regional ILI, comparison of the national baseline with local ILI may not be appropriate. It is provided in this report because no meaningful regional baselines are available for comparison. The national baseline combines all data reported by states to CDC, including ILI in outpatient, ER, urgent care, and inpatient settings.

[5] There are 10 activity levels classified as minimal (levels 1-3), low (levels 4-5), moderate (levels 6-7), and high (levels 8-10).

[6] The influenza activity reported by state and territorial epidemiologists indicates geographic spread of influenza viruses but does not measure the severity of influenza activity. Sporadic: no clusters reported to HDOH, Local: one or more clusters reported in one county, Regional: clusters reported two to three counties, Widespread: clusters reported in all counties. Hawaii does not report No Activity, as flu circulates year-round in Hawaii.

II. LABORATORY SURVEILLANCE: State Laboratories Division (SLD; the HDOH public health laboratory) and Hawaii's major private laboratories (DLS, CLH) report results of RT-PCR, which can be considered confirmatory (SLD may perform viral culture on select specimens). Specimens meeting priority criteria[7] are forwarded to SLD for sub-typing. Additionally, specimens meeting case definition from requesting sentinel providers are sent directly to SLD for sub-typing. Due to resource constraints, not all submitted specimens undergo sub-typing. Sub-typing at the commercial laboratories is only conducted on a case-by-case basis. The majority of specimens testing positive by rapid antigen testing or RT-PCR at the commercial laboratories do not meet criteria and are not subtyped. For more information on influenza tests and types, please visit the CDC website (*here*).

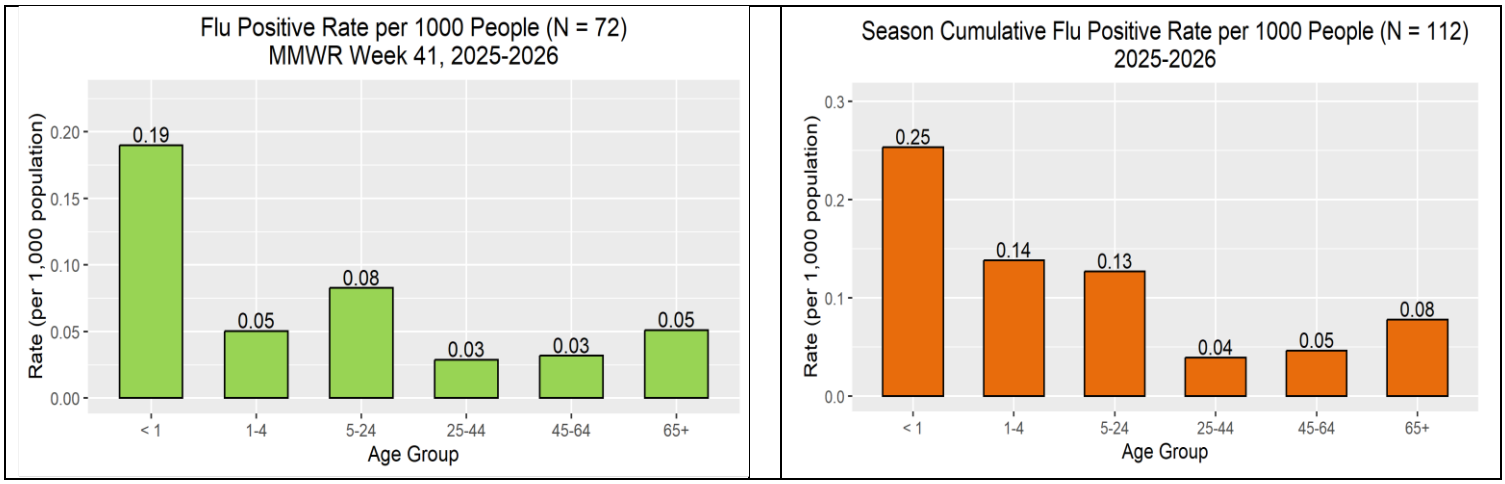
A. INFLUENZA:

- The following reflects laboratory findings for week 41 of the 2025–26 influenza season:
  - *A total of **2,027** specimens have been tested statewide for influenza viruses (positive: 72 [**3.6%**]). (Season to date: **4,056** tested (**2.8%** positive])*
    - *944 (46.6%) were screened only by rapid antigen tests with no confirmatory testing.*
    - *1,083 (53.4%) underwent confirmatory testing (either RT-PCR or viral culture).*
    - *1,955 (96.4%) were negative.*

Influenza type	*Current week 41 (%)*	*Season to date (%)*[8]
Influenza A (H1)[9]	*0 (0.0)*	*1 (2.5)*
Influenza A (H3)	*1 (1.4)*	*1 (0.0)*
Influenza A no subtyping	*69 (95.8)*	*104 (87.5)*
Influenza B (Yamagata)	*0 (0.0)*	*0 (0.0)*
Influenza B (Victoria)	*0 (0.0)*	*0 (0.0)*
Influenza B no genotyping	*2 (2.8)*	*6 (10.0)*

1. AGE DISTRIBUTION

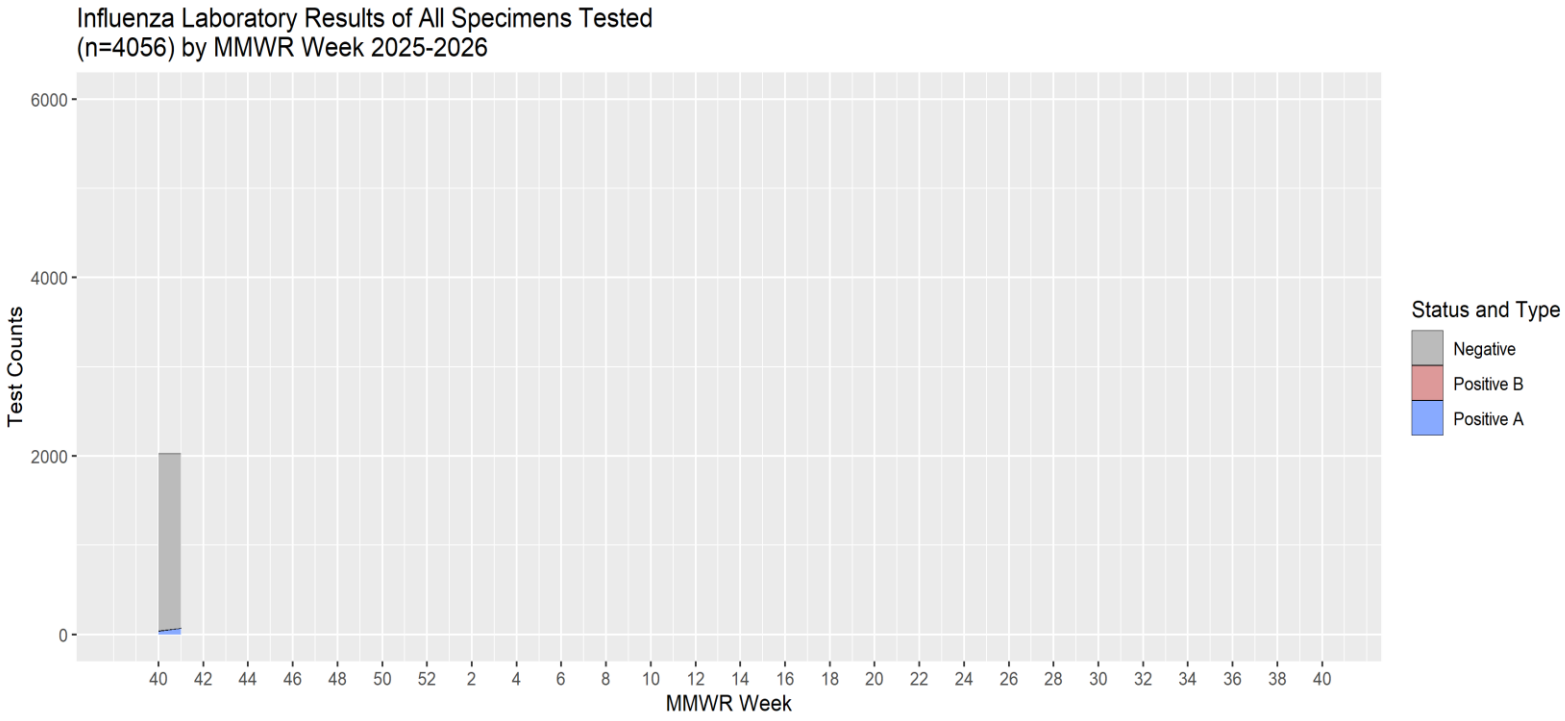
The charts below indicate the population-based rates of positive influenza cases in Hawaii by age group during the 2025–26 influenza season.[10]

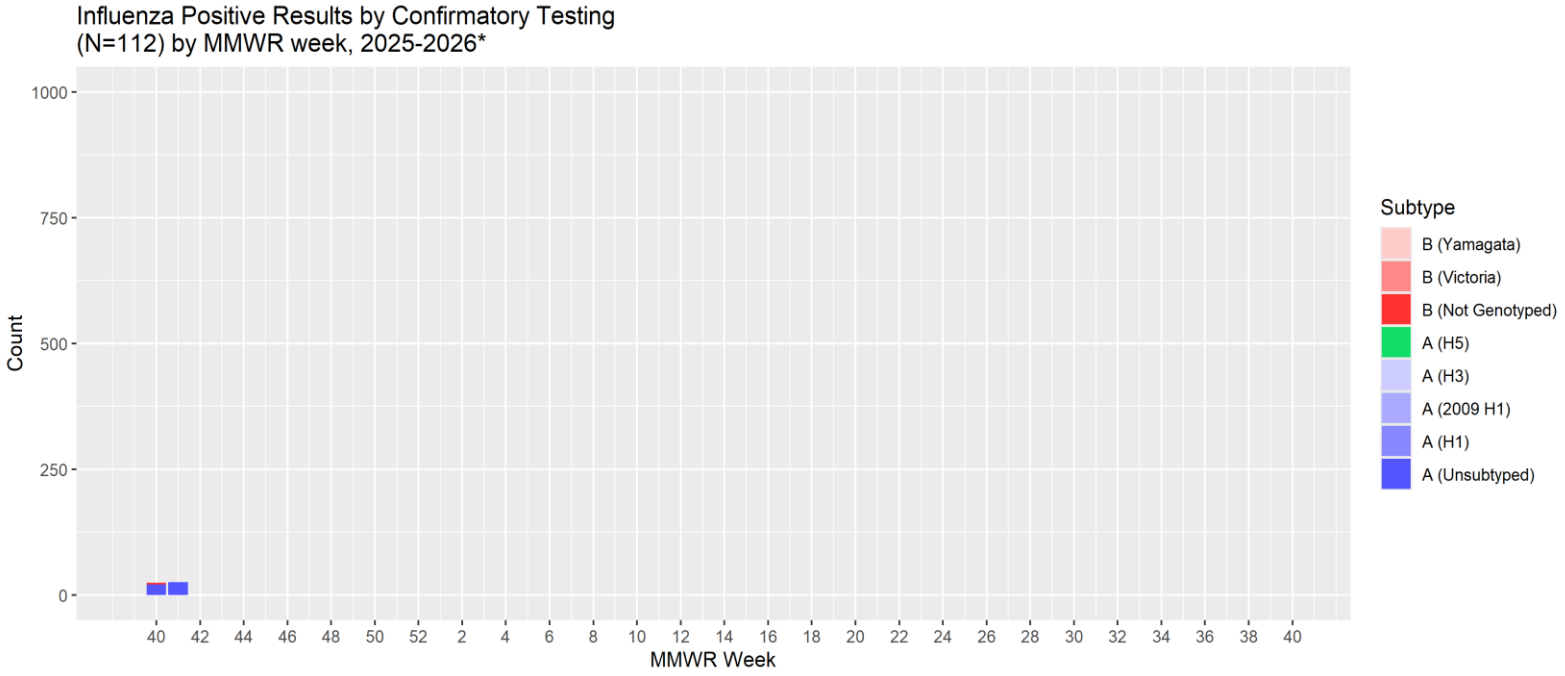


[7] Priority criteria include: hospitalized patients with acute respiratory distress syndrome [ARDS] or x-ray confirmed pneumonia; travelers with international travel history within 10 days of onset; specimens submitted by sentinel providers; specimens collected from healthcare workers, pregnant women, or women up to 6 weeks' post-partum; those with underlying medical conditions; and patients presenting with unusual or severe manifestations of influenza infection.
[8] Influenza coding were updated to reflect a more accurate count.
[9] All influenza A H1 viruses detected this season have been 2009 H1N1.
[10] This represents an estimate of population-based rates based on available data.

2. LABORATORY TESTING

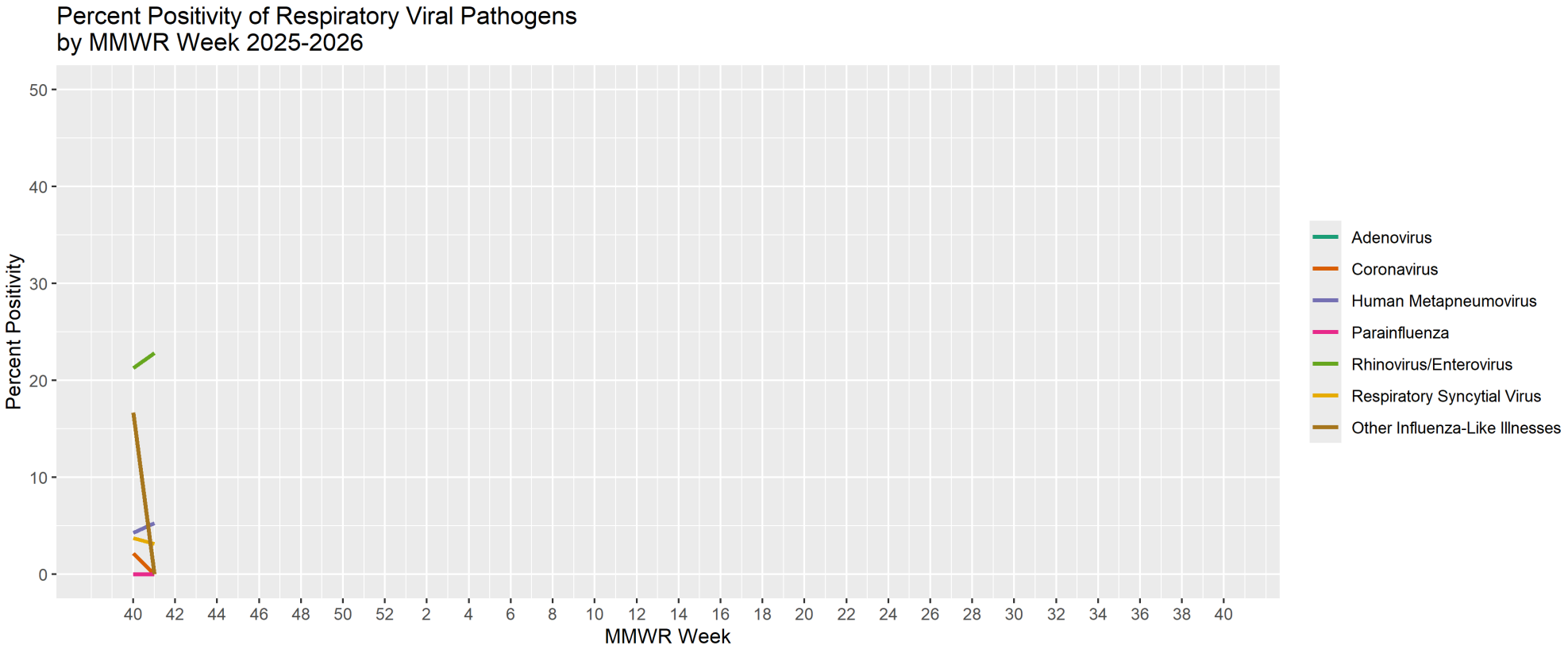
The charts below show the laboratory results of all specimens tested for influenza by MMWR week during the 2025–2026 influenza season as well as the type and subtype of positive results for influenza. Again, sub-typing is only performed on selected specimens tested by confirmatory tests (i.e., RT-PCR or viral culture).





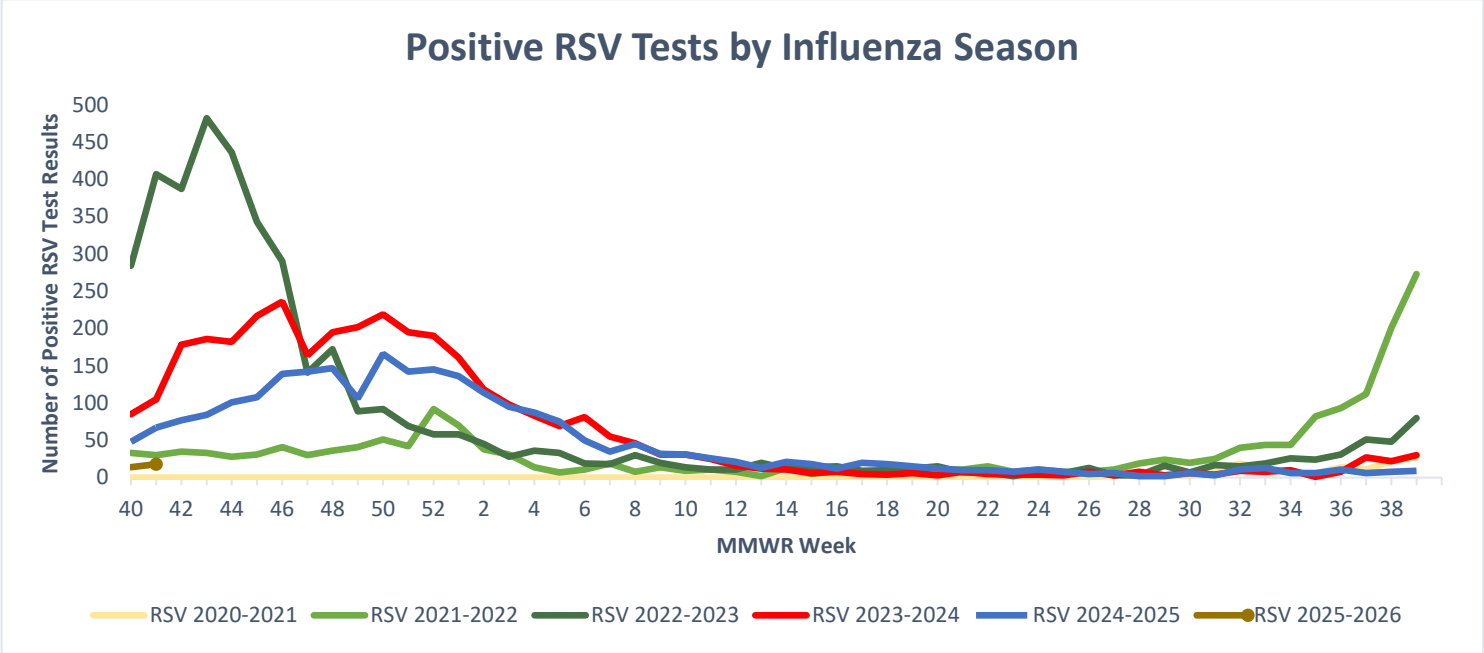
** A total of 2,143 specimens underwent confirmatory testing but not all positive influenza specimens receive confirmatory testing that are circulating in Hawaii.*

B. OTHER RESPIRATORY PATHOGENS: The major clinical and commercial laboratories throughout the state of Hawaii have the testing capacity for non-influenza respiratory pathogens and report these to HDOH. However, such testing is performed as needed and when sufficient resources are available because of the high costs associated with respiratory panel tests. **Therefore, available data represent only the presence of circulating pathogens and cannot be used to determine specific trends**.

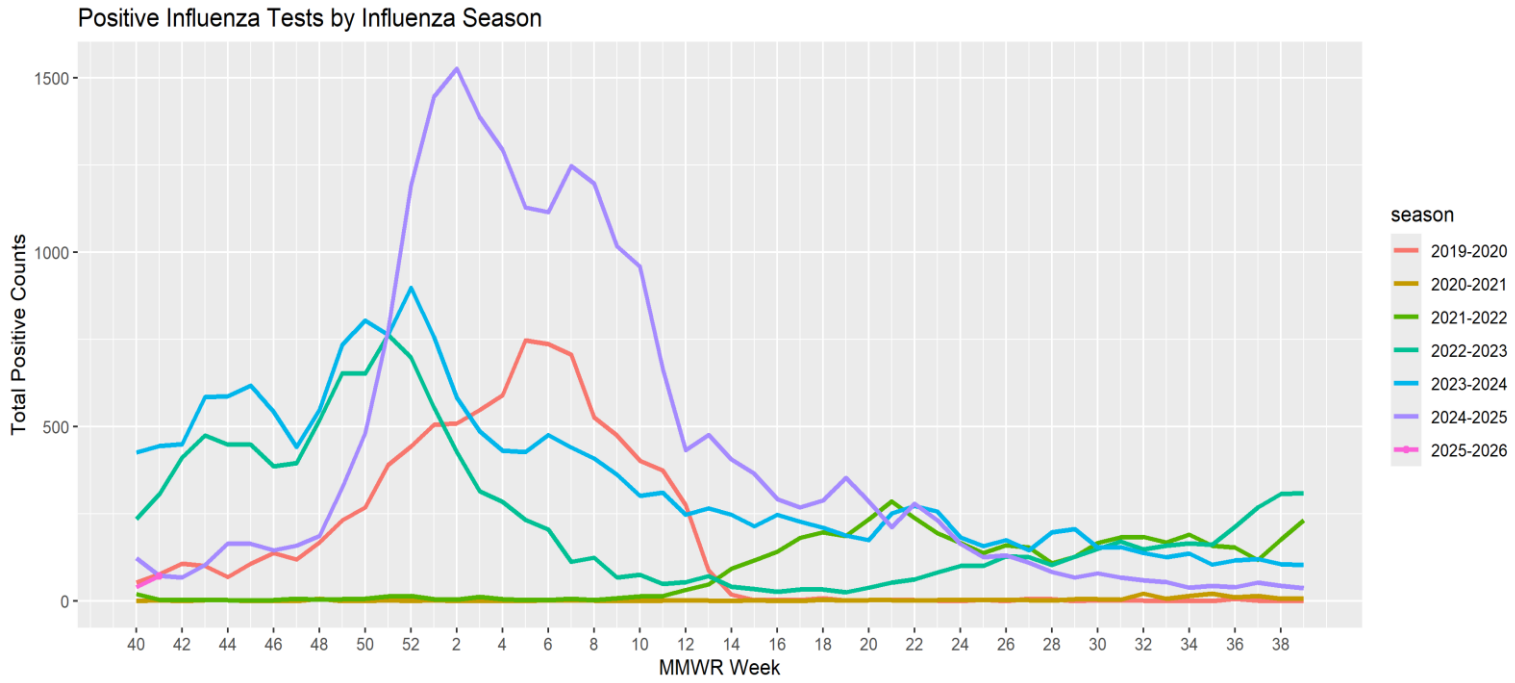


* *The coronavirus presented on this table does not indicate Severe Acute Respiratory Coronavirus-2 (i.e., COVID-19).*

RESPIRATORY SYNCYTIAL VIRUS (RSV) POSITIVE TEST RESULTS BY INFLUENZA SEASON: RSV case appears to have increased earlier than past seasons in the 2025-2026 season. Of note, significantly more tests for RSV are being performed than in pre-COVID-19 seasons.



INFLUENZA POSITIVE TEST RESULTS BY INFLUENZA SEASON: Influenza cases appear to have increased earlier than past seasons in the 2023-2024 season, but it is not yet known whether case numbers will reach a peak similar to pre-COVID-19 seasons.



C. COVID-19 SENTINEL SURVEILLANCE: Due to the low volume of samples currently available through the influenza surveillance system, the COVID-19 sentinel surveillance data may not be accurately portraying COVID-19 activity in our communities. Reporting of the COVID-19 Sentinel Surveillance data will be paused while HODH re-evaluates the program to ensure that the reported data are accurate and representative.

HDOH is continuing to monitor COVID-19 activity throughout the state. To learn more, please visit the Hawaii's COVID-19 data website (*here*). For more information on surveillance of COVID-19 activity in the United States please visit the CDC COVIDView website (*here*).

III. PNEUMONIA, INFLUENZA, AND COVID-19 (PIC) RELATED MORTALITY:

P&I mortality surveillance is collected by CDC through the National Center for Health Statistics (NCHS) using death certificate data. Each week the HDOH OHSM reports specific data from Honolulu to the CDC. CDC collects the following information by age group: the total number of deaths, total deaths from pneumonia, and total deaths related to influenza. Due to the ongoing COVID-19 pandemic, CDC included total deaths from COVID-19 by age group to the death data. Previous studies had suggested that P&I is a good indicator of influenza-related deaths; however, data has shown that pneumonia deaths associated with influenza is now being impacted by COVID-19 related pneumonia. Due to this, CDC had added COVID-19 deaths into P&I to create the PIC (pneumonia, influenza, and/or COVID-19) classification.

To standardize Hawaii's influenza surveillance with CDC influenza surveillance guidelines, PIC deaths will be reported in lieu of P&I. Hawaii's baseline will begin to include PIC deaths starting from 2019-2020 flu season.

On October 1, 2025, certain federal government activities have ceased due to a lack of appropriated funding. The National Vital Statistic System (NVSS) surveillance datasets and reports had been paused temporarily, including those used to evaluate pneumonia, influenza, and COVID-19 deaths. HDOH PIC mortality data will not be published in the Influenza/Respiratory Disease Surveillance Report for week 41. Data updates are expected to resume following the conclusion of the government shutdown.

INFLUENZA-ASSOCIATED PEDIATRIC DEATHS[11]:

- No new influenza-associated pediatric death was reported to Hawaii. There have been zero influenza-associated pediatric deaths reported in Hawaii during the 2025–2026 season.
- Nationally, no new influenza-associated pediatric deaths were reported to CDC during week 41. (2025-2026 season total: 0).

IV. INFLUENZA WATCH: As part of a comprehensive influenza surveillance system and to prevent the spread of contagious respiratory diseases in humans, it is important to monitor all circulating influenza types. Several animal-origin influenza A subtypes are currently of interest: influenza A variant virus (H3N2v, H1N2v, and H1N1v) and Avian flu (H5N1 and H7N9). These types of influenza viruses may cause zoonotic (animal-associated) disease and are a public health concern.

A. VARIANT VIRUSES:

Influenza viruses that normally circulate in pigs are called "variant" viruses when they are found in people. These viruses were first identified in U.S. pigs in 2010. In 2011, 12 cases of H3N2v infection were detected in the United States. In 2012, 309 such cases (resulting in 16 hospitalizations and one death) across 12 states were detected, including one Hawaii case who recovered. Illness associated with H3N2v infection has been mostly mild with symptoms similar to those of seasonal flu. However, serious illness, resulting in hospitalization and death, has occurred in some cases. Most of these infections have been associated with prolonged exposure to pigs at agricultural fairs or similar settings. Limited human-to-human spread of this virus has been detected in the past, but no sustained community spread of H3N2v has been identified. More information regarding H3N2v, H1N1v, and H1N2v viruses may be found on the CDC website (*here*) and (*here*).

- *No variant or novel influenza infections have been reported to HDOH during the 2025-2026 influenza season.*
- *No new human infection with novel influenza A virus, H1N1v (0), H3N2v (0), and H1N2v (0), have been reported during the 2025-2026 influenza season.*

AVIAN (OR BIRD) INFLUENZA: These types of influenza viruses cause zoonotic (animal-associated) disease of public health concern and are therefore monitored globally by the WHO. Most avian influenza viruses do not cause disease in humans and are generally not easily transmissible between person to person, but a few subtypes may cross the species barrier and cause disease in humans. Avian influenza viruses may be of various subtypes, including H5N1, H5N2, H5N8, H7N3, H7N7, H7N8, H7N9, and H9N2. On January 15th, 2016, the USDA and APHIS reported detection of HPAI H7N8 in a commercial turkey flock in Indiana. There have been no associated human infections. This is the first detection of HPAI H7N8 in wild bird surveillance in the United States. More information, the risk assessment and recommendations for HPAI H7N8 can be found (here). The WHO, CDC, and other public health agencies have also been monitoring influenza H7N9, which represents a public health concern because of its high pandemic potential. Although H7N9 has not been detected in the United States, it remains a global concern given continuing epidemics in endemic countries. Since 2013, a total of 1,568 laboratory-confirmed cases of human infection with H7N9 viruses, including at least 613 deaths, have been reported to WHO. More information on H7N9 virus infections can be found (here). For more information regarding avian influenza, please visit the CDC (*here*) or the WHO (*here*) websites. WHO reports total number of cases and deaths related to laboratory-confirmed avian influenza viruses and posts current avian influenza case counts (*here*), which were last updated on **May 27, 2025**..

[11] Influenza-associated deaths are considered pediatric in persons aged less than 18 years. It was made a nationally notifiable condition in October, 2004. All pediatric influenza-associated deaths are laboratory confirmed.

V. INFLUENZA Vaccine: Annual influenza vaccination is recommended for all persons aged 6 months and older and is the most effective way to reduce the risk of getting sick with seasonal flu and spreading it to others. Influenza vaccination can reduce illnesses, visits to the doctor, influenza-related hospitalizations, and missed work and school days. Influenza vaccines become available by the end of October. It takes at least two weeks after vaccination to confer immunity against influenza virus infection. More information regarding influenza vaccination can be found (*here*).

A. Composition of the 2025–2026 Influenza Vaccine**:**

The composition of the 2025–2026 influenza vaccine has been updated to better match circulating influenza viruses. The Advisory Committee on Immunization Practices (ACIP) has recommended that the 2025-2026 influenza trivalent vaccine contain an influenza A/Victoria/4897/2022 (H1N1) pdm09-like virus, influenza A/Croatia/10136RV/2023 (H3N2)-like virus, and influenza B/Austria/1359417/2021 (B/Victoria lineage)-like virus. United States cell culture–based inactivated (ccIIV4) and recombinant (RIV4) influenza vaccines will contain HA derived from an influenza A/Wisconsin/67/2022 (H1N1) pdm09-like virus, an A/District of Columbia/27/2023 (H3N2)-like virus, an influenza B/Austria/1359417/2021 (B/Victoria lineage)-like virus. These vaccine recommendations were based on several factors, including global influenza virologic and epidemiologic surveillance, genetic and antigenic characterization, human serology studies, antiviral susceptibility, and the availability of candidate influenza viruses.

APPENDIX 1: ADDITIONAL INFORMATION

For more information regarding local and national influenza surveillance programs, visit the following sites.

Centers for Disease Control and Prevention	General Influenza National ILI and P&I Data Vaccine Virus Selection CDC Web Tool for Respiratory Viruses
Flu.gov	General Influenza Information
HDOH Flu and Pneumonia	General Influenza Surveillance Avian Influenza Respiratory Virus Dashboard To find out more information or join the sentinel physician program, email the Influenza Surveillance Coordinator
World Health Organization	General Global and Local Influenza Avian Influenza

APPENDIX 2: MMWR WEEK DATES

Please refer to the table below to interpret data presented by MMWR week. Week 40 is considered the traditional start for the flu season for the Northern Hemisphere.

MMWR WEEK	2022	2023	2024	2025	2026
1	1/8/2022	1/7/2023	1/6/2024	1/4/2025	1/10/2026
2	1/15/2022	1/14/2023	1/13/2024	1/11/2025	1/17/2026
3	1/22/2022	1/21/2023	1/20/2024	1/18/2025	1/24/2026
4	1/29/2022	1/28/2023	1/27/2024	1/25/2025	1/31/2026
5	2/5/2022	2/4/2023	2/3/2024	2/1/2025	2/7/2026
6	2/12/2022	2/11/2023	2/10/2024	2/8/2025	2/14/2026
7	2/19/2022	2/18/2023	2/17/2024	2/15/2025	2/21/2026
8	2/26/2022	2/25/2023	2/24/2024	2/22/2025	2/28/2026
9	3/5/2022	3/4/2023	3/2/2024	3/1/2025	3/7/2026
10	3/12/2022	3/11/2023	3/9/2024	3/8/2025	3/14/2026
11	3/19/2022	3/18/2023	3/16/2024	3/15/2025	3/21/2026
12	3/26/2022	3/25/2023	3/23/2024	3/22/2025	3/28/2026
13	4/2/2022	4/1/2023	3/30/2024	3/29/2025	4/4/2026
14	4/9/2022	4/8/2023	4/6/2024	4/5/2025	4/11/2026
15	4/16/2022	4/15/2023	4/13/2024	4/12/2025	4/18/2026
16	4/23/2022	4/22/2023	4/20/2024	4/19/2025	4/25/2026
17	4/30/2022	4/29/2023	4/27/2024	4/26/2025	5/2/2026
18	5/7/2022	5/6/2023	5/4/2024	5/3/2025	5/9/2026
19	5/14/2022	5/13/2023	5/11/2024	5/10/2025	5/16/2026
20	5/21/2022	5/20/2023	5/18/2024	5/17/2025	5/23/2026
21	5/28/2022	5/27/2023	5/25/2024	5/24/2025	5/30/2026
22	6/4/2022	6/3/2023	6/1/2024	5/31/2025	6/6/2026
23	6/11/2022	6/10/2023	6/8/2024	6/7/2025	6/13/2026
24	6/18/2022	6/17/2023	6/15/2024	6/14/2025	6/20/2026
25	6/25/2022	6/24/2023	6/22/2024	6/21/2025	6/27/2026
26	7/2/2022	7/1/2023	6/29/2024	6/28/2025	7/4/2026
27	7/9/2022	7/8/2023	7/6/2024	7/5/2025	7/11/2026
28	7/16/2022	7/15/2023	7/13/2024	7/12/2025	7/18/2026
29	7/23/2022	7/22/2023	7/20/2024	7/19/2025	7/25/2026
30	7/30/2022	7/29/2023	7/27/2024	7/26/2025	8/1/2026
31	8/6/2022	8/5/2023	8/3/2024	8/2/2025	8/8/2026
32	8/13/2022	8/12/2023	8/10/2024	8/9/2025	8/15/2026
33	8/20/2022	8/19/2023	8/17/2024	8/16/2025	8/22/2026
34	8/27/2022	8/26/2023	8/24/2024	8/23/2025	8/29/2026
35	9/3/2022	9/2/2023	8/31/2024	8/30/2025	9/5/2026
36	9/10/2022	9/9/2023	9/7/2024	9/6/2025	9/12/2026
37	9/17/2022	9/16/2023	9/14/2024	9/13/2025	9/19/2026
38	9/24/2022	9/23/2023	9/21/2024	9/20/2025	9/26/2026
39	10/1/2022	9/30/2023	9/28/2024	9/27/2025	10/3/2026
40	10/8/2022	10/7/2023	10/5/2024	10/4/2025	10/10/2026
41	10/15/2022	10/14/2023	10/12/2024	10/11/2025	10/17/2026
42	10/22/2022	10/21/2023	10/19/2024	10/18/2025	10/24/2026
43	10/29/2022	10/28/2023	10/26/2024	10/25/2025	10/31/2026
44	11/5/2022	11/4/2023	11/2/2024	11/1/2025	11/7/2026
45	11/12/2022	11/11/2023	11/9/2024	11/8/2025	11/14/2026
46	11/19/2022	11/18/2023	11/16/2024	11/15/2025	11/21/2026
47	11/26/2022	11/25/2023	11/23/2024	11/22/2025	11/28/2026
48	12/3/2022	12/2/2023	11/30/2024	11/29/2025	12/5/2026
49	12/10/2022	12/9/2023	12/7/2024	12/6/2025	12/12/2026
50	12/17/2022	12/16/2023	12/14/2024	12/13/2025	12/19/2026
51	12/24/2022	12/23/2023	12/21/2024	12/20/2025	12/26/2026
52	12/31/2022	12/30/2023	12/28/2024	12/27/2025	
53				01/03/2026	

HAWAII STATE DEPARTMENT OF HEALTH
DISEASE OUTBREAK CONTROL DIVISION

Influenza/Respiratory Disease Surveillance Report

Morbidity and Mortality Weekly Report (MMWR)[1]

WEEK 42: OCTOBER 12, 2025– OCTOBER 18, 2025

OVERVIEW: The Hawaii State Department of Health (HDOH) monitors influenza and other respiratory pathogens, including COVID-19, throughout the state of Hawaii. Influenza surveillance in the state of Hawaii relies upon selected sentinel health practitioners, the State Laboratories Division (SLD), private laboratories, and the Office of Health Status Monitoring (OHSM). For detailed information concerning influenza, please visit the HDOH Disease Outbreak Control Division (HDOH DOCD) website (*here*). **All data and information are conditional and may change as more reports are received.** The data in this report reflect the 2025-2026 influenza season which began the week ending October 4, 2025 (week 40[1] 2025) and will end the week ending on October 3, 2026 (week 39 2026).

REPORT SNAPSHOT FOR WEEK 42

Surveillance for Influenza-like Illness (ILI)		
Metric	*Value*	*Comment*
Outpatient visits related to influenza-like illness (ILI) from ILINet Sentinel Providers	1.7%	Lower than the previous week. Comparable to the Hawaii's historical baseline and comparable to the national baseline. Comparison to national ILI rate is unavailable at this time.
Number of ILI clusters reported to HDOH	0	There have been 0 clusters this season.

Laboratory Surveillance		
Percent of all respiratory specimens positive for influenza this week	5.3%	Higher than the previous week. This number means that many, if not all, of the 94.7% who tested negative for influenza had illness from another respiratory etiology.
Percent of all respiratory specimens positive for influenza this season to date	3.6%	

Surveillance for Severe Outcomes		
Pneumonia, influenza and COVID-19 (PIC) mortality rate		No new report for PIC mortality rates is available this week due to a pause in data updates from the National Vital Statistics System (NVSS).
Number of influenza-associated pediatric deaths reported nationwide	0	0 influenza-associated pediatric deaths have been reported from Hawaii this season to date.

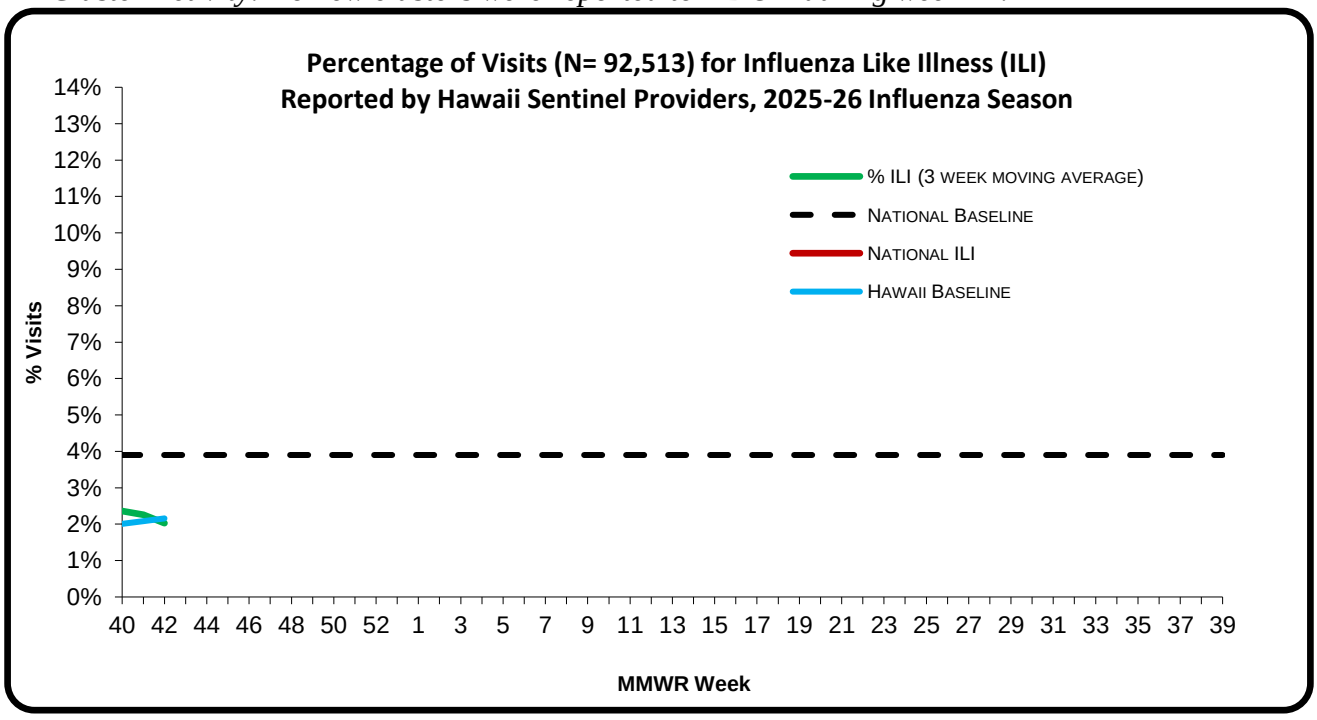
[1] MMWR stands for "Morbidity and Mortality Weekly Report," conventionally used by the Centers for Disease Control and Prevention (CDC). The weeks of a flu season are often referred to by their respective MMWR week. **See appendix 2 for interpretation of MMWR weeks.** Data reported will begin on week 40, the traditional start date of flu season.

INFLUENZA SURVEILLANCE

I. INFLUENZA-LIKE ILLNESS (ILI): HDOH collaborates with recruited doctors and healthcare providers who report the total number of outpatient visits for ILI as well as the total number of patients who complained of symptoms consistent with an ILI. A patient with ILI must have the following: a fever (temperature of 100°F [37.8°C] or greater) AND a cough and/or a sore throat. ILI is based on reported symptoms and not laboratory confirmed tests; thus, ILI may represent other respiratory pathogens and not solely influenza. Further, sentinel providers report these numbers on a weekly basis; therefore, data are preliminary and may change depending on additional reporting. In combination with laboratory testing and other surveillance systems, ILI surveillance helps monitor influenza and other respiratory pathogen activity. For more information concerning ILINet and sentinel requirements, please visit the CDC website (*here*).

For **week 42** of the current influenza season:

- ***1.7****% (season to date:* ***2.0****%) of the outpatient visits recorded by Hawaii sentinel providers were for ILI.*
- *ILI visits were comparable to the historical baseline in Hawaii[2,3] (i.e., inside the 95% confidence interval).*
- *Hawaii's ILI outpatient visits were comparable to the national baseline (**3.1%**)[4] (i.e., inside the 95% confidence interval). Comparison to national ILI rate is unavailable at this time.*
- *ILI activity level: Low[5]*
- *Geographic Spread: Sporadic Activity[6].*
- *ILI Cluster Activity: No new clusters were reported to HDOH during week 42.*



[2] The Hawaii historical baseline (%ILI) is the average of 3-week moving averages over the preceding 10 flu seasons of historical data (2015-2016, 2016-2017, 2017-2018, 2018-2019, 2019-2020, 2020-2021, 2021-2022, 2022-2023, 2023-2024 and 2024-2025).

[3] This value is based upon comparison of actual outpatient ILI with the historical baseline, which only captures outpatient ILI. The chart above represents a 3-week moving average and not the actual ILI by week.

[4] The National Baseline is calculated by CDC as the mean percentage of visits for ILI during weeks 21–39 with two standard deviations. Because of large variability in regional ILI, comparison of the national baseline with local ILI may not be appropriate. It is provided in this report because no meaningful regional baselines are available for comparison. The national baseline combines all data reported by states to CDC, including ILI in outpatient, ER, urgent care, and inpatient settings.

[5] There are 10 activity levels classified as minimal (levels 1-3), low (levels 4-5), moderate (levels 6-7), and high (levels 8-10).

[6] The influenza activity reported by state and territorial epidemiologists indicates geographic spread of influenza viruses but does not measure the severity of influenza activity. Sporadic: no clusters reported to HDOH, Local: one or more clusters reported in one county, Regional: clusters reported two to three counties, Widespread: clusters reported in all counties. Hawaii does not report No Activity, as flu circulates year-round in Hawaii.

II. LABORATORY SURVEILLANCE: State Laboratories Division (SLD; the HDOH public health laboratory) and Hawaii's major private laboratories (DLS, CLH) report results of RT-PCR, which can be considered confirmatory (SLD may perform viral culture on select specimens). Specimens meeting priority criteria[7] are forwarded to SLD for sub-typing. Additionally, specimens meeting case definition from requesting sentinel providers are sent directly to SLD for sub-typing. Due to resource constraints, not all submitted specimens undergo sub-typing. Sub-typing at the commercial laboratories is only conducted on a case-by-case basis. The majority of specimens testing positive by rapid antigen testing or RT-PCR at the commercial laboratories do not meet criteria and are not subtyped. For more information on influenza tests and types, please visit the CDC website (*here*).

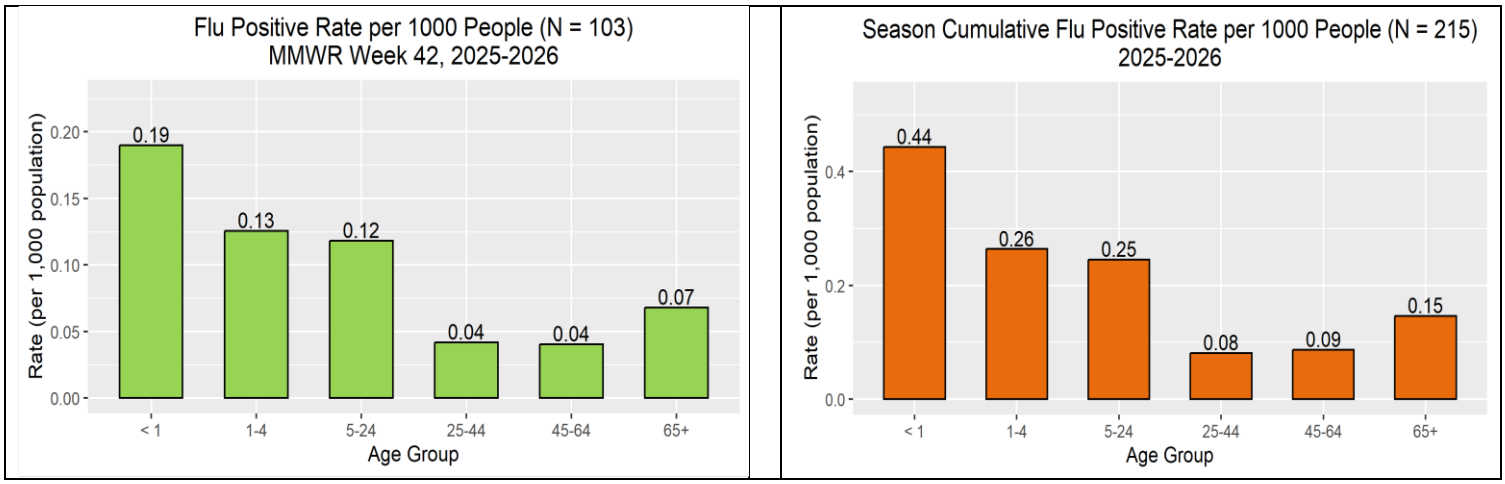
A. INFLUENZA:

- The following reflects laboratory findings for week 42 of the 2025–26 influenza season:
  - *A total of **1,941** specimens have been tested statewide for influenza viruses (positive: 103 [**5.3%**]). (Season to date: **5,997** tested (**3.6%** positive])*
    - *837 (43.1%) were screened only by rapid antigen tests with no confirmatory testing.*
    - *1,104 (56.9%) underwent confirmatory testing (either RT-PCR or viral culture).*
    - *1,838 (94.7%) were negative.*

Influenza type	*Current week 42 (%)*	*Season to date (%)*[8]
Influenza A (H1)[9]	*1 (1.0)*	*2 (0.9)*
Influenza A (H3)	*0 (0.0)*	*1 (0.5)*
Influenza A no subtyping	*97 (94.2)*	*201 (93.5)*
Influenza B (Yamagata)	*0 (0.0)*	*0 (0.0)*
Influenza B (Victoria)	*0 (0.0)*	*0 (0.0)*
Influenza B no genotyping	*5 (4.8)*	*11 (5.1)*

1. AGE DISTRIBUTION

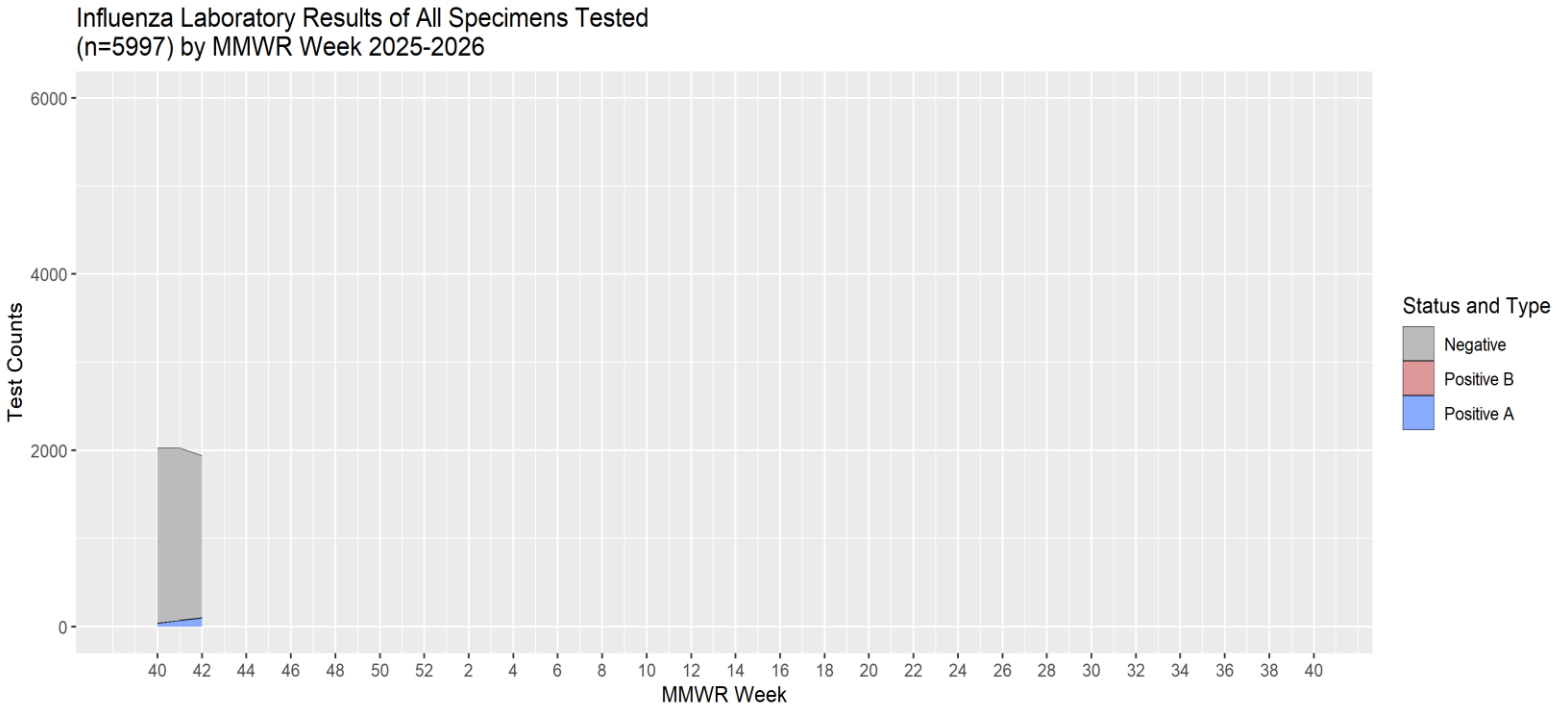
The charts below indicate the population-based rates of positive influenza cases in Hawaii by age group during the 2025–26 influenza season.[10]

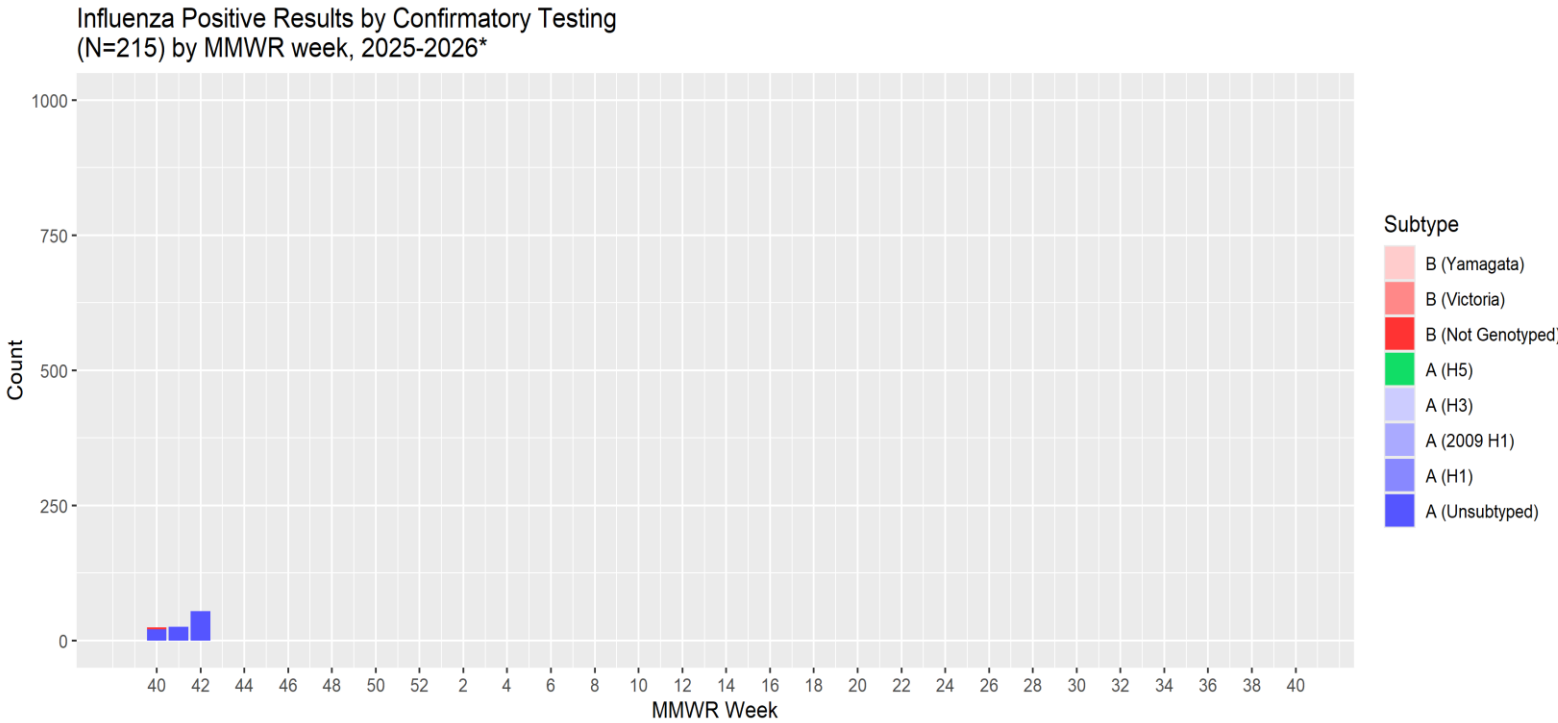


[7] Priority criteria include: hospitalized patients with acute respiratory distress syndrome [ARDS] or x-ray confirmed pneumonia; travelers with international travel history within 10 days of onset; specimens submitted by sentinel providers; specimens collected from healthcare workers, pregnant women, or women up to 6 weeks' post-partum; those with underlying medical conditions; and patients presenting with unusual or severe manifestations of influenza infection.
[8] Influenza coding were updated to reflect a more accurate count.
[9] All influenza A H1 viruses detected this season have been 2009 H1N1.
[10] This represents an estimate of population-based rates based on available data.

2. LABORATORY TESTING

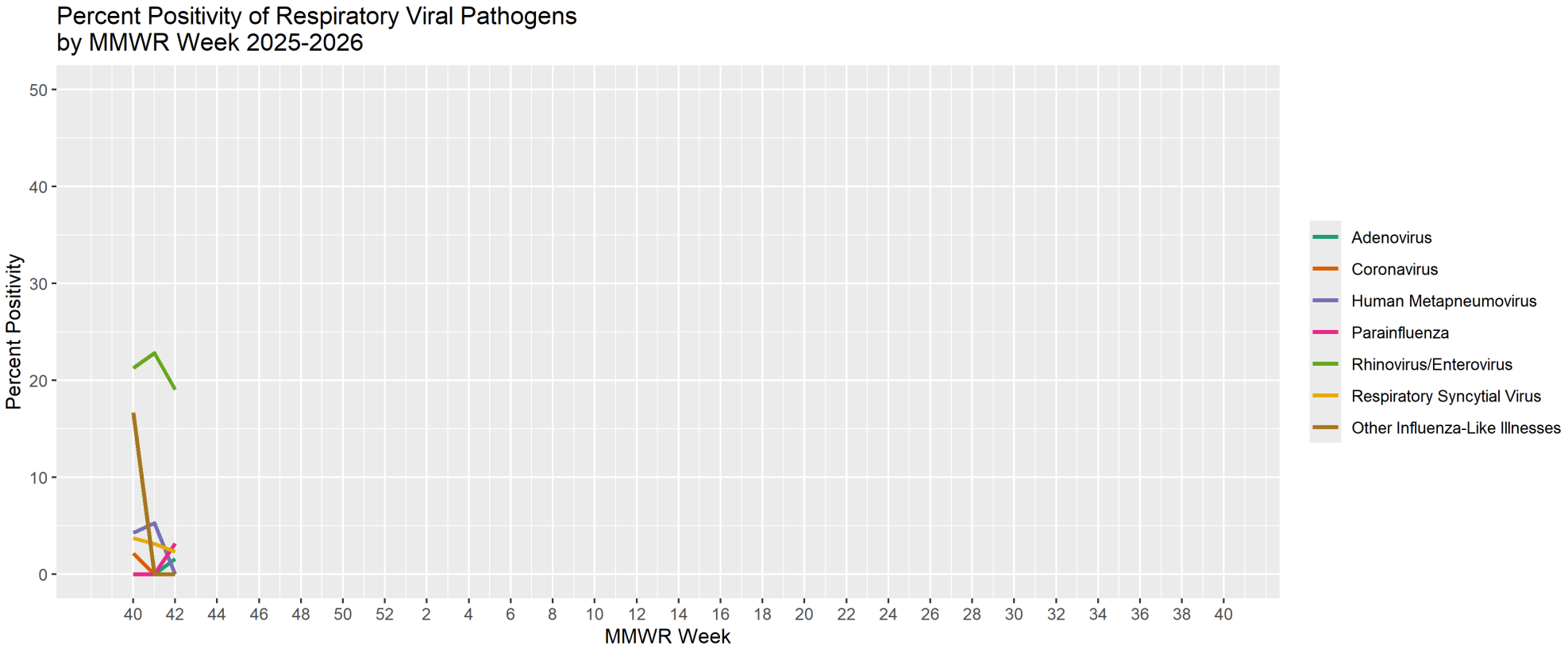
The charts below show the laboratory results of all specimens tested for influenza by MMWR week during the 2025–2026 influenza season as well as the type and subtype of positive results for influenza. Again, sub-typing is only performed on selected specimens tested by confirmatory tests (i.e., RT-PCR or viral culture).





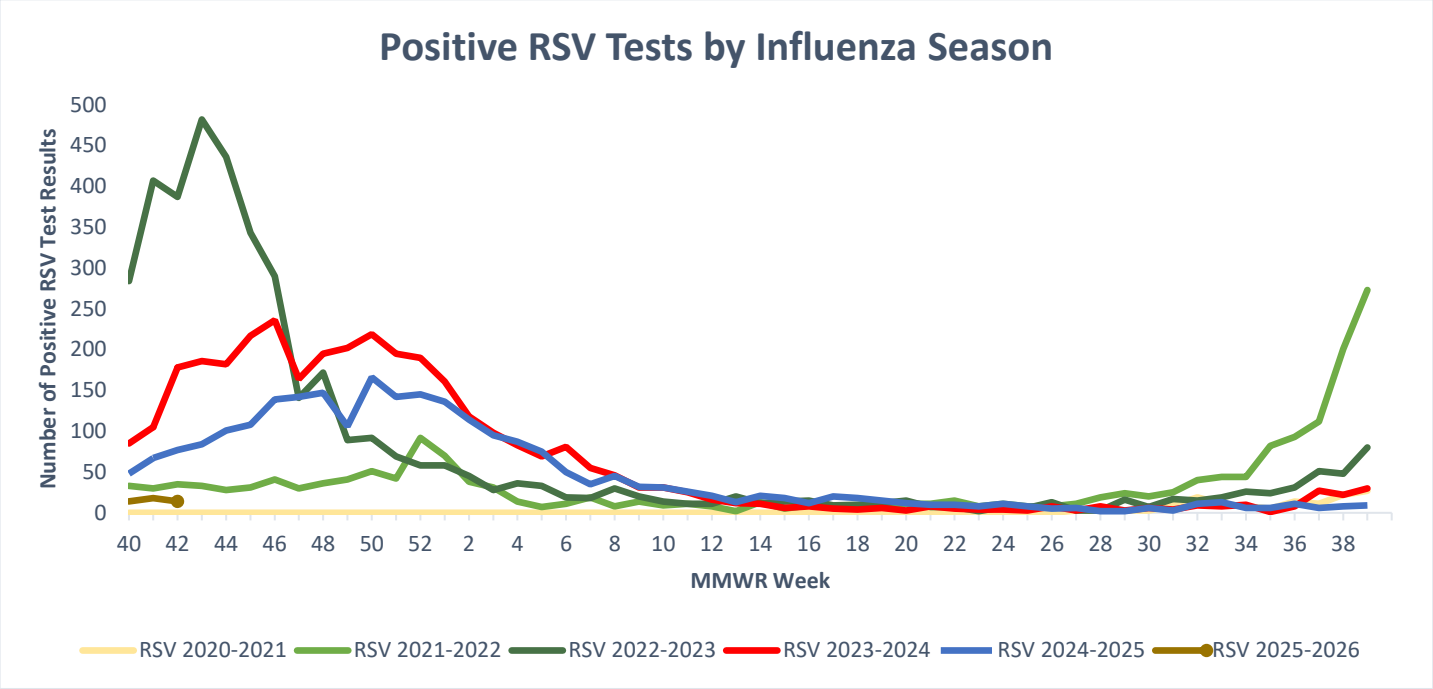
** A total of 3,247 specimens underwent confirmatory testing but not all positive influenza specimens receive confirmatory testing that are circulating in Hawaii.*

B. OTHER RESPIRATORY PATHOGENS: The major clinical and commercial laboratories throughout the state of Hawaii have the testing capacity for non-influenza respiratory pathogens and report these to HDOH. However, such testing is performed as needed and when sufficient resources are available because of the high costs associated with respiratory panel tests. **Therefore, available data represent only the presence of circulating pathogens and cannot be used to determine specific trends**.

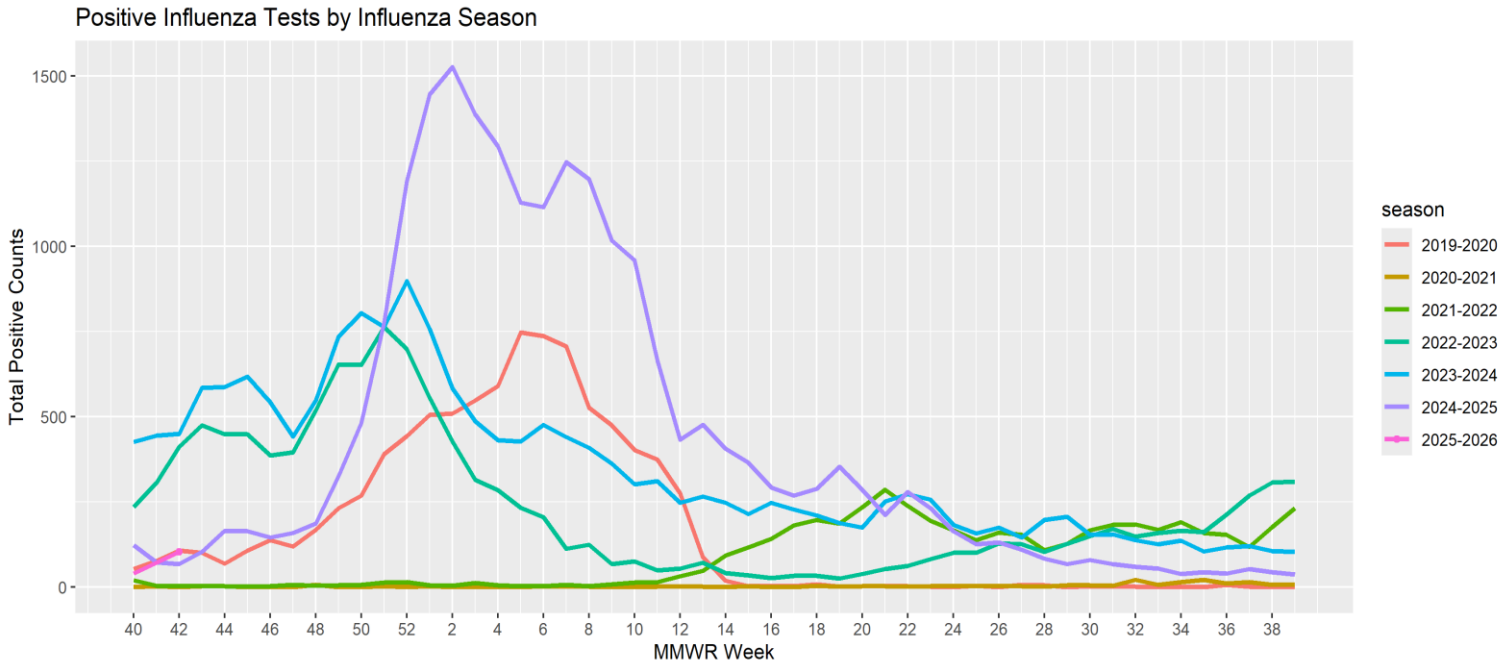


* *The coronavirus presented on this table does not indicate Severe Acute Respiratory Coronavirus-2 (i.e., COVID-19).*

RESPIRATORY SYNCYTIAL VIRUS (RSV) POSITIVE TEST RESULTS BY INFLUENZA SEASON: RSV case appears to have increased earlier than past seasons in the 2025-2026 season. Of note, significantly more tests for RSV are being performed than in pre-COVID-19 seasons.



INFLUENZA POSITIVE TEST RESULTS BY INFLUENZA SEASON: Influenza cases appear to have increased earlier than past seasons in the 2023-2024 season, but it is not yet known whether case numbers will reach a peak similar to pre-COVID-19 seasons.



C. COVID-19 SENTINEL SURVEILLANCE: Due to the low volume of samples currently available through the influenza surveillance system, the COVID-19 sentinel surveillance data may not be accurately portraying COVID-19 activity in our communities. Reporting of the COVID-19 Sentinel Surveillance data will be paused while HODH re-evaluates the program to ensure that the reported data are accurate and representative.

HDOH is continuing to monitor COVID-19 activity throughout the state. To learn more, please visit the Hawaii's COVID-19 data website (*here*). For more information on surveillance of COVID-19 activity in the United States please visit the CDC COVIDView website (*here*).

III. PNEUMONIA, INFLUENZA, AND COVID-19 (PIC) RELATED MORTALITY:

P&I mortality surveillance is collected by CDC through the National Center for Health Statistics (NCHS) using death certificate data. Each week the HDOH OHSM reports specific data from Honolulu to the CDC. CDC collects the following information by age group: the total number of deaths, total deaths from pneumonia, and total deaths related to influenza. Due to the ongoing COVID-19 pandemic, CDC included total deaths from COVID-19 by age group to the death data. Previous studies had suggested that P&I is a good indicator of influenza-related deaths; however, data has shown that pneumonia deaths associated with influenza is now being impacted by COVID-19 related pneumonia. Due to this, CDC had added COVID-19 deaths into P&I to create the PIC (pneumonia, influenza, and/or COVID-19) classification.

To standardize Hawaii's influenza surveillance with CDC influenza surveillance guidelines, PIC deaths will be reported in lieu of P&I. Hawaii's baseline will begin to include PIC deaths starting from 2019-2020 flu season.

On October 1, 2025, certain federal government activities have ceased due to a lack of appropriated funding. The National Vital Statistic System (NVSS) surveillance datasets and reports had been paused temporarily, including those used to evaluate pneumonia, influenza, and COVID-19 deaths. HDOH PIC mortality data will not be published in the Influenza/Respiratory Disease Surveillance Report for week 42. Data updates are expected to resume following the conclusion of the government shutdown.

INFLUENZA-ASSOCIATED PEDIATRIC DEATHS[11]:

- No new influenza-associated pediatric death was reported to Hawaii. There have been zero influenza-associated pediatric deaths reported in Hawaii during the 2025–2026 season.
- Nationally, no new influenza-associated pediatric deaths were reported to CDC during week 42. (2025-2026 season total: 0).

IV. INFLUENZA WATCH: As part of a comprehensive influenza surveillance system and to prevent the spread of contagious respiratory diseases in humans, it is important to monitor all circulating influenza types. Several animal-origin influenza A subtypes are currently of interest: influenza A variant virus (H3N2v, H1N2v, and H1N1v) and Avian flu (H5N1 and H7N9). These types of influenza viruses may cause zoonotic (animal-associated) disease and are a public health concern.

A. VARIANT VIRUSES:

Influenza viruses that normally circulate in pigs are called "variant" viruses when they are found in people. These viruses were first identified in U.S. pigs in 2010. In 2011, 12 cases of H3N2v infection were detected in the United States. In 2012, 309 such cases (resulting in 16 hospitalizations and one death) across 12 states were detected, including one Hawaii case who recovered. Illness associated with H3N2v infection has been mostly mild with symptoms similar to those of seasonal flu. However, serious illness, resulting in hospitalization and death, has occurred in some cases. Most of these infections have been associated with prolonged exposure to pigs at agricultural fairs or similar settings. Limited human-to-human spread of this virus has been detected in the past, but no sustained community spread of H3N2v has been identified. More information regarding H3N2v, H1N1v, and H1N2v viruses may be found on the CDC website (*here*) and (*here*).

- *No variant or novel influenza infections have been reported to HDOH during the 2025-2026 influenza season.*
- *No new human infection with novel influenza A virus, H1N1v (0), H3N2v (0), and H1N2v (0), have been reported during the 2025-2026 influenza season.*

AVIAN (OR BIRD) INFLUENZA: These types of influenza viruses cause zoonotic (animal-associated) disease of public health concern and are therefore monitored globally by the WHO. Most avian influenza viruses do not cause disease in humans and are generally not easily transmissible between person to person, but a few subtypes may cross the species barrier and cause disease in humans. Avian influenza viruses may be of various subtypes, including H5N1, H5N2, H5N8, H7N3, H7N7, H7N8, H7N9, and H9N2. On January 15th, 2016, the USDA and APHIS reported detection of HPAI H7N8 in a commercial turkey flock in Indiana. There have been no associated human infections. This is the first detection of HPAI H7N8 in wild bird surveillance in the United States. More information, the risk assessment and recommendations for HPAI H7N8 can be found (here). The WHO, CDC, and other public health agencies have also been monitoring influenza H7N9, which represents a public health concern because of its high pandemic potential. Although H7N9 has not been detected in the United States, it remains a global concern given continuing epidemics in endemic countries. Since 2013, a total of 1,568 laboratory-confirmed cases of human infection with H7N9 viruses, including at least 613 deaths, have been reported to WHO. More information on H7N9 virus infections can be found (here). For more information regarding avian influenza, please visit the CDC (*here*) or the WHO (*here*) websites. WHO reports total number of cases and deaths related to laboratory-confirmed avian influenza viruses and posts current avian influenza case counts (*here*), which were last updated on **May 27, 2025**..

[11] Influenza-associated deaths are considered pediatric in persons aged less than 18 years. It was made a nationally notifiable condition in October, 2004. All pediatric influenza-associated deaths are laboratory confirmed.

V. INFLUENZA Vaccine: Annual influenza vaccination is recommended for all persons aged 6 months and older and is the most effective way to reduce the risk of getting sick with seasonal flu and spreading it to others. Influenza vaccination can reduce illnesses, visits to the doctor, influenza-related hospitalizations, and missed work and school days. Influenza vaccines become available by the end of October. It takes at least two weeks after vaccination to confer immunity against influenza virus infection. More information regarding influenza vaccination can be found (*here*).

A. Composition of the 2025–2026 Influenza Vaccine**:**

The composition of the 2025–2026 influenza vaccine has been updated to better match circulating influenza viruses. The Advisory Committee on Immunization Practices (ACIP) has recommended that the 2025-2026 influenza trivalent vaccine contain an influenza A/Victoria/4897/2022 (H1N1) pdm09-like virus, influenza A/Croatia/10136RV/2023 (H3N2)-like virus, and influenza B/Austria/1359417/2021 (B/Victoria lineage)-like virus. United States cell culture–based inactivated (ccIIV4) and recombinant (RIV4) influenza vaccines will contain HA derived from an influenza A/Wisconsin/67/2022 (H1N1) pdm09-like virus, an A/District of Columbia/27/2023 (H3N2)-like virus, an influenza B/Austria/1359417/2021 (B/Victoria lineage)-like virus. These vaccine recommendations were based on several factors, including global influenza virologic and epidemiologic surveillance, genetic and antigenic characterization, human serology studies, antiviral susceptibility, and the availability of candidate influenza viruses.

APPENDIX 1: ADDITIONAL INFORMATION

For more information regarding local and national influenza surveillance programs, visit the following sites.

Centers for Disease Control and Prevention	General Influenza National ILI and P&I Data Vaccine Virus Selection CDC Web Tool for Respiratory Viruses
Flu.gov	General Influenza Information
HDOH Flu and Pneumonia	General Influenza Surveillance Avian Influenza Respiratory Virus Dashboard To find out more information or join the sentinel physician program, email the Influenza Surveillance Coordinator
World Health Organization	General Global and Local Influenza Avian Influenza

APPENDIX 2: MMWR WEEK DATES

Please refer to the table below to interpret data presented by MMWR week. Week 40 is considered the traditional start for the flu season for the Northern Hemisphere.

MMWR WEEK	2022	2023	2024	2025	2026
1	1/8/2022	1/7/2023	1/6/2024	1/4/2025	1/10/2026
2	1/15/2022	1/14/2023	1/13/2024	1/11/2025	1/17/2026
3	1/22/2022	1/21/2023	1/20/2024	1/18/2025	1/24/2026
4	1/29/2022	1/28/2023	1/27/2024	1/25/2025	1/31/2026
5	2/5/2022	2/4/2023	2/3/2024	2/1/2025	2/7/2026
6	2/12/2022	2/11/2023	2/10/2024	2/8/2025	2/14/2026
7	2/19/2022	2/18/2023	2/17/2024	2/15/2025	2/21/2026
8	2/26/2022	2/25/2023	2/24/2024	2/22/2025	2/28/2026
9	3/5/2022	3/4/2023	3/2/2024	3/1/2025	3/7/2026
10	3/12/2022	3/11/2023	3/9/2024	3/8/2025	3/14/2026
11	3/19/2022	3/18/2023	3/16/2024	3/15/2025	3/21/2026
12	3/26/2022	3/25/2023	3/23/2024	3/22/2025	3/28/2026
13	4/2/2022	4/1/2023	3/30/2024	3/29/2025	4/4/2026
14	4/9/2022	4/8/2023	4/6/2024	4/5/2025	4/11/2026
15	4/16/2022	4/15/2023	4/13/2024	4/12/2025	4/18/2026
16	4/23/2022	4/22/2023	4/20/2024	4/19/2025	4/25/2026
17	4/30/2022	4/29/2023	4/27/2024	4/26/2025	5/2/2026
18	5/7/2022	5/6/2023	5/4/2024	5/3/2025	5/9/2026
19	5/14/2022	5/13/2023	5/11/2024	5/10/2025	5/16/2026
20	5/21/2022	5/20/2023	5/18/2024	5/17/2025	5/23/2026
21	5/28/2022	5/27/2023	5/25/2024	5/24/2025	5/30/2026
22	6/4/2022	6/3/2023	6/1/2024	5/31/2025	6/6/2026
23	6/11/2022	6/10/2023	6/8/2024	6/7/2025	6/13/2026
24	6/18/2022	6/17/2023	6/15/2024	6/14/2025	6/20/2026
25	6/25/2022	6/24/2023	6/22/2024	6/21/2025	6/27/2026
26	7/2/2022	7/1/2023	6/29/2024	6/28/2025	7/4/2026
27	7/9/2022	7/8/2023	7/6/2024	7/5/2025	7/11/2026
28	7/16/2022	7/15/2023	7/13/2024	7/12/2025	7/18/2026
29	7/23/2022	7/22/2023	7/20/2024	7/19/2025	7/25/2026
30	7/30/2022	7/29/2023	7/27/2024	7/26/2025	8/1/2026
31	8/6/2022	8/5/2023	8/3/2024	8/2/2025	8/8/2026
32	8/13/2022	8/12/2023	8/10/2024	8/9/2025	8/15/2026
33	8/20/2022	8/19/2023	8/17/2024	8/16/2025	8/22/2026
34	8/27/2022	8/26/2023	8/24/2024	8/23/2025	8/29/2026
35	9/3/2022	9/2/2023	8/31/2024	8/30/2025	9/5/2026
36	9/10/2022	9/9/2023	9/7/2024	9/6/2025	9/12/2026
37	9/17/2022	9/16/2023	9/14/2024	9/13/2025	9/19/2026
38	9/24/2022	9/23/2023	9/21/2024	9/20/2025	9/26/2026
39	10/1/2022	9/30/2023	9/28/2024	9/27/2025	10/3/2026
40	10/8/2022	10/7/2023	10/5/2024	10/4/2025	10/10/2026
41	10/15/2022	10/14/2023	10/12/2024	10/11/2025	10/17/2026
42	10/22/2022	10/21/2023	10/19/2024	10/18/2025	10/24/2026
43	10/29/2022	10/28/2023	10/26/2024	10/25/2025	10/31/2026
44	11/5/2022	11/4/2023	11/2/2024	11/1/2025	11/7/2026
45	11/12/2022	11/11/2023	11/9/2024	11/8/2025	11/14/2026
46	11/19/2022	11/18/2023	11/16/2024	11/15/2025	11/21/2026
47	11/26/2022	11/25/2023	11/23/2024	11/22/2025	11/28/2026
48	12/3/2022	12/2/2023	11/30/2024	11/29/2025	12/5/2026
49	12/10/2022	12/9/2023	12/7/2024	12/6/2025	12/12/2026
50	12/17/2022	12/16/2023	12/14/2024	12/13/2025	12/19/2026
51	12/24/2022	12/23/2023	12/21/2024	12/20/2025	12/26/2026
52	12/31/2022	12/30/2023	12/28/2024	12/27/2025	
53				01/03/2026	

HAWAII STATE DEPARTMENT OF HEALTH
DISEASE OUTBREAK CONTROL DIVISION

Influenza/Respiratory Disease Surveillance Report

Morbidity and Mortality Weekly Report (MMWR)[1]

WEEK 43: OCTOBER 19, 2025– OCTOBER 25, 2025

OVERVIEW: The Hawaii State Department of Health (HDOH) monitors influenza and other respiratory pathogens, including COVID-19, throughout the state of Hawaii. Influenza surveillance in the state of Hawaii relies upon selected sentinel health practitioners, the State Laboratories Division (SLD), private laboratories, and the Office of Health Status Monitoring (OHSM). For detailed information concerning influenza, please visit the HDOH Disease Outbreak Control Division (HDOH DOCD) website (*here*). **All data and information are conditional and may change as more reports are received.** The data in this report reflect the 2025-2026 influenza season which began the week ending October 4, 2025 (week 40[1] 2025) and will end the week ending on October 3, 2026 (week 39 2026).

REPORT SNAPSHOT FOR WEEK 43

Surveillance for Influenza-like Illness (ILI)		
Metric	*Value*	*Comment*
Outpatient visits related to influenza-like illness (ILI) from ILINet Sentinel Providers	2.5%	Higher than the previous week. Comparable to the Hawaii's historical baseline and Lower than the national baseline. Comparison to national ILI rate is unavailable at this time.
Number of ILI clusters reported to HDOH	2	There have been 2 clusters this season.

Laboratory Surveillance		
Percent of all respiratory specimens positive for influenza this week	5.8%	Higher than the previous week. This number means that many, if not all, of the 94.2% who tested negative for influenza had illness from another respiratory etiology.
Percent of all respiratory specimens positive for influenza this season to date	4.1%	

Surveillance for Severe Outcomes		
Pneumonia, influenza and COVID-19 (PIC) mortality rate		No new report for PIC mortality rates is available this week due to a pause in data updates from the National Vital Statistics System (NVSS).
Number of influenza-associated pediatric deaths reported nationwide	0	0 influenza-associated pediatric deaths have been reported from Hawaii this season to date.

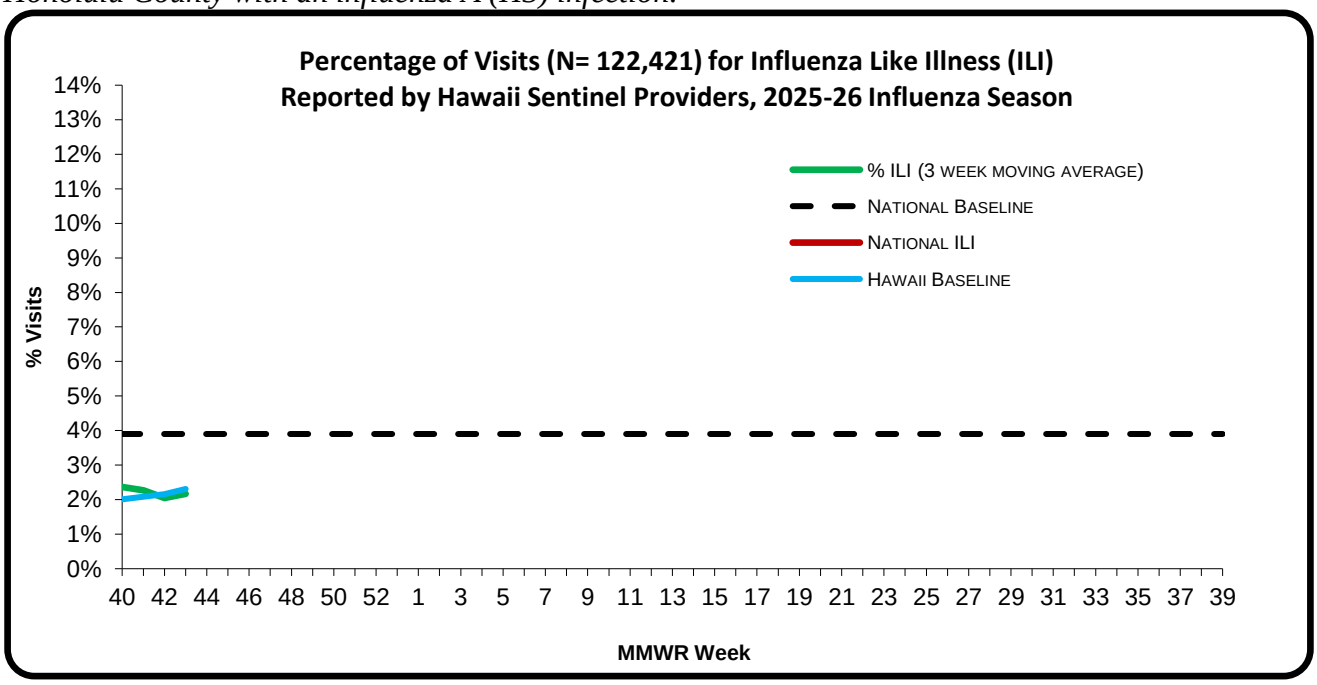
[1] MMWR stands for "Morbidity and Mortality Weekly Report," conventionally used by the Centers for Disease Control and Prevention (CDC). The weeks of a flu season are often referred to by their respective MMWR week. **See appendix 2 for interpretation of MMWR weeks.** Data reported will begin on week 40, the traditional start date of flu season.

INFLUENZA SURVEILLANCE

I. INFLUENZA-LIKE ILLNESS (ILI): HDOH collaborates with recruited doctors and healthcare providers who report the total number of outpatient visits for ILI as well as the total number of patients who complained of symptoms consistent with an ILI. A patient with ILI must have the following: a fever (temperature of 100°F [37.8°C] or greater) AND a cough and/or a sore throat. ILI is based on reported symptoms and not laboratory confirmed tests; thus, ILI may represent other respiratory pathogens and not solely influenza. Further, sentinel providers report these numbers on a weekly basis; therefore, data are preliminary and may change depending on additional reporting. In combination with laboratory testing and other surveillance systems, ILI surveillance helps monitor influenza and other respiratory pathogen activity. For more information concerning ILINet and sentinel requirements, please visit the CDC website (*here*).

For **week 43** of the current influenza season:

- ***2.5%*** *(season to date:* ***2.2%****) of the outpatient visits recorded by Hawaii sentinel providers were for ILI.*
- *ILI visits were comparable to the historical baseline in Hawaii[2,3] (i.e., inside the 95% confidence interval).*
- *Hawaii's ILI outpatient visits were lower than the national baseline (****3.1%****)[4] (i.e., inside the 95% confidence interval). Comparison to national ILI rate is unavailable at this time.*
- *ILI activity level: Low[5]*
- *Geographic Spread: Sporadic Activity[6].*
- *ILI Cluster Activity: Two new clusters were reported to HDOH during week 43 in two schools located in Honolulu County with an influenza A (H3) infection.*



[2] The Hawaii historical baseline (%ILI) is the average of 3-week moving averages over the preceding 10 flu seasons of historical data (2015-2016, 2016-2017, 2017-2018, 2018-2019, 2019-2020, 2020-2021, 2021-2022, 2022-2023, 2023-2024 and 2024-2025).

[3] This value is based upon comparison of actual outpatient ILI with the historical baseline, which only captures outpatient ILI. The chart above represents a 3-week moving average and not the actual ILI by week.

[4] The National Baseline is calculated by CDC as the mean percentage of visits for ILI during weeks 21–39 with two standard deviations. Because of large variability in regional ILI, comparison of the national baseline with local ILI may not be appropriate. It is provided in this report because no meaningful regional baselines are available for comparison. The national baseline combines all data reported by states to CDC, including ILI in outpatient, ER, urgent care, and inpatient settings.

[5] There are 10 activity levels classified as minimal (levels 1-3), low (levels 4-5), moderate (levels 6-7), and high (levels 8-10).

[6] The influenza activity reported by state and territorial epidemiologists indicates geographic spread of influenza viruses but does not measure the severity of influenza activity. Sporadic: no clusters reported to HDOH, Local: one or more clusters reported in one county, Regional: clusters reported two to three counties, Widespread: clusters reported in all counties. Hawaii does not report No Activity, as flu circulates year-round in Hawaii.

II. LABORATORY SURVEILLANCE: State Laboratories Division (SLD; the HDOH public health laboratory) and Hawaii's major private laboratories (DLS, CLH) report results of RT-PCR, which can be considered confirmatory (SLD may perform viral culture on select specimens). Specimens meeting priority criteria[7] are forwarded to SLD for sub-typing. Additionally, specimens meeting case definition from requesting sentinel providers are sent directly to SLD for sub-typing. Due to resource constraints, not all submitted specimens undergo sub-typing. Sub-typing at the commercial laboratories is only conducted on a case-by-case basis. The majority of specimens testing positive by rapid antigen testing or RT-PCR at the commercial laboratories do not meet criteria and are not subtyped. For more information on influenza tests and types, please visit the CDC website (*here*).

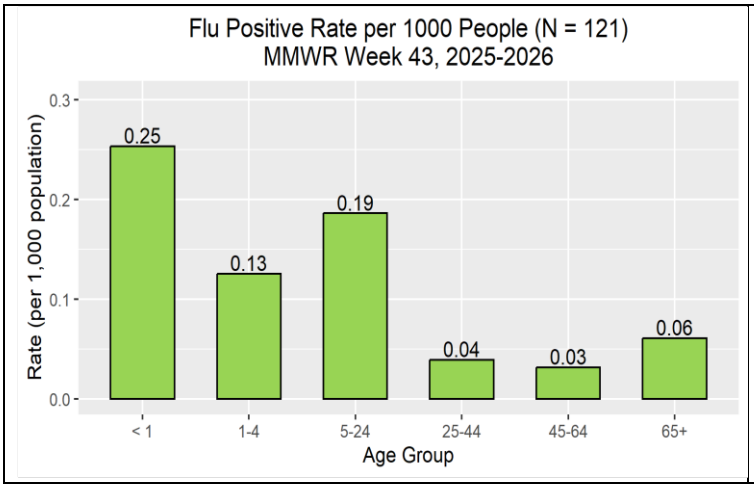
A. INFLUENZA:

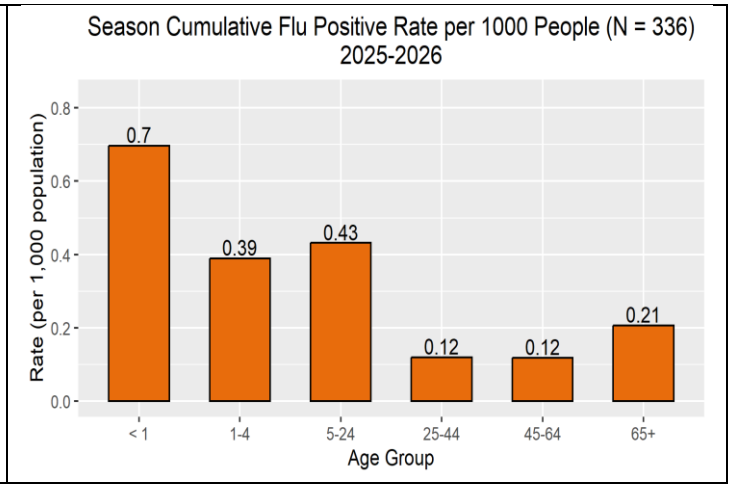
- The following reflects laboratory findings for week 43 of the 2025–26 influenza season:
  - *A total of **2,100** specimens have been tested statewide for influenza viruses (positive: 121 [**5.8%**]). (Season to date: **8,097** tested (**4.1%** positive])*
    - *948 (45.1%) were screened only by rapid antigen tests with no confirmatory testing.*
    - *1,152 (54.9%) underwent confirmatory testing (either RT-PCR or viral culture).*
    - *1,979 (94.2%) were negative.*

Influenza type	*Current week 43 (%)*	*Season to date (%)*[8]
Influenza A (H1)[9]	*3 (2.5)*	*5 (1.5)*
Influenza A (H3)	*2 (1.6)*	*3 (0.9)*
Influenza A no subtyping	*113 (93.4)*	*314 (93.4)*
Influenza B (Yamagata)	*0 (0.0)*	*0 (0.0)*
Influenza B (Victoria)	*0 (0.0)*	*0 (0.0)*
Influenza B no genotyping	*3 (2.5)*	*14 (4.2)*

1. AGE DISTRIBUTION

The charts below indicate the population-based rates of positive influenza cases in Hawaii by age group during the 2025–26 influenza season.[10]

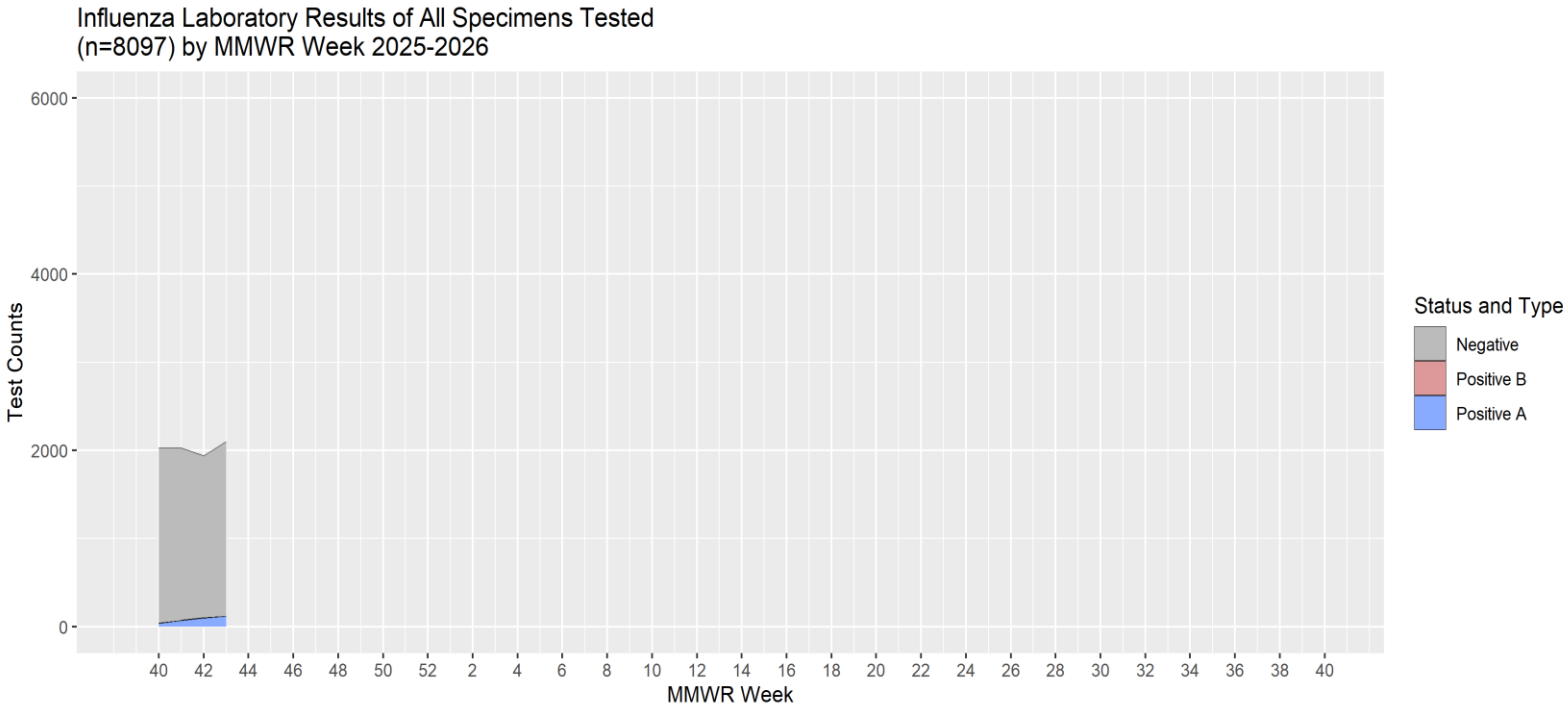


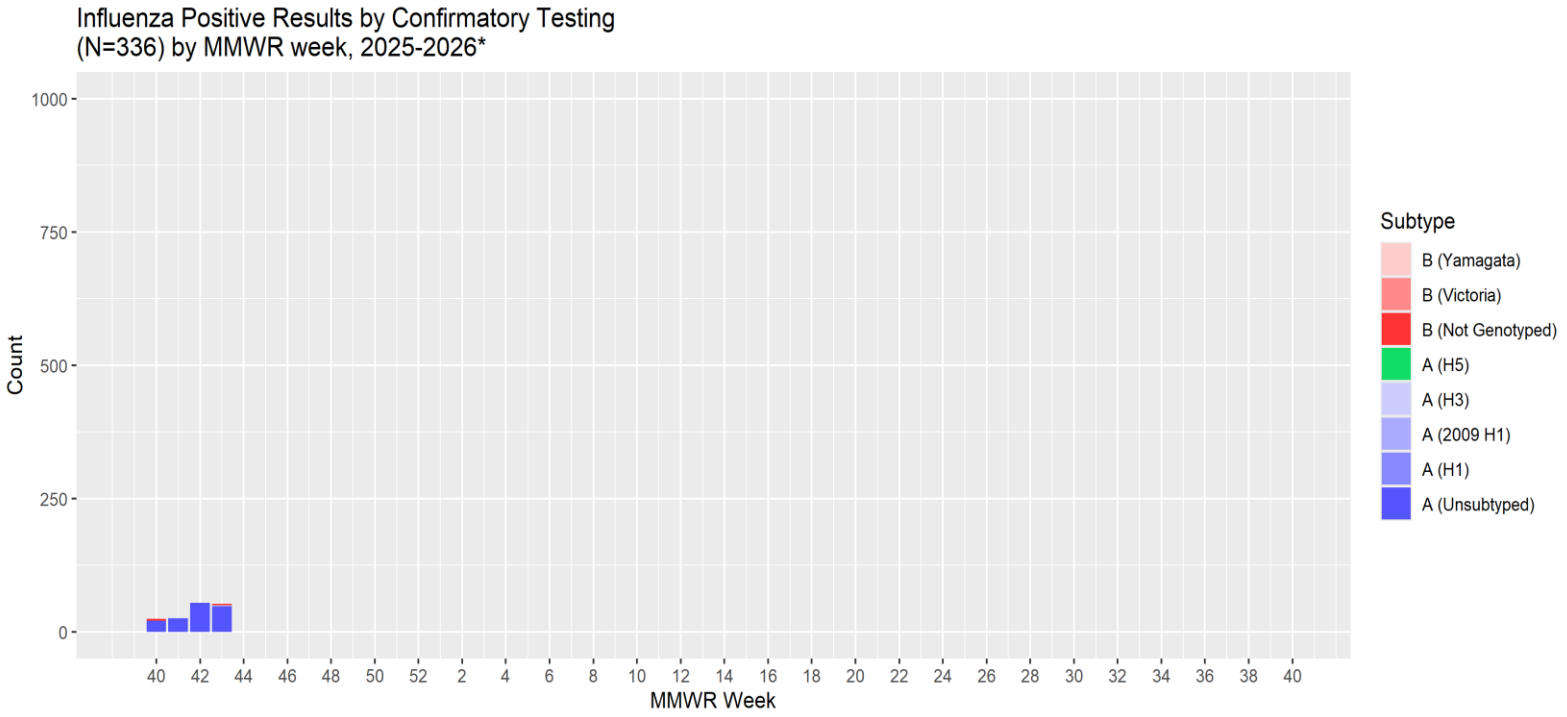


[7] Priority criteria include: hospitalized patients with acute respiratory distress syndrome [ARDS] or x-ray confirmed pneumonia; travelers with international travel history within 10 days of onset; specimens submitted by sentinel providers; specimens collected from healthcare workers, pregnant women, or women up to 6 weeks' post-partum; those with underlying medical conditions; and patients presenting with unusual or severe manifestations of influenza infection.
[8] Influenza coding were updated to reflect a more accurate count.
[9] All influenza A H1 viruses detected this season have been 2009 H1N1.
[10] This represents an estimate of population-based rates based on available data.

2. LABORATORY TESTING

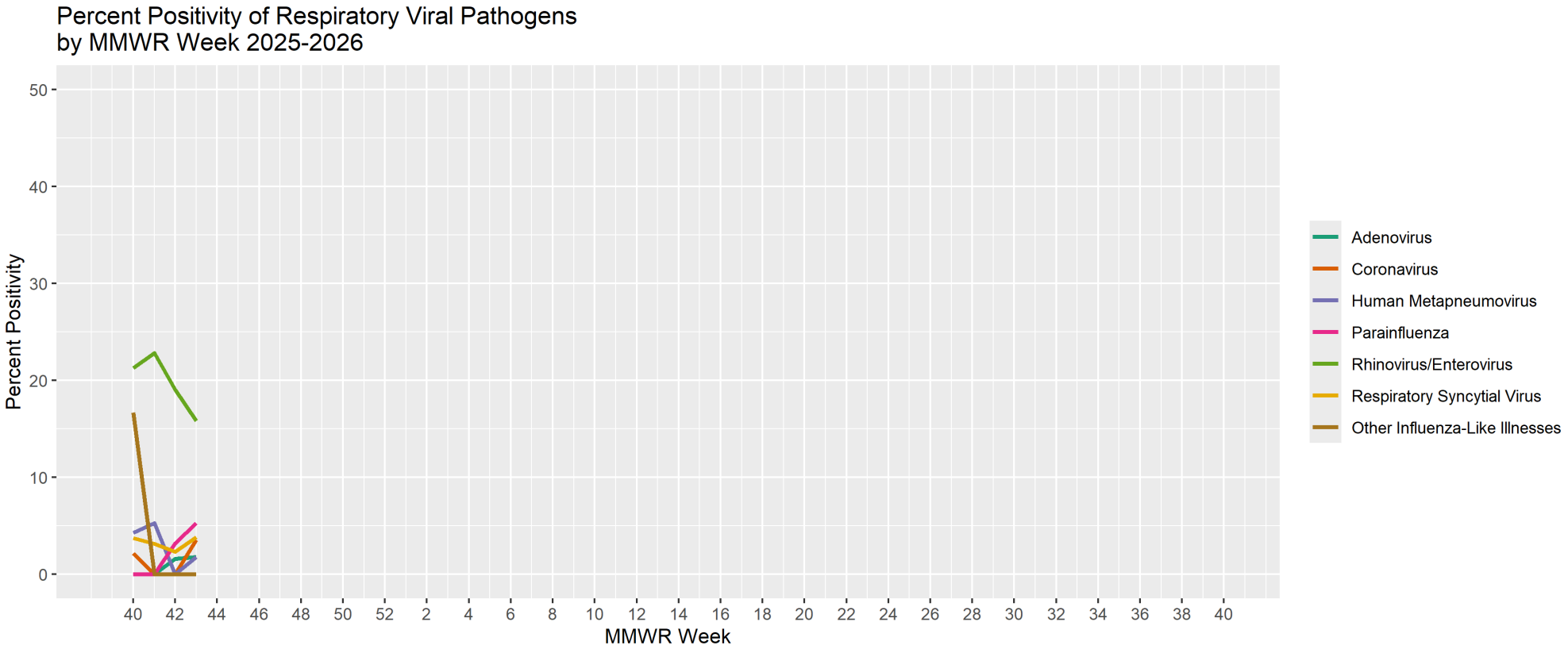
The charts below show the laboratory results of all specimens tested for influenza by MMWR week during the 2025–2026 influenza season as well as the type and subtype of positive results for influenza. Again, sub-typing is only performed on selected specimens tested by confirmatory tests (i.e., RT-PCR or viral culture).





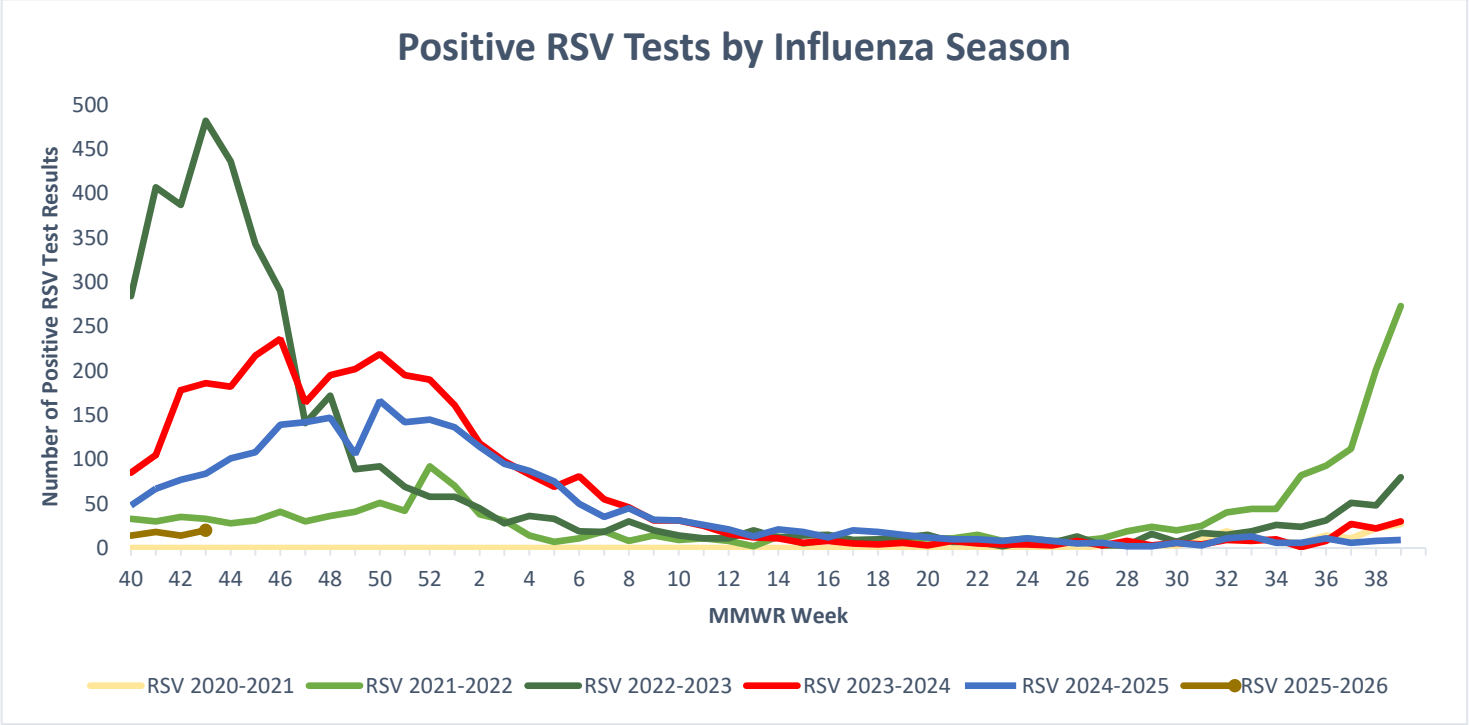
** A total of 4,399 specimens underwent confirmatory testing but not all positive influenza specimens receive confirmatory testing that are circulating in Hawaii.*

B. OTHER RESPIRATORY PATHOGENS: The major clinical and commercial laboratories throughout the state of Hawaii have the testing capacity for non-influenza respiratory pathogens and report these to HDOH. However, such testing is performed as needed and when sufficient resources are available because of the high costs associated with respiratory panel tests. **Therefore, available data represent only the presence of circulating pathogens and cannot be used to determine specific trends**.

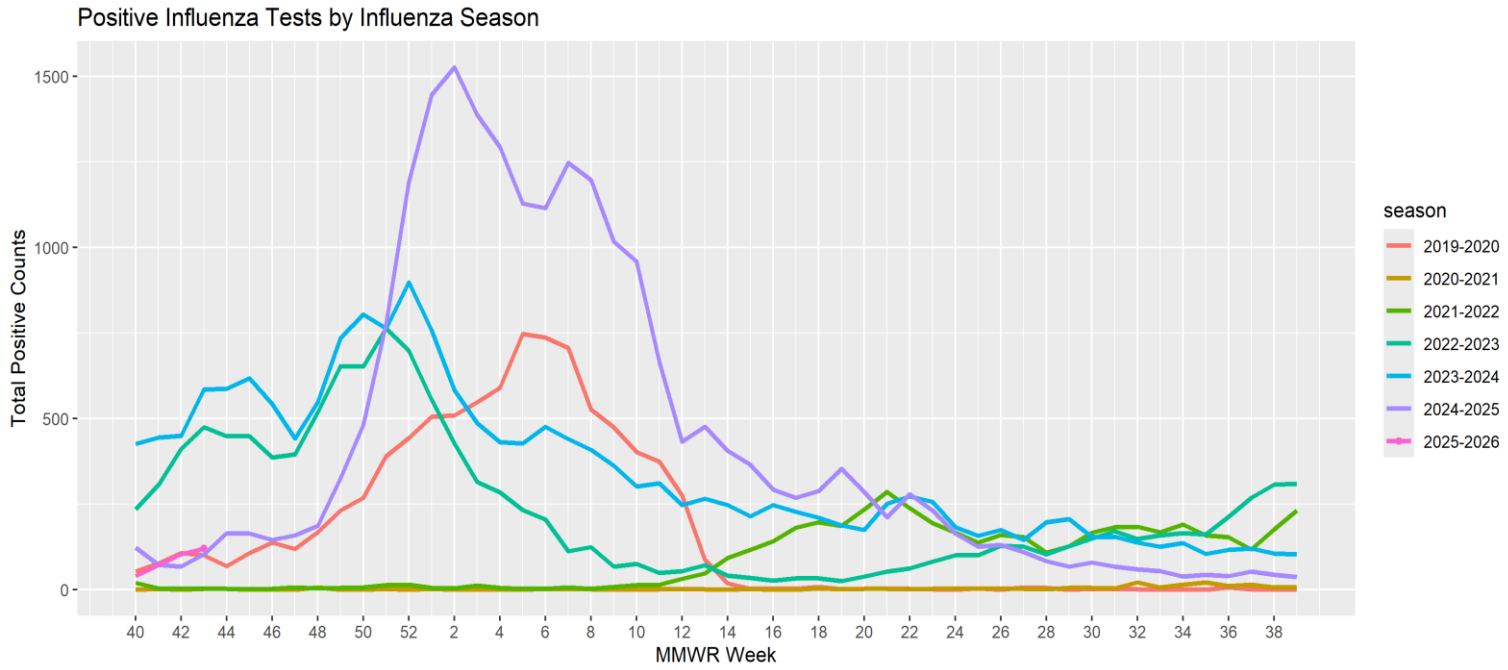


* *The coronavirus presented on this table does not indicate Severe Acute Respiratory Coronavirus-2 (i.e., COVID-19).*

RESPIRATORY SYNCYTIAL VIRUS (RSV) POSITIVE TEST RESULTS BY INFLUENZA SEASON: RSV case appears to have increased earlier than past seasons in the 2025-2026 season. Of note, significantly more tests for RSV are being performed than in pre-COVID-19 seasons.



INFLUENZA POSITIVE TEST RESULTS BY INFLUENZA SEASON: Influenza cases appear to have increased earlier than past seasons in the 2023-2024 season, but it is not yet known whether case numbers will reach a peak similar to pre-COVID-19 seasons.



C. COVID-19 SENTINEL SURVEILLANCE: Due to the low volume of samples currently available through the influenza surveillance system, the COVID-19 sentinel surveillance data may not be accurately portraying COVID-19 activity in our communities. Reporting of the COVID-19 Sentinel Surveillance data will be paused while HODH re-evaluates the program to ensure that the reported data are accurate and representative.

HDOH is continuing to monitor COVID-19 activity throughout the state. To learn more, please visit the Hawaii's COVID-19 data website (*here*). For more information on surveillance of COVID-19 activity in the United States please visit the CDC COVIDView website (*here*).

III. PNEUMONIA, INFLUENZA, AND COVID-19 (PIC) RELATED MORTALITY:

P&I mortality surveillance is collected by CDC through the National Center for Health Statistics (NCHS) using death certificate data. Each week the HDOH OHSM reports specific data from Honolulu to the CDC. CDC collects the following information by age group: the total number of deaths, total deaths from pneumonia, and total deaths related to influenza. Due to the ongoing COVID-19 pandemic, CDC included total deaths from COVID-19 by age group to the death data. Previous studies had suggested that P&I is a good indicator of influenza-related deaths; however, data has shown that pneumonia deaths associated with influenza is now being impacted by COVID-19 related pneumonia. Due to this, CDC had added COVID-19 deaths into P&I to create the PIC (pneumonia, influenza, and/or COVID-19) classification.

To standardize Hawaii's influenza surveillance with CDC influenza surveillance guidelines, PIC deaths will be reported in lieu of P&I. Hawaii's baseline will begin to include PIC deaths starting from 2019-2020 flu season.

On October 1, 2025, certain federal government activities have ceased due to a lack of appropriated funding. The National Vital Statistic System (NVSS) surveillance datasets and reports had been paused temporarily, including those used to evaluate pneumonia, influenza, and COVID-19 deaths. HDOH PIC mortality data will not be published in the Influenza/Respiratory Disease Surveillance Report for week 43. Data updates are expected to resume following the conclusion of the government shutdown.

INFLUENZA-ASSOCIATED PEDIATRIC DEATHS[11]:

- No new influenza-associated pediatric death was reported to Hawaii. There have been zero influenza-associated pediatric deaths reported in Hawaii during the 2025–2026 season.
- Nationally, no new influenza-associated pediatric deaths were reported to CDC during week 43. (2025-2026 season total: 0).

IV. INFLUENZA WATCH: As part of a comprehensive influenza surveillance system and to prevent the spread of contagious respiratory diseases in humans, it is important to monitor all circulating influenza types. Several animal-origin influenza A subtypes are currently of interest: influenza A variant virus (H3N2v, H1N2v, and H1N1v) and Avian flu (H5N1 and H7N9). These types of influenza viruses may cause zoonotic (animal-associated) disease and are a public health concern.

A. VARIANT VIRUSES:

Influenza viruses that normally circulate in pigs are called "variant" viruses when they are found in people. These viruses were first identified in U.S. pigs in 2010. In 2011, 12 cases of H3N2v infection were detected in the United States. In 2012, 309 such cases (resulting in 16 hospitalizations and one death) across 12 states were detected, including one Hawaii case who recovered. Illness associated with H3N2v infection has been mostly mild with symptoms similar to those of seasonal flu. However, serious illness, resulting in hospitalization and death, has occurred in some cases. Most of these infections have been associated with prolonged exposure to pigs at agricultural fairs or similar settings. Limited human-to-human spread of this virus has been detected in the past, but no sustained community spread of H3N2v has been identified. More information regarding H3N2v, H1N1v, and H1N2v viruses may be found on the CDC website (*here*) and (*here*).

- *No variant or novel influenza infections have been reported to HDOH during the 2025-2026 influenza season.*
- *No new human infection with novel influenza A virus, H1N1v (0), H3N2v (0), and H1N2v (0), have been reported during the 2025-2026 influenza season.*

AVIAN (OR BIRD) INFLUENZA: These types of influenza viruses cause zoonotic (animal-associated) disease of public health concern and are therefore monitored globally by the WHO. Most avian influenza viruses do not cause disease in humans and are generally not easily transmissible between person to person, but a few subtypes may cross the species barrier and cause disease in humans. Avian influenza viruses may be of various subtypes, including H5N1, H5N2, H5N8, H7N3, H7N7, H7N8, H7N9, and H9N2. On January 15th, 2016, the USDA and APHIS reported detection of HPAI H7N8 in a commercial turkey flock in Indiana. There have been no associated human infections. This is the first detection of HPAI H7N8 in wild bird surveillance in the United States. More information, the risk assessment and recommendations for HPAI H7N8 can be found (here). The WHO, CDC, and other public health agencies have also been monitoring influenza H7N9, which represents a public health concern because of its high pandemic potential. Although H7N9 has not been detected in the United States, it remains a global concern given continuing epidemics in endemic countries. Since 2013, a total of 1,568 laboratory-confirmed cases of human infection with H7N9 viruses, including at least 613 deaths, have been reported to WHO. More information on H7N9 virus infections can be found (here). For more information regarding avian influenza, please visit the CDC (*here*) or the WHO (*here*) websites. WHO reports total number of cases and deaths related to laboratory-confirmed avian influenza viruses and posts current avian influenza case counts (*here*), which were last updated on **May 27, 2025**..

[11] Influenza-associated deaths are considered pediatric in persons aged less than 18 years. It was made a nationally notifiable condition in October, 2004. All pediatric influenza-associated deaths are laboratory confirmed.

V. INFLUENZA Vaccine: Annual influenza vaccination is recommended for all persons aged 6 months and older and is the most effective way to reduce the risk of getting sick with seasonal flu and spreading it to others. Influenza vaccination can reduce illnesses, visits to the doctor, influenza-related hospitalizations, and missed work and school days. Influenza vaccines become available by the end of October. It takes at least two weeks after vaccination to confer immunity against influenza virus infection. More information regarding influenza vaccination can be found (*here*).

A. Composition of the 2025–2026 Influenza Vaccine**:**

The composition of the 2025–2026 influenza vaccine has been updated to better match circulating influenza viruses. The Advisory Committee on Immunization Practices (ACIP) has recommended that the 2025-2026 influenza trivalent vaccine contain an influenza A/Victoria/4897/2022 (H1N1) pdm09-like virus, influenza A/Croatia/10136RV/2023 (H3N2)-like virus, and influenza B/Austria/1359417/2021 (B/Victoria lineage)-like virus. United States cell culture–based inactivated (ccIIV4) and recombinant (RIV4) influenza vaccines will contain HA derived from an influenza A/Wisconsin/67/2022 (H1N1) pdm09-like virus, an A/District of Columbia/27/2023 (H3N2)-like virus, an influenza B/Austria/1359417/2021 (B/Victoria lineage)-like virus. These vaccine recommendations were based on several factors, including global influenza virologic and epidemiologic surveillance, genetic and antigenic characterization, human serology studies, antiviral susceptibility, and the availability of candidate influenza viruses.

APPENDIX 1: ADDITIONAL INFORMATION

For more information regarding local and national influenza surveillance programs, visit the following sites.

Centers for Disease Control and Prevention	General Influenza National ILI and P&I Data Vaccine Virus Selection CDC Web Tool for Respiratory Viruses
Flu.gov	General Influenza Information
HDOH Flu and Pneumonia	General Influenza Surveillance Avian Influenza Respiratory Virus Dashboard To find out more information or join the sentinel physician program, email the Influenza Surveillance Coordinator
World Health Organization	General Global and Local Influenza Avian Influenza

APPENDIX 2: MMWR WEEK DATES

Please refer to the table below to interpret data presented by MMWR week. Week 40 is considered the traditional start for the flu season for the Northern Hemisphere.

MMWR WEEK	2022	2023	2024	2025	2026
1	1/8/2022	1/7/2023	1/6/2024	1/4/2025	1/10/2026
2	1/15/2022	1/14/2023	1/13/2024	1/11/2025	1/17/2026
3	1/22/2022	1/21/2023	1/20/2024	1/18/2025	1/24/2026
4	1/29/2022	1/28/2023	1/27/2024	1/25/2025	1/31/2026
5	2/5/2022	2/4/2023	2/3/2024	2/1/2025	2/7/2026
6	2/12/2022	2/11/2023	2/10/2024	2/8/2025	2/14/2026
7	2/19/2022	2/18/2023	2/17/2024	2/15/2025	2/21/2026
8	2/26/2022	2/25/2023	2/24/2024	2/22/2025	2/28/2026
9	3/5/2022	3/4/2023	3/2/2024	3/1/2025	3/7/2026
10	3/12/2022	3/11/2023	3/9/2024	3/8/2025	3/14/2026
11	3/19/2022	3/18/2023	3/16/2024	3/15/2025	3/21/2026
12	3/26/2022	3/25/2023	3/23/2024	3/22/2025	3/28/2026
13	4/2/2022	4/1/2023	3/30/2024	3/29/2025	4/4/2026
14	4/9/2022	4/8/2023	4/6/2024	4/5/2025	4/11/2026
15	4/16/2022	4/15/2023	4/13/2024	4/12/2025	4/18/2026
16	4/23/2022	4/22/2023	4/20/2024	4/19/2025	4/25/2026
17	4/30/2022	4/29/2023	4/27/2024	4/26/2025	5/2/2026
18	5/7/2022	5/6/2023	5/4/2024	5/3/2025	5/9/2026
19	5/14/2022	5/13/2023	5/11/2024	5/10/2025	5/16/2026
20	5/21/2022	5/20/2023	5/18/2024	5/17/2025	5/23/2026
21	5/28/2022	5/27/2023	5/25/2024	5/24/2025	5/30/2026
22	6/4/2022	6/3/2023	6/1/2024	5/31/2025	6/6/2026
23	6/11/2022	6/10/2023	6/8/2024	6/7/2025	6/13/2026
24	6/18/2022	6/17/2023	6/15/2024	6/14/2025	6/20/2026
25	6/25/2022	6/24/2023	6/22/2024	6/21/2025	6/27/2026
26	7/2/2022	7/1/2023	6/29/2024	6/28/2025	7/4/2026
27	7/9/2022	7/8/2023	7/6/2024	7/5/2025	7/11/2026
28	7/16/2022	7/15/2023	7/13/2024	7/12/2025	7/18/2026
29	7/23/2022	7/22/2023	7/20/2024	7/19/2025	7/25/2026
30	7/30/2022	7/29/2023	7/27/2024	7/26/2025	8/1/2026
31	8/6/2022	8/5/2023	8/3/2024	8/2/2025	8/8/2026
32	8/13/2022	8/12/2023	8/10/2024	8/9/2025	8/15/2026
33	8/20/2022	8/19/2023	8/17/2024	8/16/2025	8/22/2026
34	8/27/2022	8/26/2023	8/24/2024	8/23/2025	8/29/2026
35	9/3/2022	9/2/2023	8/31/2024	8/30/2025	9/5/2026
36	9/10/2022	9/9/2023	9/7/2024	9/6/2025	9/12/2026
37	9/17/2022	9/16/2023	9/14/2024	9/13/2025	9/19/2026
38	9/24/2022	9/23/2023	9/21/2024	9/20/2025	9/26/2026
39	10/1/2022	9/30/2023	9/28/2024	9/27/2025	10/3/2026
40	10/8/2022	10/7/2023	10/5/2024	10/4/2025	10/10/2026
41	10/15/2022	10/14/2023	10/12/2024	10/11/2025	10/17/2026
42	10/22/2022	10/21/2023	10/19/2024	10/18/2025	10/24/2026
43	10/29/2022	10/28/2023	10/26/2024	10/25/2025	10/31/2026
44	11/5/2022	11/4/2023	11/2/2024	11/1/2025	11/7/2026
45	11/12/2022	11/11/2023	11/9/2024	11/8/2025	11/14/2026
46	11/19/2022	11/18/2023	11/16/2024	11/15/2025	11/21/2026
47	11/26/2022	11/25/2023	11/23/2024	11/22/2025	11/28/2026
48	12/3/2022	12/2/2023	11/30/2024	11/29/2025	12/5/2026
49	12/10/2022	12/9/2023	12/7/2024	12/6/2025	12/12/2026
50	12/17/2022	12/16/2023	12/14/2024	12/13/2025	12/19/2026
51	12/24/2022	12/23/2023	12/21/2024	12/20/2025	12/26/2026
52	12/31/2022	12/30/2023	12/28/2024	12/27/2025	
53				01/03/2026	

HAWAII STATE DEPARTMENT OF HEALTH
DISEASE OUTBREAK CONTROL DIVISION

Influenza/Respiratory Disease Surveillance Report

Morbidity and Mortality Weekly Report (MMWR)[1]

WEEK 44: OCTOBER 26, 2025– NOVEMBER 1, 2025

OVERVIEW: The Hawaii State Department of Health (HDOH) monitors influenza and other respiratory pathogens, including COVID-19, throughout the state of Hawaii. Influenza surveillance in the state of Hawaii relies upon selected sentinel health practitioners, the State Laboratories Division (SLD), private laboratories, and the Office of Health Status Monitoring (OHSM). For detailed information concerning influenza, please visit the HDOH Disease Outbreak Control Division (HDOH DOCD) website (*here*). **All data and information are conditional and may change as more reports are received.** The data in this report reflect the 2025-2026 influenza season which began the week ending October 4, 2025 (week 40[1] 2025) and will end the week ending on October 3, 2026 (week 39 2026).

REPORT SNAPSHOT FOR WEEK 44

Surveillance for Influenza-like Illness (ILI)		
Metric	*Value*	*Comment*
Outpatient visits related to influenza-like illness (ILI) from ILINet Sentinel Providers	2.3%	Lower than the previous week. Comparable to the Hawaii's historical baseline and lower than the national baseline. Comparison to national ILI rate is unavailable at this time.
Number of ILI clusters reported to HDOH	2	There have been 4 clusters this season.

Laboratory Surveillance		
Percent of all respiratory specimens positive for influenza this week	9.7%	Higher than the previous week. This number means that many, if not all, of the 90.3% who tested negative for influenza had illness from another respiratory etiology.
Percent of all respiratory specimens positive for influenza this season to date	5.3%	

Surveillance for Severe Outcomes		
Pneumonia, influenza and COVID-19 (PIC) mortality rate		No new report for PIC mortality rates is available this week due to a pause in data updates from the National Vital Statistics System (NVSS).
Number of influenza-associated pediatric deaths reported nationwide	0	0 influenza-associated pediatric deaths have been reported from Hawaii this season to date.

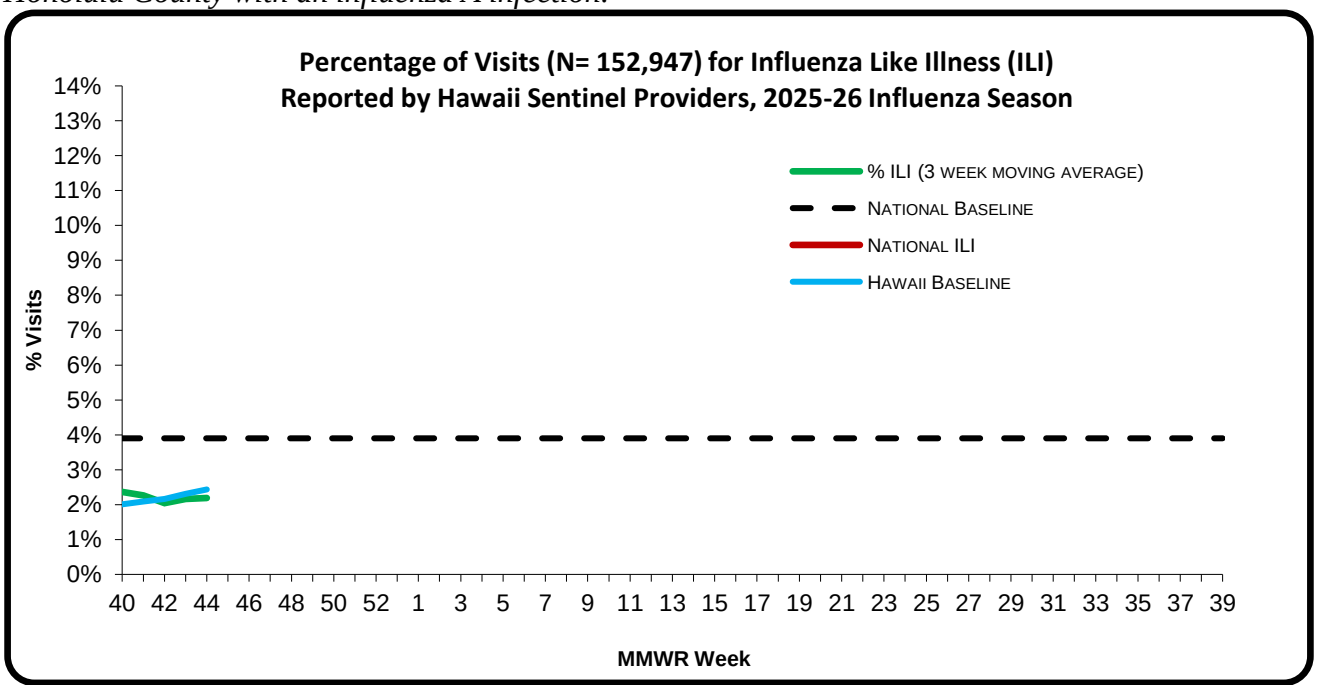
[1] MMWR stands for "Morbidity and Mortality Weekly Report," conventionally used by the Centers for Disease Control and Prevention (CDC). The weeks of a flu season are often referred to by their respective MMWR week. **See appendix 2 for interpretation of MMWR weeks.** Data reported will begin on week 40, the traditional start date of flu season.

INFLUENZA SURVEILLANCE

I. INFLUENZA-LIKE ILLNESS (ILI): HDOH collaborates with recruited doctors and healthcare providers who report the total number of outpatient visits for ILI as well as the total number of patients who complained of symptoms consistent with an ILI. A patient with ILI must have the following: a fever (temperature of 100°F [37.8°C] or greater) AND a cough and/or a sore throat. ILI is based on reported symptoms and not laboratory confirmed tests; thus, ILI may represent other respiratory pathogens and not solely influenza. Further, sentinel providers report these numbers on a weekly basis; therefore, data are preliminary and may change depending on additional reporting. In combination with laboratory testing and other surveillance systems, ILI surveillance helps monitor influenza and other respiratory pathogen activity. For more information concerning ILINet and sentinel requirements, please visit the CDC website (*here*).

For **week 44** of the current influenza season:

- ***2.3**% (season to date: **2.2**%) of the outpatient visits recorded by Hawaii sentinel providers were for ILI.*
- *ILI visits were comparable to the historical baseline in Hawaii[2,3] (i.e., inside the 95% confidence interval).*
- *Hawaii's ILI outpatient visits were lower than the national baseline (**3.1%**)[4] (i.e., inside the 95% confidence interval). Comparison to national ILI rate is unavailable at this time.*
- *ILI activity level: Low[5]*
- *Geographic Spread: Sporadic Activity[6].*
- *ILI Cluster Activity: Two new clusters were reported to HDOH during week 44 in a school located in Honolulu County with an influenza A infection.*



[2] The Hawaii historical baseline (%ILI) is the average of 3-week moving averages over the preceding 10 flu seasons of historical data (2015-2016, 2016-2017, 2017-2018, 2018-2019, 2019-2020, 2020-2021, 2021-2022, 2022-2023, 2023-2024 and 2024-2025).

[3] This value is based upon comparison of actual outpatient ILI with the historical baseline, which only captures outpatient ILI. The chart above represents a 3-week moving average and not the actual ILI by week.

[4] The National Baseline is calculated by CDC as the mean percentage of visits for ILI during weeks 21–39 with two standard deviations. Because of large variability in regional ILI, comparison of the national baseline with local ILI may not be appropriate. It is provided in this report because no meaningful regional baselines are available for comparison. The national baseline combines all data reported by states to CDC, including ILI in outpatient, ER, urgent care, and inpatient settings.

[5] There are 10 activity levels classified as minimal (levels 1-3), low (levels 4-5), moderate (levels 6-7), and high (levels 8-10).

[6] The influenza activity reported by state and territorial epidemiologists indicates geographic spread of influenza viruses but does not measure the severity of influenza activity. Sporadic: no clusters reported to HDOH, Local: one or more clusters reported in one county, Regional: clusters reported two to three counties, Widespread: clusters reported in all counties. Hawaii does not report No Activity, as flu circulates year-round in Hawaii.

II. LABORATORY SURVEILLANCE: State Laboratories Division (SLD; the HDOH public health laboratory) and Hawaii's major private laboratories (DLS, CLH) report results of RT-PCR, which can be considered confirmatory (SLD may perform viral culture on select specimens). Specimens meeting priority criteria[7] are forwarded to SLD for sub-typing. Additionally, specimens meeting case definition from requesting sentinel providers are sent directly to SLD for sub-typing. Due to resource constraints, not all submitted specimens undergo sub-typing. Sub-typing at the commercial laboratories is only conducted on a case-by-case basis. The majority of specimens testing positive by rapid antigen testing or RT-PCR at the commercial laboratories do not meet criteria and are not subtyped. For more information on influenza tests and types, please visit the CDC website (*here*).

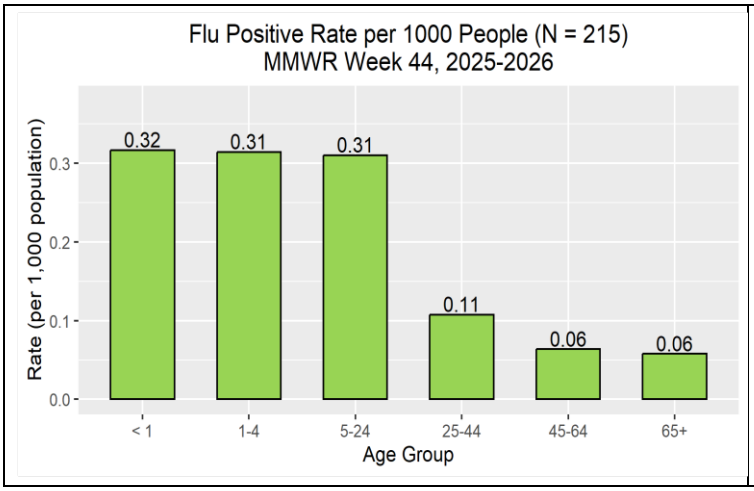
A. INFLUENZA:

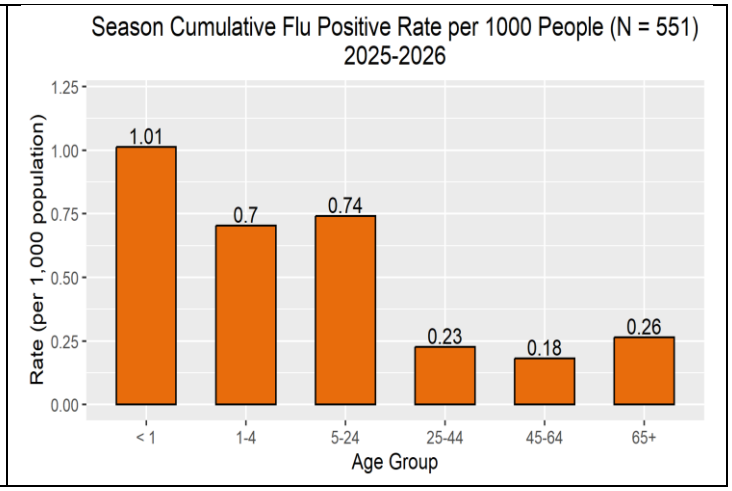
- The following reflects laboratory findings for week 44 of the 2025–26 influenza season:
  - *A total of **2,204** specimens have been tested statewide for influenza viruses (positive: 215 [**9.7%**]). (Season to date: **10,302** tested (**5.3%** positive)*
    - *1,041 (47.2%) were screened only by rapid antigen tests with no confirmatory testing.*
    - *1,163 (52.8%) underwent confirmatory testing (either RT-PCR or viral culture).*
    - *1,989 (90.3%) were negative.*

Influenza type	*Current week 44 (%)*	*Season to date (%)*[8]
Influenza A (H1)[9]	*4 (1.9)*	*9 (1.6)*
Influenza A (H3)	*4 (1.9)*	*7 (1.3)*
Influenza A no subtyping	*196 (93.8)*	*510 (93.6)*
Influenza B (Yamagata)	*0 (0.0)*	*0 (0.0)*
Influenza B (Victoria)	*0 (0.0)*	*0 (0.0)*
Influenza B no genotyping	*5 (2.4)*	*19 (3.5)*

1. AGE DISTRIBUTION

The charts below indicate the population-based rates of positive influenza cases in Hawaii by age group during the 2025–26 influenza season.[10]

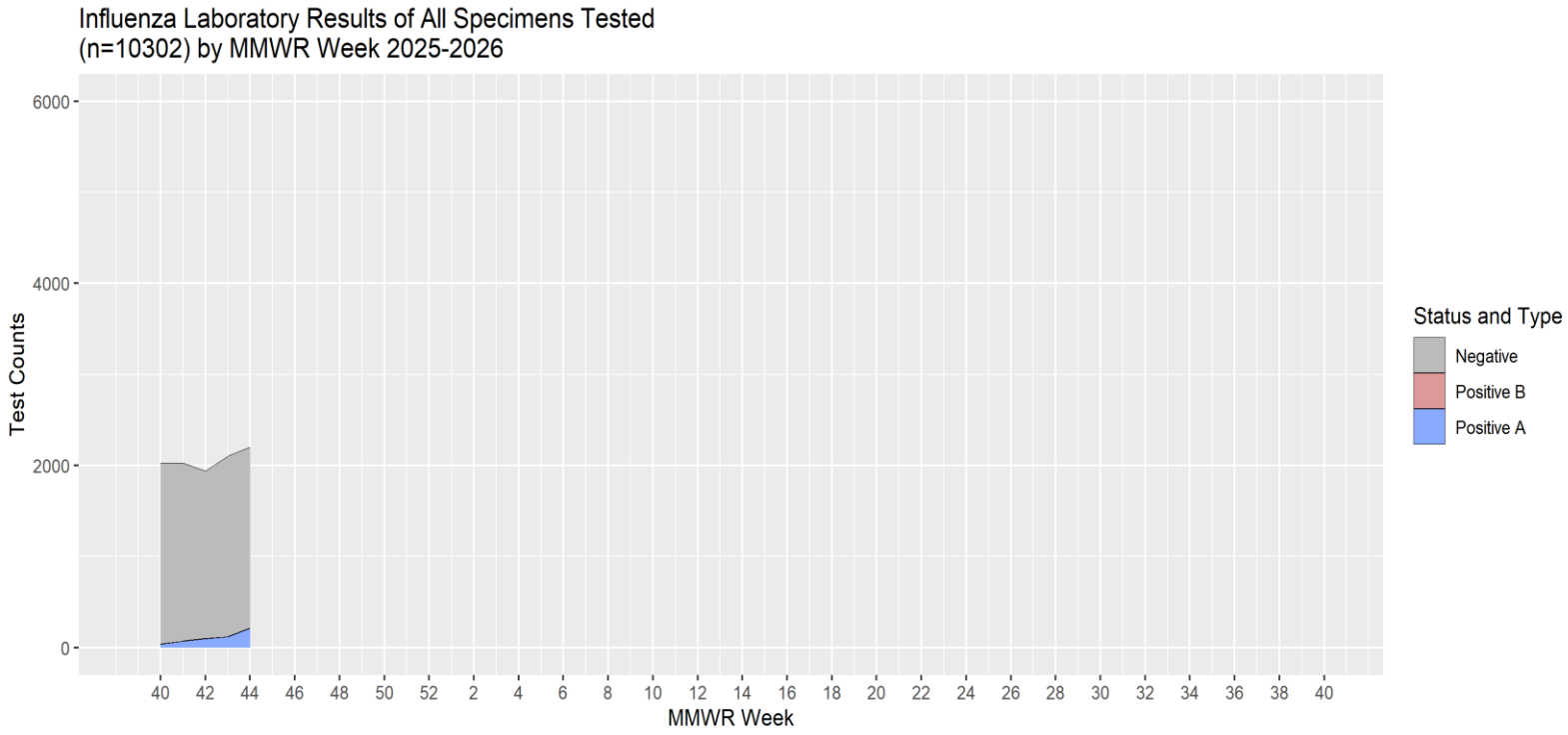


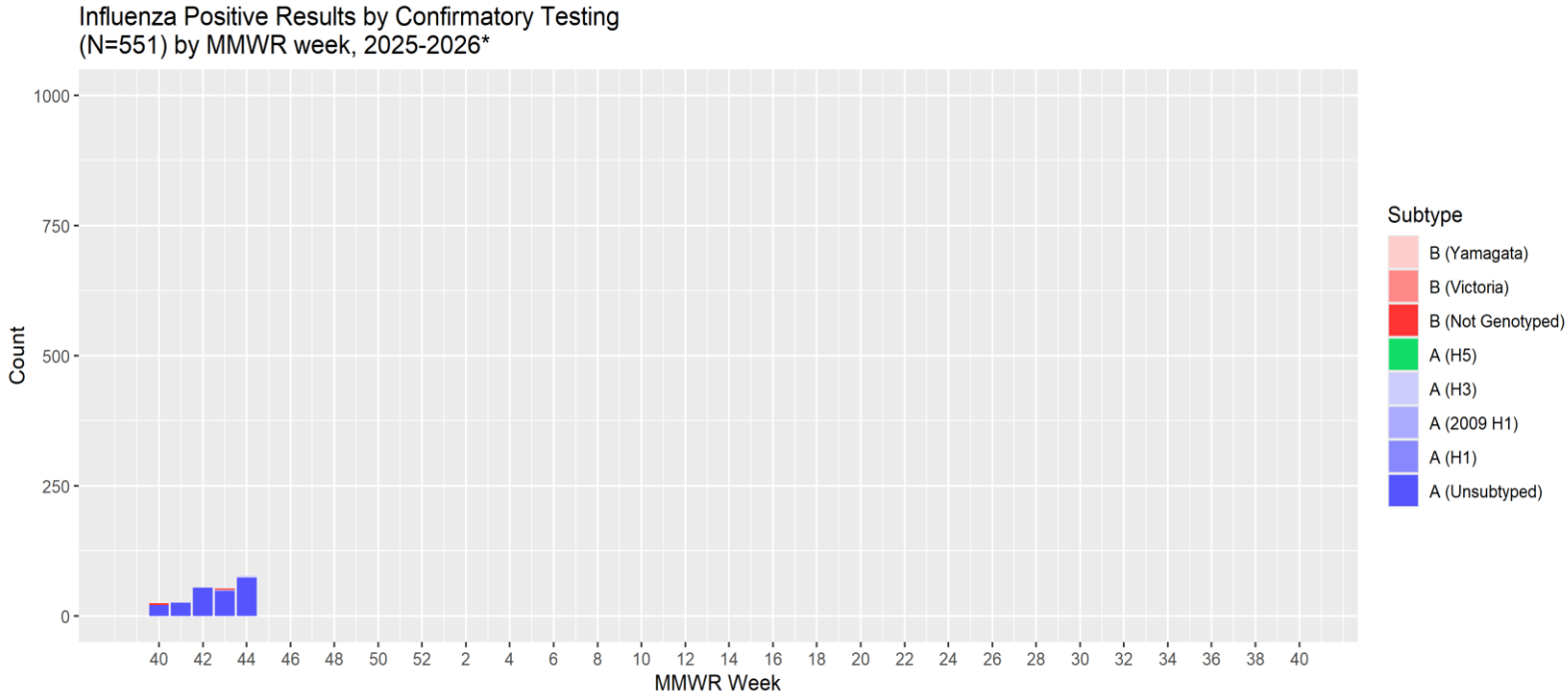


[7] Priority criteria include: hospitalized patients with acute respiratory distress syndrome [ARDS] or x-ray confirmed pneumonia; travelers with international travel history within 10 days of onset; specimens submitted by sentinel providers; specimens collected from healthcare workers, pregnant women, or women up to 6 weeks' post-partum; those with underlying medical conditions; and patients presenting with unusual or severe manifestations of influenza infection.
[8] Influenza coding were updated to reflect a more accurate count.
[9] All influenza A H1 viruses detected this season have been 2009 H1N1.
[10] This represents an estimate of population-based rates based on available data.

2. LABORATORY TESTING

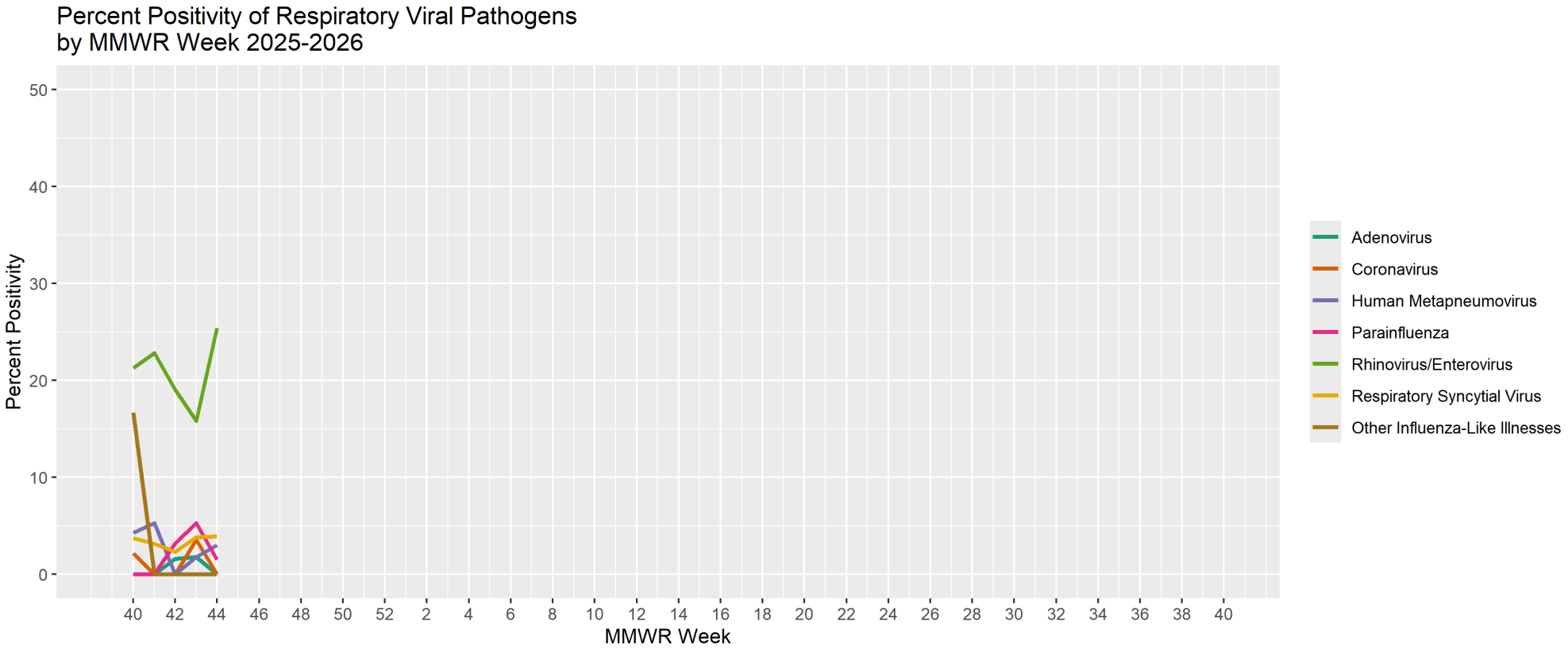
The charts below show the laboratory results of all specimens tested for influenza by MMWR week during the 2025–2026 influenza season as well as the type and subtype of positive results for influenza. Again, sub-typing is only performed on selected specimens tested by confirmatory tests (i.e., RT-PCR or viral culture).





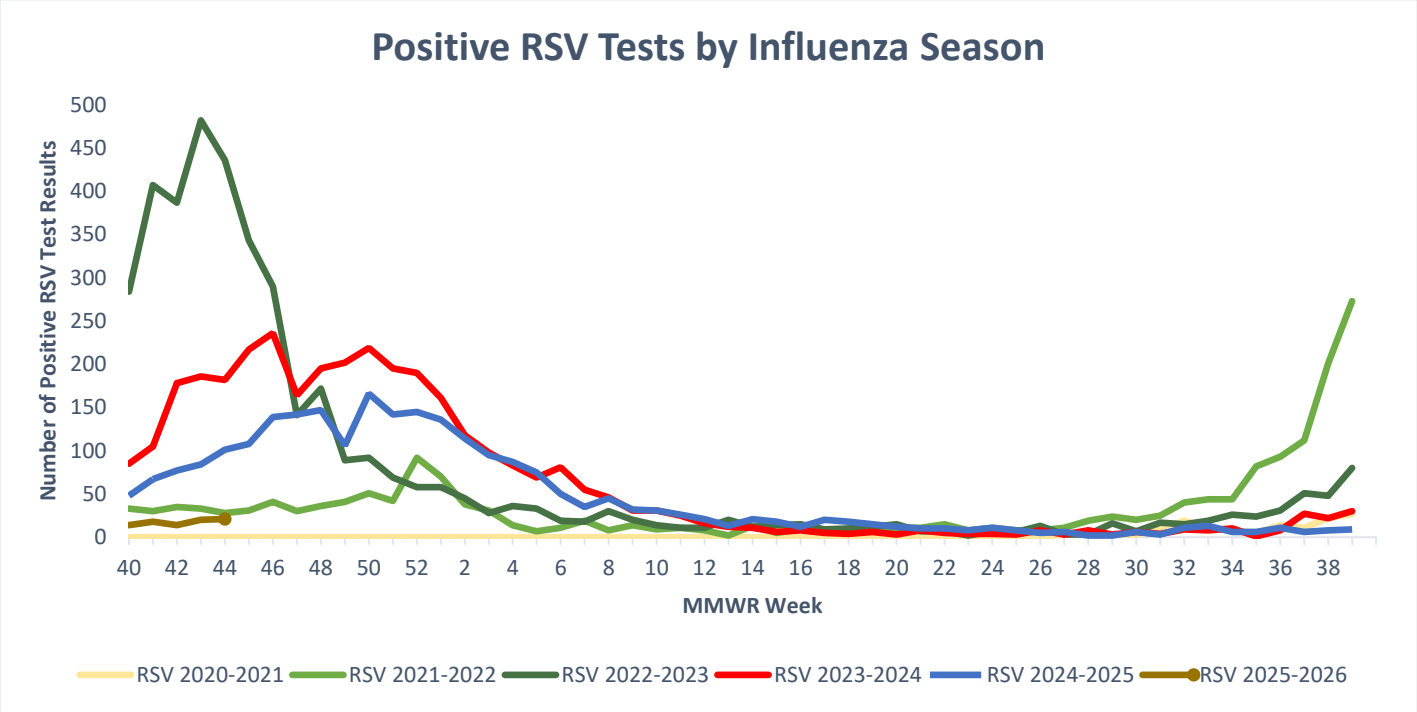
** A total of 5,562 specimens underwent confirmatory testing but not all positive influenza specimens receive confirmatory testing that are circulating in Hawaii.*

B. OTHER RESPIRATORY PATHOGENS: The major clinical and commercial laboratories throughout the state of Hawaii have the testing capacity for non-influenza respiratory pathogens and report these to HDOH. However, such testing is performed as needed and when sufficient resources are available because of the high costs associated with respiratory panel tests. **Therefore, available data represent only the presence of circulating pathogens and cannot be used to determine specific trends**.

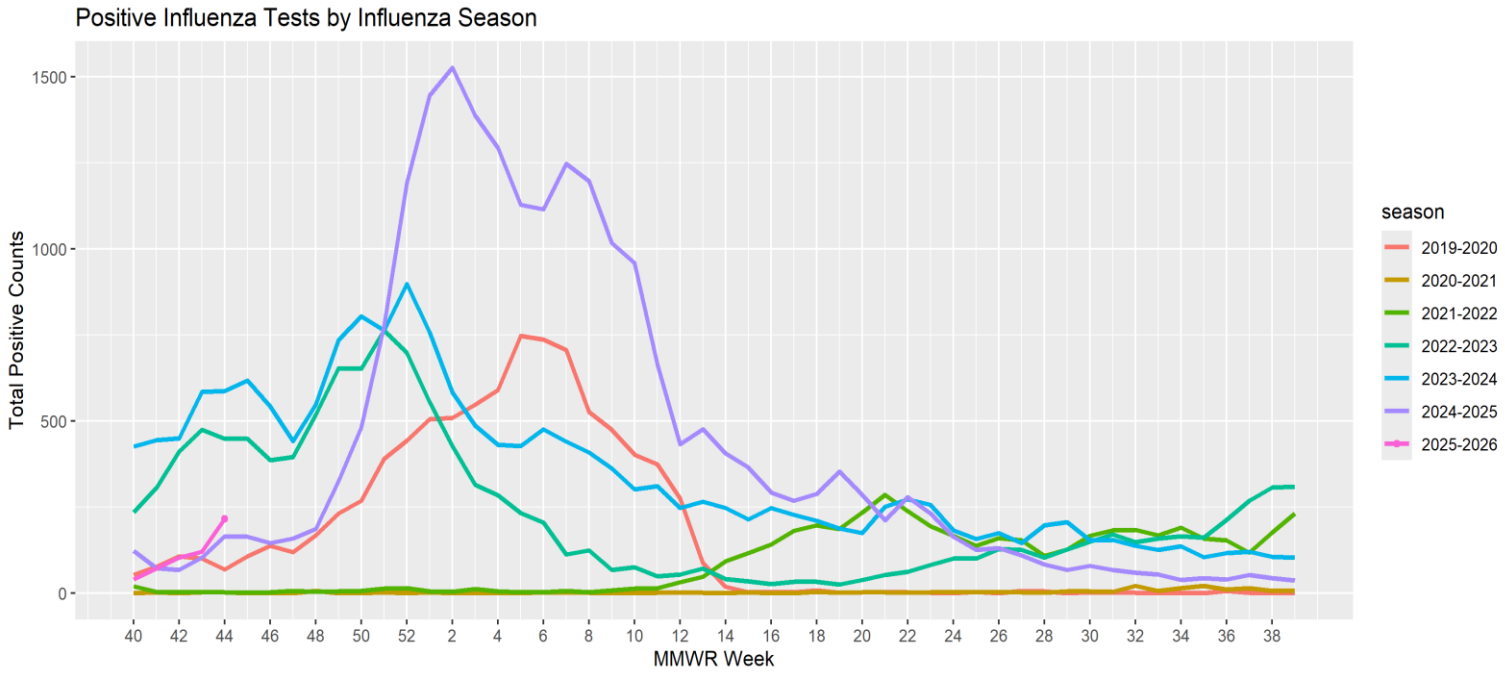


* *The coronavirus presented on this table does not indicate Severe Acute Respiratory Coronavirus-2 (i.e., COVID-19).*

RESPIRATORY SYNCYTIAL VIRUS (RSV) POSITIVE TEST RESULTS BY INFLUENZA SEASON: RSV case appears to have increased earlier than past seasons in the 2025-2026 season. Of note, significantly more tests for RSV are being performed than in pre-COVID-19 seasons.



INFLUENZA POSITIVE TEST RESULTS BY INFLUENZA SEASON: Influenza cases appear to have increased earlier than past seasons in the 2023-2024 season, but it is not yet known whether case numbers will reach a peak similar to pre-COVID-19 seasons.



C. COVID-19 SENTINEL SURVEILLANCE: Due to the low volume of samples currently available through the influenza surveillance system, the COVID-19 sentinel surveillance data may not be accurately portraying COVID-19 activity in our communities. Reporting of the COVID-19 Sentinel Surveillance data will be paused while HODH re-evaluates the program to ensure that the reported data are accurate and representative.

HDOH is continuing to monitor COVID-19 activity throughout the state. To learn more, please visit the Hawaii's COVID-19 data website (*here*). For more information on surveillance of COVID-19 activity in the United States please visit the CDC COVIDView website (*here*).

III. PNEUMONIA, INFLUENZA, AND COVID-19 (PIC) RELATED MORTALITY:

P&I mortality surveillance is collected by CDC through the National Center for Health Statistics (NCHS) using death certificate data. Each week the HDOH OHSM reports specific data from Honolulu to the CDC. CDC collects the following information by age group: the total number of deaths, total deaths from pneumonia, and total deaths related to influenza. Due to the ongoing COVID-19 pandemic, CDC included total deaths from COVID-19 by age group to the death data. Previous studies had suggested that P&I is a good indicator of influenza-related deaths; however, data has shown that pneumonia deaths associated with influenza is now being impacted by COVID-19 related pneumonia. Due to this, CDC had added COVID-19 deaths into P&I to create the PIC (pneumonia, influenza, and/or COVID-19) classification.

To standardize Hawaii's influenza surveillance with CDC influenza surveillance guidelines, PIC deaths will be reported in lieu of P&I. Hawaii's baseline will begin to include PIC deaths starting from 2019-2020 flu season.

On October 1, 2025, certain federal government activities have ceased due to a lack of appropriated funding. The National Vital Statistic System (NVSS) surveillance datasets and reports had been paused temporarily, including those used to evaluate pneumonia, influenza, and COVID-19 deaths. HDOH PIC mortality data will not be published in the Influenza/Respiratory Disease Surveillance Report for week 44. Data updates are expected to resume following the conclusion of the government shutdown.

INFLUENZA-ASSOCIATED PEDIATRIC DEATHS[11]:

- No new influenza-associated pediatric death was reported to Hawaii. There have been zero influenza-associated pediatric deaths reported in Hawaii during the 2025–2026 season.
- Nationally, no new influenza-associated pediatric deaths were reported to CDC during week 44. (2025-2026 season total: 0).

IV. INFLUENZA WATCH: As part of a comprehensive influenza surveillance system and to prevent the spread of contagious respiratory diseases in humans, it is important to monitor all circulating influenza types. Several animal-origin influenza A subtypes are currently of interest: influenza A variant virus (H3N2v, H1N2v, and H1N1v) and Avian flu (H5N1 and H7N9). These types of influenza viruses may cause zoonotic (animal-associated) disease and are a public health concern.

A. VARIANT VIRUSES:

Influenza viruses that normally circulate in pigs are called "variant" viruses when they are found in people. These viruses were first identified in U.S. pigs in 2010. In 2011, 12 cases of H3N2v infection were detected in the United States. In 2012, 309 such cases (resulting in 16 hospitalizations and one death) across 12 states were detected, including one Hawaii case who recovered. Illness associated with H3N2v infection has been mostly mild with symptoms similar to those of seasonal flu. However, serious illness, resulting in hospitalization and death, has occurred in some cases. Most of these infections have been associated with prolonged exposure to pigs at agricultural fairs or similar settings. Limited human-to-human spread of this virus has been detected in the past, but no sustained community spread of H3N2v has been identified. More information regarding H3N2v, H1N1v, and H1N2v viruses may be found on the CDC website (*here*) and (*here*).

- *No variant or novel influenza infections have been reported to HDOH during the 2025-2026 influenza season.*
- *No new human infection with novel influenza A virus, H1N1v (0), H3N2v (0), and H1N2v (0), have been reported during the 2025-2026 influenza season.*

AVIAN (OR BIRD) INFLUENZA: These types of influenza viruses cause zoonotic (animal-associated) disease of public health concern and are therefore monitored globally by the WHO. Most avian influenza viruses do not cause disease in humans and are generally not easily transmissible between person to person, but a few subtypes may cross the species barrier and cause disease in humans. Avian influenza viruses may be of various subtypes, including H5N1, H5N2, H5N8, H7N3, H7N7, H7N8, H7N9, and H9N2. On January 15th, 2016, the USDA and APHIS reported detection of HPAI H7N8 in a commercial turkey flock in Indiana. There have been no associated human infections. This is the first detection of HPAI H7N8 in wild bird surveillance in the United States. More information, the risk assessment and recommendations for HPAI H7N8 can be found (here). The WHO, CDC, and other public health agencies have also been monitoring influenza H7N9, which represents a public health concern because of its high pandemic potential. Although H7N9 has not been detected in the United States, it remains a global concern given continuing epidemics in endemic countries. Since 2013, a total of 1,568 laboratory-confirmed cases of human infection with H7N9 viruses, including at least 613 deaths, have been reported to WHO. More information on H7N9 virus infections can be found (here). For more information regarding avian influenza, please visit the CDC (*here*) or the WHO (*here*) websites. WHO reports total number of cases and deaths related to laboratory-confirmed avian influenza viruses and posts current avian influenza case counts (*here*), which were last updated on **September 29, 2025**.

[11] Influenza-associated deaths are considered pediatric in persons aged less than 18 years. It was made a nationally notifiable condition in October, 2004. All pediatric influenza-associated deaths are laboratory confirmed.

V. INFLUENZA Vaccine: Annual influenza vaccination is recommended for all persons aged 6 months and older and is the most effective way to reduce the risk of getting sick with seasonal flu and spreading it to others. Influenza vaccination can reduce illnesses, visits to the doctor, influenza-related hospitalizations, and missed work and school days. Influenza vaccines become available by the end of October. It takes at least two weeks after vaccination to confer immunity against influenza virus infection. More information regarding influenza vaccination can be found (*here*).

A. Composition of the 2025–2026 Influenza Vaccine**:**

The composition of the 2025–2026 influenza vaccine has been updated to better match circulating influenza viruses. The Advisory Committee on Immunization Practices (ACIP) has recommended that the 2025-2026 influenza trivalent vaccine contain an influenza A/Victoria/4897/2022 (H1N1) pdm09-like virus, influenza A/Croatia/10136RV/2023 (H3N2)-like virus, and influenza B/Austria/1359417/2021 (B/Victoria lineage)-like virus. United States cell culture–based inactivated (ccIIV4) and recombinant (RIV4) influenza vaccines will contain HA derived from an influenza A/Wisconsin/67/2022 (H1N1) pdm09-like virus, an A/District of Columbia/27/2023 (H3N2)-like virus, an influenza B/Austria/1359417/2021 (B/Victoria lineage)-like virus. These vaccine recommendations were based on several factors, including global influenza virologic and epidemiologic surveillance, genetic and antigenic characterization, human serology studies, antiviral susceptibility, and the availability of candidate influenza viruses.

APPENDIX 1: ADDITIONAL INFORMATION

For more information regarding local and national influenza surveillance programs, visit the following sites.

Centers for Disease Control and Prevention	General Influenza National ILI and P&I Data Vaccine Virus Selection CDC Web Tool for Respiratory Viruses
Flu.gov	General Influenza Information
HDOH Flu and Pneumonia	General Influenza Surveillance Avian Influenza Respiratory Virus Dashboard To find out more information or join the sentinel physician program, email the Influenza Surveillance Coordinator
World Health Organization	General Global and Local Influenza Avian Influenza

APPENDIX 2: MMWR WEEK DATES

Please refer to the table below to interpret data presented by MMWR week. Week 40 is considered the traditional start for the flu season for the Northern Hemisphere.

MMWR WEEK	2022	2023	2024	2025	2026
1	1/8/2022	1/7/2023	1/6/2024	1/4/2025	1/10/2026
2	1/15/2022	1/14/2023	1/13/2024	1/11/2025	1/17/2026
3	1/22/2022	1/21/2023	1/20/2024	1/18/2025	1/24/2026
4	1/29/2022	1/28/2023	1/27/2024	1/25/2025	1/31/2026
5	2/5/2022	2/4/2023	2/3/2024	2/1/2025	2/7/2026
6	2/12/2022	2/11/2023	2/10/2024	2/8/2025	2/14/2026
7	2/19/2022	2/18/2023	2/17/2024	2/15/2025	2/21/2026
8	2/26/2022	2/25/2023	2/24/2024	2/22/2025	2/28/2026
9	3/5/2022	3/4/2023	3/2/2024	3/1/2025	3/7/2026
10	3/12/2022	3/11/2023	3/9/2024	3/8/2025	3/14/2026
11	3/19/2022	3/18/2023	3/16/2024	3/15/2025	3/21/2026
12	3/26/2022	3/25/2023	3/23/2024	3/22/2025	3/28/2026
13	4/2/2022	4/1/2023	3/30/2024	3/29/2025	4/4/2026
14	4/9/2022	4/8/2023	4/6/2024	4/5/2025	4/11/2026
15	4/16/2022	4/15/2023	4/13/2024	4/12/2025	4/18/2026
16	4/23/2022	4/22/2023	4/20/2024	4/19/2025	4/25/2026
17	4/30/2022	4/29/2023	4/27/2024	4/26/2025	5/2/2026
18	5/7/2022	5/6/2023	5/4/2024	5/3/2025	5/9/2026
19	5/14/2022	5/13/2023	5/11/2024	5/10/2025	5/16/2026
20	5/21/2022	5/20/2023	5/18/2024	5/17/2025	5/23/2026
21	5/28/2022	5/27/2023	5/25/2024	5/24/2025	5/30/2026
22	6/4/2022	6/3/2023	6/1/2024	5/31/2025	6/6/2026
23	6/11/2022	6/10/2023	6/8/2024	6/7/2025	6/13/2026
24	6/18/2022	6/17/2023	6/15/2024	6/14/2025	6/20/2026
25	6/25/2022	6/24/2023	6/22/2024	6/21/2025	6/27/2026
26	7/2/2022	7/1/2023	6/29/2024	6/28/2025	7/4/2026
27	7/9/2022	7/8/2023	7/6/2024	7/5/2025	7/11/2026
28	7/16/2022	7/15/2023	7/13/2024	7/12/2025	7/18/2026
29	7/23/2022	7/22/2023	7/20/2024	7/19/2025	7/25/2026
30	7/30/2022	7/29/2023	7/27/2024	7/26/2025	8/1/2026
31	8/6/2022	8/5/2023	8/3/2024	8/2/2025	8/8/2026
32	8/13/2022	8/12/2023	8/10/2024	8/9/2025	8/15/2026
33	8/20/2022	8/19/2023	8/17/2024	8/16/2025	8/22/2026
34	8/27/2022	8/26/2023	8/24/2024	8/23/2025	8/29/2026
35	9/3/2022	9/2/2023	8/31/2024	8/30/2025	9/5/2026
36	9/10/2022	9/9/2023	9/7/2024	9/6/2025	9/12/2026
37	9/17/2022	9/16/2023	9/14/2024	9/13/2025	9/19/2026
38	9/24/2022	9/23/2023	9/21/2024	9/20/2025	9/26/2026
39	10/1/2022	9/30/2023	9/28/2024	9/27/2025	10/3/2026
40	10/8/2022	10/7/2023	10/5/2024	10/4/2025	10/10/2026
41	10/15/2022	10/14/2023	10/12/2024	10/11/2025	10/17/2026
42	10/22/2022	10/21/2023	10/19/2024	10/18/2025	10/24/2026
43	10/29/2022	10/28/2023	10/26/2024	10/25/2025	10/31/2026
44	11/5/2022	11/4/2023	11/2/2024	11/1/2025	11/7/2026
45	11/12/2022	11/11/2023	11/9/2024	11/8/2025	11/14/2026
46	11/19/2022	11/18/2023	11/16/2024	11/15/2025	11/21/2026
47	11/26/2022	11/25/2023	11/23/2024	11/22/2025	11/28/2026
48	12/3/2022	12/2/2023	11/30/2024	11/29/2025	12/5/2026
49	12/10/2022	12/9/2023	12/7/2024	12/6/2025	12/12/2026
50	12/17/2022	12/16/2023	12/14/2024	12/13/2025	12/19/2026
51	12/24/2022	12/23/2023	12/21/2024	12/20/2025	12/26/2026
52	12/31/2022	12/30/2023	12/28/2024	12/27/2025	
53				01/03/2026	

HAWAII STATE DEPARTMENT OF HEALTH
DISEASE OUTBREAK CONTROL DIVISION

Influenza/Respiratory Disease Surveillance Report

Morbidity and Mortality Weekly Report (MMWR)[1]

WEEK 45: NOVEMBER 2, 2025– NOVEMBER 8, 2025

OVERVIEW: The Hawaii State Department of Health (HDOH) monitors influenza and other respiratory pathogens, including COVID-19, throughout the state of Hawaii. Influenza surveillance in the state of Hawaii relies upon selected sentinel health practitioners, the State Laboratories Division (SLD), private laboratories, and the Office of Health Status Monitoring (OHSM). For detailed information concerning influenza, please visit the HDOH Disease Outbreak Control Division (HDOH DOCD) website (*here*). **All data and information are conditional and may change as more reports are received.** The data in this report reflect the 2025-2026 influenza season which began the week ending October 4, 2025 (week 40[1] 2025) and will end the week ending on October 3, 2026 (week 39 2026).

REPORT SNAPSHOT FOR WEEK 45

Surveillance for Influenza-like Illness (ILI)		
Metric	*Value*	*Comment*
Outpatient visits related to influenza-like illness (ILI) from ILINet Sentinel Providers	2.7%	Higher than the previous week. Comparable to the Hawaii's historical baseline and lower than the national baseline, and higher than the national ILI rate.
Number of ILI clusters reported to HDOH	2	There have been 6 clusters this season.

Laboratory Surveillance		
Percent of all respiratory specimens positive for influenza this week	13.1%	Higher than the previous week. This number means that many, if not all, of the 86.9% who tested negative for influenza had illness from another respiratory etiology.
Percent of all respiratory specimens positive for influenza this season to date	6.8%	

Surveillance for Severe Outcomes		
Pneumonia, influenza and COVID-19 (PIC) mortality rate		No new report for PIC mortality rates is available this week due to a pause in data updates from the National Vital Statistics System (NVSS).
Number of influenza-associated pediatric deaths reported nationwide	0	0 influenza-associated pediatric deaths have been reported from Hawaii this season to date.

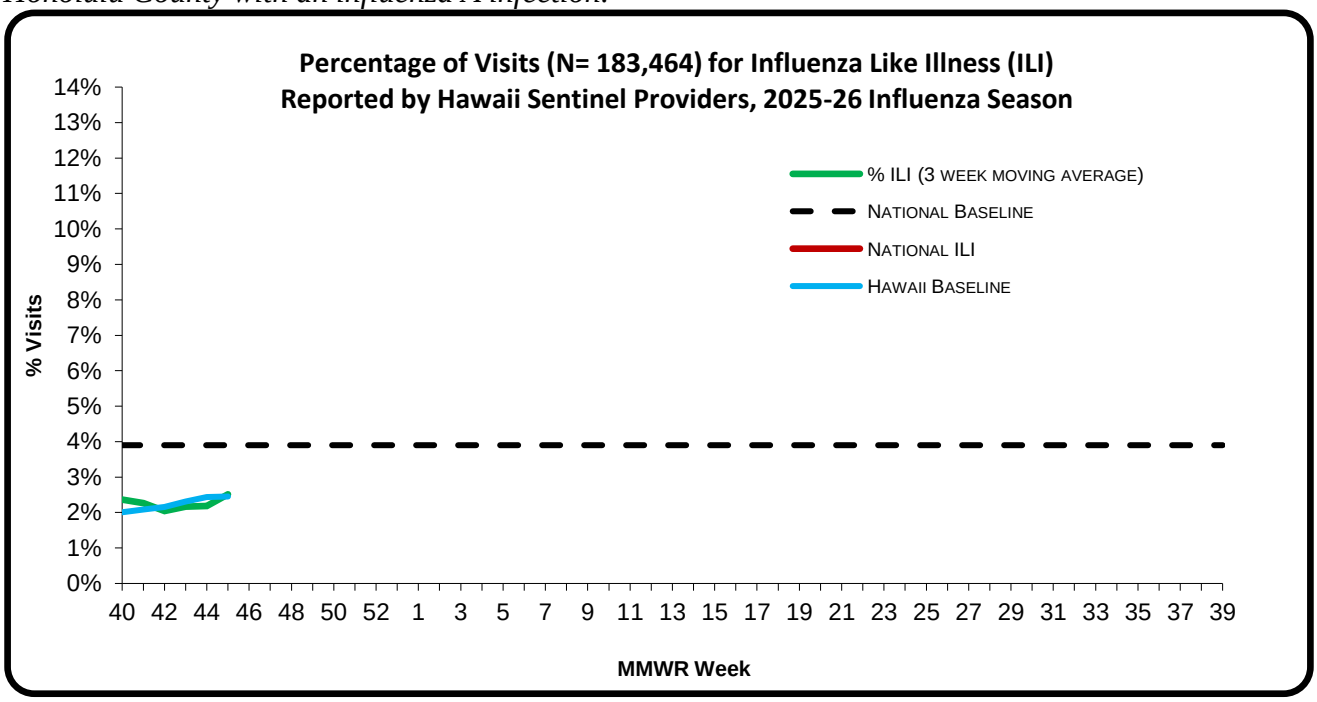
[1] MMWR stands for "Morbidity and Mortality Weekly Report," conventionally used by the Centers for Disease Control and Prevention (CDC). The weeks of a flu season are often referred to by their respective MMWR week. **See appendix 2 for interpretation of MMWR weeks.** Data reported will begin on week 40, the traditional start date of flu season.

INFLUENZA SURVEILLANCE

I. INFLUENZA-LIKE ILLNESS (ILI): HDOH collaborates with recruited doctors and healthcare providers who report the total number of outpatient visits for ILI as well as the total number of patients who complained of symptoms consistent with an ILI. A patient with ILI must have the following: a fever (temperature of 100°F [37.8°C] or greater) AND a cough and/or a sore throat. ILI is based on reported symptoms and not laboratory confirmed tests; thus, ILI may represent other respiratory pathogens and not solely influenza. Further, sentinel providers report these numbers on a weekly basis; therefore, data are preliminary and may change depending on additional reporting. In combination with laboratory testing and other surveillance systems, ILI surveillance helps monitor influenza and other respiratory pathogen activity. For more information concerning ILINet and sentinel requirements, please visit the CDC website (*here*).

For **week 45** of the current influenza season:

- ***2.7%** (season to date: **2.3**%) of the outpatient visits recorded by Hawaii sentinel providers were for ILI.*
- *ILI visits were comparable to the historical baseline in Hawaii[2,3] (i.e., inside the 95% confidence interval).*
- *Hawaii's ILI outpatient visits were lower than the national baseline (**3.1%**)[4] (i.e., inside the 95% confidence interval) and higher than the national ILI rate (**2.1%**) (i.e. outside the 95% confidence interval).*
- *ILI activity level: Low[5]*
- *Geographic Spread: Sporadic Activity[6].*
- *ILI Cluster Activity: Two new clusters were reported to HDOH during week 45 in two schools located in Honolulu County with an influenza A infection.*



[2] The Hawaii historical baseline (%ILI) is the average of 3-week moving averages over the preceding 10 flu seasons of historical data (2015-2016, 2016-2017, 2017-2018, 2018-2019, 2019-2020, 2020-2021, 2021-2022, 2022-2023, 2023-2024 and 2024-2025).
[3] This value is based upon comparison of actual outpatient ILI with the historical baseline, which only captures outpatient ILI. The chart above represents a 3-week moving average and not the actual ILI by week.
[4] The National Baseline is calculated by CDC as the mean percentage of visits for ILI during weeks 21–39 with two standard deviations. Because of large variability in regional ILI, comparison of the national baseline with local ILI may not be appropriate. It is provided in this report because no meaningful regional baselines are available for comparison. The national baseline combines all data reported by states to CDC, including ILI in outpatient, ER, urgent care, and inpatient settings.
[5] There are 10 activity levels classified as minimal (levels 1-3), low (levels 4-5), moderate (levels 6-7), and high (levels 8-10).
[6] The influenza activity reported by state and territorial epidemiologists indicates geographic spread of influenza viruses but does not measure the severity of influenza activity. Sporadic: no clusters reported to HDOH, Local: one or more clusters reported in one county, Regional: clusters reported two to three counties, Widespread: clusters reported in all counties. Hawaii does not report No Activity, as flu circulates year-round in Hawaii.

II. LABORATORY SURVEILLANCE: State Laboratories Division (SLD; the HDOH public health laboratory) and Hawaii's major private laboratories (DLS, CLH) report results of RT-PCR, which can be considered confirmatory (SLD may perform viral culture on select specimens). Specimens meeting priority criteria[7] are forwarded to SLD for sub-typing. Additionally, specimens meeting case definition from requesting sentinel providers are sent directly to SLD for sub-typing. Due to resource constraints, not all submitted specimens undergo sub-typing. Sub-typing at the commercial laboratories is only conducted on a case-by-case basis. The majority of specimens testing positive by rapid antigen testing or RT-PCR at the commercial laboratories do not meet criteria and are not subtyped. For more information on influenza tests and types, please visit the CDC website (*here*).

A. INFLUENZA:

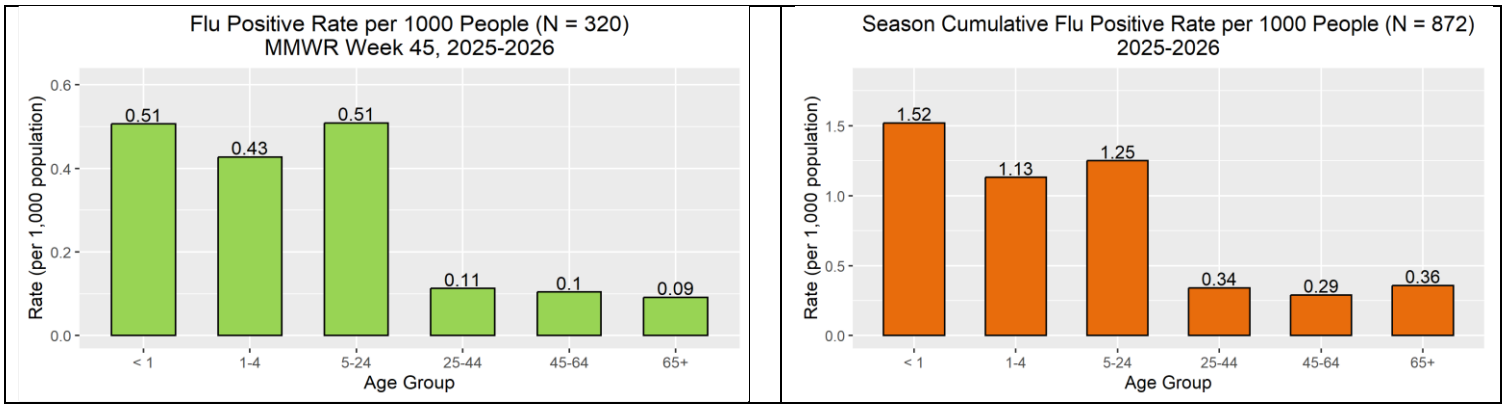
- The following reflects laboratory findings for week 45 of the 2025–26 influenza season:
  - *A total of **2,439** specimens have been tested statewide for influenza viruses (positive: 320 [**13.1%**]). (Season to date: **12,742** tested (**6.8%** positive)*
    - *1,172 (48.1%) were screened only by rapid antigen tests with no confirmatory testing.*
    - *1,267 (51.9%) underwent confirmatory testing (either RT-PCR or viral culture).*
    - *2,119 (86.9%) were negative.*
  - *Routine surveillance samples from State Laboratory Division were tested at a public health laboratory and identified as Influenza A (H3N2) subclade K.*

Influenza type	***Current week 45 (%)****	***Season to date (%)***[8]
Influenza A (H1)[9]	*5 (1.6)*	*15 (1.7)*
Influenza A (H3)	*61 (19.0)*	*71 (8.2)*
Influenza A no subtyping	*247 (76.9)*	*748 (86.9)*
Influenza B (Yamagata)	*0 (0.0)*	*0 (0.0)*
Influenza B (Victoria)	*0 (0.0)*	*0 (0.0)*
Influenza B no genotyping	*8 (2.5)*	*27 (3.1)*

**Specimens that are positive for both A and B (coinfections) are counted in both A and B totals for current and season to date*

1. AGE DISTRIBUTION

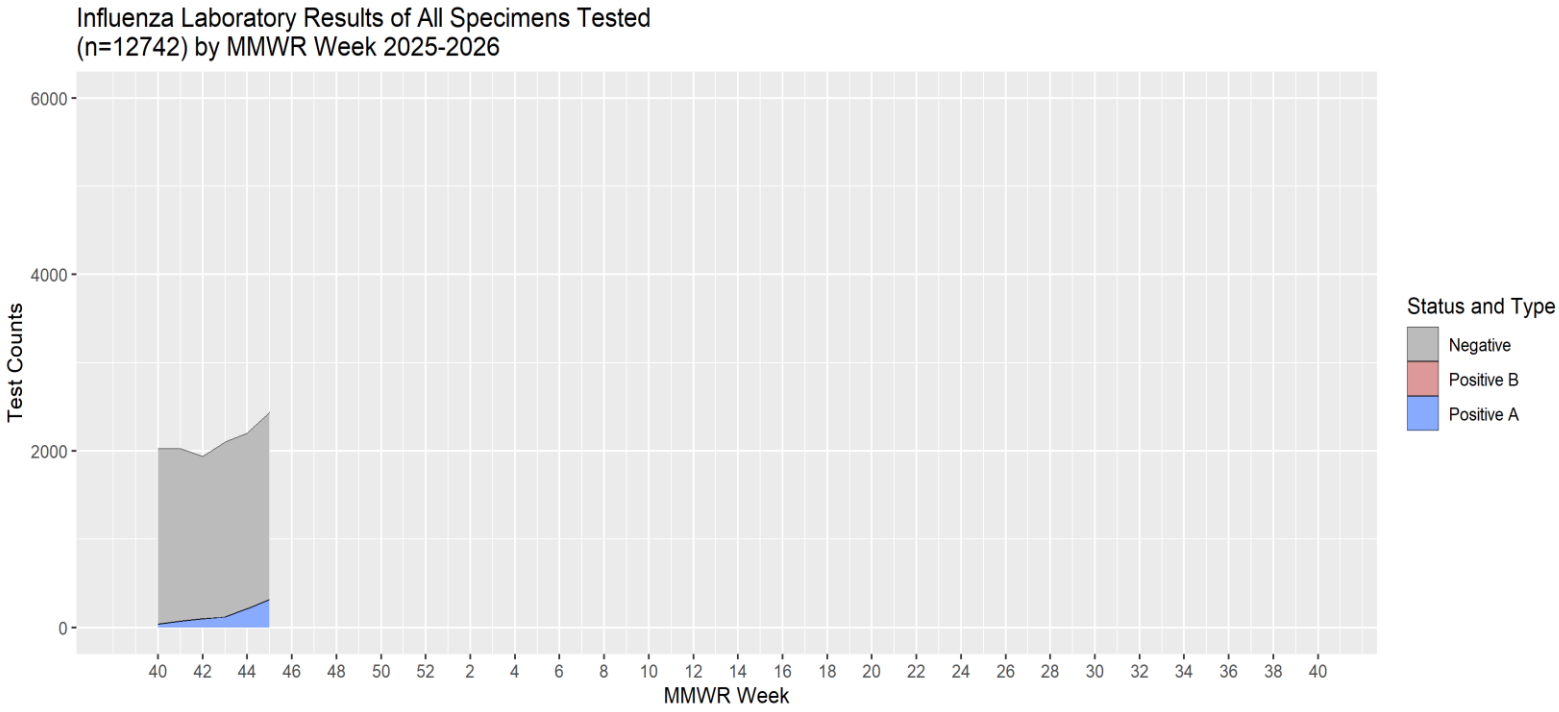
The charts below indicate the population-based rates of positive influenza cases in Hawaii by age group during the 2025–26 influenza season.[10]

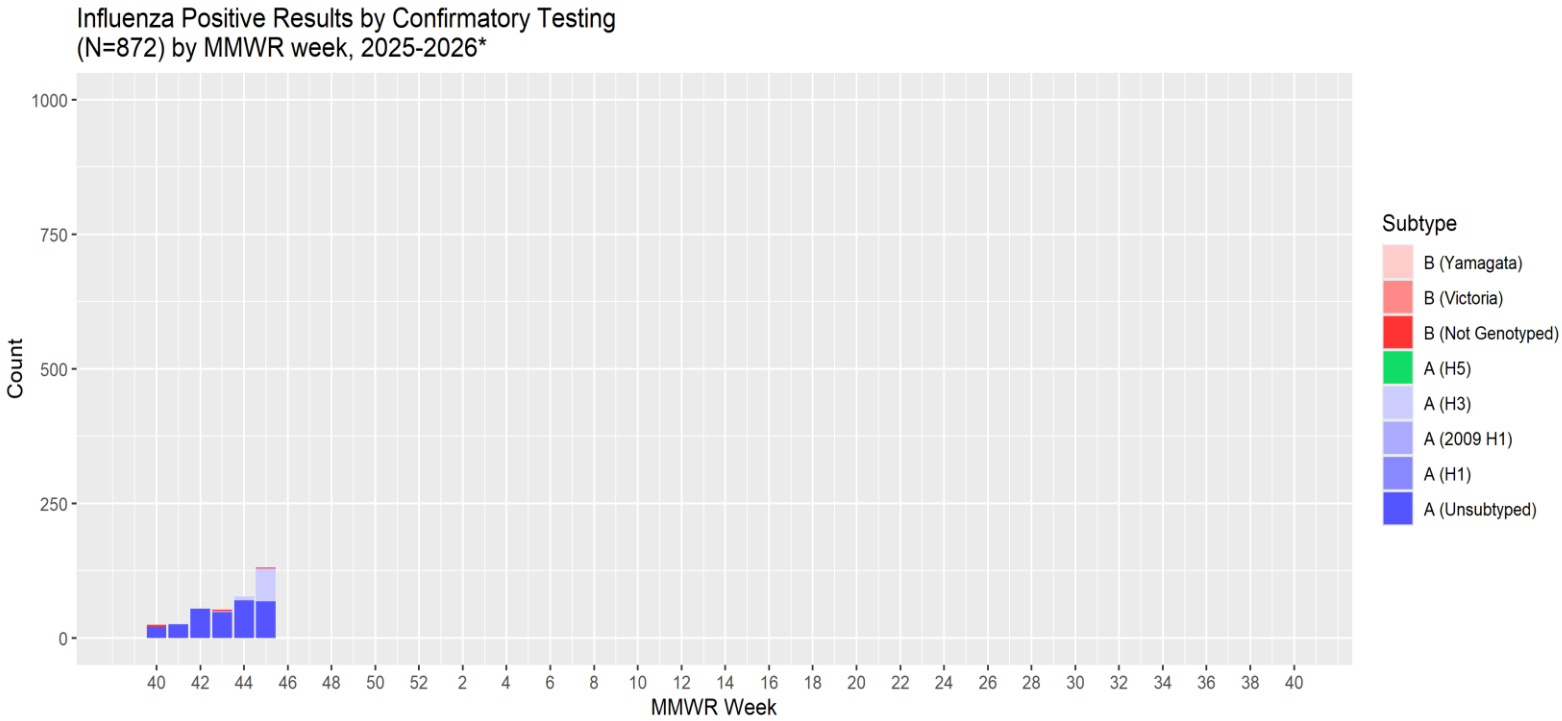


[7] Priority criteria include: hospitalized patients with acute respiratory distress syndrome [ARDS] or x-ray confirmed pneumonia; travelers with international travel history within 10 days of onset; specimens submitted by sentinel providers; specimens collected from healthcare workers, pregnant women, or women up to 6 weeks' post-partum; those with underlying medical conditions; and patients presenting with unusual or severe manifestations of influenza infection.
[8] Influenza coding were updated to reflect a more accurate count.
[9] All influenza A H1 viruses detected this season have been 2009 H1N1.
[10] This represents an estimate of population-based rates based on available data.

2. LABORATORY TESTING

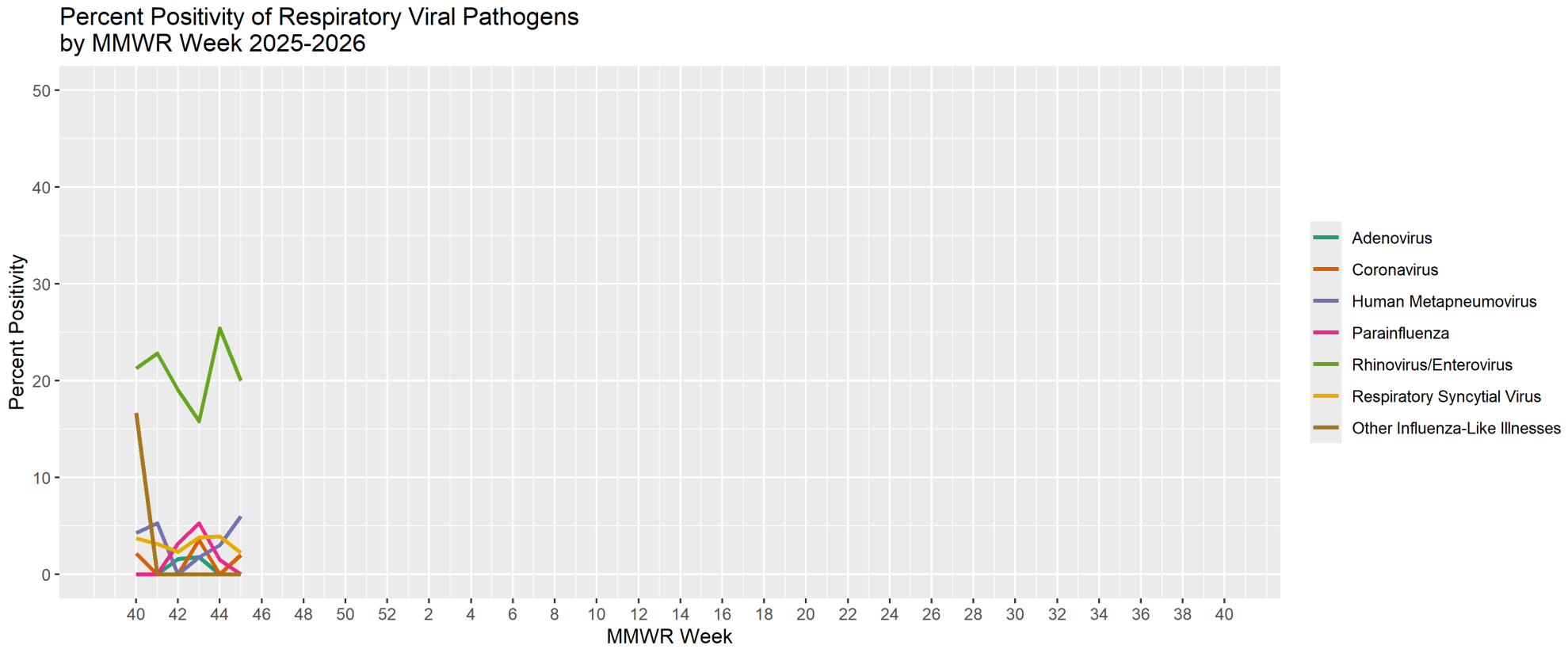
The charts below show the laboratory results of all specimens tested for influenza by MMWR week during the 2025–2026 influenza season as well as the type and subtype of positive results for influenza. Again, sub-typing is only performed on selected specimens tested by confirmatory tests (i.e., RT-PCR or viral culture).





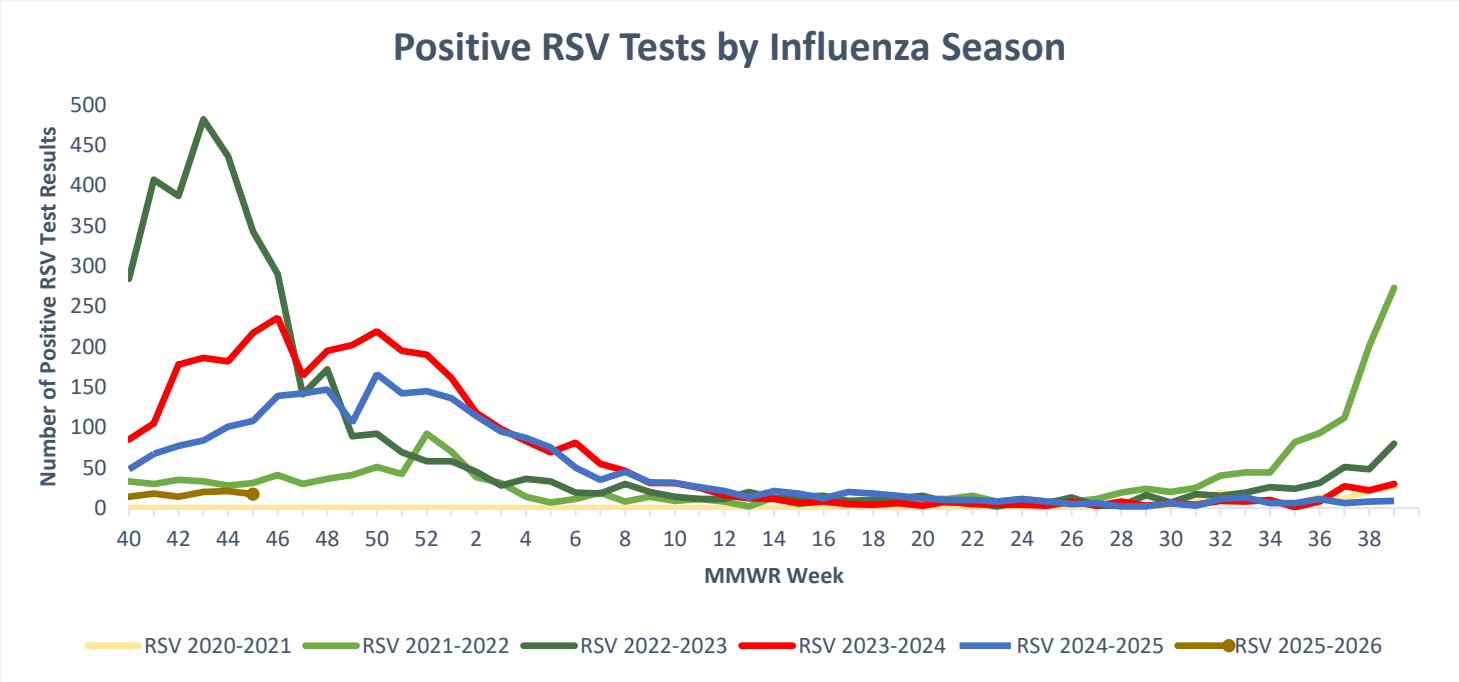
** A total of 6,829 specimens underwent confirmatory testing but not all positive influenza specimens receive confirmatory testing that are circulating in Hawaii.*

B. OTHER RESPIRATORY PATHOGENS: The major clinical and commercial laboratories throughout the state of Hawaii have the testing capacity for non-influenza respiratory pathogens and report these to HDOH. However, such testing is performed as needed and when sufficient resources are available because of the high costs associated with respiratory panel tests. **Therefore, available data represent only the presence of circulating pathogens and cannot be used to determine specific trends**.

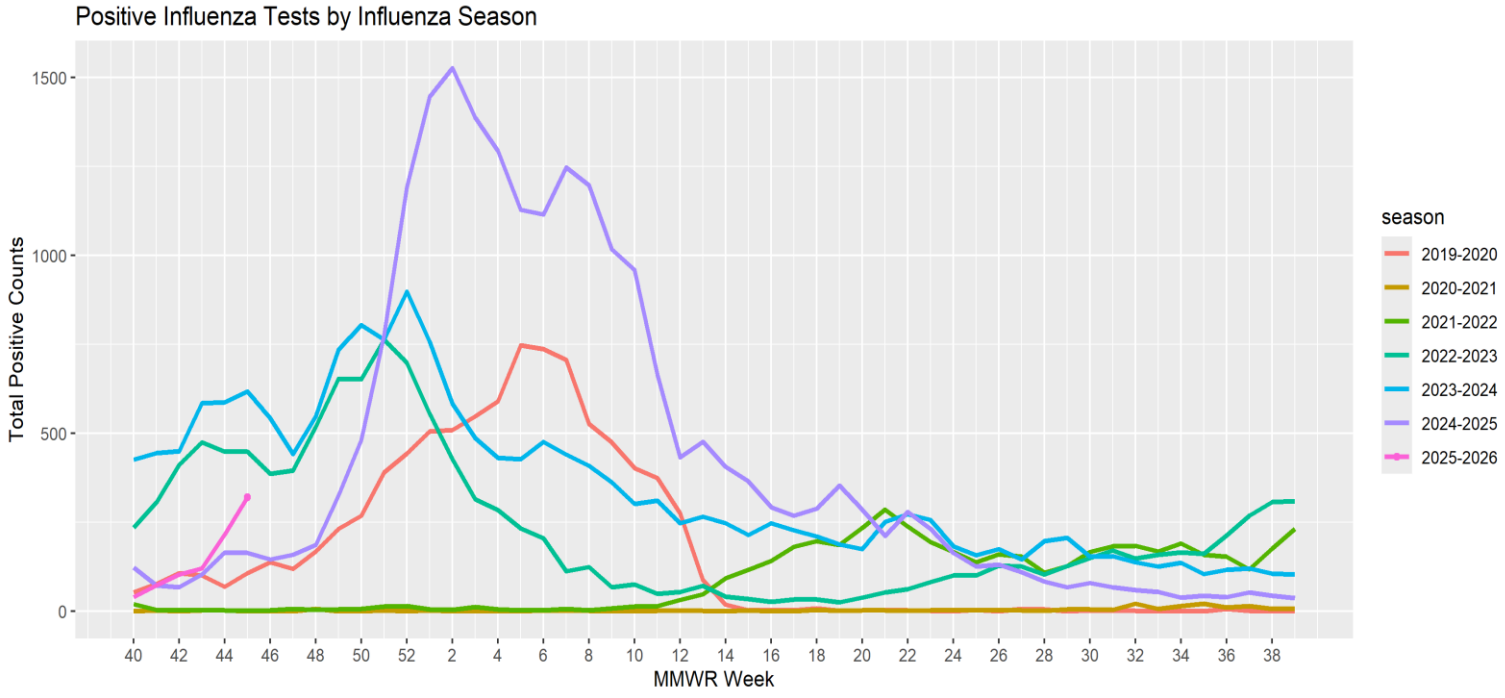


* *The coronavirus presented on this table does not indicate Severe Acute Respiratory Coronavirus-2 (i.e., COVID-19).*

RESPIRATORY SYNCYTIAL VIRUS (RSV) POSITIVE TEST RESULTS BY INFLUENZA SEASON: RSV case appears to have increased earlier than past seasons in the 2025-2026 season. Of note, significantly more tests for RSV are being performed than in pre-COVID-19 seasons.



INFLUENZA POSITIVE TEST RESULTS BY INFLUENZA SEASON: Influenza cases appear to have increased earlier than past seasons in the 2023-2024 season, but it is not yet known whether case numbers will reach a peak similar to pre-COVID-19 seasons.



C. COVID-19 SENTINEL SURVEILLANCE: Due to the low volume of samples currently available through the influenza surveillance system, the COVID-19 sentinel surveillance data may not be accurately portraying COVID-19 activity in our communities. Reporting of the COVID-19 Sentinel Surveillance data will be paused while HODH re-evaluates the program to ensure that the reported data are accurate and representative.

HDOH is continuing to monitor COVID-19 activity throughout the state. To learn more, please visit the Hawaii's COVID-19 data website (*here*). For more information on surveillance of COVID-19 activity in the United States please visit the CDC COVIDView website (*here*).

III. PNEUMONIA, INFLUENZA, AND COVID-19 (PIC) RELATED MORTALITY:

P&I mortality surveillance is collected by CDC through the National Center for Health Statistics (NCHS) using death certificate data. Each week the HDOH OHSM reports specific data from Honolulu to the CDC. CDC collects the following information by age group: the total number of deaths, total deaths from pneumonia, and total deaths related to influenza. Due to the ongoing COVID-19 pandemic, CDC included total deaths from COVID-19 by age group to the death data. Previous studies had suggested that P&I is a good indicator of influenza-related deaths; however, data has shown that pneumonia deaths associated with influenza is now being impacted by COVID-19 related pneumonia. Due to this, CDC had added COVID-19 deaths into P&I to create the PIC (pneumonia, influenza, and/or COVID-19) classification.

To standardize Hawaii's influenza surveillance with CDC influenza surveillance guidelines, PIC deaths will be reported in lieu of P&I. Hawaii's baseline will begin to include PIC deaths starting from 2019-2020 flu season.

The National Vital Statistic System (NVSS) surveillance datasets and reports had been paused temporarily, including those used to evaluate pneumonia, influenza, and COVID-19 deaths. HDOH PIC mortality data will not be published in the Influenza/Respiratory Disease Surveillance Report for week 45.

INFLUENZA-ASSOCIATED PEDIATRIC DEATHS[11]:

- No new influenza-associated pediatric death was reported to Hawaii. There have been zero influenza-associated pediatric deaths reported in Hawaii during the 2025–2026 season.
- Nationally, no new influenza-associated pediatric deaths were reported to CDC during week 45. (2025-2026 season total: 0).

IV. INFLUENZA WATCH: As part of a comprehensive influenza surveillance system and to prevent the spread of contagious respiratory diseases in humans, it is important to monitor all circulating influenza types. Several animal-origin influenza A subtypes are currently of interest: influenza A variant virus (H3N2v, H1N2v, and H1N1v) and Avian flu (H5N1 and H7N9). These types of influenza viruses may cause zoonotic (animal-associated) disease and are a public health concern.

A. VARIANT VIRUSES:

Influenza viruses that normally circulate in pigs are called "variant" viruses when they are found in people. These viruses were first identified in U.S. pigs in 2010. In 2011, 12 cases of H3N2v infection were detected in the United States. In 2012, 309 such cases (resulting in 16 hospitalizations and one death) across 12 states were detected, including one Hawaii case who recovered. Illness associated with H3N2v infection has been mostly mild with symptoms similar to those of seasonal flu. However, serious illness, resulting in hospitalization and death, has occurred in some cases. Most of these infections have been associated with prolonged exposure to pigs at agricultural fairs or similar settings. Limited human-to-human spread of this virus has been detected in the past, but no sustained community spread of H3N2v has been identified. More information regarding H3N2v, H1N1v, and H1N2v viruses may be found on the CDC website (*here*) and (*here*).

- *No variant or novel influenza infections have been reported to HDOH during the 2025-2026 influenza season.*
- *No new human infection with novel influenza A virus, H1N1v (1), H3N2v (0), and H1N2v (0), have been reported during the 2025-2026 influenza season.*

AVIAN (OR BIRD) INFLUENZA: These types of influenza viruses cause zoonotic (animal-associated) disease of public health concern and are therefore monitored globally by the WHO. Most avian influenza viruses do not cause disease in humans and are generally not easily transmissible between person to person, but a few subtypes may cross the species barrier and cause disease in humans. Avian influenza viruses may be of various subtypes, including H5N1, H5N2, H5N8, H7N3, H7N7, H7N8, H7N9, and H9N2. On January 15th, 2016, the USDA and APHIS reported detection of HPAI H7N8 in a commercial turkey flock in Indiana. There have been no associated human infections. This is the first detection of HPAI H7N8 in wild bird surveillance in the United States. More information, the risk assessment and recommendations for HPAI H7N8 can be found (here). The WHO, CDC, and other public health agencies have also been monitoring influenza H7N9, which represents a public health concern because of its high pandemic potential. Although H7N9 has not been detected in the United States, it remains a global concern given continuing epidemics in endemic countries. Since 2013, a total of 1,568 laboratory-confirmed cases of human infection with H7N9 viruses, including at least 613 deaths, have been reported to WHO. More information on H7N9 virus infections can be found (here). For more information regarding avian influenza, please visit the CDC (*here*) or the WHO (*here*) websites. WHO reports total number of cases and deaths related to laboratory-confirmed avian influenza viruses and posts current avian influenza case counts (*here*), which were last updated on **November 5, 2025**. One human case of influenza A(H5N1) were reported to WHO by Cambodia. Case was hospitalized and have since recovered. It was reported that case contact with dead backyard chickens One human cases of influenza

[11] Influenza-associated deaths are considered pediatric in persons aged less than 18 years. It was made a nationally notifiable condition in October, 2004. All pediatric influenza-associated deaths are laboratory confirmed.

A(H5N2) were reported to WHO by Mexico. Case was hospitalized and had possible exposure to animals tested positive for influenza A (H5). Two human cases of influenza A(H9N2) were reported to WHO by China. One case was not hospitalized at the time. Both cases had known exposure to backyard poultry.

V. INFLUENZA Vaccine: Annual influenza vaccination is recommended for all persons aged 6 months and older and is the most effective way to reduce the risk of getting sick with seasonal flu and spreading it to others. Influenza vaccination can reduce illnesses, visits to the doctor, influenza-related hospitalizations, and missed work and school days. Influenza vaccines become available by the end of October. It takes at least two weeks after vaccination to confer immunity against influenza virus infection. More information regarding influenza vaccination can be found (*here*).

A. Composition of the 2025–2026 Influenza Vaccine**:**

The composition of the 2025–2026 influenza vaccine has been updated to better match circulating influenza viruses. The Advisory Committee on Immunization Practices (ACIP) has recommended that the 2025-2026 influenza trivalent vaccine contain an influenza A/Victoria/4897/2022 (H1N1) pdm09-like virus, influenza A/Croatia/10136RV/2023 (H3N2)-like virus, and influenza B/Austria/1359417/2021 (B/Victoria lineage)-like virus. United States cell culture–based inactivated (ccIIV4) and recombinant (RIV4) influenza vaccines will contain HA derived from an influenza A/Wisconsin/67/2022 (H1N1) pdm09-like virus, an A/District of Columbia/27/2023 (H3N2)-like virus, an influenza B/Austria/1359417/2021 (B/Victoria lineage)-like virus. These vaccine recommendations were based on several factors, including global influenza virologic and epidemiologic surveillance, genetic and antigenic characterization, human serology studies, antiviral susceptibility, and the availability of candidate influenza viruses.

APPENDIX 1: ADDITIONAL INFORMATION

For more information regarding local and national influenza surveillance programs, visit the following sites.

Centers for Disease Control and Prevention	General Influenza National ILI and P&I Data Vaccine Virus Selection CDC Web Tool for Respiratory Viruses
Flu.gov	General Influenza Information
HDOH Flu and Pneumonia	General Influenza Surveillance Avian Influenza Respiratory Virus Dashboard To find out more information or join the sentinel physician program, email the Influenza Surveillance Coordinator
World Health Organization	General Global and Local Influenza Avian Influenza

APPENDIX 2: MMWR WEEK DATES

Please refer to the table below to interpret data presented by MMWR week. Week 40 is considered the traditional start for the flu season for the Northern Hemisphere.

MMWR WEEK	2022	2023	2024	2025	2026
1	1/8/2022	1/7/2023	1/6/2024	1/4/2025	1/10/2026
2	1/15/2022	1/14/2023	1/13/2024	1/11/2025	1/17/2026
3	1/22/2022	1/21/2023	1/20/2024	1/18/2025	1/24/2026
4	1/29/2022	1/28/2023	1/27/2024	1/25/2025	1/31/2026
5	2/5/2022	2/4/2023	2/3/2024	2/1/2025	2/7/2026
6	2/12/2022	2/11/2023	2/10/2024	2/8/2025	2/14/2026
7	2/19/2022	2/18/2023	2/17/2024	2/15/2025	2/21/2026
8	2/26/2022	2/25/2023	2/24/2024	2/22/2025	2/28/2026
9	3/5/2022	3/4/2023	3/2/2024	3/1/2025	3/7/2026
10	3/12/2022	3/11/2023	3/9/2024	3/8/2025	3/14/2026
11	3/19/2022	3/18/2023	3/16/2024	3/15/2025	3/21/2026
12	3/26/2022	3/25/2023	3/23/2024	3/22/2025	3/28/2026
13	4/2/2022	4/1/2023	3/30/2024	3/29/2025	4/4/2026
14	4/9/2022	4/8/2023	4/6/2024	4/5/2025	4/11/2026
15	4/16/2022	4/15/2023	4/13/2024	4/12/2025	4/18/2026
16	4/23/2022	4/22/2023	4/20/2024	4/19/2025	4/25/2026
17	4/30/2022	4/29/2023	4/27/2024	4/26/2025	5/2/2026
18	5/7/2022	5/6/2023	5/4/2024	5/3/2025	5/9/2026
19	5/14/2022	5/13/2023	5/11/2024	5/10/2025	5/16/2026
20	5/21/2022	5/20/2023	5/18/2024	5/17/2025	5/23/2026
21	5/28/2022	5/27/2023	5/25/2024	5/24/2025	5/30/2026
22	6/4/2022	6/3/2023	6/1/2024	5/31/2025	6/6/2026
23	6/11/2022	6/10/2023	6/8/2024	6/7/2025	6/13/2026
24	6/18/2022	6/17/2023	6/15/2024	6/14/2025	6/20/2026
25	6/25/2022	6/24/2023	6/22/2024	6/21/2025	6/27/2026
26	7/2/2022	7/1/2023	6/29/2024	6/28/2025	7/4/2026
27	7/9/2022	7/8/2023	7/6/2024	7/5/2025	7/11/2026
28	7/16/2022	7/15/2023	7/13/2024	7/12/2025	7/18/2026
29	7/23/2022	7/22/2023	7/20/2024	7/19/2025	7/25/2026
30	7/30/2022	7/29/2023	7/27/2024	7/26/2025	8/1/2026
31	8/6/2022	8/5/2023	8/3/2024	8/2/2025	8/8/2026
32	8/13/2022	8/12/2023	8/10/2024	8/9/2025	8/15/2026
33	8/20/2022	8/19/2023	8/17/2024	8/16/2025	8/22/2026
34	8/27/2022	8/26/2023	8/24/2024	8/23/2025	8/29/2026
35	9/3/2022	9/2/2023	8/31/2024	8/30/2025	9/5/2026
36	9/10/2022	9/9/2023	9/7/2024	9/6/2025	9/12/2026
37	9/17/2022	9/16/2023	9/14/2024	9/13/2025	9/19/2026
38	9/24/2022	9/23/2023	9/21/2024	9/20/2025	9/26/2026
39	10/1/2022	9/30/2023	9/28/2024	9/27/2025	10/3/2026
40	10/8/2022	10/7/2023	10/5/2024	10/4/2025	10/10/2026
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44	11/5/2022	11/4/2023	11/2/2024	11/1/2025	11/7/2026
45	11/12/2022	11/11/2023	11/9/2024	11/8/2025	11/14/2026
46	11/19/2022	11/18/2023	11/16/2024	11/15/2025	11/21/2026
47	11/26/2022	11/25/2023	11/23/2024	11/22/2025	11/28/2026
48	12/3/2022	12/2/2023	11/30/2024	11/29/2025	12/5/2026
49	12/10/2022	12/9/2023	12/7/2024	12/6/2025	12/12/2026
50	12/17/2022	12/16/2023	12/14/2024	12/13/2025	12/19/2026
51	12/24/2022	12/23/2023	12/21/2024	12/20/2025	12/26/2026
52	12/31/2022	12/30/2023	12/28/2024	12/27/2025	
53				01/03/2026	

HAWAII STATE DEPARTMENT OF HEALTH
DISEASE OUTBREAK CONTROL DIVISION

Influenza/Respiratory Disease Surveillance Report

Morbidity and Mortality Weekly Report (MMWR)[1]

WEEK 46: NOVEMBER 9, 2025– NOVEMBER 15, 2025

OVERVIEW: The Hawaii State Department of Health (HDOH) monitors influenza and other respiratory pathogens, including COVID-19, throughout the state of Hawaii. Influenza surveillance in the state of Hawaii relies upon selected sentinel health practitioners, the State Laboratories Division (SLD), private laboratories, and the Office of Health Status Monitoring (OHSM). For detailed information concerning influenza, please visit the HDOH Disease Outbreak Control Division (HDOH DOCD) website (*here*). **All data and information are conditional and may change as more reports are received.** The data in this report reflect the 2025-2026 influenza season which began the week ending October 4, 2025 (week 40[1] 2025) and will end the week ending on October 3, 2026 (week 39 2026).

REPORT SNAPSHOT FOR WEEK 46

Surveillance for Influenza-like Illness (ILI)		
Metric	*Value*	*Comment*
Outpatient visits related to influenza-like illness (ILI) from ILINet Sentinel Providers	2.7%	Same as the previous week. Comparable to the Hawaii's historical baseline and lower than the national baseline, and lower than the national ILI rate.
Number of ILI clusters reported to HDOH	0	There have been 6 clusters this season.

Laboratory Surveillance		
Percent of all respiratory specimens positive for influenza this week	16.3%	Higher than the previous week. This number means that many, if not all, of the 83.7% who tested negative for influenza had illness from another respiratory etiology.
Percent of all respiratory specimens positive for influenza this season to date	8.3%	

Surveillance for Severe Outcomes		
Pneumonia, influenza and COVID-19 (PIC) mortality rate		No new report for PIC mortality rates is available this week due to a pause in data updates from the National Vital Statistics System (NVSS).
Number of influenza-associated pediatric deaths reported nationwide	0	0 influenza-associated pediatric deaths have been reported from Hawaii this season to date.

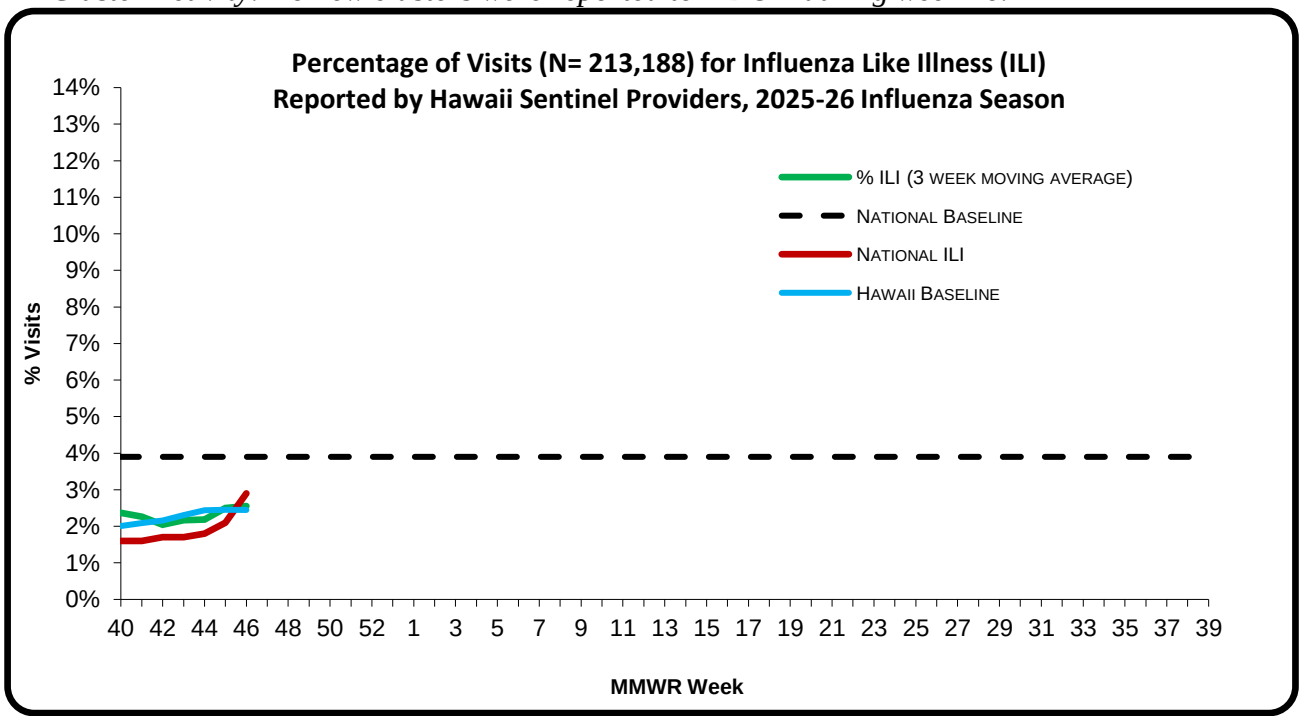
[1] MMWR stands for "Morbidity and Mortality Weekly Report," conventionally used by the Centers for Disease Control and Prevention (CDC). The weeks of a flu season are often referred to by their respective MMWR week. **See appendix 2 for interpretation of MMWR weeks.** Data reported will begin on week 40, the traditional start date of flu season.

INFLUENZA SURVEILLANCE

I. INFLUENZA-LIKE ILLNESS (ILI): HDOH collaborates with recruited doctors and healthcare providers who report the total number of outpatient visits for ILI as well as the total number of patients who complained of symptoms consistent with an ILI. A patient with ILI must have the following: a fever (temperature of 100°F [37.8°C] or greater) AND a cough and/or a sore throat. ILI is based on reported symptoms and not laboratory confirmed tests; thus, ILI may represent other respiratory pathogens and not solely influenza. Further, sentinel providers report these numbers on a weekly basis; therefore, data are preliminary and may change depending on additional reporting. In combination with laboratory testing and other surveillance systems, ILI surveillance helps monitor influenza and other respiratory pathogen activity. For more information concerning ILINet and sentinel requirements, please visit the CDC website (*here*).

For **week 46** of the current influenza season:

- ***2.7%** (season to date: **2.3**%) of the outpatient visits recorded by Hawaii sentinel providers were for ILI.*
- *ILI visits were comparable to the historical baseline in Hawaii[2,3] (i.e., inside the 95% confidence interval).*
- *Hawaii's ILI outpatient visits were lower than the national baseline (**3.9%**)[4] (i.e., outside the 95% confidence interval) and lower than the national ILI rate (**2.1%**) (i.e. outside the 95% confidence interval).*
- *ILI activity level: Low[5]*
- *Geographic Spread: Sporadic Activity[6].*
- *ILI Cluster Activity: No new clusters were reported to HDOH during week 46.*



[2] The Hawaii historical baseline (%ILI) is the average of 3-week moving averages over the preceding 10 flu seasons of historical data (2015-2016, 2016-2017, 2017-2018, 2018-2019, 2019-2020, 2020-2021, 2021-2022, 2022-2023, 2023-2024 and 2024-2025).

[3] This value is based upon comparison of actual outpatient ILI with the historical baseline, which only captures outpatient ILI. The chart above represents a 3-week moving average and not the actual ILI by week.

[4] The National Baseline is calculated by CDC as the mean percentage of visits for ILI during weeks 21–39 with two standard deviations. Because of large variability in regional ILI, comparison of the national baseline with local ILI may not be appropriate. It is provided in this report because no meaningful regional baselines are available for comparison. The national baseline combines all data reported by states to CDC, including ILI in outpatient, ER, urgent care, and inpatient settings.

[5] There are 10 activity levels classified as minimal (levels 1-3), low (levels 4-5), moderate (levels 6-7), and high (levels 8-10).

[6] The influenza activity reported by state and territorial epidemiologists indicates geographic spread of influenza viruses but does not measure the severity of influenza activity. Sporadic: no clusters reported to HDOH, Local: one or more clusters reported in one county, Regional: clusters reported two to three counties, Widespread: clusters reported in all counties. Hawaii does not report No Activity, as flu circulates year-round in Hawaii.

II. LABORATORY SURVEILLANCE: State Laboratories Division (SLD; the HDOH public health laboratory) and Hawaii's major private laboratories (DLS, CLH) report results of RT-PCR, which can be considered confirmatory (SLD may perform viral culture on select specimens). Specimens meeting priority criteria[7] are forwarded to SLD for sub-typing. Additionally, specimens meeting case definition from requesting sentinel providers are sent directly to SLD for sub-typing. Due to resource constraints, not all submitted specimens undergo sub-typing. Sub-typing at the commercial laboratories is only conducted on a case-by-case basis. The majority of specimens testing positive by rapid antigen testing or RT-PCR at the commercial laboratories do not meet criteria and are not subtyped. For more information on influenza tests and types, please visit the CDC website (*here*).

A. INFLUENZA:

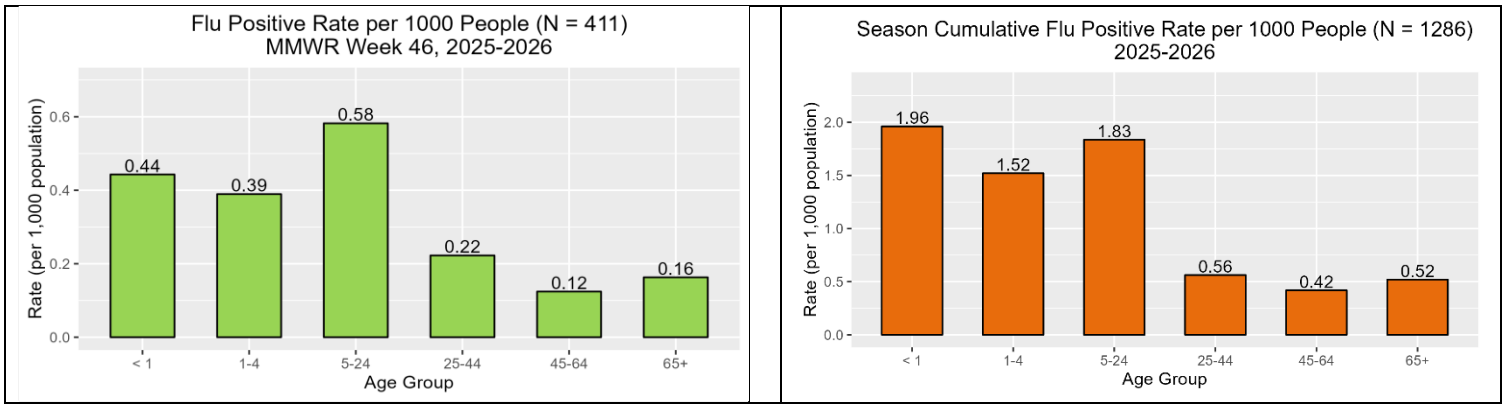
- The following reflects laboratory findings for week 46 of the 2025–26 influenza season:
  - *A total of **2,516** specimens have been tested statewide for influenza viruses (positive: 411 [**16.3%**]). (Season to date: **15,262** tested (**8.3%** positive)*
    - *1,159 (46.0%) were screened only by rapid antigen tests with no confirmatory testing.*
    - *1,359 (54.0%) underwent confirmatory testing (either RT-PCR or viral culture).*
    - *2,105 (83.7%) were negative.*
  - *Routine surveillance samples from State Laboratory Division were tested at a public health laboratory and identified as Influenza A (H3N2) subclade K.*

Influenza type	*Current week 46 (%)**	*Season to date (%)*[8]
Influenza A (H1)[9]	*10 (2.4)*	*27 (2.1)*
Influenza A (H3)	*95 (23.0)*	*172 (13.5)*
Influenza A no subtyping	*299 (72.6)*	*1,039 (81.6)*
Influenza B (Yamagata)	*0 (0.0)*	*0 (0.0)*
Influenza B (Victoria)	*0 (0.0)*	*0 (0.0)*
Influenza B no genotyping	*8 (1.9)*	*35 (2.7)*

**Specimens that are positive for both A and B (coinfections) are counted in both A and B totals for current and season to date*

1. AGE DISTRIBUTION

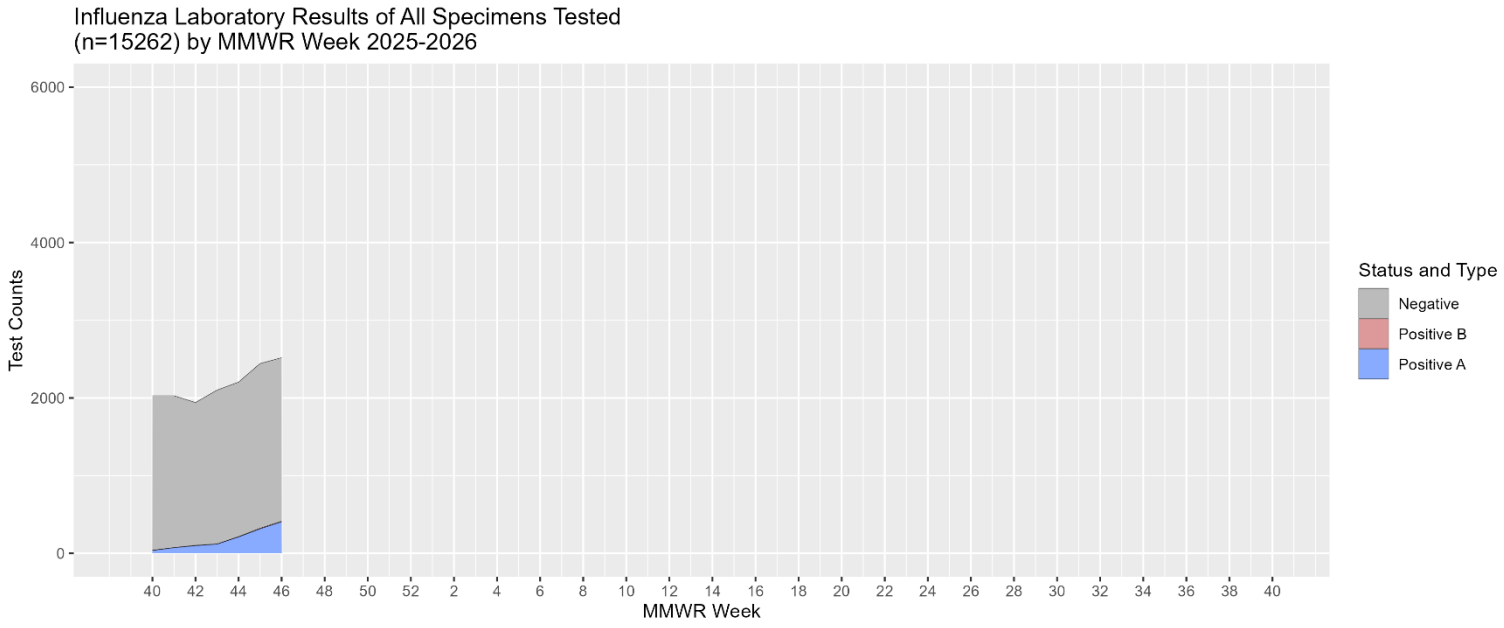
The charts below indicate the population-based rates of positive influenza cases in Hawaii by age group during the 2025–26 influenza season.[10]

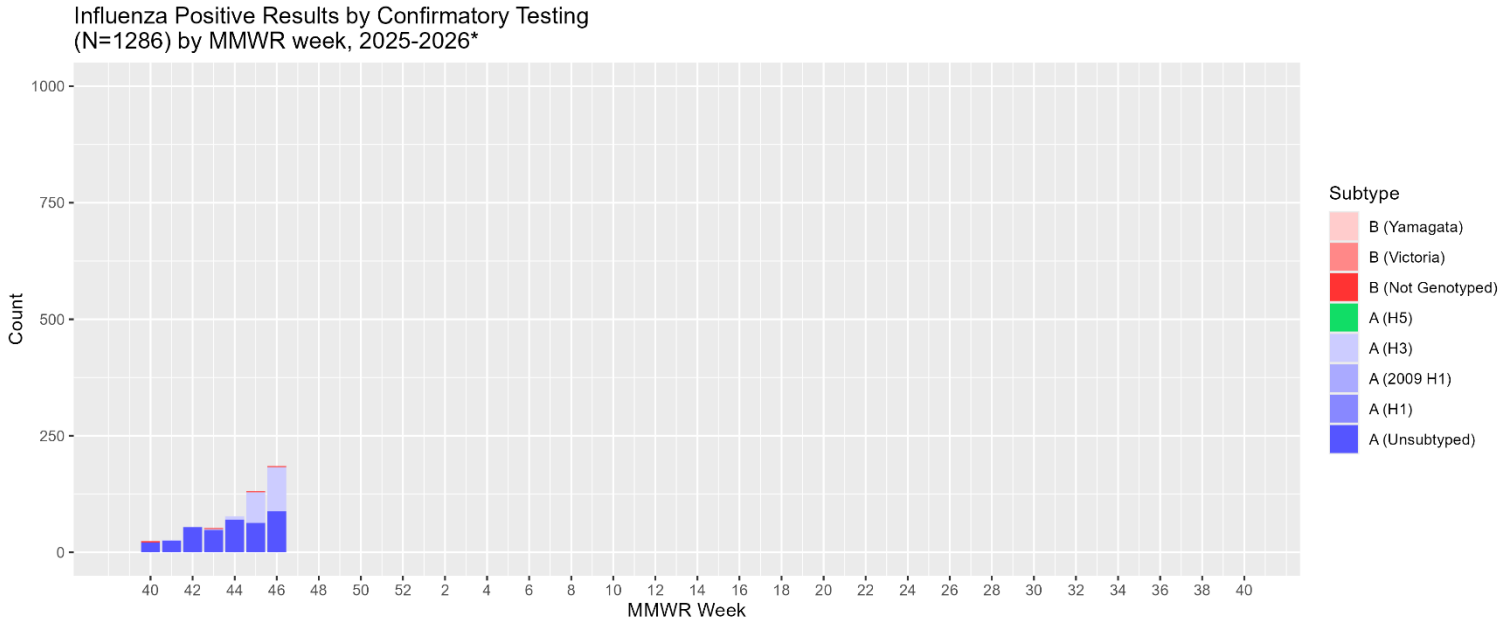


[7] Priority criteria include: hospitalized patients with acute respiratory distress syndrome [ARDS] or x-ray confirmed pneumonia; travelers with international travel history within 10 days of onset; specimens submitted by sentinel providers; specimens collected from healthcare workers, pregnant women, or women up to 6 weeks' post-partum; those with underlying medical conditions; and patients presenting with unusual or severe manifestations of influenza infection.
[8] Influenza coding were updated to reflect a more accurate count.
[9] All influenza A H1 viruses detected this season have been 2009 H1N1.
[10] This represents an estimate of population-based rates based on available data.

2. LABORATORY TESTING

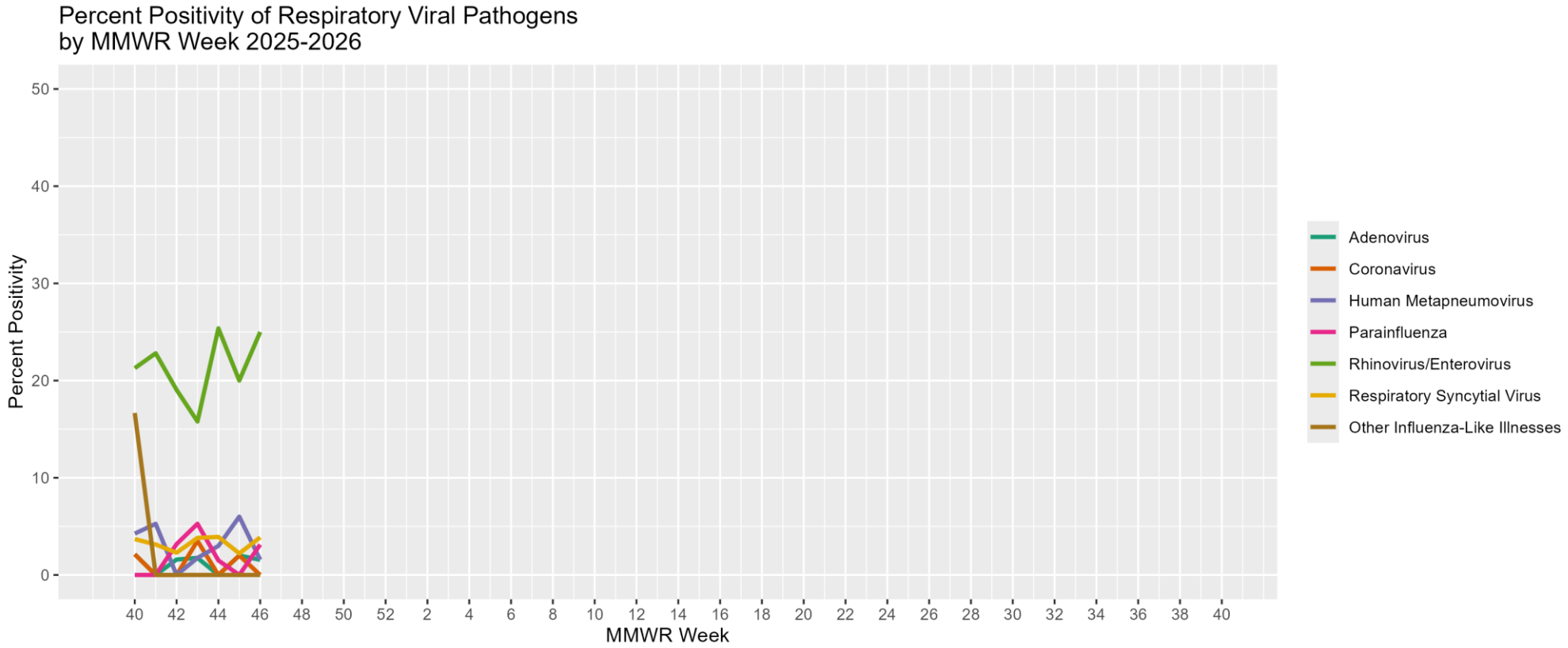
The charts below show the laboratory results of all specimens tested for influenza by MMWR week during the 2025–2026 influenza season as well as the type and subtype of positive results for influenza. Again, sub-typing is only performed on selected specimens tested by confirmatory tests (i.e., RT-PCR or viral culture).





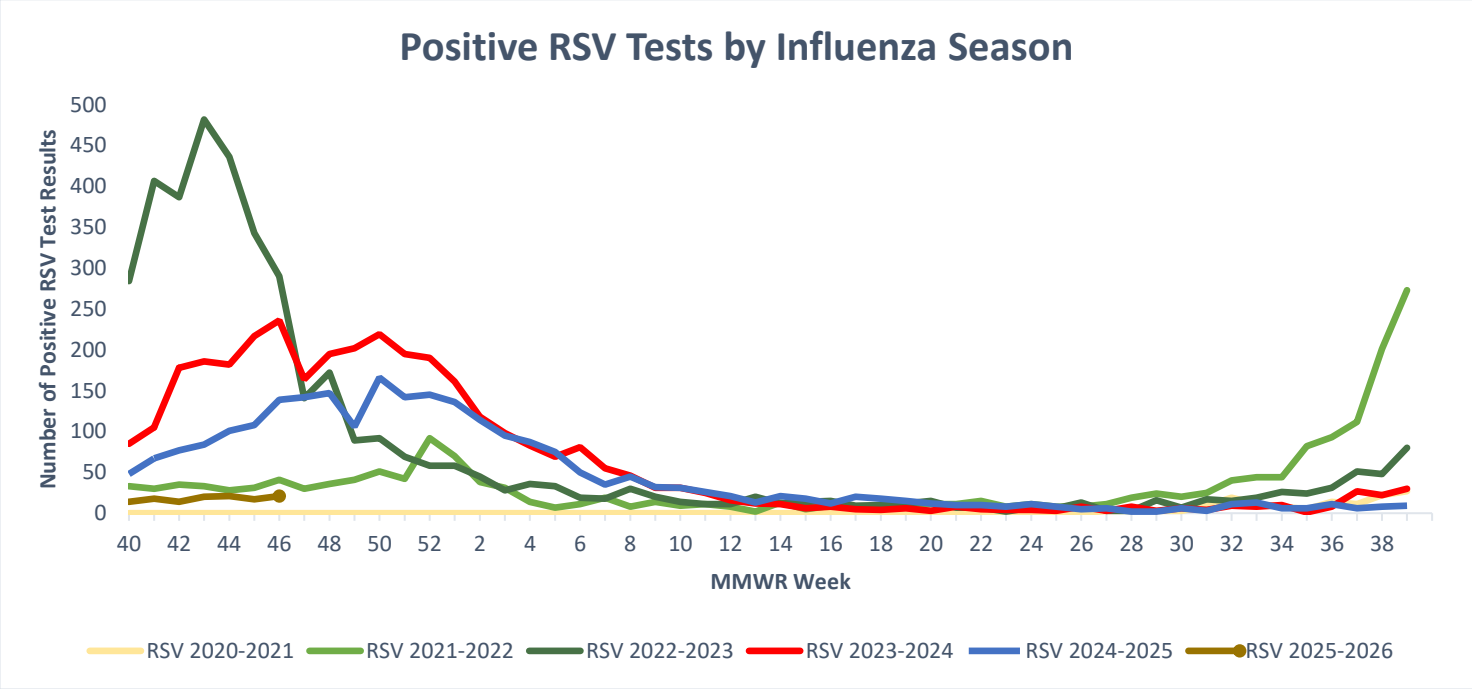
** A total of 8,197 specimens underwent confirmatory testing but not all positive influenza specimens receive confirmatory testing that are circulating in Hawaii.*

B. OTHER RESPIRATORY PATHOGENS: The major clinical and commercial laboratories throughout the state of Hawaii have the testing capacity for non-influenza respiratory pathogens and report these to HDOH. However, such testing is performed as needed and when sufficient resources are available because of the high costs associated with respiratory panel tests. **Therefore, available data represent only the presence of circulating pathogens and cannot be used to determine specific trends**.

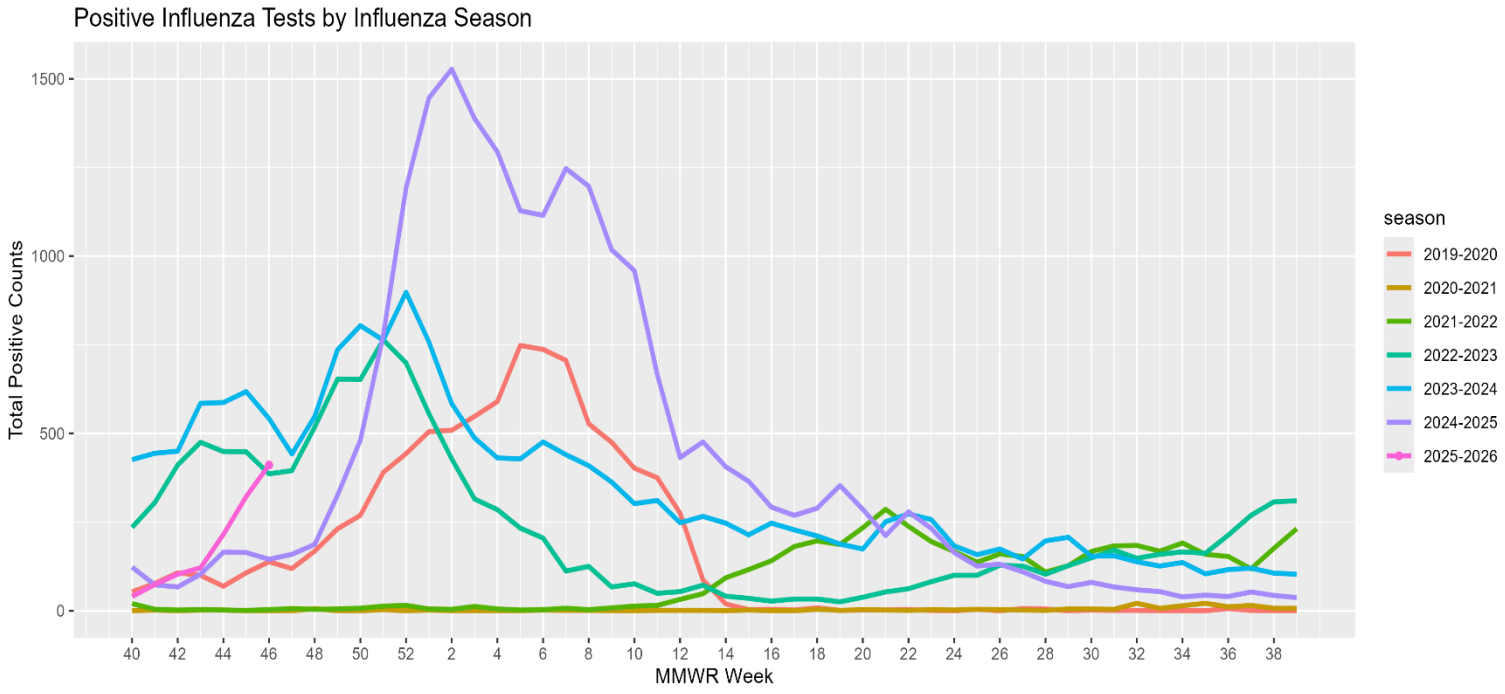


* *The coronavirus presented on this table does not indicate Severe Acute Respiratory Coronavirus-2 (i.e., COVID-19).*

RESPIRATORY SYNCYTIAL VIRUS (RSV) POSITIVE TEST RESULTS BY INFLUENZA SEASON: RSV case appears to have increased earlier than past seasons in the 2025-2026 season. Of note, significantly more tests for RSV are being performed than in pre-COVID-19 seasons.



INFLUENZA POSITIVE TEST RESULTS BY INFLUENZA SEASON: Influenza cases appear to have increased earlier than past seasons in the 2023-2024 season, but it is not yet known whether case numbers will reach a peak similar to pre-COVID-19 seasons.



C. COVID-19 SENTINEL SURVEILLANCE: Due to the low volume of samples currently available through the influenza surveillance system, the COVID-19 sentinel surveillance data may not be accurately portraying COVID-19 activity in our communities. Reporting of the COVID-19 Sentinel Surveillance data will be paused while HODH re-evaluates the program to ensure that the reported data are accurate and representative.

HDOH is continuing to monitor COVID-19 activity throughout the state. To learn more, please visit the Hawaii's COVID-19 data website (*here*). For more information on surveillance of COVID-19 activity in the United States please visit the CDC COVIDView website (*here*).

III. PNEUMONIA, INFLUENZA, AND COVID-19 (PIC) RELATED MORTALITY:

P&I mortality surveillance is collected by CDC through the National Center for Health Statistics (NCHS) using death certificate data. Each week the HDOH OHSM reports specific data from Honolulu to the CDC. CDC collects the following information by age group: the total number of deaths, total deaths from pneumonia, and total deaths related to influenza. Due to the ongoing COVID-19 pandemic, CDC included total deaths from COVID-19 by age group to the death data. Previous studies had suggested that P&I is a good indicator of influenza-related deaths; however, data has shown that pneumonia deaths associated with influenza is now being impacted by COVID-19 related pneumonia. Due to this, CDC had added COVID-19 deaths into P&I to create the PIC (pneumonia, influenza, and/or COVID-19) classification.

To standardize Hawaii's influenza surveillance with CDC influenza surveillance guidelines, PIC deaths will be reported in lieu of P&I. Hawaii's baseline will begin to include PIC deaths starting from 2019-2020 flu season.

The National Vital Statistic System (NVSS) surveillance datasets and reports had been paused temporarily, including those used to evaluate pneumonia, influenza, and COVID-19 deaths. HDOH PIC mortality data will not be published in the Influenza/Respiratory Disease Surveillance Report for week 46.

INFLUENZA-ASSOCIATED PEDIATRIC DEATHS[11]:

- No new influenza-associated pediatric death was reported to Hawaii. There have been zero influenza-associated pediatric deaths reported in Hawaii during the 2025–2026 season.
- Nationally, no new influenza-associated pediatric deaths were reported to CDC during week 46. (2025-2026 season total: 0).

IV. INFLUENZA WATCH: As part of a comprehensive influenza surveillance system and to prevent the spread of contagious respiratory diseases in humans, it is important to monitor all circulating influenza types. Several animal-origin influenza A subtypes are currently of interest: influenza A variant virus (H3N2v, H1N2v, and H1N1v) and Avian flu (H5N1 and H7N9). These types of influenza viruses may cause zoonotic (animal-associated) disease and are a public health concern.

A. VARIANT VIRUSES:

Influenza viruses that normally circulate in pigs are called "variant" viruses when they are found in people. These viruses were first identified in U.S. pigs in 2010. In 2011, 12 cases of H3N2v infection were detected in the United States. In 2012, 309 such cases (resulting in 16 hospitalizations and one death) across 12 states were detected, including one Hawaii case who recovered. Illness associated with H3N2v infection has been mostly mild with symptoms similar to those of seasonal flu. However, serious illness, resulting in hospitalization and death, has occurred in some cases. Most of these infections have been associated with prolonged exposure to pigs at agricultural fairs or similar settings. Limited human-to-human spread of this virus has been detected in the past, but no sustained community spread of H3N2v has been identified. More information regarding H3N2v, H1N1v, and H1N2v viruses may be found on the CDC website (*here*) and (*here*).

- *No variant or novel influenza infections have been reported to HDOH during the 2025-2026 influenza season.*
- *No new human infection with novel influenza A virus, H1N1v (1), H3N2v (0), and H1N2v (0), have been reported during the 2025-2026 influenza season.*

AVIAN (OR BIRD) INFLUENZA: These types of influenza viruses cause zoonotic (animal-associated) disease of public health concern and are therefore monitored globally by the WHO. Most avian influenza viruses do not cause disease in humans and are generally not easily transmissible between person to person, but a few subtypes may cross the species barrier and cause disease in humans. Avian influenza viruses may be of various subtypes, including H5N1, H5N2, H5N8, H7N3, H7N7, H7N8, H7N9, and H9N2. On January 15th, 2016, the USDA and APHIS reported detection of HPAI H7N8 in a commercial turkey flock in Indiana. There have been no associated human infections. This is the first detection of HPAI H7N8 in wild bird surveillance in the United States. More information, the risk assessment and recommendations for HPAI H7N8 can be found (here). The WHO, CDC, and other public health agencies have also been monitoring influenza H7N9, which represents a public health concern because of its high pandemic potential. Although H7N9 has not been detected in the United States, it remains a global concern given continuing epidemics in endemic countries. Since 2013, a total of 1,568 laboratory-confirmed cases of human infection with H7N9 viruses, including at least 613 deaths, have been reported to WHO. More information on H7N9 virus infections can be found (here). For more information regarding avian influenza, please visit the CDC (*here*) or the WHO (*here*) websites. WHO reports total number of cases and deaths related to laboratory-confirmed avian influenza viruses and posts current avian influenza case counts (*here*), which were last updated on **November 5, 2025**.

[11] Influenza-associated deaths are considered pediatric in persons aged less than 18 years. It was made a nationally notifiable condition in October, 2004. All pediatric influenza-associated deaths are laboratory confirmed.

V. INFLUENZA Vaccine: Annual influenza vaccination is recommended for all persons aged 6 months and older and is the most effective way to reduce the risk of getting sick with seasonal flu and spreading it to others. Influenza vaccination can reduce illnesses, visits to the doctor, influenza-related hospitalizations, and missed work and school days. Influenza vaccines become available by the end of October. It takes at least two weeks after vaccination to confer immunity against influenza virus infection. More information regarding influenza vaccination can be found (*here*).

A. Composition of the 2025–2026 Influenza Vaccine**:**

The composition of the 2025–2026 influenza vaccine has been updated to better match circulating influenza viruses. The Advisory Committee on Immunization Practices (ACIP) has recommended that the 2025-2026 influenza trivalent vaccine contain an influenza A/Victoria/4897/2022 (H1N1) pdm09-like virus, influenza A/Croatia/10136RV/2023 (H3N2)-like virus, and influenza B/Austria/1359417/2021 (B/Victoria lineage)-like virus. United States cell culture–based inactivated (ccIIV4) and recombinant (RIV4) influenza vaccines will contain HA derived from an influenza A/Wisconsin/67/2022 (H1N1) pdm09-like virus, an A/District of Columbia/27/2023 (H3N2)-like virus, an influenza B/Austria/1359417/2021 (B/Victoria lineage)-like virus. These vaccine recommendations were based on several factors, including global influenza virologic and epidemiologic surveillance, genetic and antigenic characterization, human serology studies, antiviral susceptibility, and the availability of candidate influenza viruses.

APPENDIX 1: ADDITIONAL INFORMATION

For more information regarding local and national influenza surveillance programs, visit the following sites.

Centers for Disease Control and Prevention	General Influenza National ILI and P&I Data Vaccine Virus Selection CDC Web Tool for Respiratory Viruses
Flu.gov	General Influenza Information
HDOH Flu and Pneumonia	General Influenza Surveillance Avian Influenza Respiratory Virus Dashboard To find out more information or join the sentinel physician program, email the Influenza Surveillance Coordinator
World Health Organization	General Global and Local Influenza Avian Influenza

APPENDIX 2: MMWR WEEK DATES

Please refer to the table below to interpret data presented by MMWR week. Week 40 is considered the traditional start for the flu season for the Northern Hemisphere.

MMWR WEEK	2022	2023	2024	2025	2026
1	1/8/2022	1/7/2023	1/6/2024	1/4/2025	1/10/2026
2	1/15/2022	1/14/2023	1/13/2024	1/11/2025	1/17/2026
3	1/22/2022	1/21/2023	1/20/2024	1/18/2025	1/24/2026
4	1/29/2022	1/28/2023	1/27/2024	1/25/2025	1/31/2026
5	2/5/2022	2/4/2023	2/3/2024	2/1/2025	2/7/2026
6	2/12/2022	2/11/2023	2/10/2024	2/8/2025	2/14/2026
7	2/19/2022	2/18/2023	2/17/2024	2/15/2025	2/21/2026
8	2/26/2022	2/25/2023	2/24/2024	2/22/2025	2/28/2026
9	3/5/2022	3/4/2023	3/2/2024	3/1/2025	3/7/2026
10	3/12/2022	3/11/2023	3/9/2024	3/8/2025	3/14/2026
11	3/19/2022	3/18/2023	3/16/2024	3/15/2025	3/21/2026
12	3/26/2022	3/25/2023	3/23/2024	3/22/2025	3/28/2026
13	4/2/2022	4/1/2023	3/30/2024	3/29/2025	4/4/2026
14	4/9/2022	4/8/2023	4/6/2024	4/5/2025	4/11/2026
15	4/16/2022	4/15/2023	4/13/2024	4/12/2025	4/18/2026
16	4/23/2022	4/22/2023	4/20/2024	4/19/2025	4/25/2026
17	4/30/2022	4/29/2023	4/27/2024	4/26/2025	5/2/2026
18	5/7/2022	5/6/2023	5/4/2024	5/3/2025	5/9/2026
19	5/14/2022	5/13/2023	5/11/2024	5/10/2025	5/16/2026
20	5/21/2022	5/20/2023	5/18/2024	5/17/2025	5/23/2026
21	5/28/2022	5/27/2023	5/25/2024	5/24/2025	5/30/2026
22	6/4/2022	6/3/2023	6/1/2024	5/31/2025	6/6/2026
23	6/11/2022	6/10/2023	6/8/2024	6/7/2025	6/13/2026
24	6/18/2022	6/17/2023	6/15/2024	6/14/2025	6/20/2026
25	6/25/2022	6/24/2023	6/22/2024	6/21/2025	6/27/2026
26	7/2/2022	7/1/2023	6/29/2024	6/28/2025	7/4/2026
27	7/9/2022	7/8/2023	7/6/2024	7/5/2025	7/11/2026
28	7/16/2022	7/15/2023	7/13/2024	7/12/2025	7/18/2026
29	7/23/2022	7/22/2023	7/20/2024	7/19/2025	7/25/2026
30	7/30/2022	7/29/2023	7/27/2024	7/26/2025	8/1/2026
31	8/6/2022	8/5/2023	8/3/2024	8/2/2025	8/8/2026
32	8/13/2022	8/12/2023	8/10/2024	8/9/2025	8/15/2026
33	8/20/2022	8/19/2023	8/17/2024	8/16/2025	8/22/2026
34	8/27/2022	8/26/2023	8/24/2024	8/23/2025	8/29/2026
35	9/3/2022	9/2/2023	8/31/2024	8/30/2025	9/5/2026
36	9/10/2022	9/9/2023	9/7/2024	9/6/2025	9/12/2026
37	9/17/2022	9/16/2023	9/14/2024	9/13/2025	9/19/2026
38	9/24/2022	9/23/2023	9/21/2024	9/20/2025	9/26/2026
39	10/1/2022	9/30/2023	9/28/2024	9/27/2025	10/3/2026
40	10/8/2022	10/7/2023	10/5/2024	10/4/2025	10/10/2026
41	10/15/2022	10/14/2023	10/12/2024	10/11/2025	10/17/2026
42	10/22/2022	10/21/2023	10/19/2024	10/18/2025	10/24/2026
43	10/29/2022	10/28/2023	10/26/2024	10/25/2025	10/31/2026
44	11/5/2022	11/4/2023	11/2/2024	11/1/2025	11/7/2026
45	11/12/2022	11/11/2023	11/9/2024	11/8/2025	11/14/2026
46	11/19/2022	11/18/2023	11/16/2024	11/15/2025	11/21/2026
47	11/26/2022	11/25/2023	11/23/2024	11/22/2025	11/28/2026
48	12/3/2022	12/2/2023	11/30/2024	11/29/2025	12/5/2026
49	12/10/2022	12/9/2023	12/7/2024	12/6/2025	12/12/2026
50	12/17/2022	12/16/2023	12/14/2024	12/13/2025	12/19/2026
51	12/24/2022	12/23/2023	12/21/2024	12/20/2025	12/26/2026
52	12/31/2022	12/30/2023	12/28/2024	12/27/2025	
53				01/03/2026	

HAWAII STATE DEPARTMENT OF HEALTH
DISEASE OUTBREAK CONTROL DIVISION

Influenza/Respiratory Disease Surveillance Report

Morbidity and Mortality Weekly Report (MMWR)[1]

WEEK 47: NOVEMBER 16, 2025– NOVEMBER 22, 2025

OVERVIEW: The Hawaii State Department of Health (HDOH) monitors influenza and other respiratory pathogens, including COVID-19, throughout the state of Hawaii. Influenza surveillance in the state of Hawaii relies upon selected sentinel health practitioners, the State Laboratories Division (SLD), private laboratories, and the Office of Health Status Monitoring (OHSM). For detailed information concerning influenza, please visit the HDOH Disease Outbreak Control Division (HDOH DOCD) website (*here*). **All data and information are conditional and may change as more reports are received.** The data in this report reflect the 2025-2026 influenza season which began the week ending October 4, 2025 (week 40[1] 2025) and will end the week ending on October 3, 2026 (week 39 2026).

REPORT SNAPSHOT FOR WEEK 47

Surveillance for Influenza-like Illness (ILI)		
Metric	*Value*	*Comment*
Outpatient visits related to influenza-like illness (ILI) from ILINet Sentinel Providers	2.8%	Higher than the previous week. Comparable to the Hawaii's historical baseline and lower than the national baseline, and higher than the national ILI rate.
Number of ILI clusters reported to HDOH	5	There have been 11 clusters this season.

Laboratory Surveillance		
Percent of all respiratory specimens positive for influenza this week	20.9%	Higher than the previous week. This number means that many, if not all, of the 79.1% who tested negative for influenza had illness from another respiratory etiology.
Percent of all respiratory specimens positive for influenza this season to date	10.3%	

Surveillance for Severe Outcomes		
Pneumonia, influenza and COVID-19 (PIC) mortality rate		No new report for PIC mortality rates is available this week due to a pause in data updates from the National Vital Statistics System (NVSS).
Number of influenza-associated pediatric deaths reported nationwide	0	0 influenza-associated pediatric deaths have been reported from Hawaii this season to date.

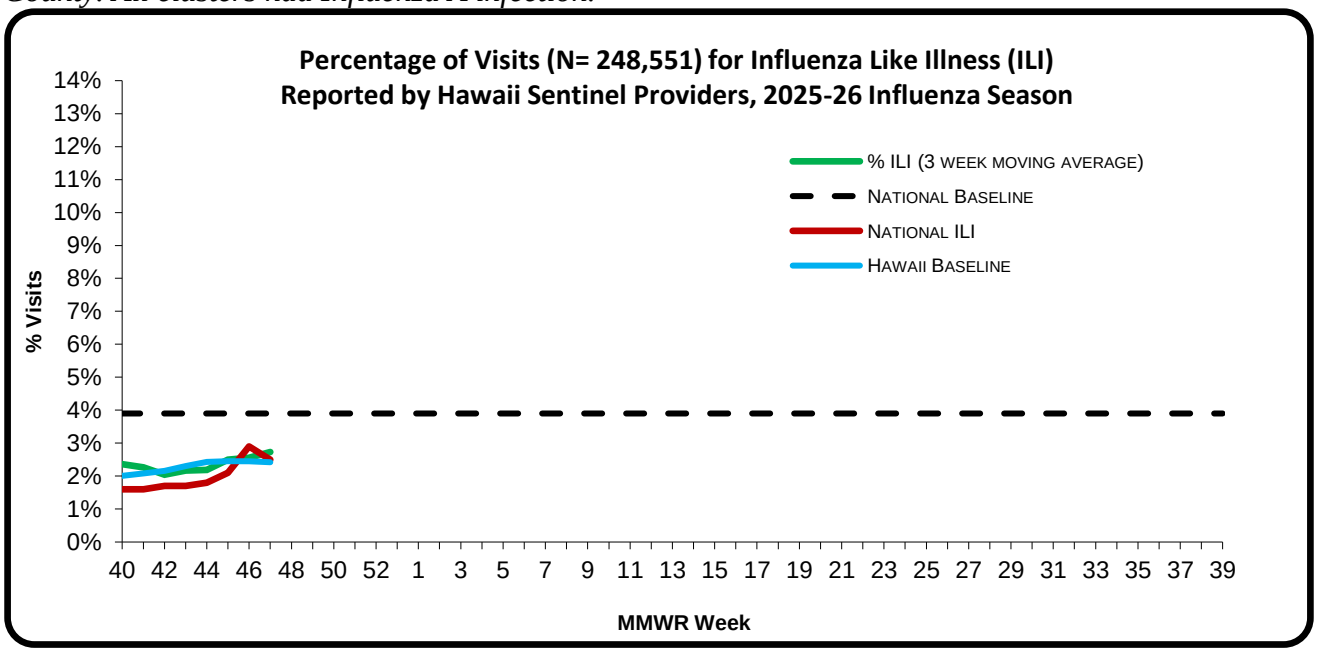
[1] MMWR stands for "Morbidity and Mortality Weekly Report," conventionally used by the Centers for Disease Control and Prevention (CDC). The weeks of a flu season are often referred to by their respective MMWR week. **See appendix 2 for interpretation of MMWR weeks.** Data reported will begin on week 40, the traditional start date of flu season.

INFLUENZA SURVEILLANCE

I. INFLUENZA-LIKE ILLNESS (ILI): HDOH collaborates with recruited doctors and healthcare providers who report the total number of outpatient visits for ILI as well as the total number of patients who complained of symptoms consistent with an ILI. A patient with ILI must have the following: a fever (temperature of 100°F [37.8°C] or greater) AND a cough and/or a sore throat. ILI is based on reported symptoms and not laboratory confirmed tests; thus, ILI may represent other respiratory pathogens and not solely influenza. Further, sentinel providers report these numbers on a weekly basis; therefore, data are preliminary and may change depending on additional reporting. In combination with laboratory testing and other surveillance systems, ILI surveillance helps monitor influenza and other respiratory pathogen activity. For more information concerning ILINet and sentinel requirements, please visit the CDC website (*here*).

For **week 47** of the current influenza season:

- ***2.8**% (season to date: **2.3**%) of the outpatient visits recorded by Hawaii sentinel providers were for ILI.*
- *ILI visits were comparable to the historical baseline in Hawaii[2,3] (i.e., inside the 95% confidence interval).*
- *Hawaii's ILI outpatient visits were lower than the national baseline (**3.9%**)[4] (i.e., outside the 95% confidence interval) and higher than the national ILI rate (**2.5%**) (i.e. outside the 95% confidence interval).*
- *ILI activity level: Low[5]*
- *Geographic Spread: Sporadic Activity[6].*
- *ILI Cluster Activity: Five new clusters were reported to HDOH during week 47. One cluster was from a long-term care facility in Honolulu County while the other four clusters were from schools in Honolulu and Hawaii County. All clusters had Influenza A infection.*



[2] The Hawaii historical baseline (%ILI) is the average of 3-week moving averages over the preceding 10 flu seasons of historical data (2015-2016, 2016-2017, 2017-2018, 2018-2019, 2019-2020, 2020-2021, 2021-2022, 2022-2023, 2023-2024 and 2024-2025).
[3] This value is based upon comparison of actual outpatient ILI with the historical baseline, which only captures outpatient ILI. The chart above represents a 3-week moving average and not the actual ILI by week.
[4] The National Baseline is calculated by CDC as the mean percentage of visits for ILI during weeks 21–39 with two standard deviations. Because of large variability in regional ILI, comparison of the national baseline with local ILI may not be appropriate. It is provided in this report because no meaningful regional baselines are available for comparison. The national baseline combines all data reported by states to CDC, including ILI in outpatient, ER, urgent care, and inpatient settings.
[5] There are 10 activity levels classified as minimal (levels 1-3), low (levels 4-5), moderate (levels 6-7), and high (levels 8-10).
[6] The influenza activity reported by state and territorial epidemiologists indicates geographic spread of influenza viruses but does not measure the severity of influenza activity. Sporadic: no clusters reported to HDOH, Local: one or more clusters reported in one county, Regional: clusters reported two to three counties, Widespread: clusters reported in all counties. Hawaii does not report No Activity, as flu circulates year-round in Hawaii.

II. LABORATORY SURVEILLANCE: State Laboratories Division (SLD; the HDOH public health laboratory) and Hawaii's major private laboratories (DLS, CLH) report results of RT-PCR, which can be considered confirmatory (SLD may perform viral culture on select specimens). Specimens meeting priority criteria[7] are forwarded to SLD for sub-typing. Additionally, specimens meeting case definition from requesting sentinel providers are sent directly to SLD for sub-typing. Due to resource constraints, not all submitted specimens undergo sub-typing. Sub-typing at the commercial laboratories is only conducted on a case-by-case basis. The majority of specimens testing positive by rapid antigen testing or RT-PCR at the commercial laboratories do not meet criteria and are not subtyped. For more information on influenza tests and types, please visit the CDC website (*here*).

A. INFLUENZA:

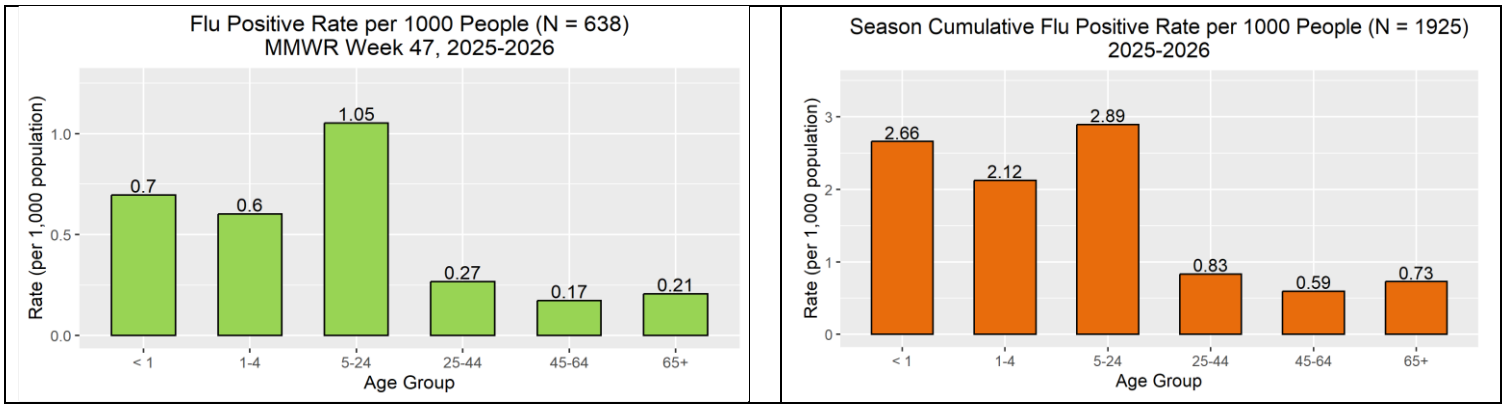
- The following reflects laboratory findings for week 47 of the 2025–26 influenza season:
  - *A total of **3,051** specimens have been tested statewide for influenza viruses (positive: 638 [**20.9%**]). (Season to date: **18,315** tested (**10.3%** positive)*
    - *1,534 (49.7%) were screened only by rapid antigen tests with no confirmatory testing.*
    - *1,517 (50.3%) underwent confirmatory testing (either RT-PCR or viral culture).*
    - *2,413 (79.1%) were negative.*
  - *Routine surveillance samples from State Laboratory Division were tested at a public health laboratory and identified as Influenza A (H3N2) subclade K.*

Influenza type	*Current week 47 (%)**	*Season to date (%)*[8]
Influenza A (H1)[9]	*5 (0.8)*	*34 (1.8)*
Influenza A (H3)	*90 (14.6)*	*267 (14.2)*
Influenza A no subtyping	*518 (83.8)*	*1,545 (81.9)*
Influenza B (Yamagata)	*0 (0.0)*	*0 (0.0)*
Influenza B (Victoria)	*0 (0.0)*	*0 (0.0)*
Influenza B no genotyping	*5 (0.8)*	*40 (2.1)*

**Specimens that are positive for both A and B (coinfections) are counted in both A and B totals for current and season to date*

1. AGE DISTRIBUTION

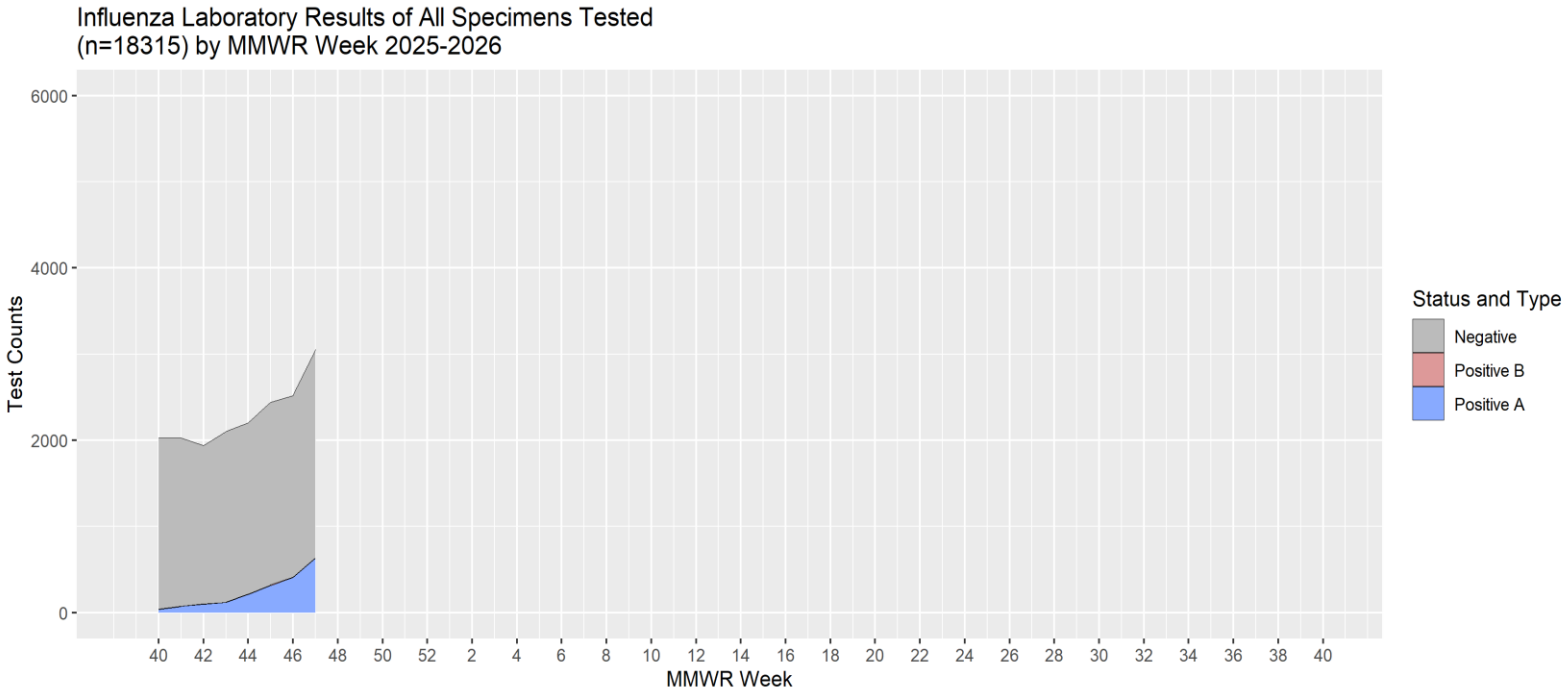
The charts below indicate the population-based rates of positive influenza cases in Hawaii by age group during the 2025–26 influenza season.[10]

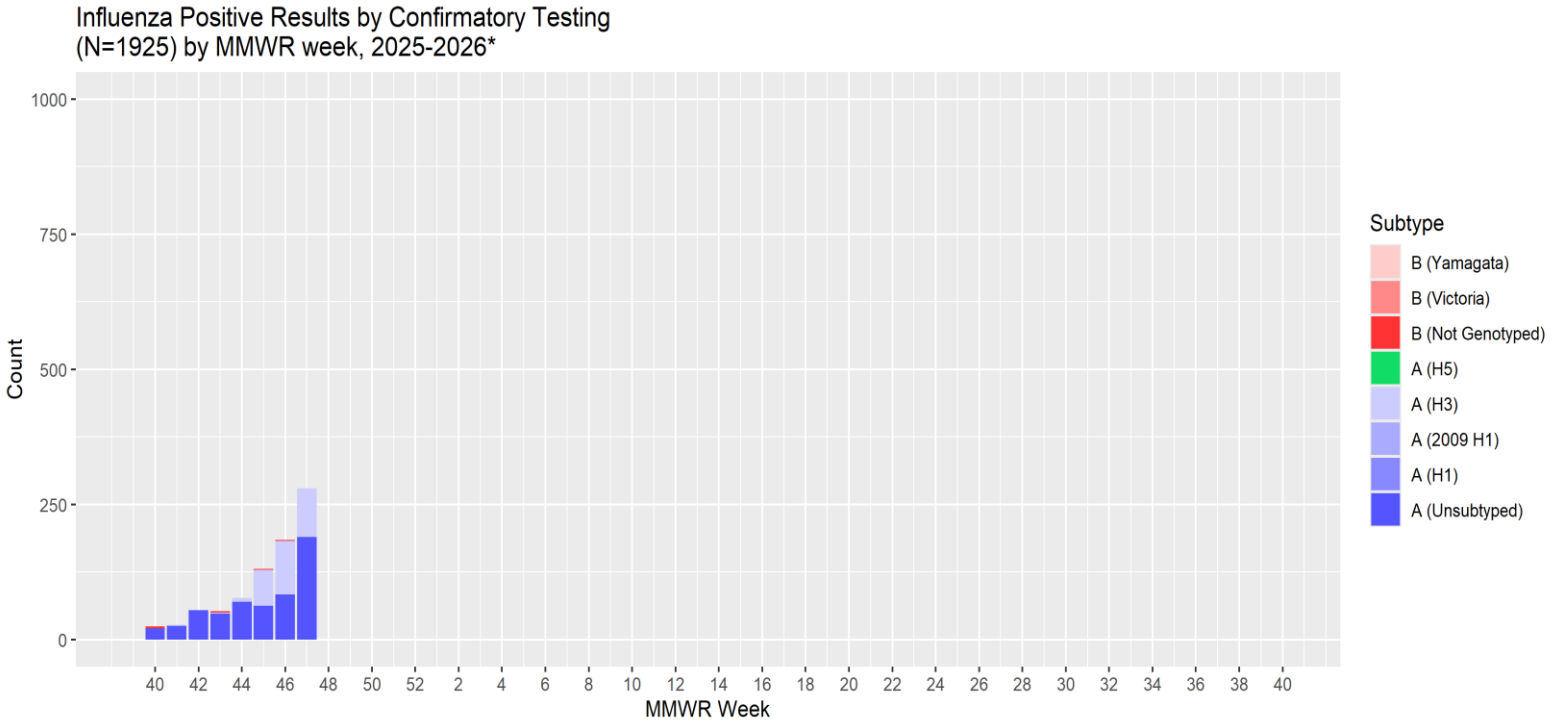


[7] Priority criteria include: hospitalized patients with acute respiratory distress syndrome [ARDS] or x-ray confirmed pneumonia; travelers with international travel history within 10 days of onset; specimens submitted by sentinel providers; specimens collected from healthcare workers, pregnant women, or women up to 6 weeks' post-partum; those with underlying medical conditions; and patients presenting with unusual or severe manifestations of influenza infection.
[8] Influenza coding were updated to reflect a more accurate count.
[9] All influenza A H1 viruses detected this season have been 2009 H1N1.
[10] This represents an estimate of population-based rates based on available data.

2. LABORATORY TESTING

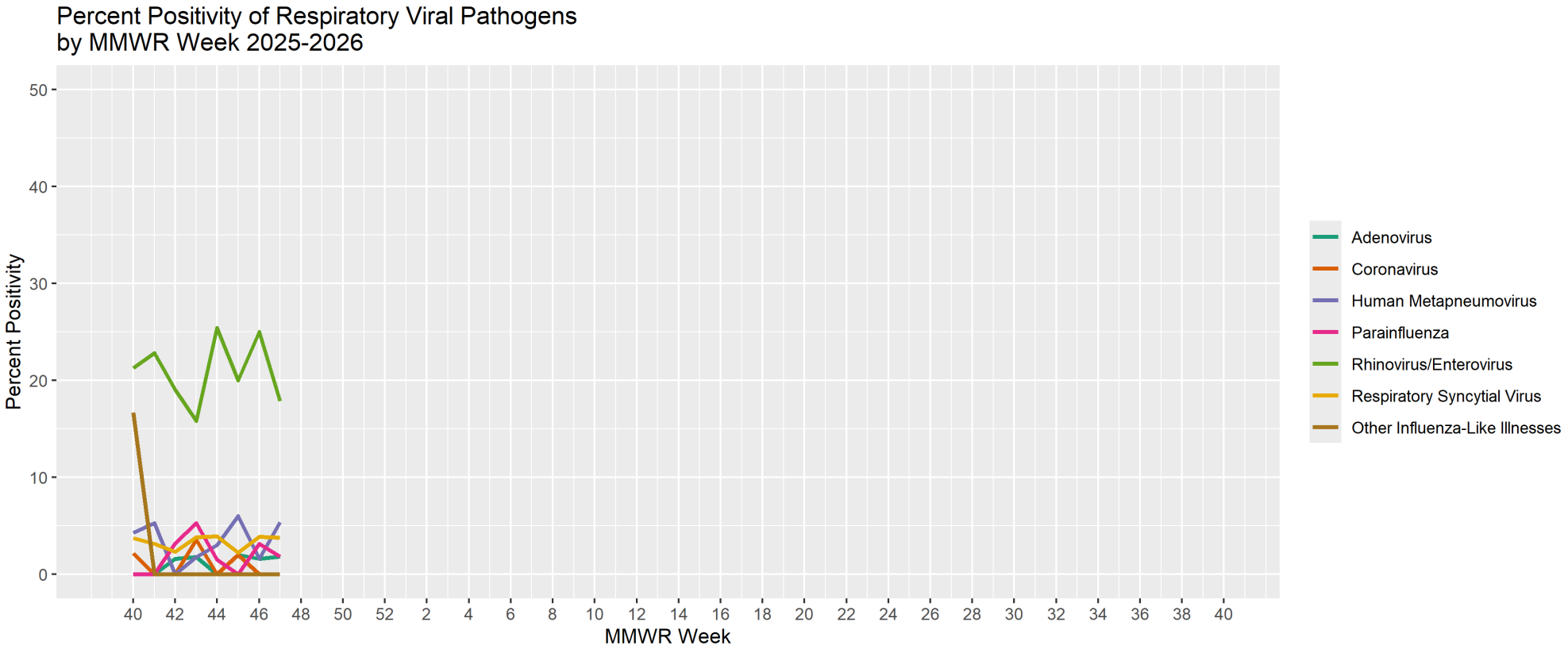
The charts below show the laboratory results of all specimens tested for influenza by MMWR week during the 2025–2026 influenza season as well as the type and subtype of positive results for influenza. Again, sub-typing is only performed on selected specimens tested by confirmatory tests (i.e., RT-PCR or viral culture).





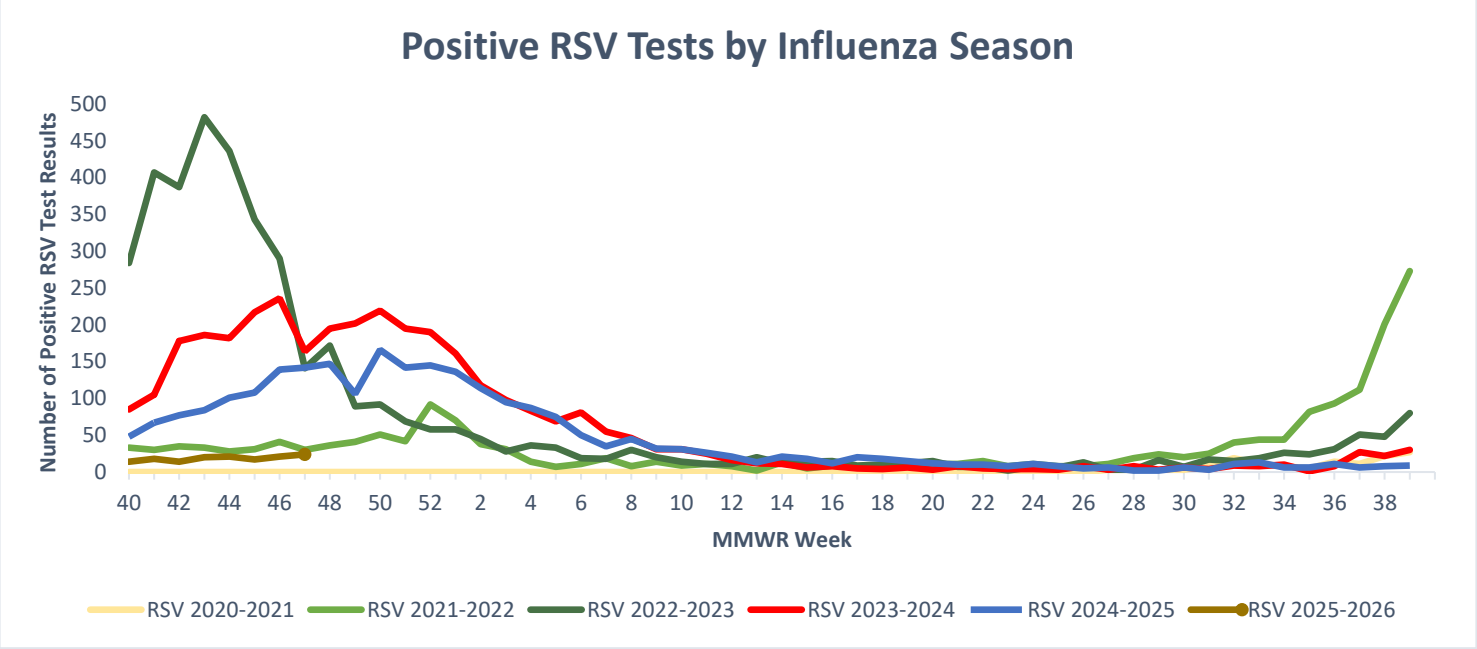
** A total of 9,716 specimens underwent confirmatory testing but not all positive influenza specimens receive confirmatory testing that are circulating in Hawaii.*

B. OTHER RESPIRATORY PATHOGENS: The major clinical and commercial laboratories throughout the state of Hawaii have the testing capacity for non-influenza respiratory pathogens and report these to HDOH. However, such testing is performed as needed and when sufficient resources are available because of the high costs associated with respiratory panel tests. **Therefore, available data represent only the presence of circulating pathogens and cannot be used to determine specific trends**.

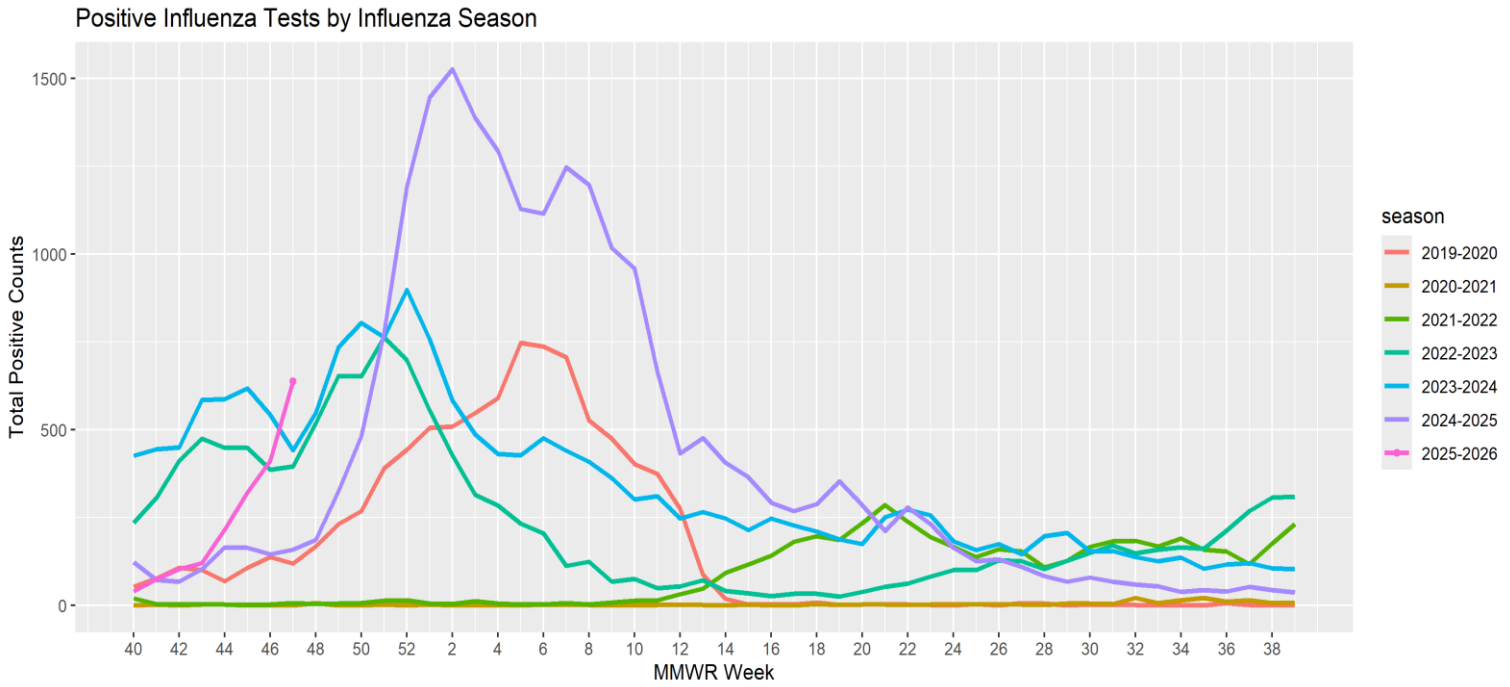


* *The coronavirus presented on this table does not indicate Severe Acute Respiratory Coronavirus-2 (i.e., COVID-19).*

RESPIRATORY SYNCYTIAL VIRUS (RSV) POSITIVE TEST RESULTS BY INFLUENZA SEASON: RSV case appears to have increased earlier than past seasons in the 2025-2026 season. Of note, significantly more tests for RSV are being performed than in pre-COVID-19 seasons.



INFLUENZA POSITIVE TEST RESULTS BY INFLUENZA SEASON: Influenza cases appear to have increased earlier than past seasons in the 2023-2024 season, but it is not yet known whether case numbers will reach a peak similar to pre-COVID-19 seasons.



C. COVID-19 SENTINEL SURVEILLANCE: Due to the low volume of samples currently available through the influenza surveillance system, the COVID-19 sentinel surveillance data may not be accurately portraying COVID-19 activity in our communities. Reporting of the COVID-19 Sentinel Surveillance data will be paused while HODH re-evaluates the program to ensure that the reported data are accurate and representative.

HDOH is continuing to monitor COVID-19 activity throughout the state. To learn more, please visit the Hawaii's COVID-19 data website (*here*). For more information on surveillance of COVID-19 activity in the United States please visit the CDC COVIDView website (*here*).

III. PNEUMONIA, INFLUENZA, AND COVID-19 (PIC) RELATED MORTALITY:

P&I mortality surveillance is collected by CDC through the National Center for Health Statistics (NCHS) using death certificate data. Each week the HDOH OHSM reports specific data from Honolulu to the CDC. CDC collects the following information by age group: the total number of deaths, total deaths from pneumonia, and total deaths related to influenza. Due to the ongoing COVID-19 pandemic, CDC included total deaths from COVID-19 by age group to the death data. Previous studies had suggested that P&I is a good indicator of influenza-related deaths; however, data has shown that pneumonia deaths associated with influenza is now being impacted by COVID-19 related pneumonia. Due to this, CDC had added COVID-19 deaths into P&I to create the PIC (pneumonia, influenza, and/or COVID-19) classification.

To standardize Hawaii's influenza surveillance with CDC influenza surveillance guidelines, PIC deaths will be reported in lieu of P&I. Hawaii's baseline will begin to include PIC deaths starting from 2019-2020 flu season.

The National Vital Statistic System (NVSS) surveillance datasets and reports had been paused temporarily, including those used to evaluate pneumonia, influenza, and COVID-19 deaths. HDOH PIC mortality data will not be published in the Influenza/Respiratory Disease Surveillance Report for week 47.

INFLUENZA-ASSOCIATED PEDIATRIC DEATHS[11]:

- No new influenza-associated pediatric death was reported to Hawaii. There have been zero influenza-associated pediatric deaths reported in Hawaii during the 2025–2026 season.
- Nationally, no new influenza-associated pediatric deaths were reported to CDC during week 47. (2025-2026 season total: 0).

IV. INFLUENZA WATCH: As part of a comprehensive influenza surveillance system and to prevent the spread of contagious respiratory diseases in humans, it is important to monitor all circulating influenza types. Several animal-origin influenza A subtypes are currently of interest: influenza A variant virus (H3N2v, H1N2v, and H1N1v) and Avian flu (H5N1 and H7N9). These types of influenza viruses may cause zoonotic (animal-associated) disease and are a public health concern.

A. VARIANT VIRUSES:

Influenza viruses that normally circulate in pigs are called "variant" viruses when they are found in people. These viruses were first identified in U.S. pigs in 2010. In 2011, 12 cases of H3N2v infection were detected in the United States. In 2012, 309 such cases (resulting in 16 hospitalizations and one death) across 12 states were detected, including one Hawaii case who recovered. Illness associated with H3N2v infection has been mostly mild with symptoms similar to those of seasonal flu. However, serious illness, resulting in hospitalization and death, has occurred in some cases. Most of these infections have been associated with prolonged exposure to pigs at agricultural fairs or similar settings. Limited human-to-human spread of this virus has been detected in the past, but no sustained community spread of H3N2v has been identified. More information regarding H3N2v, H1N1v, and H1N2v viruses may be found on the CDC website (*here*) and (*here*).

- *No variant or novel influenza infections have been reported to HDOH during the 2025-2026 influenza season.*
- *No new human infection with novel influenza A virus, H1N1v (1), H3N2v (0), and H1N2v (0), have been reported during the 2025-2026 influenza season.*

AVIAN (OR BIRD) INFLUENZA: These types of influenza viruses cause zoonotic (animal-associated) disease of public health concern and are therefore monitored globally by the WHO. Most avian influenza viruses do not cause disease in humans and are generally not easily transmissible between person to person, but a few subtypes may cross the species barrier and cause disease in humans. Avian influenza viruses may be of various subtypes, including H5N1, H5N2, H5N8, H7N3, H7N7, H7N8, H7N9, and H9N2. On January 15th, 2016, the USDA and APHIS reported detection of HPAI H7N8 in a commercial turkey flock in Indiana. There have been no associated human infections. This is the first detection of HPAI H7N8 in wild bird surveillance in the United States. More information, the risk assessment and recommendations for HPAI H7N8 can be found (here). The WHO, CDC, and other public health agencies have also been monitoring influenza H7N9, which represents a public health concern because of its high pandemic potential. Although H7N9 has not been detected in the United States, it remains a global concern given continuing epidemics in endemic countries. Since 2013, a total of 1,568 laboratory-confirmed cases of human infection with H7N9 viruses, including at least 613 deaths, have been reported to WHO. More information on H7N9 virus infections can be found (here). For more information regarding avian influenza, please visit the CDC (*here*) or the WHO (*here*) websites. WHO reports total number of cases and deaths related to laboratory-confirmed avian influenza viruses and posts current avian influenza case counts (*here*), which were last updated on **November 5, 2025**.

[11] Influenza-associated deaths are considered pediatric in persons aged less than 18 years. It was made a nationally notifiable condition in October, 2004. All pediatric influenza-associated deaths are laboratory confirmed.

V. INFLUENZA Vaccine: Annual influenza vaccination is recommended for all persons aged 6 months and older and is the most effective way to reduce the risk of getting sick with seasonal flu and spreading it to others. Influenza vaccination can reduce illnesses, visits to the doctor, influenza-related hospitalizations, and missed work and school days. Influenza vaccines become available by the end of October. It takes at least two weeks after vaccination to confer immunity against influenza virus infection. More information regarding influenza vaccination can be found (*here*).

A. Composition of the 2025–2026 Influenza Vaccine**:**

The composition of the 2025–2026 influenza vaccine has been updated to better match circulating influenza viruses. The Advisory Committee on Immunization Practices (ACIP) has recommended that the 2025-2026 influenza trivalent vaccine contain an influenza A/Victoria/4897/2022 (H1N1) pdm09-like virus, influenza A/Croatia/10136RV/2023 (H3N2)-like virus, and influenza B/Austria/1359417/2021 (B/Victoria lineage)-like virus. United States cell culture–based inactivated (ccIIV4) and recombinant (RIV4) influenza vaccines will contain HA derived from an influenza A/Wisconsin/67/2022 (H1N1) pdm09-like virus, an A/District of Columbia/27/2023 (H3N2)-like virus, an influenza B/Austria/1359417/2021 (B/Victoria lineage)-like virus. These vaccine recommendations were based on several factors, including global influenza virologic and epidemiologic surveillance, genetic and antigenic characterization, human serology studies, antiviral susceptibility, and the availability of candidate influenza viruses.

APPENDIX 1: ADDITIONAL INFORMATION

For more information regarding local and national influenza surveillance programs, visit the following sites.

Centers for Disease Control and Prevention	General Influenza National ILI and P&I Data Vaccine Virus Selection CDC Web Tool for Respiratory Viruses
Flu.gov	General Influenza Information
HDOH Flu and Pneumonia	General Influenza Surveillance Avian Influenza Respiratory Virus Dashboard To find out more information or join the sentinel physician program, email the Influenza Surveillance Coordinator
World Health Organization	General Global and Local Influenza Avian Influenza

APPENDIX 2: MMWR WEEK DATES

Please refer to the table below to interpret data presented by MMWR week. Week 40 is considered the traditional start for the flu season for the Northern Hemisphere.

MMWR WEEK	2022	2023	2024	2025	2026
1	1/8/2022	1/7/2023	1/6/2024	1/4/2025	1/10/2026
2	1/15/2022	1/14/2023	1/13/2024	1/11/2025	1/17/2026
3	1/22/2022	1/21/2023	1/20/2024	1/18/2025	1/24/2026
4	1/29/2022	1/28/2023	1/27/2024	1/25/2025	1/31/2026
5	2/5/2022	2/4/2023	2/3/2024	2/1/2025	2/7/2026
6	2/12/2022	2/11/2023	2/10/2024	2/8/2025	2/14/2026
7	2/19/2022	2/18/2023	2/17/2024	2/15/2025	2/21/2026
8	2/26/2022	2/25/2023	2/24/2024	2/22/2025	2/28/2026
9	3/5/2022	3/4/2023	3/2/2024	3/1/2025	3/7/2026
10	3/12/2022	3/11/2023	3/9/2024	3/8/2025	3/14/2026
11	3/19/2022	3/18/2023	3/16/2024	3/15/2025	3/21/2026
12	3/26/2022	3/25/2023	3/23/2024	3/22/2025	3/28/2026
13	4/2/2022	4/1/2023	3/30/2024	3/29/2025	4/4/2026
14	4/9/2022	4/8/2023	4/6/2024	4/5/2025	4/11/2026
15	4/16/2022	4/15/2023	4/13/2024	4/12/2025	4/18/2026
16	4/23/2022	4/22/2023	4/20/2024	4/19/2025	4/25/2026
17	4/30/2022	4/29/2023	4/27/2024	4/26/2025	5/2/2026
18	5/7/2022	5/6/2023	5/4/2024	5/3/2025	5/9/2026
19	5/14/2022	5/13/2023	5/11/2024	5/10/2025	5/16/2026
20	5/21/2022	5/20/2023	5/18/2024	5/17/2025	5/23/2026
21	5/28/2022	5/27/2023	5/25/2024	5/24/2025	5/30/2026
22	6/4/2022	6/3/2023	6/1/2024	5/31/2025	6/6/2026
23	6/11/2022	6/10/2023	6/8/2024	6/7/2025	6/13/2026
24	6/18/2022	6/17/2023	6/15/2024	6/14/2025	6/20/2026
25	6/25/2022	6/24/2023	6/22/2024	6/21/2025	6/27/2026
26	7/2/2022	7/1/2023	6/29/2024	6/28/2025	7/4/2026
27	7/9/2022	7/8/2023	7/6/2024	7/5/2025	7/11/2026
28	7/16/2022	7/15/2023	7/13/2024	7/12/2025	7/18/2026
29	7/23/2022	7/22/2023	7/20/2024	7/19/2025	7/25/2026
30	7/30/2022	7/29/2023	7/27/2024	7/26/2025	8/1/2026
31	8/6/2022	8/5/2023	8/3/2024	8/2/2025	8/8/2026
32	8/13/2022	8/12/2023	8/10/2024	8/9/2025	8/15/2026
33	8/20/2022	8/19/2023	8/17/2024	8/16/2025	8/22/2026
34	8/27/2022	8/26/2023	8/24/2024	8/23/2025	8/29/2026
35	9/3/2022	9/2/2023	8/31/2024	8/30/2025	9/5/2026
36	9/10/2022	9/9/2023	9/7/2024	9/6/2025	9/12/2026
37	9/17/2022	9/16/2023	9/14/2024	9/13/2025	9/19/2026
38	9/24/2022	9/23/2023	9/21/2024	9/20/2025	9/26/2026
39	10/1/2022	9/30/2023	9/28/2024	9/27/2025	10/3/2026
40	10/8/2022	10/7/2023	10/5/2024	10/4/2025	10/10/2026
41	10/15/2022	10/14/2023	10/12/2024	10/11/2025	10/17/2026
42	10/22/2022	10/21/2023	10/19/2024	10/18/2025	10/24/2026
43	10/29/2022	10/28/2023	10/26/2024	10/25/2025	10/31/2026
44	11/5/2022	11/4/2023	11/2/2024	11/1/2025	11/7/2026
45	11/12/2022	11/11/2023	11/9/2024	11/8/2025	11/14/2026
46	11/19/2022	11/18/2023	11/16/2024	11/15/2025	11/21/2026
47	11/26/2022	11/25/2023	11/23/2024	11/22/2025	11/28/2026
48	12/3/2022	12/2/2023	11/30/2024	11/29/2025	12/5/2026
49	12/10/2022	12/9/2023	12/7/2024	12/6/2025	12/12/2026
50	12/17/2022	12/16/2023	12/14/2024	12/13/2025	12/19/2026
51	12/24/2022	12/23/2023	12/21/2024	12/20/2025	12/26/2026
52	12/31/2022	12/30/2023	12/28/2024	12/27/2025	
53				01/03/2026	

HAWAII STATE DEPARTMENT OF HEALTH
DISEASE OUTBREAK CONTROL DIVISION

Influenza/Respiratory Disease Surveillance Report

Morbidity and Mortality Weekly Report (MMWR)[1]

WEEK 48: NOVEMBER 23, 2025– NOVEMBER 29, 2025

OVERVIEW: The Hawaii State Department of Health (HDOH) monitors influenza and other respiratory pathogens, including COVID-19, throughout the state of Hawaii. Influenza surveillance in the state of Hawaii relies upon selected sentinel health practitioners, the State Laboratories Division (SLD), private laboratories, and the Office of Health Status Monitoring (OHSM). For detailed information concerning influenza, please visit the HDOH Disease Outbreak Control Division (HDOH DOCD) website (*here*). **All data and information are conditional and may change as more reports are received.** The data in this report reflect the 2025-2026 influenza season which began the week ending October 4, 2025 (week 40[1] 2025) and will end the week ending on October 3, 2026 (week 39 2026).

REPORT SNAPSHOT FOR WEEK 48

Surveillance for Influenza-like Illness (ILI)		
Metric	*Value*	*Comment*
Outpatient visits related to influenza-like illness (ILI) from ILINet Sentinel Providers	4.4%	Higher than the previous week. Comparable to the Hawaii's historical baseline and lower than the national baseline, and lower than the national ILI rate.
Number of ILI clusters reported to HDOH	0	There have been 11 clusters this season.

Laboratory Surveillance		
Percent of all respiratory specimens positive for influenza this week	24.7%	Higher than the previous week. This number means that many, if not all, of the 75.3% who tested negative for influenza had illness from another respiratory etiology.
Percent of all respiratory specimens positive for influenza this season to date	12.6%	

Surveillance for Severe Outcomes		
Pneumonia, influenza and COVID-19 (PIC) mortality rate		No new report for PIC mortality rates is available this week due to a pause in data updates from the National Vital Statistics System (NVSS).
Number of influenza-associated pediatric deaths reported nationwide	0	0 influenza-associated pediatric deaths have been reported from Hawaii this season to date.

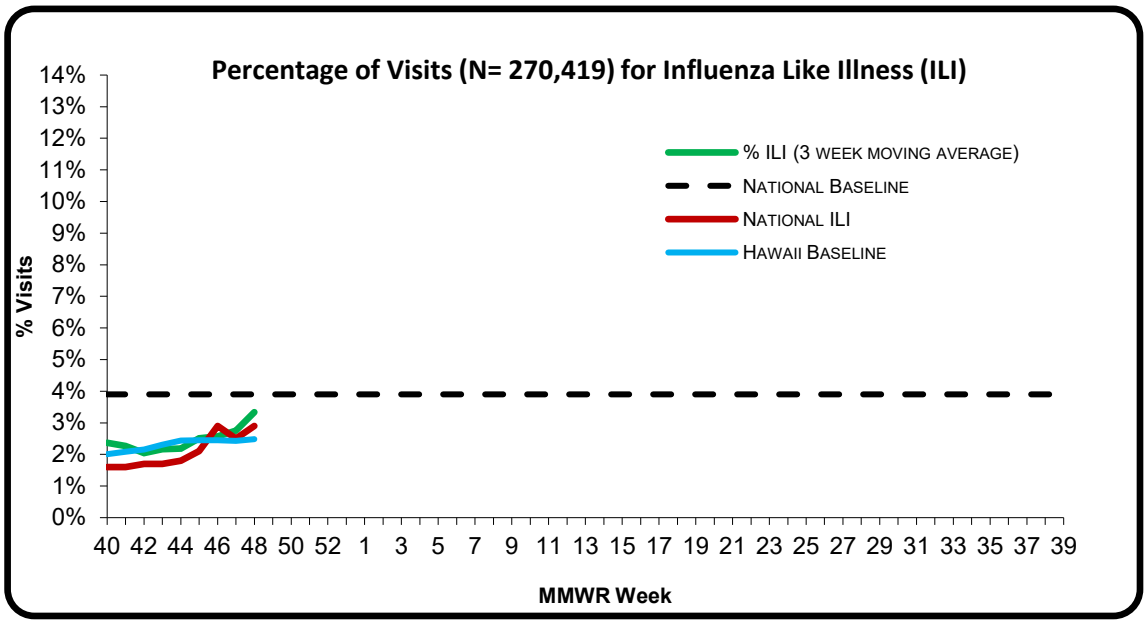
[1] MMWR stands for "Morbidity and Mortality Weekly Report," conventionally used by the Centers for Disease Control and Prevention (CDC). The weeks of a flu season are often referred to by their respective MMWR week. **See appendix 2 for interpretation of MMWR weeks.** Data reported will begin on week 40, the traditional start date of flu season.

INFLUENZA SURVEILLANCE

I. INFLUENZA-LIKE ILLNESS (ILI): HDOH collaborates with recruited doctors and healthcare providers who report the total number of outpatient visits for ILI as well as the total number of patients who complained of symptoms consistent with an ILI. A patient with ILI must have the following: a fever (temperature of 100°F [37.8°C] or greater) AND a cough and/or a sore throat. ILI is based on reported symptoms and not laboratory confirmed tests; thus, ILI may represent other respiratory pathogens and not solely influenza. Further, sentinel providers report these numbers on a weekly basis; therefore, data are preliminary and may change depending on additional reporting. In combination with laboratory testing and other surveillance systems, ILI surveillance helps monitor influenza and other respiratory pathogen activity. For more information concerning ILINet and sentinel requirements, please visit the CDC website (*here*).

For **week 48** of the current influenza season:

- ***4.4%** (season to date: **2.6%**) of the outpatient visits recorded by Hawaii sentinel providers were for ILI.*
- *ILI visits were comparable to the historical baseline in Hawaii[2,3] (i.e., inside the 95% confidence interval).*
- *Hawaii's ILI outpatient visits were lower than the national baseline (**3.9%**)[4] (i.e., outside the 95% confidence interval) and lower than the national ILI rate (**2.9%**) (i.e. outside the 95% confidence interval).*
- *ILI activity level: Minimal[5]*
- *Geographic Spread: Sporadic Activity[6].*
- *ILI Cluster Activity: No new clusters were reported to HDOH during week 48.*



[2] The Hawaii historical baseline (%ILI) is the average of 3-week moving averages over the preceding 10 flu seasons of historical data (2015-2016, 2016-2017, 2017-2018, 2018-2019, 2019-2020, 2020-2021, 2021-2022, 2022-2023, 2023-2024 and 2024-2025).
[3] This value is based upon comparison of actual outpatient ILI with the historical baseline, which only captures outpatient ILI. The chart above represents a 3-week moving average and not the actual ILI by week.
[4] The National Baseline is calculated by CDC as the mean percentage of visits for ILI during weeks 21–39 with two standard deviations. Because of large variability in regional ILI, comparison of the national baseline with local ILI may not be appropriate. It is provided in this report because no meaningful regional baselines are available for comparison. The national baseline combines all data reported by states to CDC, including ILI in outpatient, ER, urgent care, and inpatient settings.
[5] There are 10 activity levels classified as minimal (levels 1-3), low (levels 4-5), moderate (levels 6-7), and high (levels 8-10).
[6] The influenza activity reported by state and territorial epidemiologists indicates geographic spread of influenza viruses but does not measure the severity of influenza activity. Sporadic: no clusters reported to HDOH, Local: one or more clusters reported in one county, Regional: clusters reported two to three counties, Widespread: clusters reported in all counties. Hawaii does not report No Activity, as flu circulates year-round in Hawaii.

II. LABORATORY SURVEILLANCE: State Laboratories Division (SLD; the HDOH public health laboratory) and Hawaii's major private laboratories (DLS, CLH) report results of RT-PCR, which can be considered confirmatory (SLD may perform viral culture on select specimens). Specimens meeting priority criteria[7] are forwarded to SLD for sub-typing. Additionally, specimens meeting case definition from requesting sentinel providers are sent directly to SLD for sub-typing. Due to resource constraints, not all submitted specimens undergo sub-typing. Sub-typing at the commercial laboratories is only conducted on a case-by-case basis. The majority of specimens testing positive by rapid antigen testing or RT-PCR at the commercial laboratories do not meet criteria and are not subtyped. For more information on influenza tests and types, please visit the CDC website (*here*).

A. INFLUENZA:

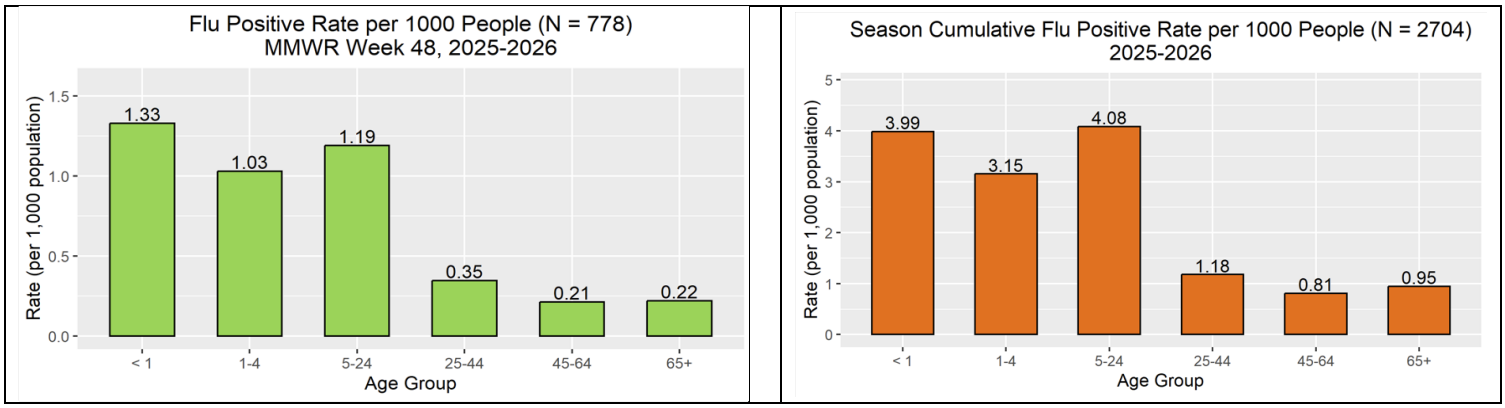
- The following reflects laboratory findings for week 48 of the 2025–26 influenza season:
  - *A total of **3,148** specimens have been tested statewide for influenza viruses (positive: 778 [**24.7%**]). (Season to date: **21,463** tested (**12.6%** positive)*
    - *1,494 (47.5%) were screened only by rapid antigen tests with no confirmatory testing.*
    - *1,654 (52.4%) underwent confirmatory testing (either RT-PCR or viral culture).*
    - *2,370 (75.3%) were negative.*
  - *Routine surveillance samples from State Laboratory Division were tested at a public health laboratory and identified as Influenza A (H3N2) subclade K.*

Influenza type	***Current week 48 (%)****	***Season to date (%)***[8]
Influenza A (H1)[9]	*2 (0.3)*	*37 (1.4)*
Influenza A (H3)	*58 (7.4)*	*358 (13.3)*
Influenza A no subtyping	*712 (91.4)*	*2,250 (83.6)*
Influenza B (Yamagata)	*0 (0.0)*	*0 (0.0)*
Influenza B (Victoria)	*0 (0.0)*	*0 (0.0)*
Influenza B no genotyping	*7 (0.9)*	*47 (1.7)*

**Specimens that are positive for both A and B (coinfections) are counted in both A and B totals for current and season to date*

1. AGE DISTRIBUTION

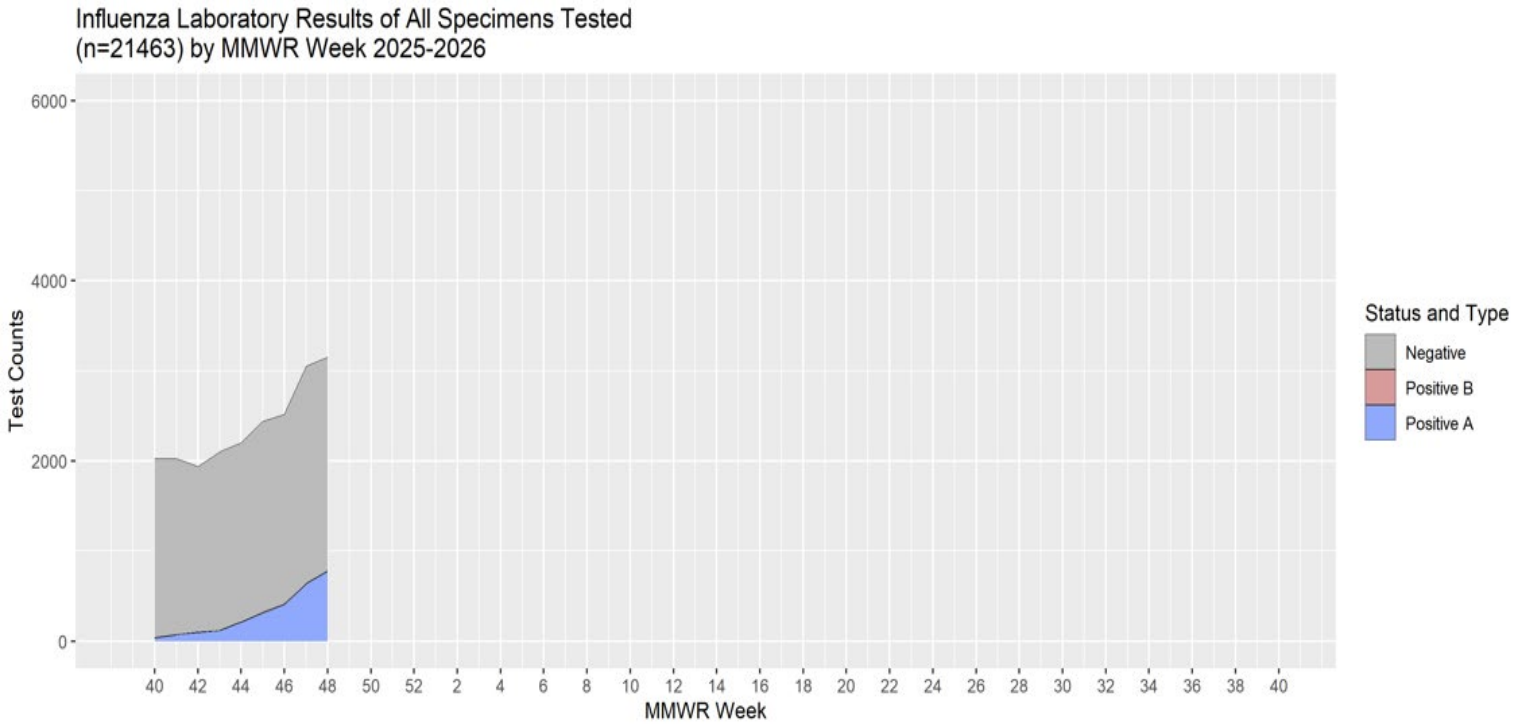
The charts below indicate the population-based rates of positive influenza cases in Hawaii by age group during the 2025–26 influenza season.[10]

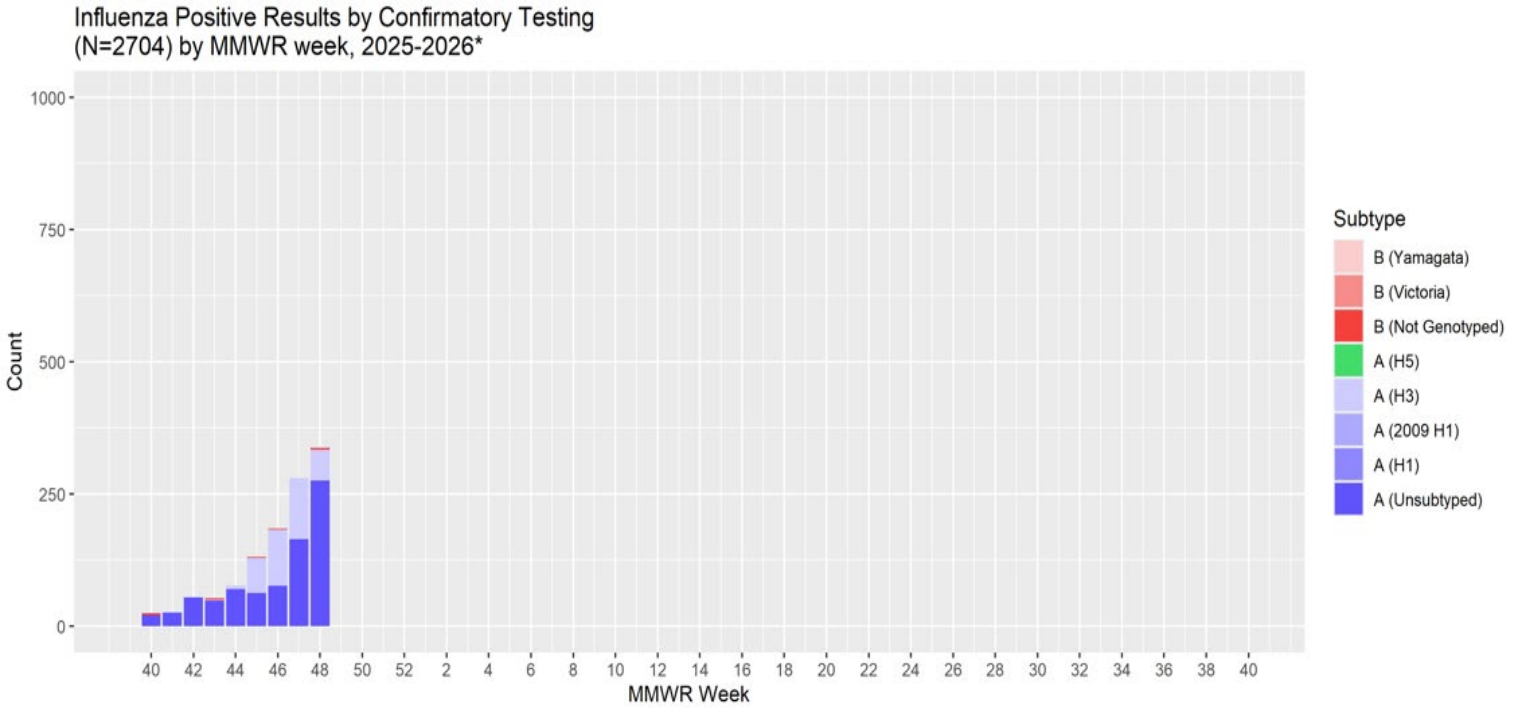


[7] Priority criteria include: hospitalized patients with acute respiratory distress syndrome [ARDS] or x-ray confirmed pneumonia; travelers with international travel history within 10 days of onset; specimens submitted by sentinel providers; specimens collected from healthcare workers, pregnant women, or women up to 6 weeks' post-partum; those with underlying medical conditions; and patients presenting with unusual or severe manifestations of influenza infection.
[8] Influenza coding were updated to reflect a more accurate count.
[9] All influenza A H1 viruses detected this season have been 2009 H1N1.
[10] This represents an estimate of population-based rates based on available data.

2. LABORATORY TESTING

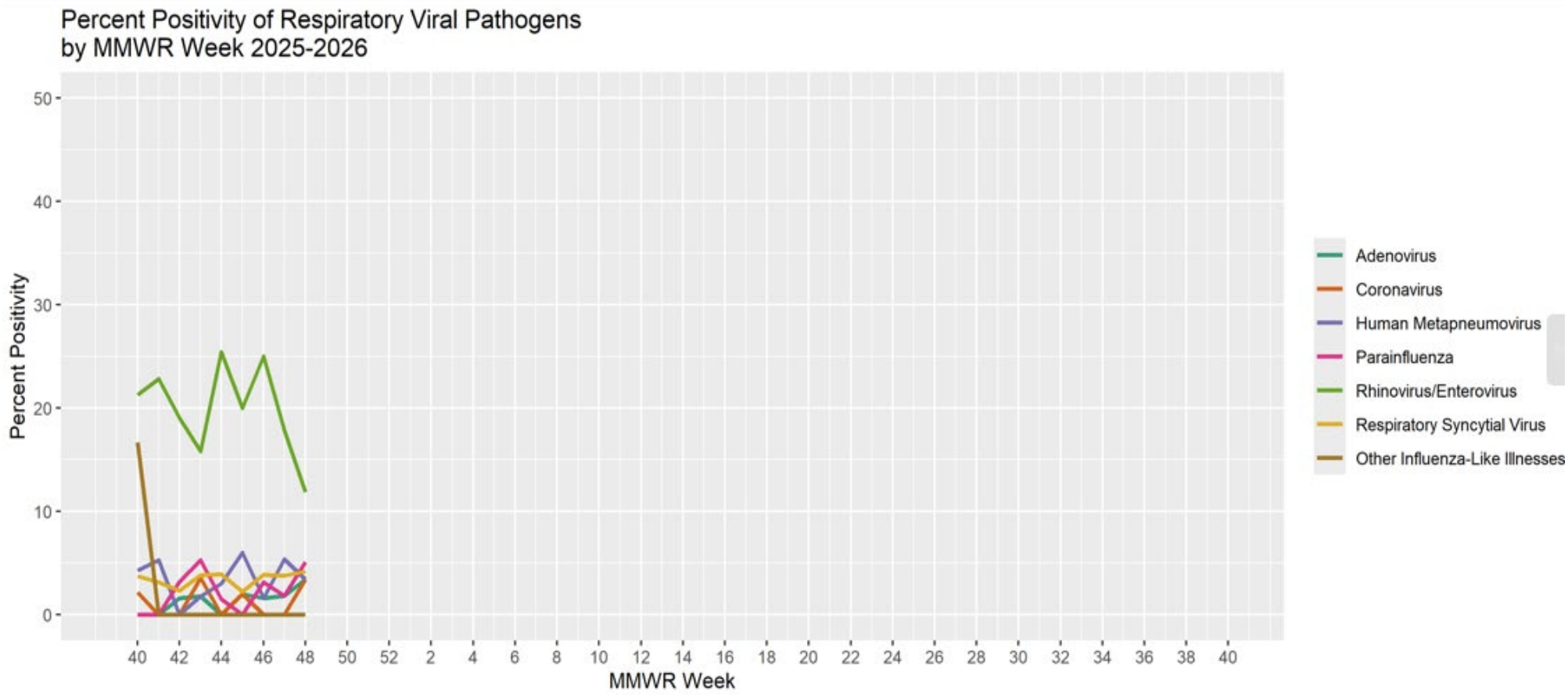
The charts below show the laboratory results of all specimens tested for influenza by MMWR week during the 2025–2026 influenza season as well as the type and subtype of positive results for influenza. Again, sub-typing is only performed on selected specimens tested by confirmatory tests (i.e., RT-PCR or viral culture).





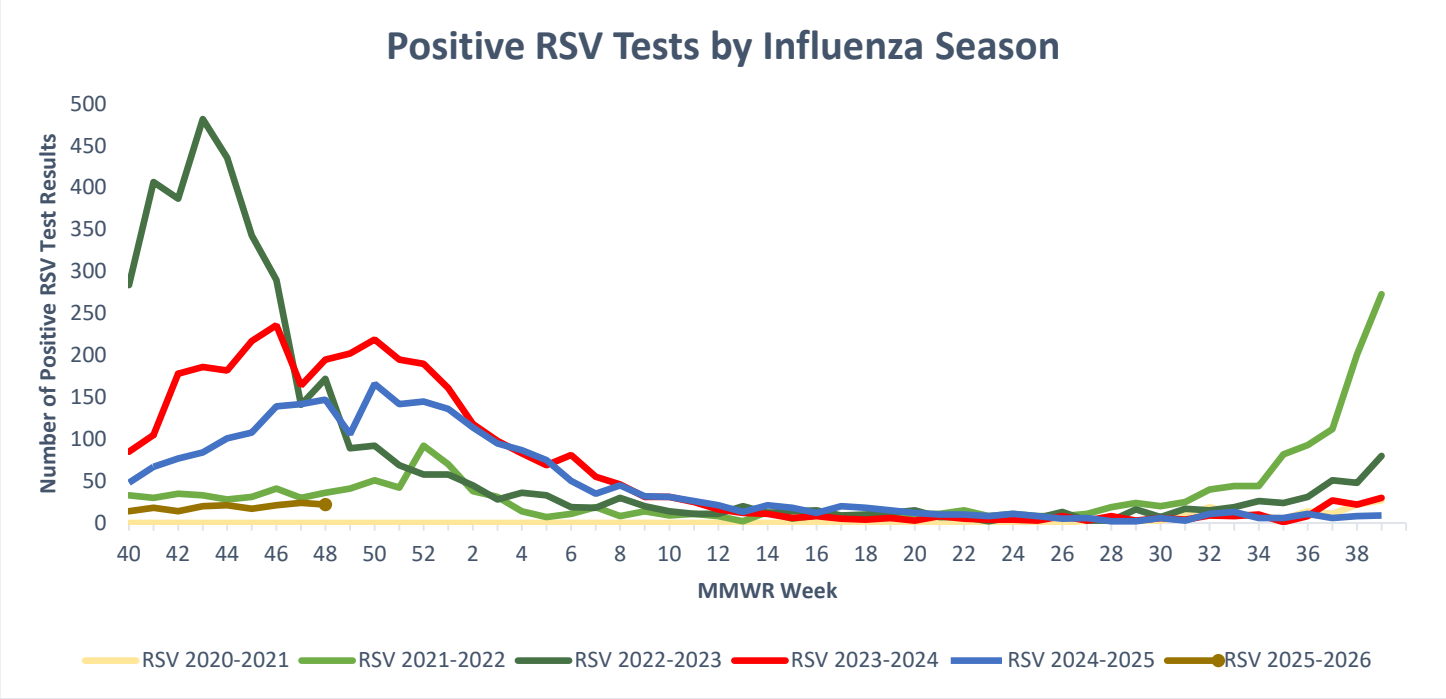
** A total of 9,716 specimens underwent confirmatory testing but not all positive influenza specimens receive confirmatory testing that are circulating in Hawaii.*

B. OTHER RESPIRATORY PATHOGENS: The major clinical and commercial laboratories throughout the state of Hawaii have the testing capacity for non-influenza respiratory pathogens and report these to HDOH. However, such testing is performed as needed and when sufficient resources are available because of the high costs associated with respiratory panel tests. **Therefore, available data represent only the presence of circulating pathogens and cannot be used to determine specific trends**.

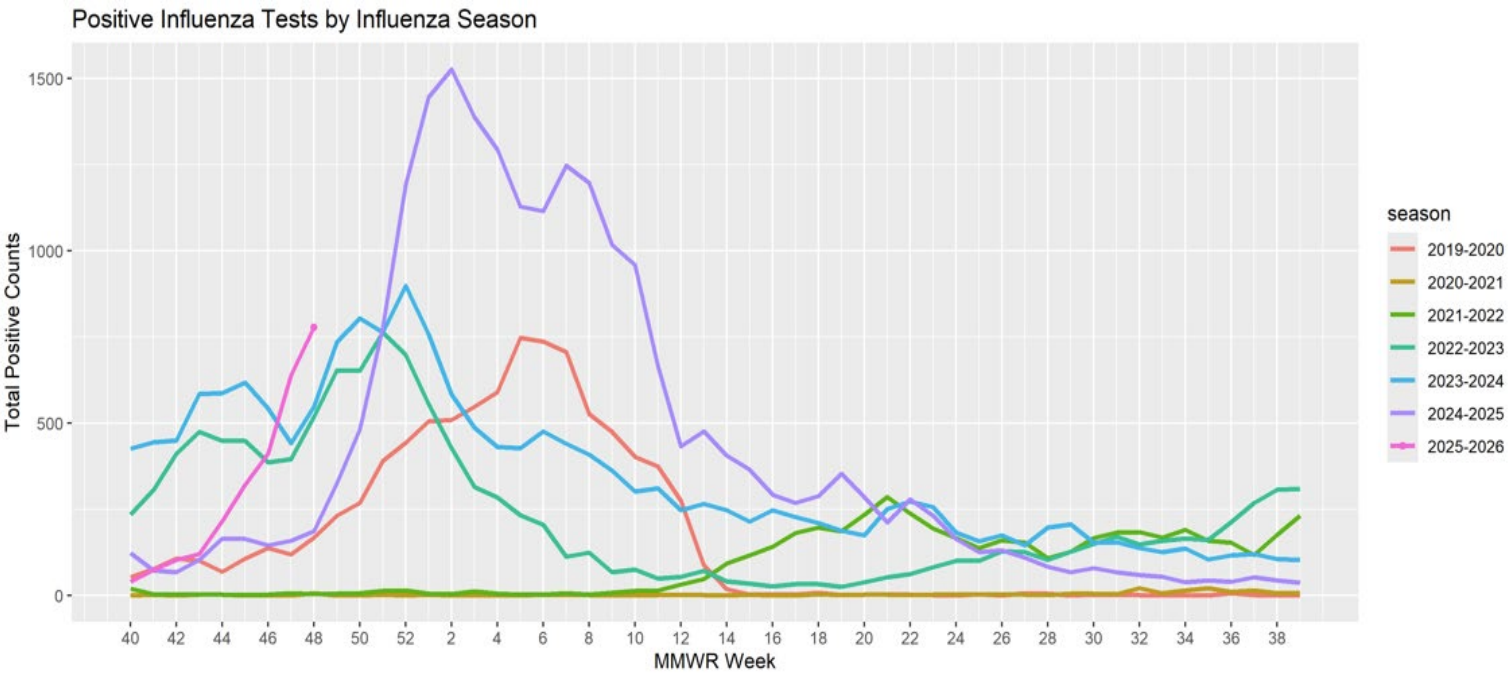


* *The coronavirus presented on this table does not indicate Severe Acute Respiratory Coronavirus-2 (i.e., COVID-19).*

RESPIRATORY SYNCYTIAL VIRUS (RSV) POSITIVE TEST RESULTS BY INFLUENZA SEASON: RSV case appears to have increased earlier than past seasons in the 2025-2026 season. Of note, significantly more tests for RSV are being performed than in pre-COVID-19 seasons.



INFLUENZA POSITIVE TEST RESULTS BY INFLUENZA SEASON: Influenza cases appear to have increased earlier than past seasons in the 2023-2024 season, but it is not yet known whether case numbers will reach a peak similar to pre-COVID-19 seasons.



C. COVID-19 SENTINEL SURVEILLANCE: Due to the low volume of samples currently available through the influenza surveillance system, the COVID-19 sentinel surveillance data may not be accurately portraying COVID-19 activity in our communities. Reporting of the COVID-19 Sentinel Surveillance data will be paused while HODH re-evaluates the program to ensure that the reported data are accurate and representative.

HDOH is continuing to monitor COVID-19 activity throughout the state. To learn more, please visit the Hawaii's COVID-19 data website (*here*). For more information on surveillance of COVID-19 activity in the United States please visit the CDC COVIDView website (*here*).

III. PNEUMONIA, INFLUENZA, AND COVID-19 (PIC) RELATED MORTALITY:

P&I mortality surveillance is collected by CDC through the National Center for Health Statistics (NCHS) using death certificate data. Each week the HDOH OHSM reports specific data from Honolulu to the CDC. CDC collects the following information by age group: the total number of deaths, total deaths from pneumonia, and total deaths related to influenza. Due to the ongoing COVID-19 pandemic, CDC included total deaths from COVID-19 by age group to the death data. Previous studies had suggested that P&I is a good indicator of influenza-related deaths; however, data has shown that pneumonia deaths associated with influenza is now being impacted by COVID-19 related pneumonia. Due to this, CDC had added COVID-19 deaths into P&I to create the PIC (pneumonia, influenza, and/or COVID-19) classification.

To standardize Hawaii's influenza surveillance with CDC influenza surveillance guidelines, PIC deaths will be reported in lieu of P&I. Hawaii's baseline will begin to include PIC deaths starting from 2019-2020 flu season.

The National Vital Statistic System (NVSS) surveillance datasets and reports had been paused temporarily, including those used to evaluate pneumonia, influenza, and COVID-19 deaths. HDOH PIC mortality data will not be published in the Influenza/Respiratory Disease Surveillance Report for week 48.

INFLUENZA-ASSOCIATED PEDIATRIC DEATHS[11]:

- No new influenza-associated pediatric death was reported to Hawaii. There have been zero influenza-associated pediatric deaths reported in Hawaii during the 2025–2026 season.
- Nationally, no new influenza-associated pediatric deaths were reported to CDC during week 48. (2025-2026 season total: 0).

IV. INFLUENZA WATCH: As part of a comprehensive influenza surveillance system and to prevent the spread of contagious respiratory diseases in humans, it is important to monitor all circulating influenza types. Several animal-origin influenza A subtypes are currently of interest: influenza A variant virus (H3N2v, H1N2v, and H1N1v) and Avian flu (H5N1 and H7N9). These types of influenza viruses may cause zoonotic (animal-associated) disease and are a public health concern.

A. VARIANT VIRUSES:

Influenza viruses that normally circulate in pigs are called "variant" viruses when they are found in people. These viruses were first identified in U.S. pigs in 2010. In 2011, 12 cases of H3N2v infection were detected in the United States. In 2012, 309 such cases (resulting in 16 hospitalizations and one death) across 12 states were detected, including one Hawaii case who recovered. Illness associated with H3N2v infection has been mostly mild with symptoms similar to those of seasonal flu. However, serious illness, resulting in hospitalization and death, has occurred in some cases. Most of these infections have been associated with prolonged exposure to pigs at agricultural fairs or similar settings. Limited human-to-human spread of this virus has been detected in the past, but no sustained community spread of H3N2v has been identified. More information regarding H3N2v, H1N1v, and H1N2v viruses may be found on the CDC website (*here*) and (*here*).

- *No variant or novel influenza infections have been reported to HDOH during the 2025-2026 influenza season.*
- *No new human infection with novel influenza A virus, H1N1v (1), H3N2v (0), and H1N2v (0), have been reported during the 2025-2026 influenza season.*

AVIAN (OR BIRD) INFLUENZA: These types of influenza viruses cause zoonotic (animal-associated) disease of public health concern and are therefore monitored globally by the WHO. Most avian influenza viruses do not cause disease in humans and are generally not easily transmissible between person to person, but a few subtypes may cross the species barrier and cause disease in humans. Avian influenza viruses may be of various subtypes, including H5N1, H5N2, H5N8, H7N3, H7N7, H7N8, H7N9, and H9N2. On January 15th, 2016, the USDA and APHIS reported detection of HPAI H7N8 in a commercial turkey flock in Indiana. There have been no associated human infections. This is the first detection of HPAI H7N8 in wild bird surveillance in the United States. More information, the risk assessment and recommendations for HPAI H7N8 can be found (here). The WHO, CDC, and other public health agencies have also been monitoring influenza H7N9, which represents a public health concern because of its high pandemic potential. Although H7N9 has not been detected in the United States, it remains a global concern given continuing epidemics in endemic countries. Since 2013, a total of 1,568 laboratory-confirmed cases of human infection with H7N9 viruses, including at least 613 deaths, have been reported to WHO. More information on H7N9 virus infections can be found (here). For more information regarding avian influenza, please visit the CDC (*here*) or the WHO (*here*) websites. WHO reports total number of cases and deaths related to laboratory-confirmed avian influenza viruses and posts current avian influenza case counts (*here*), which were last updated on **November 5, 2025**.

[11] Influenza-associated deaths are considered pediatric in persons aged less than 18 years. It was made a nationally notifiable condition in October, 2004. All pediatric influenza-associated deaths are laboratory confirmed.

V. INFLUENZA Vaccine: Annual influenza vaccination is recommended for all persons aged 6 months and older and is the most effective way to reduce the risk of getting sick with seasonal flu and spreading it to others. Influenza vaccination can reduce illnesses, visits to the doctor, influenza-related hospitalizations, and missed work and school days. Influenza vaccines become available by the end of October. It takes at least two weeks after vaccination to confer immunity against influenza virus infection. More information regarding influenza vaccination can be found (*here*).

A. Composition of the 2025–2026 Influenza Vaccine**:**

The composition of the 2025–2026 influenza vaccine has been updated to better match circulating influenza viruses. The Advisory Committee on Immunization Practices (ACIP) has recommended that the 2025-2026 influenza trivalent vaccine contain an influenza A/Victoria/4897/2022 (H1N1) pdm09-like virus, influenza A/Croatia/10136RV/2023 (H3N2)-like virus, and influenza B/Austria/1359417/2021 (B/Victoria lineage)-like virus. United States cell culture–based inactivated (ccIIV4) and recombinant (RIV4) influenza vaccines will contain HA derived from an influenza A/Wisconsin/67/2022 (H1N1) pdm09-like virus, an A/District of Columbia/27/2023 (H3N2)-like virus, an influenza B/Austria/1359417/2021 (B/Victoria lineage)-like virus. These vaccine recommendations were based on several factors, including global influenza virologic and epidemiologic surveillance, genetic and antigenic characterization, human serology studies, antiviral susceptibility, and the availability of candidate influenza viruses.

APPENDIX 1: ADDITIONAL INFORMATION

For more information regarding local and national influenza surveillance programs, visit the following sites.

Centers for Disease Control and Prevention	General Influenza National ILI and P&I Data Vaccine Virus Selection CDC Web Tool for Respiratory Viruses
Flu.gov	General Influenza Information
HDOH Flu and Pneumonia	General Influenza Surveillance Avian Influenza Respiratory Virus Dashboard To find out more information or join the sentinel physician program, email the Influenza Surveillance Coordinator
World Health Organization	General Global and Local Influenza Avian Influenza

APPENDIX 2: MMWR WEEK DATES

Please refer to the table below to interpret data presented by MMWR week. Week 40 is considered the traditional start for the flu season for the Northern Hemisphere.

MMWR WEEK	2022	2023	2024	2025	2026
1	1/8/2022	1/7/2023	1/6/2024	1/4/2025	1/10/2026
2	1/15/2022	1/14/2023	1/13/2024	1/11/2025	1/17/2026
3	1/22/2022	1/21/2023	1/20/2024	1/18/2025	1/24/2026
4	1/29/2022	1/28/2023	1/27/2024	1/25/2025	1/31/2026
5	2/5/2022	2/4/2023	2/3/2024	2/1/2025	2/7/2026
6	2/12/2022	2/11/2023	2/10/2024	2/8/2025	2/14/2026
7	2/19/2022	2/18/2023	2/17/2024	2/15/2025	2/21/2026
8	2/26/2022	2/25/2023	2/24/2024	2/22/2025	2/28/2026
9	3/5/2022	3/4/2023	3/2/2024	3/1/2025	3/7/2026
10	3/12/2022	3/11/2023	3/9/2024	3/8/2025	3/14/2026
11	3/19/2022	3/18/2023	3/16/2024	3/15/2025	3/21/2026
12	3/26/2022	3/25/2023	3/23/2024	3/22/2025	3/28/2026
13	4/2/2022	4/1/2023	3/30/2024	3/29/2025	4/4/2026
14	4/9/2022	4/8/2023	4/6/2024	4/5/2025	4/11/2026
15	4/16/2022	4/15/2023	4/13/2024	4/12/2025	4/18/2026
16	4/23/2022	4/22/2023	4/20/2024	4/19/2025	4/25/2026
17	4/30/2022	4/29/2023	4/27/2024	4/26/2025	5/2/2026
18	5/7/2022	5/6/2023	5/4/2024	5/3/2025	5/9/2026
19	5/14/2022	5/13/2023	5/11/2024	5/10/2025	5/16/2026
20	5/21/2022	5/20/2023	5/18/2024	5/17/2025	5/23/2026
21	5/28/2022	5/27/2023	5/25/2024	5/24/2025	5/30/2026
22	6/4/2022	6/3/2023	6/1/2024	5/31/2025	6/6/2026
23	6/11/2022	6/10/2023	6/8/2024	6/7/2025	6/13/2026
24	6/18/2022	6/17/2023	6/15/2024	6/14/2025	6/20/2026
25	6/25/2022	6/24/2023	6/22/2024	6/21/2025	6/27/2026
26	7/2/2022	7/1/2023	6/29/2024	6/28/2025	7/4/2026
27	7/9/2022	7/8/2023	7/6/2024	7/5/2025	7/11/2026
28	7/16/2022	7/15/2023	7/13/2024	7/12/2025	7/18/2026
29	7/23/2022	7/22/2023	7/20/2024	7/19/2025	7/25/2026
30	7/30/2022	7/29/2023	7/27/2024	7/26/2025	8/1/2026
31	8/6/2022	8/5/2023	8/3/2024	8/2/2025	8/8/2026
32	8/13/2022	8/12/2023	8/10/2024	8/9/2025	8/15/2026
33	8/20/2022	8/19/2023	8/17/2024	8/16/2025	8/22/2026
34	8/27/2022	8/26/2023	8/24/2024	8/23/2025	8/29/2026
35	9/3/2022	9/2/2023	8/31/2024	8/30/2025	9/5/2026
36	9/10/2022	9/9/2023	9/7/2024	9/6/2025	9/12/2026
37	9/17/2022	9/16/2023	9/14/2024	9/13/2025	9/19/2026
38	9/24/2022	9/23/2023	9/21/2024	9/20/2025	9/26/2026
39	10/1/2022	9/30/2023	9/28/2024	9/27/2025	10/3/2026
40	10/8/2022	10/7/2023	10/5/2024	10/4/2025	10/10/2026
41	10/15/2022	10/14/2023	10/12/2024	10/11/2025	10/17/2026
42	10/22/2022	10/21/2023	10/19/2024	10/18/2025	10/24/2026
43	10/29/2022	10/28/2023	10/26/2024	10/25/2025	10/31/2026
44	11/5/2022	11/4/2023	11/2/2024	11/1/2025	11/7/2026
45	11/12/2022	11/11/2023	11/9/2024	11/8/2025	11/14/2026
46	11/19/2022	11/18/2023	11/16/2024	11/15/2025	11/21/2026
47	11/26/2022	11/25/2023	11/23/2024	11/22/2025	11/28/2026
48	12/3/2022	12/2/2023	11/30/2024	11/29/2025	12/5/2026
49	12/10/2022	12/9/2023	12/7/2024	12/6/2025	12/12/2026
50	12/17/2022	12/16/2023	12/14/2024	12/13/2025	12/19/2026
51	12/24/2022	12/23/2023	12/21/2024	12/20/2025	12/26/2026
52	12/31/2022	12/30/2023	12/28/2024	12/27/2025	
53				01/03/2026	

HAWAII STATE DEPARTMENT OF HEALTH
DISEASE OUTBREAK CONTROL DIVISION

Influenza/Respiratory Disease Surveillance Report

Morbidity and Mortality Weekly Report (MMWR)[1]

WEEK 49: NOVEMBER 30, 2025– DECEMBER 6, 2025

OVERVIEW: The Hawaii State Department of Health (HDOH) monitors influenza and other respiratory pathogens, including COVID-19, throughout the state of Hawaii. Influenza surveillance in the state of Hawaii relies upon selected sentinel health practitioners, the State Laboratories Division (SLD), private laboratories, and the Office of Health Status Monitoring (OHSM). For detailed information concerning influenza, please visit the HDOH Disease Outbreak Control Division (HDOH DOCD) website (*here*). **All data and information are conditional and may change as more reports are received.** The data in this report reflect the 2025-2026 influenza season which began the week ending October 4, 2025 (week 40[1] 2025) and will end the week ending on October 3, 2026 (week 39 2026).

REPORT SNAPSHOT FOR WEEK 49

Surveillance for Influenza-like Illness (ILI)		
Metric	*Value*	*Comment*
Outpatient visits related to influenza-like illness (ILI) from ILINet Sentinel Providers	3.6%	Lower than the previous week. Comparable to the Hawaii's historical baseline and lower than the national baseline, and higher than the national ILI rate.
Number of ILI clusters reported to HDOH	0	There have been 11 clusters this season.

Laboratory Surveillance		
Percent of all respiratory specimens positive for influenza this week	24.4%	Lower than the previous week. This number means that many, if not all, of the 75.6% who tested negative for influenza had illness from another respiratory etiology.
Percent of all respiratory specimens positive for influenza this season to date	14.5%	

Surveillance for Severe Outcomes		
Pneumonia, influenza and COVID-19 (PIC) mortality rate		No new report for PIC mortality rates is available this week due to a pause in data updates from the National Vital Statistics System (NVSS).
Number of influenza-associated pediatric deaths reported nationwide	1	0 influenza-associated pediatric deaths have been reported from Hawaii this season to date.

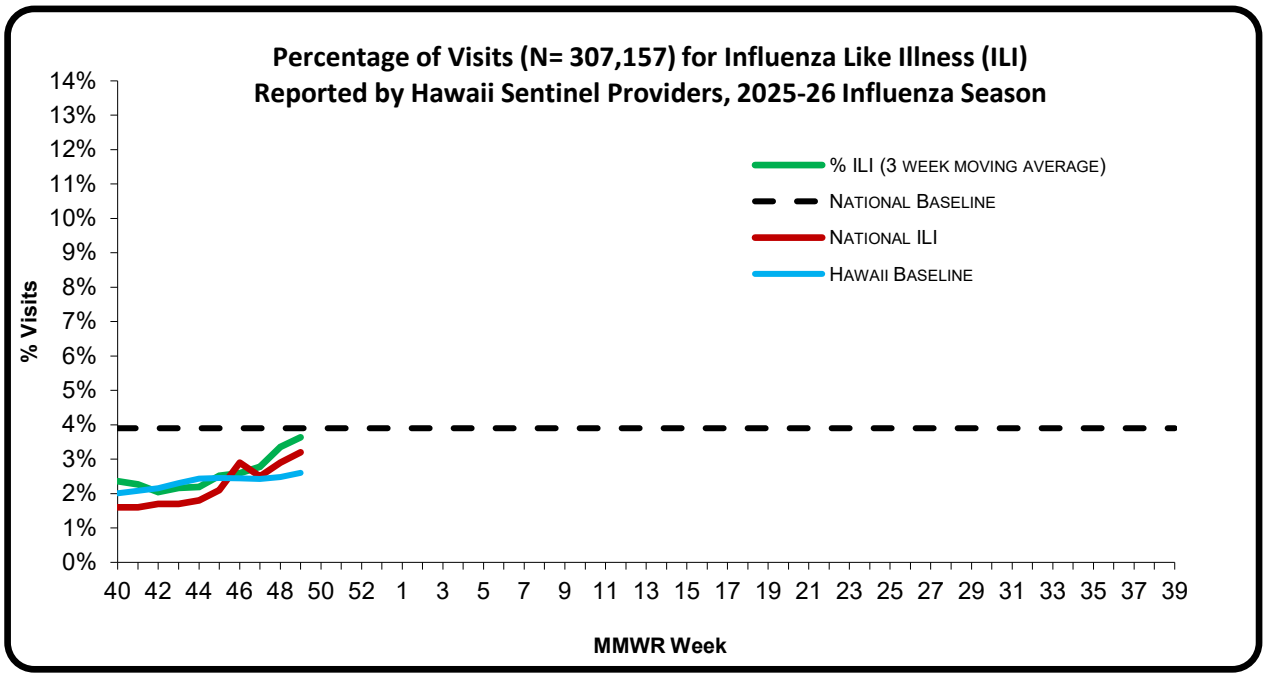
[1] MMWR stands for "Morbidity and Mortality Weekly Report," conventionally used by the Centers for Disease Control and Prevention (CDC). The weeks of a flu season are often referred to by their respective MMWR week. **See appendix 2 for interpretation of MMWR weeks.** Data reported will begin on week 40, the traditional start date of flu season.

INFLUENZA SURVEILLANCE

I. INFLUENZA-LIKE ILLNESS (ILI): HDOH collaborates with recruited doctors and healthcare providers who report the total number of outpatient visits for ILI as well as the total number of patients who complained of symptoms consistent with an ILI. A patient with ILI must have the following: a fever (temperature of 100°F [37.8°C] or greater) AND a cough and/or a sore throat. ILI is based on reported symptoms and not laboratory confirmed tests; thus, ILI may represent other respiratory pathogens and not solely influenza. Further, sentinel providers report these numbers on a weekly basis; therefore, data are preliminary and may change depending on additional reporting. In combination with laboratory testing and other surveillance systems, ILI surveillance helps monitor influenza and other respiratory pathogen activity. For more information concerning ILINet and sentinel requirements, please visit the CDC website (*here*).

For **week 49** of the current influenza season:

- ***3.6****% (season to date:* ***2.7****%) of the outpatient visits recorded by Hawaii sentinel providers were for ILI.*
- *ILI visits were comparable to the historical baseline in Hawaii[2,3] (i.e., inside the 95% confidence interval).*
- *Hawaii's ILI outpatient visits were lower than the national baseline (**3.9%**)[4] (i.e., outside the 95% confidence interval) and higher than the national ILI rate (**3.2%**) (i.e. outside the 95% confidence interval).*
- *ILI activity level: Low[5]*
- *Geographic Spread: Sporadic Activity[6].*
- *ILI Cluster Activity: No new clusters were reported to HDOH during week 49.*



[2] The Hawaii historical baseline (%ILI) is the average of 3-week moving averages over the preceding 10 flu seasons of historical data (2015-2016, 2016-2017, 2017-2018, 2018-2019, 2019-2020, 2020-2021, 2021-2022, 2022-2023, 2023-2024 and 2024-2025).
[3] This value is based upon comparison of actual outpatient ILI with the historical baseline, which only captures outpatient ILI. The chart above represents a 3-week moving average and not the actual ILI by week.
[4] The National Baseline is calculated by CDC as the mean percentage of visits for ILI during weeks 21–39 with two standard deviations. Because of large variability in regional ILI, comparison of the national baseline with local ILI may not be appropriate. It is provided in this report because no meaningful regional baselines are available for comparison. The national baseline combines all data reported by states to CDC, including ILI in outpatient, ER, urgent care, and inpatient settings.
[5] There are 10 activity levels classified as minimal (levels 1-3), low (levels 4-5), moderate (levels 6-7), and high (levels 8-10).
[6] The influenza activity reported by state and territorial epidemiologists indicates geographic spread of influenza viruses but does not measure the severity of influenza activity. Sporadic: no clusters reported to HDOH, Local: one or more clusters reported in one county, Regional: clusters reported two to three counties, Widespread: clusters reported in all counties. Hawaii does not report No Activity, as flu circulates year-round in Hawaii.

II. LABORATORY SURVEILLANCE: State Laboratories Division (SLD; the HDOH public health laboratory) and Hawaii's major private laboratories (DLS, CLH) report results of RT-PCR, which can be considered confirmatory (SLD may perform viral culture on select specimens). Specimens meeting priority criteria[7] are forwarded to SLD for sub-typing. Additionally, specimens meeting case definition from requesting sentinel providers are sent directly to SLD for sub-typing. Due to resource constraints, not all submitted specimens undergo sub-typing. Sub-typing at the commercial laboratories is only conducted on a case-by-case basis. The majority of specimens testing positive by rapid antigen testing or RT-PCR at the commercial laboratories do not meet criteria and are not subtyped. For more information on influenza tests and types, please visit the CDC website (*here*).

A. INFLUENZA:

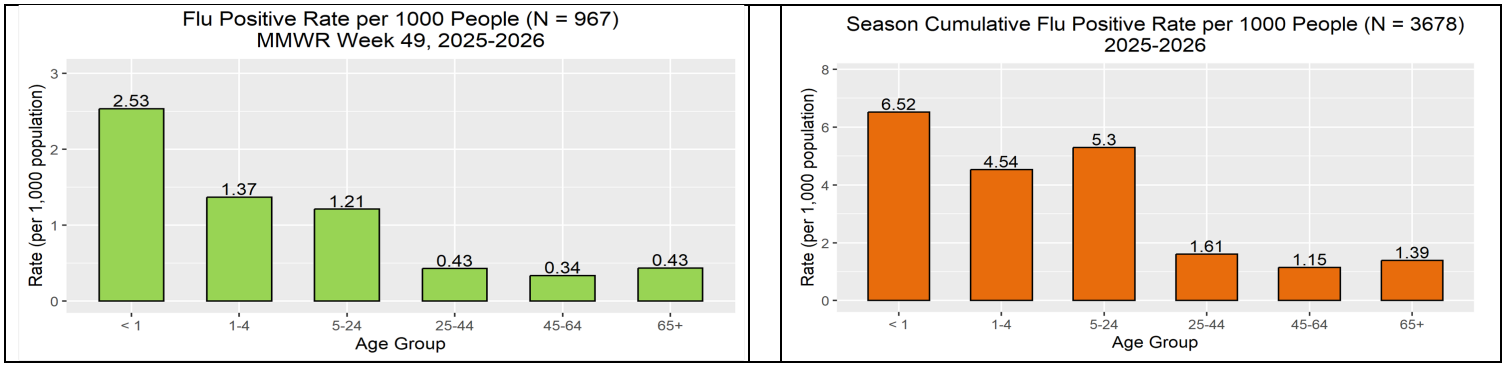
- The following reflects laboratory findings for week 49 of the 2025–26 influenza season:
  - *A total of **3,961** specimens have been tested statewide for influenza viruses (positive: 967 [**24.4%**]). (Season to date: **25,431** tested (**14.5%** positive)*
    - *1,945 (49.1%) were screened only by rapid antigen tests with no confirmatory testing.*
    - *2,016 (50.9%) underwent confirmatory testing (either RT-PCR or viral culture).*
    - *2,370 (75.6%) were negative.*
  - *Routine surveillance samples from State Laboratory Division were tested at a public health laboratory and identified as Influenza A (H3N2) subclade K.*

Influenza type	***Current week 49 (%)****	***Season to date (%)***[8]
Influenza A (H1)[9]	*2 (0.2)*	*45 (1.2)*
Influenza A (H3)	*17 (1.8)*	*449 (12.3)*
Influenza A no subtyping	*939 (97.1)*	*3,115 (85.0)*
Influenza B (Yamagata)	*0 (0.0)*	*0 (0.0)*
Influenza B (Victoria)	*0 (0.0)*	*0 (0.0)*
Influenza B no genotyping	*9 (0.9)*	*56 (1.5)*

**Specimens that are positive for both A and B (coinfections) are counted in both A and B totals for current and season to date*

1. AGE DISTRIBUTION

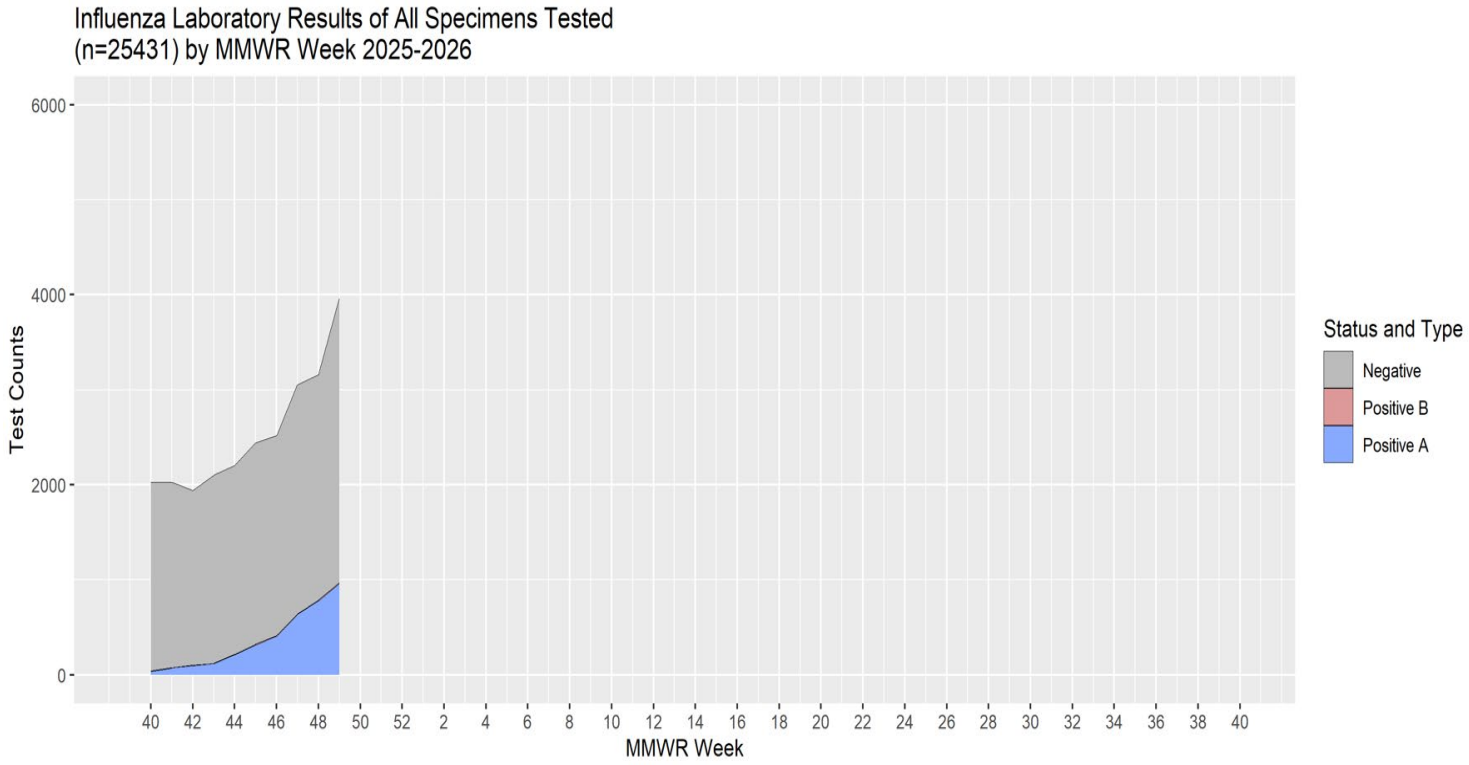
The charts below indicate the population-based rates of positive influenza cases in Hawaii by age group during the 2025–26 influenza season.[10]

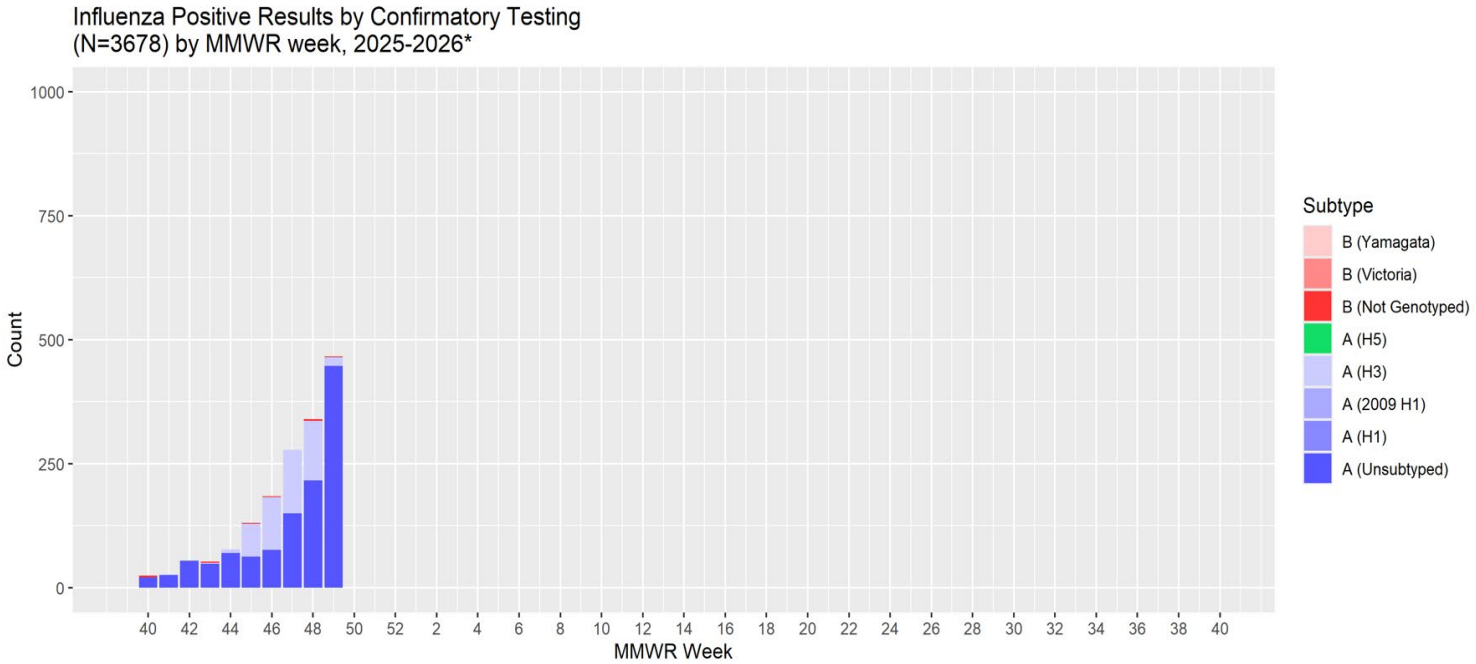


[7] Priority criteria include: hospitalized patients with acute respiratory distress syndrome [ARDS] or x-ray confirmed pneumonia; travelers with international travel history within 10 days of onset; specimens submitted by sentinel providers; specimens collected from healthcare workers, pregnant women, or women up to 6 weeks' post-partum; those with underlying medical conditions; and patients presenting with unusual or severe manifestations of influenza infection.
[8] Influenza coding were updated to reflect a more accurate count.
[9] All influenza A H1 viruses detected this season have been 2009 H1N1.
[10] This represents an estimate of population-based rates based on available data.

2. LABORATORY TESTING

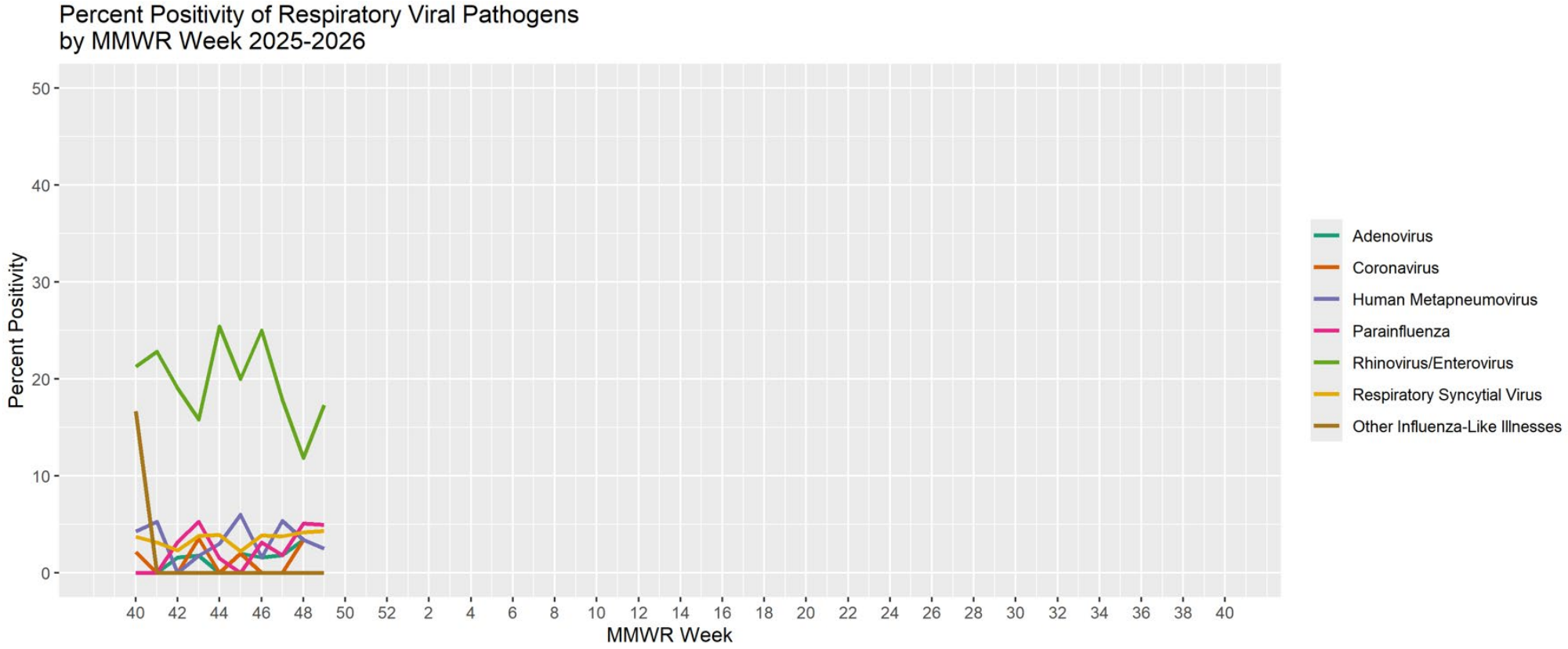
The charts below show the laboratory results of all specimens tested for influenza by MMWR week during the 2025–2026 influenza season as well as the type and subtype of positive results for influenza. Again, sub-typing is only performed on selected specimens tested by confirmatory tests (i.e., RT-PCR or viral culture).





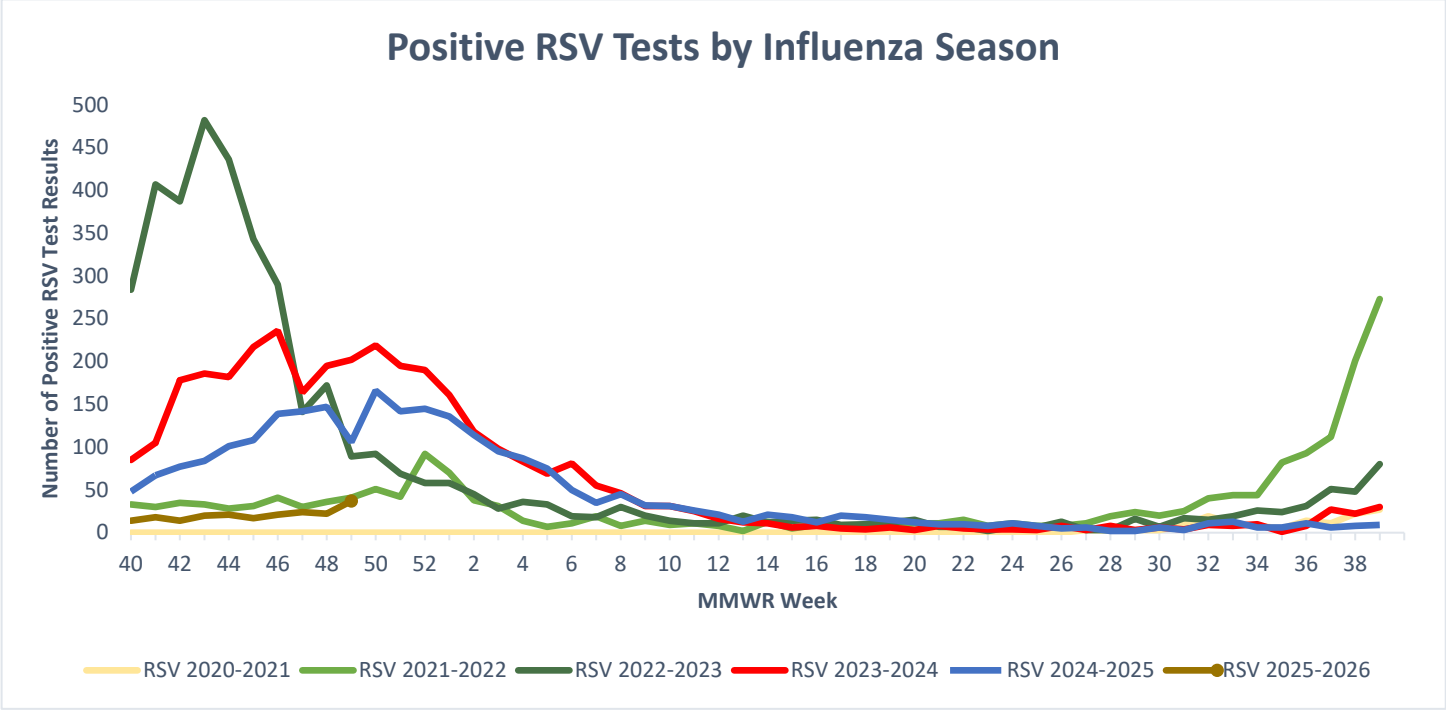
** A total of 13,393 specimens underwent confirmatory testing but not all positive influenza specimens receive confirmatory testing that are circulating in Hawaii.*

B. OTHER RESPIRATORY PATHOGENS: The major clinical and commercial laboratories throughout the state of Hawaii have the testing capacity for non-influenza respiratory pathogens and report these to HDOH. However, such testing is performed as needed and when sufficient resources are available because of the high costs associated with respiratory panel tests. **Therefore, available data represent only the presence of circulating pathogens and cannot be used to determine specific trends**.

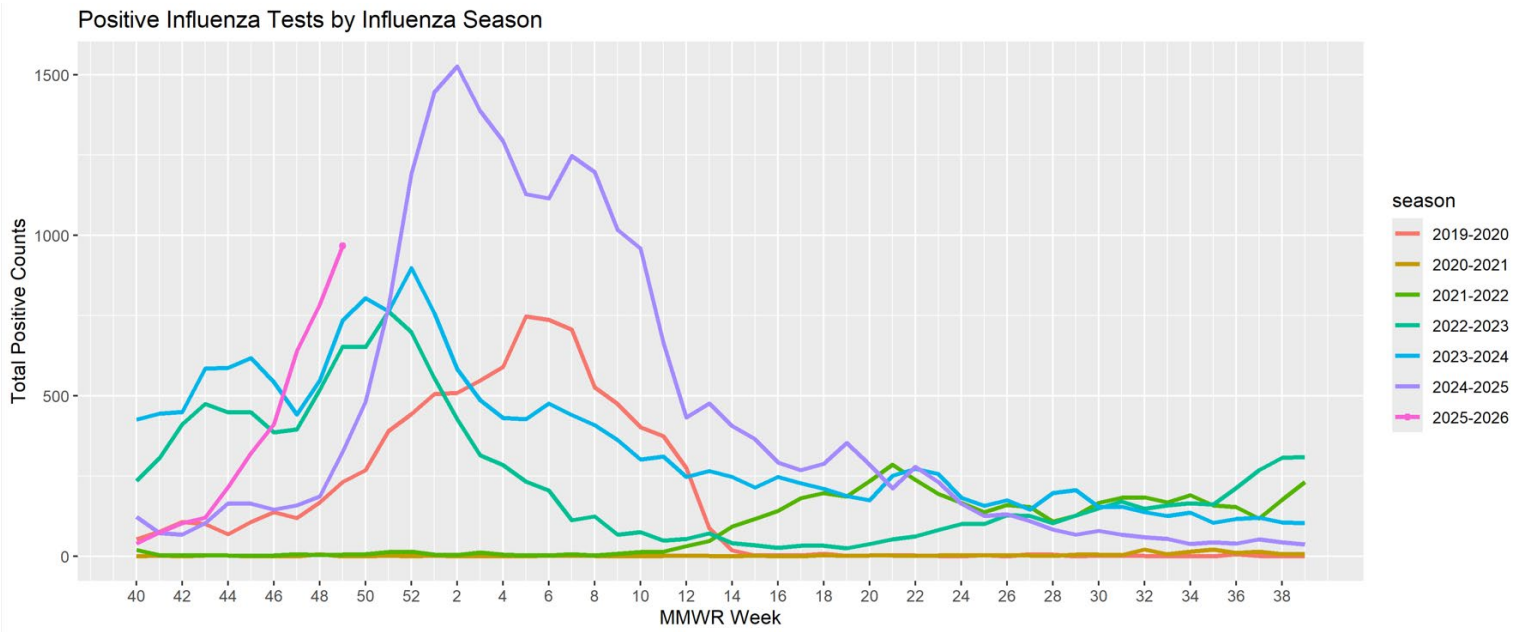


* *The coronavirus presented on this table does not indicate Severe Acute Respiratory Coronavirus-2 (i.e., COVID-19).*

RESPIRATORY SYNCYTIAL VIRUS (RSV) POSITIVE TEST RESULTS BY INFLUENZA SEASON: RSV case appears to have increased earlier than past seasons in the 2025-2026 season. Of note, significantly more tests for RSV are being performed than in pre-COVID-19 seasons.



INFLUENZA POSITIVE TEST RESULTS BY INFLUENZA SEASON: Influenza cases appear to have increased earlier than past seasons in the 2023-2024 season, but it is not yet known whether case numbers will reach a peak similar to pre-COVID-19 seasons.



C. COVID-19 SENTINEL SURVEILLANCE: Due to the low volume of samples currently available through the influenza surveillance system, the COVID-19 sentinel surveillance data may not be accurately portraying COVID-19 activity in our communities. Reporting of the COVID-19 Sentinel Surveillance data will be paused while HODH re-evaluates the program to ensure that the reported data are accurate and representative.

HDOH is continuing to monitor COVID-19 activity throughout the state. To learn more, please visit the Hawaii's COVID-19 data website (*here*). For more information on surveillance of COVID-19 activity in the United States please visit the CDC COVIDView website (*here*).

III. PNEUMONIA, INFLUENZA, AND COVID-19 (PIC) RELATED MORTALITY:

P&I mortality surveillance is collected by CDC through the National Center for Health Statistics (NCHS) using death certificate data. Each week the HDOH OHSM reports specific data from Honolulu to the CDC. CDC collects the following information by age group: the total number of deaths, total deaths from pneumonia, and total deaths related to influenza. Due to the ongoing COVID-19 pandemic, CDC included total deaths from COVID-19 by age group to the death data. Previous studies had suggested that P&I is a good indicator of influenza-related deaths; however, data has shown that pneumonia deaths associated with influenza is now being impacted by COVID-19 related pneumonia. Due to this, CDC had added COVID-19 deaths into P&I to create the PIC (pneumonia, influenza, and/or COVID-19) classification.

To standardize Hawaii's influenza surveillance with CDC influenza surveillance guidelines, PIC deaths will be reported in lieu of P&I. Hawaii's baseline will begin to include PIC deaths starting from 2019-2020 flu season.

The National Vital Statistic System (NVSS) surveillance datasets and reports had been paused temporarily, including those used to evaluate pneumonia, influenza, and COVID-19 deaths. HDOH PIC mortality data will not be published in the Influenza/Respiratory Disease Surveillance Report for week 49.

INFLUENZA-ASSOCIATED PEDIATRIC DEATHS[11]:

- No new influenza-associated pediatric death was reported to Hawaii. There have been zero influenza-associated pediatric deaths reported in Hawaii during the 2025–2026 season.
- Nationally, no new influenza-associated pediatric deaths were reported to CDC during week 49. (2025-2026 season total: 0).

IV. INFLUENZA WATCH: As part of a comprehensive influenza surveillance system and to prevent the spread of contagious respiratory diseases in humans, it is important to monitor all circulating influenza types. Several animal-origin influenza A subtypes are currently of interest: influenza A variant virus (H3N2v, H1N2v, and H1N1v) and Avian flu (H5N1 and H7N9). These types of influenza viruses may cause zoonotic (animal-associated) disease and are a public health concern.

A. VARIANT VIRUSES:

Influenza viruses that normally circulate in pigs are called "variant" viruses when they are found in people. These viruses were first identified in U.S. pigs in 2010. In 2011, 12 cases of H3N2v infection were detected in the United States. In 2012, 309 such cases (resulting in 16 hospitalizations and one death) across 12 states were detected, including one Hawaii case who recovered. Illness associated with H3N2v infection has been mostly mild with symptoms similar to those of seasonal flu. However, serious illness, resulting in hospitalization and death, has occurred in some cases. Most of these infections have been associated with prolonged exposure to pigs at agricultural fairs or similar settings. Limited human-to-human spread of this virus has been detected in the past, but no sustained community spread of H3N2v has been identified. More information regarding H3N2v, H1N1v, and H1N2v viruses may be found on the CDC website (*here*) and (*here*).

- *No variant or novel influenza infections have been reported to HDOH during the 2025-2026 influenza season.*
- *No new human infection with novel influenza A virus, H1N1v (1), H3N2v (0), and H1N2v (0), have been reported during the 2025-2026 influenza season.*

AVIAN (OR BIRD) INFLUENZA: These types of influenza viruses cause zoonotic (animal-associated) disease of public health concern and are therefore monitored globally by the WHO. Most avian influenza viruses do not cause disease in humans and are generally not easily transmissible between person to person, but a few subtypes may cross the species barrier and cause disease in humans. Avian influenza viruses may be of various subtypes, including H5N1, H5N2, H5N8, H7N3, H7N7, H7N8, H7N9, and H9N2. On January 15th, 2016, the USDA and APHIS reported detection of HPAI H7N8 in a commercial turkey flock in Indiana. There have been no associated human infections. This is the first detection of HPAI H7N8 in wild bird surveillance in the United States. More information, the risk assessment and recommendations for HPAI H7N8 can be found (here). The WHO, CDC, and other public health agencies have also been monitoring influenza H7N9, which represents a public health concern because of its high pandemic potential. Although H7N9 has not been detected in the United States, it remains a global concern given continuing epidemics in endemic countries. Since 2013, a total of 1,568 laboratory-confirmed cases of human infection with H7N9 viruses, including at least 613 deaths, have been reported to WHO. More information on H7N9 virus infections can be found (here). For more information regarding avian influenza, please visit the CDC (*here*) or the WHO (*here*) websites. WHO reports total number of cases and deaths related to laboratory-confirmed avian influenza viruses and posts current avian influenza case counts (*here*), which were last updated on **November 5, 2025**.

[11] Influenza-associated deaths are considered pediatric in persons aged less than 18 years. It was made a nationally notifiable condition in October, 2004. All pediatric influenza-associated deaths are laboratory confirmed.

V. INFLUENZA Vaccine: Annual influenza vaccination is recommended for all persons aged 6 months and older and is the most effective way to reduce the risk of getting sick with seasonal flu and spreading it to others. Influenza vaccination can reduce illnesses, visits to the doctor, influenza-related hospitalizations, and missed work and school days. Influenza vaccines become available by the end of October. It takes at least two weeks after vaccination to confer immunity against influenza virus infection. More information regarding influenza vaccination can be found (*here*).

A. Composition of the 2025–2026 Influenza Vaccine:

The composition of the 2025–2026 influenza vaccine has been updated to better match circulating influenza viruses. The Advisory Committee on Immunization Practices (ACIP) has recommended that the 2025-2026 influenza trivalent vaccine contain an influenza A/Victoria/4897/2022 (H1N1) pdm09-like virus, influenza A/Croatia/10136RV/2023 (H3N2)-like virus, and influenza B/Austria/1359417/2021 (B/Victoria lineage)-like virus. United States cell culture–based inactivated (ccIIV4) and recombinant (RIV4) influenza vaccines will contain HA derived from an influenza A/Wisconsin/67/2022 (H1N1) pdm09-like virus, an A/District of Columbia/27/2023 (H3N2)-like virus, an influenza B/Austria/1359417/2021 (B/Victoria lineage)-like virus. These vaccine recommendations were based on several factors, including global influenza virologic and epidemiologic surveillance, genetic and antigenic characterization, human serology studies, antiviral susceptibility, and the availability of candidate influenza viruses.

APPENDIX 1: ADDITIONAL INFORMATION

For more information regarding local and national influenza surveillance programs, visit the following sites.

Centers for Disease Control and Prevention	General Influenza National ILI and P&I Data Vaccine Virus Selection CDC Web Tool for Respiratory Viruses
Flu.gov	General Influenza Information
HDOH Flu and Pneumonia	General Influenza Surveillance Avian Influenza Respiratory Virus Dashboard To find out more information or join the sentinel physician program, email the Influenza Surveillance Coordinator
World Health Organization	General Global and Local Influenza Avian Influenza

APPENDIX 2: MMWR WEEK DATES

Please refer to the table below to interpret data presented by MMWR week. Week 40 is considered the traditional start for the flu season for the Northern Hemisphere.

MMWR WEEK	2022	2023	2024	2025	2026
1	1/8/2022	1/7/2023	1/6/2024	1/4/2025	1/10/2026
2	1/15/2022	1/14/2023	1/13/2024	1/11/2025	1/17/2026
3	1/22/2022	1/21/2023	1/20/2024	1/18/2025	1/24/2026
4	1/29/2022	1/28/2023	1/27/2024	1/25/2025	1/31/2026
5	2/5/2022	2/4/2023	2/3/2024	2/1/2025	2/7/2026
6	2/12/2022	2/11/2023	2/10/2024	2/8/2025	2/14/2026
7	2/19/2022	2/18/2023	2/17/2024	2/15/2025	2/21/2026
8	2/26/2022	2/25/2023	2/24/2024	2/22/2025	2/28/2026
9	3/5/2022	3/4/2023	3/2/2024	3/1/2025	3/7/2026
10	3/12/2022	3/11/2023	3/9/2024	3/8/2025	3/14/2026
11	3/19/2022	3/18/2023	3/16/2024	3/15/2025	3/21/2026
12	3/26/2022	3/25/2023	3/23/2024	3/22/2025	3/28/2026
13	4/2/2022	4/1/2023	3/30/2024	3/29/2025	4/4/2026
14	4/9/2022	4/8/2023	4/6/2024	4/5/2025	4/11/2026
15	4/16/2022	4/15/2023	4/13/2024	4/12/2025	4/18/2026
16	4/23/2022	4/22/2023	4/20/2024	4/19/2025	4/25/2026
17	4/30/2022	4/29/2023	4/27/2024	4/26/2025	5/2/2026
18	5/7/2022	5/6/2023	5/4/2024	5/3/2025	5/9/2026
19	5/14/2022	5/13/2023	5/11/2024	5/10/2025	5/16/2026
20	5/21/2022	5/20/2023	5/18/2024	5/17/2025	5/23/2026
21	5/28/2022	5/27/2023	5/25/2024	5/24/2025	5/30/2026
22	6/4/2022	6/3/2023	6/1/2024	5/31/2025	6/6/2026
23	6/11/2022	6/10/2023	6/8/2024	6/7/2025	6/13/2026
24	6/18/2022	6/17/2023	6/15/2024	6/14/2025	6/20/2026
25	6/25/2022	6/24/2023	6/22/2024	6/21/2025	6/27/2026
26	7/2/2022	7/1/2023	6/29/2024	6/28/2025	7/4/2026
27	7/9/2022	7/8/2023	7/6/2024	7/5/2025	7/11/2026
28	7/16/2022	7/15/2023	7/13/2024	7/12/2025	7/18/2026
29	7/23/2022	7/22/2023	7/20/2024	7/19/2025	7/25/2026
30	7/30/2022	7/29/2023	7/27/2024	7/26/2025	8/1/2026
31	8/6/2022	8/5/2023	8/3/2024	8/2/2025	8/8/2026
32	8/13/2022	8/12/2023	8/10/2024	8/9/2025	8/15/2026
33	8/20/2022	8/19/2023	8/17/2024	8/16/2025	8/22/2026
34	8/27/2022	8/26/2023	8/24/2024	8/23/2025	8/29/2026
35	9/3/2022	9/2/2023	8/31/2024	8/30/2025	9/5/2026
36	9/10/2022	9/9/2023	9/7/2024	9/6/2025	9/12/2026
37	9/17/2022	9/16/2023	9/14/2024	9/13/2025	9/19/2026
38	9/24/2022	9/23/2023	9/21/2024	9/20/2025	9/26/2026
39	10/1/2022	9/30/2023	9/28/2024	9/27/2025	10/3/2026
40	10/8/2022	10/7/2023	10/5/2024	10/4/2025	10/10/2026
41	10/15/2022	10/14/2023	10/12/2024	10/11/2025	10/17/2026
42	10/22/2022	10/21/2023	10/19/2024	10/18/2025	10/24/2026
43	10/29/2022	10/28/2023	10/26/2024	10/25/2025	10/31/2026
44	11/5/2022	11/4/2023	11/2/2024	11/1/2025	11/7/2026
45	11/12/2022	11/11/2023	11/9/2024	11/8/2025	11/14/2026
46	11/19/2022	11/18/2023	11/16/2024	11/15/2025	11/21/2026
47	11/26/2022	11/25/2023	11/23/2024	11/22/2025	11/28/2026
48	12/3/2022	12/2/2023	11/30/2024	11/29/2025	12/5/2026
49	12/10/2022	12/9/2023	12/7/2024	12/6/2025	12/12/2026
50	12/17/2022	12/16/2023	12/14/2024	12/13/2025	12/19/2026
51	12/24/2022	12/23/2023	12/21/2024	12/20/2025	12/26/2026
52	12/31/2022	12/30/2023	12/28/2024	12/27/2025	
53				01/03/2026	

HAWAII STATE DEPARTMENT OF HEALTH
DISEASE OUTBREAK CONTROL DIVISION

Influenza/Respiratory Disease Surveillance Report

Morbidity and Mortality Weekly Report (MMWR)[1]

WEEK 50: DECEMBER 7, 2025– DECEMBER 13, 2025

OVERVIEW: The Hawaii State Department of Health (HDOH) monitors influenza and other respiratory pathogens, including COVID-19, throughout the state of Hawaii. Influenza surveillance in the state of Hawaii relies upon selected sentinel health practitioners, the State Laboratories Division (SLD), private laboratories, and the Office of Health Status Monitoring (OHSM). For detailed information concerning influenza, please visit the HDOH Disease Outbreak Control Division (HDOH DOCD) website (*here*). **All data and information are conditional and may change as more reports are received.** The data in this report reflect the 2025-2026 influenza season which began the week ending October 4, 2025 (week 40[1] 2025) and will end the week ending on October 3, 2026 (week 39 2026).

REPORT SNAPSHOT FOR WEEK 50

Surveillance for Influenza-like Illness (ILI)		
Metric	*Value*	*Comment*
Outpatient visits related to influenza-like illness (ILI) from ILINet Sentinel Providers	4.0%	Higher than the previous week. Comparable to the Hawaii's historical baseline and comparable to the national baseline, and comparable to the national ILI rate.
Number of ILI clusters reported to HDOH	0	There have been 11 clusters this season.

Laboratory Surveillance		
Percent of all respiratory specimens positive for influenza this week	27.3%	Higher than the previous week. This number means that many, if not all, of the 72.7% who tested negative for influenza had illness from another respiratory etiology.
Percent of all respiratory specimens positive for influenza this season to date	16.3%	

Surveillance for Severe Outcomes		
Pneumonia, influenza and COVID-19 (PIC) mortality rate		No new report for PIC mortality rates is available this week due to a pause in data updates from the National Vital Statistics System (NVSS).
Number of influenza-associated pediatric deaths reported nationwide	3	0 influenza-associated pediatric deaths have been reported from Hawaii this season to date.

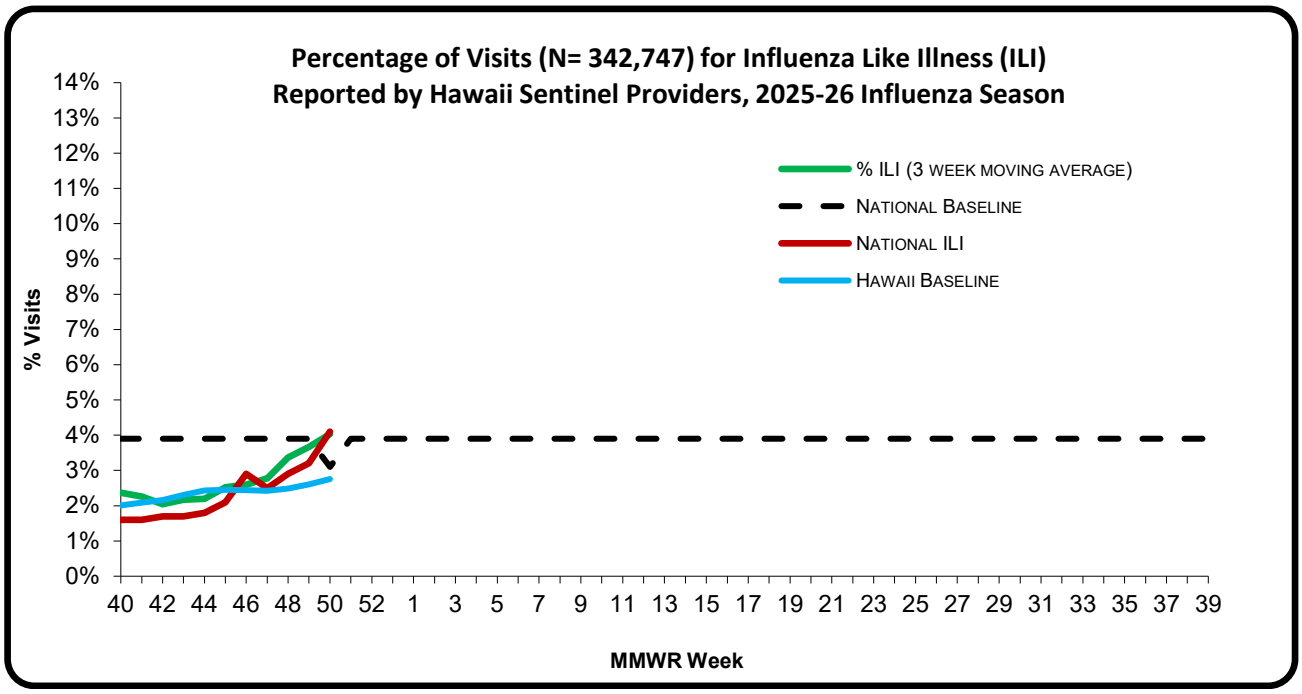
[1] MMWR stands for "Morbidity and Mortality Weekly Report," conventionally used by the Centers for Disease Control and Prevention (CDC). The weeks of a flu season are often referred to by their respective MMWR week. **See appendix 2 for interpretation of MMWR weeks.** Data reported will begin on week 40, the traditional start date of flu season.

INFLUENZA SURVEILLANCE

I. INFLUENZA-LIKE ILLNESS (ILI): HDOH collaborates with recruited doctors and healthcare providers who report the total number of outpatient visits for ILI as well as the total number of patients who complained of symptoms consistent with an ILI. A patient with ILI must have the following: a fever (temperature of 100°F [37.8°C] or greater) AND a cough and/or a sore throat. ILI is based on reported symptoms and not laboratory confirmed tests; thus, ILI may represent other respiratory pathogens and not solely influenza. Further, sentinel providers report these numbers on a weekly basis; therefore, data are preliminary and may change depending on additional reporting. In combination with laboratory testing and other surveillance systems, ILI surveillance helps monitor influenza and other respiratory pathogen activity. For more information concerning ILINet and sentinel requirements, please visit the CDC website (*here*).

For **week 50** of the current influenza season:

- ***4.0**% (season to date: **2.8**%) of the outpatient visits recorded by Hawaii sentinel providers were for ILI.*
- *ILI visits were comparable to the historical baseline in Hawaii[2,3] (i.e., inside the 95% confidence interval).*
- *Hawaii's ILI outpatient visits were comparable to the national baseline (**3.9%**)[4] (i.e., inside the 95% confidence interval) and comparable to the national ILI rate (**4.1%**) (i.e. inside the 95% confidence interval).*
- *ILI activity level: Low[5]*
- *Geographic Spread: Sporadic Activity[6].*
- *ILI Cluster Activity: No new clusters were reported to HDOH during week 50.*



[2] The Hawaii historical baseline (%ILI) is the average of 3-week moving averages over the preceding 10 flu seasons of historical data (2015-2016, 2016-2017, 2017-2018, 2018-2019, 2019-2020, 2020-2021, 2021-2022, 2022-2023, 2023-2024 and 2024-2025).
[3] This value is based upon comparison of actual outpatient ILI with the historical baseline, which only captures outpatient ILI. The chart above represents a 3-week moving average and not the actual ILI by week.
[4] The National Baseline is calculated by CDC as the mean percentage of visits for ILI during weeks 21–39 with two standard deviations. Because of large variability in regional ILI, comparison of the national baseline with local ILI may not be appropriate. It is provided in this report because no meaningful regional baselines are available for comparison. The national baseline combines all data reported by states to CDC, including ILI in outpatient, ER, urgent care, and inpatient settings.
[5] There are 10 activity levels classified as minimal (levels 1-3), low (levels 4-5), moderate (levels 6-7), and high (levels 8-10).
[6] The influenza activity reported by state and territorial epidemiologists indicates geographic spread of influenza viruses but does not measure the severity of influenza activity. Sporadic: no clusters reported to HDOH, Local: one or more clusters reported in one county, Regional: clusters reported two to three counties, Widespread: clusters reported in all counties. Hawaii does not report No Activity, as flu circulates year-round in Hawaii.

II. LABORATORY SURVEILLANCE: State Laboratories Division (SLD; the HDOH public health laboratory) and Hawaii's major private laboratories (DLS, CLH) report results of RT-PCR, which can be considered confirmatory (SLD may perform viral culture on select specimens). Specimens meeting priority criteria[7] are forwarded to SLD for sub-typing. Additionally, specimens meeting case definition from requesting sentinel providers are sent directly to SLD for sub-typing. Due to resource constraints, not all submitted specimens undergo sub-typing. Sub-typing at the commercial laboratories is only conducted on a case-by-case basis. The majority of specimens testing positive by rapid antigen testing or RT-PCR at the commercial laboratories do not meet criteria and are not subtyped. For more information on influenza tests and types, please visit the CDC website (*here*).

A. INFLUENZA:

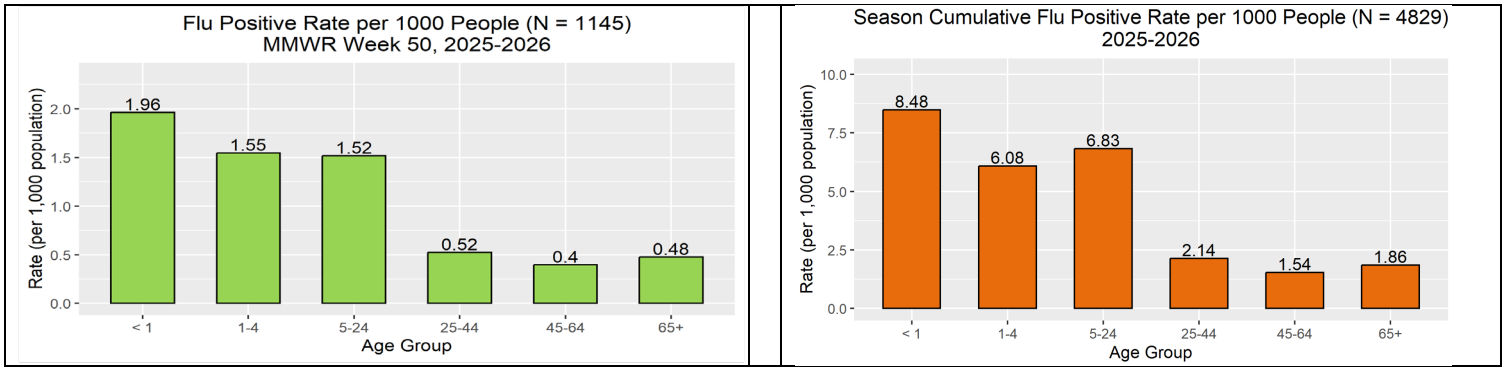
- The following reflects laboratory findings for week 50 of the 2025–26 influenza season:
  - *A total of **4,194** specimens have been tested statewide for influenza viruses (positive: 1,146 [**27.3%**]). (Season to date: **29,636** tested (**16.3%** positive)*
    - *1,998 (47.6%) were screened only by rapid antigen tests with no confirmatory testing.*
    - *2,196 (52.4%) underwent confirmatory testing (either RT-PCR or viral culture).*
    - *3,049 (73.7%) were negative.*
  - *Routine surveillance samples from State Laboratory Division were tested at a public health laboratory and identified as Influenza A (H3N2) subclade K.*

Influenza type	***Current week 50 (%)****	***Season to date (%)***[8]
Influenza A (H1)[9]	*4 (0.4)*	*56 (1.2)*
Influenza A (H3)	*86 (7.5)*	*587 (12.3)*
Influenza A no subtyping	*1045 (91.4)*	*4,078 (85.2)*
Influenza B (Yamagata)	*0 (0.0)*	*0 (0.0)*
Influenza B (Victoria)	*0 (0.0)*	*0 (0.0)*
Influenza B no genotyping	*8 (0.7)*	*64 (1.3)*

**Specimens that are positive for both A and B (coinfections) are counted in both A and B totals for current and season to date*

1. AGE DISTRIBUTION

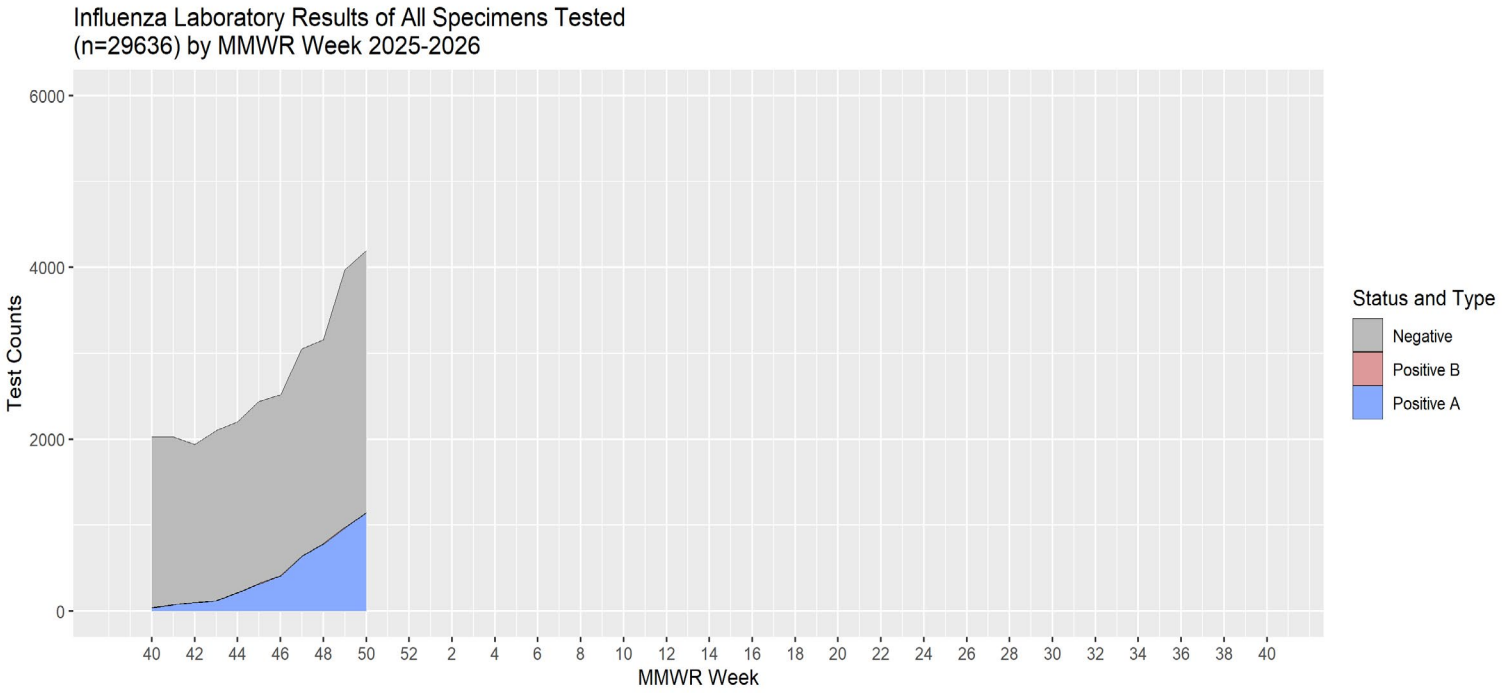
The charts below indicate the population-based rates of positive influenza cases in Hawaii by age group during the 2025–26 influenza season.[10]

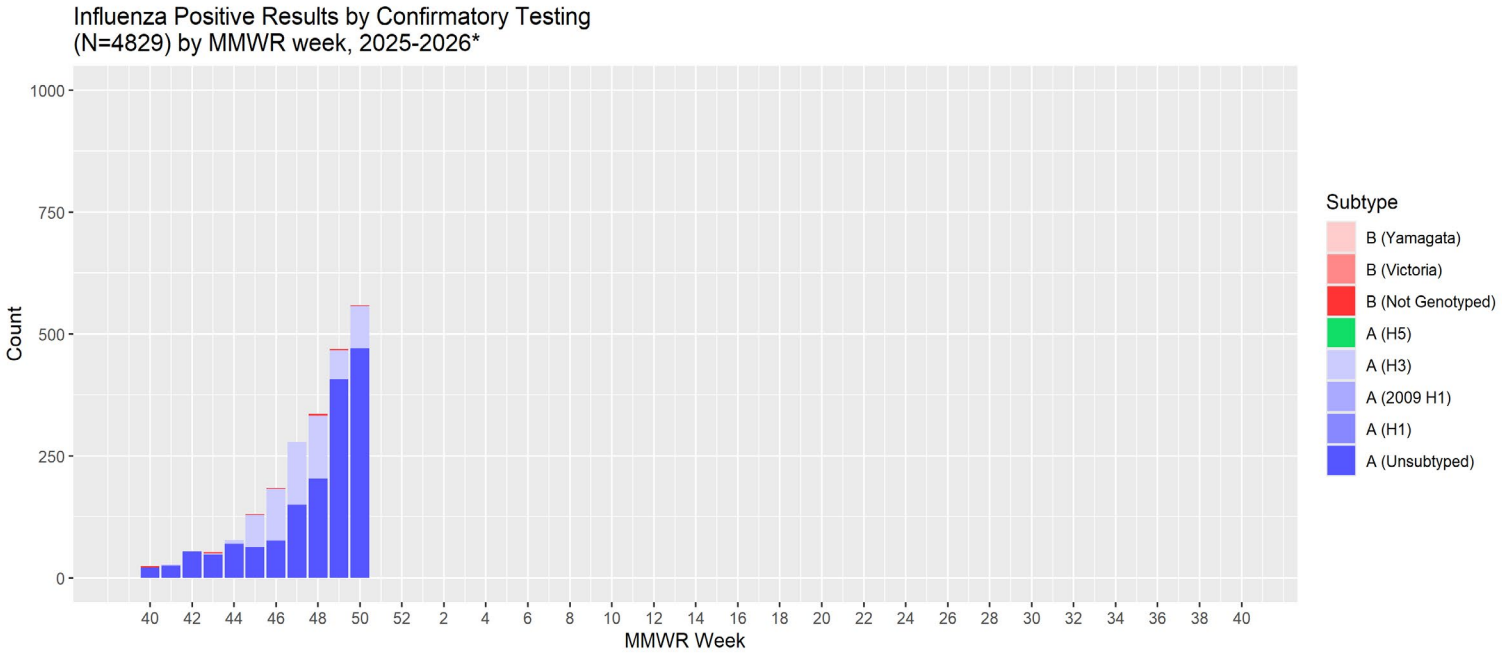


[7] Priority criteria include: hospitalized patients with acute respiratory distress syndrome [ARDS] or x-ray confirmed pneumonia; travelers with international travel history within 10 days of onset; specimens submitted by sentinel providers; specimens collected from healthcare workers, pregnant women, or women up to 6 weeks' post-partum; those with underlying medical conditions; and patients presenting with unusual or severe manifestations of influenza infection.
[8] Influenza coding were updated to reflect a more accurate count.
[9] All influenza A H1 viruses detected this season have been 2009 H1N1.
[10] This represents an estimate of population-based rates based on available data.

2. LABORATORY TESTING

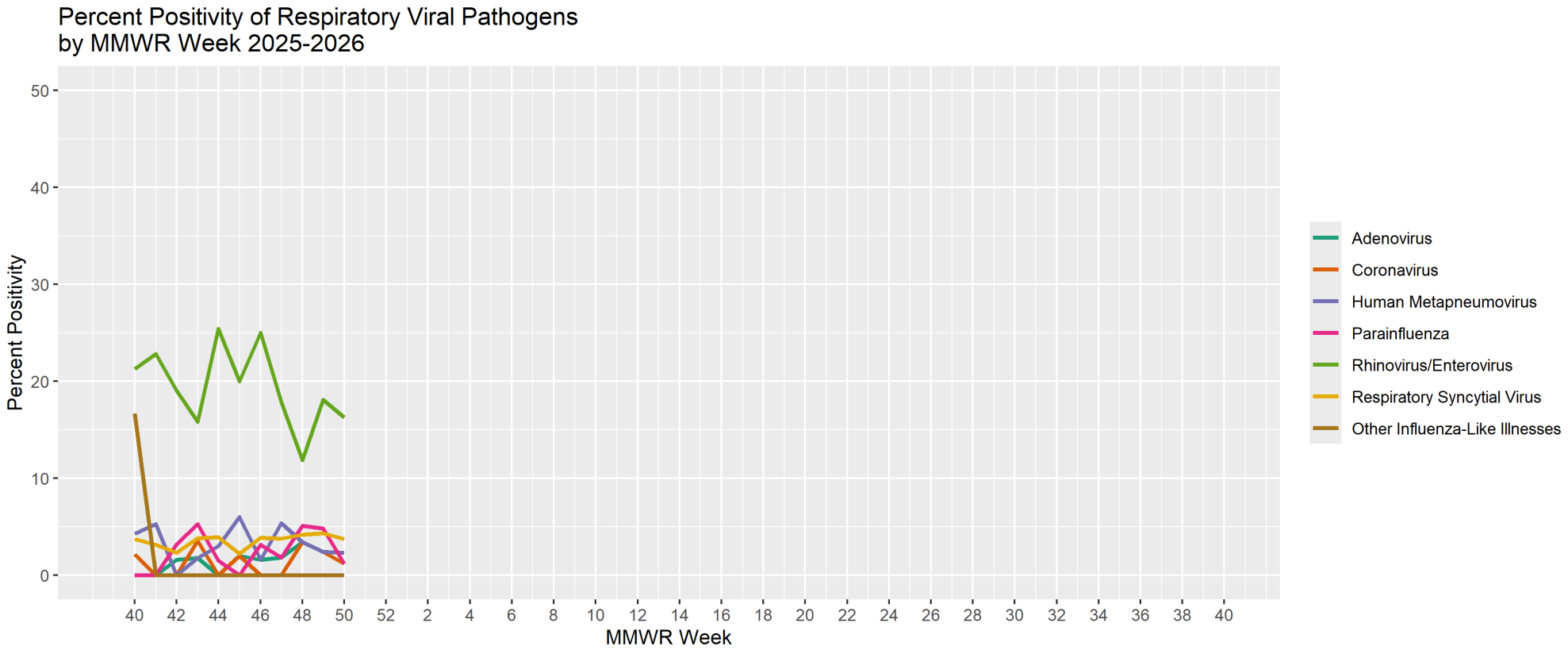
The charts below show the laboratory results of all specimens tested for influenza by MMWR week during the 2025–2026 influenza season as well as the type and subtype of positive results for influenza. Again, sub-typing is only performed on selected specimens tested by confirmatory tests (i.e., RT-PCR or viral culture).





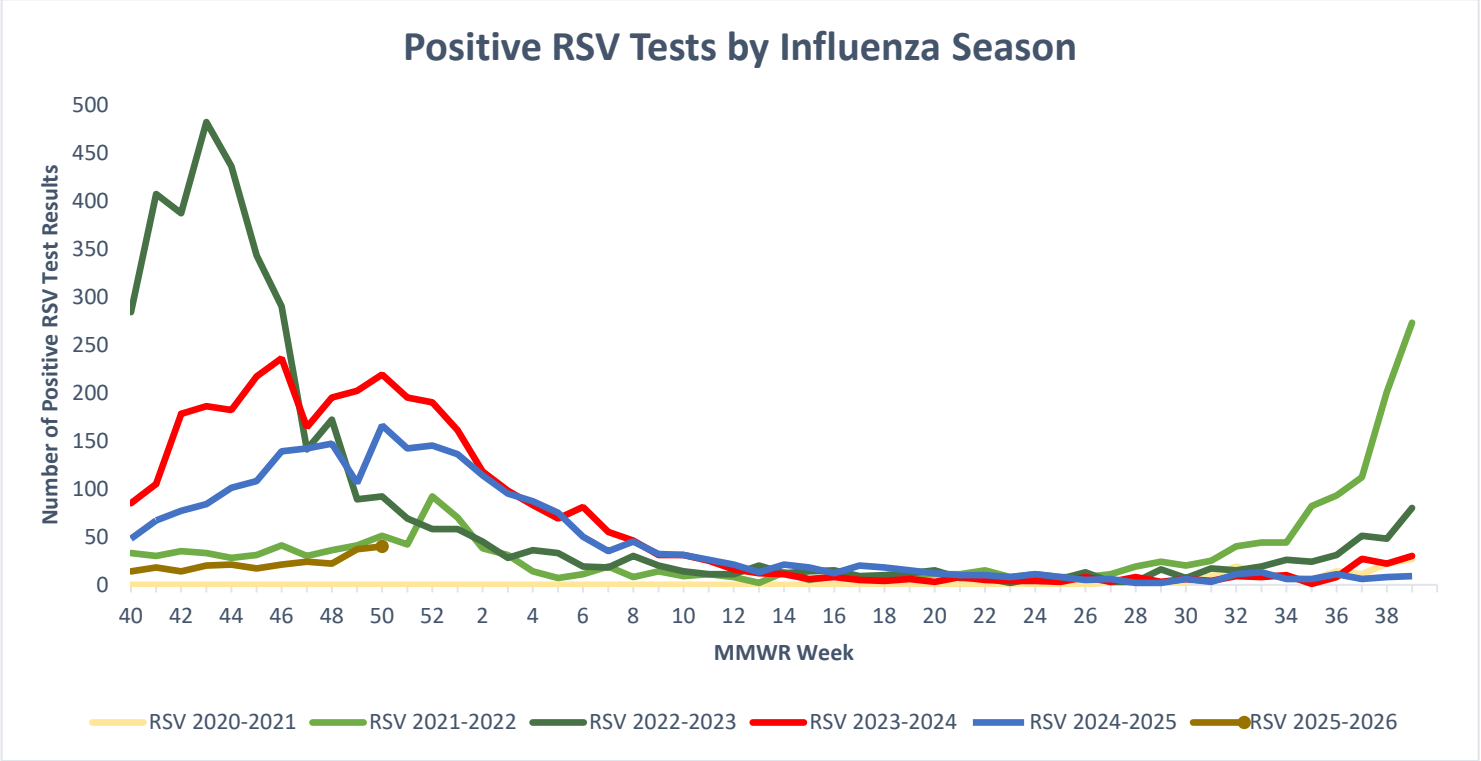
** A total of 15,600 specimens underwent confirmatory testing but not all positive influenza specimens receive confirmatory testing that are circulating in Hawaii.*

B. OTHER RESPIRATORY PATHOGENS: The major clinical and commercial laboratories throughout the state of Hawaii have the testing capacity for non-influenza respiratory pathogens and report these to HDOH. However, such testing is performed as needed and when sufficient resources are available because of the high costs associated with respiratory panel tests. **Therefore, available data represent only the presence of circulating pathogens and cannot be used to determine specific trends**.

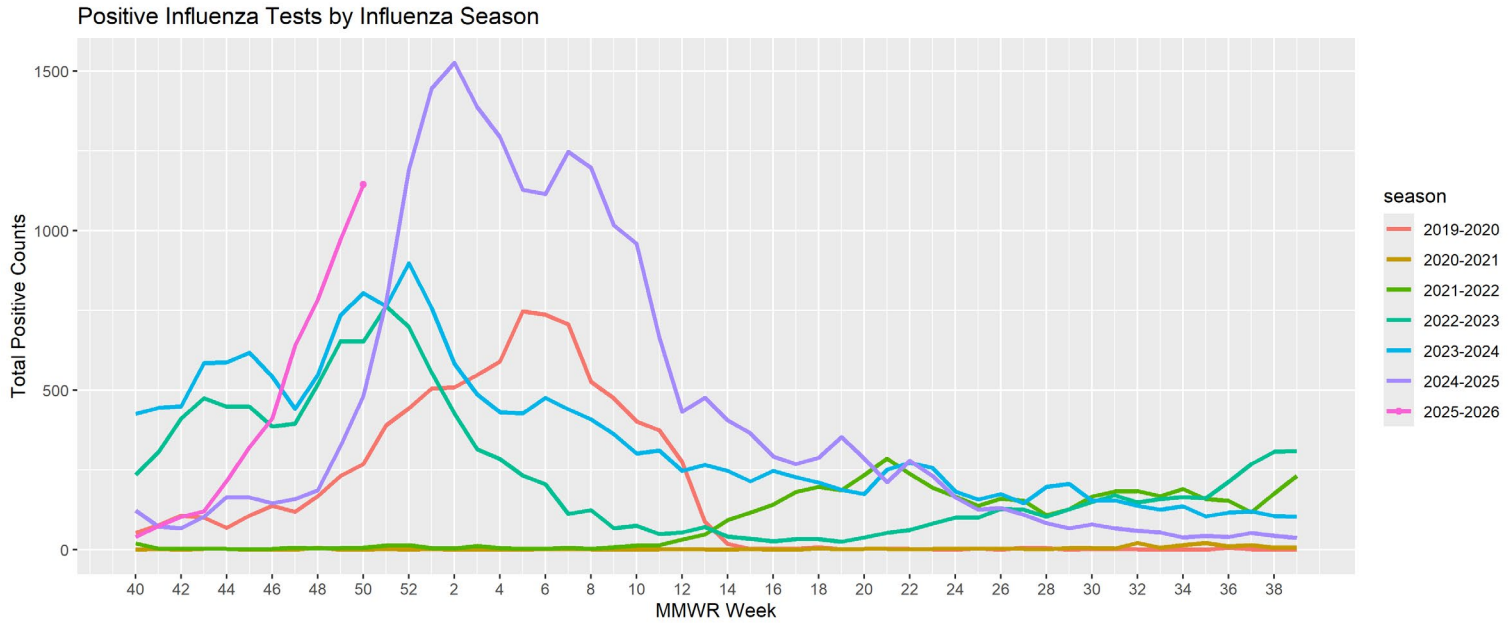


* *The coronavirus presented on this table does not indicate Severe Acute Respiratory Coronavirus-2 (i.e., COVID-19).*

RESPIRATORY SYNCYTIAL VIRUS (RSV) POSITIVE TEST RESULTS BY INFLUENZA SEASON: RSV case appears to have increased earlier than past seasons in the 2025-2026 season. Of note, significantly more tests for RSV are being performed than in pre-COVID-19 seasons.



INFLUENZA POSITIVE TEST RESULTS BY INFLUENZA SEASON: Influenza cases appear to have increased earlier than past seasons in the 2023-2024 season, but it is not yet known whether case numbers will reach a peak similar to pre-COVID-19 seasons.



C. COVID-19 SENTINEL SURVEILLANCE: Due to the low volume of samples currently available through the influenza surveillance system, the COVID-19 sentinel surveillance data may not be accurately portraying COVID-19 activity in our communities. Reporting of the COVID-19 Sentinel Surveillance data will be paused while HODH re-evaluates the program to ensure that the reported data are accurate and representative.

HDOH is continuing to monitor COVID-19 activity throughout the state. To learn more, please visit the Hawaii's COVID-19 data website (*here*). For more information on surveillance of COVID-19 activity in the United States please visit the CDC COVIDView website (*here*).

III. PNEUMONIA, INFLUENZA, AND COVID-19 (PIC) RELATED MORTALITY:

P&I mortality surveillance is collected by CDC through the National Center for Health Statistics (NCHS) using death certificate data. Each week the HDOH OHSM reports specific data from Honolulu to the CDC. CDC collects the following information by age group: the total number of deaths, total deaths from pneumonia, and total deaths related to influenza. Due to the ongoing COVID-19 pandemic, CDC included total deaths from COVID-19 by age group to the death data. Previous studies had suggested that P&I is a good indicator of influenza-related deaths; however, data has shown that pneumonia deaths associated with influenza is now being impacted by COVID-19 related pneumonia. Due to this, CDC had added COVID-19 deaths into P&I to create the PIC (pneumonia, influenza, and/or COVID-19) classification.

To standardize Hawaii's influenza surveillance with CDC influenza surveillance guidelines, PIC deaths will be reported in lieu of P&I. Hawaii's baseline will begin to include PIC deaths starting from 2019-2020 flu season.

The National Vital Statistic System (NVSS) surveillance datasets and reports had been paused temporarily, including those used to evaluate pneumonia, influenza, and COVID-19 deaths. HDOH PIC mortality data will not be published in the Influenza/Respiratory Disease Surveillance Report for week 50.

INFLUENZA-ASSOCIATED PEDIATRIC DEATHS[11]:

- No new influenza-associated pediatric death was reported to Hawaii. There have been zero influenza-associated pediatric deaths reported in Hawaii during the 2025–2026 season.
- Nationally, no new influenza-associated pediatric deaths were reported to CDC during week 50. (2025-2026 season total: 0).

IV. INFLUENZA WATCH: As part of a comprehensive influenza surveillance system and to prevent the spread of contagious respiratory diseases in humans, it is important to monitor all circulating influenza types. Several animal-origin influenza A subtypes are currently of interest: influenza A variant virus (H3N2v, H1N2v, and H1N1v) and Avian flu (H5N1 and H7N9). These types of influenza viruses may cause zoonotic (animal-associated) disease and are a public health concern.

A. VARIANT VIRUSES:

Influenza viruses that normally circulate in pigs are called "variant" viruses when they are found in people. These viruses were first identified in U.S. pigs in 2010. In 2011, 12 cases of H3N2v infection were detected in the United States. In 2012, 309 such cases (resulting in 16 hospitalizations and one death) across 12 states were detected, including one Hawaii case who recovered. Illness associated with H3N2v infection has been mostly mild with symptoms similar to those of seasonal flu. However, serious illness, resulting in hospitalization and death, has occurred in some cases. Most of these infections have been associated with prolonged exposure to pigs at agricultural fairs or similar settings. Limited human-to-human spread of this virus has been detected in the past, but no sustained community spread of H3N2v has been identified. More information regarding H3N2v, H1N1v, and H1N2v viruses may be found on the CDC website (*here*) and (*here*).

- *No variant or novel influenza infections have been reported to HDOH during the 2025-2026 influenza season.*
- *No new human infection with novel influenza A virus, H1N1v (1), H3N2v (0), and H1N2v (0), have been reported during the 2025-2026 influenza season.*

AVIAN (OR BIRD) INFLUENZA: These types of influenza viruses cause zoonotic (animal-associated) disease of public health concern and are therefore monitored globally by the WHO. Most avian influenza viruses do not cause disease in humans and are generally not easily transmissible between person to person, but a few subtypes may cross the species barrier and cause disease in humans. Avian influenza viruses may be of various subtypes, including H5N1, H5N2, H5N8, H7N3, H7N7, H7N8, H7N9, and H9N2. On January 15th, 2016, the USDA and APHIS reported detection of HPAI H7N8 in a commercial turkey flock in Indiana. There have been no associated human infections. This is the first detection of HPAI H7N8 in wild bird surveillance in the United States. More information, the risk assessment and recommendations for HPAI H7N8 can be found (here). The WHO, CDC, and other public health agencies have also been monitoring influenza H7N9, which represents a public health concern because of its high pandemic potential. Although H7N9 has not been detected in the United States, it remains a global concern given continuing epidemics in endemic countries. Since 2013, a total of 1,568 laboratory-confirmed cases of human infection with H7N9 viruses, including at least 613 deaths, have been reported to WHO. More information on H7N9 virus infections can be found (here). For more information regarding avian influenza, please visit the CDC (*here*) or the WHO (*here*) websites. WHO reports total number of cases and deaths related to laboratory-confirmed avian influenza viruses and posts current avian influenza case counts (*here*), which were last updated on **November 5, 2025**.

[11] Influenza-associated deaths are considered pediatric in persons aged less than 18 years. It was made a nationally notifiable condition in October, 2004. All pediatric influenza-associated deaths are laboratory confirmed.

V. INFLUENZA Vaccine: Annual influenza vaccination is recommended for all persons aged 6 months and older and is the most effective way to reduce the risk of getting sick with seasonal flu and spreading it to others. Influenza vaccination can reduce illnesses, visits to the doctor, influenza-related hospitalizations, and missed work and school days. Influenza vaccines become available by the end of October. It takes at least two weeks after vaccination to confer immunity against influenza virus infection. More information regarding influenza vaccination can be found (*here*).

A. Composition of the 2025–2026 Influenza Vaccine**:**

The composition of the 2025–2026 influenza vaccine has been updated to better match circulating influenza viruses. The Advisory Committee on Immunization Practices (ACIP) has recommended that the 2025-2026 influenza trivalent vaccine contain an influenza A/Victoria/4897/2022 (H1N1) pdm09-like virus, influenza A/Croatia/10136RV/2023 (H3N2)-like virus, and influenza B/Austria/1359417/2021 (B/Victoria lineage)-like virus. United States cell culture–based inactivated (ccIIV4) and recombinant (RIV4) influenza vaccines will contain HA derived from an influenza A/Wisconsin/67/2022 (H1N1) pdm09-like virus, an A/District of Columbia/27/2023 (H3N2)-like virus, an influenza B/Austria/1359417/2021 (B/Victoria lineage)-like virus. These vaccine recommendations were based on several factors, including global influenza virologic and epidemiologic surveillance, genetic and antigenic characterization, human serology studies, antiviral susceptibility, and the availability of candidate influenza viruses.

APPENDIX 1: ADDITIONAL INFORMATION

For more information regarding local and national influenza surveillance programs, visit the following sites.

Centers for Disease Control and Prevention	General Influenza National ILI and P&I Data Vaccine Virus Selection CDC Web Tool for Respiratory Viruses
Flu.gov	General Influenza Information
HDOH Flu and Pneumonia	General Influenza Surveillance Avian Influenza Respiratory Virus Dashboard To find out more information or join the sentinel physician program, email the Influenza Surveillance Coordinator
World Health Organization	General Global and Local Influenza Avian Influenza

APPENDIX 2: MMWR WEEK DATES

Please refer to the table below to interpret data presented by MMWR week. Week 40 is considered the traditional start for the flu season for the Northern Hemisphere.

MMWR WEEK	2022	2023	2024	2025	2026
1	1/8/2022	1/7/2023	1/6/2024	1/4/2025	1/10/2026
2	1/15/2022	1/14/2023	1/13/2024	1/11/2025	1/17/2026
3	1/22/2022	1/21/2023	1/20/2024	1/18/2025	1/24/2026
4	1/29/2022	1/28/2023	1/27/2024	1/25/2025	1/31/2026
5	2/5/2022	2/4/2023	2/3/2024	2/1/2025	2/7/2026
6	2/12/2022	2/11/2023	2/10/2024	2/8/2025	2/14/2026
7	2/19/2022	2/18/2023	2/17/2024	2/15/2025	2/21/2026
8	2/26/2022	2/25/2023	2/24/2024	2/22/2025	2/28/2026
9	3/5/2022	3/4/2023	3/2/2024	3/1/2025	3/7/2026
10	3/12/2022	3/11/2023	3/9/2024	3/8/2025	3/14/2026
11	3/19/2022	3/18/2023	3/16/2024	3/15/2025	3/21/2026
12	3/26/2022	3/25/2023	3/23/2024	3/22/2025	3/28/2026
13	4/2/2022	4/1/2023	3/30/2024	3/29/2025	4/4/2026
14	4/9/2022	4/8/2023	4/6/2024	4/5/2025	4/11/2026
15	4/16/2022	4/15/2023	4/13/2024	4/12/2025	4/18/2026
16	4/23/2022	4/22/2023	4/20/2024	4/19/2025	4/25/2026
17	4/30/2022	4/29/2023	4/27/2024	4/26/2025	5/2/2026
18	5/7/2022	5/6/2023	5/4/2024	5/3/2025	5/9/2026
19	5/14/2022	5/13/2023	5/11/2024	5/10/2025	5/16/2026
20	5/21/2022	5/20/2023	5/18/2024	5/17/2025	5/23/2026
21	5/28/2022	5/27/2023	5/25/2024	5/24/2025	5/30/2026
22	6/4/2022	6/3/2023	6/1/2024	5/31/2025	6/6/2026
23	6/11/2022	6/10/2023	6/8/2024	6/7/2025	6/13/2026
24	6/18/2022	6/17/2023	6/15/2024	6/14/2025	6/20/2026
25	6/25/2022	6/24/2023	6/22/2024	6/21/2025	6/27/2026
26	7/2/2022	7/1/2023	6/29/2024	6/28/2025	7/4/2026
27	7/9/2022	7/8/2023	7/6/2024	7/5/2025	7/11/2026
28	7/16/2022	7/15/2023	7/13/2024	7/12/2025	7/18/2026
29	7/23/2022	7/22/2023	7/20/2024	7/19/2025	7/25/2026
30	7/30/2022	7/29/2023	7/27/2024	7/26/2025	8/1/2026
31	8/6/2022	8/5/2023	8/3/2024	8/2/2025	8/8/2026
32	8/13/2022	8/12/2023	8/10/2024	8/9/2025	8/15/2026
33	8/20/2022	8/19/2023	8/17/2024	8/16/2025	8/22/2026
34	8/27/2022	8/26/2023	8/24/2024	8/23/2025	8/29/2026
35	9/3/2022	9/2/2023	8/31/2024	8/30/2025	9/5/2026
36	9/10/2022	9/9/2023	9/7/2024	9/6/2025	9/12/2026
37	9/17/2022	9/16/2023	9/14/2024	9/13/2025	9/19/2026
38	9/24/2022	9/23/2023	9/21/2024	9/20/2025	9/26/2026
39	10/1/2022	9/30/2023	9/28/2024	9/27/2025	10/3/2026
40	10/8/2022	10/7/2023	10/5/2024	10/4/2025	10/10/2026
41	10/15/2022	10/14/2023	10/12/2024	10/11/2025	10/17/2026
42	10/22/2022	10/21/2023	10/19/2024	10/18/2025	10/24/2026
43	10/29/2022	10/28/2023	10/26/2024	10/25/2025	10/31/2026
44	11/5/2022	11/4/2023	11/2/2024	11/1/2025	11/7/2026
45	11/12/2022	11/11/2023	11/9/2024	11/8/2025	11/14/2026
46	11/19/2022	11/18/2023	11/16/2024	11/15/2025	11/21/2026
47	11/26/2022	11/25/2023	11/23/2024	11/22/2025	11/28/2026
48	12/3/2022	12/2/2023	11/30/2024	11/29/2025	12/5/2026
49	12/10/2022	12/9/2023	12/7/2024	12/6/2025	12/12/2026
50	12/17/2022	12/16/2023	12/14/2024	12/13/2025	12/19/2026
51	12/24/2022	12/23/2023	12/21/2024	12/20/2025	12/26/2026
52	12/31/2022	12/30/2023	12/28/2024	12/27/2025	
53				01/03/2026	

HAWAII STATE DEPARTMENT OF HEALTH
DISEASE OUTBREAK CONTROL DIVISION

Influenza/Respiratory Disease Surveillance Report

Morbidity and Mortality Weekly Report (MMWR)[1]

WEEK 51: DECEMBER 14, 2025– DECEMBER 20, 2025

OVERVIEW: The Hawaii State Department of Health (HDOH) monitors influenza and other respiratory pathogens, including COVID-19, throughout the state of Hawaii. Influenza surveillance in the state of Hawaii relies upon selected sentinel health practitioners, the State Laboratories Division (SLD), private laboratories, and the Office of Health Status Monitoring (OHSM). For detailed information concerning influenza, please visit the HDOH Disease Outbreak Control Division (HDOH DOCD) website (*here*). **All data and information are conditional and may change as more reports are received.** The data in this report reflect the 2025-2026 influenza season which began the week ending October 4, 2025 (week 40[1] 2025) and will end the week ending on October 3, 2026 (week 39 2026).

REPORT SNAPSHOT FOR WEEK 51

Surveillance for Influenza-like Illness (ILI)		
Metric	*Value*	*Comment*
Outpatient visits related to influenza-like illness (ILI) from ILINet Sentinel Providers	4.0%	Higher than the previous week. Comparable to the Hawaii's historical baseline and comparable to the national baseline, and lower than the national ILI rate.
Number of ILI clusters reported to HDOH	2	There have been 13 clusters this season.

Laboratory Surveillance		
Percent of all respiratory specimens positive for influenza this week	29.6%	Higher than the previous week. This number means that many, if not all, of the 70.4% who tested negative for influenza had illness from another respiratory etiology.
Percent of all respiratory specimens positive for influenza this season to date	17.8%	

Surveillance for Severe Outcomes		
Pneumonia, influenza and COVID-19 (PIC) mortality rate	3.5%	Lower than to the Hawaii's historical baseline, comparable to the national epidemic threshold and comparable to the NCHS average.
Number of influenza-associated pediatric deaths reported nationwide	8	0 influenza-associated pediatric deaths have been reported from Hawaii this season to date.

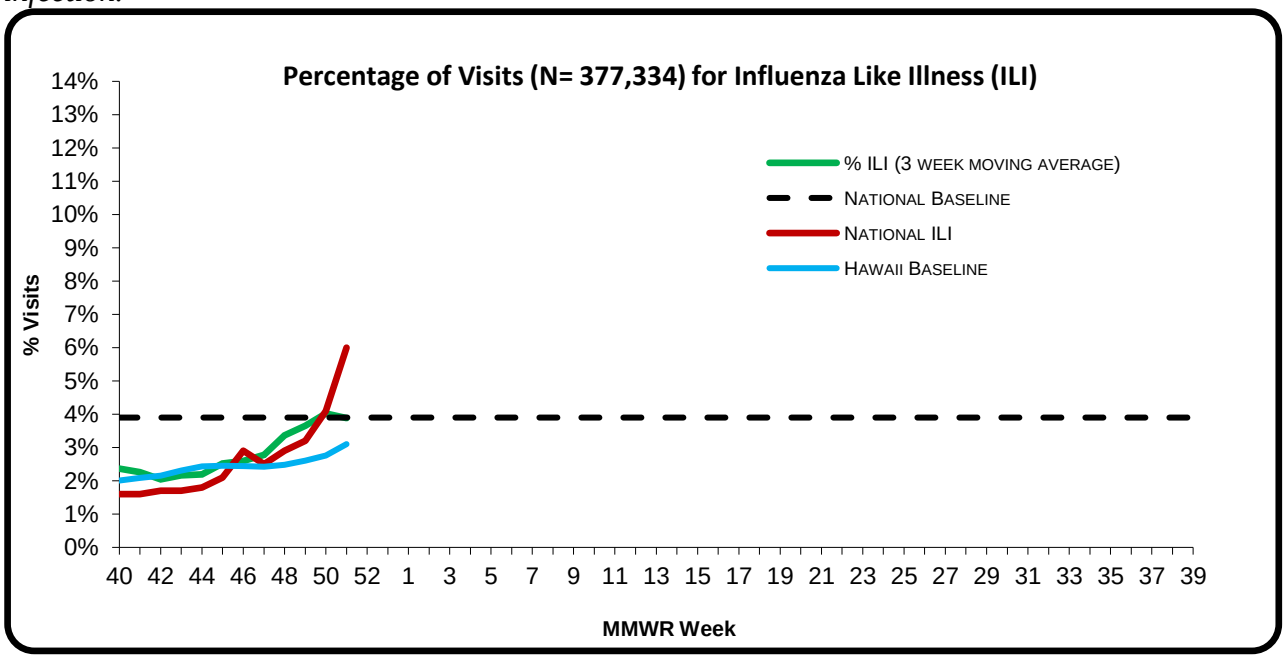
[1] MMWR stands for "Morbidity and Mortality Weekly Report," conventionally used by the Centers for Disease Control and Prevention (CDC). The weeks of a flu season are often referred to by their respective MMWR week. **See appendix 2 for interpretation of MMWR weeks.** Data reported will begin on week 40, the traditional start date of flu season.

INFLUENZA SURVEILLANCE

I. INFLUENZA-LIKE ILLNESS (ILI): HDOH collaborates with recruited doctors and healthcare providers who report the total number of outpatient visits for ILI as well as the total number of patients who complained of symptoms consistent with an ILI. A patient with ILI must have the following: a fever (temperature of 100°F [37.8°C] or greater) AND a cough and/or a sore throat. ILI is based on reported symptoms and not laboratory confirmed tests; thus, ILI may represent other respiratory pathogens and not solely influenza. Further, sentinel providers report these numbers on a weekly basis; therefore, data are preliminary and may change depending on additional reporting. In combination with laboratory testing and other surveillance systems, ILI surveillance helps monitor influenza and other respiratory pathogen activity. For more information concerning ILINet and sentinel requirements, please visit the CDC website (*here*).

For **week 51** of the current influenza season:

- ***4.0**% (season to date: **3.0**%) of the outpatient visits recorded by Hawaii sentinel providers were for ILI.*
- *ILI visits were comparable to the historical baseline in Hawaii[2,3] (i.e., inside the 95% confidence interval).*
- *Hawaii's ILI outpatient visits were comparable to the national baseline (**3.9%**)[4] (i.e., inside the 95% confidence interval) and lower than the national ILI rate (**6.9%**) (i.e. outside the 95% confidence interval).*
- *ILI activity level: Low[5]*
- *Geographic Spread: Sporadic Activity[6].*
- *ILI Cluster Activity: Two new clusters were reported to HDOH during week 51. One cluster was from a long-term care facility and another in a school. Both clusters were located in Honolulu County with an influenza A infection.*



[2] The Hawaii historical baseline (%ILI) is the average of 3-week moving averages over the preceding 10 flu seasons of historical data (2015-2016, 2016-2017, 2017-2018, 2018-2019, 2019-2020, 2020-2021, 2021-2022, 2022-2023, 2023-2024 and 2024-2025).
[3] This value is based upon comparison of actual outpatient ILI with the historical baseline, which only captures outpatient ILI. The chart above represents a 3-week moving average and not the actual ILI by week.
[4] The National Baseline is calculated by CDC as the mean percentage of visits for ILI during weeks 21–39 with two standard deviations. Because of large variability in regional ILI, comparison of the national baseline with local ILI may not be appropriate. It is provided in this report because no meaningful regional baselines are available for comparison. The national baseline combines all data reported by states to CDC, including ILI in outpatient, ER, urgent care, and inpatient settings.
[5] There are 10 activity levels classified as minimal (levels 1-3), low (levels 4-5), moderate (levels 6-7), and high (levels 8-10).
[6] The influenza activity reported by state and territorial epidemiologists indicates geographic spread of influenza viruses but does not measure the severity of influenza activity. Sporadic: no clusters reported to HDOH, Local: one or more clusters reported in one county, Regional: clusters reported two to three counties, Widespread: clusters reported in all counties. Hawaii does not report No Activity, as flu circulates year-round in Hawaii.

II. LABORATORY SURVEILLANCE: State Laboratories Division (SLD; the HDOH public health laboratory) and Hawaii's major private laboratories (DLS, CLH) report results of RT-PCR, which can be considered confirmatory (SLD may perform viral culture on select specimens). Specimens meeting priority criteria[7] are forwarded to SLD for sub-typing. Additionally, specimens meeting case definition from requesting sentinel providers are sent directly to SLD for sub-typing. Due to resource constraints, not all submitted specimens undergo sub-typing. Sub-typing at the commercial laboratories is only conducted on a case-by-case basis. The majority of specimens testing positive by rapid antigen testing or RT-PCR at the commercial laboratories do not meet criteria and are not subtyped. For more information on influenza tests and types, please visit the CDC website (*here*).

A. INFLUENZA:

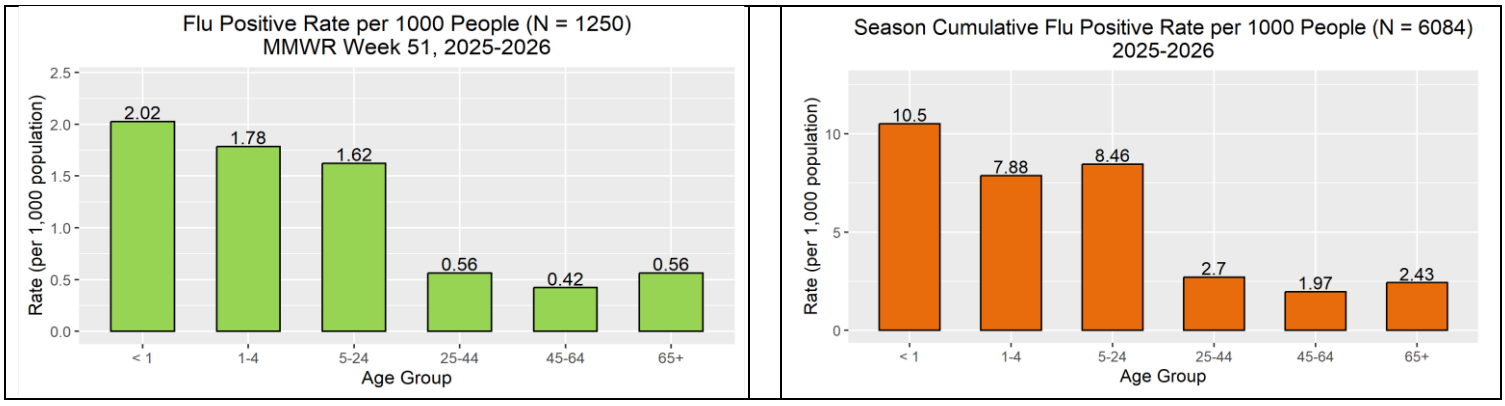
- The following reflects laboratory findings for week 51 of the 2025–26 influenza season:
  - *A total of **4,228** specimens have been tested statewide for influenza viruses (positive: 1,250 [**29.6%**]). (Season to date: **33,869** tested (**17.8%** positive)*
    - *2,020 (47.8%) were screened only by rapid antigen tests with no confirmatory testing.*
    - *2,208 (52.2%) underwent confirmatory testing (either RT-PCR or viral culture).*
    - *2,978 (70.4%) were negative.*
  - *Routine surveillance samples from State Laboratory Division were tested at a public health laboratory and identified as Influenza A (H3N2) subclade K.*

Influenza type	*Current week 51 (%)**	*Season to date (%)*[8]
Influenza A (H1)[9]	*2 (0.2)*	*62 (1.0)*
Influenza A (H3)	*17 (1.4)*	*641 (10.6)*
Influenza A no subtyping	*1,229 (98.2)*	*5,271 (87.3)*
Influenza B (Yamagata)	*0 (0.0)*	*0 (0.0)*
Influenza B (Victoria)	*0 (0.0)*	*0 (0.0)*
Influenza B no genotyping	*3 (0.2)*	*67 (1.1)*

**Specimens that are positive for both A and B (coinfections) are counted in both A and B totals for current and season to date*

1. AGE DISTRIBUTION

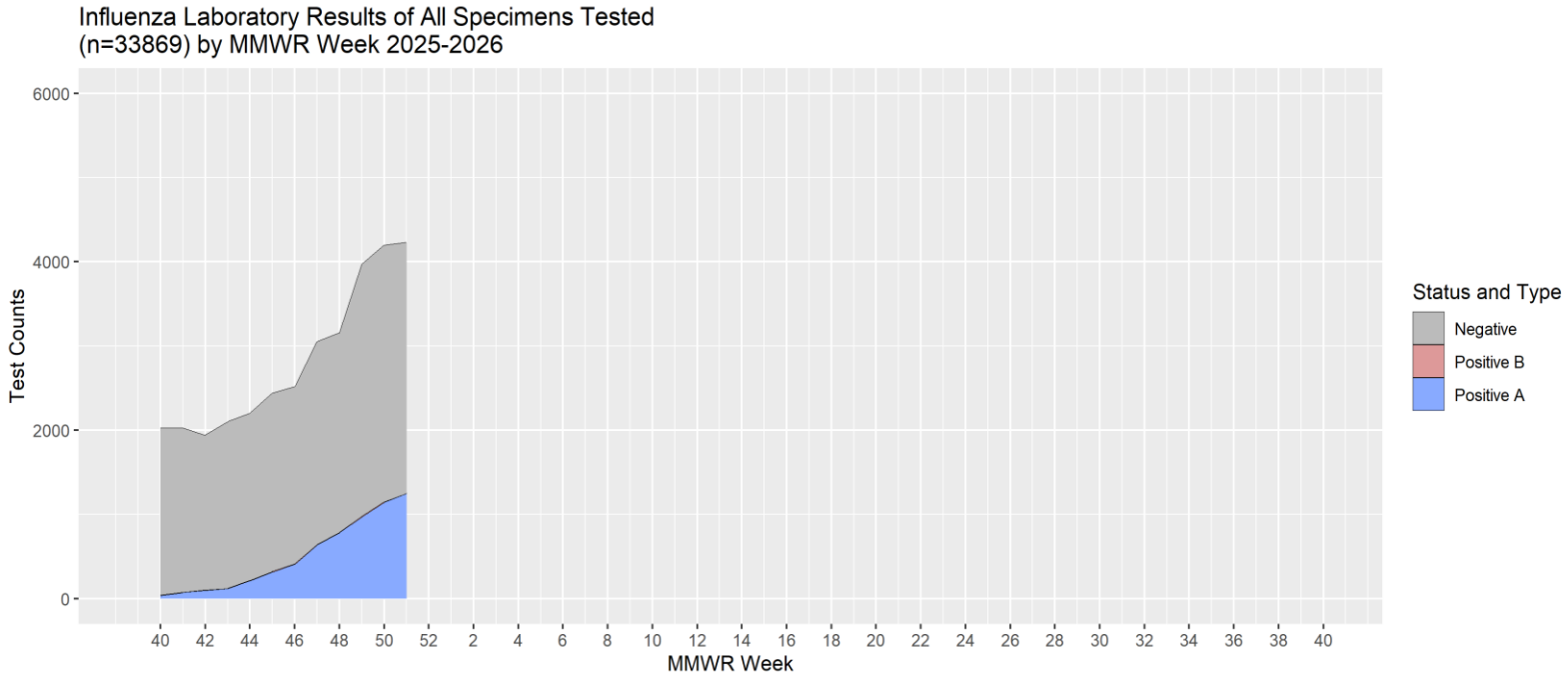
The charts below indicate the population-based rates of positive influenza cases in Hawaii by age group during the 2025–26 influenza season.[10]

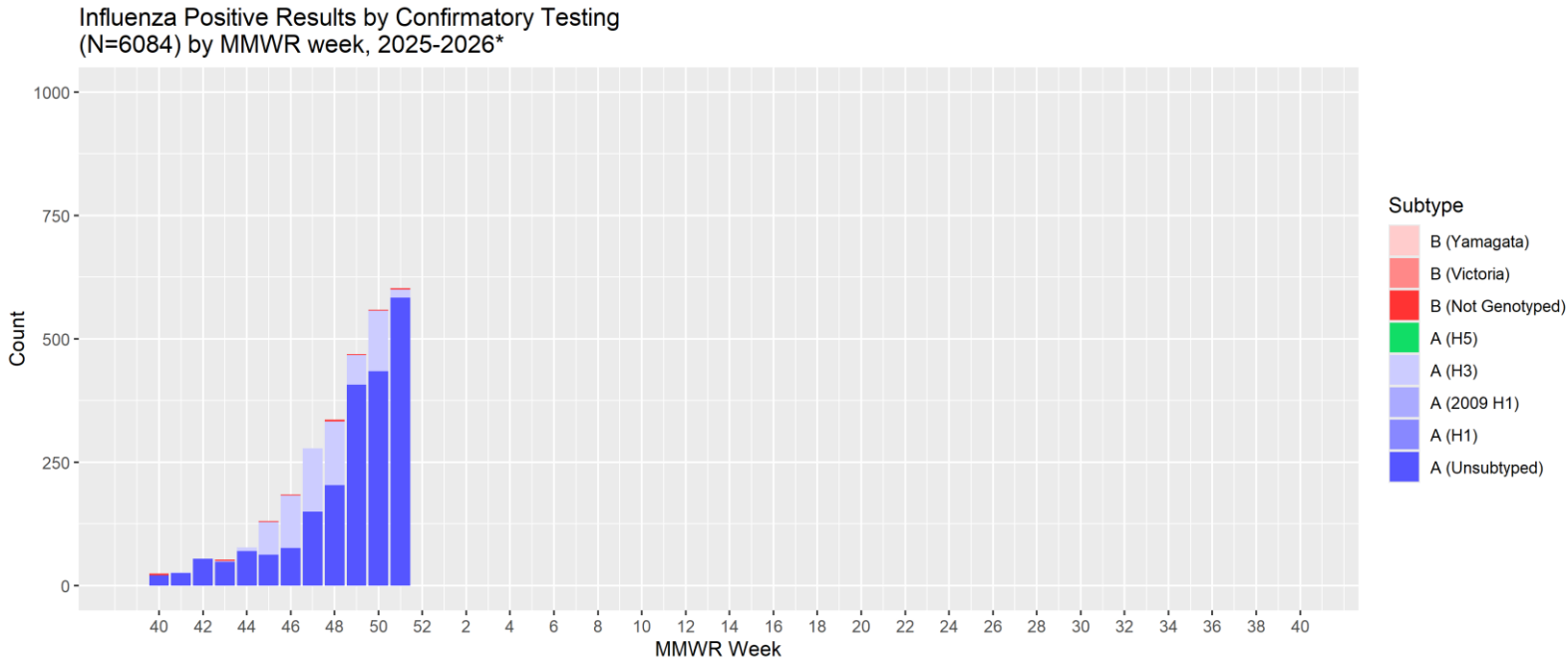


[7] Priority criteria include: hospitalized patients with acute respiratory distress syndrome [ARDS] or x-ray confirmed pneumonia; travelers with international travel history within 10 days of onset; specimens submitted by sentinel providers; specimens collected from healthcare workers, pregnant women, or women up to 6 weeks' post-partum; those with underlying medical conditions; and patients presenting with unusual or severe manifestations of influenza infection.
[8] Influenza coding were updated to reflect a more accurate count.
[9] All influenza A H1 viruses detected this season have been 2009 H1N1.
[10] This represents an estimate of population-based rates based on available data.

2. LABORATORY TESTING

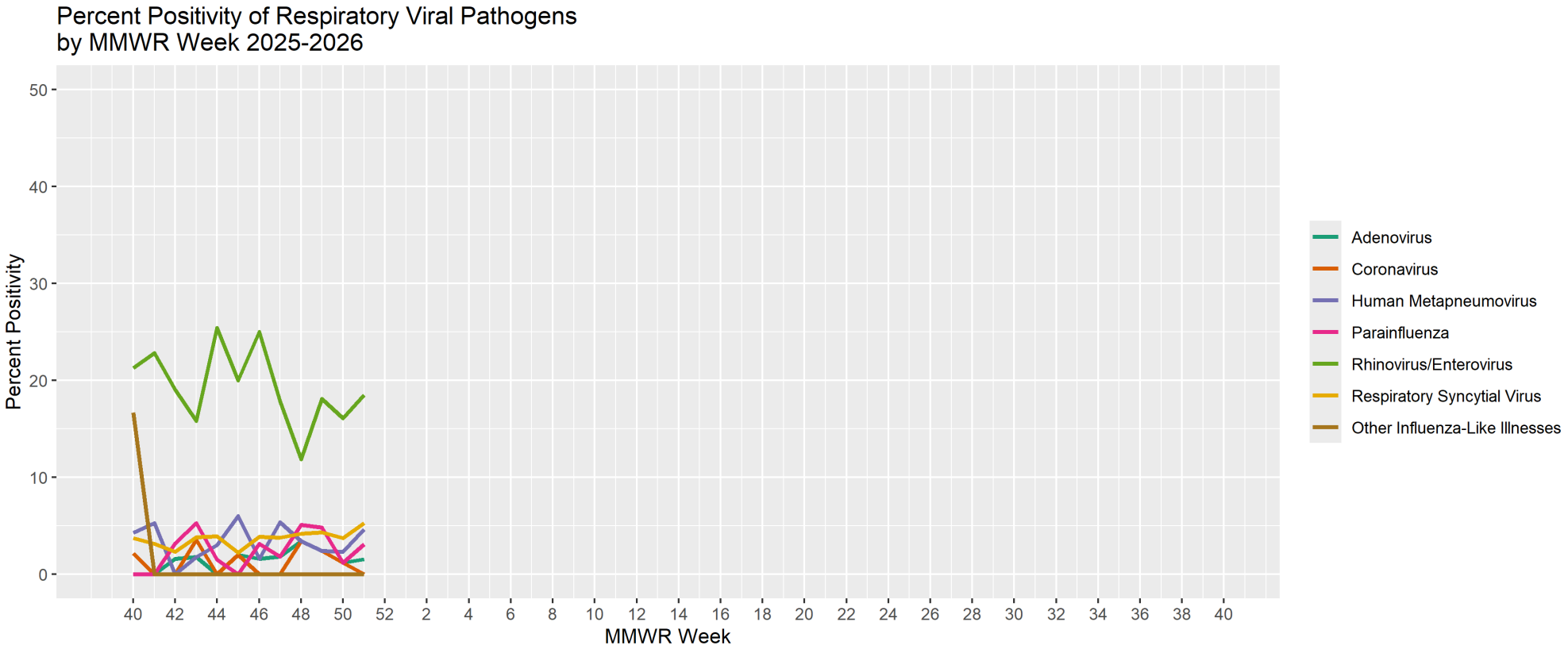
The charts below show the laboratory results of all specimens tested for influenza by MMWR week during the 2025–2026 influenza season as well as the type and subtype of positive results for influenza. Again, sub-typing is only performed on selected specimens tested by confirmatory tests (i.e., RT-PCR or viral culture).





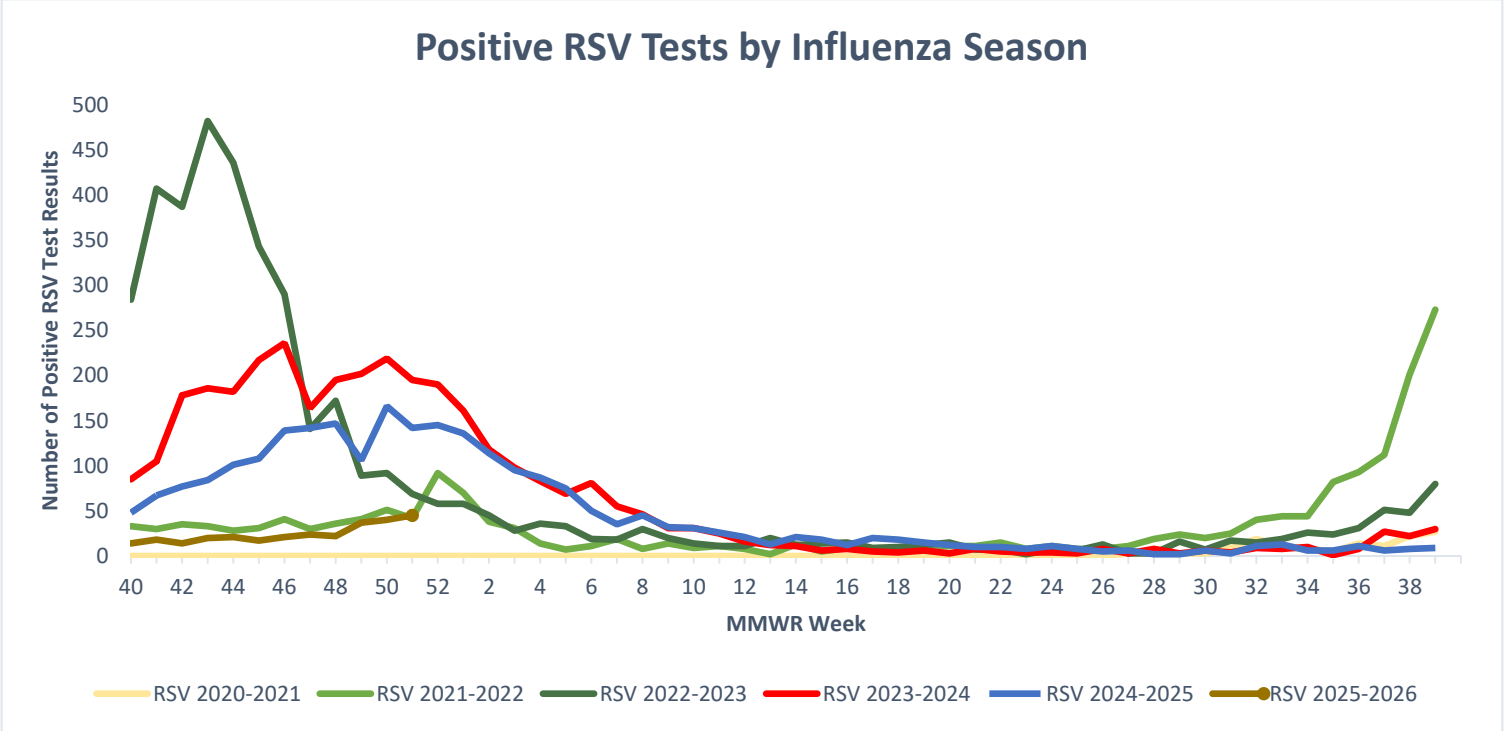
** A total of 17,812 specimens underwent confirmatory testing but not all positive influenza specimens receive confirmatory testing that are circulating in Hawaii.*

B. OTHER RESPIRATORY PATHOGENS: The major clinical and commercial laboratories throughout the state of Hawaii have the testing capacity for non-influenza respiratory pathogens and report these to HDOH. However, such testing is performed as needed and when sufficient resources are available because of the high costs associated with respiratory panel tests. **Therefore, available data represent only the presence of circulating pathogens and cannot be used to determine specific trends**.

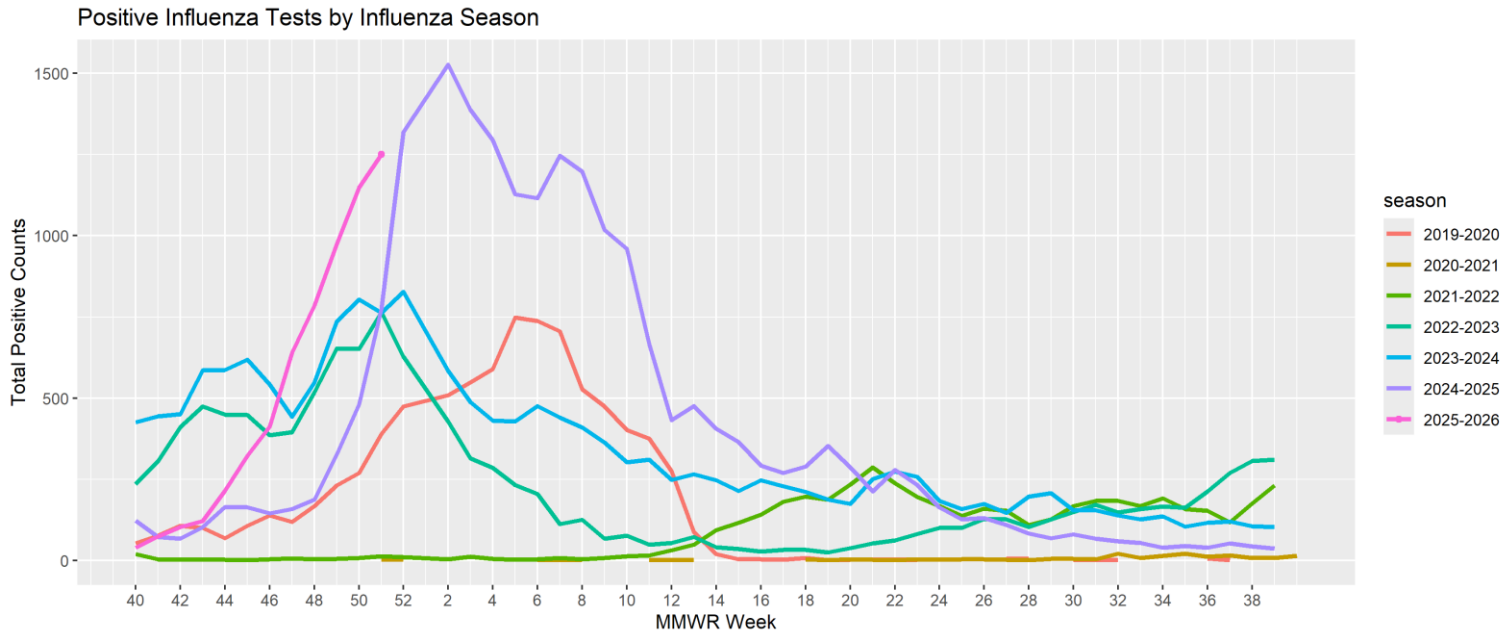


* *The coronavirus presented on this table does not indicate Severe Acute Respiratory Coronavirus-2 (i.e., COVID-19).*

RESPIRATORY SYNCYTIAL VIRUS (RSV) POSITIVE TEST RESULTS BY INFLUENZA SEASON: RSV case appears to have increased earlier than past seasons in the 2025-2026 season. Of note, significantly more tests for RSV are being performed than in pre-COVID-19 seasons.



INFLUENZA POSITIVE TEST RESULTS BY INFLUENZA SEASON: Influenza cases appear to have increased earlier than past seasons in the 2023-2024 season, but it is not yet known whether case numbers will reach a peak similar to pre-COVID-19 seasons.



C. COVID-19 SENTINEL SURVEILLANCE: Due to the low volume of samples currently available through the influenza surveillance system, the COVID-19 sentinel surveillance data may not be accurately portraying COVID-19 activity in our communities. Reporting of the COVID-19 Sentinel Surveillance data will be paused while HODH re-evaluates the program to ensure that the reported data are accurate and representative.

HDOH is continuing to monitor COVID-19 activity throughout the state. To learn more, please visit the Hawaii's COVID-19 data website (*here*). For more information on surveillance of COVID-19 activity in the United States please visit the CDC COVIDView website (*here*).

III. PNEUMONIA, INFLUENZA, AND COVID-19 (PIC) RELATED MORTALITY:

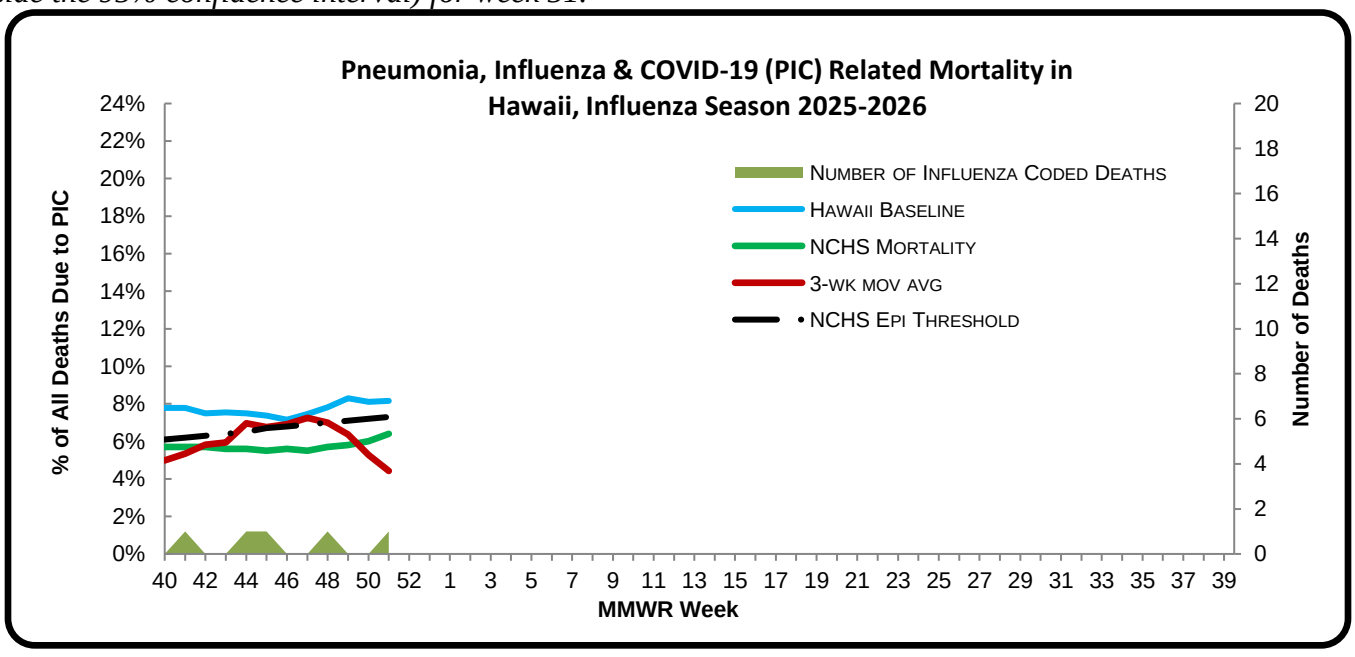
P&I mortality surveillance is collected by CDC through the National Center for Health Statistics (NCHS) using death certificate data. Each week the HDOH OHSM reports specific data from Honolulu to the CDC. CDC collects the following information by age group: the total number of deaths, total deaths from pneumonia, and total deaths related to influenza. Due to the ongoing COVID-19 pandemic, CDC included total deaths from COVID-19 by age group to the death data. Previous studies had suggested that P&I is a good indicator of influenza-related deaths; however, data has shown that pneumonia deaths associated with influenza is now being impacted by COVID-19 related pneumonia. Due to this, CDC had added COVID-19 deaths into P&I to create the PIC (pneumonia, influenza, and/or COVID-19) classification.

To standardize Hawaii's influenza surveillance with CDC influenza surveillance guidelines, PIC deaths will be reported in lieu of P&I. Hawaii's baseline will begin to include PIC deaths starting from 2019-2020 flu season.

For **week 51** of the current influenza season:

- ***3.5%*** *of all deaths that occurred in Hawaii during week 51 were related to pneumonia, influenza or COVID-19 (PIC)*[11]*. For the current season (season to date:* ***6.2%****), there have been 2,536 deaths from any cause, 157 of which were due to PIC*[12]*.*
- *The PIC rate was lower than the historical baseline in Hawaii*[13] *(i.e., outside the 95% confidence interval).*

The Hawaii PIC rate was comparable to the CDC's National Center for Health Statistics (NCHS) PIC mortality[14] *(**6.4%**) (i.e., outside the 95% confidence interval) and comparable to the national epidemic threshold (**7.3**%) (i.e., inside the 95% confidence interval) for week 51.*



[11] The percent of deaths due to PIC displayed on the graph is the 3-week moving averages.

[12] PIC data reflect 99.2% of the data reported for the MMWR week. Changes to data are expected when PIC data reaches 100% completion.

[13] The Hawaii historical baseline (%PIC) is the average of 3-week moving averages over the preceding 10 flu seasons of historical data (2014-2015, 2015-2016, 2016-2017, 2017-2018, 2018-2019, 2019-2020, 2020-2021, 2021-2022, 2022-2023, and 2023-2024).

[14] Each week, the vital statistics offices of 122 cities across the United States report the total number of death certificates processed and the number of those for which pneumonia, influenza, or COVID-19 was listed as the underlying or contributing cause of death by age group (Under 28 days, 28 days–1 year, 1–14 years, 15–24 years, 25–44 years, 45–64 years, 65–74 years, 75–84 years, and ≥85 years). The COVID-19 death counts reported by NCHS are provisional and will not match counts in other sources, such as media reports or numbers from health departments. COVID-19 deaths may be classified or defined differently in various reporting and surveillance systems. The percentage of deaths due to pneumonia, influenza, and COVID-19 (PIC) are compared with a seasonal baseline and epidemic threshold value calculated for each week.

INFLUENZA-ASSOCIATED PEDIATRIC DEATHS[15]:

- No new influenza-associated pediatric death was reported to Hawaii. There have been zero influenza-associated pediatric deaths reported in Hawaii during the 2025–2026 season.
- Nationally, five new influenza-associated pediatric deaths were reported to CDC during week 51. (2025-2026 season total: 8).

IV. INFLUENZA WATCH: As part of a comprehensive influenza surveillance system and to prevent the spread of contagious respiratory diseases in humans, it is important to monitor all circulating influenza types. Several animal-origin influenza A subtypes are currently of interest: influenza A variant virus (H3N2v, H1N2v, and H1N1v) and Avian flu (H5N1 and H7N9). These types of influenza viruses may cause zoonotic (animal-associated) disease and are a public health concern.

A. VARIANT VIRUSES:

Influenza viruses that normally circulate in pigs are called "variant" viruses when they are found in people. These viruses were first identified in U.S. pigs in 2010. In 2011, 12 cases of H3N2v infection were detected in the United States. In 2012, 309 such cases (resulting in 16 hospitalizations and one death) across 12 states were detected, including one Hawaii case who recovered. Illness associated with H3N2v infection has been mostly mild with symptoms similar to those of seasonal flu. However, serious illness, resulting in hospitalization and death, has occurred in some cases. Most of these infections have been associated with prolonged exposure to pigs at agricultural fairs or similar settings. Limited human-to-human spread of this virus has been detected in the past, but no sustained community spread of H3N2v has been identified. More information regarding H3N2v, H1N1v, and H1N2v viruses may be found on the CDC website (*here*) and (*here*).

- *No variant or novel influenza infections have been reported to HDOH during the 2025-2026 influenza season.*
- *No new human infection with novel influenza A virus, H1N1v (1), H3N2v (0), and H1N2v (0), have been reported during the 2025-2026 influenza season.*

AVIAN (OR BIRD) INFLUENZA: These types of influenza viruses cause zoonotic (animal-associated) disease of public health concern and are therefore monitored globally by the WHO. Most avian influenza viruses do not cause disease in humans and are generally not easily transmissible between person to person, but a few subtypes may cross the species barrier and cause disease in humans. Avian influenza viruses may be of various subtypes, including H5N1, H5N2, H5N8, H7N3, H7N7, H7N8, H7N9, and H9N2. On January 15th, 2016, the USDA and APHIS reported detection of HPAI H7N8 in a commercial turkey flock in Indiana. There have been no associated human infections. This is the first detection of HPAI H7N8 in wild bird surveillance in the United States. More information, the risk assessment and recommendations for HPAI H7N8 can be found (here). The WHO, CDC, and other public health agencies have also been monitoring influenza H7N9, which represents a public health concern because of its high pandemic potential. Although H7N9 has not been detected in the United States, it remains a global concern given continuing epidemics in endemic countries. Since 2013, a total of 1,568 laboratory-confirmed cases of human infection with H7N9 viruses, including at least 613 deaths, have been reported to WHO. More information on H7N9 virus infections can be found (here). For more information regarding avian influenza, please visit the CDC (*here*) or the WHO (*here*) websites. WHO reports total number of cases and deaths related to laboratory-confirmed avian influenza viruses and posts current avian influenza case counts (*here*), which were last updated on **November 5, 2025**.

[15] Influenza-associated deaths are considered pediatric in persons aged less than 18 years. It was made a nationally notifiable condition in October, 2004. All pediatric influenza-associated deaths are laboratory confirmed.

V. INFLUENZA Vaccine: Annual influenza vaccination is recommended for all persons aged 6 months and older and is the most effective way to reduce the risk of getting sick with seasonal flu and spreading it to others. Influenza vaccination can reduce illnesses, visits to the doctor, influenza-related hospitalizations, and missed work and school days. Influenza vaccines become available by the end of October. It takes at least two weeks after vaccination to confer immunity against influenza virus infection. More information regarding influenza vaccination can be found (*here*).

A. Composition of the 2025–2026 Influenza Vaccine**:**

The composition of the 2025–2026 influenza vaccine has been updated to better match circulating influenza viruses. The Advisory Committee on Immunization Practices (ACIP) has recommended that the 2025-2026 influenza trivalent vaccine contain an influenza A/Victoria/4897/2022 (H1N1) pdm09-like virus, influenza A/Croatia/10136RV/2023 (H3N2)-like virus, and influenza B/Austria/1359417/2021 (B/Victoria lineage)-like virus. United States cell culture–based inactivated (ccIIV4) and recombinant (RIV4) influenza vaccines will contain HA derived from an influenza A/Wisconsin/67/2022 (H1N1) pdm09-like virus, an A/District of Columbia/27/2023 (H3N2)-like virus, an influenza B/Austria/1359417/2021 (B/Victoria lineage)-like virus. These vaccine recommendations were based on several factors, including global influenza virologic and epidemiologic surveillance, genetic and antigenic characterization, human serology studies, antiviral susceptibility, and the availability of candidate influenza viruses.

APPENDIX 1: ADDITIONAL INFORMATION

For more information regarding local and national influenza surveillance programs, visit the following sites.

Centers for Disease Control and Prevention	General Influenza National ILI and P&I Data Vaccine Virus Selection CDC Web Tool for Respiratory Viruses
Flu.gov	General Influenza Information
HDOH Flu and Pneumonia	General Influenza Surveillance Avian Influenza Respiratory Virus Dashboard To find out more information or join the sentinel physician program, email the Influenza Surveillance Coordinator
World Health Organization	General Global and Local Influenza Avian Influenza

APPENDIX 2: MMWR WEEK DATES

Please refer to the table below to interpret data presented by MMWR week. Week 40 is considered the traditional start for the flu season for the Northern Hemisphere.

MMWR WEEK	2022	2023	2024	2025	2026
1	1/8/2022	1/7/2023	1/6/2024	1/4/2025	1/10/2026
2	1/15/2022	1/14/2023	1/13/2024	1/11/2025	1/17/2026
3	1/22/2022	1/21/2023	1/20/2024	1/18/2025	1/24/2026
4	1/29/2022	1/28/2023	1/27/2024	1/25/2025	1/31/2026
5	2/5/2022	2/4/2023	2/3/2024	2/1/2025	2/7/2026
6	2/12/2022	2/11/2023	2/10/2024	2/8/2025	2/14/2026
7	2/19/2022	2/18/2023	2/17/2024	2/15/2025	2/21/2026
8	2/26/2022	2/25/2023	2/24/2024	2/22/2025	2/28/2026
9	3/5/2022	3/4/2023	3/2/2024	3/1/2025	3/7/2026
10	3/12/2022	3/11/2023	3/9/2024	3/8/2025	3/14/2026
11	3/19/2022	3/18/2023	3/16/2024	3/15/2025	3/21/2026
12	3/26/2022	3/25/2023	3/23/2024	3/22/2025	3/28/2026
13	4/2/2022	4/1/2023	3/30/2024	3/29/2025	4/4/2026
14	4/9/2022	4/8/2023	4/6/2024	4/5/2025	4/11/2026
15	4/16/2022	4/15/2023	4/13/2024	4/12/2025	4/18/2026
16	4/23/2022	4/22/2023	4/20/2024	4/19/2025	4/25/2026
17	4/30/2022	4/29/2023	4/27/2024	4/26/2025	5/2/2026
18	5/7/2022	5/6/2023	5/4/2024	5/3/2025	5/9/2026
19	5/14/2022	5/13/2023	5/11/2024	5/10/2025	5/16/2026
20	5/21/2022	5/20/2023	5/18/2024	5/17/2025	5/23/2026
21	5/28/2022	5/27/2023	5/25/2024	5/24/2025	5/30/2026
22	6/4/2022	6/3/2023	6/1/2024	5/31/2025	6/6/2026
23	6/11/2022	6/10/2023	6/8/2024	6/7/2025	6/13/2026
24	6/18/2022	6/17/2023	6/15/2024	6/14/2025	6/20/2026
25	6/25/2022	6/24/2023	6/22/2024	6/21/2025	6/27/2026
26	7/2/2022	7/1/2023	6/29/2024	6/28/2025	7/4/2026
27	7/9/2022	7/8/2023	7/6/2024	7/5/2025	7/11/2026
28	7/16/2022	7/15/2023	7/13/2024	7/12/2025	7/18/2026
29	7/23/2022	7/22/2023	7/20/2024	7/19/2025	7/25/2026
30	7/30/2022	7/29/2023	7/27/2024	7/26/2025	8/1/2026
31	8/6/2022	8/5/2023	8/3/2024	8/2/2025	8/8/2026
32	8/13/2022	8/12/2023	8/10/2024	8/9/2025	8/15/2026
33	8/20/2022	8/19/2023	8/17/2024	8/16/2025	8/22/2026
34	8/27/2022	8/26/2023	8/24/2024	8/23/2025	8/29/2026
35	9/3/2022	9/2/2023	8/31/2024	8/30/2025	9/5/2026
36	9/10/2022	9/9/2023	9/7/2024	9/6/2025	9/12/2026
37	9/17/2022	9/16/2023	9/14/2024	9/13/2025	9/19/2026
38	9/24/2022	9/23/2023	9/21/2024	9/20/2025	9/26/2026
39	10/1/2022	9/30/2023	9/28/2024	9/27/2025	10/3/2026
40	10/8/2022	10/7/2023	10/5/2024	10/4/2025	10/10/2026
41	10/15/2022	10/14/2023	10/12/2024	10/11/2025	10/17/2026
42	10/22/2022	10/21/2023	10/19/2024	10/18/2025	10/24/2026
43	10/29/2022	10/28/2023	10/26/2024	10/25/2025	10/31/2026
44	11/5/2022	11/4/2023	11/2/2024	11/1/2025	11/7/2026
45	11/12/2022	11/11/2023	11/9/2024	11/8/2025	11/14/2026
46	11/19/2022	11/18/2023	11/16/2024	11/15/2025	11/21/2026
47	11/26/2022	11/25/2023	11/23/2024	11/22/2025	11/28/2026
48	12/3/2022	12/2/2023	11/30/2024	11/29/2025	12/5/2026
49	12/10/2022	12/9/2023	12/7/2024	12/6/2025	12/12/2026
50	12/17/2022	12/16/2023	12/14/2024	12/13/2025	12/19/2026
51	12/24/2022	12/23/2023	12/21/2024	12/20/2025	12/26/2026
52	12/31/2022	12/30/2023	12/28/2024	12/27/2025	
53				01/03/2026	

HAWAII STATE DEPARTMENT OF HEALTH
DISEASE OUTBREAK CONTROL DIVISION

Influenza/Respiratory Disease Surveillance Report

Morbidity and Mortality Weekly Report (MMWR)[1]

WEEK 52: DECEMBER 21, 2025– DECEMBER 27, 2025

OVERVIEW: The Hawaii State Department of Health (HDOH) monitors influenza and other respiratory pathogens, including COVID-19, throughout the state of Hawaii. Influenza surveillance in the state of Hawaii relies upon selected sentinel health practitioners, the State Laboratories Division (SLD), private laboratories, and the Office of Health Status Monitoring (OHSM). For detailed information concerning influenza, please visit the HDOH Disease Outbreak Control Division (HDOH DOCD) website (*here*). **All data and information are conditional and may change as more reports are received.** The data in this report reflect the 2025-2026 influenza season which began the week ending October 4, 2025 (week 40[1] 2025) and will end the week ending on October 3, 2026 (week 39 2026).

REPORT SNAPSHOT FOR WEEK 52

Surveillance for Influenza-like Illness (ILI)		
Metric	*Value*	*Comment*
Outpatient visits related to influenza-like illness (ILI) from ILINet Sentinel Providers	6.3%	Higher than the previous week. Comparable to the Hawaii's historical baseline and higher than the national baseline, and lower than the national ILI rate.
Number of ILI clusters reported to HDOH	1	There have been 14 clusters this season.

Laboratory Surveillance		
Percent of all respiratory specimens positive for influenza this week	37.1%	Higher than the previous week. This number means that many, if not all, of the 62.9% who tested negative for influenza had illness from another respiratory etiology.
Percent of all respiratory specimens positive for influenza this season to date	20.2%	

Surveillance for Severe Outcomes		
Pneumonia, influenza and COVID-19 (PIC) mortality rate	0.0%	Lower than to the Hawaii's historical baseline, lower than the national epidemic threshold and lower than the NCHS average.
Number of influenza-associated pediatric deaths reported nationwide	9	0 influenza-associated pediatric deaths have been reported from Hawaii this season to date.

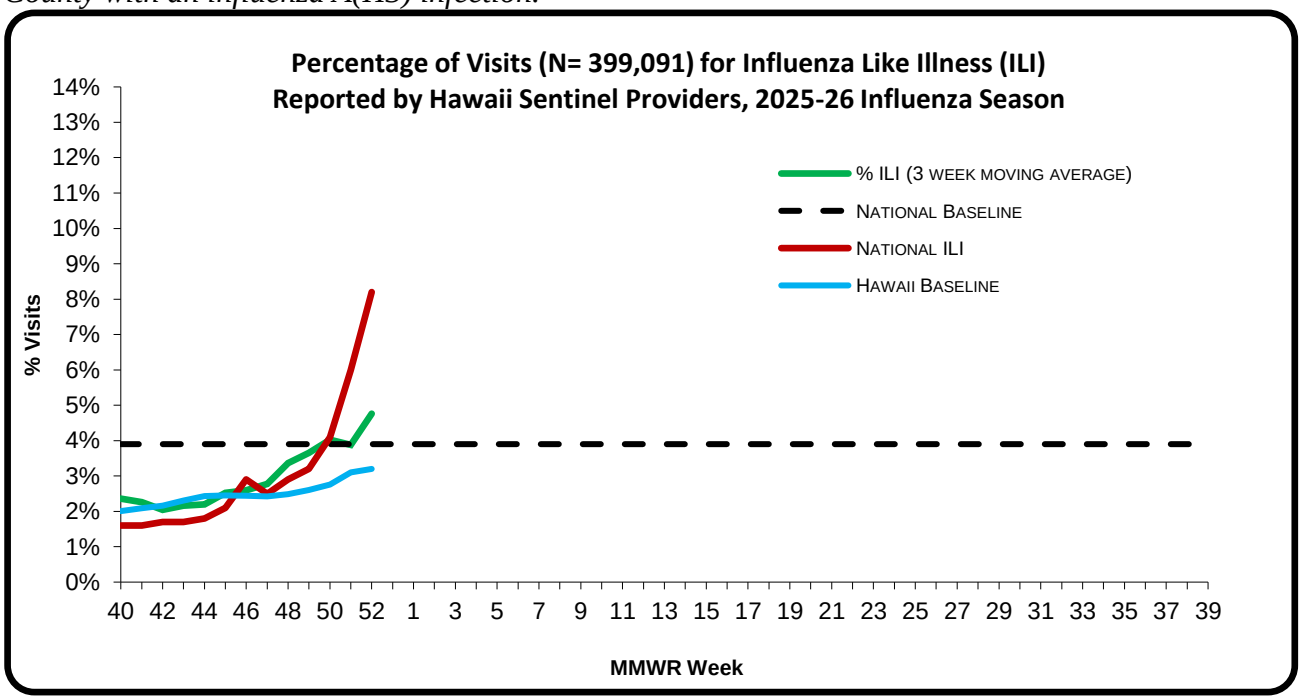
[1] MMWR stands for "Morbidity and Mortality Weekly Report," conventionally used by the Centers for Disease Control and Prevention (CDC). The weeks of a flu season are often referred to by their respective MMWR week. **See appendix 2 for interpretation of MMWR weeks.** Data reported will begin on week 40, the traditional start date of flu season.

INFLUENZA SURVEILLANCE

I. INFLUENZA-LIKE ILLNESS (ILI): HDOH collaborates with recruited doctors and healthcare providers who report the total number of outpatient visits for ILI as well as the total number of patients who complained of symptoms consistent with an ILI. A patient with ILI must have the following: a fever (temperature of 100°F [37.8°C] or greater) AND a cough and/or a sore throat. ILI is based on reported symptoms and not laboratory confirmed tests; thus, ILI may represent other respiratory pathogens and not solely influenza. Further, sentinel providers report these numbers on a weekly basis; therefore, data are preliminary and may change depending on additional reporting. In combination with laboratory testing and other surveillance systems, ILI surveillance helps monitor influenza and other respiratory pathogen activity. For more information concerning ILINet and sentinel requirements, please visit the CDC website (*here*).

For **week 52** of the current influenza season:

- ***6.3**% (season to date: **3.1**%) of the outpatient visits recorded by Hawaii sentinel providers were for ILI.*
- *ILI visits were comparable to the historical baseline in Hawaii[2,3] (i.e., inside the 95% confidence interval).*
- *Hawaii's ILI outpatient visits were higher than the national baseline (**3.9%**)[4] (i.e., inside the 95% confidence interval) and lower than the national ILI rate (**8.2%**) (i.e. outside the 95% confidence interval).*
- *ILI activity level: Low[5]*
- *Geographic Spread: Sporadic Activity[6].*
- *ILI Cluster Activity: One new cluster was reported to HDOH during week 52. Cluster was located in Honolulu County with an influenza A(H3) infection.*



[2] The Hawaii historical baseline (%ILI) is the average of 3-week moving averages over the preceding 10 flu seasons of historical data (2015-2016, 2016-2017, 2017-2018, 2018-2019, 2019-2020, 2020-2021, 2021-2022, 2022-2023, 2023-2024 and 2024-2025).

[3] This value is based upon comparison of actual outpatient ILI with the historical baseline, which only captures outpatient ILI. The chart above represents a 3-week moving average and not the actual ILI by week.

[4] The National Baseline is calculated by CDC as the mean percentage of visits for ILI during weeks 21–39 with two standard deviations. Because of large variability in regional ILI, comparison of the national baseline with local ILI may not be appropriate. It is provided in this report because no meaningful regional baselines are available for comparison. The national baseline combines all data reported by states to CDC, including ILI in outpatient, ER, urgent care, and inpatient settings.

[5] There are 10 activity levels classified as minimal (levels 1-3), low (levels 4-5), moderate (levels 6-7), and high (levels 8-10).

[6] The influenza activity reported by state and territorial epidemiologists indicates geographic spread of influenza viruses but does not measure the severity of influenza activity. Sporadic: no clusters reported to HDOH, Local: one or more clusters reported in one county, Regional: clusters reported two to three counties, Widespread: clusters reported in all counties. Hawaii does not report No Activity, as flu circulates year-round in Hawaii.

II. LABORATORY SURVEILLANCE: State Laboratories Division (SLD; the HDOH public health laboratory) and Hawaii's major private laboratories (DLS, CLH) report results of RT-PCR, which can be considered confirmatory (SLD may perform viral culture on select specimens). Specimens meeting priority criteria[7] are forwarded to SLD for sub-typing. Additionally, specimens meeting case definition from requesting sentinel providers are sent directly to SLD for sub-typing. Due to resource constraints, not all submitted specimens undergo sub-typing. Sub-typing at the commercial laboratories is only conducted on a case-by-case basis. The majority of specimens testing positive by rapid antigen testing or RT-PCR at the commercial laboratories do not meet criteria and are not subtyped. For more information on influenza tests and types, please visit the CDC website (*here*).

A. INFLUENZA:

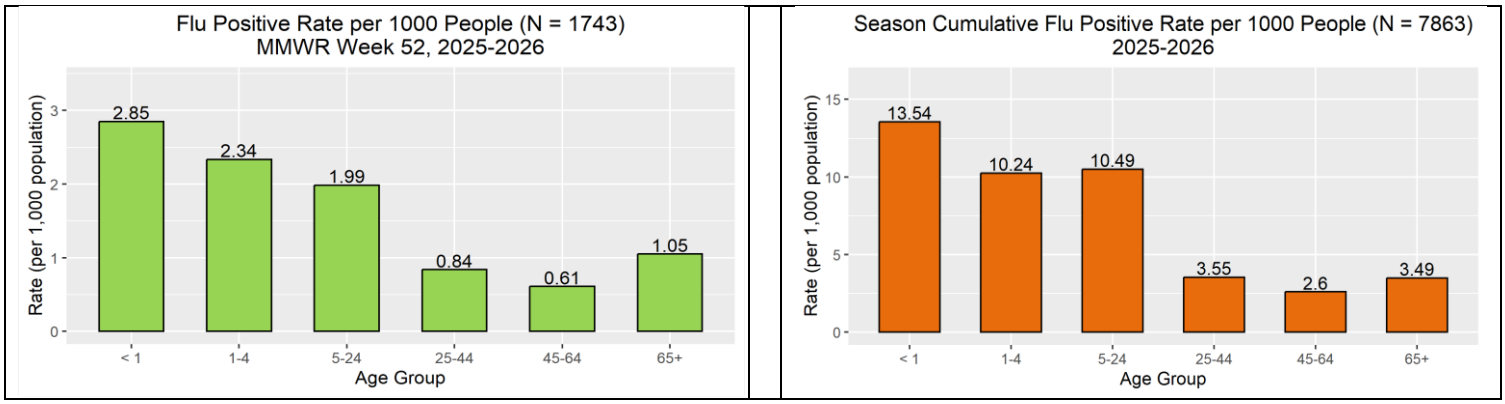
- The following reflects laboratory findings for week 52 of the 2025–26 influenza season:
  - *A total of **4,692** specimens have been tested statewide for influenza viruses (positive: 1,743 [**37.1%**]). (Season to date: **38,598** tested (**20.2%** positive)*
    - *2,098 (44.7%) were screened only by rapid antigen tests with no confirmatory testing.*
    - *2,594 (55.3%) underwent confirmatory testing (either RT-PCR or viral culture).*
    - *2,949 (62.9%) were negative.*
  - *Routine surveillance samples from State Laboratory Division were tested at a public health laboratory and identified as Influenza A (H3N2) subclade K.*

Influenza type	*Current week 52 (%)**	*Season to date (%)*[8]
Influenza A (H1)[9]	*2 (0.1)*	*65 (0.8)*
Influenza A (H3)	*12 (0.7)*	*657 (8.4)*
Influenza A no subtyping	*1,718 (98.5)*	*7,000 (89.7)*
Influenza B (Yamagata)	*0 (0.0)*	*0 (0.0)*
Influenza B (Victoria)	*0 (0.0)*	*0 (0.0)*
Influenza B no genotyping	*13 (0.7)*	*82 (1.1)*

**Specimens that are positive for both A and B (coinfections) are counted in both A and B totals for current and season to date*

1. AGE DISTRIBUTION

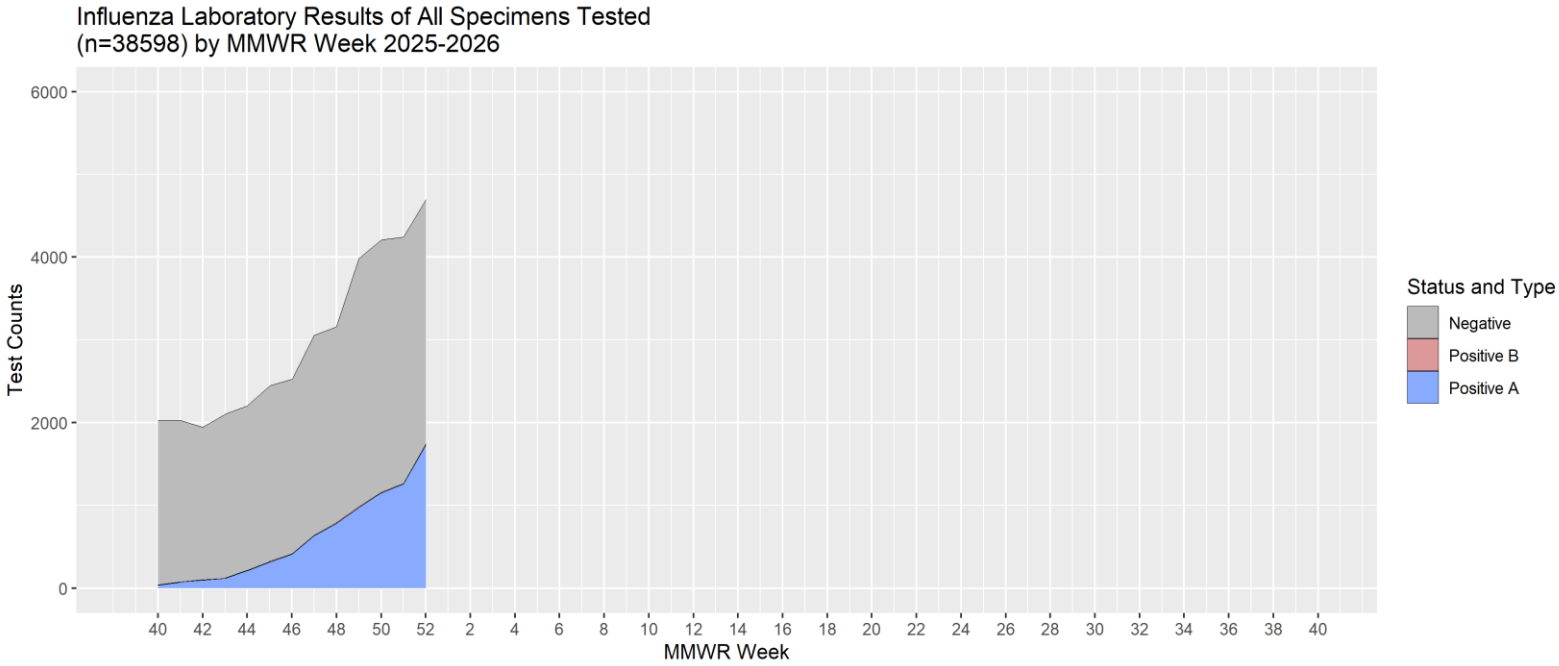
The charts below indicate the population-based rates of positive influenza cases in Hawaii by age group during the 2025–26 influenza season.[10]

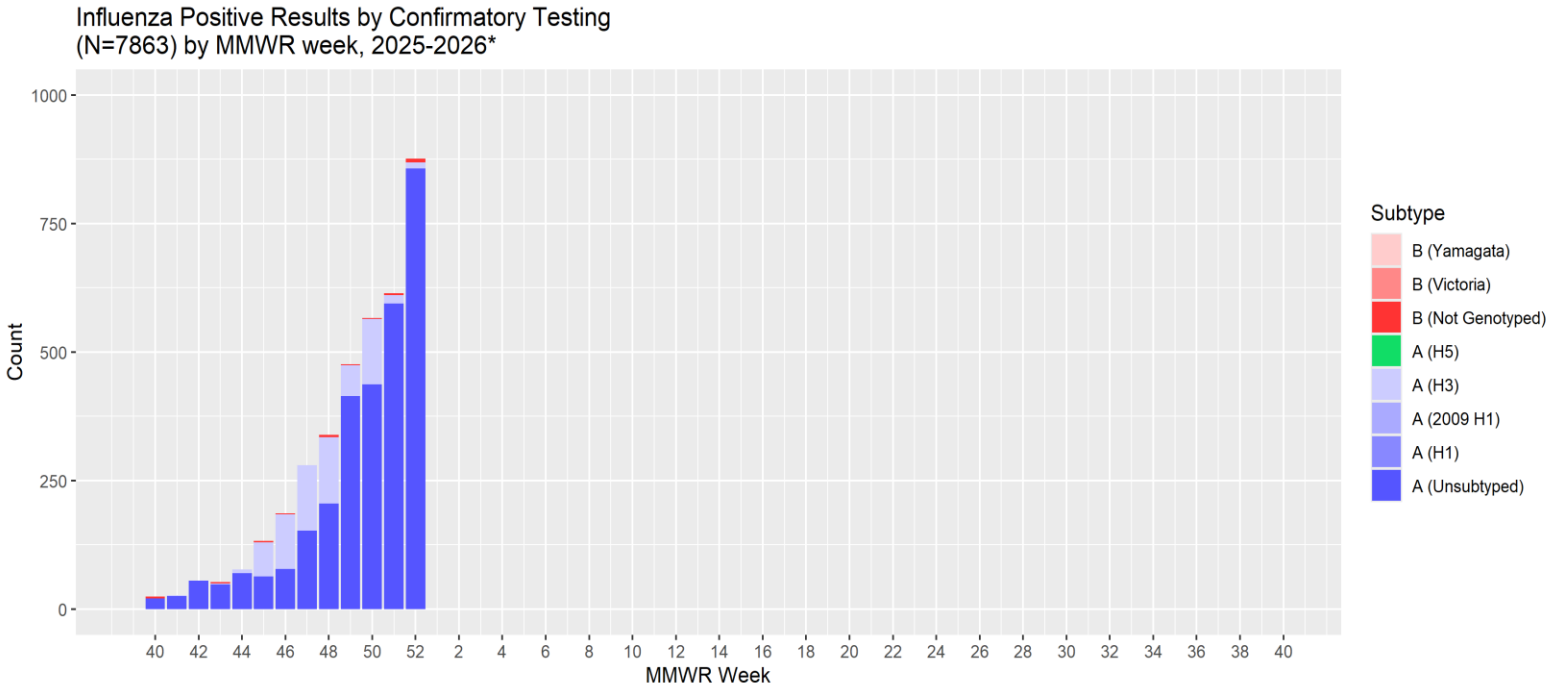


[7] Priority criteria include: hospitalized patients with acute respiratory distress syndrome [ARDS] or x-ray confirmed pneumonia; travelers with international travel history within 10 days of onset; specimens submitted by sentinel providers; specimens collected from healthcare workers, pregnant women, or women up to 6 weeks' post-partum; those with underlying medical conditions; and patients presenting with unusual or severe manifestations of influenza infection.
[8] Influenza coding were updated to reflect a more accurate count.
[9] All influenza A H1 viruses detected this season have been 2009 H1N1.
[10] This represents an estimate of population-based rates based on available data.

2. LABORATORY TESTING

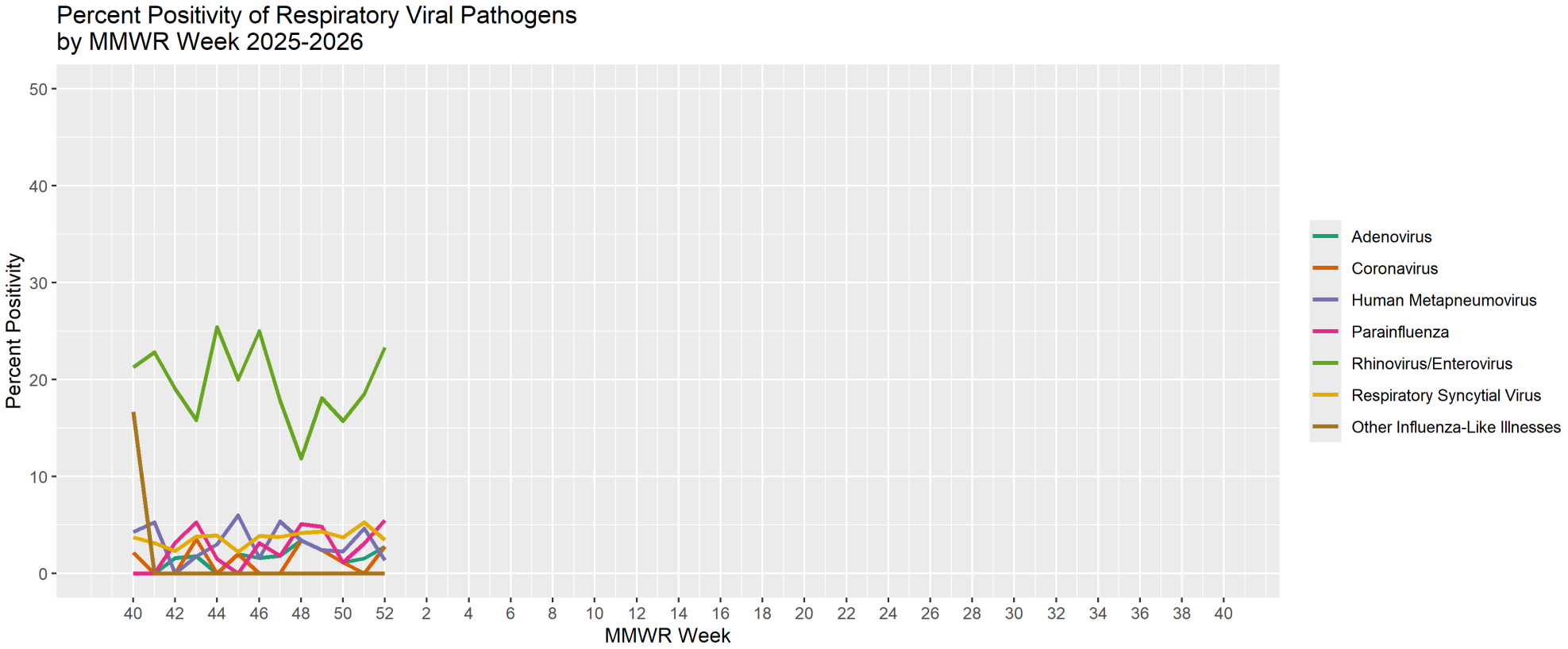
The charts below show the laboratory results of all specimens tested for influenza by MMWR week during the 2025–2026 influenza season as well as the type and subtype of positive results for influenza. Again, sub-typing is only performed on selected specimens tested by confirmatory tests (i.e., RT-PCR or viral culture).





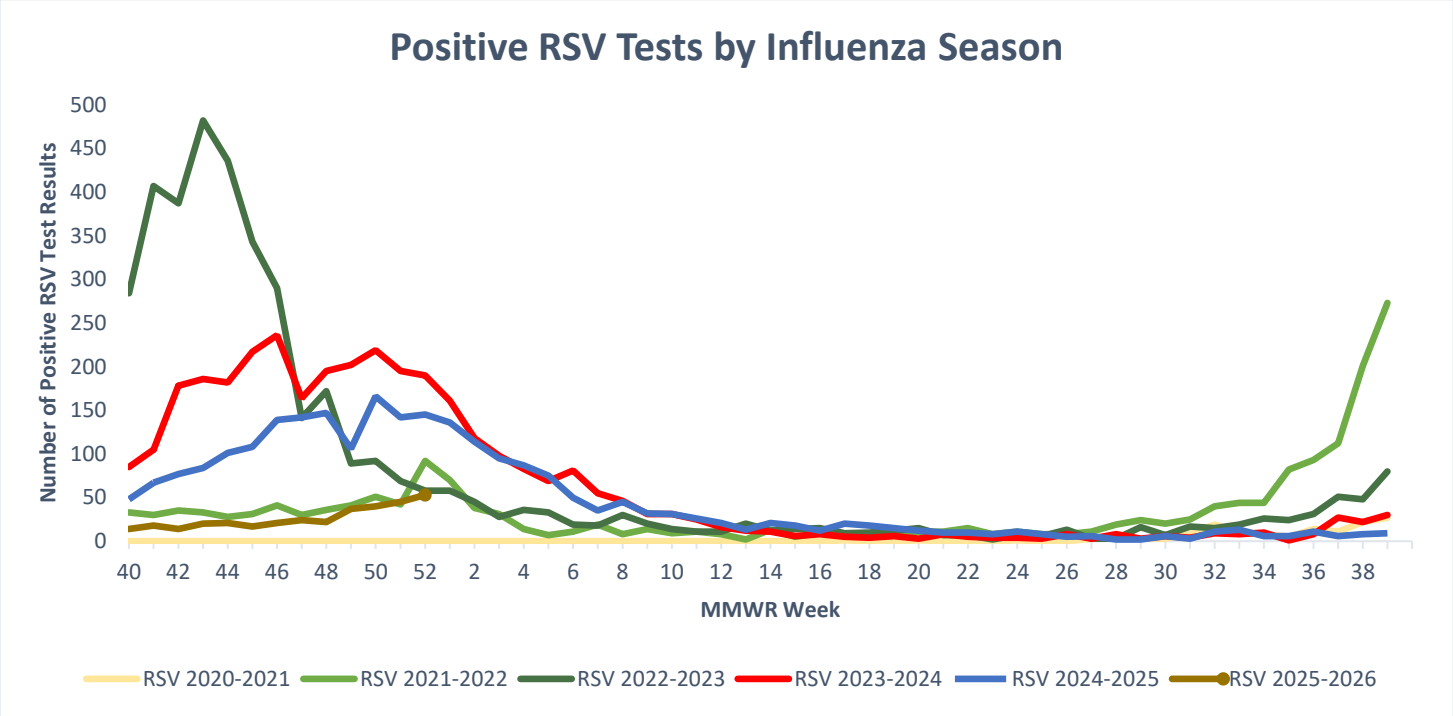
** A total of 20,443 specimens underwent confirmatory testing but not all positive influenza specimens receive confirmatory testing that are circulating in Hawaii.*

B. OTHER RESPIRATORY PATHOGENS: The major clinical and commercial laboratories throughout the state of Hawaii have the testing capacity for non-influenza respiratory pathogens and report these to HDOH. However, such testing is performed as needed and when sufficient resources are available because of the high costs associated with respiratory panel tests. **Therefore, available data represent only the presence of circulating pathogens and cannot be used to determine specific trends**.

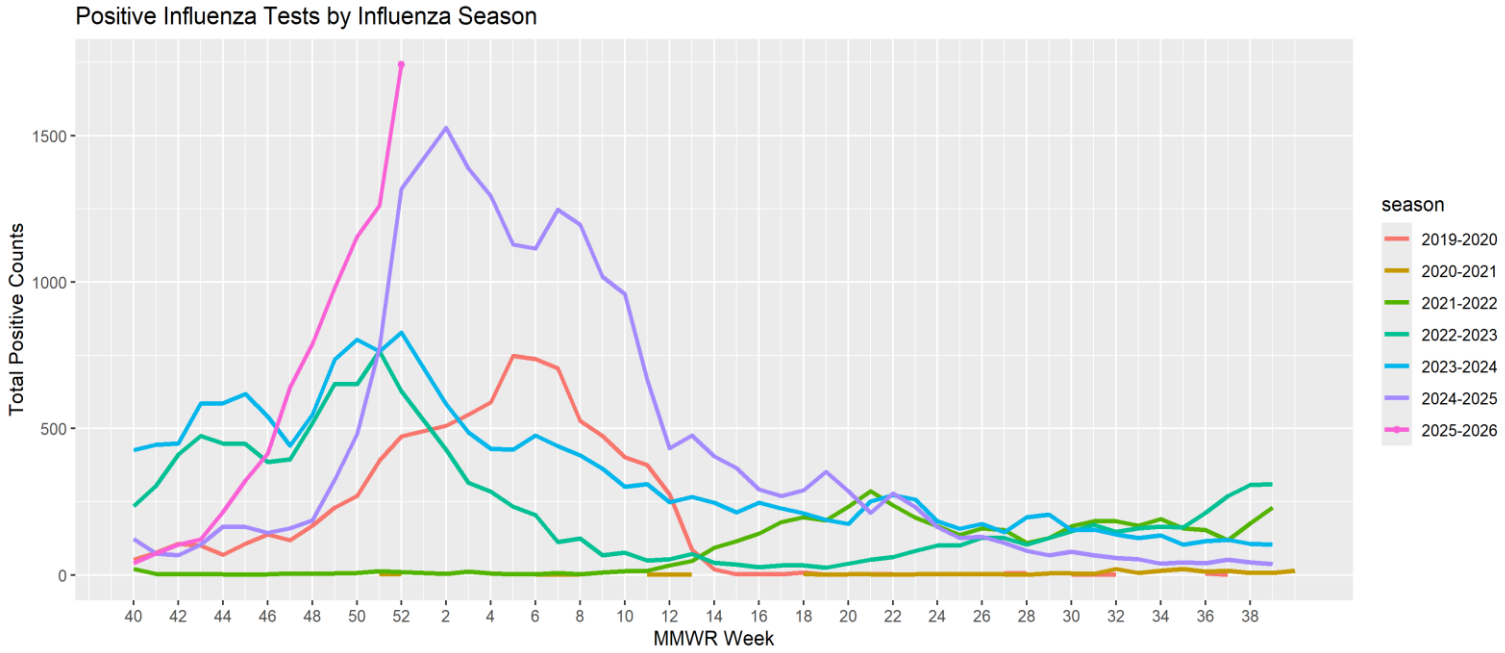


* *The coronavirus presented on this table does not indicate Severe Acute Respiratory Coronavirus-2 (i.e., COVID-19).*

RESPIRATORY SYNCYTIAL VIRUS (RSV) POSITIVE TEST RESULTS BY INFLUENZA SEASON: RSV case appears to have increased earlier than past seasons in the 2025-2026 season. Of note, significantly more tests for RSV are being performed than in pre-COVID-19 seasons.



INFLUENZA POSITIVE TEST RESULTS BY INFLUENZA SEASON: Influenza cases appear to have increased earlier than past seasons in the 2025-2026 season.



C. COVID-19 SENTINEL SURVEILLANCE: Due to the low volume of samples currently available through the influenza surveillance system, the COVID-19 sentinel surveillance data may not be accurately portraying COVID-19 activity in our communities. Reporting of the COVID-19 Sentinel Surveillance data will be paused while HODH re-evaluates the program to ensure that the reported data are accurate and representative.

HDOH is continuing to monitor COVID-19 activity throughout the state. To learn more, please visit the Hawaii's COVID-19 data website (*here*). For more information on surveillance of COVID-19 activity in the United States please visit the CDC COVIDView website (*here*).

III. PNEUMONIA, INFLUENZA, AND COVID-19 (PIC) RELATED MORTALITY:

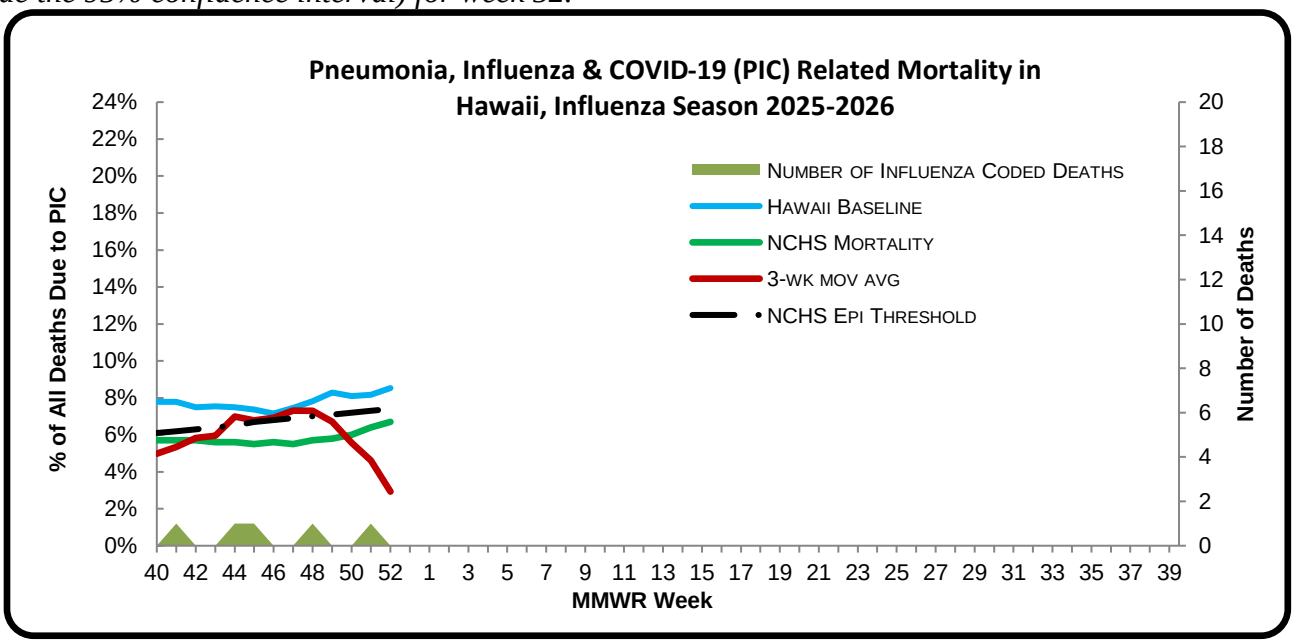
P&I mortality surveillance is collected by CDC through the National Center for Health Statistics (NCHS) using death certificate data. Each week the HDOH OHSM reports specific data from Honolulu to the CDC. CDC collects the following information by age group: the total number of deaths, total deaths from pneumonia, and total deaths related to influenza. Due to the ongoing COVID-19 pandemic, CDC included total deaths from COVID-19 by age group to the death data. Previous studies had suggested that P&I is a good indicator of influenza-related deaths; however, data has shown that pneumonia deaths associated with influenza is now being impacted by COVID-19 related pneumonia. Due to this, CDC had added COVID-19 deaths into P&I to create the PIC (pneumonia, influenza, and/or COVID-19) classification.

To standardize Hawaii's influenza surveillance with CDC influenza surveillance guidelines, PIC deaths will be reported in lieu of P&I. Hawaii's baseline will begin to include PIC deaths starting from 2019-2020 flu season.

For **week 52** of the current influenza season:

- ***0.0%*** *of all deaths that occurred in Hawaii during week 52 were related to pneumonia, influenza or COVID-19 (PIC)*[11]*. For the current season (season to date:* ***6.1%****), there have been 2,688 deaths from any cause, 165 of which were due to PIC*[12]*.*
- *The PIC rate was lower than the historical baseline in Hawaii*[13] *(i.e., outside the 95% confidence interval).*

The Hawaii PIC rate was lower than the CDC's National Center for Health Statistics (NCHS) PIC mortality[14] *(**6.7%**) (i.e., outside the 95% confidence interval) and lower than the national epidemic threshold (**7.4%**) (i.e., outside the 95% confidence interval) for week 52.*



[11] The percent of deaths due to PIC displayed on the graph is the 3-week moving averages.

[12] PIC data reflect 46.6% of the data reported for the MMWR week. Changes to data are expected when PIC data reaches 100% completion.

[13] The Hawaii historical baseline (%PIC) is the average of 3-week moving averages over the preceding 10 flu seasons of historical data (2014-2015, 2015-2016, 2016-2017, 2017-2018, 2018-2019, 2019-2020, 2020-2021, 2021-2022, 2022-2023, and 2023-2024).

[14] Each week, the vital statistics offices of 122 cities across the United States report the total number of death certificates processed and the number of those for which pneumonia, influenza, or COVID-19 was listed as the underlying or contributing cause of death by age group (Under 28 days, 28 days–1 year, 1–14 years, 15–24 years, 25–44 years, 45–64 years, 65–74 years, 75–84 years, and ≥85 years). The COVID-19 death counts reported by NCHS are provisional and will not match counts in other sources, such as media reports or numbers from health departments. COVID-19 deaths may be classified or defined differently in various reporting and surveillance systems. The percentage of deaths due to pneumonia, influenza, and COVID-19 (PIC) are compared with a seasonal baseline and epidemic threshold value calculated for each week.

INFLUENZA-ASSOCIATED PEDIATRIC DEATHS[15]:

- No new influenza-associated pediatric death was reported to Hawaii. There have been zero influenza-associated pediatric deaths reported in Hawaii during the 2025–2026 season.
- Nationally, two new influenza-associated pediatric deaths were reported to CDC during week 52. (2025-2026 season total: 9). One of the deaths occurred during the 2024-2025 season. (2024-2025 season total: 289).

IV. INFLUENZA WATCH: As part of a comprehensive influenza surveillance system and to prevent the spread of contagious respiratory diseases in humans, it is important to monitor all circulating influenza types. Several animal-origin influenza A subtypes are currently of interest: influenza A variant virus (H3N2v, H1N2v, and H1N1v) and Avian flu (H5N1 and H7N9). These types of influenza viruses may cause zoonotic (animal-associated) disease and are a public health concern.

A. VARIANT VIRUSES:

Influenza viruses that normally circulate in pigs are called "variant" viruses when they are found in people. These viruses were first identified in U.S. pigs in 2010. In 2011, 12 cases of H3N2v infection were detected in the United States. In 2012, 309 such cases (resulting in 16 hospitalizations and one death) across 12 states were detected, including one Hawaii case who recovered. Illness associated with H3N2v infection has been mostly mild with symptoms similar to those of seasonal flu. However, serious illness, resulting in hospitalization and death, has occurred in some cases. Most of these infections have been associated with prolonged exposure to pigs at agricultural fairs or similar settings. Limited human-to-human spread of this virus has been detected in the past, but no sustained community spread of H3N2v has been identified. More information regarding H3N2v, H1N1v, and H1N2v viruses may be found on the CDC website (*here*) and (*here*).

- *No variant or novel influenza infections have been reported to HDOH during the 2025-2026 influenza season.*
- *One new human infection with novel influenza A virus, H1N1v (0), H3N2v (0), and H1N2v (1), have been reported during the 2025-2026 influenza season.*
    - *One new human infection with influenza A(H1N1v) virus has been reported to WHO from China during the 2025-2026 influenza season.*

AVIAN (OR BIRD) INFLUENZA: These types of influenza viruses cause zoonotic (animal-associated) disease of public health concern and are therefore monitored globally by the WHO. Most avian influenza viruses do not cause disease in humans and are generally not easily transmissible between person to person, but a few subtypes may cross the species barrier and cause disease in humans. Avian influenza viruses may be of various subtypes, including H5N1, H5N2, H5N8, H7N3, H7N7, H7N8, H7N9, and H9N2. On January 15th, 2016, the USDA and APHIS reported detection of HPAI H7N8 in a commercial turkey flock in Indiana. There have been no associated human infections. This is the first detection of HPAI H7N8 in wild bird surveillance in the United States. More information, the risk assessment and recommendations for HPAI H7N8 can be found (here). The WHO, CDC, and other public health agencies have also been monitoring influenza H7N9, which represents a public health concern because of its high pandemic potential. Although H7N9 has not been detected in the United States, it remains a global concern given continuing epidemics in endemic countries. Since 2013, a total of 1,568 laboratory-confirmed cases of human infection with H7N9 viruses, including at least 613 deaths, have been reported to WHO. More information on H7N9 virus infections can be found (here). For more information regarding avian influenza, please visit the CDC (*here*) or the WHO (*here*) websites. WHO reports total number of cases and deaths related to laboratory-confirmed avian influenza viruses and posts current avian influenza case counts (*here*), which were last updated on **December 19, 2025**.

[15] Influenza-associated deaths are considered pediatric in persons aged less than 18 years. It was made a nationally notifiable condition in October, 2004. All pediatric influenza-associated deaths are laboratory confirmed.

V. INFLUENZA Vaccine: Annual influenza vaccination is recommended for all persons aged 6 months and older and is the most effective way to reduce the risk of getting sick with seasonal flu and spreading it to others. Influenza vaccination can reduce illnesses, visits to the doctor, influenza-related hospitalizations, and missed work and school days. Influenza vaccines become available by the end of October. It takes at least two weeks after vaccination to confer immunity against influenza virus infection. More information regarding influenza vaccination can be found (*here*).

A. Composition of the 2025–2026 Influenza Vaccine**:**

The composition of the 2025–2026 influenza vaccine has been updated to better match circulating influenza viruses. The Advisory Committee on Immunization Practices (ACIP) has recommended that the 2025-2026 influenza trivalent vaccine contain an influenza A/Victoria/4897/2022 (H1N1) pdm09-like virus, influenza A/Croatia/10136RV/2023 (H3N2)-like virus, and influenza B/Austria/1359417/2021 (B/Victoria lineage)-like virus. United States cell culture–based inactivated (ccIIV4) and recombinant (RIV4) influenza vaccines will contain HA derived from an influenza A/Wisconsin/67/2022 (H1N1) pdm09-like virus, an A/District of Columbia/27/2023 (H3N2)-like virus, an influenza B/Austria/1359417/2021 (B/Victoria lineage)-like virus. These vaccine recommendations were based on several factors, including global influenza virologic and epidemiologic surveillance, genetic and antigenic characterization, human serology studies, antiviral susceptibility, and the availability of candidate influenza viruses.

APPENDIX 1: ADDITIONAL INFORMATION

For more information regarding local and national influenza surveillance programs, visit the following sites.

Centers for Disease Control and Prevention	General Influenza National ILI and P&I Data Vaccine Virus Selection CDC Web Tool for Respiratory Viruses
Flu.gov	General Influenza Information
HDOH Flu and Pneumonia	General Influenza Surveillance Avian Influenza Respiratory Virus Dashboard To find out more information or join the sentinel physician program, email the Influenza Surveillance Coordinator
World Health Organization	General Global and Local Influenza Avian Influenza

APPENDIX 2: MMWR WEEK DATES

Please refer to the table below to interpret data presented by MMWR week. Week 40 is considered the traditional start for the flu season for the Northern Hemisphere.

MMWR WEEK	2022	2023	2024	2025	2026
1	1/8/2022	1/7/2023	1/6/2024	1/4/2025	1/10/2026
2	1/15/2022	1/14/2023	1/13/2024	1/11/2025	1/17/2026
3	1/22/2022	1/21/2023	1/20/2024	1/18/2025	1/24/2026
4	1/29/2022	1/28/2023	1/27/2024	1/25/2025	1/31/2026
5	2/5/2022	2/4/2023	2/3/2024	2/1/2025	2/7/2026
6	2/12/2022	2/11/2023	2/10/2024	2/8/2025	2/14/2026
7	2/19/2022	2/18/2023	2/17/2024	2/15/2025	2/21/2026
8	2/26/2022	2/25/2023	2/24/2024	2/22/2025	2/28/2026
9	3/5/2022	3/4/2023	3/2/2024	3/1/2025	3/7/2026
10	3/12/2022	3/11/2023	3/9/2024	3/8/2025	3/14/2026
11	3/19/2022	3/18/2023	3/16/2024	3/15/2025	3/21/2026
12	3/26/2022	3/25/2023	3/23/2024	3/22/2025	3/28/2026
13	4/2/2022	4/1/2023	3/30/2024	3/29/2025	4/4/2026
14	4/9/2022	4/8/2023	4/6/2024	4/5/2025	4/11/2026
15	4/16/2022	4/15/2023	4/13/2024	4/12/2025	4/18/2026
16	4/23/2022	4/22/2023	4/20/2024	4/19/2025	4/25/2026
17	4/30/2022	4/29/2023	4/27/2024	4/26/2025	5/2/2026
18	5/7/2022	5/6/2023	5/4/2024	5/3/2025	5/9/2026
19	5/14/2022	5/13/2023	5/11/2024	5/10/2025	5/16/2026
20	5/21/2022	5/20/2023	5/18/2024	5/17/2025	5/23/2026
21	5/28/2022	5/27/2023	5/25/2024	5/24/2025	5/30/2026
22	6/4/2022	6/3/2023	6/1/2024	5/31/2025	6/6/2026
23	6/11/2022	6/10/2023	6/8/2024	6/7/2025	6/13/2026
24	6/18/2022	6/17/2023	6/15/2024	6/14/2025	6/20/2026
25	6/25/2022	6/24/2023	6/22/2024	6/21/2025	6/27/2026
26	7/2/2022	7/1/2023	6/29/2024	6/28/2025	7/4/2026
27	7/9/2022	7/8/2023	7/6/2024	7/5/2025	7/11/2026
28	7/16/2022	7/15/2023	7/13/2024	7/12/2025	7/18/2026
29	7/23/2022	7/22/2023	7/20/2024	7/19/2025	7/25/2026
30	7/30/2022	7/29/2023	7/27/2024	7/26/2025	8/1/2026
31	8/6/2022	8/5/2023	8/3/2024	8/2/2025	8/8/2026
32	8/13/2022	8/12/2023	8/10/2024	8/9/2025	8/15/2026
33	8/20/2022	8/19/2023	8/17/2024	8/16/2025	8/22/2026
34	8/27/2022	8/26/2023	8/24/2024	8/23/2025	8/29/2026
35	9/3/2022	9/2/2023	8/31/2024	8/30/2025	9/5/2026
36	9/10/2022	9/9/2023	9/7/2024	9/6/2025	9/12/2026
37	9/17/2022	9/16/2023	9/14/2024	9/13/2025	9/19/2026
38	9/24/2022	9/23/2023	9/21/2024	9/20/2025	9/26/2026
39	10/1/2022	9/30/2023	9/28/2024	9/27/2025	10/3/2026
40	10/8/2022	10/7/2023	10/5/2024	10/4/2025	10/10/2026
41	10/15/2022	10/14/2023	10/12/2024	10/11/2025	10/17/2026
42	10/22/2022	10/21/2023	10/19/2024	10/18/2025	10/24/2026
43	10/29/2022	10/28/2023	10/26/2024	10/25/2025	10/31/2026
44	11/5/2022	11/4/2023	11/2/2024	11/1/2025	11/7/2026
45	11/12/2022	11/11/2023	11/9/2024	11/8/2025	11/14/2026
46	11/19/2022	11/18/2023	11/16/2024	11/15/2025	11/21/2026
47	11/26/2022	11/25/2023	11/23/2024	11/22/2025	11/28/2026
48	12/3/2022	12/2/2023	11/30/2024	11/29/2025	12/5/2026
49	12/10/2022	12/9/2023	12/7/2024	12/6/2025	12/12/2026
50	12/17/2022	12/16/2023	12/14/2024	12/13/2025	12/19/2026
51	12/24/2022	12/23/2023	12/21/2024	12/20/2025	12/26/2026
52	12/31/2022	12/30/2023	12/28/2024	12/27/2025	
53				01/03/2026	

HAWAII STATE DEPARTMENT OF HEALTH
DISEASE OUTBREAK CONTROL DIVISION

Influenza/Respiratory Disease Surveillance Report

Morbidity and Mortality Weekly Report (MMWR)[1]

WEEK 53: DECEMBER 28, 2025– JANUARY 3, 2026

OVERVIEW: The Hawaii State Department of Health (HDOH) monitors influenza and other respiratory pathogens, including COVID-19, throughout the state of Hawaii. Influenza surveillance in the state of Hawaii relies upon selected sentinel health practitioners, the State Laboratories Division (SLD), private laboratories, and the Office of Health Status Monitoring (OHSM). For detailed information concerning influenza, please visit the HDOH Disease Outbreak Control Division (HDOH DOCD) website (*here*). **All data and information are conditional and may change as more reports are received.** The data in this report reflect the 2025-2026 influenza season which began the week ending October 4, 2025 (week 40[1] 2025) and will end the week ending on October 3, 2026 (week 39 2026).

REPORT SNAPSHOT FOR WEEK 53

Surveillance for Influenza-like Illness (ILI)		
Metric	*Value*	*Comment*
Outpatient visits related to influenza-like illness (ILI) from ILINet Sentinel Providers	6.4%	Higher than the previous week. Higher than the Hawaii's historical baseline and higher than the national baseline, and lower than the national ILI rate.
Number of ILI clusters reported to HDOH	3	There have been 17 clusters this season.

Laboratory Surveillance		
Percent of all respiratory specimens positive for influenza this week	30.1%	Lower than the previous week. This number means that many, if not all, of the 69.9% who tested negative for influenza had illness from another respiratory etiology.
Percent of all respiratory specimens positive for influenza this season to date	21.3%	

Surveillance for Severe Outcomes		
Pneumonia, influenza and COVID-19 (PIC) mortality rate	6.8%	Comparable to the Hawaii's historical baseline, comparable to the national epidemic threshold and comparable to the NCHS average.
Number of influenza-associated pediatric deaths reported nationwide	17	0 influenza-associated pediatric deaths have been reported from Hawaii this season to date.

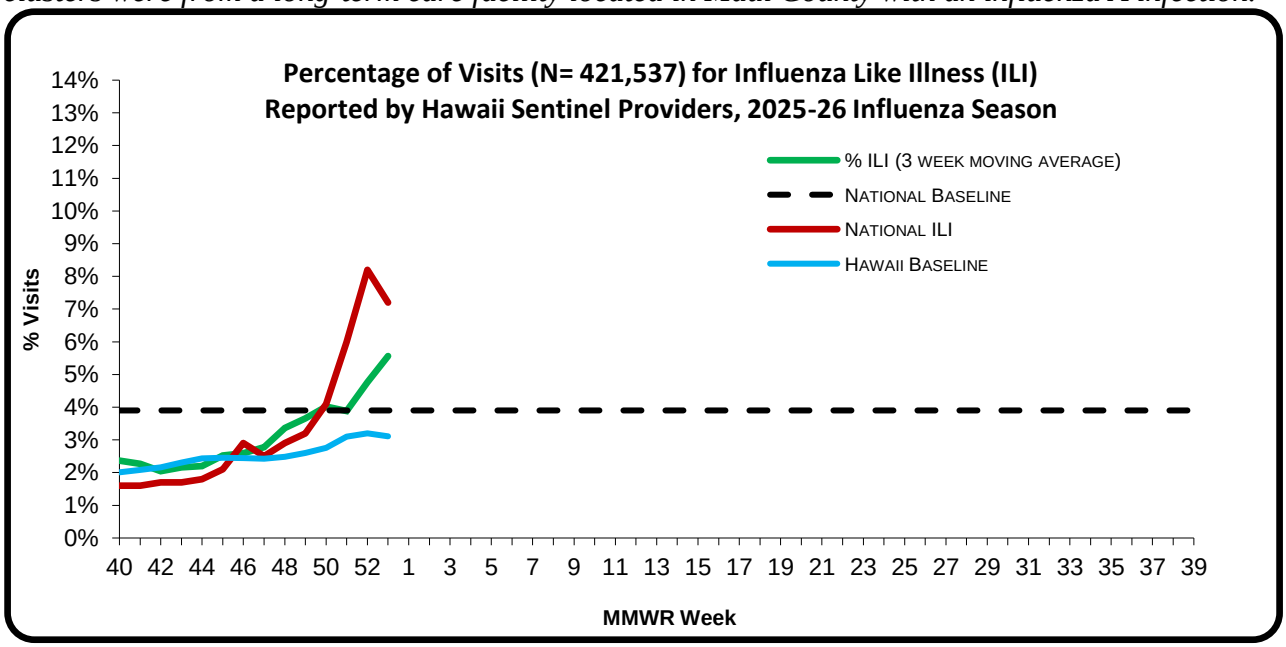
[1] MMWR stands for "Morbidity and Mortality Weekly Report," conventionally used by the Centers for Disease Control and Prevention (CDC). The weeks of a flu season are often referred to by their respective MMWR week. **See appendix 2 for interpretation of MMWR weeks.** Data reported will begin on week 40, the traditional start date of flu season.

INFLUENZA SURVEILLANCE

I. INFLUENZA-LIKE ILLNESS (ILI): HDOH collaborates with recruited doctors and healthcare providers who report the total number of outpatient visits for ILI as well as the total number of patients who complained of symptoms consistent with an ILI. A patient with ILI must have the following: a fever (temperature of 100°F [37.8°C] or greater) AND a cough and/or a sore throat. ILI is based on reported symptoms and not laboratory confirmed tests; thus, ILI may represent other respiratory pathogens and not solely influenza. Further, sentinel providers report these numbers on a weekly basis; therefore, data are preliminary and may change depending on additional reporting. In combination with laboratory testing and other surveillance systems, ILI surveillance helps monitor influenza and other respiratory pathogen activity. For more information concerning ILINet and sentinel requirements, please visit the CDC website (*here*).

For **week 53** of the current influenza season:

- ***6.4**% (season to date: **3.1**%) of the outpatient visits recorded by Hawaii sentinel providers were for ILI.*
- *ILI visits were higher than the historical baseline in Hawaii[2,3] (i.e., outside the 95% confidence interval).*
- *Hawaii's ILI outpatient visits were higher than the national baseline (**3.9%**)[4] (i.e., inside the 95% confidence interval) and lower than the national ILI rate (**7.2%**) (i.e. outside the 95% confidence interval).*
- *ILI activity level: Low[5]*
- *Geographic Spread: Sporadic Activity[6].*
- *ILI Cluster Activity: Three new clusters were reported to HDOH during week 53. Two of the clusters were from long term care facilities located in Honolulu County with an influenza A(H3) infection. One of the clusters were from a long-term care facility located in Maui County with an influenza A infection.*



[2] The Hawaii historical baseline (%ILI) is the average of 3-week moving averages over the preceding 10 flu seasons of historical data (2015-2016, 2016-2017, 2017-2018, 2018-2019, 2019-2020, 2020-2021, 2021-2022, 2022-2023, 2023-2024 and 2024-2025).

[3] This value is based upon comparison of actual outpatient ILI with the historical baseline, which only captures outpatient ILI. The chart above represents a 3-week moving average and not the actual ILI by week.

[4] The National Baseline is calculated by CDC as the mean percentage of visits for ILI during weeks 21–39 with two standard deviations. Because of large variability in regional ILI, comparison of the national baseline with local ILI may not be appropriate. It is provided in this report because no meaningful regional baselines are available for comparison. The national baseline combines all data reported by states to CDC, including ILI in outpatient, ER, urgent care, and inpatient settings.

[5] There are 10 activity levels classified as minimal (levels 1-3), low (levels 4-5), moderate (levels 6-7), and high (levels 8-10).

[6] The influenza activity reported by state and territorial epidemiologists indicates geographic spread of influenza viruses but does not measure the severity of influenza activity. Sporadic: no clusters reported to HDOH, Local: one or more clusters reported in one county, Regional: clusters reported two to three counties, Widespread: clusters reported in all counties. Hawaii does not report No Activity, as flu circulates year-round in Hawaii.

II. LABORATORY SURVEILLANCE: State Laboratories Division (SLD; the HDOH public health laboratory) and Hawaii's major private laboratories (DLS, CLH) report results of RT-PCR, which can be considered confirmatory (SLD may perform viral culture on select specimens). Specimens meeting priority criteria[7] are forwarded to SLD for sub-typing. Additionally, specimens meeting case definition from requesting sentinel providers are sent directly to SLD for sub-typing. Due to resource constraints, not all submitted specimens undergo sub-typing. Sub-typing at the commercial laboratories is only conducted on a case-by-case basis. The majority of specimens testing positive by rapid antigen testing or RT-PCR at the commercial laboratories do not meet criteria and are not subtyped. For more information on influenza tests and types, please visit the CDC website (*here*).

A. INFLUENZA:

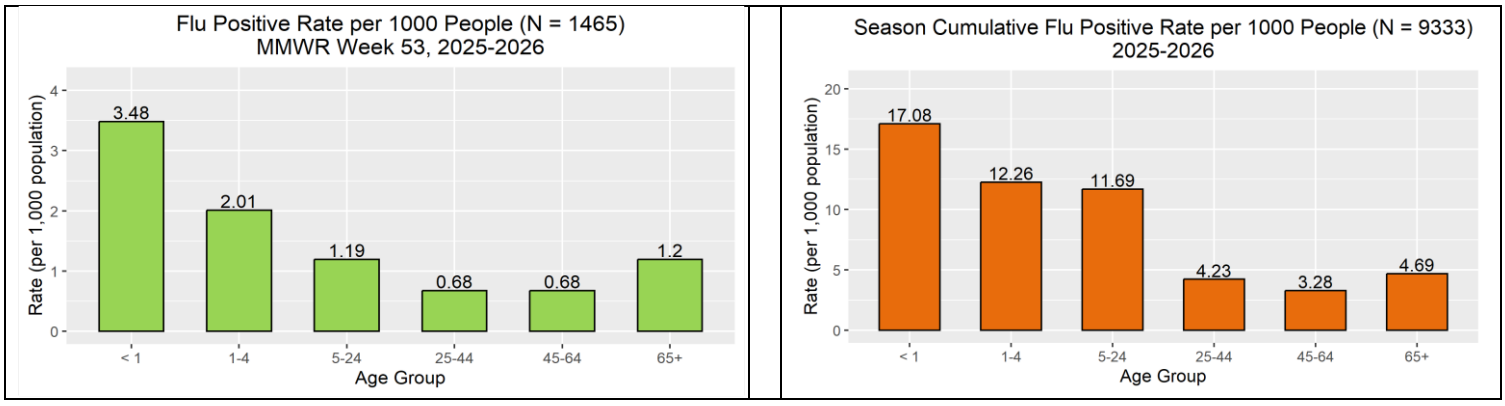
- The following reflects laboratory findings for week 53 of the 2025–26 influenza season:
  - *A total of **4,868** specimens have been tested statewide for influenza viruses (positive: 1,465 [**30.1%**]). (Season to date: **43,471** tested (**21.3%** positive)*
    - *2,124 (43.6%) were screened only by rapid antigen tests with no confirmatory testing.*
    - *2,744 (56.4%) underwent confirmatory testing (either RT-PCR or viral culture).*
    - *3,403 (69.9%) were negative.*
  - *Routine surveillance samples from State Laboratory Division were tested at a public health laboratory and identified as Influenza A (H3N2) subclade K.*

Influenza type	*Current week 53 (%)**	*Season to date (%)*[8]
Influenza A (H1)[9]	*2 (0.1)*	*73 (0.8)*
Influenza A (H3)	*9 (0.6)*	*704 (7.6)*
Influenza A no subtyping	*1,429 (97.3)*	*8,383 (90.4)*
Influenza B (Yamagata)	*0 (0.0)*	*0 (0.0)*
Influenza B (Victoria)	*0 (0.0)*	*0 (0.0)*
Influenza B no genotyping	*28 (1.9)*	*110 (1.2)*

**Specimens that are positive for both A and B (coinfections) are counted in both A and B totals for current and season to date*

1. AGE DISTRIBUTION

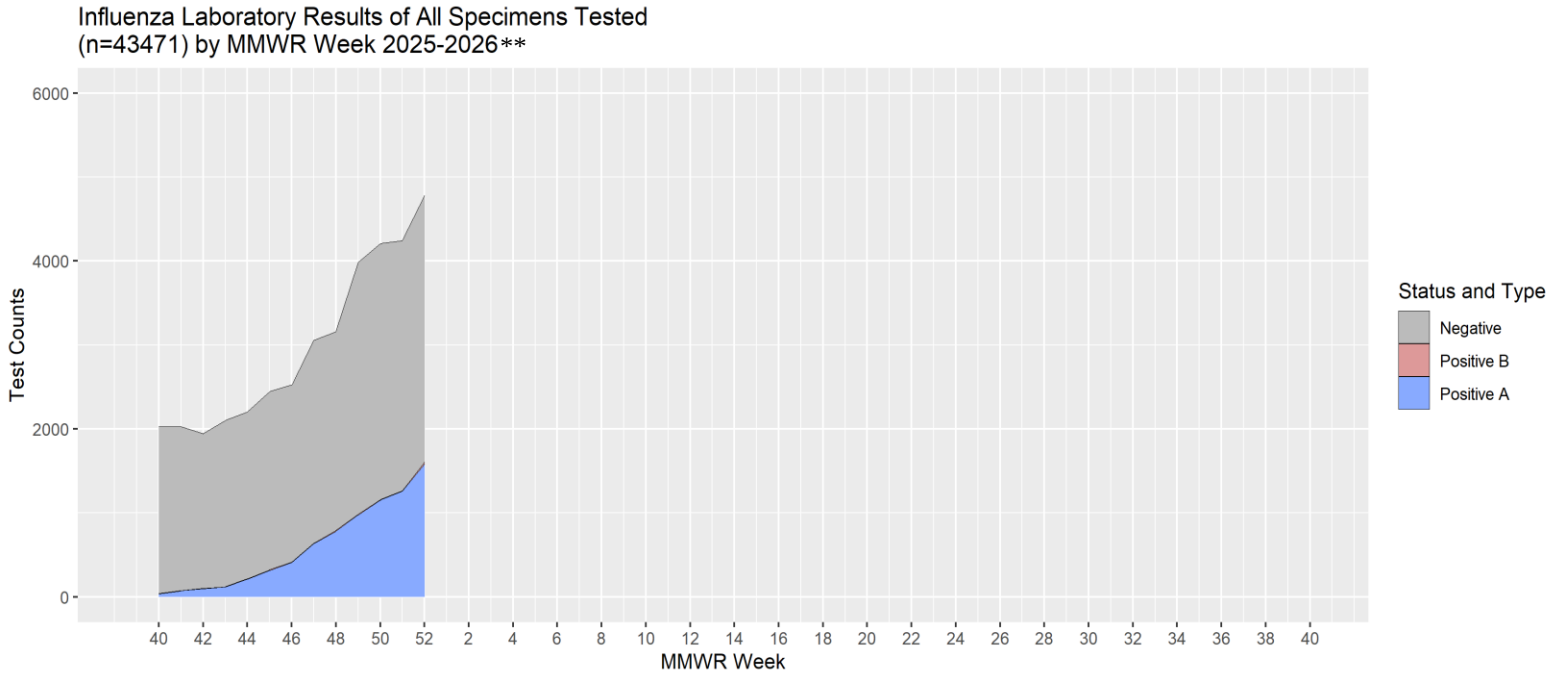
The charts below indicate the population-based rates of positive influenza cases in Hawaii by age group during the 2025–26 influenza season.[10]

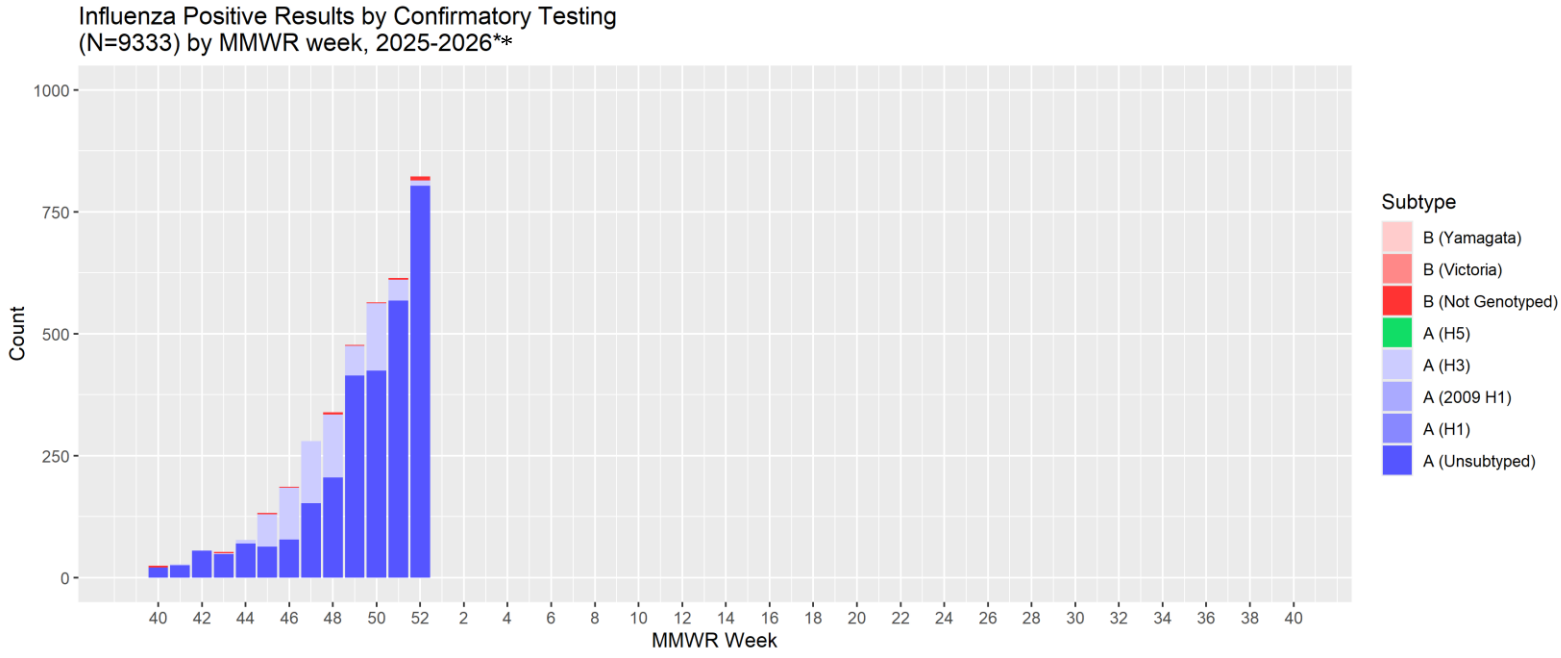


[7] Priority criteria include: hospitalized patients with acute respiratory distress syndrome [ARDS] or x-ray confirmed pneumonia; travelers with international travel history within 10 days of onset; specimens submitted by sentinel providers; specimens collected from healthcare workers, pregnant women, or women up to 6 weeks' post-partum; those with underlying medical conditions; and patients presenting with unusual or severe manifestations of influenza infection.
[8] Influenza coding were updated to reflect a more accurate count.
[9] All influenza A H1 viruses detected this season have been 2009 H1N1.
[10] This represents an estimate of population-based rates based on available data.

2. LABORATORY TESTING

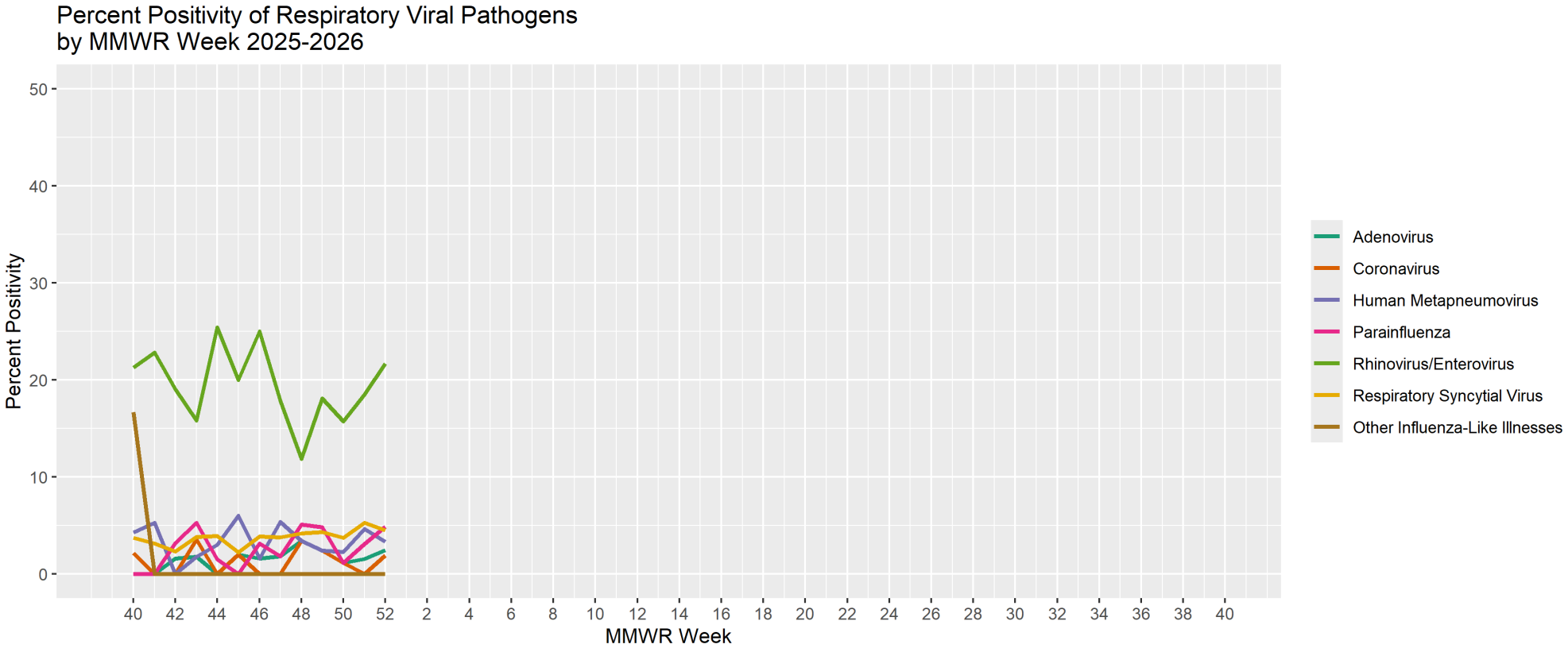
The charts below show the laboratory results of all specimens tested for influenza by MMWR week during the 2025–2026 influenza season as well as the type and subtype of positive results for influenza. Again, sub-typing is only performed on selected specimens tested by confirmatory tests (i.e., RT-PCR or viral culture).





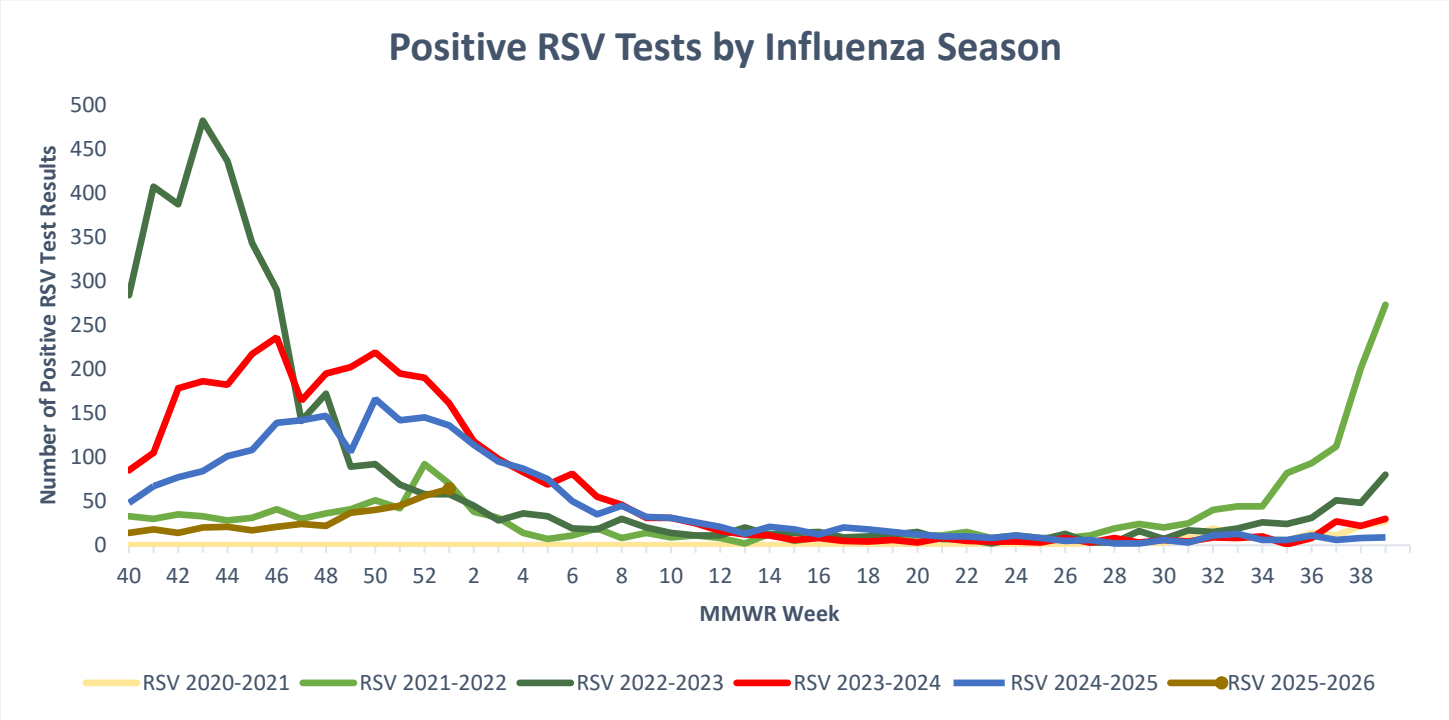
** A total of 23,192 specimens underwent confirmatory testing but not all positive influenza specimens receive confirmatory testing that are circulating in Hawaii.*
*** For MMWR Week 53, results are reported under MMWR Week 52, where the average of Weeks 52 and 53 was calculated.*

B. OTHER RESPIRATORY PATHOGENS: The major clinical and commercial laboratories throughout the state of Hawaii have the testing capacity for non-influenza respiratory pathogens and report these to HDOH. However, such testing is performed as needed and when sufficient resources are available because of the high costs associated with respiratory panel tests. **Therefore, available data represent only the presence of circulating pathogens and cannot be used to determine specific trends**.

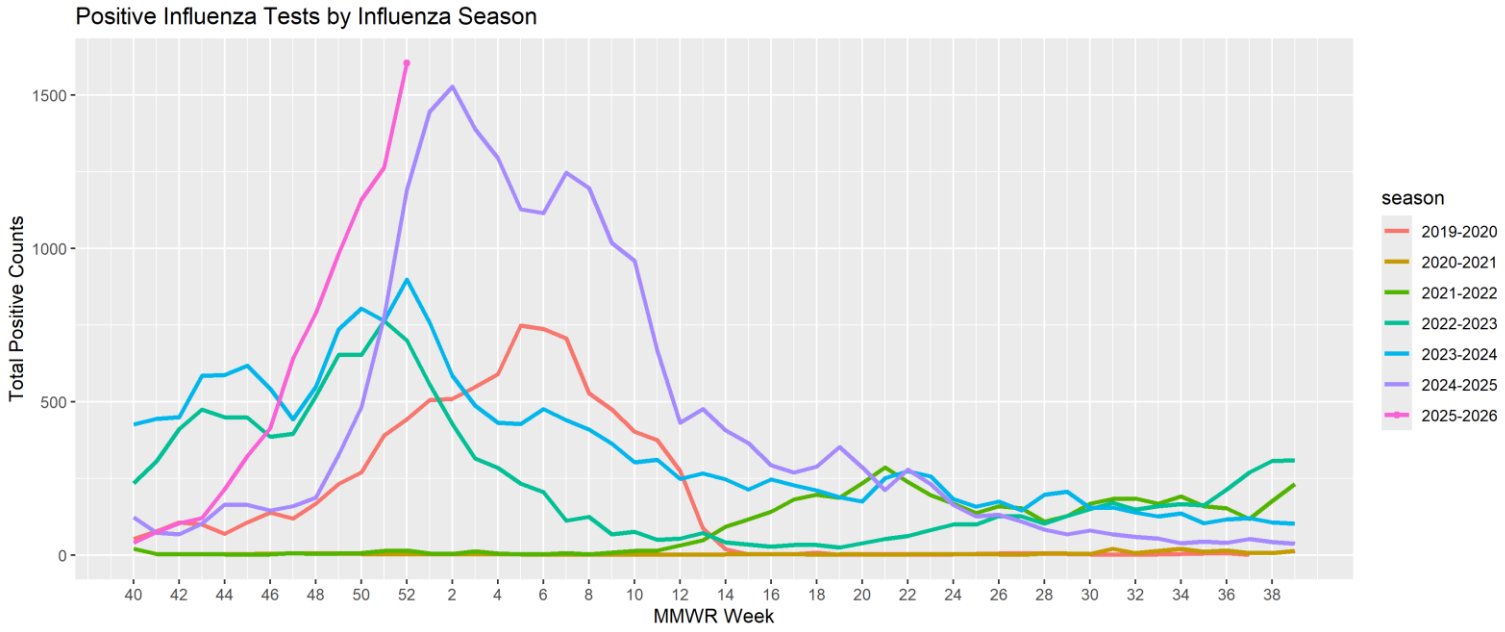


* *The coronavirus presented on this table does not indicate Severe Acute Respiratory Coronavirus-2 (i.e., COVID-19). For MMWR Week 53, results are reported under MMWR Week 52, where the average of Weeks 52 and 53 was calculated*

RESPIRATORY SYNCYTIAL VIRUS (RSV) POSITIVE TEST RESULTS BY INFLUENZA SEASON: RSV case appears to have increased earlier than past seasons in the 2025-2026 season. Of note, significantly more tests for RSV are being performed than in pre-COVID-19 seasons.



INFLUENZA POSITIVE TEST RESULTS BY INFLUENZA SEASON: Influenza cases appear to have increased earlier than past seasons in the 2025-2026 season. For MMWR Week 53, results are reported under MMWR Week 52, where the average of Weeks 52 and 53 was calculated



C. COVID-19 SENTINEL SURVEILLANCE: Due to the low volume of samples currently available through the influenza surveillance system, the COVID-19 sentinel surveillance data may not be accurately portraying COVID-19 activity in our communities. Reporting of the COVID-19 Sentinel Surveillance data will be paused while HODH re-evaluates the program to ensure that the reported data are accurate and representative.

HDOH is continuing to monitor COVID-19 activity throughout the state. To learn more, please visit the Hawaii's COVID-19 data website (*here*). For more information on surveillance of COVID-19 activity in the United States please visit the CDC COVIDView website (*here*).

III. PNEUMONIA, INFLUENZA, AND COVID-19 (PIC) RELATED MORTALITY:

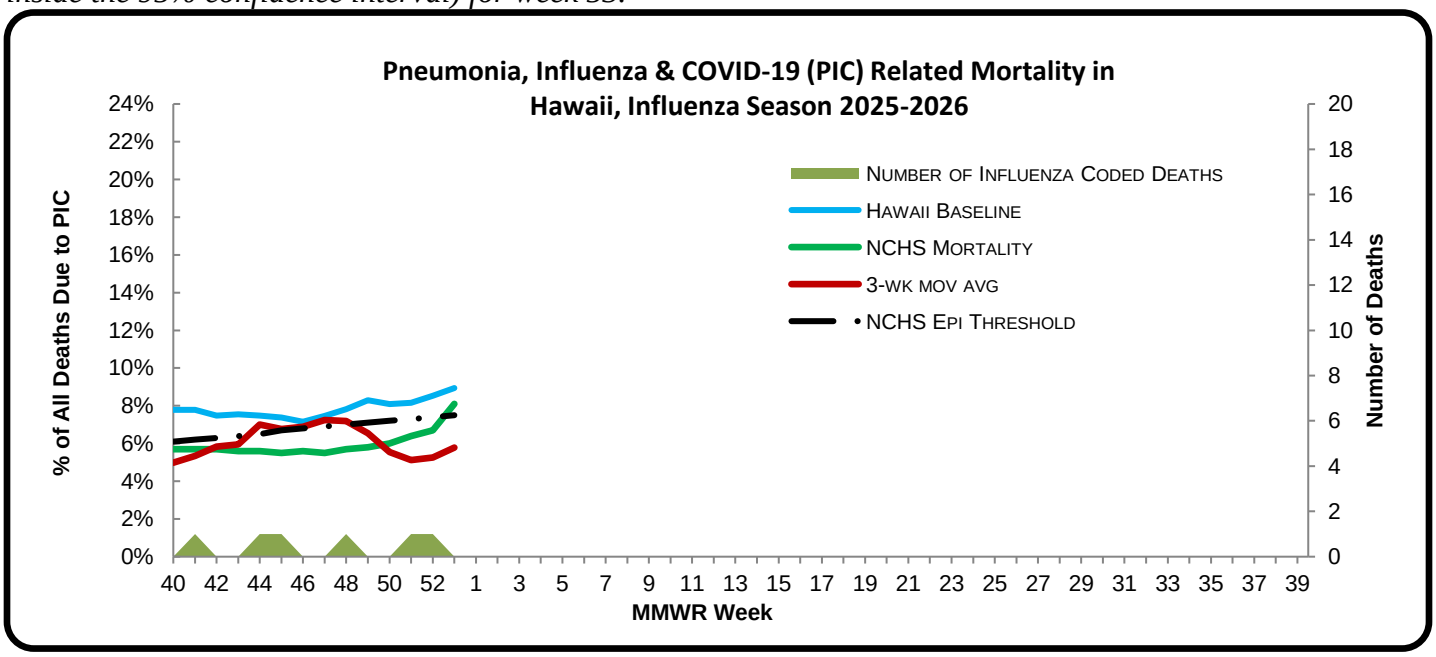
P&I mortality surveillance is collected by CDC through the National Center for Health Statistics (NCHS) using death certificate data. Each week the HDOH OHSM reports specific data from Honolulu to the CDC. CDC collects the following information by age group: the total number of deaths, total deaths from pneumonia, and total deaths related to influenza. Due to the ongoing COVID-19 pandemic, CDC included total deaths from COVID-19 by age group to the death data. Previous studies had suggested that P&I is a good indicator of influenza-related deaths; however, data has shown that pneumonia deaths associated with influenza is now being impacted by COVID-19 related pneumonia. Due to this, CDC had added COVID-19 deaths into P&I to create the PIC (pneumonia, influenza, and/or COVID-19) classification.

To standardize Hawaii's influenza surveillance with CDC influenza surveillance guidelines, PIC deaths will be reported in lieu of P&I. Hawaii's baseline will begin to include PIC deaths starting from 2019-2020 flu season.

For **week 53** of the current influenza season:

- ***6.8%*** *of all deaths that occurred in Hawaii during week 53 were related to pneumonia, influenza or COVID-19 (PIC)[11]. For the current season (season to date:* ***6.1%****), there have been 2,943 deaths from any cause, 183 of which were due to PIC[12].*
- *The PIC rate was comparable to the historical baseline in Hawaii[13] (i.e., inside the 95% confidence interval).*

*The Hawaii PIC rate was comparable to the CDC's National Center for Health Statistics (NCHS) PIC mortality[14] (****8.1%****) (i.e., inside the 95% confidence interval) and comparable to the national epidemic threshold (****7.5****%) (i.e., inside the 95% confidence interval) for week 53.*



[11] The percent of deaths due to PIC displayed on the graph is the 3-week moving averages.

[12] PIC data reflect 69.3% of the data reported for the MMWR week. Changes to data are expected when PIC data reaches 100% completion.

[13] The Hawaii historical baseline (%PIC) is the average of 3-week moving averages over the preceding 10 flu seasons of historical data (2014-2015, 2015-2016, 2016-2017, 2017-2018, 2018-2019, 2019-2020, 2020-2021, 2021-2022, 2022-2023, and 2023-2024).

[14] Each week, the vital statistics offices of 122 cities across the United States report the total number of death certificates processed and the number of those for which pneumonia, influenza, or COVID-19 was listed as the underlying or contributing cause of death by age group (Under 28 days, 28 days–1 year, 1–14 years, 15–24 years, 25–44 years, 45–64 years, 65–74 years, 75–84 years, and ≥85 years). The COVID-19 death counts reported by NCHS are provisional and will not match counts in other sources, such as media reports or numbers from health departments. COVID-19 deaths may be classified or defined differently in various reporting and surveillance systems. The percentage of deaths due to pneumonia, influenza, and COVID-19 (PIC) are compared with a seasonal baseline and epidemic threshold value calculated for each week.

INFLUENZA-ASSOCIATED PEDIATRIC DEATHS[15]:

- No new influenza-associated pediatric death was reported to Hawaii. There have been zero influenza-associated pediatric deaths reported in Hawaii during the 2025–2026 season.
- Nationally, eight new influenza-associated pediatric deaths were reported to CDC during week 53. (2025-2026 season total: 17).

IV. INFLUENZA WATCH: As part of a comprehensive influenza surveillance system and to prevent the spread of contagious respiratory diseases in humans, it is important to monitor all circulating influenza types. Several animal-origin influenza A subtypes are currently of interest: influenza A variant virus (H3N2v, H1N2v, and H1N1v) and Avian flu (H5N1 and H7N9). These types of influenza viruses may cause zoonotic (animal-associated) disease and are a public health concern.

A. VARIANT VIRUSES:

Influenza viruses that normally circulate in pigs are called "variant" viruses when they are found in people. These viruses were first identified in U.S. pigs in 2010. In 2011, 12 cases of H3N2v infection were detected in the United States. In 2012, 309 such cases (resulting in 16 hospitalizations and one death) across 12 states were detected, including one Hawaii case who recovered. Illness associated with H3N2v infection has been mostly mild with symptoms similar to those of seasonal flu. However, serious illness, resulting in hospitalization and death, has occurred in some cases. Most of these infections have been associated with prolonged exposure to pigs at agricultural fairs or similar settings. Limited human-to-human spread of this virus has been detected in the past, but no sustained community spread of H3N2v has been identified. More information regarding H3N2v, H1N1v, and H1N2v viruses may be found on the CDC website (*here*) and (*here*).

- *No variant or novel influenza infections have been reported to HDOH during the 2025-2026 influenza season.*
- *One new human infection with novel influenza A virus, H1N1v (0), H3N2v (0), and H1N2v (1), have been reported during the 2025-2026 influenza season.*
    - *One new human infection with influenza A(H1N1v) virus has been reported to WHO from China during the 2025-2026 influenza season.*

AVIAN (OR BIRD) INFLUENZA: These types of influenza viruses cause zoonotic (animal-associated) disease of public health concern and are therefore monitored globally by the WHO. Most avian influenza viruses do not cause disease in humans and are generally not easily transmissible between person to person, but a few subtypes may cross the species barrier and cause disease in humans. Avian influenza viruses may be of various subtypes, including H5N1, H5N2, H5N8, H7N3, H7N7, H7N8, H7N9, and H9N2. On January 15th, 2016, the USDA and APHIS reported detection of HPAI H7N8 in a commercial turkey flock in Indiana. There have been no associated human infections. This is the first detection of HPAI H7N8 in wild bird surveillance in the United States. More information, the risk assessment and recommendations for HPAI H7N8 can be found (here). The WHO, CDC, and other public health agencies have also been monitoring influenza H7N9, which represents a public health concern because of its high pandemic potential. Although H7N9 has not been detected in the United States, it remains a global concern given continuing epidemics in endemic countries. Since 2013, a total of 1,568 laboratory-confirmed cases of human infection with H7N9 viruses, including at least 613 deaths, have been reported to WHO. More information on H7N9 virus infections can be found (here). For more information regarding avian influenza, please visit the CDC (*here*) or the WHO (*here*) websites. WHO reports total number of cases and deaths related to laboratory-confirmed avian influenza viruses and posts current avian influenza case counts (*here*), which were last updated on **December 19, 2025**.

[15] Influenza-associated deaths are considered pediatric in persons aged less than 18 years. It was made a nationally notifiable condition in October, 2004. All pediatric influenza-associated deaths are laboratory confirmed.

V. INFLUENZA Vaccine: Annual influenza vaccination is recommended for all persons aged 6 months and older and is the most effective way to reduce the risk of getting sick with seasonal flu and spreading it to others. Influenza vaccination can reduce illnesses, visits to the doctor, influenza-related hospitalizations, and missed work and school days. Influenza vaccines become available by the end of October. It takes at least two weeks after vaccination to confer immunity against influenza virus infection. More information regarding influenza vaccination can be found (*here*).

A. Composition of the 2025–2026 Influenza Vaccine**:**

The composition of the 2025–2026 influenza vaccine has been updated to better match circulating influenza viruses. The Advisory Committee on Immunization Practices (ACIP) has recommended that the 2025-2026 influenza trivalent vaccine contain an influenza A/Victoria/4897/2022 (H1N1) pdm09-like virus, influenza A/Croatia/10136RV/2023 (H3N2)-like virus, and influenza B/Austria/1359417/2021 (B/Victoria lineage)-like virus. United States cell culture–based inactivated (ccIIV4) and recombinant (RIV4) influenza vaccines will contain HA derived from an influenza A/Wisconsin/67/2022 (H1N1) pdm09-like virus, an A/District of Columbia/27/2023 (H3N2)-like virus, an influenza B/Austria/1359417/2021 (B/Victoria lineage)-like virus. These vaccine recommendations were based on several factors, including global influenza virologic and epidemiologic surveillance, genetic and antigenic characterization, human serology studies, antiviral susceptibility, and the availability of candidate influenza viruses.

APPENDIX 1: ADDITIONAL INFORMATION

For more information regarding local and national influenza surveillance programs, visit the following sites.

Centers for Disease Control and Prevention	General Influenza National ILI and P&I Data Vaccine Virus Selection CDC Web Tool for Respiratory Viruses
Flu.gov	General Influenza Information
HDOH Flu and Pneumonia	General Influenza Surveillance Avian Influenza Respiratory Virus Dashboard To find out more information or join the sentinel physician program, email the Influenza Surveillance Coordinator
World Health Organization	General Global and Local Influenza Avian Influenza

APPENDIX 2: MMWR WEEK DATES

Please refer to the table below to interpret data presented by MMWR week. Week 40 is considered the traditional start for the flu season for the Northern Hemisphere.

MMWR WEEK	2022	2023	2024	2025	2026
1	1/8/2022	1/7/2023	1/6/2024	1/4/2025	1/10/2026
2	1/15/2022	1/14/2023	1/13/2024	1/11/2025	1/17/2026
3	1/22/2022	1/21/2023	1/20/2024	1/18/2025	1/24/2026
4	1/29/2022	1/28/2023	1/27/2024	1/25/2025	1/31/2026
5	2/5/2022	2/4/2023	2/3/2024	2/1/2025	2/7/2026
6	2/12/2022	2/11/2023	2/10/2024	2/8/2025	2/14/2026
7	2/19/2022	2/18/2023	2/17/2024	2/15/2025	2/21/2026
8	2/26/2022	2/25/2023	2/24/2024	2/22/2025	2/28/2026
9	3/5/2022	3/4/2023	3/2/2024	3/1/2025	3/7/2026
10	3/12/2022	3/11/2023	3/9/2024	3/8/2025	3/14/2026
11	3/19/2022	3/18/2023	3/16/2024	3/15/2025	3/21/2026
12	3/26/2022	3/25/2023	3/23/2024	3/22/2025	3/28/2026
13	4/2/2022	4/1/2023	3/30/2024	3/29/2025	4/4/2026
14	4/9/2022	4/8/2023	4/6/2024	4/5/2025	4/11/2026
15	4/16/2022	4/15/2023	4/13/2024	4/12/2025	4/18/2026
16	4/23/2022	4/22/2023	4/20/2024	4/19/2025	4/25/2026
17	4/30/2022	4/29/2023	4/27/2024	4/26/2025	5/2/2026
18	5/7/2022	5/6/2023	5/4/2024	5/3/2025	5/9/2026
19	5/14/2022	5/13/2023	5/11/2024	5/10/2025	5/16/2026
20	5/21/2022	5/20/2023	5/18/2024	5/17/2025	5/23/2026
21	5/28/2022	5/27/2023	5/25/2024	5/24/2025	5/30/2026
22	6/4/2022	6/3/2023	6/1/2024	5/31/2025	6/6/2026
23	6/11/2022	6/10/2023	6/8/2024	6/7/2025	6/13/2026
24	6/18/2022	6/17/2023	6/15/2024	6/14/2025	6/20/2026
25	6/25/2022	6/24/2023	6/22/2024	6/21/2025	6/27/2026
26	7/2/2022	7/1/2023	6/29/2024	6/28/2025	7/4/2026
27	7/9/2022	7/8/2023	7/6/2024	7/5/2025	7/11/2026
28	7/16/2022	7/15/2023	7/13/2024	7/12/2025	7/18/2026
29	7/23/2022	7/22/2023	7/20/2024	7/19/2025	7/25/2026
30	7/30/2022	7/29/2023	7/27/2024	7/26/2025	8/1/2026
31	8/6/2022	8/5/2023	8/3/2024	8/2/2025	8/8/2026
32	8/13/2022	8/12/2023	8/10/2024	8/9/2025	8/15/2026
33	8/20/2022	8/19/2023	8/17/2024	8/16/2025	8/22/2026
34	8/27/2022	8/26/2023	8/24/2024	8/23/2025	8/29/2026
35	9/3/2022	9/2/2023	8/31/2024	8/30/2025	9/5/2026
36	9/10/2022	9/9/2023	9/7/2024	9/6/2025	9/12/2026
37	9/17/2022	9/16/2023	9/14/2024	9/13/2025	9/19/2026
38	9/24/2022	9/23/2023	9/21/2024	9/20/2025	9/26/2026
39	10/1/2022	9/30/2023	9/28/2024	9/27/2025	10/3/2026
40	10/8/2022	10/7/2023	10/5/2024	10/4/2025	10/10/2026
41	10/15/2022	10/14/2023	10/12/2024	10/11/2025	10/17/2026
42	10/22/2022	10/21/2023	10/19/2024	10/18/2025	10/24/2026
43	10/29/2022	10/28/2023	10/26/2024	10/25/2025	10/31/2026
44	11/5/2022	11/4/2023	11/2/2024	11/1/2025	11/7/2026
45	11/12/2022	11/11/2023	11/9/2024	11/8/2025	11/14/2026
46	11/19/2022	11/18/2023	11/16/2024	11/15/2025	11/21/2026
47	11/26/2022	11/25/2023	11/23/2024	11/22/2025	11/28/2026
48	12/3/2022	12/2/2023	11/30/2024	11/29/2025	12/5/2026
49	12/10/2022	12/9/2023	12/7/2024	12/6/2025	12/12/2026
50	12/17/2022	12/16/2023	12/14/2024	12/13/2025	12/19/2026
51	12/24/2022	12/23/2023	12/21/2024	12/20/2025	12/26/2026
52	12/31/2022	12/30/2023	12/28/2024	12/27/2025	
53				01/03/2026	

HAWAII STATE DEPARTMENT OF HEALTH
DISEASE OUTBREAK CONTROL DIVISION

Influenza/Respiratory Disease Surveillance Report

Morbidity and Mortality Weekly Report (MMWR)[1]

WEEK 1: JANUARY 4, 2026– JANUARY 10, 2026

OVERVIEW: The Hawaii State Department of Health (HDOH) monitors influenza and other respiratory pathogens, including COVID-19, throughout the state of Hawaii. Influenza surveillance in the state of Hawaii relies upon selected sentinel health practitioners, the State Laboratories Division (SLD), private laboratories, and the Office of Health Status Monitoring (OHSM). For detailed information concerning influenza, please visit the HDOH Disease Outbreak Control Division (HDOH DOCD) website (*here*). **All data and information are conditional and may change as more reports are received.** The data in this report reflect the 2025-2026 influenza season which began the week ending October 4, 2025 (week 40[1] 2025) and will end the week ending on October 3, 2026 (week 39 2026).

REPORT SNAPSHOT FOR WEEK 1

Surveillance for Influenza-like Illness (ILI)		
Metric	*Value*	*Comment*
Outpatient visits related to influenza-like illness (ILI) from ILINet Sentinel Providers	4.0%	Lower than the previous week. Comparable to Hawaii's historical baseline and comparable to the national baseline, and lower than the national ILI rate.
Number of ILI clusters reported to HDOH	2	There have been 19 clusters this season.

Laboratory Surveillance		
Percent of all respiratory specimens positive for influenza this week	23.0%	Lower than the previous week. This number means that many, if not all, of the 77.0% who tested negative for influenza had illness from another respiratory etiology.
Percent of all respiratory specimens positive for influenza this season to date	21.5%	

Surveillance for Severe Outcomes		
Pneumonia, influenza and COVID-19 (PIC) mortality rate	2.9%	Lower than Hawaii's historical baseline, lower than the national epidemic threshold and lower than the NCHS average.
Number of influenza-associated pediatric deaths reported nationwide	32	0 influenza-associated pediatric deaths have been reported from Hawaii this season to date.

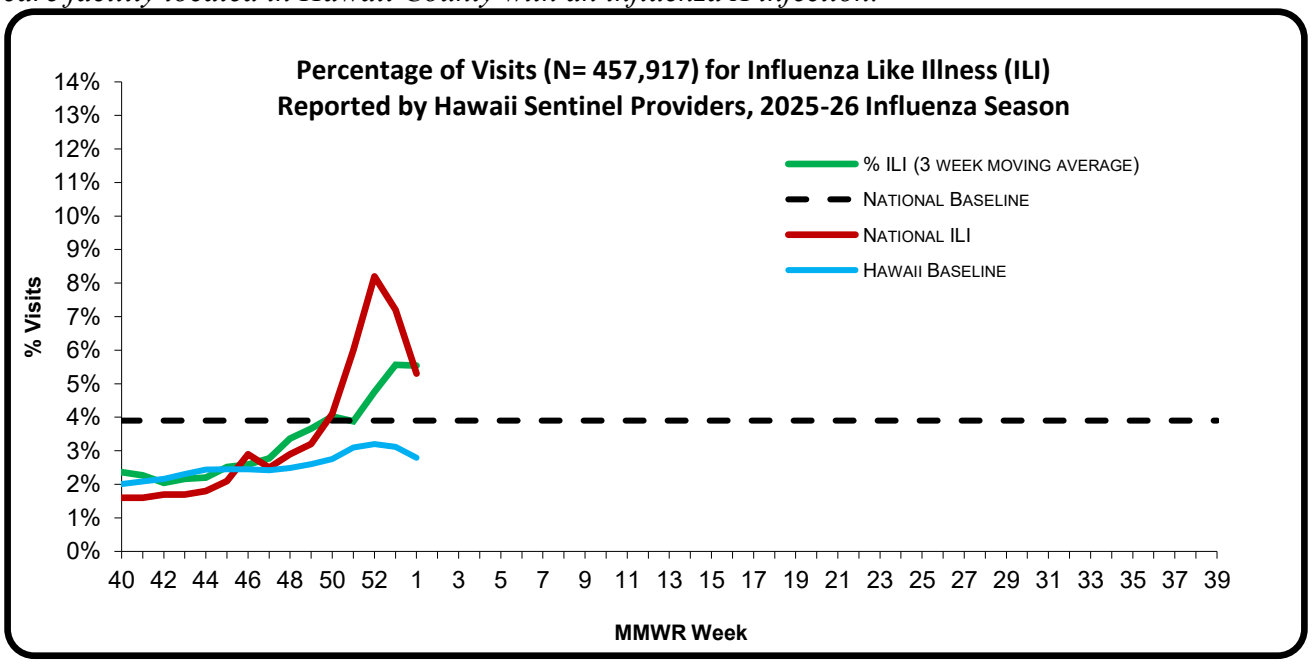
[1] MMWR stands for "Morbidity and Mortality Weekly Report," conventionally used by the Centers for Disease Control and Prevention (CDC). The weeks of a flu season are often referred to by their respective MMWR week. **See appendix 2 for interpretation of MMWR weeks.** Data reported will begin on week 40, the traditional start date of flu season.

INFLUENZA SURVEILLANCE

I. INFLUENZA-LIKE ILLNESS (ILI): HDOH collaborates with recruited doctors and healthcare providers who report the total number of outpatient visits for ILI as well as the total number of patients who complained of symptoms consistent with an ILI. A patient with ILI must have the following: a fever (temperature of 100°F [37.8°C] or greater) AND a cough and/or a sore throat. ILI is based on reported symptoms and not laboratory confirmed tests; thus, ILI may represent other respiratory pathogens and not solely influenza. Further, sentinel providers report these numbers on a weekly basis; therefore, data are preliminary and may change depending on additional reporting. In combination with laboratory testing and other surveillance systems, ILI surveillance helps monitor influenza and other respiratory pathogen activity. For more information concerning ILINet and sentinel requirements, please visit the CDC website (*here*).

For **week 1** of the current influenza season:

- ***4.0**% (season to date: **3.4**%) of the outpatient visits recorded by Hawaii sentinel providers were for ILI.*
- *ILI visits were comparable to the historical baseline in Hawaii[2,3] (i.e., inside the 95% confidence interval).*
- *Hawaii's ILI outpatient visits were comparable to the national baseline (**3.9%**)[4] (i.e., inside the 95% confidence interval) and lower than the national ILI rate (**5.3%**) (i.e. outside the 95% confidence interval).*
- *ILI activity level: Low[5]*
- *Geographic Spread: Sporadic Activity[6].*
- *ILI Cluster Activity: Two new clusters were reported to HDOH during week 1. One of the clusters was from a school located in Honolulu County with an influenza A infection. One of the clusters was from a long-term care facility located in Hawaii County with an influenza A infection.*



[2] The Hawaii historical baseline (%ILI) is the average of 3-week moving averages over the preceding 10 flu seasons of historical data (2015-2016, 2016-2017, 2017-2018, 2018-2019, 2019-2020, 2020-2021, 2021-2022, 2022-2023, 2023-2024 and 2024-2025).

[3] This value is based upon comparison of actual outpatient ILI with the historical baseline, which only captures outpatient ILI. The chart above represents a 3-week moving average and not the actual ILI by week.

[4] The National Baseline is calculated by CDC as the mean percentage of visits for ILI during weeks 21–39 with two standard deviations. Because of large variability in regional ILI, comparison of the national baseline with local ILI may not be appropriate. It is provided in this report because no meaningful regional baselines are available for comparison. The national baseline combines all data reported by states to CDC, including ILI in outpatient, ER, urgent care, and inpatient settings.

[5] There are 10 activity levels classified as minimal (levels 1-3), low (levels 4-5), moderate (levels 6-7), and high (levels 8-10).

[6] The influenza activity reported by state and territorial epidemiologists indicates geographic spread of influenza viruses but does not measure the severity of influenza activity. Sporadic: no clusters reported to HDOH, Local: one or more clusters reported in one county, Regional: clusters reported two to three counties, Widespread: clusters reported in all counties. Hawaii does not report No Activity, as flu circulates year-round in Hawaii.

II. LABORATORY SURVEILLANCE: State Laboratories Division (SLD; the HDOH public health laboratory) and Hawaii's major private laboratories (DLS, CLH) report results of RT-PCR, which can be considered confirmatory (SLD may perform viral culture on select specimens). Specimens meeting priority criteria[7] are forwarded to SLD for sub-typing. Additionally, specimens meeting case definition from requesting sentinel providers are sent directly to SLD for sub-typing. Due to resource constraints, not all submitted specimens undergo sub-typing. Sub-typing at the commercial laboratories is only conducted on a case-by-case basis. The majority of specimens testing positive by rapid antigen testing or RT-PCR at the commercial laboratories do not meet criteria and are not subtyped. For more information on influenza tests and types, please visit the CDC website (*here*).

A. INFLUENZA:

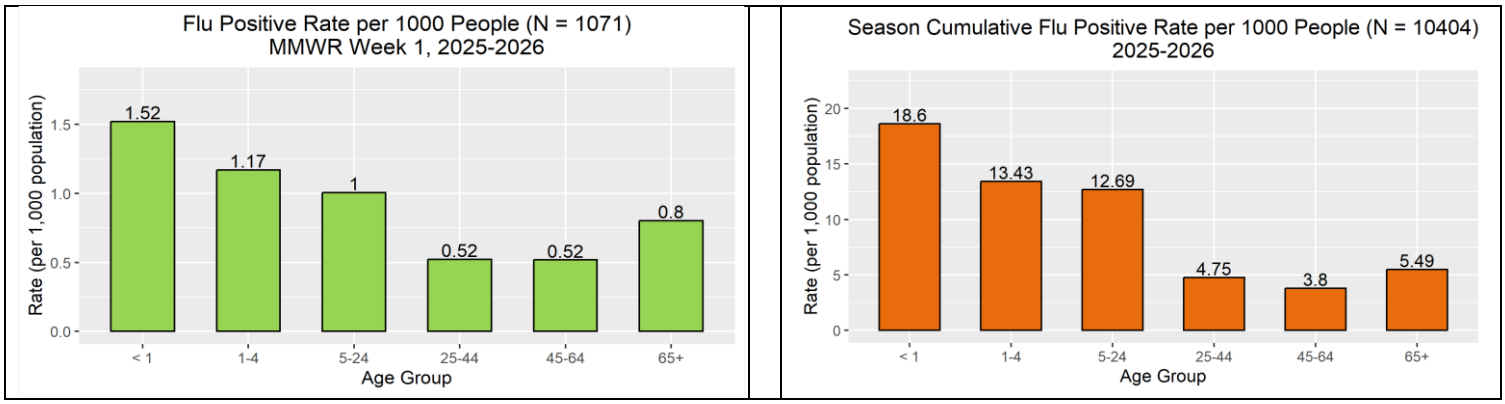
- The following reflects laboratory findings for week 1 of the 2025–26 influenza season:
  - *A total of **4,664** specimens has been tested statewide for influenza viruses (positive: 1,071 [**23.0%**]). (Season to date: **48,135** tested (**21.5%** positive)*
    - *2,073 (44.4%) were screened only by rapid antigen tests with no confirmatory testing.*
    - *2,591 (55.6%) underwent confirmatory testing (either RT-PCR or viral culture).*
    - *3,593 (77.0%) were negative.*
  - *Routine surveillance samples from State Laboratory Division were tested at a public health laboratory and identified as Influenza A (H3N2) subclade K.*

Influenza type	*Current week 1 (%)**	*Season to date (%)*[8]
Influenza A (H1)[9]	*1 (0.1)*	*74 (0.7)*
Influenza A (H3)	*23 (2.1)*	*731 (7.1)*
Influenza A no subtyping	*998 (93.1)*	*9,377 (90.7)*
Influenza B (Yamagata)	*0 (0.0)*	*0 (0.0)*
Influenza B (Victoria)	*0 (0.0)*	*0 (0.0)*
Influenza B no genotyping	*50 (4.7)*	*160 (1.5)*

**Specimens that are positive for both A and B (coinfections) are counted in both A and B totals for current and season to date*

1. AGE DISTRIBUTION

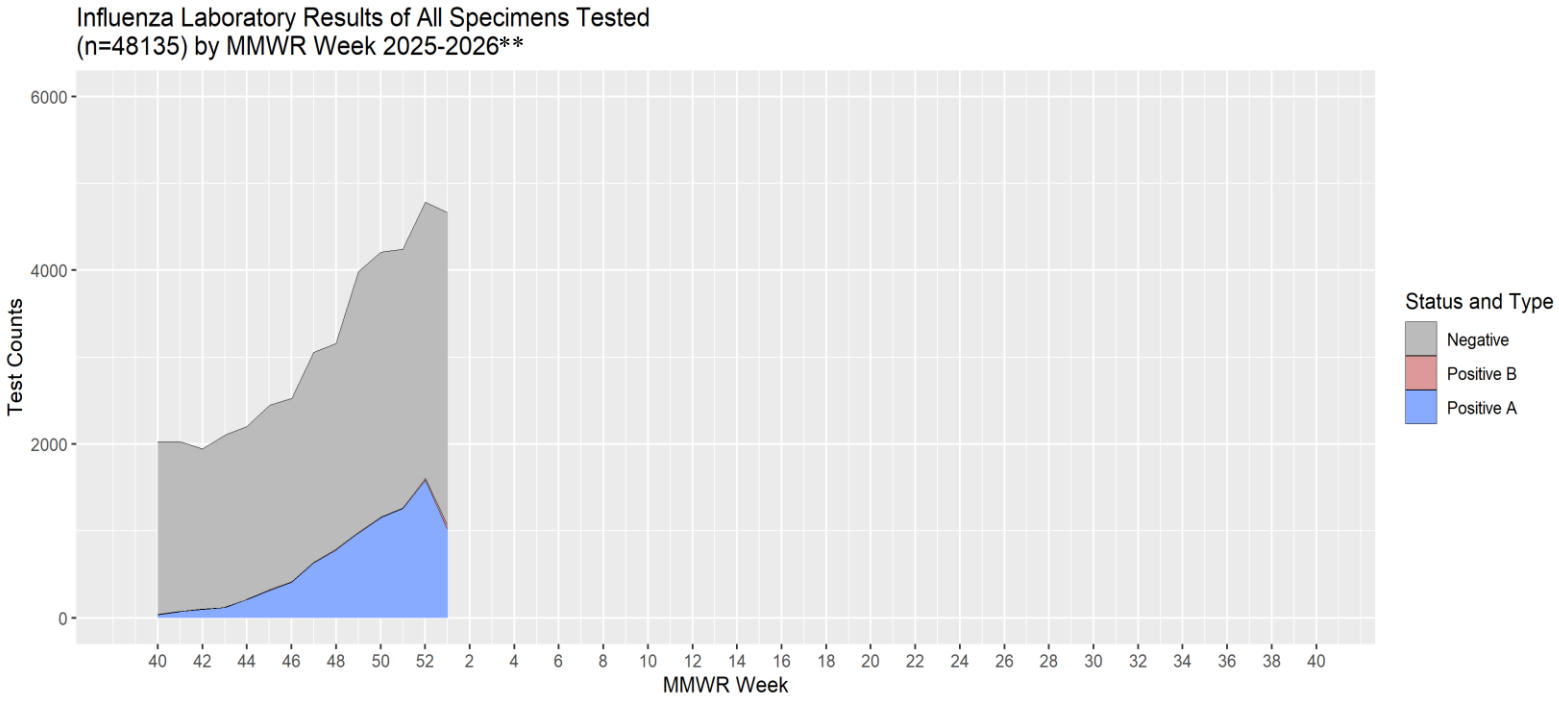
The charts below indicate the population-based rates of positive influenza cases in Hawaii by age group during the 2025–26 influenza season.[10]

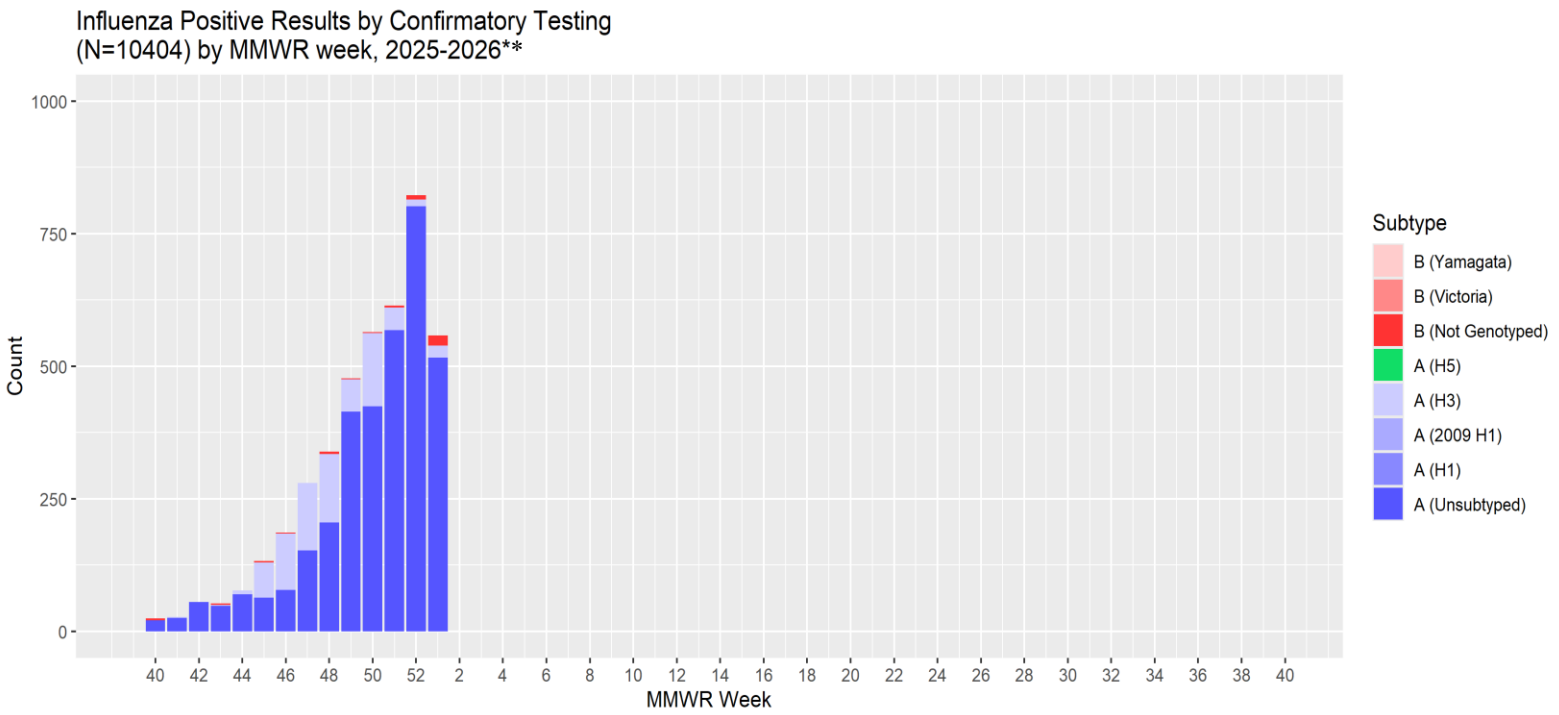


[7] Priority criteria include: hospitalized patients with acute respiratory distress syndrome [ARDS] or x-ray confirmed pneumonia; travelers with international travel history within 10 days of onset; specimens submitted by sentinel providers; specimens collected from healthcare workers, pregnant women, or women up to 6 weeks' post-partum; those with underlying medical conditions; and patients presenting with unusual or severe manifestations of influenza infection.
[8] Influenza coding were updated to reflect a more accurate count.
[9] All influenza A H1 viruses detected this season have been 2009 H1N1.
[10] This represents an estimate of population-based rates based on available data.

2. LABORATORY TESTING

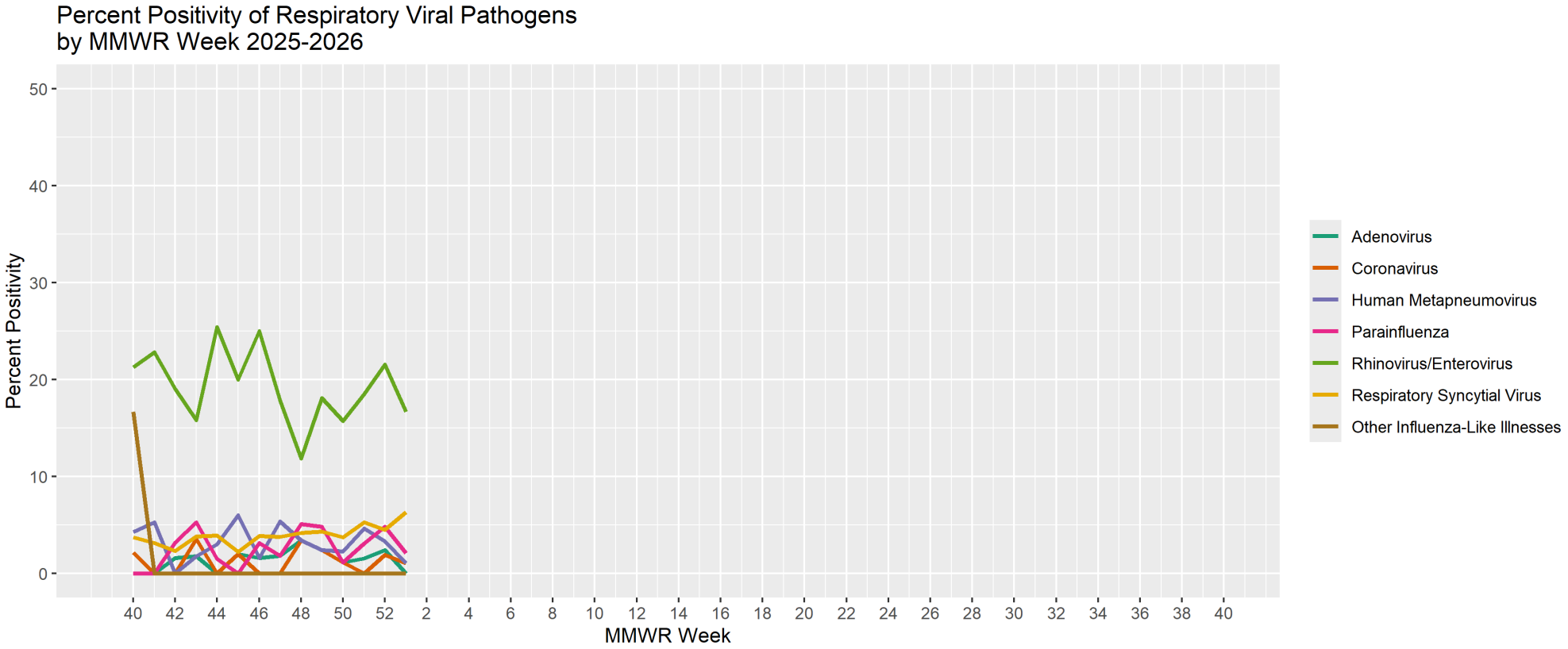
The charts below show the laboratory results of all specimens tested for influenza by MMWR week during the 2025–2026 influenza season as well as the type and subtype of positive results for influenza. Again, sub-typing is only performed on selected specimens tested by confirmatory tests (i.e., RT-PCR or viral culture).





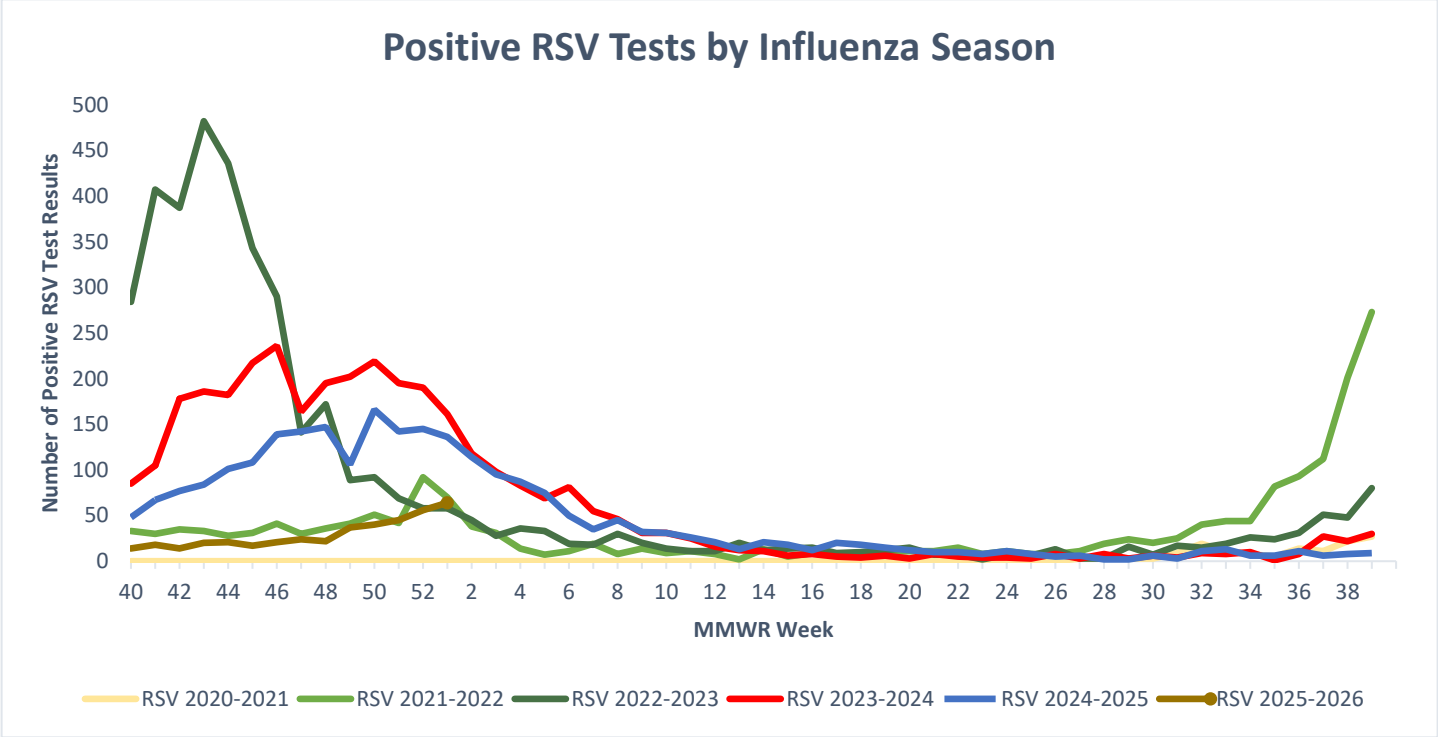
** A total of 25,783 specimens underwent confirmatory testing but not all positive influenza specimens receive confirmatory testing that are circulating in Hawaii.*
*** For MMWR Week 53, results are reported under MMWR Week 52, where the average of Weeks 52 and 53 was calculated.*

B. OTHER RESPIRATORY PATHOGENS: The major clinical and commercial laboratories throughout the state of Hawaii have the testing capacity for non-influenza respiratory pathogens and report these to HDOH. However, such testing is performed as needed and when sufficient resources are available because of the high costs associated with respiratory panel tests. **Therefore, available data represent only the presence of circulating pathogens and cannot be used to determine specific trends**.

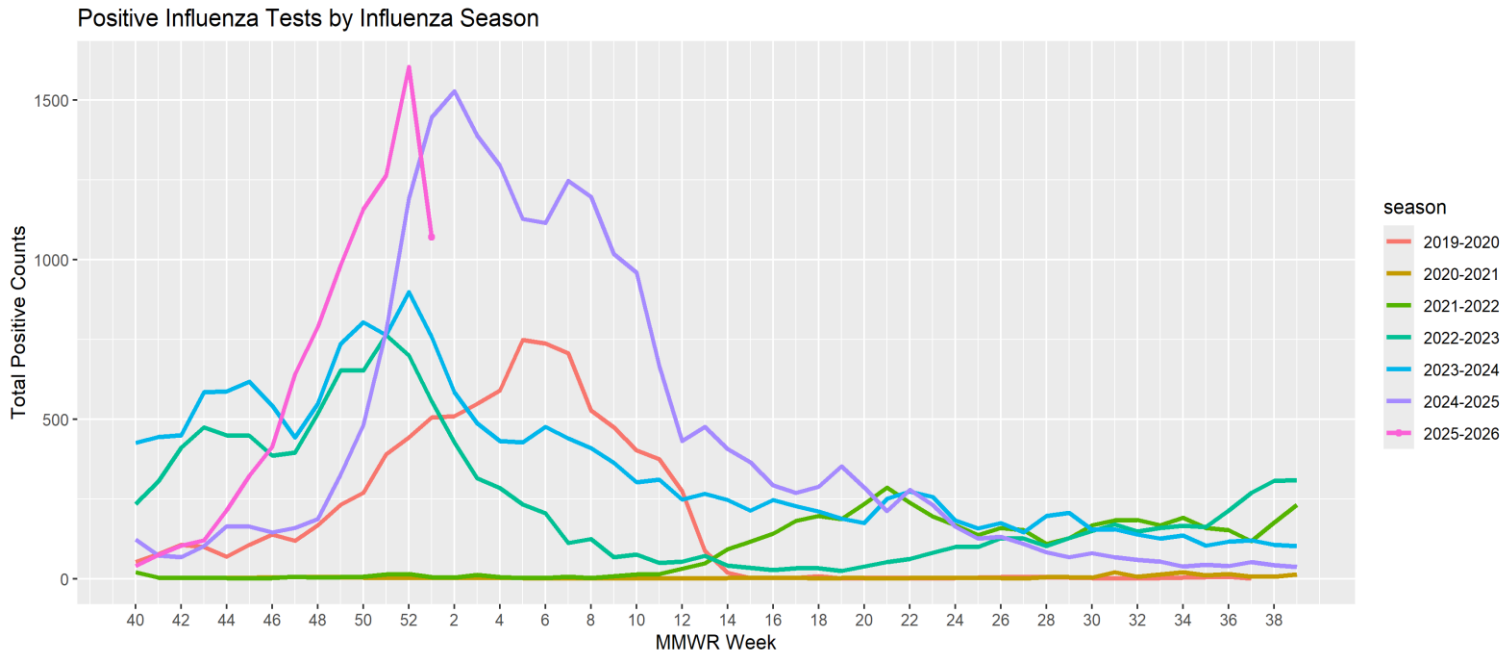


* *The coronavirus presented on this table does not indicate Severe Acute Respiratory Coronavirus-2 (i.e., COVID-19). For MMWR Week 53, results are reported under MMWR Week 52, where the average of Weeks 52 and 53 was calculated*

RESPIRATORY SYNCYTIAL VIRUS (RSV) POSITIVE TEST RESULTS BY INFLUENZA SEASON: RSV case appears to have increased earlier than past seasons in the 2025-2026 season. Of note, significantly more tests for RSV are being performed than in pre-COVID-19 seasons.



INFLUENZA POSITIVE TEST RESULTS BY INFLUENZA SEASON: Influenza cases appear to have increased earlier than past seasons in the 2025-2026 season. For MMWR Week 53, results are reported under MMWR Week 52, where the average of Weeks 52 and 53 was calculated.



C. COVID-19 SENTINEL SURVEILLANCE: Due to the low volume of samples currently available through the influenza surveillance system, the COVID-19 sentinel surveillance data may not be accurately portraying COVID-19 activity in our communities. Reporting of the COVID-19 Sentinel Surveillance data will be paused while HODH re-evaluates the program to ensure that the reported data are accurate and representative.

HDOH is continuing to monitor COVID-19 activity throughout the state. To learn more, please visit the Hawaii's COVID-19 data website (*here*). For more information on surveillance of COVID-19 activity in the United States please visit the CDC COVIDView website (*here*).

III. PNEUMONIA, INFLUENZA, AND COVID-19 (PIC) RELATED MORTALITY:

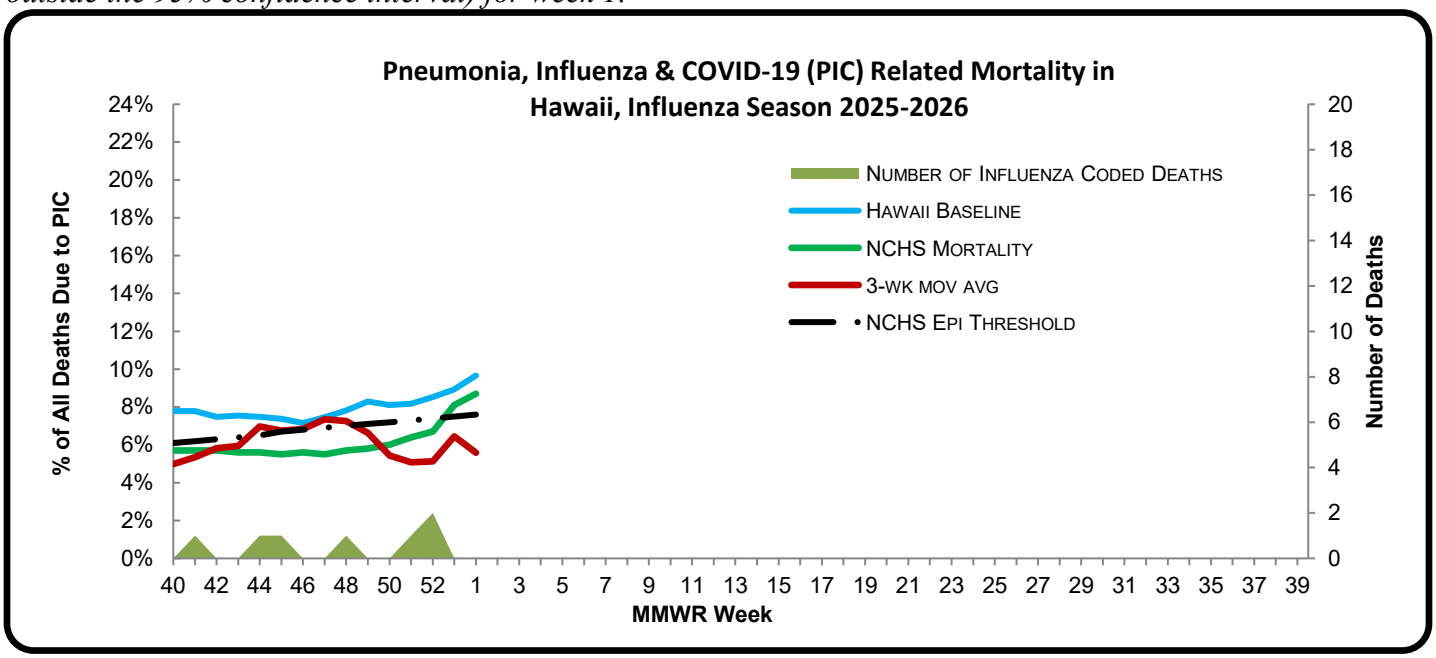
P&I mortality surveillance is collected by CDC through the National Center for Health Statistics (NCHS) using death certificate data. Each week the HDOH OHSM reports specific data from Honolulu to the CDC. CDC collects the following information by age group: the total number of deaths, total deaths from pneumonia, and total deaths related to influenza. Due to the ongoing COVID-19 pandemic, CDC included total deaths from COVID-19 by age group to the death data. Previous studies had suggested that P&I is a good indicator of influenza-related deaths; however, data has shown that pneumonia deaths associated with influenza is now being impacted by COVID-19 related pneumonia. Due to this, CDC had added COVID-19 deaths into P&I to create the PIC (pneumonia, influenza, and/or COVID-19) classification.

To standardize Hawaii's influenza surveillance with CDC influenza surveillance guidelines, PIC deaths will be reported in lieu of P&I. Hawaii's baseline will begin to include PIC deaths starting from 2019-2020 flu season.

For **week 1** of the current influenza season:

- ***2.9%*** *of all deaths that occurred in Hawaii during week 1 were related to pneumonia, influenza or COVID-19 (PIC)*[11]*. For the current season (season to date:* ***6.2%****), there have been 3,206 deaths from any cause, 200 of which were due to PIC*[12]*.*
- *The PIC rate was lower than the historical baseline in Hawaii*[13] *(i.e., outside the 95% confidence interval).*

The Hawaii PIC rate was lower than the CDC's National Center for Health Statistics (NCHS) PIC mortality[14] *(****8.7%****) (i.e., outside the 95% confidence interval) and lower than the national epidemic threshold (****7.6%****) (i.e., outside the 95% confidence interval) for week 1.*



[11] The percent of deaths due to PIC displayed on the graph is the 3-week moving averages.

[12] PIC data reflect 83.8% of the data reported for the MMWR week. Changes to data are expected when PIC data reaches 100% completion.

[13] The Hawaii historical baseline (%PIC) is the average of 3-week moving averages over the preceding 10 flu seasons of historical data (2014-2015, 2015-2016, 2016-2017, 2017-2018, 2018-2019, 2019-2020, 2020-2021, 2021-2022, 2022-2023, and 2023-2024).

[14] Each week, the vital statistics offices of 122 cities across the United States report the total number of death certificates processed and the number of those for which pneumonia, influenza, or COVID-19 was listed as the underlying or contributing cause of death by age group (Under 28 days, 28 days–1 year, 1–14 years, 15–24 years, 25–44 years, 45–64 years, 65–74 years, 75–84 years, and ≥85 years). The COVID-19 death counts reported by NCHS are provisional and will not match counts in other sources, such as media reports or numbers from health departments. COVID-19 deaths may be classified or defined differently in various reporting and surveillance systems. The percentage of deaths due to pneumonia, influenza, and COVID-19 (PIC) are compared with a seasonal baseline and epidemic threshold value calculated for each week.

INFLUENZA-ASSOCIATED PEDIATRIC DEATHS[15]:

- No new influenza-associated pediatric death was reported to Hawaii. There have been zero influenza-associated pediatric deaths reported in Hawaii during the 2025–2026 season.
- Nationally, fifteen new influenza-associated pediatric deaths were reported to CDC during week 1. (2025-2026 season total: 32).

IV. INFLUENZA WATCH: As part of a comprehensive influenza surveillance system and to prevent the spread of contagious respiratory diseases in humans, it is important to monitor all circulating influenza types. Several animal-origin influenza A subtypes are currently of interest: influenza A variant virus (H3N2v, H1N2v, and H1N1v) and Avian flu (H5N1 and H7N9). These types of influenza viruses may cause zoonotic (animal-associated) disease and are a public health concern.

A. VARIANT VIRUSES:

Influenza viruses that normally circulate in pigs are called "variant" viruses when they are found in people. These viruses were first identified in U.S. pigs in 2010. In 2011, 12 cases of H3N2v infection were detected in the United States. In 2012, 309 such cases (resulting in 16 hospitalizations and one death) across 12 states were detected, including one Hawaii case who recovered. Illness associated with H3N2v infection has been mostly mild with symptoms similar to those of seasonal flu. However, serious illness, resulting in hospitalization and death, has occurred in some cases. Most of these infections have been associated with prolonged exposure to pigs at agricultural fairs or similar settings. Limited human-to-human spread of this virus has been detected in the past, but no sustained community spread of H3N2v has been identified. More information regarding H3N2v, H1N1v, and H1N2v viruses may be found on the CDC website (*here*) and (*here*).

- *No variant or novel influenza infections have been reported to HDOH during the 2025-2026 influenza season.*
- *One new human infection with novel influenza A virus, H1N1v (0), H3N2v (0), and H1N2v (1), have been reported during the 2025-2026 influenza season.*
    - *One new human infection with influenza A(H1N1v) virus has been reported to WHO from China during the 2025-2026 influenza season.*

AVIAN (OR BIRD) INFLUENZA: These types of influenza viruses cause zoonotic (animal-associated) disease of public health concern and are therefore monitored globally by the WHO. Most avian influenza viruses do not cause disease in humans and are generally not easily transmissible between person to person, but a few subtypes may cross the species barrier and cause disease in humans. Avian influenza viruses may be of various subtypes, including H5N1, H5N2, H5N8, H7N3, H7N7, H7N8, H7N9, and H9N2. On January 15th, 2016, the USDA and APHIS reported detection of HPAI H7N8 in a commercial turkey flock in Indiana. There have been no associated human infections. This is the first detection of HPAI H7N8 in wild bird surveillance in the United States. More information, the risk assessment and recommendations for HPAI H7N8 can be found (here). The WHO, CDC, and other public health agencies have also been monitoring influenza H7N9, which represents a public health concern because of its high pandemic potential. Although H7N9 has not been detected in the United States, it remains a global concern given continuing epidemics in endemic countries. Since 2013, a total of 1,568 laboratory-confirmed cases of human infection with H7N9 viruses, including at least 613 deaths, have been reported to WHO. More information on H7N9 virus infections can be found (here). For more information regarding avian influenza, please visit the CDC (*here*) or the WHO (*here*) websites. WHO reports total number of cases and deaths related to laboratory-confirmed avian influenza viruses and posts current avian influenza case counts (*here*), which were last updated on **December 19, 2025**.

[15] Influenza-associated deaths are considered pediatric in persons aged less than 18 years. It was made a nationally notifiable condition in October, 2004. All pediatric influenza-associated deaths are laboratory confirmed.

V. INFLUENZA Vaccine: Annual influenza vaccination is recommended for all persons aged 6 months and older and is the most effective way to reduce the risk of getting sick with seasonal flu and spreading it to others. Influenza vaccination can reduce illnesses, visits to the doctor, influenza-related hospitalizations, and missed work and school days. Influenza vaccines become available by the end of October. It takes at least two weeks after vaccination to confer immunity against influenza virus infection. More information regarding influenza vaccination can be found (*here*).

A. Composition of the 2025–2026 Influenza Vaccine:

The composition of the 2025–2026 influenza vaccine has been updated to better match circulating influenza viruses. The Advisory Committee on Immunization Practices (ACIP) has recommended that the 2025-2026 influenza trivalent vaccine contain an influenza A/Victoria/4897/2022 (H1N1) pdm09-like virus, influenza A/Croatia/10136RV/2023 (H3N2)-like virus, and influenza B/Austria/1359417/2021 (B/Victoria lineage)-like virus. United States cell culture–based inactivated (ccIIV4) and recombinant (RIV4) influenza vaccines will contain HA derived from an influenza A/Wisconsin/67/2022 (H1N1) pdm09-like virus, an A/District of Columbia/27/2023 (H3N2)-like virus, an influenza B/Austria/1359417/2021 (B/Victoria lineage)-like virus. These vaccine recommendations were based on several factors, including global influenza virologic and epidemiologic surveillance, genetic and antigenic characterization, human serology studies, antiviral susceptibility, and the availability of candidate influenza viruses.

APPENDIX 1: ADDITIONAL INFORMATION

For more information regarding local and national influenza surveillance programs, visit the following sites.

Centers for Disease Control and Prevention	General Influenza National ILI and P&I Data Vaccine Virus Selection CDC Web Tool for Respiratory Viruses
Flu.gov	General Influenza Information
HDOH Flu and Pneumonia	General Influenza Surveillance Avian Influenza Respiratory Virus Dashboard To find out more information or join the sentinel physician program, email the Influenza Surveillance Coordinator
World Health Organization	General Global and Local Influenza Avian Influenza

APPENDIX 2: MMWR WEEK DATES

Please refer to the table below to interpret data presented by MMWR week. Week 40 is considered the traditional start for the flu season for the Northern Hemisphere.

MMWR WEEK	2022	2023	2024	2025	2026
1	1/8/2022	1/7/2023	1/6/2024	1/4/2025	1/10/2026
2	1/15/2022	1/14/2023	1/13/2024	1/11/2025	1/17/2026
3	1/22/2022	1/21/2023	1/20/2024	1/18/2025	1/24/2026
4	1/29/2022	1/28/2023	1/27/2024	1/25/2025	1/31/2026
5	2/5/2022	2/4/2023	2/3/2024	2/1/2025	2/7/2026
6	2/12/2022	2/11/2023	2/10/2024	2/8/2025	2/14/2026
7	2/19/2022	2/18/2023	2/17/2024	2/15/2025	2/21/2026
8	2/26/2022	2/25/2023	2/24/2024	2/22/2025	2/28/2026
9	3/5/2022	3/4/2023	3/2/2024	3/1/2025	3/7/2026
10	3/12/2022	3/11/2023	3/9/2024	3/8/2025	3/14/2026
11	3/19/2022	3/18/2023	3/16/2024	3/15/2025	3/21/2026
12	3/26/2022	3/25/2023	3/23/2024	3/22/2025	3/28/2026
13	4/2/2022	4/1/2023	3/30/2024	3/29/2025	4/4/2026
14	4/9/2022	4/8/2023	4/6/2024	4/5/2025	4/11/2026
15	4/16/2022	4/15/2023	4/13/2024	4/12/2025	4/18/2026
16	4/23/2022	4/22/2023	4/20/2024	4/19/2025	4/25/2026
17	4/30/2022	4/29/2023	4/27/2024	4/26/2025	5/2/2026
18	5/7/2022	5/6/2023	5/4/2024	5/3/2025	5/9/2026
19	5/14/2022	5/13/2023	5/11/2024	5/10/2025	5/16/2026
20	5/21/2022	5/20/2023	5/18/2024	5/17/2025	5/23/2026
21	5/28/2022	5/27/2023	5/25/2024	5/24/2025	5/30/2026
22	6/4/2022	6/3/2023	6/1/2024	5/31/2025	6/6/2026
23	6/11/2022	6/10/2023	6/8/2024	6/7/2025	6/13/2026
24	6/18/2022	6/17/2023	6/15/2024	6/14/2025	6/20/2026
25	6/25/2022	6/24/2023	6/22/2024	6/21/2025	6/27/2026
26	7/2/2022	7/1/2023	6/29/2024	6/28/2025	7/4/2026
27	7/9/2022	7/8/2023	7/6/2024	7/5/2025	7/11/2026
28	7/16/2022	7/15/2023	7/13/2024	7/12/2025	7/18/2026
29	7/23/2022	7/22/2023	7/20/2024	7/19/2025	7/25/2026
30	7/30/2022	7/29/2023	7/27/2024	7/26/2025	8/1/2026
31	8/6/2022	8/5/2023	8/3/2024	8/2/2025	8/8/2026
32	8/13/2022	8/12/2023	8/10/2024	8/9/2025	8/15/2026
33	8/20/2022	8/19/2023	8/17/2024	8/16/2025	8/22/2026
34	8/27/2022	8/26/2023	8/24/2024	8/23/2025	8/29/2026
35	9/3/2022	9/2/2023	8/31/2024	8/30/2025	9/5/2026
36	9/10/2022	9/9/2023	9/7/2024	9/6/2025	9/12/2026
37	9/17/2022	9/16/2023	9/14/2024	9/13/2025	9/19/2026
38	9/24/2022	9/23/2023	9/21/2024	9/20/2025	9/26/2026
39	10/1/2022	9/30/2023	9/28/2024	9/27/2025	10/3/2026
40	10/8/2022	10/7/2023	10/5/2024	10/4/2025	10/10/2026
41	10/15/2022	10/14/2023	10/12/2024	10/11/2025	10/17/2026
42	10/22/2022	10/21/2023	10/19/2024	10/18/2025	10/24/2026
43	10/29/2022	10/28/2023	10/26/2024	10/25/2025	10/31/2026
44	11/5/2022	11/4/2023	11/2/2024	11/1/2025	11/7/2026
45	11/12/2022	11/11/2023	11/9/2024	11/8/2025	11/14/2026
46	11/19/2022	11/18/2023	11/16/2024	11/15/2025	11/21/2026
47	11/26/2022	11/25/2023	11/23/2024	11/22/2025	11/28/2026
48	12/3/2022	12/2/2023	11/30/2024	11/29/2025	12/5/2026
49	12/10/2022	12/9/2023	12/7/2024	12/6/2025	12/12/2026
50	12/17/2022	12/16/2023	12/14/2024	12/13/2025	12/19/2026
51	12/24/2022	12/23/2023	12/21/2024	12/20/2025	12/26/2026
52	12/31/2022	12/30/2023	12/28/2024	12/27/2025	
53				01/03/2026	

HAWAII STATE DEPARTMENT OF HEALTH
DISEASE OUTBREAK CONTROL DIVISION

Influenza/Respiratory Disease Surveillance Report

Morbidity and Mortality Weekly Report (MMWR)[1]

WEEK 2: JANUARY 11, 2026– JANUARY 17, 2026

OVERVIEW: The Hawaii State Department of Health (HDOH) monitors influenza and other respiratory pathogens, including COVID-19, throughout the state of Hawaii. Influenza surveillance in the state of Hawaii relies upon selected sentinel health practitioners, the State Laboratories Division (SLD), private laboratories, and the Office of Health Status Monitoring (OHSM). For detailed information concerning influenza, please visit the HDOH Disease Outbreak Control Division (HDOH DOCD) website (*here*). **All data and information are conditional and may change as more reports are received.** The data in this report reflects the 2025-2026 influenza season which began the week ending October 4, 2025 (week 40[1] 2025) and will end the week ending on October 3, 2026 (week 39 2026).

REPORT SNAPSHOT FOR WEEK 2

Surveillance for Influenza-like Illness (ILI)		
Metric	*Value*	*Comment*
Outpatient visits related to influenza-like illness (ILI) from ILINet Sentinel Providers	3.5%	Lower than the previous week. Comparable to Hawaii's historical baseline and lower than the national baseline, and lower than the national ILI rate.
Number of ILI clusters reported to HDOH	0	There have been 19 clusters this season.

Laboratory Surveillance		
Percent of all respiratory specimens positive for influenza this week	20.9%	Lower than the previous week. This number means that many, if not all, of the 79.9% who tested negative for influenza had illness from another respiratory etiology.
Percent of all respiratory specimens positive for influenza this season to date	21.3%	

Surveillance for Severe Outcomes		
Pneumonia, influenza and COVID-19 (PIC) mortality rate	5.8%	Comparable to Hawaii's historical baseline, comparable to the national epidemic threshold and comparable to the NCHS average.
Number of influenza-associated pediatric deaths reported nationwide	44	0 influenza-associated pediatric deaths have been reported from Hawaii this season to date.

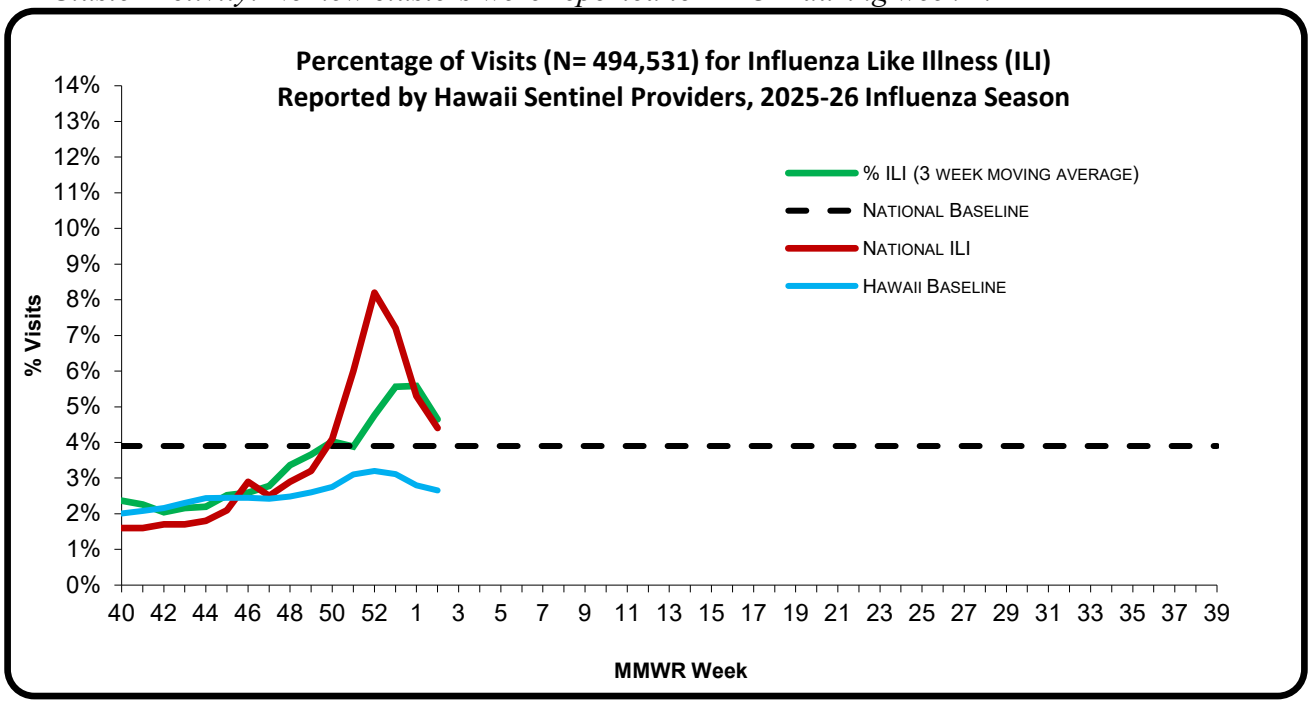
[1] MMWR stands for "Morbidity and Mortality Weekly Report," conventionally used by the Centers for Disease Control and Prevention (CDC). The weeks of a flu season are often referred to by their respective MMWR week. **See appendix 2 for interpretation of MMWR weeks.** Data reported will begin on week 40, the traditional start date of flu season.

INFLUENZA SURVEILLANCE

I. INFLUENZA-LIKE ILLNESS (ILI): HDOH collaborates with recruited doctors and healthcare providers who report the total number of outpatient visits for ILI as well as the total number of patients who complained of symptoms consistent with ILI. A patient with ILI must have the following: a fever (temperature of 100°F [37.8°C] or greater) AND a cough and/or a sore throat. ILI is based on reported symptoms and not laboratory confirmed tests; thus, ILI may represent other respiratory pathogens and not solely influenza. Further, sentinel providers report these numbers on a weekly basis; therefore, data are preliminary and may change depending on additional reporting. In combination with laboratory testing and other surveillance systems, ILI surveillance helps monitor influenza and other respiratory pathogen activity. For more information concerning ILINet and sentinel requirements, please visit the CDC website (*here*).

For **week 2** of the current influenza season:

- ***3.5%** (season to date: **3.4%**) of the outpatient visits recorded by Hawaii sentinel providers were for ILI.*
- *ILI visits were comparable to the historical baseline in Hawaii[2,3] (i.e., inside the 95% confidence interval).*
- *Hawaii's ILI outpatient visits were lower than the national baseline (**3.9%**)[4] (i.e., outside the 95% confidence interval) and lower than the national ILI rate (**5.3%**) (i.e. outside the 95% confidence interval).*
- *ILI activity level: Low[5]*
- *Geographic Spread: Sporadic Activity[6].*
- *ILI Cluster Activity: No new clusters were reported to HDOH during week 2.*



[2] The Hawaii historical baseline (%ILI) is the average of 3-week moving averages over the preceding 10 flu seasons of historical data (2015-2016, 2016-2017, 2017-2018, 2018-2019, 2019-2020, 2020-2021, 2021-2022, 2022-2023, 2023-2024 and 2024-2025).
[3] This value is based upon comparison of actual outpatient ILI with the historical baseline, which only captures outpatient ILI. The chart above represents a 3-week moving average and not the actual ILI by week.
[4] The National Baseline is calculated by CDC as the mean percentage of visits for ILI during weeks 21–39 with two standard deviations. Because of large variability in regional ILI, comparison of the national baseline with local ILI may not be appropriate. It is provided in this report because no meaningful regional baselines are available for comparison. The national baseline combines all data reported by states to CDC, including ILI in outpatient, ER, urgent care, and inpatient settings.
[5] There are 10 activity levels classified as minimal (levels 1-3), low (levels 4-5), moderate (levels 6-7), and high (levels 8-10).
[6] The influenza activity reported by state and territorial epidemiologists indicates geographic spread of influenza viruses but does not measure the severity of influenza activity. Sporadic: no clusters reported to HDOH, Local: one or more clusters reported in one county, Regional: clusters reported two to three counties, Widespread: clusters reported in all counties. Hawaii does not report No Activity, as flu circulates year-round in Hawaii.

II. LABORATORY SURVEILLANCE: State Laboratories Division (SLD; the HDOH public health laboratory) and Hawaii's major private laboratories (DLS, CLH) report results of RT-PCR, which can be considered confirmatory (SLD may perform viral culture on select specimens). Specimens meeting priority criteria[7] are forwarded to SLD for sub-typing. Additionally, specimens meeting case definition from requesting sentinel providers are sent directly to SLD for sub-typing. Due to resource constraints, not all submitted specimens undergo sub-typing. Sub-typing at the commercial laboratories is only conducted on a case-by-case basis. The majority of specimens testing positive by rapid antigen testing or RT-PCR at the commercial laboratories do not meet criteria and are not subtyped. For more information on influenza tests and types, please visit the CDC website (*here*).

A. INFLUENZA:

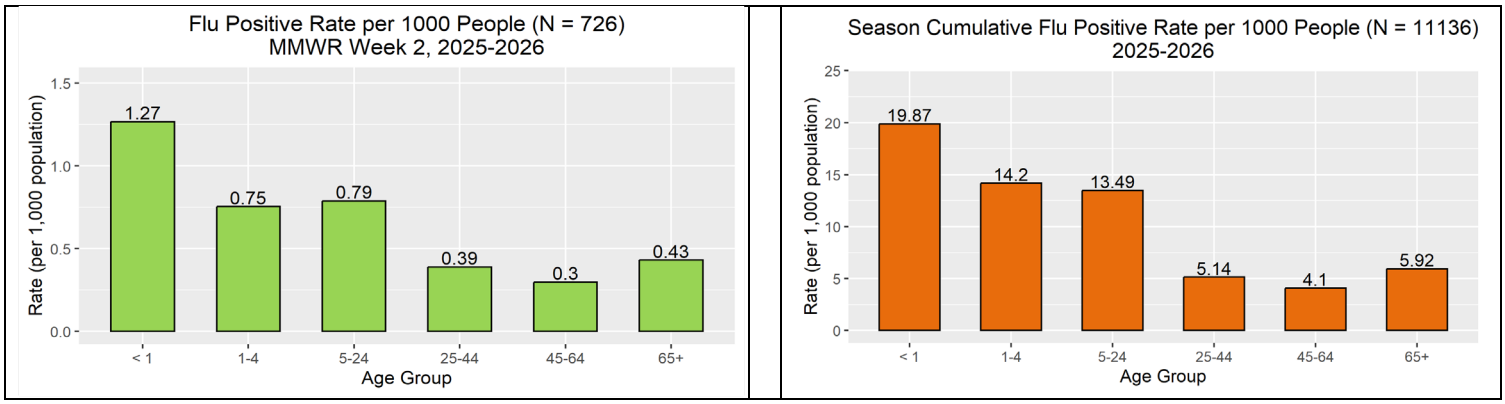
- The following reflects laboratory findings for week 2 of the 2025–26 influenza season:
  - *A total of **3,476** specimens has been tested statewide for influenza viruses (positive: 726 [**20.9%**]). (Season to date: **51,809** tested (**21.3%** positive)*
    - *1,476 (42.5%) were screened only by rapid antigen tests with no confirmatory testing.*
    - *2,000 (57.5%) underwent confirmatory testing (either RT-PCR or viral culture).*
    - *2,750 (79.9%) were negative.*
  - *Routine surveillance samples from State Laboratory Division were tested at a public health laboratory and identified as Influenza A (H3N2) subclade K. 11056*

Influenza type	*Current week 2 (%)**	*Season to date (%)*[8]
Influenza A (H1)[9]	*4 (0.5)*	*79 (0.7)*
Influenza A (H3)	*13 (1.8)*	*781 (7.1)*
Influenza A no subtyping	*641 (88.0)*	*9,966 (90.1)*
Influenza B (Yamagata)	*0 (0.0)*	*0 (0.0)*
Influenza B (Victoria)	*0 (0.0)*	*0 (0.0)*
Influenza B no genotyping	*70 (9.6)*	*230 (2.1)*

**Specimens that are positive for both A and B (coinfections) are counted in both A and B totals for current and season to date*

1. AGE DISTRIBUTION

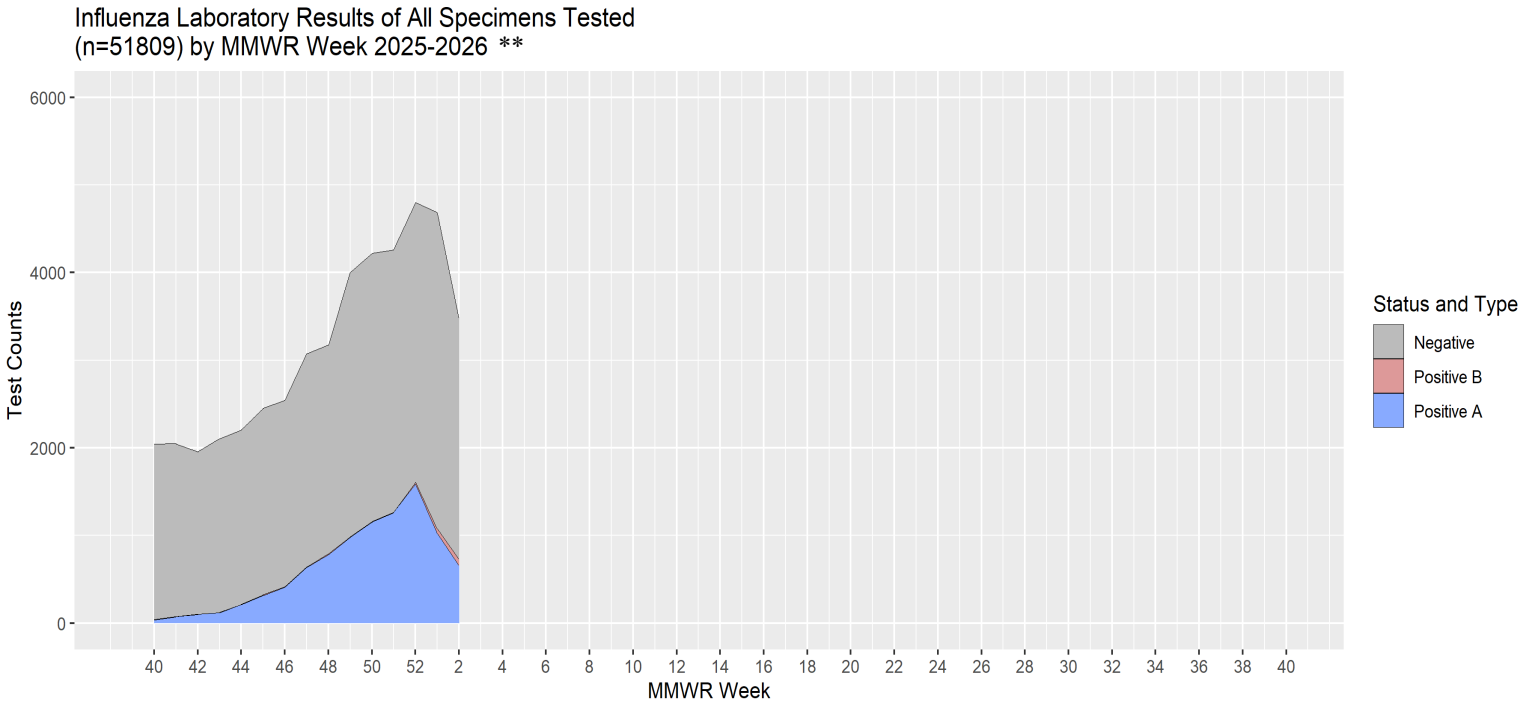
The charts below indicate the population-based rates of positive influenza cases in Hawaii by age group during the 2025–26 influenza season.[10]

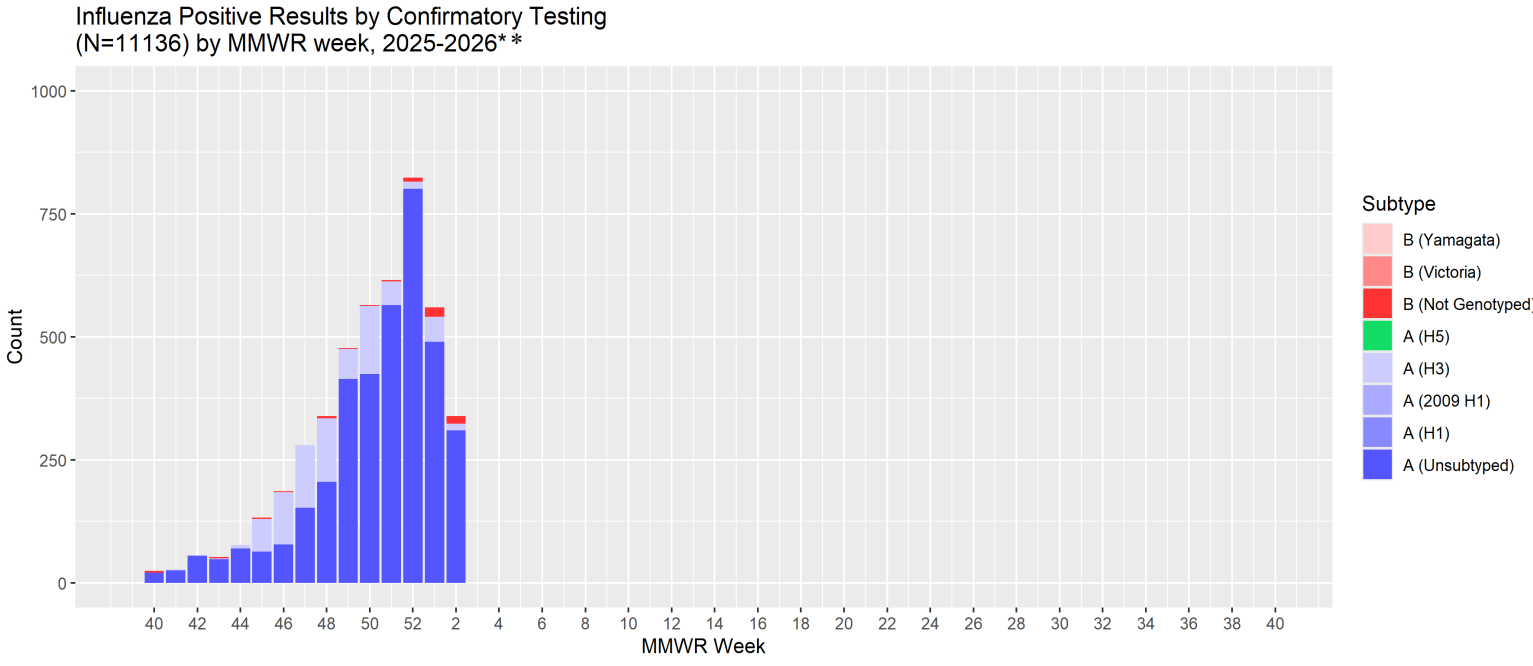


[7] Priority criteria include: hospitalized patients with acute respiratory distress syndrome [ARDS] or x-ray confirmed pneumonia; travelers with international travel history within 10 days of onset; specimens submitted by sentinel providers; specimens collected from healthcare workers, pregnant women, or women up to 6 weeks' post-partum; those with underlying medical conditions; and patients presenting with unusual or severe manifestations of influenza infection.
[8] Influenza coding were updated to reflect a more accurate count.
[9] All influenza A H1 viruses detected this season have been 2009 H1N1.
[10] This represents an estimate of population-based rates based on available data.

2. LABORATORY TESTING

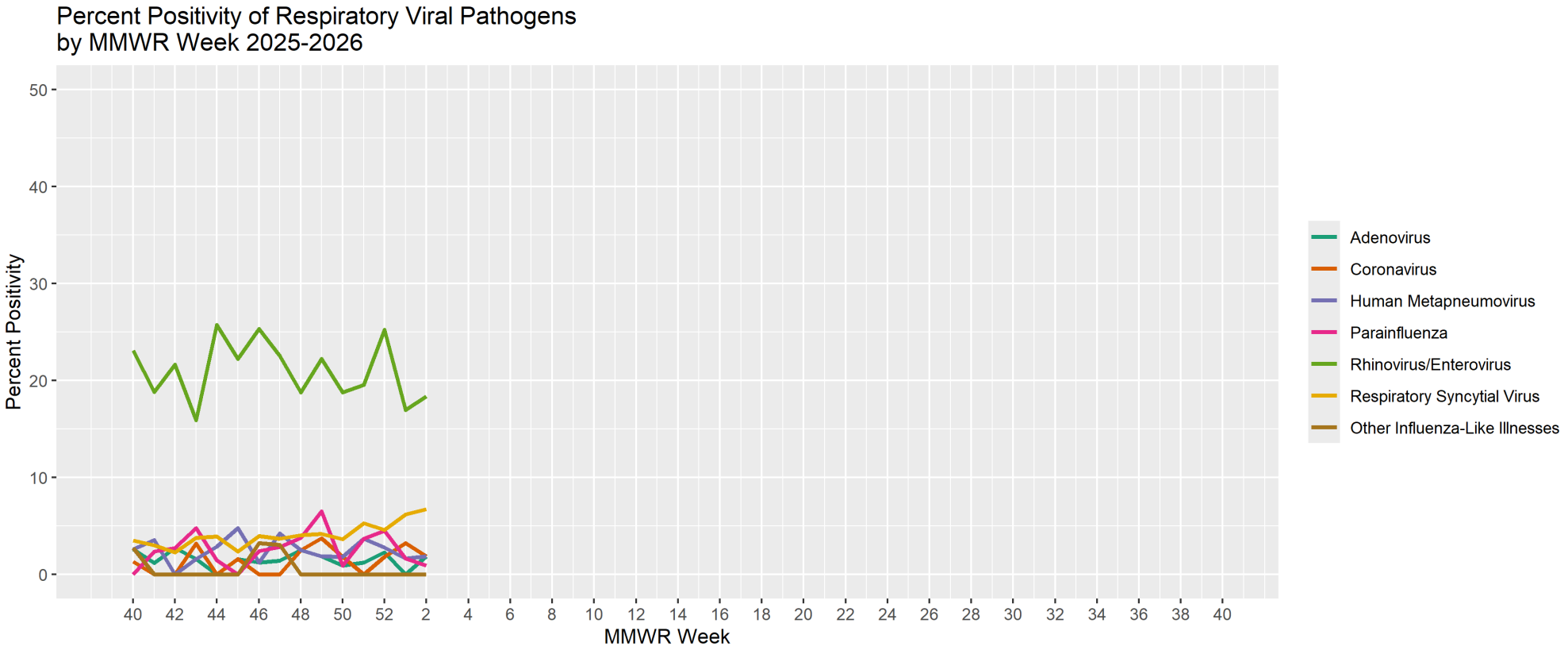
The charts below show the laboratory results of all specimens tested for influenza by MMWR week during the 2025–2026 influenza season as well as the type and subtype of positive results for influenza. Again, sub-typing is only performed on selected specimens tested by confirmatory tests (i.e., RT-PCR or viral culture).





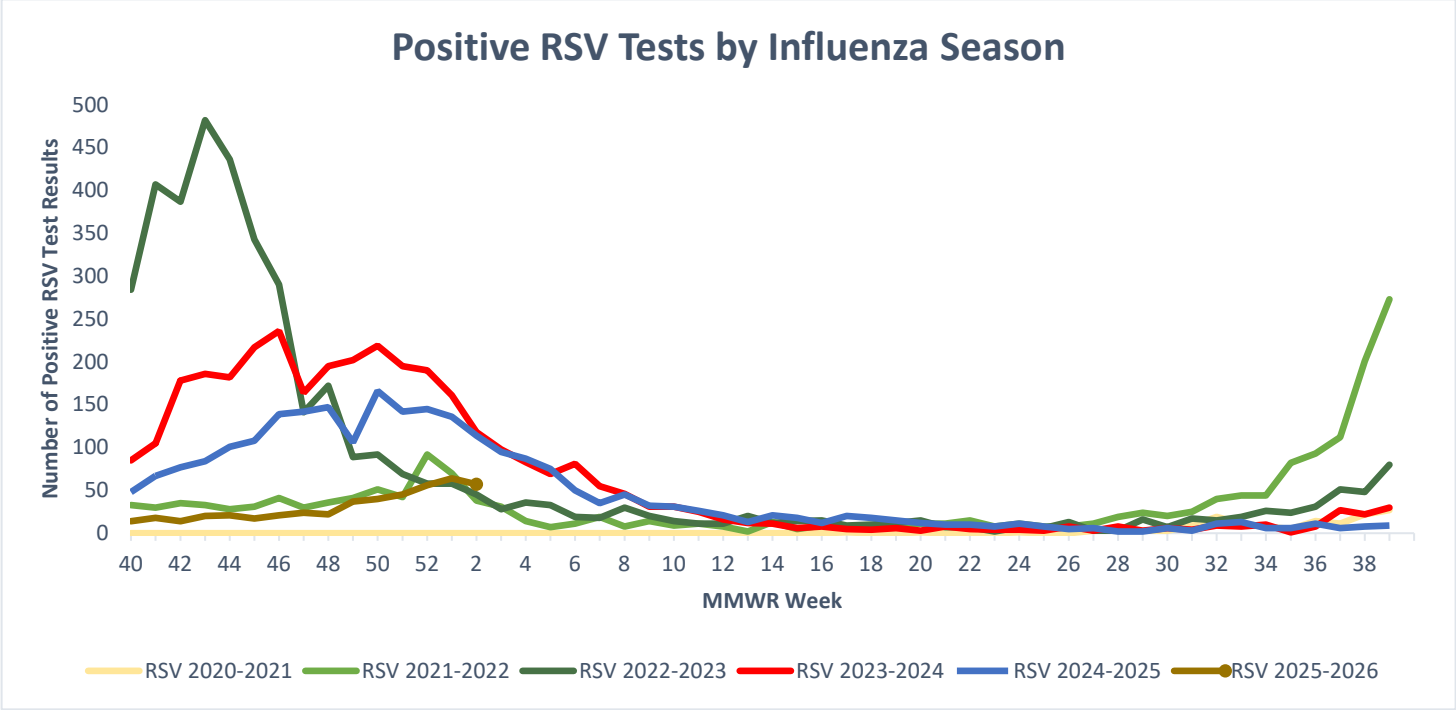
** A total of 27,981 specimens underwent confirmatory testing, but not all positive influenza specimens receive confirmatory testing that are circulating in Hawaii.*
*** For MMWR Week 53, results are reported under MMWR Week 52, where the average of Weeks 52 and 53 was calculated.*

B. **OTHER RESPIRATORY PATHOGENS:** The major clinical and commercial laboratories throughout the state of Hawaii have the testing capacity for non-influenza respiratory pathogens and report these to HDOH. However, such testing is performed as needed and when sufficient resources are available because of the high costs associated with respiratory panel tests. **Therefore, available data represent only the presence of circulating pathogens and cannot be used to determine specific trends**.

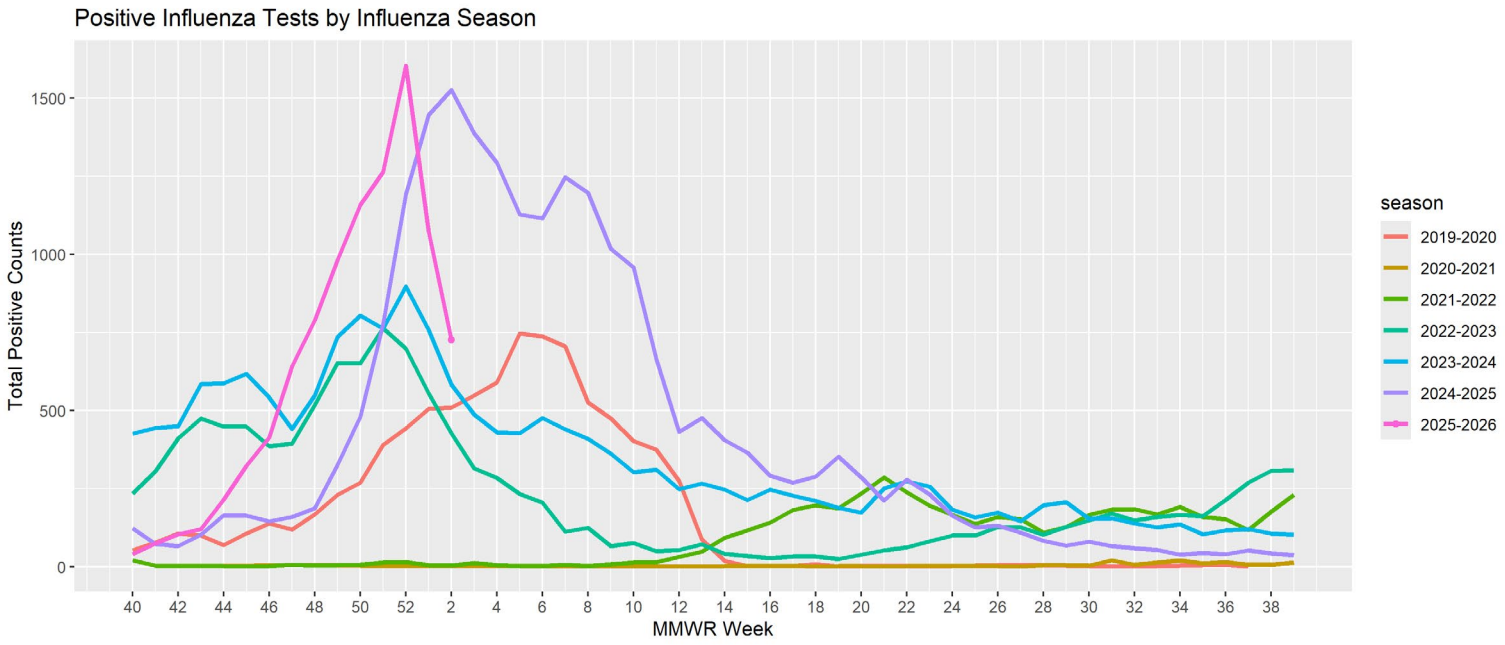


* *The coronavirus presented on this table does not indicate Severe Acute Respiratory Coronavirus-2 (i.e., COVID-19). For MMWR Week 53, results are reported under MMWR Week 52, where the average of Weeks 52 and 53 was calculated*

RESPIRATORY SYNCYTIAL VIRUS (RSV) POSITIVE TEST RESULTS BY INFLUENZA SEASON: RSV case appears to have increased earlier than past seasons in the 2025-2026 season. Of note, significantly more tests for RSV are being performed than in pre-COVID-19 seasons.



INFLUENZA POSITIVE TEST RESULTS BY INFLUENZA SEASON: Influenza cases appear to have increased earlier than past seasons in the 2025-2026 season. For MMWR Week 53, results are reported under MMWR Week 52, where the average of Weeks 52 and 53 was calculated.



C. COVID-19 SENTINEL SURVEILLANCE: Due to the low volume of samples currently available through the influenza surveillance system, the COVID-19 sentinel surveillance data may not be accurately portraying COVID-19 activity in our communities. Reporting of the COVID-19 Sentinel Surveillance data will be paused while HODH re-evaluates the program to ensure that the reported data are accurate and representative.

HDOH is continuing to monitor COVID-19 activity throughout the state. To learn more, please visit the Hawaii's COVID-19 data website (*here*). For more information on surveillance of COVID-19 activity in the United States please visit the CDC COVIDView website (*here*).

III. PNEUMONIA, INFLUENZA, AND COVID-19 (PIC) RELATED MORTALITY:

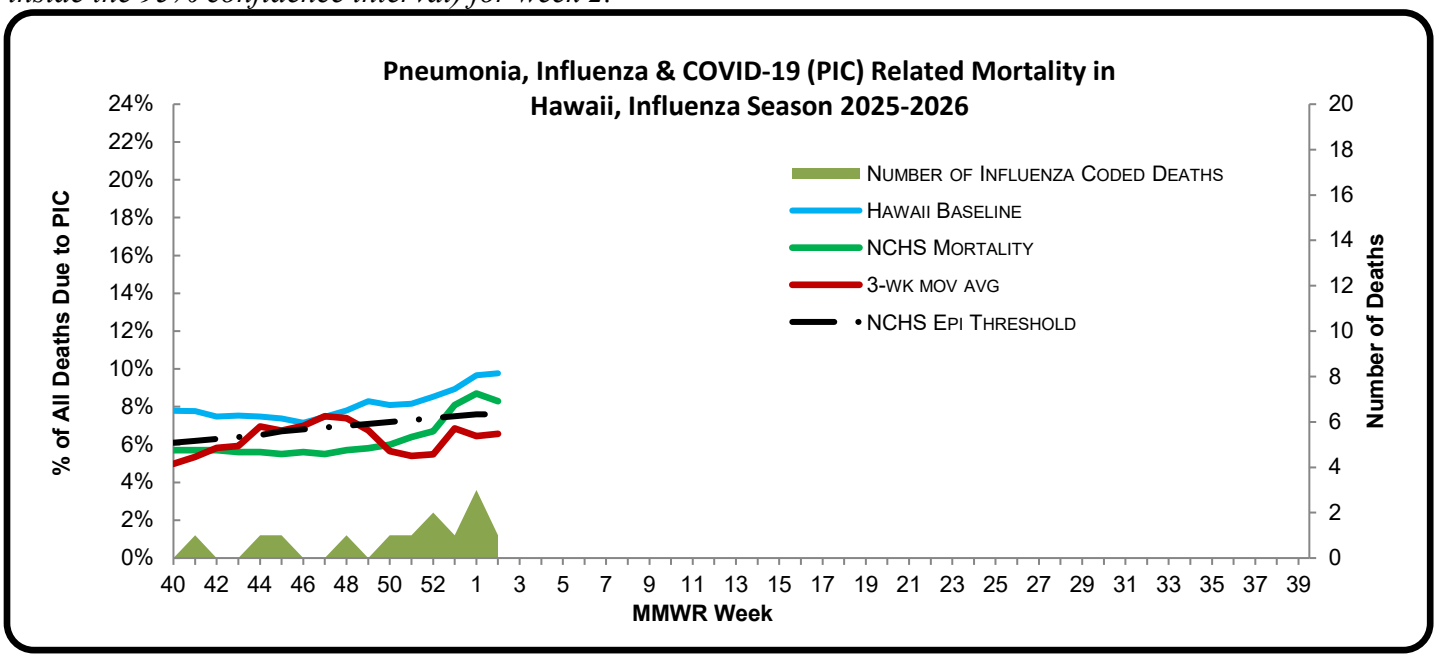
P&I mortality surveillance is collected by CDC through the National Center for Health Statistics (NCHS) using death certificate data. Each week the HDOH OHSM reports specific data from Honolulu to the CDC. CDC collects the following information by age group: the total number of deaths, total deaths from pneumonia, and total deaths related to influenza. Due to the ongoing COVID-19 pandemic, CDC included total deaths from COVID-19 by age group to the death data. Previous studies had suggested that P&I is a good indicator of influenza-related deaths; however, data has shown that pneumonia deaths associated with influenza is now being impacted by COVID-19 related pneumonia. Due to this, CDC had added COVID-19 deaths into P&I to create the PIC (pneumonia, influenza, and/or COVID-19) classification.

To standardize Hawaii's influenza surveillance with CDC influenza surveillance guidelines, PIC deaths will be reported in lieu of P&I. Hawaii's baseline will begin to include PIC deaths starting from 2019-2020 flu season.

For **week 2** of the current influenza season:

- ***5.8%*** *of all deaths that occurred in Hawaii during week 2 were related to pneumonia, influenza or COVID-19 (PIC)*[11]*. For the current season (season to date:* ***6.2%****), there have been 3,454 deaths from any cause, 220 of which were due to PIC*[12]*.*
- *The PIC rate was comparable to the historical baseline in Hawaii*[13] *(i.e., inside the 95% confidence interval).*

The Hawaii PIC rate was comparable to the CDC's National Center for Health Statistics (NCHS) PIC mortality[14] ***(8.3%)*** *(i.e., inside the 95% confidence interval) and comparable to the national epidemic threshold (****7.6****%) (i.e., inside the 95% confidence interval) for week 2.*



[11] The percent of deaths due to PIC displayed on the graph is the 3-week moving averages.

[12] PIC data reflect 83.7% of the data reported for the MMWR week. Changes to data are expected when PIC data reaches 100% completion.

[13] The Hawaii historical baseline (%PIC) is the average of 3-week moving averages over the preceding 10 flu seasons of historical data (2014-2015, 2015-2016, 2016-2017, 2017-2018, 2018-2019, 2019-2020, 2020-2021, 2021-2022, 2022-2023, and 2023-2024).

[14] Each week, the vital statistics offices of 122 cities across the United States report the total number of death certificates processed and the number of those for which pneumonia, influenza, or COVID-19 was listed as the underlying or contributing cause of death by age group (Under 28 days, 28 days–1 year, 1–14 years, 15–24 years, 25–44 years, 45–64 years, 65–74 years, 75–84 years, and ≥85 years). The COVID-19 death counts reported by NCHS are provisional and will not match counts in other sources, such as media reports or numbers from health departments. COVID-19 deaths may be classified or defined differently in various reporting and surveillance systems. The percentage of deaths due to pneumonia, influenza, and COVID-19 (PIC) are compared with a seasonal baseline and epidemic threshold value calculated for each week.

INFLUENZA-ASSOCIATED PEDIATRIC DEATHS[15]:

- No new influenza-associated pediatric death was reported to Hawaii. There have been zero influenza-associated pediatric deaths reported in Hawaii during the 2025–2026 season.
- Nationally, twelve new influenza-associated pediatric deaths were reported to CDC during week 2. (2025-2026 season total: 44).

IV. INFLUENZA WATCH: As part of a comprehensive influenza surveillance system and to prevent the spread of contagious respiratory diseases in humans, it is important to monitor all circulating influenza types. Several animal-origin influenza A subtypes are currently of interest: influenza A variant virus (H3N2v, H1N2v, and H1N1v) and Avian flu (H5N1 and H7N9). These types of influenza viruses may cause zoonotic (animal-associated) disease and are a public health concern.

A. VARIANT VIRUSES:

Influenza viruses that normally circulate in pigs are called "variant" viruses when they are found in people. These viruses were first identified in U.S. pigs in 2010. In 2011, 12 cases of H3N2v infection were detected in the United States. In 2012, 309 such cases (resulting in 16 hospitalizations and one death) across 12 states were detected, including one Hawaii case who recovered. Illness associated with H3N2v infection has been mostly mild with symptoms similar to those of seasonal flu. However, serious illness, resulting in hospitalization and death, has occurred in some cases. Most of these infections have been associated with prolonged exposure to pigs at agricultural fairs or similar settings. Limited human-to-human spread of this virus has been detected in the past, but no sustained community spread of H3N2v has been identified. More information regarding H3N2v, H1N1v, and H1N2v viruses may be found on the CDC website (*here*) and (*here*).

- *No variant or novel influenza infections have been reported to HDOH during the 2025-2026 influenza season.*
- *One new human infection with novel influenza A virus, H1N1v (0), H3N2v (0), and H1N2v (1), have been reported during the 2025-2026 influenza season.*
    - *One new human infection with influenza A(H1N1v) virus has been reported to WHO from China during the 2025-2026 influenza season.*

AVIAN (OR BIRD) INFLUENZA: These types of influenza viruses cause zoonotic (animal-associated) disease of public health concern and are therefore monitored globally by the WHO. Most avian influenza viruses do not cause disease in humans and are generally not easily transmissible between person to person, but a few subtypes may cross the species barrier and cause disease in humans. Avian influenza viruses may be of various subtypes, including H5N1, H5N2, H5N8, H7N3, H7N7, H7N8, H7N9, and H9N2. On January 15th, 2016, the USDA and APHIS reported detection of HPAI H7N8 in a commercial turkey flock in Indiana. There have been no associated human infections. This is the first detection of HPAI H7N8 in wild bird surveillance in the United States. More information, the risk assessment and recommendations for HPAI H7N8 can be found (here). The WHO, CDC, and other public health agencies have also been monitoring influenza H7N9, which represents a public health concern because of its high pandemic potential. Although H7N9 has not been detected in the United States, it remains a global concern given continuing epidemics in endemic countries. Since 2013, a total of 1,568 laboratory-confirmed cases of human infection with H7N9 viruses, including at least 613 deaths, have been reported to WHO. More information on H7N9 virus infections can be found (here). For more information regarding avian influenza, please visit the CDC (*here*) or the WHO (*here*) websites. WHO reports total number of cases and deaths related to laboratory-confirmed avian influenza viruses and posts current avian influenza case counts (*here*), which were last updated on **December 19, 2025**.

[15] Influenza-associated deaths are considered pediatric in persons aged less than 18 years. It was made a nationally notifiable condition in October, 2004. All pediatric influenza-associated deaths are laboratory confirmed.

V. INFLUENZA Vaccine: Annual influenza vaccination is recommended for all persons aged 6 months and older and is the most effective way to reduce the risk of getting sick with seasonal flu and spreading it to others. Influenza vaccination can reduce illnesses, visits to the doctor, influenza-related hospitalizations, and missed work and school days. Influenza vaccines become available by the end of October. It takes at least two weeks after vaccination to confer immunity against influenza virus infection. More information regarding influenza vaccination can be found (*here*).

A. Composition of the 2025–2026 Influenza Vaccine:

The composition of the 2025–2026 influenza vaccine has been updated to better match circulating influenza viruses. The Advisory Committee on Immunization Practices (ACIP) has recommended that the 2025-2026 influenza trivalent vaccine contain an influenza A/Victoria/4897/2022 (H1N1) pdm09-like virus, influenza A/Croatia/10136RV/2023 (H3N2)-like virus, and influenza B/Austria/1359417/2021 (B/Victoria lineage)-like virus. United States cell culture–based inactivated (ccIIV4) and recombinant (RIV4) influenza vaccines will contain HA derived from an influenza A/Wisconsin/67/2022 (H1N1) pdm09-like virus, an A/District of Columbia/27/2023 (H3N2)-like virus, an influenza B/Austria/1359417/2021 (B/Victoria lineage)-like virus. These vaccine recommendations were based on several factors, including global influenza virologic and epidemiologic surveillance, genetic and antigenic characterization, human serology studies, antiviral susceptibility, and the availability of candidate influenza viruses.

APPENDIX 1: ADDITIONAL INFORMATION

For more information regarding local and national influenza surveillance programs, visit the following sites.

Centers for Disease Control and Prevention	General Influenza National ILI and P&I Data Vaccine Virus Selection CDC Web Tool for Respiratory Viruses
Flu.gov	General Influenza Information
HDOH Flu and Pneumonia	General Influenza Surveillance Avian Influenza Respiratory Virus Dashboard To find out more information or join the sentinel physician program, email the Influenza Surveillance Coordinator
World Health Organization	General Global and Local Influenza Avian Influenza

APPENDIX 2: MMWR WEEK DATES

Please refer to the table below to interpret data presented by MMWR week. Week 40 is considered the traditional start for the flu season for the Northern Hemisphere.

MMWR WEEK	2022	2023	2024	2025	2026
1	1/8/2022	1/7/2023	1/6/2024	1/4/2025	1/10/2026
2	1/15/2022	1/14/2023	1/13/2024	1/11/2025	1/17/2026
3	1/22/2022	1/21/2023	1/20/2024	1/18/2025	1/24/2026
4	1/29/2022	1/28/2023	1/27/2024	1/25/2025	1/31/2026
5	2/5/2022	2/4/2023	2/3/2024	2/1/2025	2/7/2026
6	2/12/2022	2/11/2023	2/10/2024	2/8/2025	2/14/2026
7	2/19/2022	2/18/2023	2/17/2024	2/15/2025	2/21/2026
8	2/26/2022	2/25/2023	2/24/2024	2/22/2025	2/28/2026
9	3/5/2022	3/4/2023	3/2/2024	3/1/2025	3/7/2026
10	3/12/2022	3/11/2023	3/9/2024	3/8/2025	3/14/2026
11	3/19/2022	3/18/2023	3/16/2024	3/15/2025	3/21/2026
12	3/26/2022	3/25/2023	3/23/2024	3/22/2025	3/28/2026
13	4/2/2022	4/1/2023	3/30/2024	3/29/2025	4/4/2026
14	4/9/2022	4/8/2023	4/6/2024	4/5/2025	4/11/2026
15	4/16/2022	4/15/2023	4/13/2024	4/12/2025	4/18/2026
16	4/23/2022	4/22/2023	4/20/2024	4/19/2025	4/25/2026
17	4/30/2022	4/29/2023	4/27/2024	4/26/2025	5/2/2026
18	5/7/2022	5/6/2023	5/4/2024	5/3/2025	5/9/2026
19	5/14/2022	5/13/2023	5/11/2024	5/10/2025	5/16/2026
20	5/21/2022	5/20/2023	5/18/2024	5/17/2025	5/23/2026
21	5/28/2022	5/27/2023	5/25/2024	5/24/2025	5/30/2026
22	6/4/2022	6/3/2023	6/1/2024	5/31/2025	6/6/2026
23	6/11/2022	6/10/2023	6/8/2024	6/7/2025	6/13/2026
24	6/18/2022	6/17/2023	6/15/2024	6/14/2025	6/20/2026
25	6/25/2022	6/24/2023	6/22/2024	6/21/2025	6/27/2026
26	7/2/2022	7/1/2023	6/29/2024	6/28/2025	7/4/2026
27	7/9/2022	7/8/2023	7/6/2024	7/5/2025	7/11/2026
28	7/16/2022	7/15/2023	7/13/2024	7/12/2025	7/18/2026
29	7/23/2022	7/22/2023	7/20/2024	7/19/2025	7/25/2026
30	7/30/2022	7/29/2023	7/27/2024	7/26/2025	8/1/2026
31	8/6/2022	8/5/2023	8/3/2024	8/2/2025	8/8/2026
32	8/13/2022	8/12/2023	8/10/2024	8/9/2025	8/15/2026
33	8/20/2022	8/19/2023	8/17/2024	8/16/2025	8/22/2026
34	8/27/2022	8/26/2023	8/24/2024	8/23/2025	8/29/2026
35	9/3/2022	9/2/2023	8/31/2024	8/30/2025	9/5/2026
36	9/10/2022	9/9/2023	9/7/2024	9/6/2025	9/12/2026
37	9/17/2022	9/16/2023	9/14/2024	9/13/2025	9/19/2026
38	9/24/2022	9/23/2023	9/21/2024	9/20/2025	9/26/2026
39	10/1/2022	9/30/2023	9/28/2024	9/27/2025	10/3/2026
40	10/8/2022	10/7/2023	10/5/2024	10/4/2025	10/10/2026
41	10/15/2022	10/14/2023	10/12/2024	10/11/2025	10/17/2026
42	10/22/2022	10/21/2023	10/19/2024	10/18/2025	10/24/2026
43	10/29/2022	10/28/2023	10/26/2024	10/25/2025	10/31/2026
44	11/5/2022	11/4/2023	11/2/2024	11/1/2025	11/7/2026
45	11/12/2022	11/11/2023	11/9/2024	11/8/2025	11/14/2026
46	11/19/2022	11/18/2023	11/16/2024	11/15/2025	11/21/2026
47	11/26/2022	11/25/2023	11/23/2024	11/22/2025	11/28/2026
48	12/3/2022	12/2/2023	11/30/2024	11/29/2025	12/5/2026
49	12/10/2022	12/9/2023	12/7/2024	12/6/2025	12/12/2026
50	12/17/2022	12/16/2023	12/14/2024	12/13/2025	12/19/2026
51	12/24/2022	12/23/2023	12/21/2024	12/20/2025	12/26/2026
52	12/31/2022	12/30/2023	12/28/2024	12/27/2025	
53				01/03/2026	

HAWAII STATE DEPARTMENT OF HEALTH
DISEASE OUTBREAK CONTROL DIVISION

Influenza/Respiratory Disease Surveillance Report

Morbidity and Mortality Weekly Report (MMWR)[1]

WEEK 3: JANUARY 18, 2026– JANUARY 24, 2026

OVERVIEW: The Hawaii State Department of Health (HDOH) monitors influenza and other respiratory pathogens, including COVID-19, throughout the state of Hawaii. Influenza surveillance in the state of Hawaii relies upon selected sentinel health practitioners, the State Laboratories Division (SLD), private laboratories, and the Office of Health Status Monitoring (OHSM). For detailed information concerning influenza, please visit the HDOH Disease Outbreak Control Division (HDOH DOCD) website (*here*). **All data and information are conditional and may change as more reports are received.** The data in this report reflects the 2025-2026 influenza season which began the week ending October 4, 2025 (week 40[1] 2025) and will end the week ending on October 3, 2026 (week 39 2026).

REPORT SNAPSHOT FOR WEEK 3

Surveillance for Influenza-like Illness (ILI)		
Metric	*Value*	*Comment*
Outpatient visits related to influenza-like illness (ILI) from ILINet Sentinel Providers	3.1%	Lower than the previous week. Comparable to Hawaii's historical baseline and lower than the national baseline, and lower than the national ILI rate.
Number of ILI clusters reported to HDOH	0	There have been 19 clusters this season.

Laboratory Surveillance		
Percent of all respiratory specimens positive for influenza this week	13.3%	Lower than the previous week. This number means that many, if not all, of the 86.7% who tested negative for influenza had illness from another respiratory etiology.
Percent of all respiratory specimens positive for influenza this season to date	20.6%	

Surveillance for Severe Outcomes		
Pneumonia, influenza and COVID-19 (PIC) mortality rate	8.2%	Comparable to Hawaii's historical baseline, comparable to the national epidemic threshold and comparable to the NCHS average.
Number of influenza-associated pediatric deaths reported nationwide	52	0 influenza-associated pediatric deaths have been reported from Hawaii this season to date.

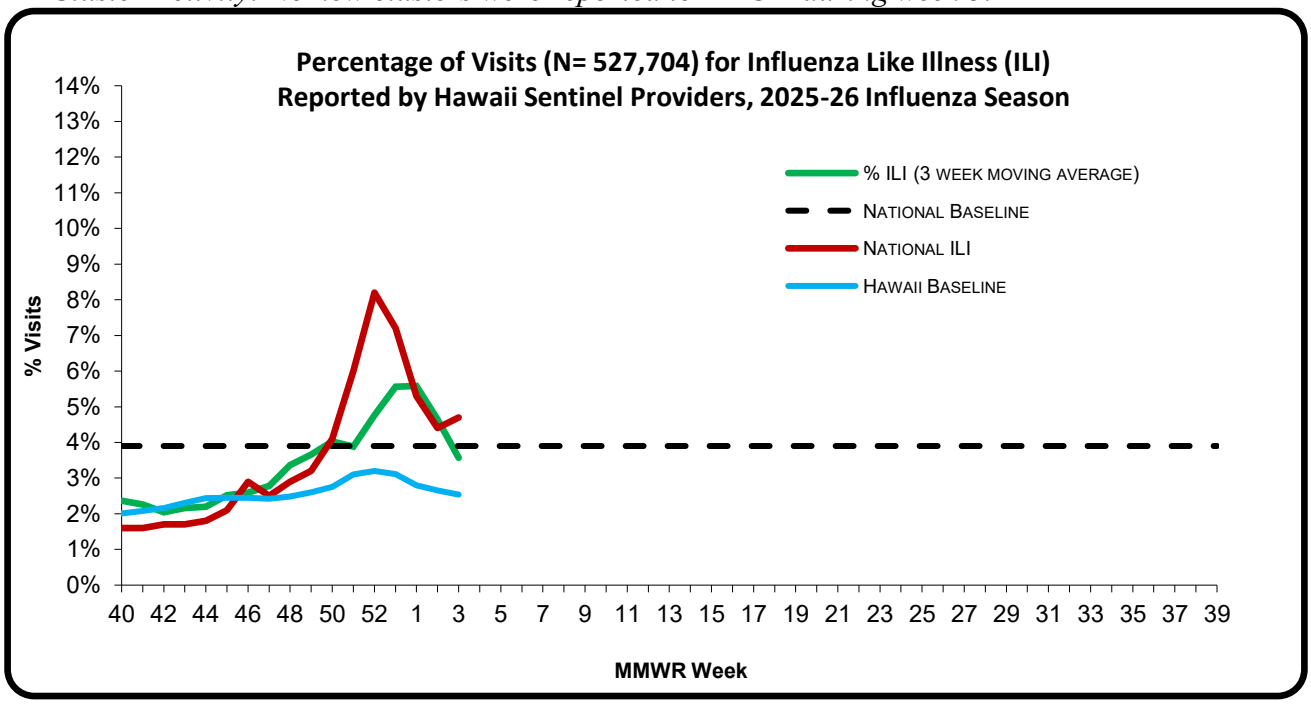
[1] MMWR stands for "Morbidity and Mortality Weekly Report," conventionally used by the Centers for Disease Control and Prevention (CDC). The weeks of a flu season are often referred to by their respective MMWR week. **See appendix 2 for interpretation of MMWR weeks.** Data reported will begin on week 40, the traditional start date of flu season.

INFLUENZA SURVEILLANCE

I. INFLUENZA-LIKE ILLNESS (ILI): HDOH collaborates with recruited doctors and healthcare providers who report the total number of outpatient visits for ILI as well as the total number of patients who complained of symptoms consistent with ILI. A patient with ILI must have the following: a fever (temperature of 100°F [37.8°C] or greater) AND a cough and/or a sore throat. ILI is based on reported symptoms and not laboratory confirmed tests; thus, ILI may represent other respiratory pathogens and not solely influenza. Further, sentinel providers report these numbers on a weekly basis; therefore, data are preliminary and may change depending on additional reporting. In combination with laboratory testing and other surveillance systems, ILI surveillance helps monitor influenza and other respiratory pathogen activity. For more information concerning ILINet and sentinel requirements, please visit the CDC website (*here*).

For **week 3** of the current influenza season:

- ***3.1****% (season to date:* ***3.4****%) of the outpatient visits recorded by Hawaii sentinel providers were for ILI.*
- *ILI visits were comparable to the historical baseline in Hawaii[2,3] (i.e., inside the 95% confidence interval).*
- *Hawaii's ILI outpatient visits were lower than the national baseline (**3.9%**)[4] (i.e., outside the 95% confidence interval) and lower than the national ILI rate (**4.7%**) (i.e. outside the 95% confidence interval).*
- *ILI activity level: Low[5]*
- *Geographic Spread: Sporadic Activity[6].*
- *ILI Cluster Activity: No new clusters were reported to HDOH during week 3.*



[2] The Hawaii historical baseline (%ILI) is the average of 3-week moving averages over the preceding 10 flu seasons of historical data (2015-2016, 2016-2017, 2017-2018, 2018-2019, 2019-2020, 2020-2021, 2021-2022, 2022-2023, 2023-2024 and 2024-2025).

[3] This value is based upon comparison of actual outpatient ILI with the historical baseline, which only captures outpatient ILI. The chart above represents a 3-week moving average and not the actual ILI by week.

[4] The National Baseline is calculated by CDC as the mean percentage of visits for ILI during weeks 21–39 with two standard deviations. Because of large variability in regional ILI, comparison of the national baseline with local ILI may not be appropriate. It is provided in this report because no meaningful regional baselines are available for comparison. The national baseline combines all data reported by states to CDC, including ILI in outpatient, ER, urgent care, and inpatient settings.

[5] There are 10 activity levels classified as minimal (levels 1-3), low (levels 4-5), moderate (levels 6-7), and high (levels 8-10).

[6] The influenza activity reported by state and territorial epidemiologists indicates geographic spread of influenza viruses but does not measure the severity of influenza activity. Sporadic: no clusters reported to HDOH, Local: one or more clusters reported in one county, Regional: clusters reported two to three counties, Widespread: clusters reported in all counties. Hawaii does not report No Activity, as flu circulates year-round in Hawaii.

II. LABORATORY SURVEILLANCE: State Laboratories Division (SLD; the HDOH public health laboratory) and Hawaii's major private laboratories (DLS, CLH) report results of RT-PCR, which can be considered confirmatory (SLD may perform viral culture on select specimens). Specimens meeting priority criteria[7] are forwarded to SLD for sub-typing. Additionally, specimens meeting case definition from requesting sentinel providers are sent directly to SLD for sub-typing. Due to resource constraints, not all submitted specimens undergo sub-typing. Sub-typing at the commercial laboratories is only conducted on a case-by-case basis. The majority of specimens testing positive by rapid antigen testing or RT-PCR at the commercial laboratories do not meet criteria and are not subtyped. For more information on influenza tests and types, please visit the CDC website (*here*).

A. INFLUENZA:

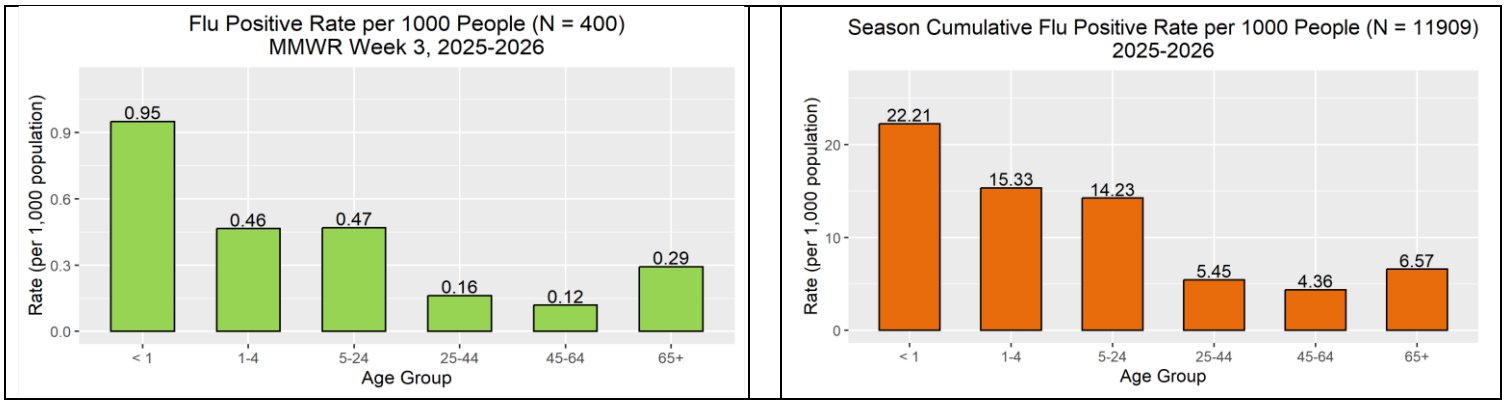
- The following reflects laboratory findings for week 3 of the 2025–26 influenza season:
  - *A total of **3,009** specimens has been tested statewide for influenza viruses (positive: 400 [**13.3%**]). (Season to date: **57,798** tested (**20.6%** positive)*
    - *977 (32.5%) were screened only by rapid antigen tests with no confirmatory testing.*
    - *2,032 (67.5%) underwent confirmatory testing (either RT-PCR or viral culture).*
    - *2,609 (86.7%) were negative.*
  - *Routine surveillance samples from State Laboratory Division were tested at a public health laboratory and identified as Influenza A (H3N2) subclade K.*

Influenza type	*Current week 3 (%)**	*Season to date (%)*[8]
Influenza A (H1)[9]	*1 (0.2)*	*81 (0.7)*
Influenza A (H3)	*2 (0.5)*	*900 (7.6)*
Influenza A no subtyping	*321 (80.3)*	*10,605 (89.1)*
Influenza B (Yamagata)	*0 (0.0)*	*0 (0.0)*
Influenza B (Victoria)	*0 (0.0)*	*0 (0.0)*
Influenza B no genotyping	*76 (19.0)*	*316 (2.6)*

**Specimens that are positive for both A and B (coinfections) are counted in both A and B totals for current and season to date*

1. AGE DISTRIBUTION

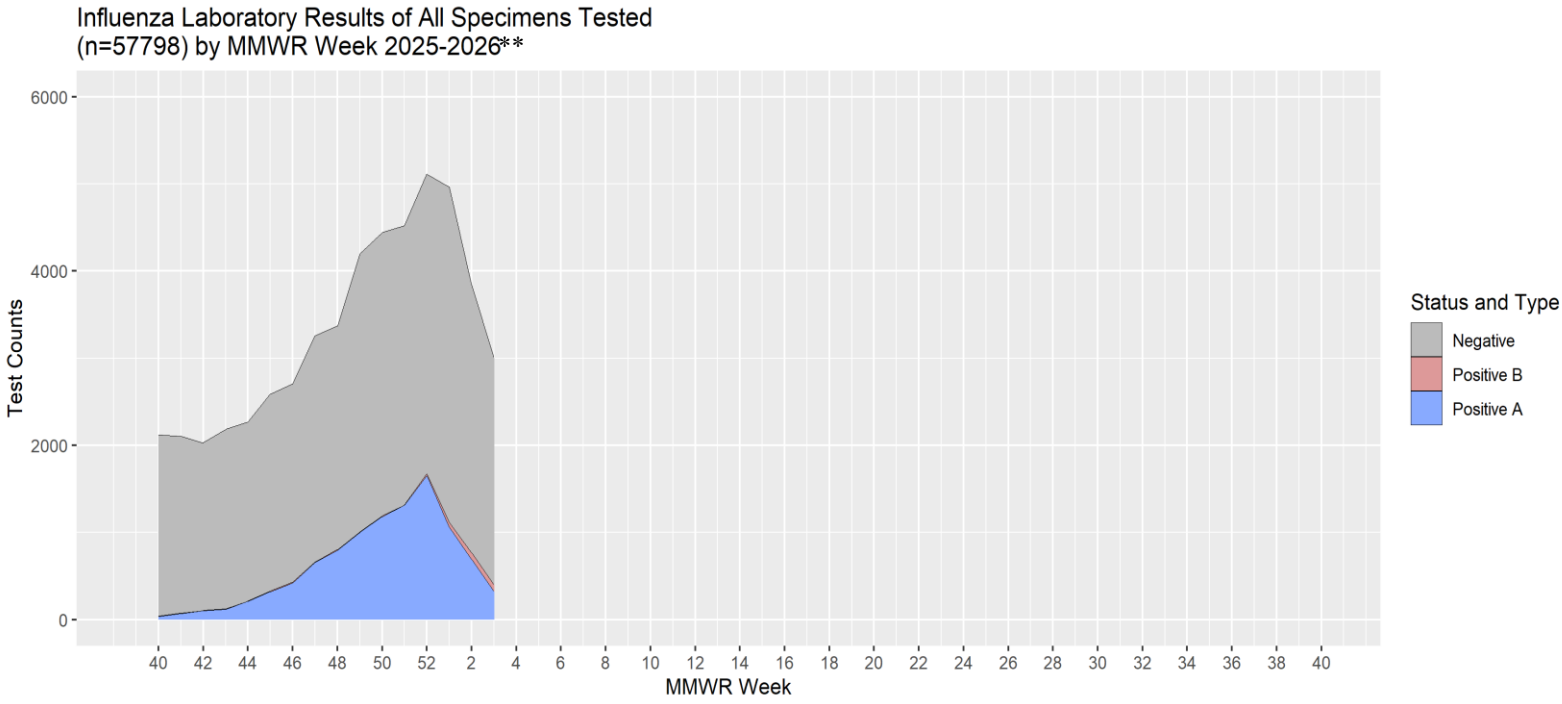
The charts below indicate the population-based rates of positive influenza cases in Hawaii by age group during the 2025–26 influenza season.[10]

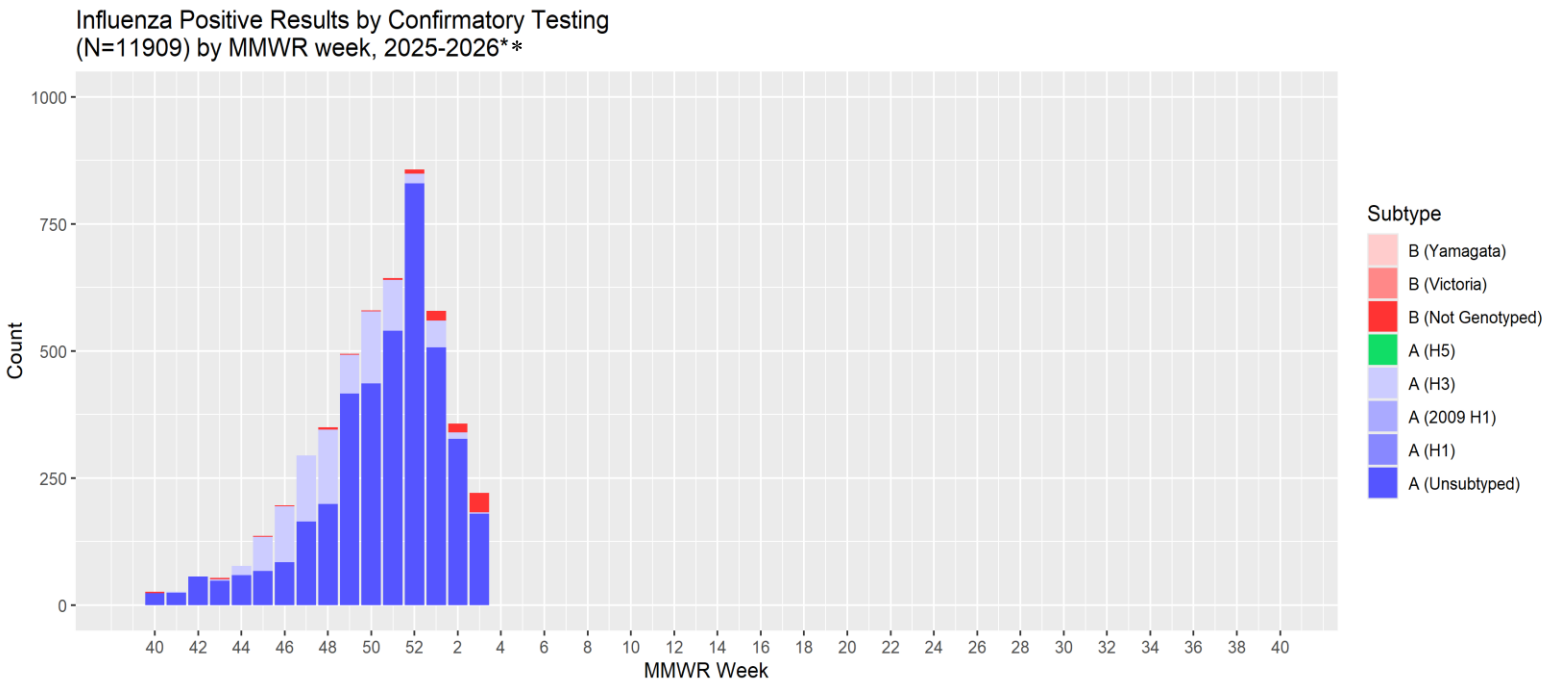


[7] Priority criteria include: hospitalized patients with acute respiratory distress syndrome [ARDS] or x-ray confirmed pneumonia; travelers with international travel history within 10 days of onset; specimens submitted by sentinel providers; specimens collected from healthcare workers, pregnant women, or women up to 6 weeks' post-partum; those with underlying medical conditions; and patients presenting with unusual or severe manifestations of influenza infection.
[8] Influenza coding were updated to reflect a more accurate count.
[9] All influenza A H1 viruses detected this season have been 2009 H1N1.
[10] This represents an estimate of population-based rates based on available data.

2. LABORATORY TESTING

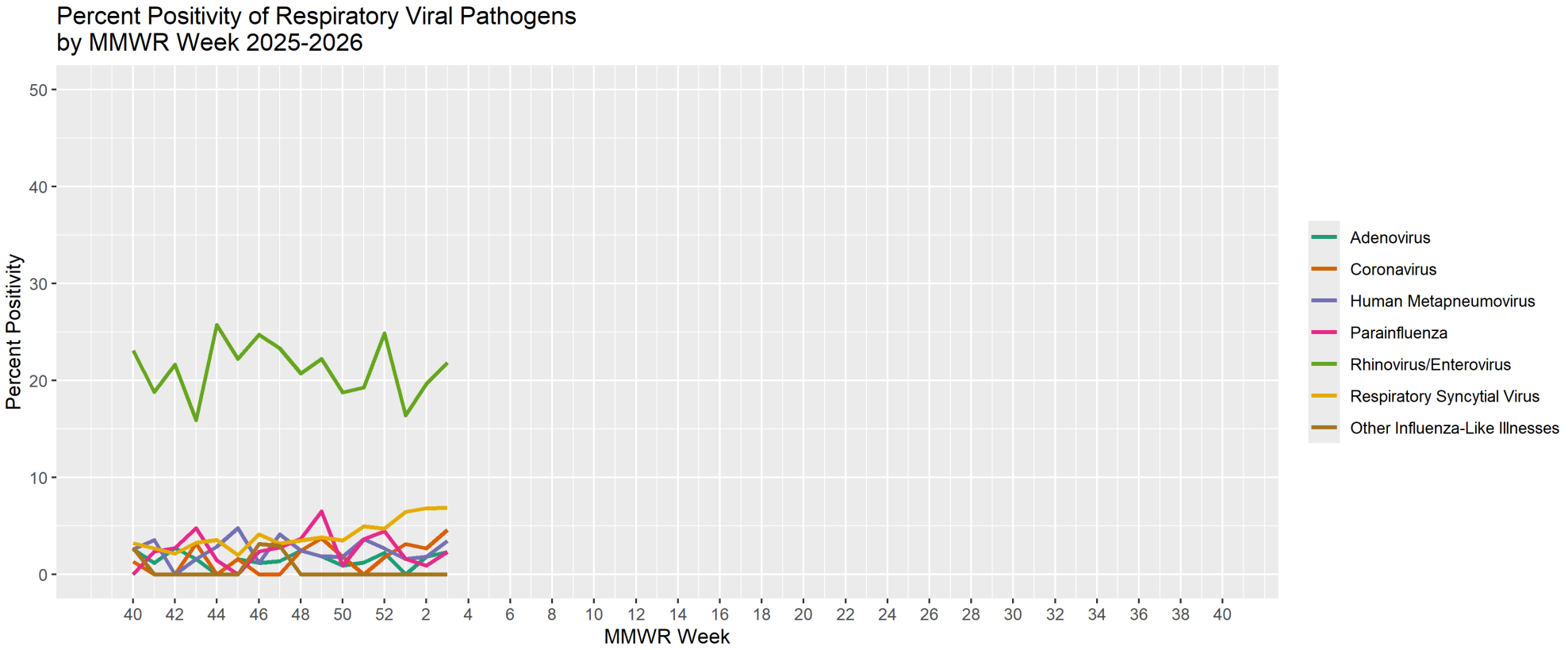
The charts below show the laboratory results of all specimens tested for influenza by MMWR week during the 2025–2026 influenza season as well as the type and subtype of positive results for influenza. Again, sub-typing is only performed on selected specimens tested by confirmatory tests (i.e., RT-PCR or viral culture).





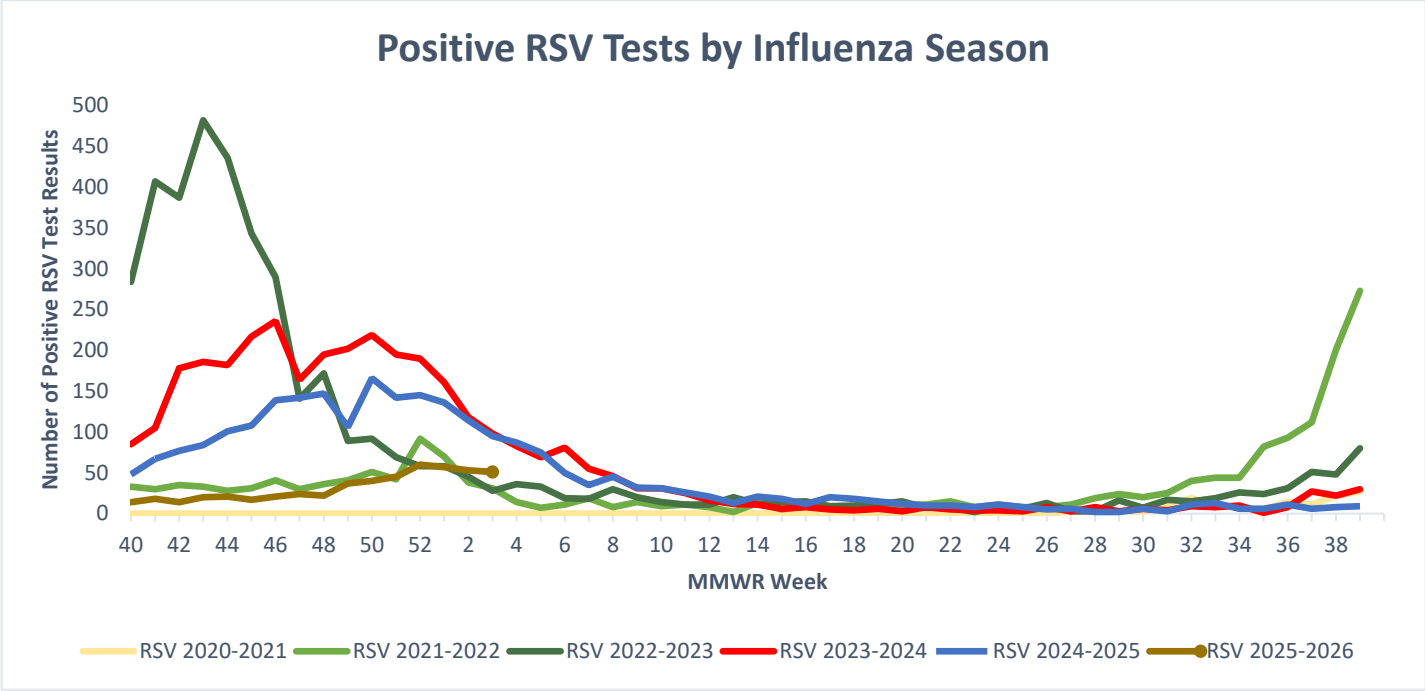
** A total of 32,174 specimens underwent confirmatory testing, but not all positive influenza specimens receive confirmatory testing that are circulating in Hawaii.*
*** For MMWR Week 53, results are reported under MMWR Week 52, where the average of Weeks 52 and 53 was calculated.*

B. **OTHER RESPIRATORY PATHOGENS:** The major clinical and commercial laboratories throughout the state of Hawaii have the testing capacity for non-influenza respiratory pathogens and report these to HDOH. However, such testing is performed as needed and when sufficient resources are available because of the high costs associated with respiratory panel tests. **Therefore, available data represent only the presence of circulating pathogens and cannot be used to determine specific trends**.

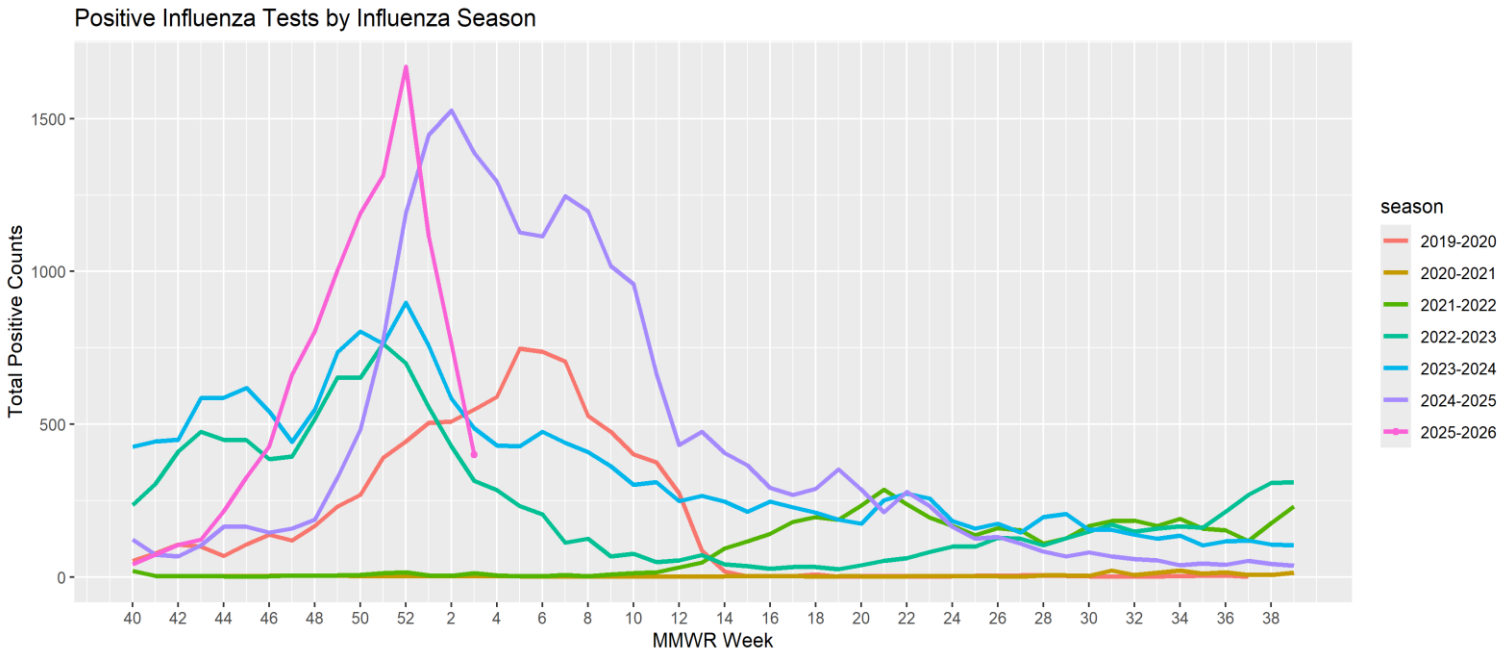


* *The coronavirus presented on this table does not indicate Severe Acute Respiratory Coronavirus-2 (i.e., COVID-19). For MMWR Week 53, results are reported under MMWR Week 52, where the average of Weeks 52 and 53 was calculated*

RESPIRATORY SYNCYTIAL VIRUS (RSV) POSITIVE TEST RESULTS BY INFLUENZA SEASON: RSV case appears to have increased earlier than past seasons in the 2025-2026 season. Of note, significantly more tests for RSV are being performed than in pre-COVID-19 seasons. For MMWR Week 53, results are reported under MMWR Week 52, where the average of Weeks 52 and 53 was calculated.



INFLUENZA POSITIVE TEST RESULTS BY INFLUENZA SEASON: Influenza cases appear to have increased earlier than past seasons in the 2025-2026 season. For MMWR Week 53, results are reported under MMWR Week 52, where the average of Weeks 52 and 53 was calculated.



C. COVID-19 SENTINEL SURVEILLANCE: Due to the low volume of samples currently available through the influenza surveillance system, the COVID-19 sentinel surveillance data may not be accurately portraying COVID-19 activity in our communities. Reporting of the COVID-19 Sentinel Surveillance data will be paused while HODH re-evaluates the program to ensure that the reported data are accurate and representative.

HDOH is continuing to monitor COVID-19 activity throughout the state. To learn more, please visit the Hawaii's COVID-19 data website (*here*). For more information on surveillance of COVID-19 activity in the United States please visit the CDC COVIDView website (*here*).

III. PNEUMONIA, INFLUENZA, AND COVID-19 (PIC) RELATED MORTALITY:

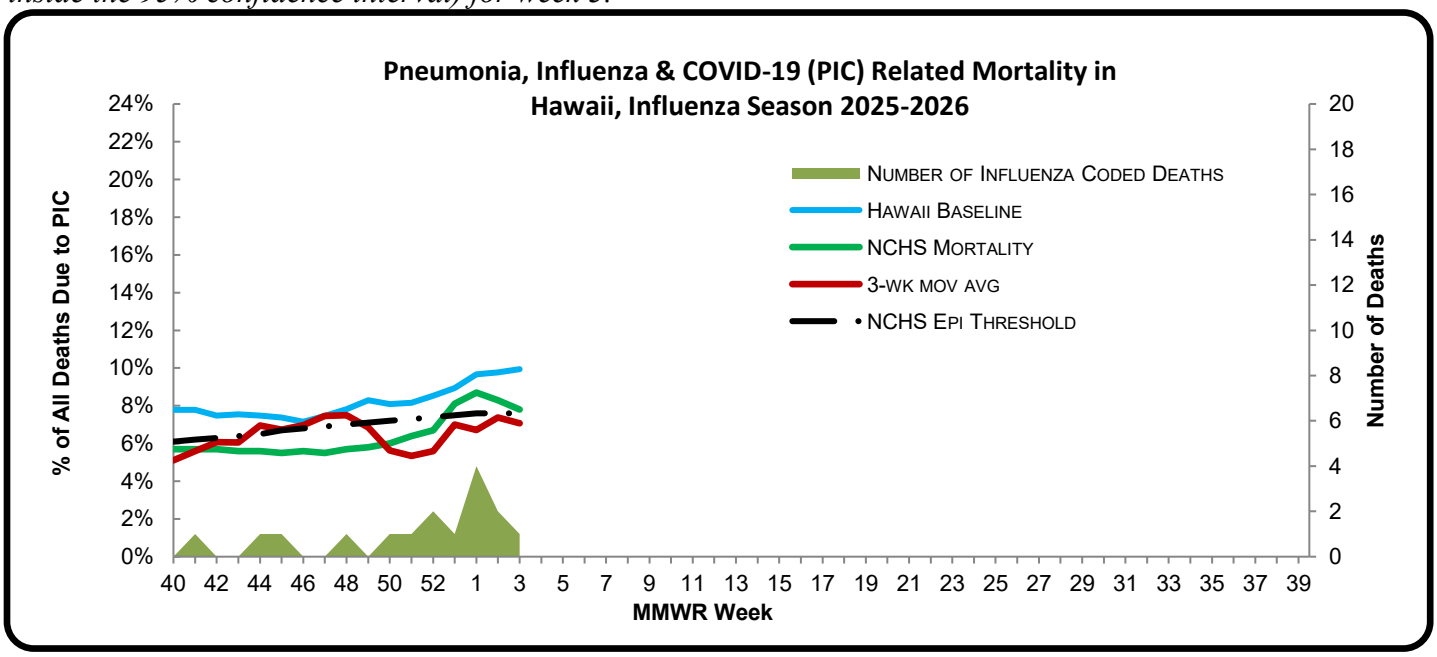
P&I mortality surveillance is collected by CDC through the National Center for Health Statistics (NCHS) using death certificate data. Each week the HDOH OHSM reports specific data from Honolulu to the CDC. CDC collects the following information by age group: the total number of deaths, total deaths from pneumonia, and total deaths related to influenza. Due to the ongoing COVID-19 pandemic, CDC included total deaths from COVID-19 by age group to the death data. Previous studies had suggested that P&I is a good indicator of influenza-related deaths; however, data has shown that pneumonia deaths associated with influenza is now being impacted by COVID-19 related pneumonia. Due to this, CDC had added COVID-19 deaths into P&I to create the PIC (pneumonia, influenza, and/or COVID-19) classification.

To standardize Hawaii's influenza surveillance with CDC influenza surveillance guidelines, PIC deaths will be reported in lieu of P&I. Hawaii's baseline will begin to include PIC deaths starting from 2019-2020 flu season.

For **week 3** of the current influenza season:

- ***8.2%*** *of all deaths that occurred in Hawaii during week 3 were related to pneumonia, influenza or COVID-19 (PIC)*[11]*. For the current season (season to date:* ***6.6%****), there have been 3,696 deaths from any cause, 243 of which were due to PIC*[12]*.*
- *The PIC rate was comparable to the historical baseline in Hawaii*[13] *(i.e., inside the 95% confidence interval).*

The Hawaii PIC rate was comparable to the CDC's National Center for Health Statistics (NCHS) PIC mortality[14] *(****7.8%****) (i.e., inside the 95% confidence interval) and comparable to the national epidemic threshold (****7.6%****) (i.e., inside the 95% confidence interval) for week 3.*



[11] The percent of deaths due to PIC displayed on the graph is the 3-week moving averages.

[12] PIC data reflect 75.2% of the data reported for the MMWR week. Changes to data are expected when PIC data reaches 100% completion.

[13] The Hawaii historical baseline (%PIC) is the average of 3-week moving averages over the preceding 10 flu seasons of historical data (2014-2015, 2015-2016, 2016-2017, 2017-2018, 2018-2019, 2019-2020, 2020-2021, 2021-2022, 2022-2023, and 2023-2024).

[14] Each week, the vital statistics offices of 122 cities across the United States report the total number of death certificates processed and the number of those for which pneumonia, influenza, or COVID-19 was listed as the underlying or contributing cause of death by age group (Under 28 days, 28 days–1 year, 1–14 years, 15–24 years, 25–44 years, 45–64 years, 65–74 years, 75–84 years, and ≥85 years). The COVID-19 death counts reported by NCHS are provisional and will not match counts in other sources, such as media reports or numbers from health departments. COVID-19 deaths may be classified or defined differently in various reporting and surveillance systems. The percentage of deaths due to pneumonia, influenza, and COVID-19 (PIC) are compared with a seasonal baseline and epidemic threshold value calculated for each week.

INFLUENZA-ASSOCIATED PEDIATRIC DEATHS[15]:

- No new influenza-associated pediatric death was reported to Hawaii. There have been zero influenza-associated pediatric deaths reported in Hawaii during the 2025–2026 season.
- Nationally, eight new influenza-associated pediatric deaths were reported to CDC during week 3. (2025-2026 season total: 52).

IV. INFLUENZA WATCH: As part of a comprehensive influenza surveillance system and to prevent the spread of contagious respiratory diseases in humans, it is important to monitor all circulating influenza types. Several animal-origin influenza A subtypes are currently of interest: influenza A variant virus (H3N2v, H1N2v, and H1N1v) and Avian flu (H5N1 and H7N9). These types of influenza viruses may cause zoonotic (animal-associated) disease and are a public health concern.

A. VARIANT VIRUSES:

Influenza viruses that normally circulate in pigs are called "variant" viruses when they are found in people. These viruses were first identified in U.S. pigs in 2010. In 2011, 12 cases of H3N2v infection were detected in the United States. In 2012, 309 such cases (resulting in 16 hospitalizations and one death) across 12 states were detected, including one Hawaii case who recovered. Illness associated with H3N2v infection has been mostly mild with symptoms similar to those of seasonal flu. However, serious illness, resulting in hospitalization and death, has occurred in some cases. Most of these infections have been associated with prolonged exposure to pigs at agricultural fairs or similar settings. Limited human-to-human spread of this virus has been detected in the past, but no sustained community spread of H3N2v has been identified. More information regarding H3N2v, H1N1v, and H1N2v viruses may be found on the CDC website (*here*) and (*here*).

- *No variant or novel influenza infections have been reported to HDOH during the 2025-2026 influenza season.*
- *One new human infection with novel influenza A virus, H1N1v (0), H3N2v (0), and H1N2v (1), have been reported during the 2025-2026 influenza season.*
    - *One new human infection with influenza A(H1N1v) virus has been reported to WHO from China during the 2025-2026 influenza season.*

AVIAN (OR BIRD) INFLUENZA: These types of influenza viruses cause zoonotic (animal-associated) disease of public health concern and are therefore monitored globally by the WHO. Most avian influenza viruses do not cause disease in humans and are generally not easily transmissible between person to person, but a few subtypes may cross the species barrier and cause disease in humans. Avian influenza viruses may be of various subtypes, including H5N1, H5N2, H5N8, H7N3, H7N7, H7N8, H7N9, and H9N2. On January 15th, 2016, the USDA and APHIS reported detection of HPAI H7N8 in a commercial turkey flock in Indiana. There have been no associated human infections. This is the first detection of HPAI H7N8 in wild bird surveillance in the United States. More information, the risk assessment and recommendations for HPAI H7N8 can be found (here). The WHO, CDC, and other public health agencies have also been monitoring influenza H7N9, which represents a public health concern because of its high pandemic potential. Although H7N9 has not been detected in the United States, it remains a global concern given continuing epidemics in endemic countries. Since 2013, a total of 1,568 laboratory-confirmed cases of human infection with H7N9 viruses, including at least 613 deaths, have been reported to WHO. More information on H7N9 virus infections can be found (here). For more information regarding avian influenza, please visit the CDC (*here*) or the WHO (*here*) websites. WHO reports total number of cases and deaths related to laboratory-confirmed avian influenza viruses and posts current avian influenza case counts (*here*), which were last updated on **December 19, 2025**.

[15] Influenza-associated deaths are considered pediatric in persons aged less than 18 years. It was made a nationally notifiable condition in October, 2004. All pediatric influenza-associated deaths are laboratory confirmed.

V. INFLUENZA Vaccine: Annual influenza vaccination is recommended for all persons aged 6 months and older and is the most effective way to reduce the risk of getting sick with seasonal flu and spreading it to others. Influenza vaccination can reduce illnesses, visits to the doctor, influenza-related hospitalizations, and missed work and school days. Influenza vaccines become available by the end of October. It takes at least two weeks after vaccination to confer immunity against influenza virus infection. More information regarding influenza vaccination can be found (*here*).

A. Composition of the 2025–2026 Influenza Vaccine**:**

The composition of the 2025–2026 influenza vaccine has been updated to better match circulating influenza viruses. The Advisory Committee on Immunization Practices (ACIP) has recommended that the 2025-2026 influenza trivalent vaccine contain an influenza A/Victoria/4897/2022 (H1N1) pdm09-like virus, influenza A/Croatia/10136RV/2023 (H3N2)-like virus, and influenza B/Austria/1359417/2021 (B/Victoria lineage)-like virus. United States cell culture–based inactivated (ccIIV4) and recombinant (RIV4) influenza vaccines will contain HA derived from an influenza A/Wisconsin/67/2022 (H1N1) pdm09-like virus, an A/District of Columbia/27/2023 (H3N2)-like virus, an influenza B/Austria/1359417/2021 (B/Victoria lineage)-like virus. These vaccine recommendations were based on several factors, including global influenza virologic and epidemiologic surveillance, genetic and antigenic characterization, human serology studies, antiviral susceptibility, and the availability of candidate influenza viruses.

APPENDIX 1: ADDITIONAL INFORMATION

For more information regarding local and national influenza surveillance programs, visit the following sites.

Centers for Disease Control and Prevention	General Influenza National ILI and P&I Data Vaccine Virus Selection CDC Web Tool for Respiratory Viruses
Flu.gov	General Influenza Information
HDOH Flu and Pneumonia	General Influenza Surveillance Avian Influenza Respiratory Virus Dashboard To find out more information or join the sentinel physician program, email the Influenza Surveillance Coordinator
World Health Organization	General Global and Local Influenza Avian Influenza

APPENDIX 2: MMWR WEEK DATES

Please refer to the table below to interpret data presented by MMWR week. Week 40 is considered the traditional start for the flu season for the Northern Hemisphere.

MMWR WEEK	2022	2023	2024	2025	2026
1	1/8/2022	1/7/2023	1/6/2024	1/4/2025	1/10/2026
2	1/15/2022	1/14/2023	1/13/2024	1/11/2025	1/17/2026
3	1/22/2022	1/21/2023	1/20/2024	1/18/2025	1/24/2026
4	1/29/2022	1/28/2023	1/27/2024	1/25/2025	1/31/2026
5	2/5/2022	2/4/2023	2/3/2024	2/1/2025	2/7/2026
6	2/12/2022	2/11/2023	2/10/2024	2/8/2025	2/14/2026
7	2/19/2022	2/18/2023	2/17/2024	2/15/2025	2/21/2026
8	2/26/2022	2/25/2023	2/24/2024	2/22/2025	2/28/2026
9	3/5/2022	3/4/2023	3/2/2024	3/1/2025	3/7/2026
10	3/12/2022	3/11/2023	3/9/2024	3/8/2025	3/14/2026
11	3/19/2022	3/18/2023	3/16/2024	3/15/2025	3/21/2026
12	3/26/2022	3/25/2023	3/23/2024	3/22/2025	3/28/2026
13	4/2/2022	4/1/2023	3/30/2024	3/29/2025	4/4/2026
14	4/9/2022	4/8/2023	4/6/2024	4/5/2025	4/11/2026
15	4/16/2022	4/15/2023	4/13/2024	4/12/2025	4/18/2026
16	4/23/2022	4/22/2023	4/20/2024	4/19/2025	4/25/2026
17	4/30/2022	4/29/2023	4/27/2024	4/26/2025	5/2/2026
18	5/7/2022	5/6/2023	5/4/2024	5/3/2025	5/9/2026
19	5/14/2022	5/13/2023	5/11/2024	5/10/2025	5/16/2026
20	5/21/2022	5/20/2023	5/18/2024	5/17/2025	5/23/2026
21	5/28/2022	5/27/2023	5/25/2024	5/24/2025	5/30/2026
22	6/4/2022	6/3/2023	6/1/2024	5/31/2025	6/6/2026
23	6/11/2022	6/10/2023	6/8/2024	6/7/2025	6/13/2026
24	6/18/2022	6/17/2023	6/15/2024	6/14/2025	6/20/2026
25	6/25/2022	6/24/2023	6/22/2024	6/21/2025	6/27/2026
26	7/2/2022	7/1/2023	6/29/2024	6/28/2025	7/4/2026
27	7/9/2022	7/8/2023	7/6/2024	7/5/2025	7/11/2026
28	7/16/2022	7/15/2023	7/13/2024	7/12/2025	7/18/2026
29	7/23/2022	7/22/2023	7/20/2024	7/19/2025	7/25/2026
30	7/30/2022	7/29/2023	7/27/2024	7/26/2025	8/1/2026
31	8/6/2022	8/5/2023	8/3/2024	8/2/2025	8/8/2026
32	8/13/2022	8/12/2023	8/10/2024	8/9/2025	8/15/2026
33	8/20/2022	8/19/2023	8/17/2024	8/16/2025	8/22/2026
34	8/27/2022	8/26/2023	8/24/2024	8/23/2025	8/29/2026
35	9/3/2022	9/2/2023	8/31/2024	8/30/2025	9/5/2026
36	9/10/2022	9/9/2023	9/7/2024	9/6/2025	9/12/2026
37	9/17/2022	9/16/2023	9/14/2024	9/13/2025	9/19/2026
38	9/24/2022	9/23/2023	9/21/2024	9/20/2025	9/26/2026
39	10/1/2022	9/30/2023	9/28/2024	9/27/2025	10/3/2026
40	10/8/2022	10/7/2023	10/5/2024	10/4/2025	10/10/2026
41	10/15/2022	10/14/2023	10/12/2024	10/11/2025	10/17/2026
42	10/22/2022	10/21/2023	10/19/2024	10/18/2025	10/24/2026
43	10/29/2022	10/28/2023	10/26/2024	10/25/2025	10/31/2026
44	11/5/2022	11/4/2023	11/2/2024	11/1/2025	11/7/2026
45	11/12/2022	11/11/2023	11/9/2024	11/8/2025	11/14/2026
46	11/19/2022	11/18/2023	11/16/2024	11/15/2025	11/21/2026
47	11/26/2022	11/25/2023	11/23/2024	11/22/2025	11/28/2026
48	12/3/2022	12/2/2023	11/30/2024	11/29/2025	12/5/2026
49	12/10/2022	12/9/2023	12/7/2024	12/6/2025	12/12/2026
50	12/17/2022	12/16/2023	12/14/2024	12/13/2025	12/19/2026
51	12/24/2022	12/23/2023	12/21/2024	12/20/2025	12/26/2026
52	12/31/2022	12/30/2023	12/28/2024	12/27/2025	
53				01/03/2026	

HAWAII STATE DEPARTMENT OF HEALTH
DISEASE OUTBREAK CONTROL DIVISION

Influenza/Respiratory Disease Surveillance Report

Morbidity and Mortality Weekly Report (MMWR)[1]

WEEK 4: JANUARY 25, 2026– JANUARY 31, 2026

OVERVIEW: The Hawaii State Department of Health (HDOH) monitors influenza and other respiratory pathogens, including COVID-19, throughout the state of Hawaii. Influenza surveillance in the state of Hawaii relies upon selected sentinel health practitioners, the State Laboratories Division (SLD), private laboratories, and the Office of Health Status Monitoring (OHSM). For detailed information concerning influenza, please visit the HDOH Disease Outbreak Control Division (HDOH DOCD) website (*here*). **All data and information are conditional and may change as more reports are received.** The data in this report reflects the 2025-2026 influenza season which began the week ending October 4, 2025 (week 40[1] 2025) and will end the week ending on October 3, 2026 (week 39 2026).

REPORT SNAPSHOT FOR WEEK 4

Surveillance for Influenza-like Illness (ILI)		
Metric	*Value*	*Comment*
Outpatient visits related to influenza-like illness (ILI) from ILINet Sentinel Providers	2.8%	Lower than the previous week. Comparable to Hawaii's historical baseline and lower than the national baseline, and lower than the national ILI rate.
Number of ILI clusters reported to HDOH	0	There have been 19 clusters this season.

Laboratory Surveillance		
Percent of all respiratory specimens positive for influenza this week	12.6%	Lower than the previous week. This number means that many, if not all, of the 87.4% who tested negative for influenza had illness from another respiratory etiology.
Percent of all respiratory specimens positive for influenza this season to date	20.1%	

Surveillance for Severe Outcomes		
Pneumonia, influenza and COVID-19 (PIC) mortality rate	8.2%	Comparable to Hawaii's historical baseline, comparable to the national epidemic threshold and comparable to the NCHS average.
Number of influenza-associated pediatric deaths reported nationwide	60	0 influenza-associated pediatric deaths have been reported from Hawaii this season to date.

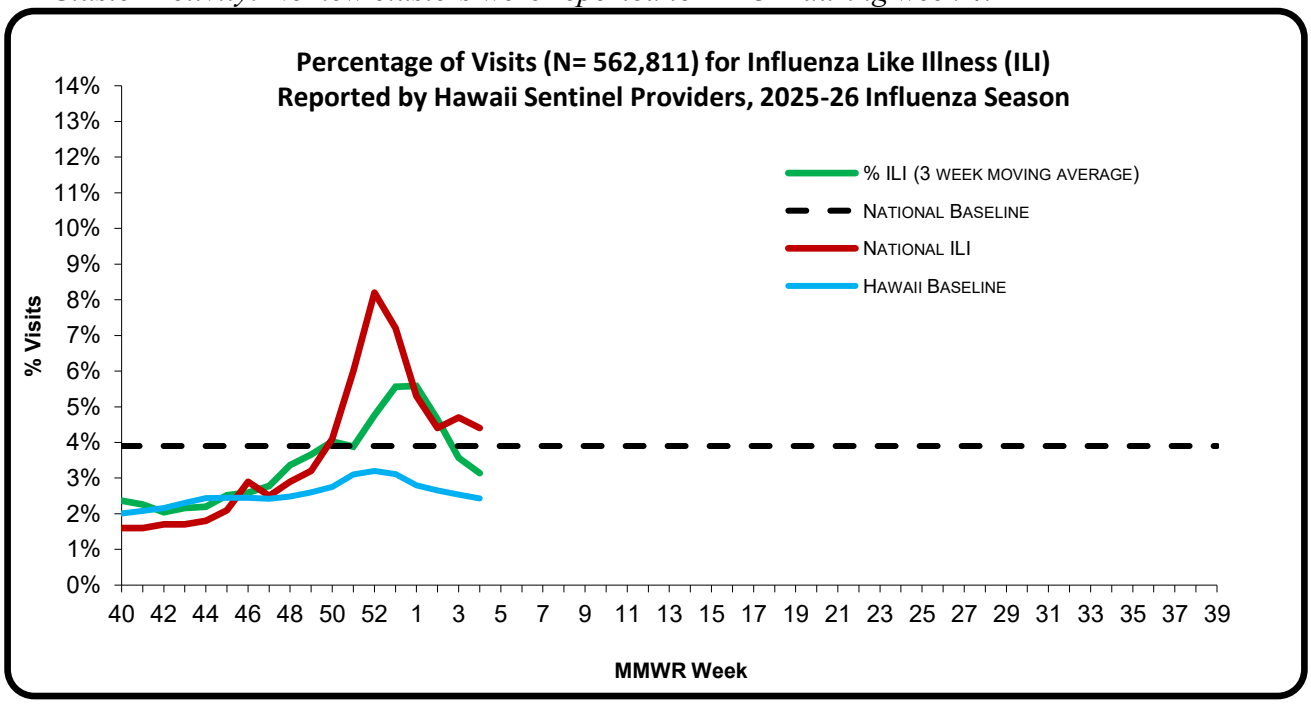
[1] MMWR stands for "Morbidity and Mortality Weekly Report," conventionally used by the Centers for Disease Control and Prevention (CDC). The weeks of a flu season are often referred to by their respective MMWR week. **See appendix 2 for interpretation of MMWR weeks.** Data reported will begin on week 40, the traditional start date of flu season.

INFLUENZA SURVEILLANCE

I. INFLUENZA-LIKE ILLNESS (ILI): HDOH collaborates with recruited doctors and healthcare providers who report the total number of outpatient visits for ILI as well as the total number of patients who complained of symptoms consistent with ILI. A patient with ILI must have the following: a fever (temperature of 100°F [37.8°C] or greater) AND a cough and/or a sore throat. ILI is based on reported symptoms and not laboratory confirmed tests; thus, ILI may represent other respiratory pathogens and not solely influenza. Further, sentinel providers report these numbers on a weekly basis; therefore, data are preliminary and may change depending on additional reporting. In combination with laboratory testing and other surveillance systems, ILI surveillance helps monitor influenza and other respiratory pathogen activity. For more information concerning ILINet and sentinel requirements, please visit the CDC website (*here*).

For **week 4** of the current influenza season:

- ***2.8**% (season to date: **3.3**%) of the outpatient visits recorded by Hawaii sentinel providers were for ILI.*
- *ILI visits were comparable to the historical baseline in Hawaii[2,3] (i.e., inside the 95% confidence interval).*
- *Hawaii's ILI outpatient visits were lower than the national baseline (**3.9%**)[4] (i.e., outside the 95% confidence interval) and lower than the national ILI rate (**4.4%**) (i.e. outside the 95% confidence interval).*
- *ILI activity level: Low[5]*
- *Geographic Spread: Sporadic Activity[6].*
- *ILI Cluster Activity: No new clusters were reported to HDOH during week 4.*



[2] The Hawaii historical baseline (%ILI) is the average of 3-week moving averages over the preceding 10 flu seasons of historical data (2015-2016, 2016-2017, 2017-2018, 2018-2019, 2019-2020, 2020-2021, 2021-2022, 2022-2023, 2023-2024 and 2024-2025).

[3] This value is based upon comparison of actual outpatient ILI with the historical baseline, which only captures outpatient ILI. The chart above represents a 3-week moving average and not the actual ILI by week.

[4] The National Baseline is calculated by CDC as the mean percentage of visits for ILI during weeks 21–39 with two standard deviations. Because of large variability in regional ILI, comparison of the national baseline with local ILI may not be appropriate. It is provided in this report because no meaningful regional baselines are available for comparison. The national baseline combines all data reported by states to CDC, including ILI in outpatient, ER, urgent care, and inpatient settings.

[5] There are 10 activity levels classified as minimal (levels 1-3), low (levels 4-5), moderate (levels 6-7), and high (levels 8-10).

[6] The influenza activity reported by state and territorial epidemiologists indicates geographic spread of influenza viruses but does not measure the severity of influenza activity. Sporadic: no clusters reported to HDOH, Local: one or more clusters reported in one county, Regional: clusters reported two to three counties, Widespread: clusters reported in all counties. Hawaii does not report No Activity, as flu circulates year-round in Hawaii.

II. LABORATORY SURVEILLANCE: State Laboratories Division (SLD; the HDOH public health laboratory) and Hawaii's major private laboratories (DLS, CLH) report results of RT-PCR, which can be considered confirmatory (SLD may perform viral culture on select specimens). Specimens meeting priority criteria[7] are forwarded to SLD for sub-typing. Additionally, specimens meeting case definition from requesting sentinel providers are sent directly to SLD for sub-typing. Due to resource constraints, not all submitted specimens undergo sub-typing. Sub-typing at the commercial laboratories is only conducted on a case-by-case basis. The majority of specimens testing positive by rapid antigen testing or RT-PCR at the commercial laboratories do not meet criteria and are not subtyped. For more information on influenza tests and types, please visit the CDC website (*here*).

A. INFLUENZA:

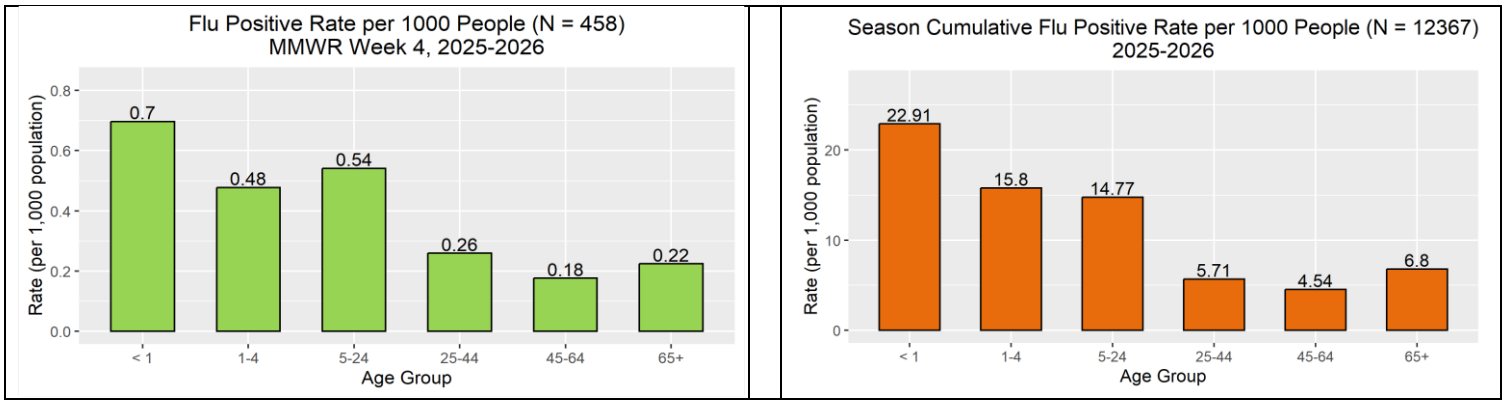
- The following reflects laboratory findings for week 4 of the 2025–26 influenza season:
  - *A total of **3,620** specimens has been tested statewide for influenza viruses (positive: 458 [**12.6%**]). (Season to date: **61,418** tested (**20.1%** positive)*
    - *1,634 (45.1%) were screened only by rapid antigen tests with no confirmatory testing.*
    - *1,986 (54.9%) underwent confirmatory testing (either RT-PCR or viral culture).*
    - *3,162 (87.4%) were negative.*
  - *Routine surveillance samples from State Laboratory Division were tested at a public health laboratory and identified as Influenza A (H3N2) subclade K.*

Influenza type	*Current week 4 (%)**	*Season to date (%)*[8]
Influenza A (H1)[9]	*0 (0.0)*	*81 (0.6)*
Influenza A (H3)	*2 (0.4)*	*902 (7.3)*
Influenza A no subtyping	*345 (75.1)*	*10,950 (88.6)*
Influenza B (Yamagata)	*0 (0.0)*	*0 (0.0)*
Influenza B (Victoria)	*0 (0.0)*	*0 (0.0)*
Influenza B no genotyping	*112 (24.4)*	*428 (3.5)*

**Specimens that are positive for both A and B (coinfections) are counted in both A and B totals for current and season to date*

1. AGE DISTRIBUTION

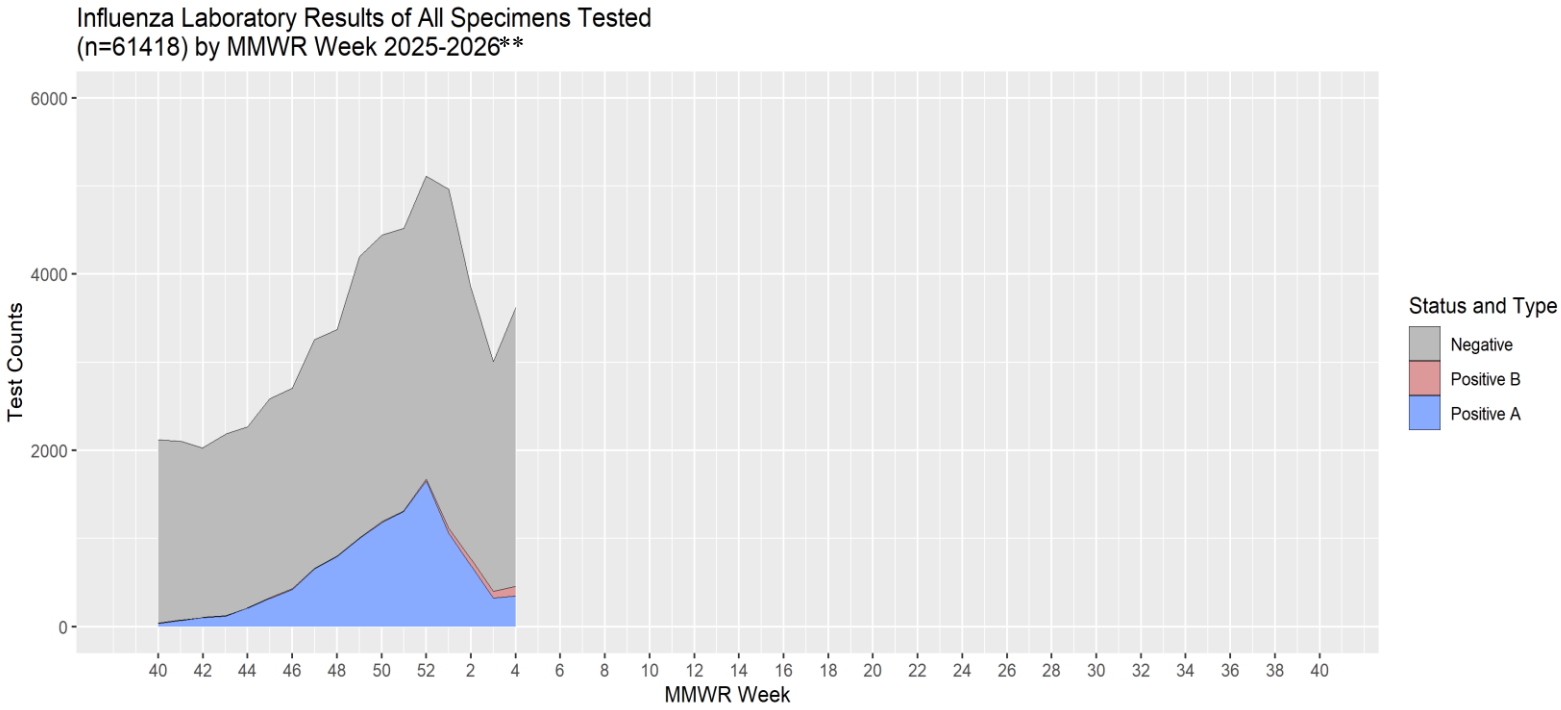
The charts below indicate the population-based rates of positive influenza cases in Hawaii by age group during the 2025–26 influenza season.[10]

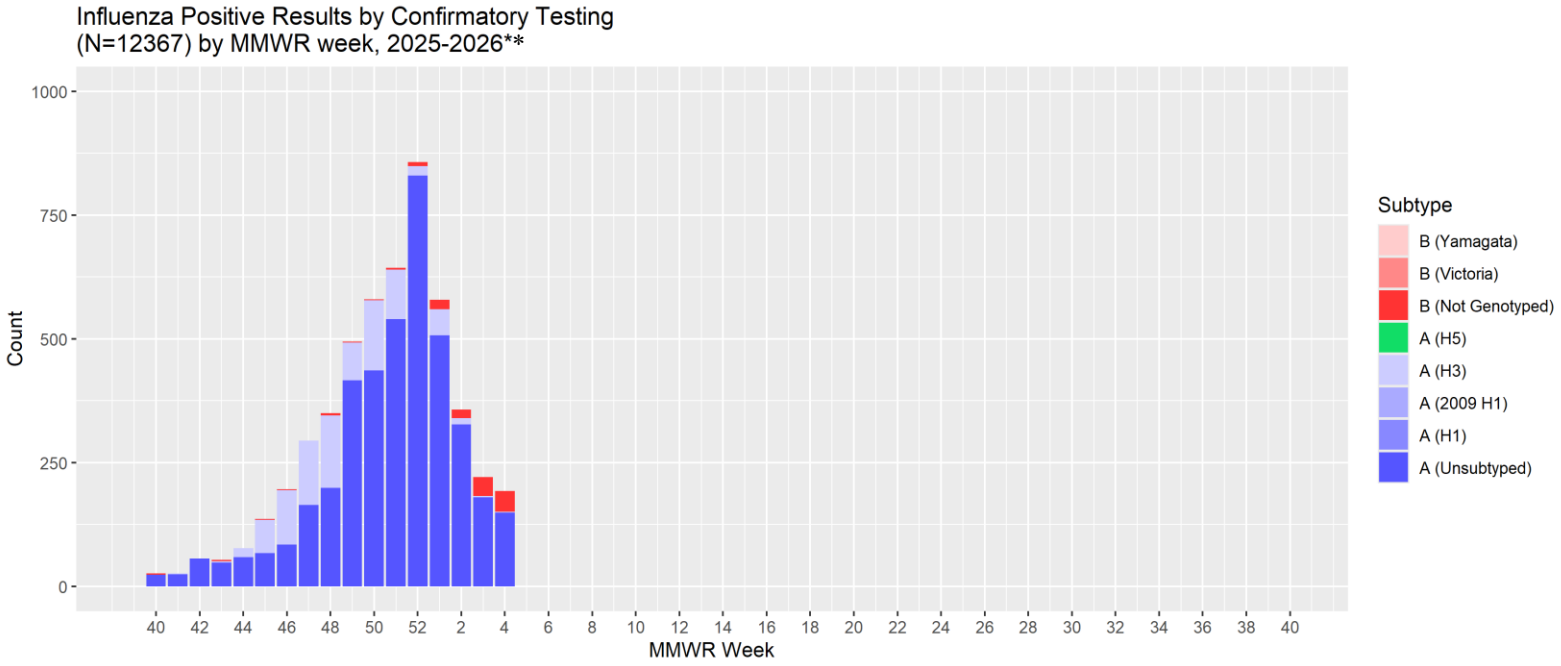


[7] Priority criteria include: hospitalized patients with acute respiratory distress syndrome [ARDS] or x-ray confirmed pneumonia; travelers with international travel history within 10 days of onset; specimens submitted by sentinel providers; specimens collected from healthcare workers, pregnant women, or women up to 6 weeks' post-partum; those with underlying medical conditions; and patients presenting with unusual or severe manifestations of influenza infection.
[8] Influenza coding were updated to reflect a more accurate count.
[9] All influenza A H1 viruses detected this season have been 2009 H1N1.
[10] This represents an estimate of population-based rates based on available data.

2. LABORATORY TESTING

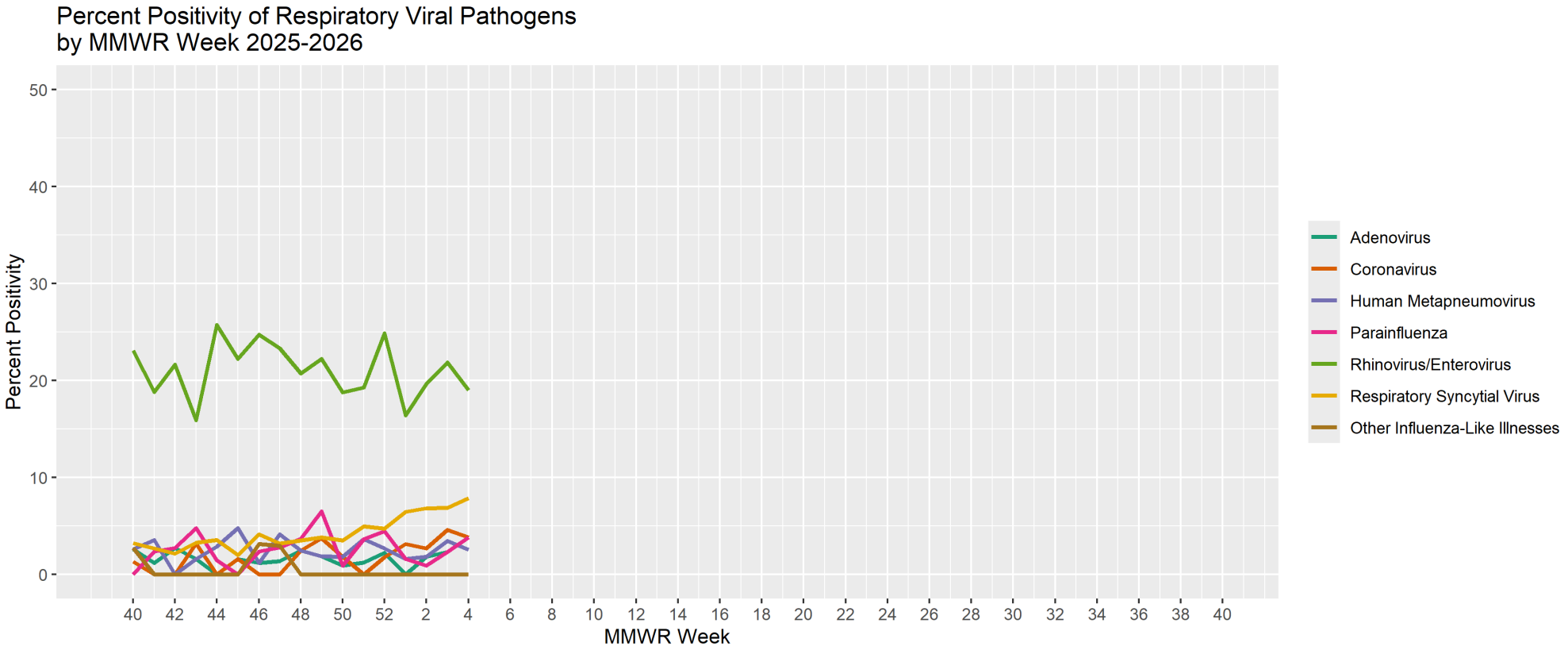
The charts below show the laboratory results of all specimens tested for influenza by MMWR week during the 2025–2026 influenza season as well as the type and subtype of positive results for influenza. Again, sub-typing is only performed on selected specimens tested by confirmatory tests (i.e., RT-PCR or viral culture).





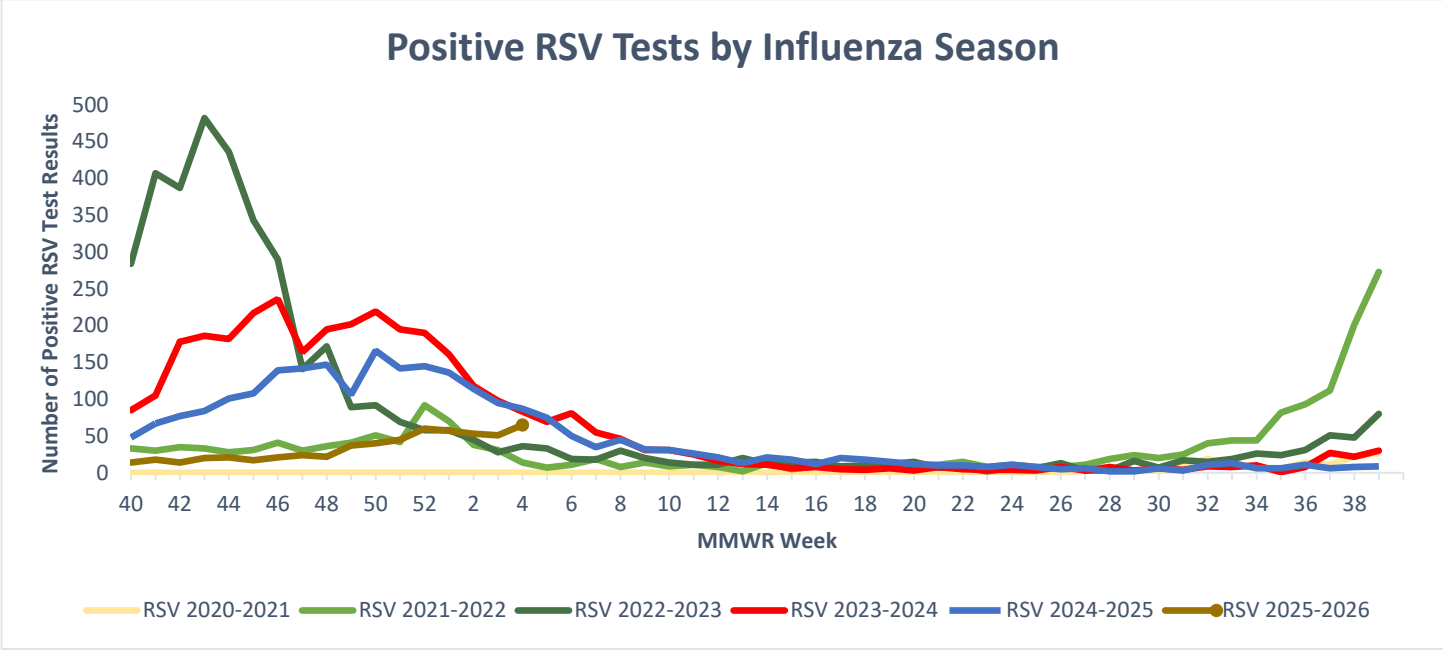
** A total of 34,160 specimens underwent confirmatory testing, but not all positive influenza specimens receive confirmatory testing that are circulating in Hawaii.*
*** For MMWR Week 53, results are reported under MMWR Week 52, where the average of Weeks 52 and 53 was calculated.*

B. **OTHER RESPIRATORY PATHOGENS:** The major clinical and commercial laboratories throughout the state of Hawaii have the testing capacity for non-influenza respiratory pathogens and report these to HDOH. However, such testing is performed as needed and when sufficient resources are available because of the high costs associated with respiratory panel tests. **Therefore, available data represent only the presence of circulating pathogens and cannot be used to determine specific trends**.

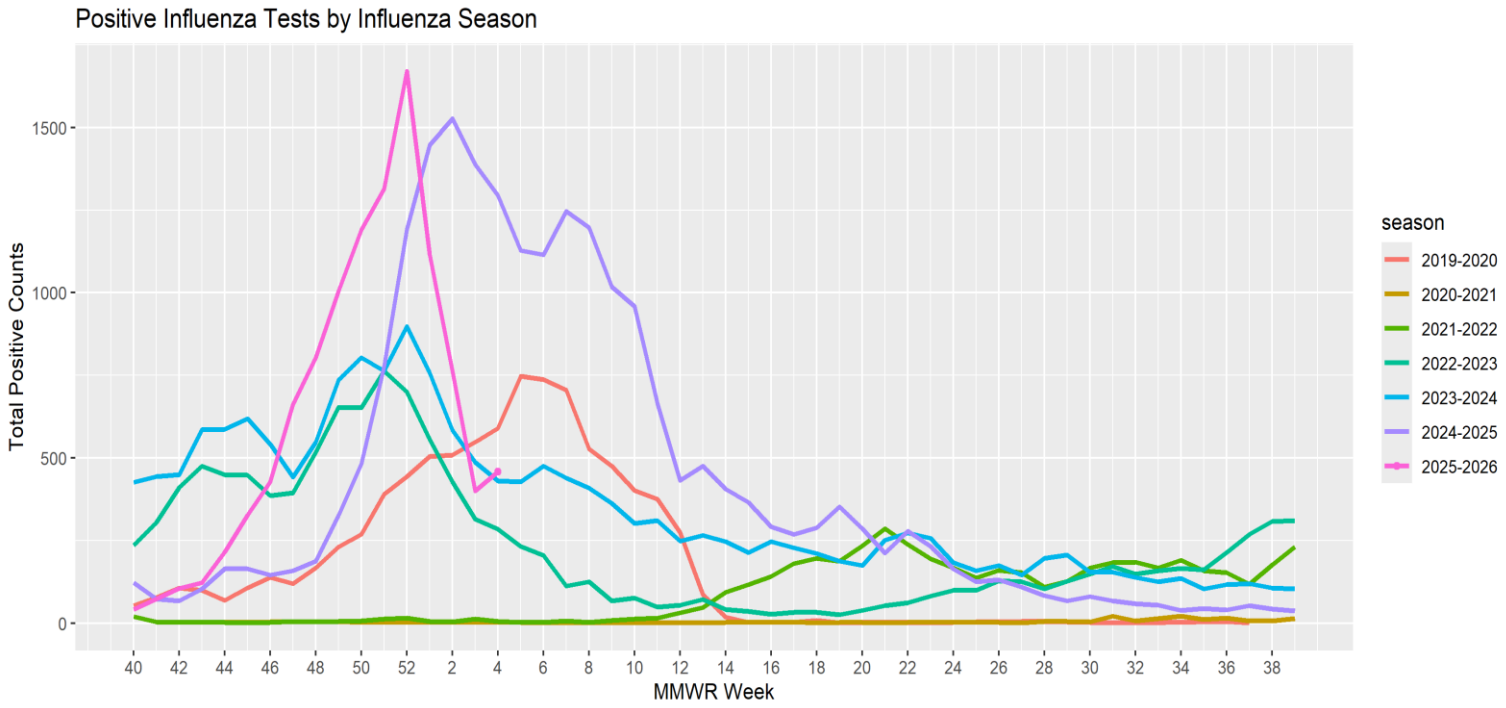


* *The coronavirus presented on this table does not indicate Severe Acute Respiratory Coronavirus-2 (i.e., COVID-19). For MMWR Week 53, results are reported under MMWR Week 52, where the average of Weeks 52 and 53 was calculated*

RESPIRATORY SYNCYTIAL VIRUS (RSV) POSITIVE TEST RESULTS BY INFLUENZA SEASON: RSV case appears to have increased later than past seasons in the 2025-2026 season. For MMWR Week 53, results are reported under MMWR Week 52, where the average of Weeks 52 and 53 was calculated.



INFLUENZA POSITIVE TEST RESULTS BY INFLUENZA SEASON: Influenza cases appear to have increased earlier than past seasons in the 2025-2026 season. For MMWR Week 53, results are reported under MMWR Week 52, where the average of Weeks 52 and 53 was calculated.



C. COVID-19 SENTINEL SURVEILLANCE: Due to the low volume of samples currently available through the influenza surveillance system, the COVID-19 sentinel surveillance data may not be accurately portraying COVID-19 activity in our communities. Reporting of the COVID-19 Sentinel Surveillance data will be paused while HODH re-evaluates the program to ensure that the reported data are accurate and representative.

HDOH is continuing to monitor COVID-19 activity throughout the state. To learn more, please visit the Hawaii's COVID-19 data website (*here*). For more information on surveillance of COVID-19 activity in the United States please visit the CDC COVIDView website (*here*).

III. PNEUMONIA, INFLUENZA, AND COVID-19 (PIC) RELATED MORTALITY:

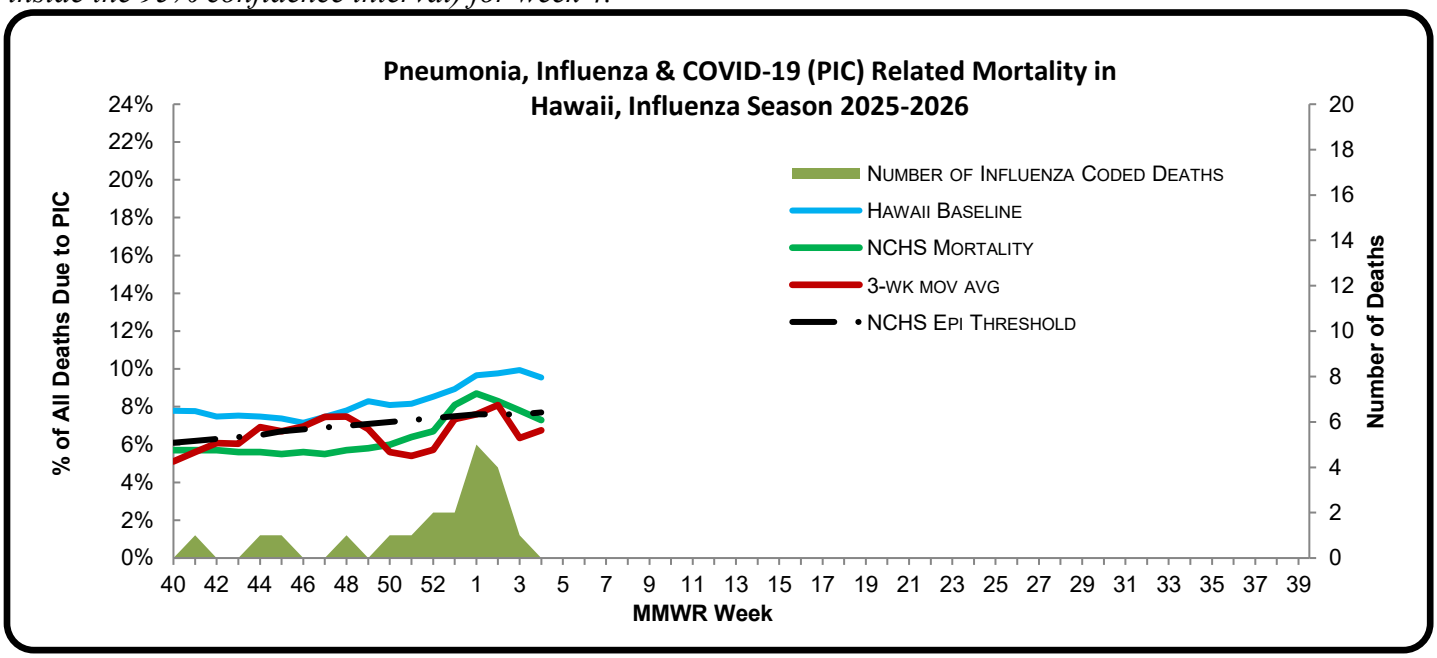
P&I mortality surveillance is collected by CDC through the National Center for Health Statistics (NCHS) using death certificate data. Each week the HDOH OHSM reports specific data from Honolulu to the CDC. CDC collects the following information by age group: the total number of deaths, total deaths from pneumonia, and total deaths related to influenza. Due to the ongoing COVID-19 pandemic, CDC included total deaths from COVID-19 by age group to the death data. Previous studies had suggested that P&I is a good indicator of influenza-related deaths; however, data has shown that pneumonia deaths associated with influenza is now being impacted by COVID-19 related pneumonia. Due to this, CDC had added COVID-19 deaths into P&I to create the PIC (pneumonia, influenza, and/or COVID-19) classification.

To standardize Hawaii's influenza surveillance with CDC influenza surveillance guidelines, PIC deaths will be reported in lieu of P&I. Hawaii's baseline will begin to include PIC deaths starting from 2019-2020 flu season.

For **week 4** of the current influenza season:

- ***8.2%*** *of all deaths that occurred in Hawaii during week 4 were related to pneumonia, influenza or COVID-19 (PIC)*[11]*. For the current season (season to date:* ***6.7%****), there have been 3,980 deaths from any cause, 265 of which were due to PIC*[12]*.*
- *The PIC rate was comparable to the historical baseline in Hawaii*[13] *(i.e., inside the 95% confidence interval).*

The Hawaii PIC rate was comparable to the CDC's National Center for Health Statistics (NCHS) PIC mortality[14] *(****7.3%****) (i.e., inside the 95% confidence interval) and comparable to the national epidemic threshold (****7.7%****) (i.e., inside the 95% confidence interval) for week 4.*



[11] The percent of deaths due to PIC displayed on the graph is the 3-week moving averages.

[12] PIC data reflect 76.5% of the data reported for the MMWR week. Changes to data are expected when PIC data reaches 100% completion.

[13] The Hawaii historical baseline (%PIC) is the average of 3-week moving averages over the preceding 10 flu seasons of historical data (2014-2015, 2015-2016, 2016-2017, 2017-2018, 2018-2019, 2019-2020, 2020-2021, 2021-2022, 2022-2023, and 2023-2024).

[14] Each week, the vital statistics offices of 122 cities across the United States report the total number of death certificates processed and the number of those for which pneumonia, influenza, or COVID-19 was listed as the underlying or contributing cause of death by age group (Under 28 days, 28 days–1 year, 1–14 years, 15–24 years, 25–44 years, 45–64 years, 65–74 years, 75–84 years, and ≥85 years). The COVID-19 death counts reported by NCHS are provisional and will not match counts in other sources, such as media reports or numbers from health departments. COVID-19 deaths may be classified or defined differently in various reporting and surveillance systems. The percentage of deaths due to pneumonia, influenza, and COVID-19 (PIC) are compared with a seasonal baseline and epidemic threshold value calculated for each week.

INFLUENZA-ASSOCIATED PEDIATRIC DEATHS[15]:

- No new influenza-associated pediatric death was reported to Hawaii. There have been zero influenza-associated pediatric deaths reported in Hawaii during the 2025–2026 season.
- Nationally, eight new influenza-associated pediatric deaths were reported to CDC during week 4. (2025-2026 season total: 60).

IV. INFLUENZA WATCH: As part of a comprehensive influenza surveillance system and to prevent the spread of contagious respiratory diseases in humans, it is important to monitor all circulating influenza types. Several animal-origin influenza A subtypes are currently of interest: influenza A variant virus (H3N2v, H1N2v, and H1N1v) and Avian flu (H5N1 and H7N9). These types of influenza viruses may cause zoonotic (animal-associated) disease and are a public health concern.

A. VARIANT VIRUSES:

Influenza viruses that normally circulate in pigs are called "variant" viruses when they are found in people. These viruses were first identified in U.S. pigs in 2010. In 2011, 12 cases of H3N2v infection were detected in the United States. In 2012, 309 such cases (resulting in 16 hospitalizations and one death) across 12 states were detected, including one Hawaii case who recovered. Illness associated with H3N2v infection has been mostly mild with symptoms similar to those of seasonal flu. However, serious illness, resulting in hospitalization and death, has occurred in some cases. Most of these infections have been associated with prolonged exposure to pigs at agricultural fairs or similar settings. Limited human-to-human spread of this virus has been detected in the past, but no sustained community spread of H3N2v has been identified. More information regarding H3N2v, H1N1v, and H1N2v viruses may be found on the CDC website (*here*) and (*here*).

- *No variant or novel influenza infections have been reported to HDOH during the 2025-2026 influenza season.*
- *One new human infection with novel influenza A virus, H1N1v (0), H3N2v (0), and H1N2v (1), have been reported during the 2025-2026 influenza season.*
    - *One new human infection with influenza A(H1N1v) virus has been reported to WHO from China during the 2025-2026 influenza season.*

AVIAN (OR BIRD) INFLUENZA: These types of influenza viruses cause zoonotic (animal-associated) disease of public health concern and are therefore monitored globally by the WHO. Most avian influenza viruses do not cause disease in humans and are generally not easily transmissible between person to person, but a few subtypes may cross the species barrier and cause disease in humans. Avian influenza viruses may be of various subtypes, including H5N1, H5N2, H5N8, H7N3, H7N7, H7N8, H7N9, and H9N2. On January 15th, 2016, the USDA and APHIS reported detection of HPAI H7N8 in a commercial turkey flock in Indiana. There have been no associated human infections. This is the first detection of HPAI H7N8 in wild bird surveillance in the United States. More information, the risk assessment and recommendations for HPAI H7N8 can be found (here). The WHO, CDC, and other public health agencies have also been monitoring influenza H7N9, which represents a public health concern because of its high pandemic potential. Although H7N9 has not been detected in the United States, it remains a global concern given continuing epidemics in endemic countries. Since 2013, a total of 1,568 laboratory-confirmed cases of human infection with H7N9 viruses, including at least 613 deaths, have been reported to WHO. More information on H7N9 virus infections can be found (here). For more information regarding avian influenza, please visit the CDC (*here*) or the WHO (*here*) websites. WHO reports total number of cases and deaths related to laboratory-confirmed avian influenza viruses and posts current avian influenza case counts (*here*), which were last updated on **December 19, 2025**.

[15] Influenza-associated deaths are considered pediatric in persons aged less than 18 years. It was made a nationally notifiable condition in October, 2004. All pediatric influenza-associated deaths are laboratory confirmed.

V. INFLUENZA Vaccine: Annual influenza vaccination is recommended for all persons aged 6 months and older and is the most effective way to reduce the risk of getting sick with seasonal flu and spreading it to others. Influenza vaccination can reduce illnesses, visits to the doctor, influenza-related hospitalizations, and missed work and school days. Influenza vaccines become available by the end of October. It takes at least two weeks after vaccination to confer immunity against influenza virus infection. More information regarding influenza vaccination can be found (*here*).

A. Composition of the 2025–2026 Influenza Vaccine:

The composition of the 2025–2026 influenza vaccine has been updated to better match circulating influenza viruses. The Advisory Committee on Immunization Practices (ACIP) has recommended that the 2025-2026 influenza trivalent vaccine contain an influenza A/Victoria/4897/2022 (H1N1) pdm09-like virus, influenza A/Croatia/10136RV/2023 (H3N2)-like virus, and influenza B/Austria/1359417/2021 (B/Victoria lineage)-like virus. United States cell culture–based inactivated (ccIIV4) and recombinant (RIV4) influenza vaccines will contain HA derived from an influenza A/Wisconsin/67/2022 (H1N1) pdm09-like virus, an A/District of Columbia/27/2023 (H3N2)-like virus, an influenza B/Austria/1359417/2021 (B/Victoria lineage)-like virus. These vaccine recommendations were based on several factors, including global influenza virologic and epidemiologic surveillance, genetic and antigenic characterization, human serology studies, antiviral susceptibility, and the availability of candidate influenza viruses.

APPENDIX 1: ADDITIONAL INFORMATION

For more information regarding local and national influenza surveillance programs, visit the following sites.

Centers for Disease Control and Prevention	General Influenza National ILI and P&I Data Vaccine Virus Selection CDC Web Tool for Respiratory Viruses
Flu.gov	General Influenza Information
HDOH Flu and Pneumonia	General Influenza Surveillance Avian Influenza Respiratory Virus Dashboard To find out more information or join the sentinel physician program, email the Influenza Surveillance Coordinator
World Health Organization	General Global and Local Influenza Avian Influenza

APPENDIX 2: MMWR WEEK DATES

Please refer to the table below to interpret data presented by MMWR week. Week 40 is considered the traditional start for the flu season for the Northern Hemisphere.

MMWR WEEK	2022	2023	2024	2025	2026
1	1/8/2022	1/7/2023	1/6/2024	1/4/2025	1/10/2026
2	1/15/2022	1/14/2023	1/13/2024	1/11/2025	1/17/2026
3	1/22/2022	1/21/2023	1/20/2024	1/18/2025	1/24/2026
4	1/29/2022	1/28/2023	1/27/2024	1/25/2025	1/31/2026
5	2/5/2022	2/4/2023	2/3/2024	2/1/2025	2/7/2026
6	2/12/2022	2/11/2023	2/10/2024	2/8/2025	2/14/2026
7	2/19/2022	2/18/2023	2/17/2024	2/15/2025	2/21/2026
8	2/26/2022	2/25/2023	2/24/2024	2/22/2025	2/28/2026
9	3/5/2022	3/4/2023	3/2/2024	3/1/2025	3/7/2026
10	3/12/2022	3/11/2023	3/9/2024	3/8/2025	3/14/2026
11	3/19/2022	3/18/2023	3/16/2024	3/15/2025	3/21/2026
12	3/26/2022	3/25/2023	3/23/2024	3/22/2025	3/28/2026
13	4/2/2022	4/1/2023	3/30/2024	3/29/2025	4/4/2026
14	4/9/2022	4/8/2023	4/6/2024	4/5/2025	4/11/2026
15	4/16/2022	4/15/2023	4/13/2024	4/12/2025	4/18/2026
16	4/23/2022	4/22/2023	4/20/2024	4/19/2025	4/25/2026
17	4/30/2022	4/29/2023	4/27/2024	4/26/2025	5/2/2026
18	5/7/2022	5/6/2023	5/4/2024	5/3/2025	5/9/2026
19	5/14/2022	5/13/2023	5/11/2024	5/10/2025	5/16/2026
20	5/21/2022	5/20/2023	5/18/2024	5/17/2025	5/23/2026
21	5/28/2022	5/27/2023	5/25/2024	5/24/2025	5/30/2026
22	6/4/2022	6/3/2023	6/1/2024	5/31/2025	6/6/2026
23	6/11/2022	6/10/2023	6/8/2024	6/7/2025	6/13/2026
24	6/18/2022	6/17/2023	6/15/2024	6/14/2025	6/20/2026
25	6/25/2022	6/24/2023	6/22/2024	6/21/2025	6/27/2026
26	7/2/2022	7/1/2023	6/29/2024	6/28/2025	7/4/2026
27	7/9/2022	7/8/2023	7/6/2024	7/5/2025	7/11/2026
28	7/16/2022	7/15/2023	7/13/2024	7/12/2025	7/18/2026
29	7/23/2022	7/22/2023	7/20/2024	7/19/2025	7/25/2026
30	7/30/2022	7/29/2023	7/27/2024	7/26/2025	8/1/2026
31	8/6/2022	8/5/2023	8/3/2024	8/2/2025	8/8/2026
32	8/13/2022	8/12/2023	8/10/2024	8/9/2025	8/15/2026
33	8/20/2022	8/19/2023	8/17/2024	8/16/2025	8/22/2026
34	8/27/2022	8/26/2023	8/24/2024	8/23/2025	8/29/2026
35	9/3/2022	9/2/2023	8/31/2024	8/30/2025	9/5/2026
36	9/10/2022	9/9/2023	9/7/2024	9/6/2025	9/12/2026
37	9/17/2022	9/16/2023	9/14/2024	9/13/2025	9/19/2026
38	9/24/2022	9/23/2023	9/21/2024	9/20/2025	9/26/2026
39	10/1/2022	9/30/2023	9/28/2024	9/27/2025	10/3/2026
40	10/8/2022	10/7/2023	10/5/2024	10/4/2025	10/10/2026
41	10/15/2022	10/14/2023	10/12/2024	10/11/2025	10/17/2026
42	10/22/2022	10/21/2023	10/19/2024	10/18/2025	10/24/2026
43	10/29/2022	10/28/2023	10/26/2024	10/25/2025	10/31/2026
44	11/5/2022	11/4/2023	11/2/2024	11/1/2025	11/7/2026
45	11/12/2022	11/11/2023	11/9/2024	11/8/2025	11/14/2026
46	11/19/2022	11/18/2023	11/16/2024	11/15/2025	11/21/2026
47	11/26/2022	11/25/2023	11/23/2024	11/22/2025	11/28/2026
48	12/3/2022	12/2/2023	11/30/2024	11/29/2025	12/5/2026
49	12/10/2022	12/9/2023	12/7/2024	12/6/2025	12/12/2026
50	12/17/2022	12/16/2023	12/14/2024	12/13/2025	12/19/2026
51	12/24/2022	12/23/2023	12/21/2024	12/20/2025	12/26/2026
52	12/31/2022	12/30/2023	12/28/2024	12/27/2025	
53				01/03/2026	

HAWAII STATE DEPARTMENT OF HEALTH
DISEASE OUTBREAK CONTROL DIVISION

Influenza/Respiratory Disease Surveillance Report

Morbidity and Mortality Weekly Report (MMWR)[1]

WEEK 5: FEBRUARY 1, 2026– FEBRUARY 7, 2026

OVERVIEW: The Hawaii State Department of Health (HDOH) monitors influenza and other respiratory pathogens, including COVID-19, throughout the state of Hawaii. Influenza surveillance in the state of Hawaii relies upon selected sentinel health practitioners, the State Laboratories Division (SLD), private laboratories, and the Office of Health Status Monitoring (OHSM). For detailed information concerning influenza, please visit the HDOH Disease Outbreak Control Division (HDOH DOCD) website (*here*). **All data and information are conditional and may change as more reports are received.** The data in this report reflects the 2025-2026 influenza season which began the week ending October 4, 2025 (week 40[1] 2025) and will end the week ending on October 3, 2026 (week 39 2026).

REPORT SNAPSHOT FOR WEEK 5

Surveillance for Influenza-like Illness (ILI)		
Metric	*Value*	*Comment*
Outpatient visits related to influenza-like illness (ILI) from ILINet Sentinel Providers	3.3%	Lower than the previous week. Comparable to Hawaii's historical baseline and lower than the national baseline, and lower than the national ILI rate.
Number of ILI clusters reported to HDOH	1	There have been 20 clusters this season.

Laboratory Surveillance		
Percent of all respiratory specimens positive for influenza this week	13.5%	Higher than the previous week. This number means that many, if not all, of the 86.5% who tested negative for influenza had illness from another respiratory etiology.
Percent of all respiratory specimens positive for influenza this season to date	19.5%	

Surveillance for Severe Outcomes		
Pneumonia, influenza and COVID-19 (PIC) mortality rate	3.4%	Lower than Hawaii's historical baseline, comparable to the national epidemic threshold and comparable to the NCHS average.
Number of influenza-associated pediatric deaths reported nationwide	66	0 influenza-associated pediatric deaths have been reported from Hawaii this season to date.

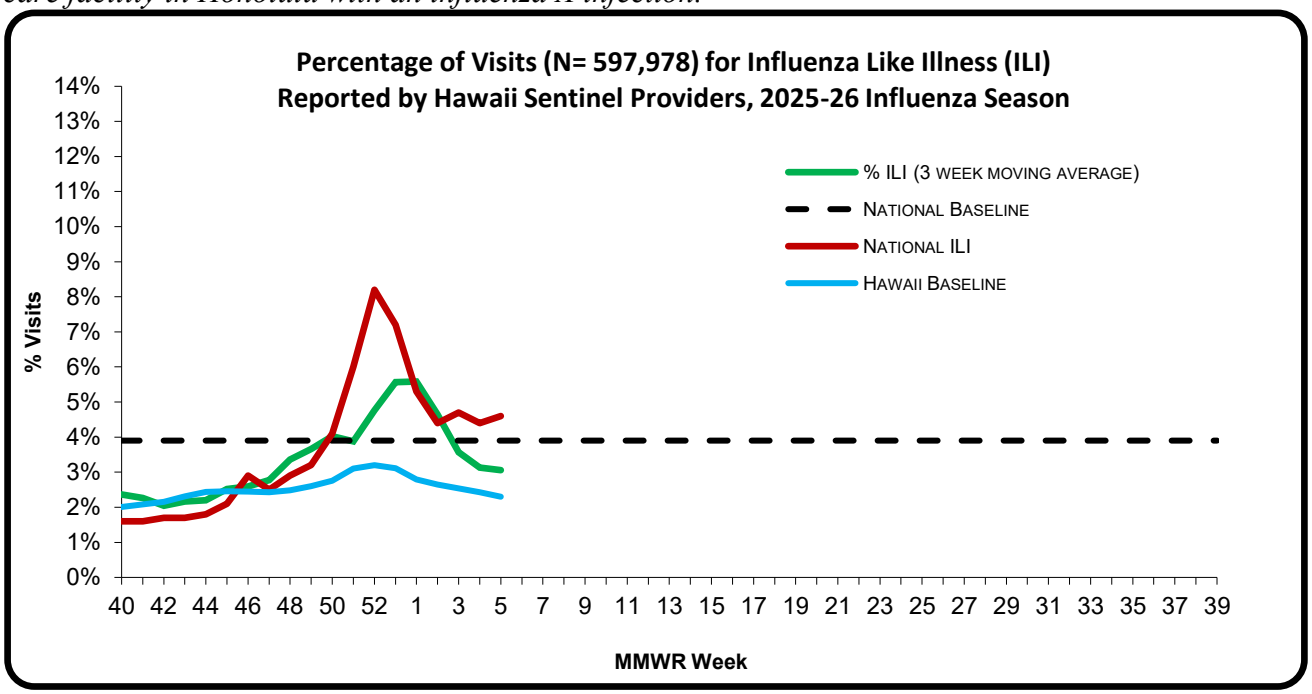
[1] MMWR stands for "Morbidity and Mortality Weekly Report," conventionally used by the Centers for Disease Control and Prevention (CDC). The weeks of a flu season are often referred to by their respective MMWR week. **See appendix 2 for interpretation of MMWR weeks.** Data reported will begin on week 40, the traditional start date of flu season.

INFLUENZA SURVEILLANCE

I. INFLUENZA-LIKE ILLNESS (ILI): HDOH collaborates with recruited doctors and healthcare providers who report the total number of outpatient visits for ILI as well as the total number of patients who complained of symptoms consistent with ILI. A patient with ILI must have the following: a fever (temperature of 100°F [37.8°C] or greater) AND a cough and/or a sore throat. ILI is based on reported symptoms and not laboratory confirmed tests; thus, ILI may represent other respiratory pathogens and not solely influenza. Further, sentinel providers report these numbers on a weekly basis; therefore, data are preliminary and may change depending on additional reporting. In combination with laboratory testing and other surveillance systems, ILI surveillance helps monitor influenza and other respiratory pathogen activity. For more information concerning ILINet and sentinel requirements, please visit the CDC website (*here*).

For **week 5** of the current influenza season:

- ***3.3**% (season to date: **3.3**%) of the outpatient visits recorded by Hawaii sentinel providers were for ILI.*
- *ILI visits were comparable to the historical baseline in Hawaii[2,3] (i.e., inside the 95% confidence interval).*
- *Hawaii's ILI outpatient visits were lower than the national baseline (**3.9%**)[4] (i.e., outside the 95% confidence interval) and lower than the national ILI rate (**4.6%**) (i.e. outside the 95% confidence interval).*
- *ILI activity level: Low[5]*
- *Geographic Spread: Sporadic Activity[6].*
- *ILI Cluster Activity: One new cluster was reported to HDOH during week 5. Cluster occurred at a long-term care facility in Honolulu with an influenza A infection.*



[2] The Hawaii historical baseline (%ILI) is the average of 3-week moving averages over the preceding 10 flu seasons of historical data (2015-2016, 2016-2017, 2017-2018, 2018-2019, 2019-2020, 2020-2021, 2021-2022, 2022-2023, 2023-2024 and 2024-2025).

[3] This value is based upon comparison of actual outpatient ILI with the historical baseline, which only captures outpatient ILI. The chart above represents a 3-week moving average and not the actual ILI by week.

[4] The National Baseline is calculated by CDC as the mean percentage of visits for ILI during weeks 21–39 with two standard deviations. Because of large variability in regional ILI, comparison of the national baseline with local ILI may not be appropriate. It is provided in this report because no meaningful regional baselines are available for comparison. The national baseline combines all data reported by states to CDC, including ILI in outpatient, ER, urgent care, and inpatient settings.

[5] There are 10 activity levels classified as minimal (levels 1-3), low (levels 4-5), moderate (levels 6-7), and high (levels 8-10).

[6] The influenza activity reported by state and territorial epidemiologists indicates geographic spread of influenza viruses but does not measure the severity of influenza activity. Sporadic: no clusters reported to HDOH, Local: one or more clusters reported in one county, Regional: clusters reported two to three counties, Widespread: clusters reported in all counties. Hawaii does not report No Activity, as flu circulates year-round in Hawaii.

II. LABORATORY SURVEILLANCE: State Laboratories Division (SLD; the HDOH public health laboratory) and Hawaii's major private laboratories (DLS, CLH) report results of RT-PCR, which can be considered confirmatory (SLD may perform viral culture on select specimens). Specimens meeting priority criteria[7] are forwarded to SLD for sub-typing. Additionally, specimens meeting case definition from requesting sentinel providers are sent directly to SLD for sub-typing. Due to resource constraints, not all submitted specimens undergo sub-typing. Sub-typing at the commercial laboratories is only conducted on a case-by-case basis. The majority of specimens testing positive by rapid antigen testing or RT-PCR at the commercial laboratories do not meet criteria and are not subtyped. For more information on influenza tests and types, please visit the CDC website (*here*).

A. INFLUENZA:

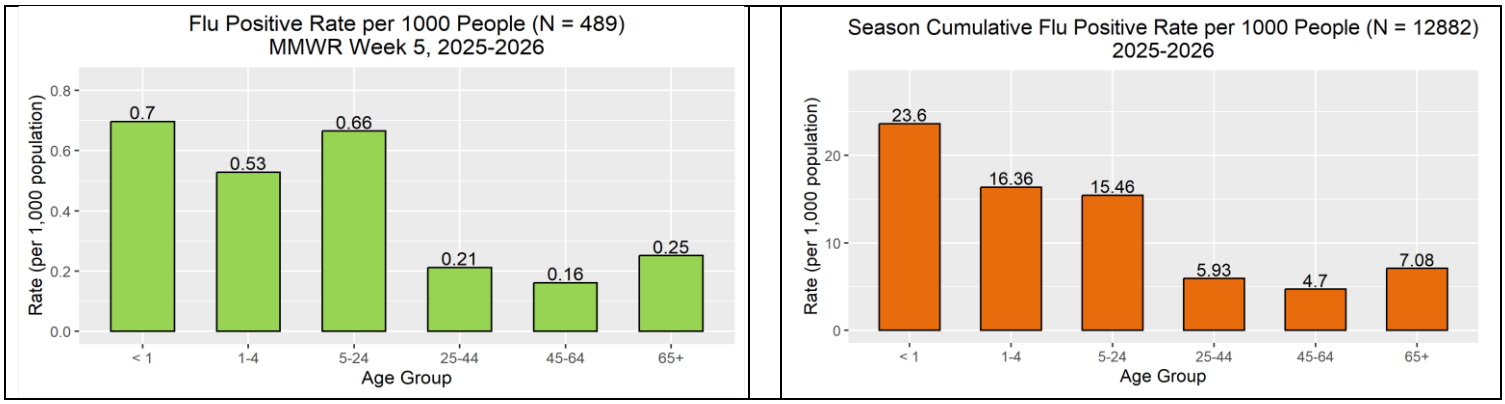
- The following reflects laboratory findings for week 5 of the 2025–26 influenza season:
  - *A total of **3,614** specimens has been tested statewide for influenza viruses (positive: 489 [**13.5%**]). (Season to date: **65,087** tested (**19.5%** positive)*
    - *1,605 (44.4%) were screened only by rapid antigen tests with no confirmatory testing.*
    - *2,009 (55.6%) underwent confirmatory testing (either RT-PCR or viral culture).*
    - *3,125 (86.5%) were negative.*
  - *Routine surveillance samples from State Laboratory Division were tested at a public health laboratory and identified as Influenza A (H3N2) subclade K.*

Influenza type	*Current week 5 (%)**	*Season to date (%)*[8]
Influenza A (H1)[9]	*0 (0.0)*	*100 (0.8)*
Influenza A (H3)	*5 (1.0)*	*977 (7.7)*
Influenza A no subtyping	*321 (65.5)*	*11,021 (86.8)*
Influenza B (Yamagata)	*0 (0.0)*	*0 (0.0)*
Influenza B (Victoria)	*0 (0.0)*	*0 (0.0)*
Influenza B no genotyping	*164 (33.5)*	*597 (4.7)*

**Specimens that are positive for both A and B (coinfections) are counted in both A and B totals for current and season to date*

1. AGE DISTRIBUTION

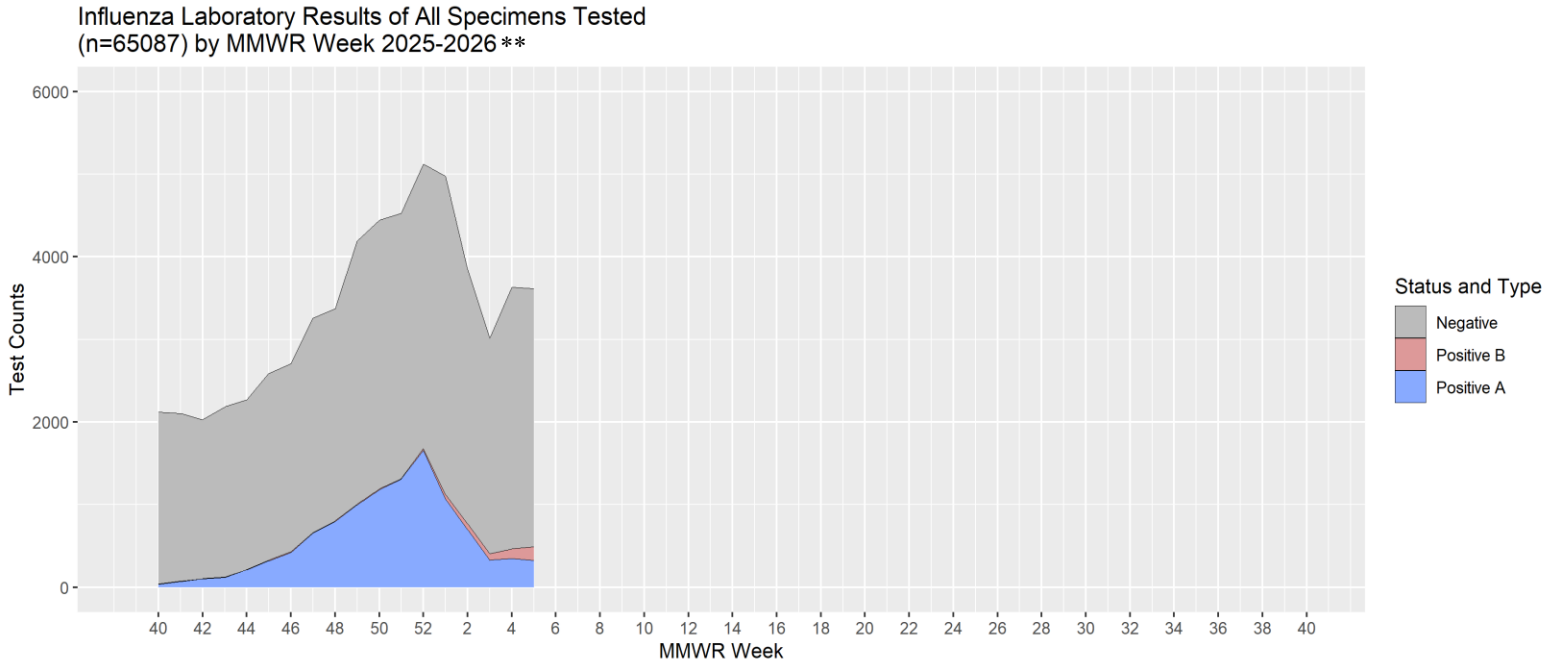
The charts below indicate the population-based rates of positive influenza cases in Hawaii by age group during the 2025–26 influenza season.[10]

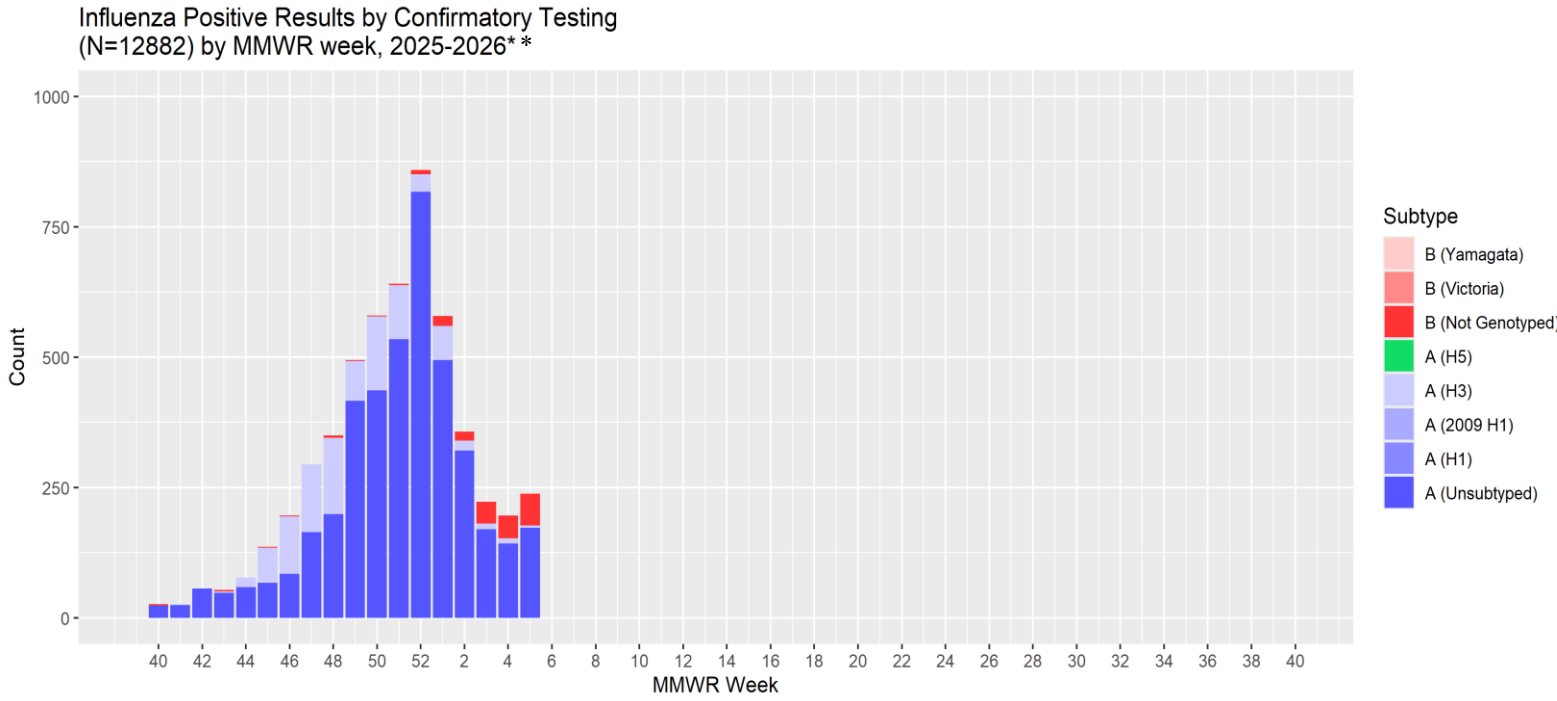


[7] Priority criteria include: hospitalized patients with acute respiratory distress syndrome [ARDS] or x-ray confirmed pneumonia; travelers with international travel history within 10 days of onset; specimens submitted by sentinel providers; specimens collected from healthcare workers, pregnant women, or women up to 6 weeks' post-partum; those with underlying medical conditions; and patients presenting with unusual or severe manifestations of influenza infection.
[8] Influenza coding were updated to reflect a more accurate count.
[9] All influenza A H1 viruses detected this season have been 2009 H1N1.
[10] This represents an estimate of population-based rates based on available data.

2. LABORATORY TESTING

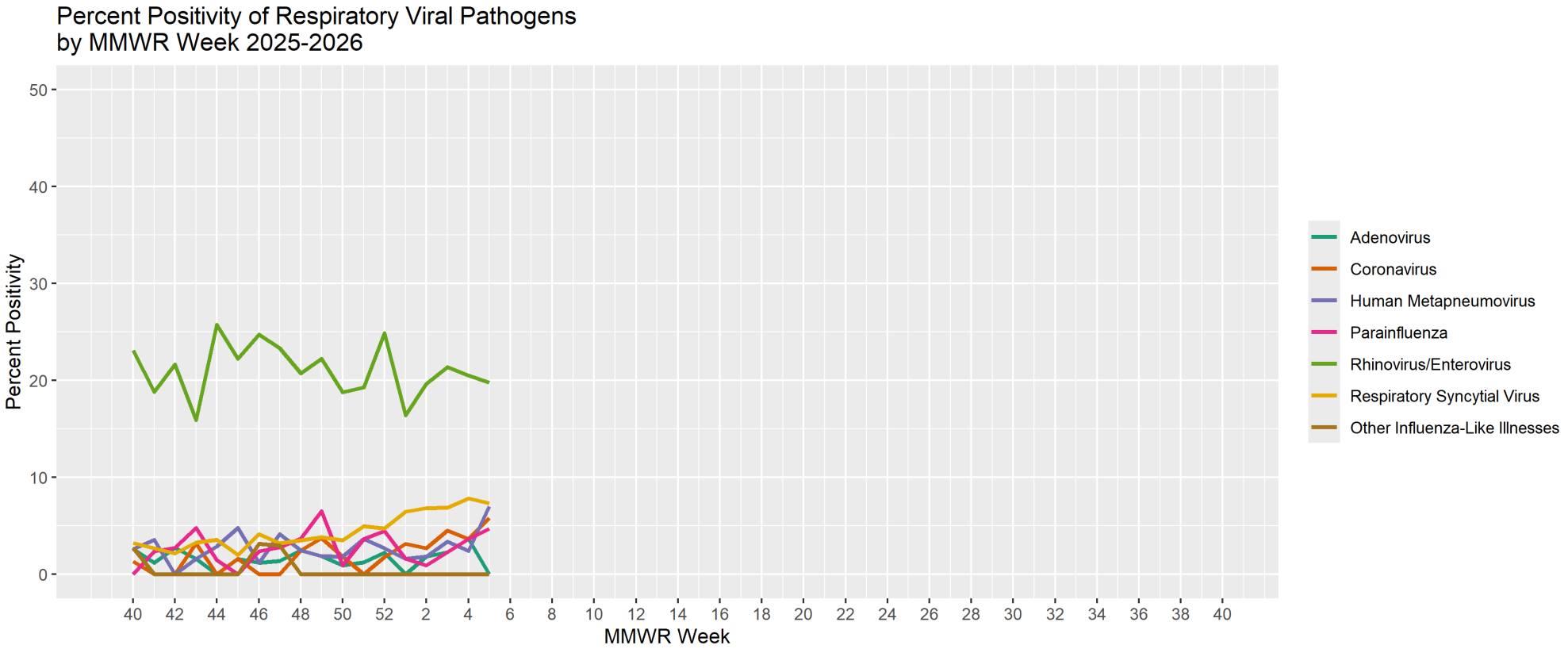
The charts below show the laboratory results of all specimens tested for influenza by MMWR week during the 2025–2026 influenza season as well as the type and subtype of positive results for influenza. Again, sub-typing is only performed on selected specimens tested by confirmatory tests (i.e., RT-PCR or viral culture).





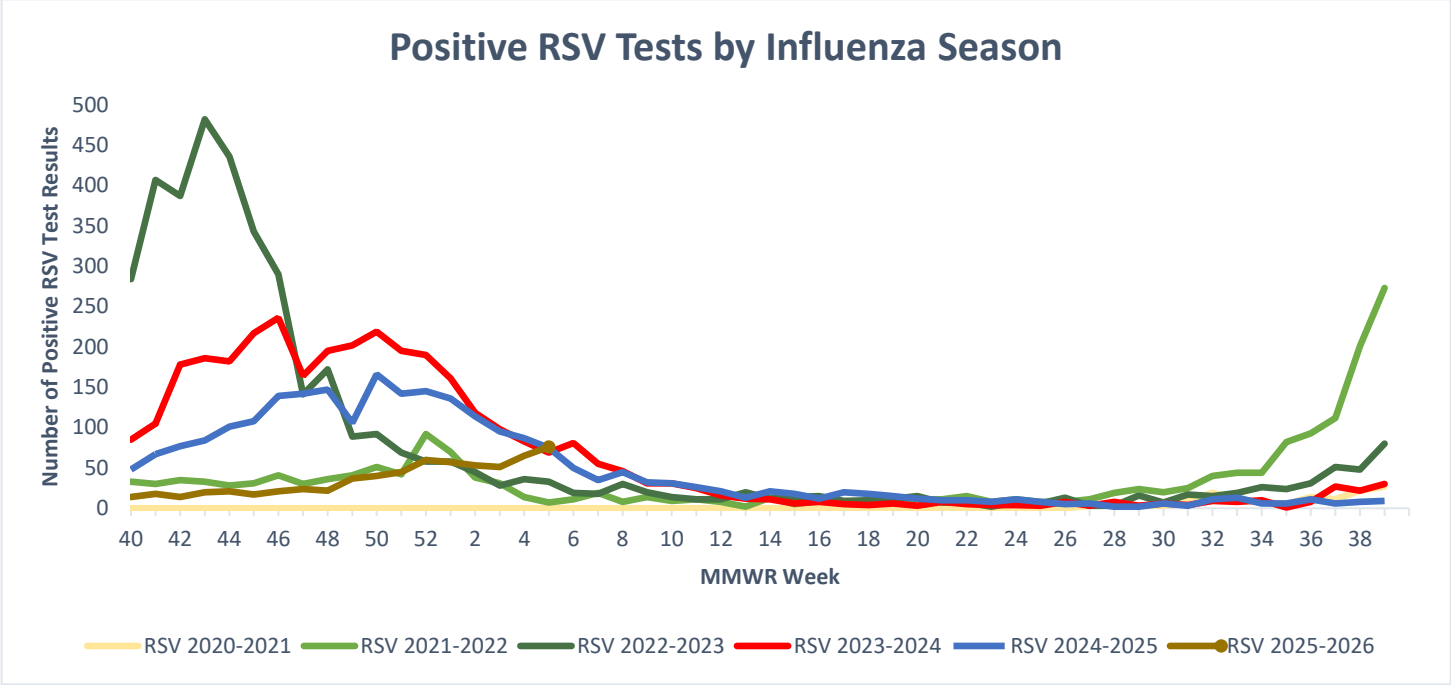
** A total of 36,224 specimens underwent confirmatory testing, but not all positive influenza specimens receive confirmatory testing that are circulating in Hawaii.*
*** For MMWR Week 53, results are reported under MMWR Week 52, where the average of Weeks 52 and 53 was calculated.*

B. **OTHER RESPIRATORY PATHOGENS:** The major clinical and commercial laboratories throughout the state of Hawaii have the testing capacity for non-influenza respiratory pathogens and report these to HDOH. However, such testing is performed as needed and when sufficient resources are available because of the high costs associated with respiratory panel tests. **Therefore, available data represent only the presence of circulating pathogens and cannot be used to determine specific trends**.

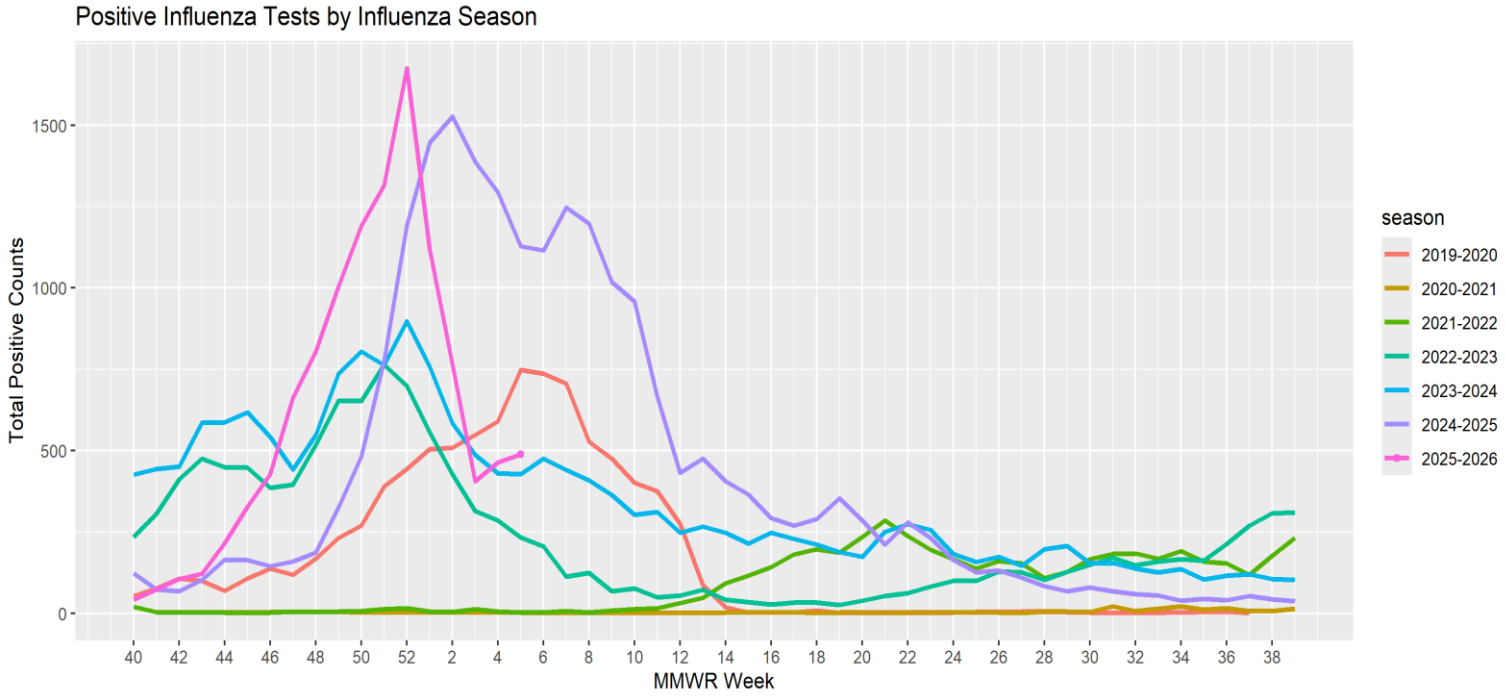


* *The coronavirus presented on this table does not indicate Severe Acute Respiratory Coronavirus-2 (i.e., COVID-19). For MMWR Week 53, results are reported under MMWR Week 52, where the average of Weeks 52 and 53 was calculated*

RESPIRATORY SYNCYTIAL VIRUS (RSV) POSITIVE TEST RESULTS BY INFLUENZA SEASON: RSV case appears to have increased later than past seasons in the 2025-2026 season. For MMWR Week 53, results are reported under MMWR Week 52, where the average of Weeks 52 and 53 was calculated.



INFLUENZA POSITIVE TEST RESULTS BY INFLUENZA SEASON: Influenza cases appear to have increased earlier than past seasons in the 2025-2026 season. For MMWR Week 53, results are reported under MMWR Week 52, where the average of Weeks 52 and 53 was calculated.



C. COVID-19 SENTINEL SURVEILLANCE: Due to the low volume of samples currently available through the influenza surveillance system, the COVID-19 sentinel surveillance data may not be accurately portraying COVID-19 activity in our communities. Reporting of the COVID-19 Sentinel Surveillance data will be paused while HODH re-evaluates the program to ensure that the reported data are accurate and representative.

HDOH is continuing to monitor COVID-19 activity throughout the state. To learn more, please visit the Hawaii's COVID-19 data website (*here*). For more information on surveillance of COVID-19 activity in the United States please visit the CDC COVIDView website (*here*).

III. PNEUMONIA, INFLUENZA, AND COVID-19 (PIC) RELATED MORTALITY:

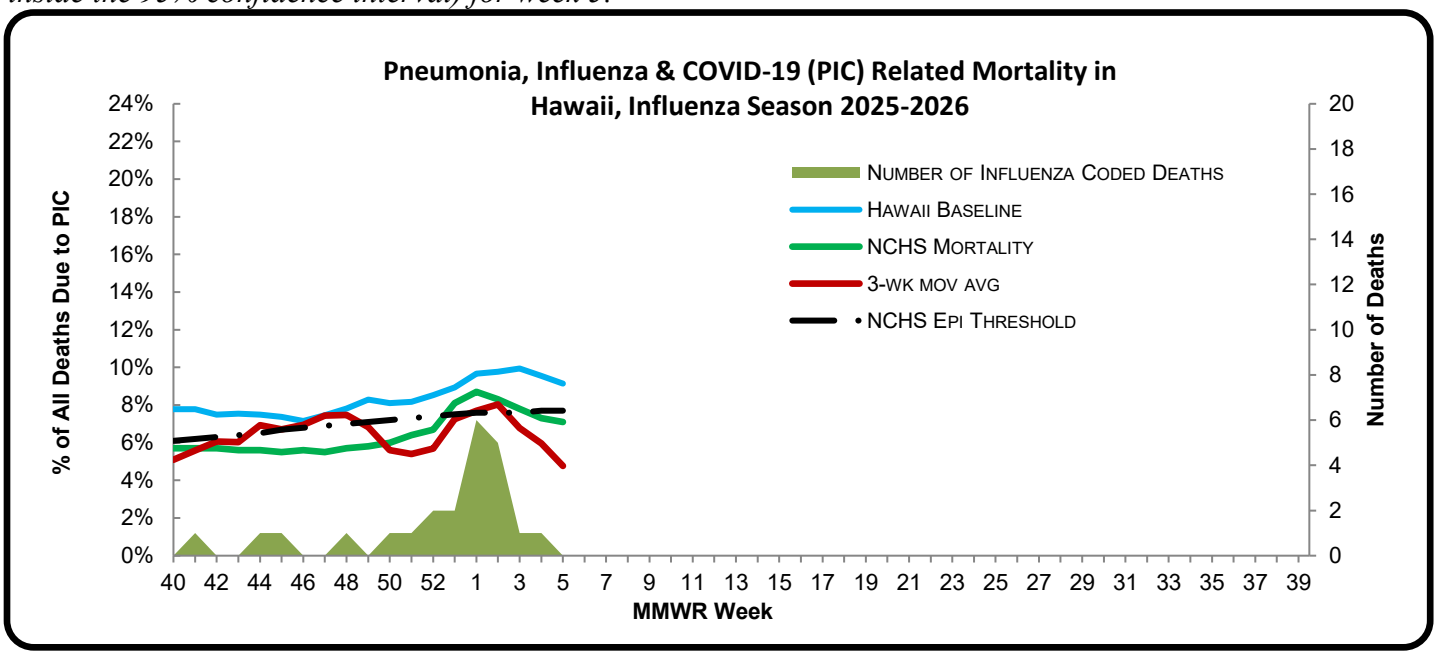
P&I mortality surveillance is collected by CDC through the National Center for Health Statistics (NCHS) using death certificate data. Each week the HDOH OHSM reports specific data from Honolulu to the CDC. CDC collects the following information by age group: the total number of deaths, total deaths from pneumonia, and total deaths related to influenza. Due to the ongoing COVID-19 pandemic, CDC included total deaths from COVID-19 by age group to the death data. Previous studies had suggested that P&I is a good indicator of influenza-related deaths; however, data has shown that pneumonia deaths associated with influenza is now being impacted by COVID-19 related pneumonia. Due to this, CDC had added COVID-19 deaths into P&I to create the PIC (pneumonia, influenza, and/or COVID-19) classification.

To standardize Hawaii's influenza surveillance with CDC influenza surveillance guidelines, PIC deaths will be reported in lieu of P&I. Hawaii's baseline will begin to include PIC deaths starting from 2019-2020 flu season.

For **week 5** of the current influenza season:

- ***3.4%*** *of all deaths that occurred in Hawaii during week 5 were related to pneumonia, influenza or COVID-19 (PIC)*[11]*. For the current season (season to date:* ***6.5%****), there have been 4,244 deaths from any cause, 278 of which were due to PIC*[12]*.*
- *The PIC rate was lower than the historical baseline in Hawaii*[13] *(i.e., outside the 95% confidence interval).*

The Hawaii PIC rate was comparable to the CDC's National Center for Health Statistics (NCHS) PIC mortality[14] *(**7.1%**) (i.e., inside the 95% confidence interval) and comparable to the national epidemic threshold (**7.7%**) (i.e., inside the 95% confidence interval) for week 5.*



[11] The percent of deaths due to PIC displayed on the graph is the 3-week moving averages.

[12] PIC data reflect 74.5% of the data reported for the MMWR week. Changes to data are expected when PIC data reaches 100% completion.

[13] The Hawaii historical baseline (%PIC) is the average of 3-week moving averages over the preceding 10 flu seasons of historical data (2014-2015, 2015-2016, 2016-2017, 2017-2018, 2018-2019, 2019-2020, 2020-2021, 2021-2022, 2022-2023, and 2023-2024).

[14] Each week, the vital statistics offices of 122 cities across the United States report the total number of death certificates processed and the number of those for which pneumonia, influenza, or COVID-19 was listed as the underlying or contributing cause of death by age group (Under 28 days, 28 days–1 year, 1–14 years, 15–24 years, 25–44 years, 45–64 years, 65–74 years, 75–84 years, and ≥85 years). The COVID-19 death counts reported by NCHS are provisional and will not match counts in other sources, such as media reports or numbers from health departments. COVID-19 deaths may be classified or defined differently in various reporting and surveillance systems. The percentage of deaths due to pneumonia, influenza, and COVID-19 (PIC) are compared with a seasonal baseline and epidemic threshold value calculated for each week.

INFLUENZA-ASSOCIATED PEDIATRIC DEATHS[15]:

- No new influenza-associated pediatric death was reported to Hawaii. There have been zero influenza-associated pediatric deaths reported in Hawaii during the 2025–2026 season.
- Nationally, six new influenza-associated pediatric deaths were reported to CDC during week 5. (2025-2026 season total: 66).

IV. INFLUENZA WATCH: As part of a comprehensive influenza surveillance system and to prevent the spread of contagious respiratory diseases in humans, it is important to monitor all circulating influenza types. Several animal-origin influenza A subtypes are currently of interest: influenza A variant virus (H3N2v, H1N2v, and H1N1v) and Avian flu (H5N1 and H7N9). These types of influenza viruses may cause zoonotic (animal-associated) disease and are a public health concern.

A. VARIANT VIRUSES:

Influenza viruses that normally circulate in pigs are called "variant" viruses when they are found in people. These viruses were first identified in U.S. pigs in 2010. In 2011, 12 cases of H3N2v infection were detected in the United States. In 2012, 309 such cases (resulting in 16 hospitalizations and one death) across 12 states were detected, including one Hawaii case who recovered. Illness associated with H3N2v infection has been mostly mild with symptoms similar to those of seasonal flu. However, serious illness, resulting in hospitalization and death, has occurred in some cases. Most of these infections have been associated with prolonged exposure to pigs at agricultural fairs or similar settings. Limited human-to-human spread of this virus has been detected in the past, but no sustained community spread of H3N2v has been identified. More information regarding H3N2v, H1N1v, and H1N2v viruses may be found on the CDC website (*here*) and (*here*).

- *No variant or novel influenza infections have been reported to HDOH during the 2025-2026 influenza season.*
- *One new human infection with novel influenza A virus, H1N1v (0), H3N2v (0), and H1N2v (1), have been reported during the 2025-2026 influenza season.*
    - *One new human infection with influenza A(H1N1v) virus has been reported to WHO from China during the 2025-2026 influenza season.*

AVIAN (OR BIRD) INFLUENZA: These types of influenza viruses cause zoonotic (animal-associated) disease of public health concern and are therefore monitored globally by the WHO. Most avian influenza viruses do not cause disease in humans and are generally not easily transmissible between person to person, but a few subtypes may cross the species barrier and cause disease in humans. Avian influenza viruses may be of various subtypes, including H5N1, H5N2, H5N8, H7N3, H7N7, H7N8, H7N9, and H9N2. On January 15th, 2016, the USDA and APHIS reported detection of HPAI H7N8 in a commercial turkey flock in Indiana. There have been no associated human infections. This is the first detection of HPAI H7N8 in wild bird surveillance in the United States. More information, the risk assessment and recommendations for HPAI H7N8 can be found (here). The WHO, CDC, and other public health agencies have also been monitoring influenza H7N9, which represents a public health concern because of its high pandemic potential. Although H7N9 has not been detected in the United States, it remains a global concern given continuing epidemics in endemic countries. Since 2013, a total of 1,568 laboratory-confirmed cases of human infection with H7N9 viruses, including at least 613 deaths, have been reported to WHO. More information on H7N9 virus infections can be found (here). For more information regarding avian influenza, please visit the CDC (*here*) or the WHO (*here*) websites. WHO reports total number of cases and deaths related to laboratory-confirmed avian influenza viruses and posts current avian influenza case counts (*here*), which were last updated on **December 19, 2025**.

[15] Influenza-associated deaths are considered pediatric in persons aged less than 18 years. It was made a nationally notifiable condition in October, 2004. All pediatric influenza-associated deaths are laboratory confirmed.

V. INFLUENZA Vaccine: Annual influenza vaccination is recommended for all persons aged 6 months and older and is the most effective way to reduce the risk of getting sick with seasonal flu and spreading it to others. Influenza vaccination can reduce illnesses, visits to the doctor, influenza-related hospitalizations, and missed work and school days. Influenza vaccines become available by the end of October. It takes at least two weeks after vaccination to confer immunity against influenza virus infection. More information regarding influenza vaccination can be found (*here*).

A. Composition of the 2025–2026 Influenza Vaccine:

The composition of the 2025–2026 influenza vaccine has been updated to better match circulating influenza viruses. The Advisory Committee on Immunization Practices (ACIP) has recommended that the 2025-2026 influenza trivalent vaccine contain an influenza A/Victoria/4897/2022 (H1N1) pdm09-like virus, influenza A/Croatia/10136RV/2023 (H3N2)-like virus, and influenza B/Austria/1359417/2021 (B/Victoria lineage)-like virus. United States cell culture–based inactivated (ccIIV4) and recombinant (RIV4) influenza vaccines will contain HA derived from an influenza A/Wisconsin/67/2022 (H1N1) pdm09-like virus, an A/District of Columbia/27/2023 (H3N2)-like virus, an influenza B/Austria/1359417/2021 (B/Victoria lineage)-like virus. These vaccine recommendations were based on several factors, including global influenza virologic and epidemiologic surveillance, genetic and antigenic characterization, human serology studies, antiviral susceptibility, and the availability of candidate influenza viruses.

APPENDIX 1: ADDITIONAL INFORMATION

For more information regarding local and national influenza surveillance programs, visit the following sites.

Centers for Disease Control and Prevention	General Influenza National ILI and P&I Data Vaccine Virus Selection CDC Web Tool for Respiratory Viruses
Flu.gov	General Influenza Information
HDOH Flu and Pneumonia	General Influenza Surveillance Avian Influenza Respiratory Virus Dashboard To find out more information or join the sentinel physician program, email the Influenza Surveillance Coordinator
World Health Organization	General Global and Local Influenza Avian Influenza

APPENDIX 2: MMWR WEEK DATES

Please refer to the table below to interpret data presented by MMWR week. Week 40 is considered the traditional start for the flu season for the Northern Hemisphere.

MMWR WEEK	2022	2023	2024	2025	2026
1	1/8/2022	1/7/2023	1/6/2024	1/4/2025	1/10/2026
2	1/15/2022	1/14/2023	1/13/2024	1/11/2025	1/17/2026
3	1/22/2022	1/21/2023	1/20/2024	1/18/2025	1/24/2026
4	1/29/2022	1/28/2023	1/27/2024	1/25/2025	1/31/2026
5	2/5/2022	2/4/2023	2/3/2024	2/1/2025	2/7/2026
6	2/12/2022	2/11/2023	2/10/2024	2/8/2025	2/14/2026
7	2/19/2022	2/18/2023	2/17/2024	2/15/2025	2/21/2026
8	2/26/2022	2/25/2023	2/24/2024	2/22/2025	2/28/2026
9	3/5/2022	3/4/2023	3/2/2024	3/1/2025	3/7/2026
10	3/12/2022	3/11/2023	3/9/2024	3/8/2025	3/14/2026
11	3/19/2022	3/18/2023	3/16/2024	3/15/2025	3/21/2026
12	3/26/2022	3/25/2023	3/23/2024	3/22/2025	3/28/2026
13	4/2/2022	4/1/2023	3/30/2024	3/29/2025	4/4/2026
14	4/9/2022	4/8/2023	4/6/2024	4/5/2025	4/11/2026
15	4/16/2022	4/15/2023	4/13/2024	4/12/2025	4/18/2026
16	4/23/2022	4/22/2023	4/20/2024	4/19/2025	4/25/2026
17	4/30/2022	4/29/2023	4/27/2024	4/26/2025	5/2/2026
18	5/7/2022	5/6/2023	5/4/2024	5/3/2025	5/9/2026
19	5/14/2022	5/13/2023	5/11/2024	5/10/2025	5/16/2026
20	5/21/2022	5/20/2023	5/18/2024	5/17/2025	5/23/2026
21	5/28/2022	5/27/2023	5/25/2024	5/24/2025	5/30/2026
22	6/4/2022	6/3/2023	6/1/2024	5/31/2025	6/6/2026
23	6/11/2022	6/10/2023	6/8/2024	6/7/2025	6/13/2026
24	6/18/2022	6/17/2023	6/15/2024	6/14/2025	6/20/2026
25	6/25/2022	6/24/2023	6/22/2024	6/21/2025	6/27/2026
26	7/2/2022	7/1/2023	6/29/2024	6/28/2025	7/4/2026
27	7/9/2022	7/8/2023	7/6/2024	7/5/2025	7/11/2026
28	7/16/2022	7/15/2023	7/13/2024	7/12/2025	7/18/2026
29	7/23/2022	7/22/2023	7/20/2024	7/19/2025	7/25/2026
30	7/30/2022	7/29/2023	7/27/2024	7/26/2025	8/1/2026
31	8/6/2022	8/5/2023	8/3/2024	8/2/2025	8/8/2026
32	8/13/2022	8/12/2023	8/10/2024	8/9/2025	8/15/2026
33	8/20/2022	8/19/2023	8/17/2024	8/16/2025	8/22/2026
34	8/27/2022	8/26/2023	8/24/2024	8/23/2025	8/29/2026
35	9/3/2022	9/2/2023	8/31/2024	8/30/2025	9/5/2026
36	9/10/2022	9/9/2023	9/7/2024	9/6/2025	9/12/2026
37	9/17/2022	9/16/2023	9/14/2024	9/13/2025	9/19/2026
38	9/24/2022	9/23/2023	9/21/2024	9/20/2025	9/26/2026
39	10/1/2022	9/30/2023	9/28/2024	9/27/2025	10/3/2026
40	10/8/2022	10/7/2023	10/5/2024	10/4/2025	10/10/2026
41	10/15/2022	10/14/2023	10/12/2024	10/11/2025	10/17/2026
42	10/22/2022	10/21/2023	10/19/2024	10/18/2025	10/24/2026
43	10/29/2022	10/28/2023	10/26/2024	10/25/2025	10/31/2026
44	11/5/2022	11/4/2023	11/2/2024	11/1/2025	11/7/2026
45	11/12/2022	11/11/2023	11/9/2024	11/8/2025	11/14/2026
46	11/19/2022	11/18/2023	11/16/2024	11/15/2025	11/21/2026
47	11/26/2022	11/25/2023	11/23/2024	11/22/2025	11/28/2026
48	12/3/2022	12/2/2023	11/30/2024	11/29/2025	12/5/2026
49	12/10/2022	12/9/2023	12/7/2024	12/6/2025	12/12/2026
50	12/17/2022	12/16/2023	12/14/2024	12/13/2025	12/19/2026
51	12/24/2022	12/23/2023	12/21/2024	12/20/2025	12/26/2026
52	12/31/2022	12/30/2023	12/28/2024	12/27/2025	
53				01/03/2026	

HAWAII STATE DEPARTMENT OF HEALTH
DISEASE OUTBREAK CONTROL DIVISION

Influenza/Respiratory Disease Surveillance Report

Morbidity and Mortality Weekly Report (MMWR)[1]

WEEK 6: FEBRUARY 8, 2026– FEBRUARY 14, 2026

OVERVIEW: The Hawaii State Department of Health (HDOH) monitors influenza and other respiratory pathogens, including COVID-19, throughout the state of Hawaii. Influenza surveillance in the state of Hawaii relies upon selected sentinel health practitioners, the State Laboratories Division (SLD), private laboratories, and the Office of Health Status Monitoring (OHSM). For detailed information concerning influenza, please visit the HDOH Disease Outbreak Control Division (HDOH DOCD) website (*here*). **All data and information are conditional and may change as more reports are received.** The data in this report reflects the 2025-2026 influenza season which began the week ending October 4, 2025 (week 40[1] 2025) and will end the week ending on October 3, 2026 (week 39 2026).

REPORT SNAPSHOT FOR WEEK 6

Surveillance for Influenza-like Illness (ILI)		
Metric	*Value*	*Comment*
Outpatient visits related to influenza-like illness (ILI) from ILINet Sentinel Providers	3.2%	Lower than the previous week. Comparable to Hawaii's historical baseline and lower than the national baseline, and lower than the national ILI rate.
Number of ILI clusters reported to HDOH	0	There have been 20 clusters this season.

Laboratory Surveillance		
Percent of all respiratory specimens positive for influenza this week	13.9%	Higher than the previous week. This number means that many, if not all, of the 86.1% who tested negative for influenza had illness from another respiratory etiology.
Percent of all respiratory specimens positive for influenza this season to date	19.2%	

Surveillance for Severe Outcomes		
Pneumonia, influenza and COVID-19 (PIC) mortality rate	3.7%	Lower than Hawaii's historical baseline, comparable to the national epidemic threshold and comparable to the NCHS average.
Number of influenza-associated pediatric deaths reported nationwide	71	0 influenza-associated pediatric deaths have been reported from Hawaii this season to date.

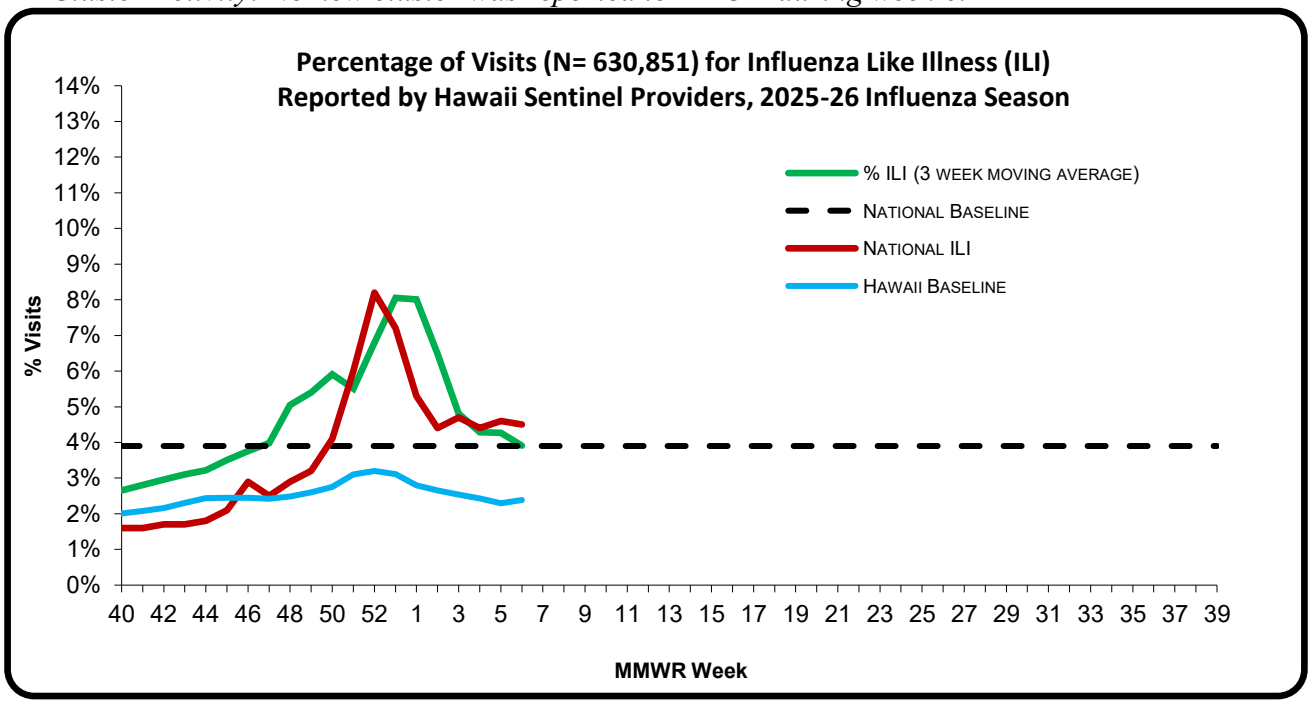
[1] MMWR stands for "Morbidity and Mortality Weekly Report," conventionally used by the Centers for Disease Control and Prevention (CDC). The weeks of a flu season are often referred to by their respective MMWR week. **See appendix 2 for interpretation of MMWR weeks.** Data reported will begin on week 40, the traditional start date of flu season.

INFLUENZA SURVEILLANCE

I. INFLUENZA-LIKE ILLNESS (ILI): HDOH collaborates with recruited doctors and healthcare providers who report the total number of outpatient visits for ILI as well as the total number of patients who complained of symptoms consistent with ILI. A patient with ILI must have the following: a fever (temperature of 100°F [37.8°C] or greater) AND a cough and/or a sore throat. ILI is based on reported symptoms and not laboratory confirmed tests; thus, ILI may represent other respiratory pathogens and not solely influenza. Further, sentinel providers report these numbers on a weekly basis; therefore, data are preliminary and may change depending on additional reporting. In combination with laboratory testing and other surveillance systems, ILI surveillance helps monitor influenza and other respiratory pathogen activity. For more information concerning ILINet and sentinel requirements, please visit the CDC website (*here*).

For **week 6** of the current influenza season:

- ***3.2**% (season to date: **4.6**%) of the outpatient visits recorded by Hawaii sentinel providers were for ILI.*
- *ILI visits were comparable to the historical baseline in Hawaii[2,3] (i.e., inside the 95% confidence interval).*
- *Hawaii's ILI outpatient visits were lower than the national baseline (**3.9%**)[4] (i.e., outside the 95% confidence interval) and lower than the national ILI rate (**4.5%**) (i.e. outside the 95% confidence interval).*
- *ILI activity level: Low[5]*
- *Geographic Spread: Sporadic Activity[6].*
- *ILI Cluster Activity: No new cluster was reported to HDOH during week 6.*



[2] The Hawaii historical baseline (%ILI) is the average of 3-week moving averages over the preceding 10 flu seasons of historical data (2015-2016, 2016-2017, 2017-2018, 2018-2019, 2019-2020, 2020-2021, 2021-2022, 2022-2023, 2023-2024 and 2024-2025).

[3] This value is based upon comparison of actual outpatient ILI with the historical baseline, which only captures outpatient ILI. The chart above represents a 3-week moving average and not the actual ILI by week.

[4] The National Baseline is calculated by CDC as the mean percentage of visits for ILI during weeks 21–39 with two standard deviations. Because of large variability in regional ILI, comparison of the national baseline with local ILI may not be appropriate. It is provided in this report because no meaningful regional baselines are available for comparison. The national baseline combines all data reported by states to CDC, including ILI in outpatient, ER, urgent care, and inpatient settings.

[5] There are 10 activity levels classified as minimal (levels 1-3), low (levels 4-5), moderate (levels 6-7), and high (levels 8-10).

[6] The influenza activity reported by state and territorial epidemiologists indicates geographic spread of influenza viruses but does not measure the severity of influenza activity. Sporadic: no clusters reported to HDOH, Local: one or more clusters reported in one county, Regional: clusters reported two to three counties, Widespread: clusters reported in all counties. Hawaii does not report No Activity, as flu circulates year-round in Hawaii.

II. LABORATORY SURVEILLANCE: State Laboratories Division (SLD; the HDOH public health laboratory) and Hawaii's major private laboratories (DLS, CLH) report results of RT-PCR, which can be considered confirmatory (SLD may perform viral culture on select specimens). Specimens meeting priority criteria[7] are forwarded to SLD for sub-typing. Additionally, specimens meeting case definition from requesting sentinel providers are sent directly to SLD for sub-typing. Due to resource constraints, not all submitted specimens undergo sub-typing. Sub-typing at the commercial laboratories is only conducted on a case-by-case basis. The majority of specimens testing positive by rapid antigen testing or RT-PCR at the commercial laboratories do not meet criteria and are not subtyped. For more information on influenza tests and types, please visit the CDC website (*here*).

A. INFLUENZA:

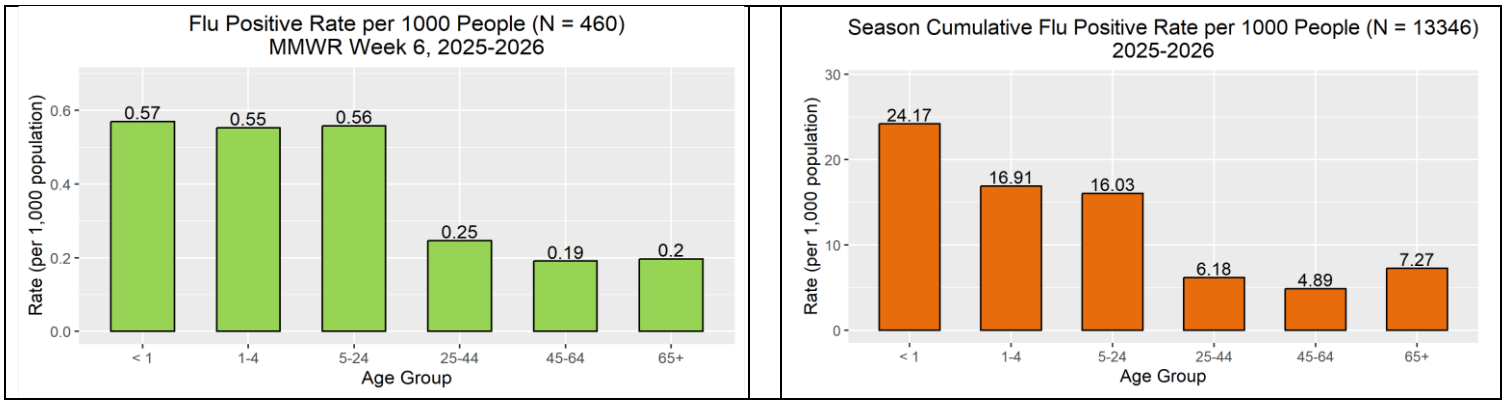
- The following reflects laboratory findings for week 6 of the 2025–26 influenza season:
  - *A total of **3,313** specimens has been tested statewide for influenza viruses (positive: 460 [**13.9%**]). (Season to date: **68,410** tested (**19.2%** positive)*
    - *1,522 (45.9%) were screened only by rapid antigen tests with no confirmatory testing.*
    - *1,791 (54.1%) underwent confirmatory testing (either RT-PCR or viral culture).*
    - *2,853 (86.1%) were negative.*
  - *Routine surveillance samples from State Laboratory Division were tested at a public health laboratory and identified as Influenza A (H3N2) subclade K.*

Influenza type	*Current week 6 (%)**	*Season to date (%)*[8]
Influenza A (H1)[9]	*1 (0.2)*	*104 (0.8)*
Influenza A (H3)	*3 (0.6)*	*995 (7.6)*
Influenza A no subtyping	*275 (59.7)*	*11,234 (85.7)*
Influenza B (Yamagata)	*0 (0.0)*	*0 (0.0)*
Influenza B (Victoria)	*0 (0.0)*	*0 (0.0)*
Influenza B no genotyping	*182 (39.5)*	*779 (5.9)*

**Specimens that are positive for both A and B (coinfections) are counted in both A and B totals for current and season to date*

1. AGE DISTRIBUTION

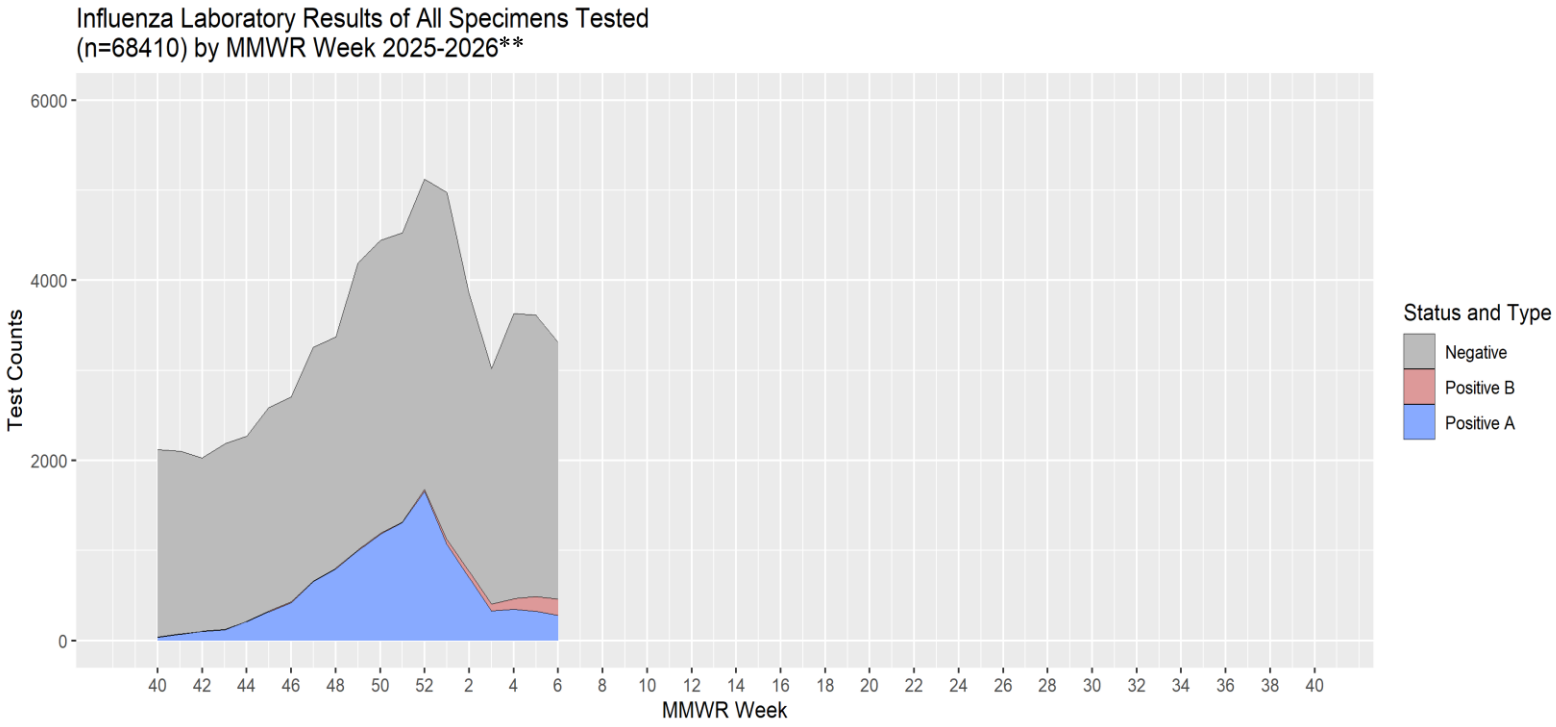
The charts below indicate the population-based rates of positive influenza cases in Hawaii by age group during the 2025–26 influenza season.[10]

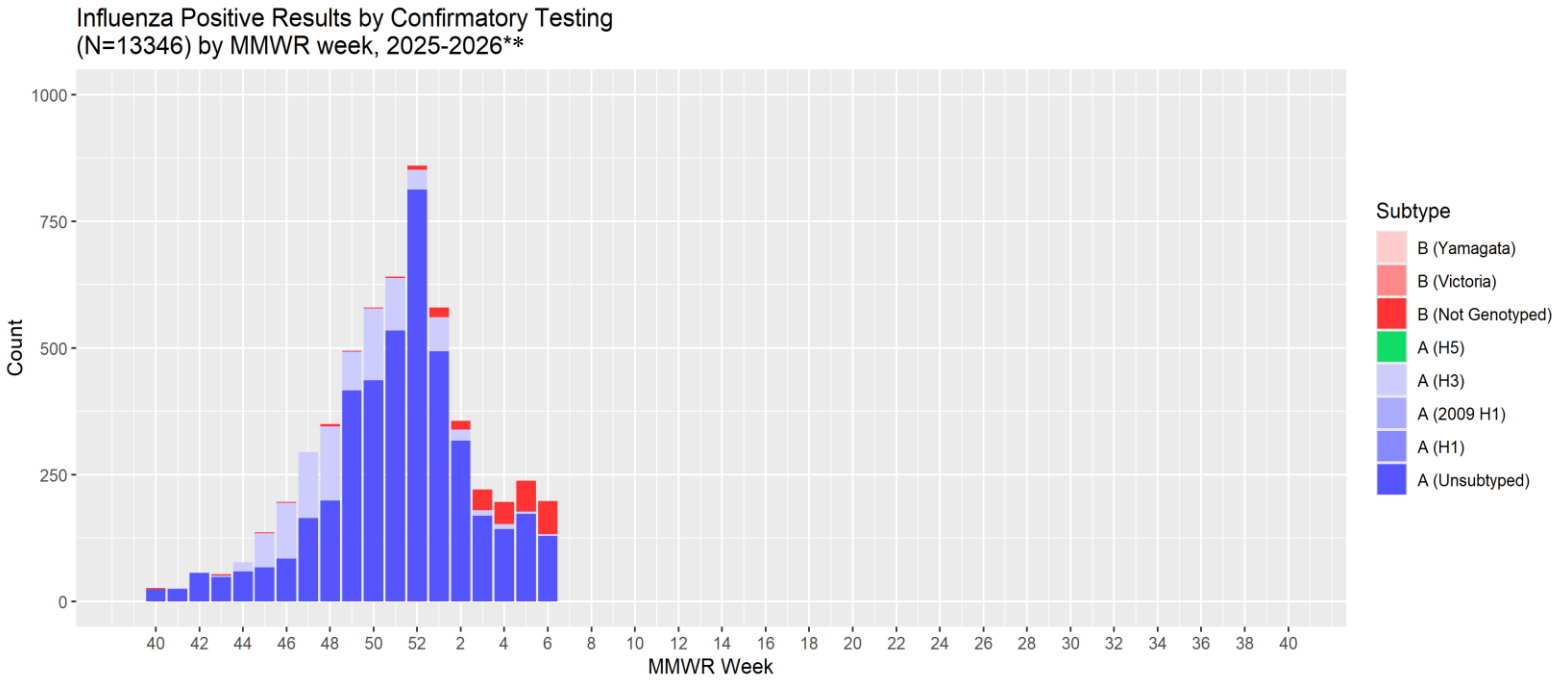


[7] Priority criteria include: hospitalized patients with acute respiratory distress syndrome [ARDS] or x-ray confirmed pneumonia; travelers with international travel history within 10 days of onset; specimens submitted by sentinel providers; specimens collected from healthcare workers, pregnant women, or women up to 6 weeks' post-partum; those with underlying medical conditions; and patients presenting with unusual or severe manifestations of influenza infection.
[8] Influenza coding were updated to reflect a more accurate count.
[9] All influenza A H1 viruses detected this season have been 2009 H1N1.
[10] This represents an estimate of population-based rates based on available data.

2. LABORATORY TESTING

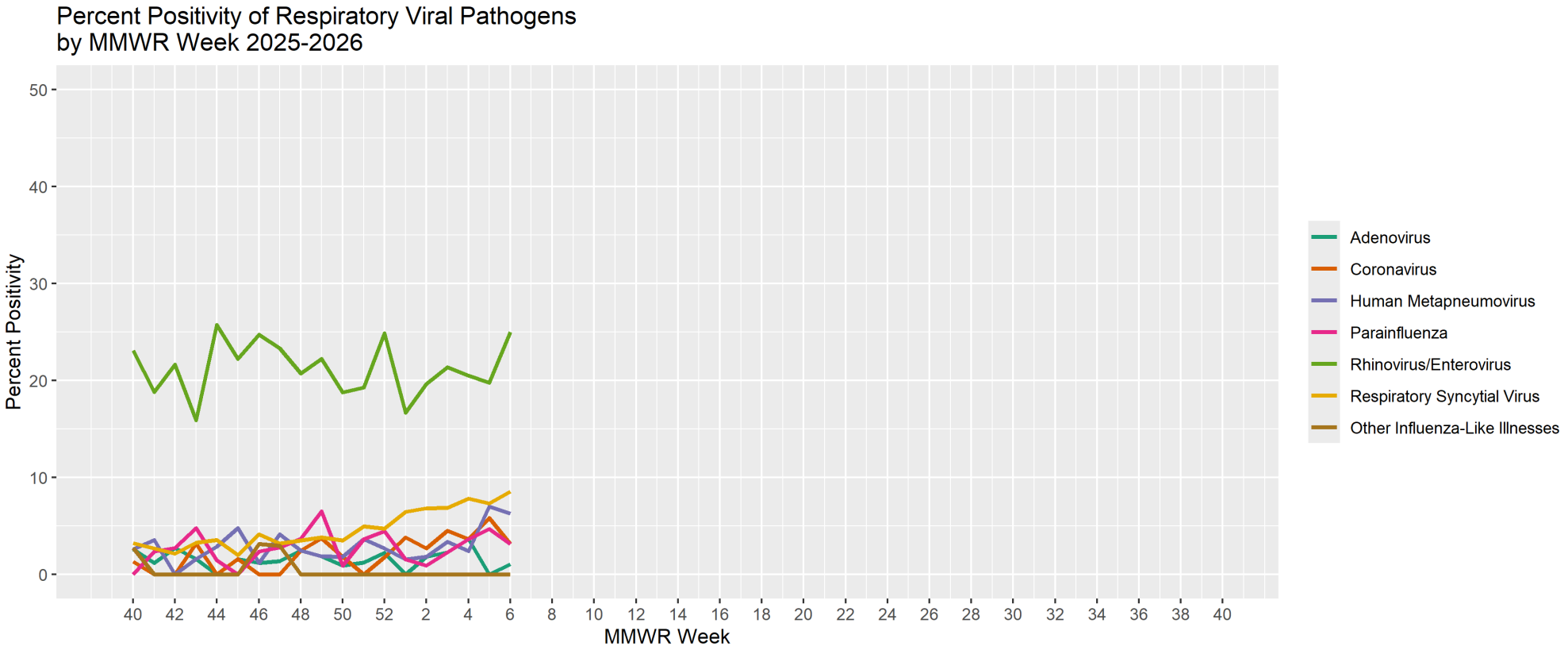
The charts below show the laboratory results of all specimens tested for influenza by MMWR week during the 2025–2026 influenza season as well as the type and subtype of positive results for influenza. Again, sub-typing is only performed on selected specimens tested by confirmatory tests (i.e., RT-PCR or viral culture).





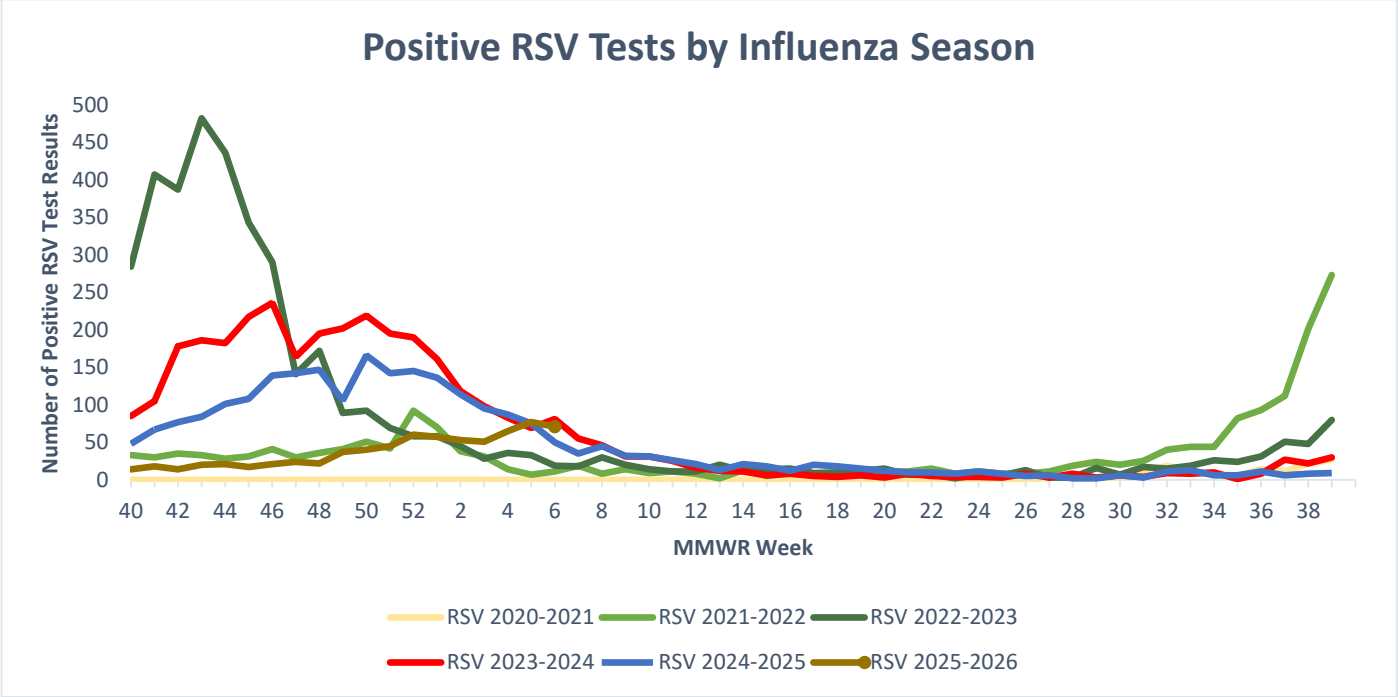
** A total of 38,024 specimens underwent confirmatory testing, but not all positive influenza specimens receive confirmatory testing that are circulating in Hawaii.*
*** For MMWR Week 53, results are reported under MMWR Week 52, where the average of Weeks 52 and 53 was calculated.*

B. **OTHER RESPIRATORY PATHOGENS:** The major clinical and commercial laboratories throughout the state of Hawaii have the testing capacity for non-influenza respiratory pathogens and report these to HDOH. However, such testing is performed as needed and when sufficient resources are available because of the high costs associated with respiratory panel tests. **Therefore, available data represent only the presence of circulating pathogens and cannot be used to determine specific trends**.

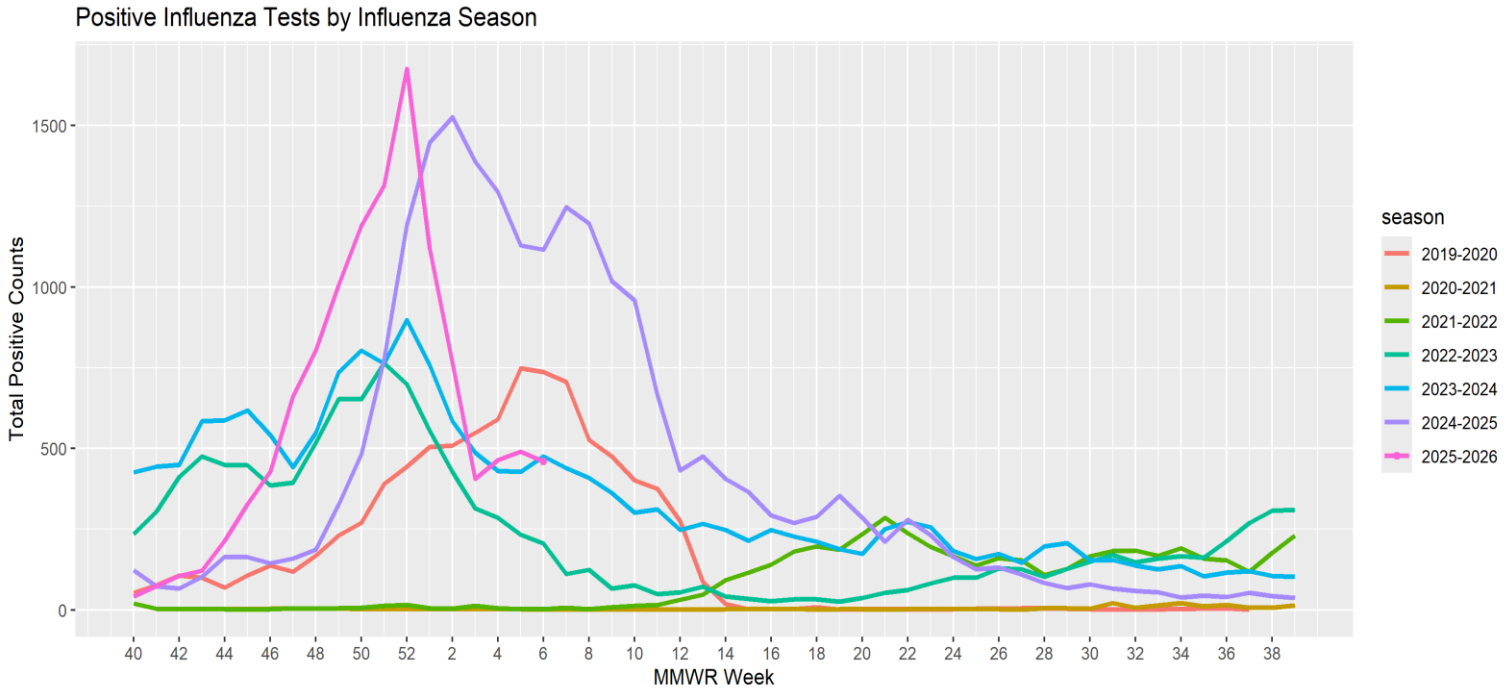


* *The coronavirus presented on this table does not indicate Severe Acute Respiratory Coronavirus-2 (i.e., COVID-19). For MMWR Week 53, results are reported under MMWR Week 52, where the average of Weeks 52 and 53 was calculated*

RESPIRATORY SYNCYTIAL VIRUS (RSV) POSITIVE TEST RESULTS BY INFLUENZA SEASON: RSV case appears to have increased later than past seasons in the 2025-2026 season. For MMWR Week 53, results are reported under MMWR Week 52, where the average of Weeks 52 and 53 was calculated.



INFLUENZA POSITIVE TEST RESULTS BY INFLUENZA SEASON: Influenza cases appear to have increased earlier than past seasons in the 2025-2026 season. For MMWR Week 53, results are reported under MMWR Week 52, where the average of Weeks 52 and 53 was calculated.



C. COVID-19 SENTINEL SURVEILLANCE: Due to the low volume of samples currently available through the influenza surveillance system, the COVID-19 sentinel surveillance data may not be accurately portraying COVID-19 activity in our communities. Reporting of the COVID-19 Sentinel Surveillance data will be paused while HODH re-evaluates the program to ensure that the reported data are accurate and representative.

HDOH is continuing to monitor COVID-19 activity throughout the state. To learn more, please visit the Hawaii's COVID-19 data website (*here*). For more information on surveillance of COVID-19 activity in the United States please visit the CDC COVIDView website (*here*).

III. PNEUMONIA, INFLUENZA, AND COVID-19 (PIC) RELATED MORTALITY:

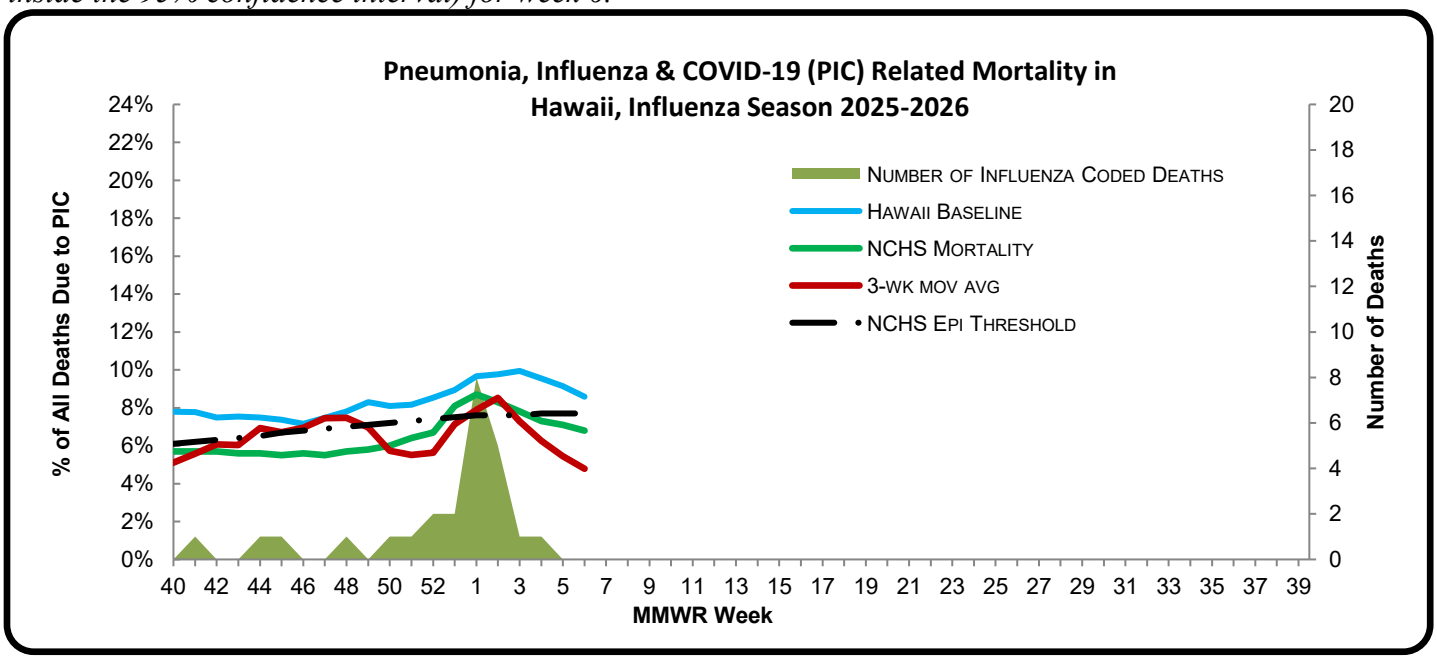
P&I mortality surveillance is collected by CDC through the National Center for Health Statistics (NCHS) using death certificate data. Each week the HDOH OHSM reports specific data from Honolulu to the CDC. CDC collects the following information by age group: the total number of deaths, total deaths from pneumonia, and total deaths related to influenza. Due to the ongoing COVID-19 pandemic, CDC included total deaths from COVID-19 by age group to the death data. Previous studies had suggested that P&I is a good indicator of influenza-related deaths; however, data has shown that pneumonia deaths associated with influenza is now being impacted by COVID-19 related pneumonia. Due to this, CDC had added COVID-19 deaths into P&I to create the PIC (pneumonia, influenza, and/or COVID-19) classification.

To standardize Hawaii's influenza surveillance with CDC influenza surveillance guidelines, PIC deaths will be reported in lieu of P&I. Hawaii's baseline will begin to include PIC deaths starting from 2019-2020 flu season.

For **week 6** of the current influenza season:

- ***3.7%*** *of all deaths that occurred in Hawaii during week 6 were related to pneumonia, influenza or COVID-19 (PIC)[11]. For the current season (season to date:* ***6.5%****), there have been 4,523 deaths from any cause, 298 of which were due to PIC[12].*
- *The PIC rate was lower than the historical baseline in Hawaii[13] (i.e., outside the 95% confidence interval).*

The Hawaii PIC rate was comparable to the CDC's National Center for Health Statistics (NCHS) PIC mortality[14] ***(6.8%)*** *(i.e., inside the 95% confidence interval) and comparable to the national epidemic threshold (****7.7%****) (i.e., inside the 95% confidence interval) for week 6.*



[11] The percent of deaths due to PIC displayed on the graph is the 3-week moving averages.

[12] PIC data reflect 100.0% of the data reported for the MMWR week. Changes to data are expected when PIC data reaches 100% completion.

[13] The Hawaii historical baseline (%PIC) is the average of 3-week moving averages over the preceding 10 flu seasons of historical data (2014-2015, 2015-2016, 2016-2017, 2017-2018, 2018-2019, 2019-2020, 2020-2021, 2021-2022, 2022-2023, and 2023-2024).

[14] Each week, the vital statistics offices of 122 cities across the United States report the total number of death certificates processed and the number of those for which pneumonia, influenza, or COVID-19 was listed as the underlying or contributing cause of death by age group (Under 28 days, 28 days–1 year, 1–14 years, 15–24 years, 25–44 years, 45–64 years, 65–74 years, 75–84 years, and ≥85 years). The COVID-19 death counts reported by NCHS are provisional and will not match counts in other sources, such as media reports or numbers from health departments. COVID-19 deaths may be classified or defined differently in various reporting and surveillance systems. The percentage of deaths due to pneumonia, influenza, and COVID-19 (PIC) are compared with a seasonal baseline and epidemic threshold value calculated for each week.

INFLUENZA-ASSOCIATED PEDIATRIC DEATHS[15]:

- No new influenza-associated pediatric death was reported to Hawaii. There have been zero influenza-associated pediatric deaths reported in Hawaii during the 2025–2026 season.
- Nationally, five new influenza-associated pediatric deaths were reported to CDC during week 6. (2025-2026 season total: 71).

IV. INFLUENZA WATCH: As part of a comprehensive influenza surveillance system and to prevent the spread of contagious respiratory diseases in humans, it is important to monitor all circulating influenza types. Several animal-origin influenza A subtypes are currently of interest: influenza A variant virus (H3N2v, H1N2v, and H1N1v) and Avian flu (H5N1 and H7N9). These types of influenza viruses may cause zoonotic (animal-associated) disease and are a public health concern.

A. VARIANT VIRUSES:

Influenza viruses that normally circulate in pigs are called "variant" viruses when they are found in people. These viruses were first identified in U.S. pigs in 2010. In 2011, 12 cases of H3N2v infection were detected in the United States. In 2012, 309 such cases (resulting in 16 hospitalizations and one death) across 12 states were detected, including one Hawaii case who recovered. Illness associated with H3N2v infection has been mostly mild with symptoms similar to those of seasonal flu. However, serious illness, resulting in hospitalization and death, has occurred in some cases. Most of these infections have been associated with prolonged exposure to pigs at agricultural fairs or similar settings. Limited human-to-human spread of this virus has been detected in the past, but no sustained community spread of H3N2v has been identified. More information regarding H3N2v, H1N1v, and H1N2v viruses may be found on the CDC website (*here*) and (*here*).

- *No variant or novel influenza infections have been reported to HDOH during the 2025-2026 influenza season.*
- *One new human infection with novel influenza A virus, H1N1v (0), H3N2v (0), and H1N2v (1), have been reported during the 2025-2026 influenza season.*
    - *One new human infection with influenza A(H1N1v) virus has been reported to WHO from China during the 2025-2026 influenza season.*

AVIAN (OR BIRD) INFLUENZA: These types of influenza viruses cause zoonotic (animal-associated) disease of public health concern and are therefore monitored globally by the WHO. Most avian influenza viruses do not cause disease in humans and are generally not easily transmissible between person to person, but a few subtypes may cross the species barrier and cause disease in humans. Avian influenza viruses may be of various subtypes, including H5N1, H5N2, H5N8, H7N3, H7N7, H7N8, H7N9, and H9N2. On January 15th, 2016, the USDA and APHIS reported detection of HPAI H7N8 in a commercial turkey flock in Indiana. There have been no associated human infections. This is the first detection of HPAI H7N8 in wild bird surveillance in the United States. More information, the risk assessment and recommendations for HPAI H7N8 can be found (here). The WHO, CDC, and other public health agencies have also been monitoring influenza H7N9, which represents a public health concern because of its high pandemic potential. Although H7N9 has not been detected in the United States, it remains a global concern given continuing epidemics in endemic countries. Since 2013, a total of 1,568 laboratory-confirmed cases of human infection with H7N9 viruses, including at least 613 deaths, have been reported to WHO. More information on H7N9 virus infections can be found (here). For more information regarding avian influenza, please visit the CDC (*here*) or the WHO (*here*) websites. WHO reports total number of cases and deaths related to laboratory-confirmed avian influenza viruses and posts current avian influenza case counts (*here*), which were last updated on **January 22, 2026**.

[15] Influenza-associated deaths are considered pediatric in persons aged less than 18 years. It was made a nationally notifiable condition in October, 2004. All pediatric influenza-associated deaths are laboratory confirmed.

V. INFLUENZA Vaccine: Annual influenza vaccination is recommended for all persons aged 6 months and older and is the most effective way to reduce the risk of getting sick with seasonal flu and spreading it to others. Influenza vaccination can reduce illnesses, visits to the doctor, influenza-related hospitalizations, and missed work and school days. Influenza vaccines become available by the end of October. It takes at least two weeks after vaccination to confer immunity against influenza virus infection. More information regarding influenza vaccination can be found (*here*).

A. Composition of the 2025–2026 Influenza Vaccine**:**

The composition of the 2025–2026 influenza vaccine has been updated to better match circulating influenza viruses. The Advisory Committee on Immunization Practices (ACIP) has recommended that the 2025-2026 influenza trivalent vaccine contain an influenza A/Victoria/4897/2022 (H1N1) pdm09-like virus, influenza A/Croatia/10136RV/2023 (H3N2)-like virus, and influenza B/Austria/1359417/2021 (B/Victoria lineage)-like virus. United States cell culture–based inactivated (ccIIV4) and recombinant (RIV4) influenza vaccines will contain HA derived from an influenza A/Wisconsin/67/2022 (H1N1) pdm09-like virus, an A/District of Columbia/27/2023 (H3N2)-like virus, an influenza B/Austria/1359417/2021 (B/Victoria lineage)-like virus. These vaccine recommendations were based on several factors, including global influenza virologic and epidemiologic surveillance, genetic and antigenic characterization, human serology studies, antiviral susceptibility, and the availability of candidate influenza viruses.

APPENDIX 1: ADDITIONAL INFORMATION

For more information regarding local and national influenza surveillance programs, visit the following sites.

Centers for Disease Control and Prevention	General Influenza National ILI and P&I Data Vaccine Virus Selection CDC Web Tool for Respiratory Viruses
Flu.gov	General Influenza Information
HDOH Flu and Pneumonia	General Influenza Surveillance Avian Influenza Respiratory Virus Dashboard To find out more information or join the sentinel physician program, email the Influenza Surveillance Coordinator
World Health Organization	General Global and Local Influenza Avian Influenza

APPENDIX 2: MMWR WEEK DATES

Please refer to the table below to interpret data presented by MMWR week. Week 40 is considered the traditional start for the flu season for the Northern Hemisphere.

MMWR WEEK	2022	2023	2024	2025	2026
1	1/8/2022	1/7/2023	1/6/2024	1/4/2025	1/10/2026
2	1/15/2022	1/14/2023	1/13/2024	1/11/2025	1/17/2026
3	1/22/2022	1/21/2023	1/20/2024	1/18/2025	1/24/2026
4	1/29/2022	1/28/2023	1/27/2024	1/25/2025	1/31/2026
5	2/5/2022	2/4/2023	2/3/2024	2/1/2025	2/7/2026
6	2/12/2022	2/11/2023	2/10/2024	2/8/2025	2/14/2026
7	2/19/2022	2/18/2023	2/17/2024	2/15/2025	2/21/2026
8	2/26/2022	2/25/2023	2/24/2024	2/22/2025	2/28/2026
9	3/5/2022	3/4/2023	3/2/2024	3/1/2025	3/7/2026
10	3/12/2022	3/11/2023	3/9/2024	3/8/2025	3/14/2026
11	3/19/2022	3/18/2023	3/16/2024	3/15/2025	3/21/2026
12	3/26/2022	3/25/2023	3/23/2024	3/22/2025	3/28/2026
13	4/2/2022	4/1/2023	3/30/2024	3/29/2025	4/4/2026
14	4/9/2022	4/8/2023	4/6/2024	4/5/2025	4/11/2026
15	4/16/2022	4/15/2023	4/13/2024	4/12/2025	4/18/2026
16	4/23/2022	4/22/2023	4/20/2024	4/19/2025	4/25/2026
17	4/30/2022	4/29/2023	4/27/2024	4/26/2025	5/2/2026
18	5/7/2022	5/6/2023	5/4/2024	5/3/2025	5/9/2026
19	5/14/2022	5/13/2023	5/11/2024	5/10/2025	5/16/2026
20	5/21/2022	5/20/2023	5/18/2024	5/17/2025	5/23/2026
21	5/28/2022	5/27/2023	5/25/2024	5/24/2025	5/30/2026
22	6/4/2022	6/3/2023	6/1/2024	5/31/2025	6/6/2026
23	6/11/2022	6/10/2023	6/8/2024	6/7/2025	6/13/2026
24	6/18/2022	6/17/2023	6/15/2024	6/14/2025	6/20/2026
25	6/25/2022	6/24/2023	6/22/2024	6/21/2025	6/27/2026
26	7/2/2022	7/1/2023	6/29/2024	6/28/2025	7/4/2026
27	7/9/2022	7/8/2023	7/6/2024	7/5/2025	7/11/2026
28	7/16/2022	7/15/2023	7/13/2024	7/12/2025	7/18/2026
29	7/23/2022	7/22/2023	7/20/2024	7/19/2025	7/25/2026
30	7/30/2022	7/29/2023	7/27/2024	7/26/2025	8/1/2026
31	8/6/2022	8/5/2023	8/3/2024	8/2/2025	8/8/2026
32	8/13/2022	8/12/2023	8/10/2024	8/9/2025	8/15/2026
33	8/20/2022	8/19/2023	8/17/2024	8/16/2025	8/22/2026
34	8/27/2022	8/26/2023	8/24/2024	8/23/2025	8/29/2026
35	9/3/2022	9/2/2023	8/31/2024	8/30/2025	9/5/2026
36	9/10/2022	9/9/2023	9/7/2024	9/6/2025	9/12/2026
37	9/17/2022	9/16/2023	9/14/2024	9/13/2025	9/19/2026
38	9/24/2022	9/23/2023	9/21/2024	9/20/2025	9/26/2026
39	10/1/2022	9/30/2023	9/28/2024	9/27/2025	10/3/2026
40	10/8/2022	10/7/2023	10/5/2024	10/4/2025	10/10/2026
41	10/15/2022	10/14/2023	10/12/2024	10/11/2025	10/17/2026
42	10/22/2022	10/21/2023	10/19/2024	10/18/2025	10/24/2026
43	10/29/2022	10/28/2023	10/26/2024	10/25/2025	10/31/2026
44	11/5/2022	11/4/2023	11/2/2024	11/1/2025	11/7/2026
45	11/12/2022	11/11/2023	11/9/2024	11/8/2025	11/14/2026
46	11/19/2022	11/18/2023	11/16/2024	11/15/2025	11/21/2026
47	11/26/2022	11/25/2023	11/23/2024	11/22/2025	11/28/2026
48	12/3/2022	12/2/2023	11/30/2024	11/29/2025	12/5/2026
49	12/10/2022	12/9/2023	12/7/2024	12/6/2025	12/12/2026
50	12/17/2022	12/16/2023	12/14/2024	12/13/2025	12/19/2026
51	12/24/2022	12/23/2023	12/21/2024	12/20/2025	12/26/2026
52	12/31/2022	12/30/2023	12/28/2024	12/27/2025	
53				01/03/2026	

HAWAII STATE DEPARTMENT OF HEALTH
DISEASE OUTBREAK CONTROL DIVISION

Influenza/Respiratory Disease Surveillance Report

Morbidity and Mortality Weekly Report (MMWR)[1]

WEEK 7: FEBRUARY 15, 2026– FEBRUARY 21, 2026

OVERVIEW: The Hawaii State Department of Health (HDOH) monitors influenza and other respiratory pathogens, including COVID-19, throughout the state of Hawaii. Influenza surveillance in the state of Hawaii relies upon selected sentinel health practitioners, the State Laboratories Division (SLD), private laboratories, and the Office of Health Status Monitoring (OHSM). For detailed information concerning influenza, please visit the HDOH Disease Outbreak Control Division (HDOH DOCD) website (*here*). **All data and information are conditional and may change as more reports are received.** The data in this report reflects the 2025-2026 influenza season which began the week ending October 4, 2025 (week 40[1] 2025) and will end the week ending on October 3, 2026 (week 39 2026).

REPORT SNAPSHOT FOR WEEK 7

Surveillance for Influenza-like Illness (ILI)		
Metric	*Value*	*Comment*
Outpatient visits related to influenza-like illness (ILI) from ILINet Sentinel Providers	3.6%	Higher than the previous week. Comparable to Hawaii's historical baseline and lower than the national baseline, and lower than the national ILI rate.
Number of ILI clusters reported to HDOH	3	There have been 23 clusters this season.

Laboratory Surveillance		
Percent of all respiratory specimens positive for influenza this week	13.5%	Lower than the previous week. This number means that many, if not all, of the 86.5% who tested negative for influenza had illness from another respiratory etiology.
Percent of all respiratory specimens positive for influenza this season to date	18.9%	

Surveillance for Severe Outcomes		
Pneumonia, influenza and COVID-19 (PIC) mortality rate	12.3%	Higher than Hawaii's historical baseline, comparable to the national epidemic threshold and comparable to the NCHS average.
Number of influenza-associated pediatric deaths reported nationwide	79	0 influenza-associated pediatric deaths have been reported from Hawaii this season to date.

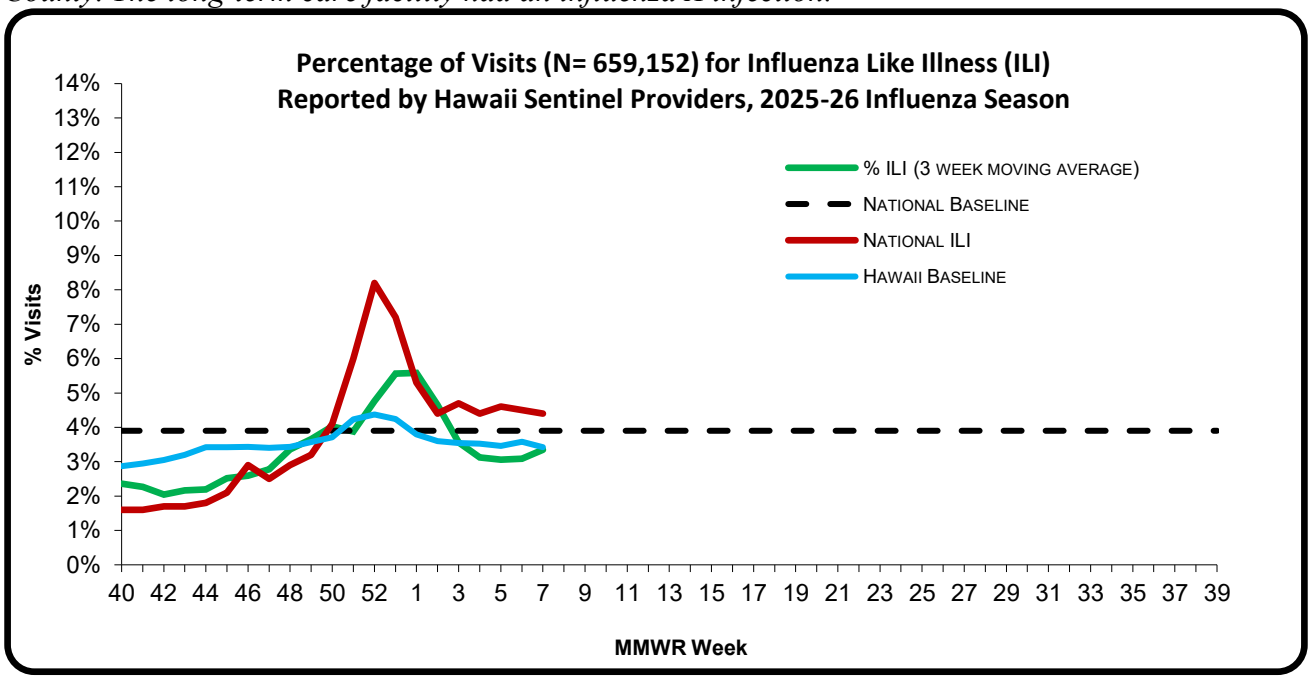
[1] MMWR stands for "Morbidity and Mortality Weekly Report," conventionally used by the Centers for Disease Control and Prevention (CDC). The weeks of a flu season are often referred to by their respective MMWR week. **See appendix 2 for interpretation of MMWR weeks.** Data reported will begin on week 40, the traditional start date of flu season.

INFLUENZA SURVEILLANCE

I. INFLUENZA-LIKE ILLNESS (ILI): HDOH collaborates with recruited doctors and healthcare providers who report the total number of outpatient visits for ILI as well as the total number of patients who complained of symptoms consistent with ILI. A patient with ILI must have the following: a fever (temperature of 100°F [37.8°C] or greater) AND a cough and/or a sore throat. ILI is based on reported symptoms and not laboratory confirmed tests; thus, ILI may represent other respiratory pathogens and not solely influenza. Further, sentinel providers report these numbers on a weekly basis; therefore, data are preliminary and may change depending on additional reporting. In combination with laboratory testing and other surveillance systems, ILI surveillance helps monitor influenza and other respiratory pathogen activity. For more information concerning ILINet and sentinel requirements, please visit the CDC website (*here*).

For **week 7** of the current influenza season:

- ***3.6**% (season to date: **3.3**%) of the outpatient visits recorded by Hawaii sentinel providers were for ILI.*
- *ILI visits were comparable to the historical baseline in Hawaii[2,3] (i.e., inside the 95% confidence interval).*
- *Hawaii's ILI outpatient visits were lower than the national baseline (**3.9%**)[4] (i.e., outside the 95% confidence interval) and lower than the national ILI rate (**4.4%**) (i.e. outside the 95% confidence interval).*
- *ILI activity level: Low[5]*
- *Geographic Spread: Sporadic Activity[6].*
- *ILI Cluster Activity: Three new clusters were reported to HDOH during week 7. Two were reported from long term care facilities (one in Honolulu County and one in Hawaii County) as well as a school facility in Maui County. The long-term care facility had an influenza A infection.*



[2] The Hawaii historical baseline (%ILI) is the average of 3-week moving averages over the preceding 3 flu seasons of historical data (2022-2023, 2023-2024 and 2024-2025).
[3] This value is based upon comparison of actual outpatient ILI with the historical baseline, which only captures outpatient ILI. The chart above represents a 3-week moving average and not the actual ILI by week.
[4] The National Baseline is calculated by CDC as the mean percentage of visits for ILI during weeks 21–39 with two standard deviations. Because of large variability in regional ILI, comparison of the national baseline with local ILI may not be appropriate. It is provided in this report because no meaningful regional baselines are available for comparison. The national baseline combines all data reported by states to CDC, including ILI in outpatient, ER, urgent care, and inpatient settings.
[5] There are 10 activity levels classified as minimal (levels 1-3), low (levels 4-5), moderate (levels 6-7), and high (levels 8-10).
[6] The influenza activity reported by state and territorial epidemiologists indicates geographic spread of influenza viruses but does not measure the severity of influenza activity. Sporadic: no clusters reported to HDOH, Local: one or more clusters reported in one county, Regional: clusters reported two to three counties, Widespread: clusters reported in all counties. Hawaii does not report No Activity, as flu circulates year-round in Hawaii.

II. LABORATORY SURVEILLANCE: State Laboratories Division (SLD; the HDOH public health laboratory) and Hawaii's major private laboratories (DLS, CLH) report results of RT-PCR, which can be considered confirmatory (SLD may perform viral culture on select specimens). Specimens meeting priority criteria[7] are forwarded to SLD for sub-typing. Additionally, specimens meeting case definition from requesting sentinel providers are sent directly to SLD for sub-typing. Due to resource constraints, not all submitted specimens undergo sub-typing. Sub-typing at the commercial laboratories is only conducted on a case-by-case basis. The majority of specimens testing positive by rapid antigen testing or RT-PCR at the commercial laboratories do not meet criteria and are not subtyped. For more information on influenza tests and types, please visit the CDC website (*here*).

A. INFLUENZA:

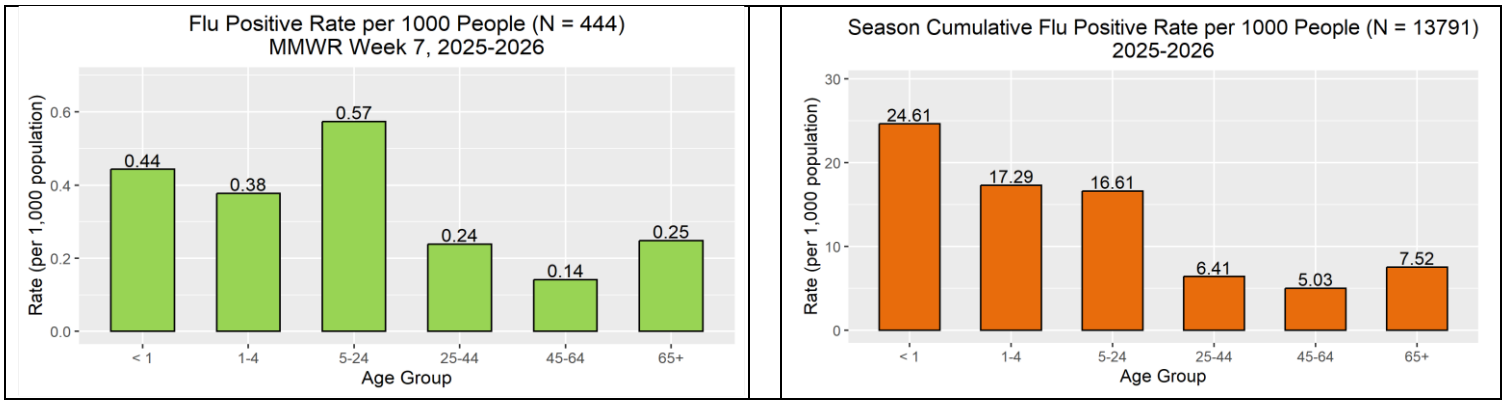
- The following reflects laboratory findings for week 7 of the 2025–26 influenza season:
  - *A total of **3,294** specimens has been tested statewide for influenza viruses (positive: 444 [**13.5%**]). (Season to date: **71,709** tested (**18.9%** positive)*
    - *1,465 (44.5%) were screened only by rapid antigen tests with no confirmatory testing.*
    - *1,838 (55.5%) underwent confirmatory testing (either RT-PCR or viral culture).*
    - *2,850 (86.5%) were negative.*
  - *Routine surveillance samples from State Laboratory Division were tested at a public health laboratory and identified as Influenza A (H3N2) subclade K.*

Influenza type	***Current week 7 (%)****	***Season to date (%)***[8]
Influenza A (H1)[9]	*3 (0.7)*	*107 (0.8)*
Influenza A (H3)	*2 (0.4)*	*997 (7.4)*
Influenza A no subtyping	*223 (50.2)*	*11,458 (84.4)*
Influenza B (Yamagata)	*0 (0.0)*	*0 (0.0)*
Influenza B (Victoria)	*0 (0.0)*	*0 (0.0)*
Influenza B no genotyping	*216 (48.6)*	*998 (7.4)*

**Specimens that are positive for both A and B (coinfections) are counted in both A and B totals for current and season to date*

1. AGE DISTRIBUTION

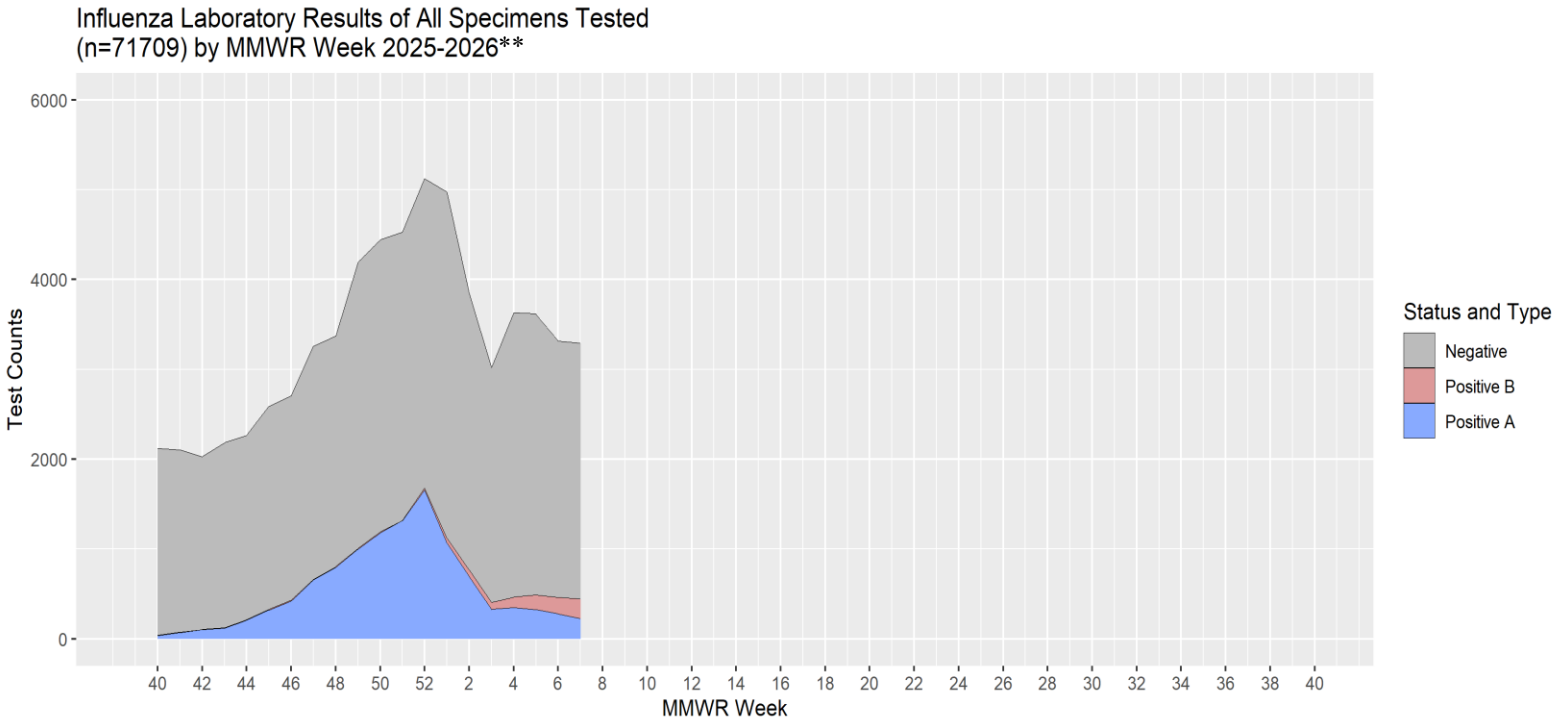
The charts below indicate the population-based rates of positive influenza cases in Hawaii by age group during the 2025–26 influenza season.[10]

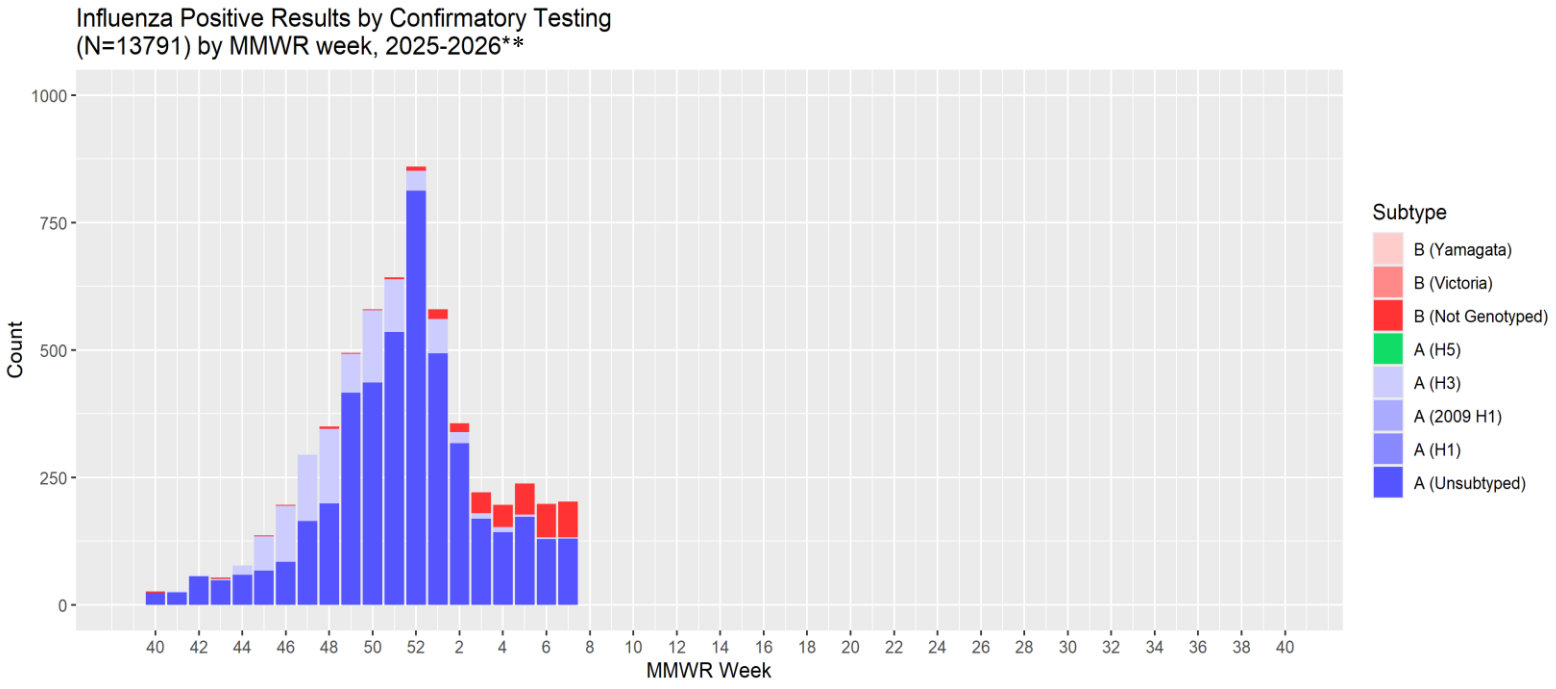


[7] Priority criteria include: hospitalized patients with acute respiratory distress syndrome [ARDS] or x-ray confirmed pneumonia; travelers with international travel history within 10 days of onset; specimens submitted by sentinel providers; specimens collected from healthcare workers, pregnant women, or women up to 6 weeks' post-partum; those with underlying medical conditions; and patients presenting with unusual or severe manifestations of influenza infection.
[8] Influenza coding was updated to reflect a more accurate count.
[9] All influenza A H1 viruses detected this season have been 2009 H1N1.
[10] This represents an estimate of population-based rates based on available data.

2. LABORATORY TESTING

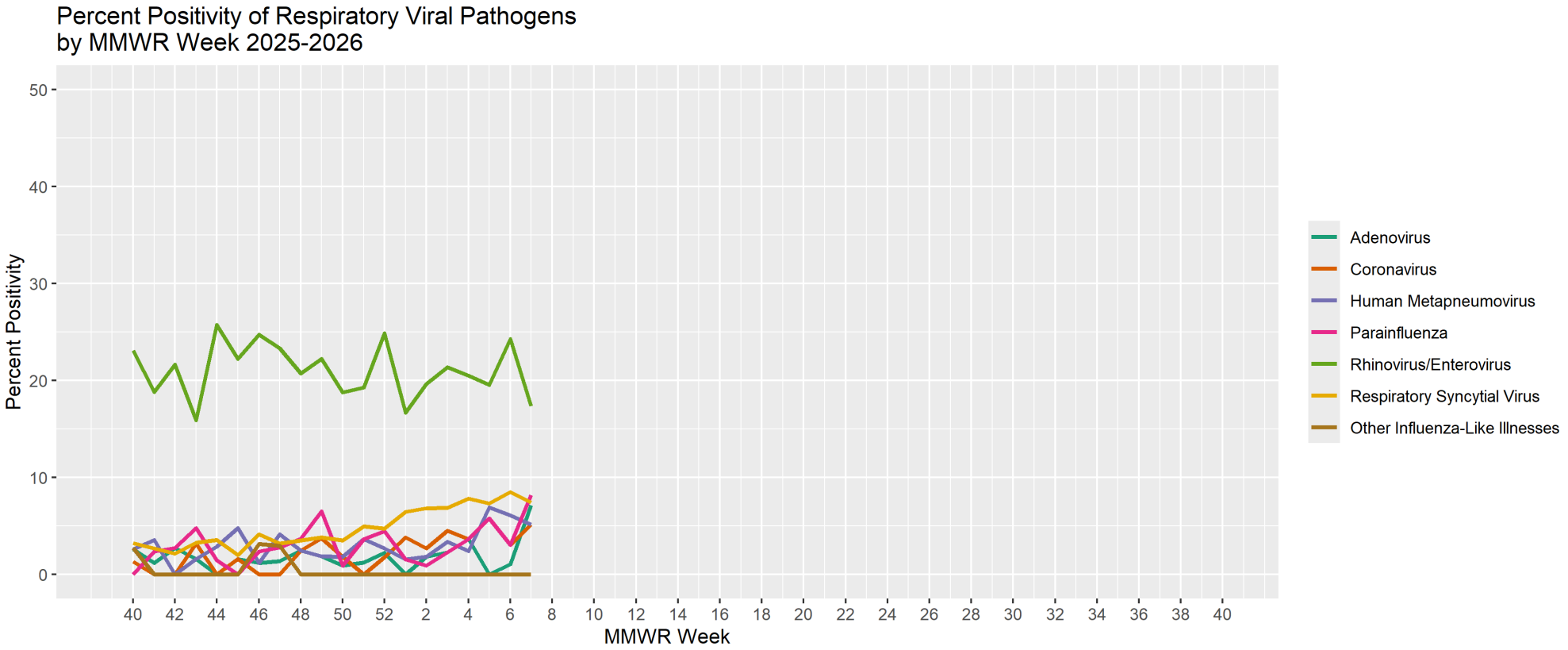
The charts below show the laboratory results of all specimens tested for influenza by MMWR week during the 2025–2026 influenza season as well as the type and subtype of positive results for influenza. Again, sub-typing is only performed on selected specimens tested by confirmatory tests (i.e., RT-PCR or viral culture).





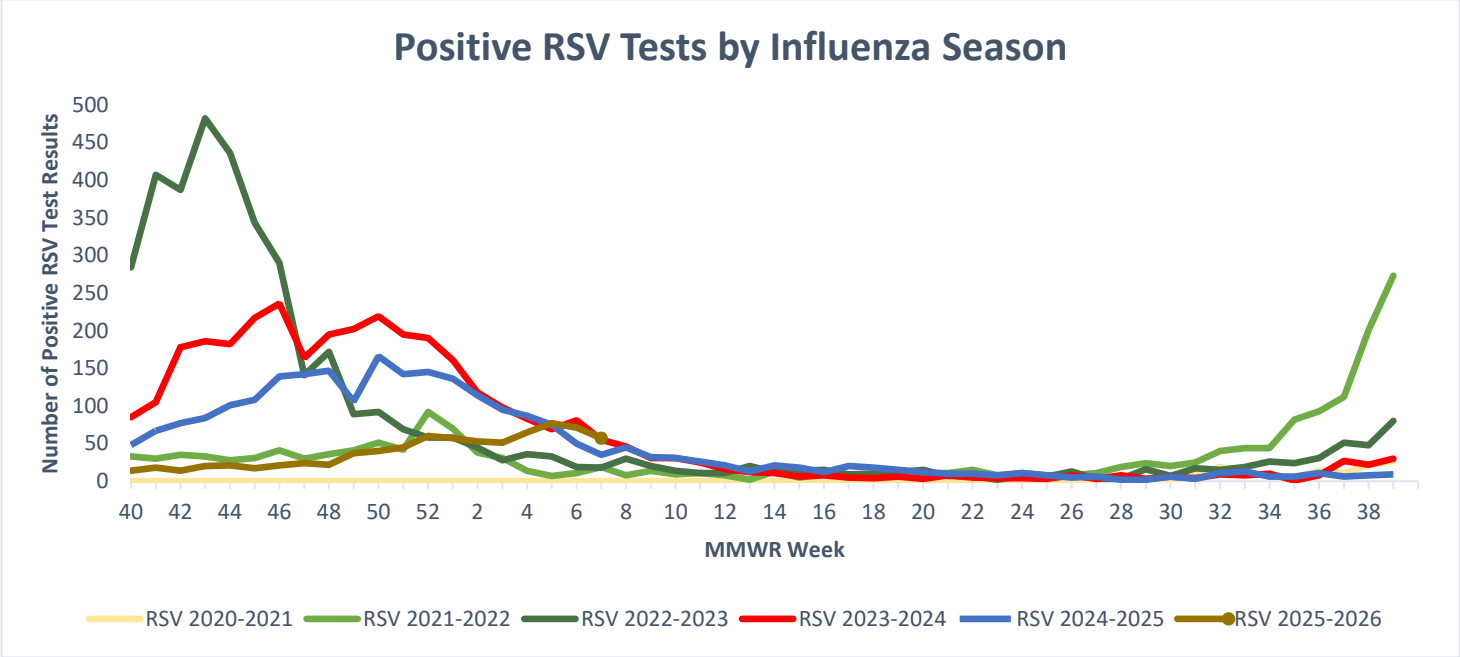
** A total of 39,867 specimens underwent confirmatory testing, but not all positive influenza specimens receive confirmatory testing that are circulating in Hawaii.*
*** For MMWR Week 53, results are reported under MMWR Week 52, where the average of Weeks 52 and 53 was calculated.*

B. **OTHER RESPIRATORY PATHOGENS:** The major clinical and commercial laboratories throughout the state of Hawaii have the testing capacity for non-influenza respiratory pathogens and report these to HDOH. However, such testing is performed as needed and when sufficient resources are available because of the high costs associated with respiratory panel tests. **Therefore, available data represent only the presence of circulating pathogens and cannot be used to determine specific trends**.

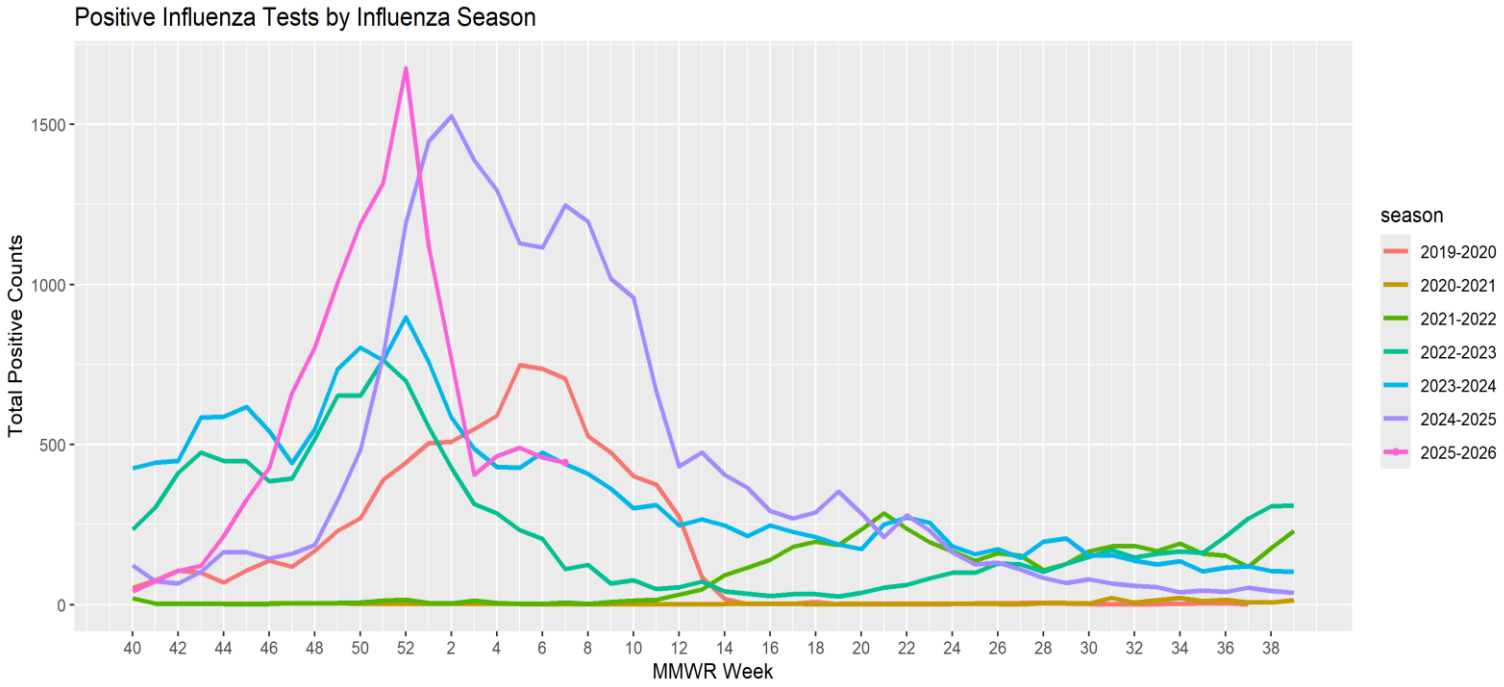


* *The coronavirus presented on this table does not indicate Severe Acute Respiratory Coronavirus-2 (i.e., COVID-19). For MMWR Week 53, results are reported under MMWR Week 52, where the average of Weeks 52 and 53 was calculated*

RESPIRATORY SYNCYTIAL VIRUS (RSV) POSITIVE TEST RESULTS BY INFLUENZA SEASON: RSV case appears to have increased later than past seasons in the 2025-2026 season. For MMWR Week 53, results are reported under MMWR Week 52, where the average of Weeks 52 and 53 was calculated.



INFLUENZA POSITIVE TEST RESULTS BY INFLUENZA SEASON: Influenza cases appear to have increased earlier than past seasons in the 2025-2026 season. For MMWR Week 53, results are reported under MMWR Week 52, where the average of Weeks 52 and 53 was calculated.



C. COVID-19 SENTINEL SURVEILLANCE: Due to the low volume of samples currently available through the influenza surveillance system, the COVID-19 sentinel surveillance data may not be accurately portraying COVID-19 activity in our communities. Reporting of the COVID-19 Sentinel Surveillance data will be paused while HODH re-evaluates the program to ensure that the reported data are accurate and representative.

HDOH is continuing to monitor COVID-19 activity throughout the state. To learn more, please visit the Hawaii's COVID-19 data website (*here*). For more information on surveillance of COVID-19 activity in the United States please visit the CDC COVIDView website (*here*).

III. PNEUMONIA, INFLUENZA, AND COVID-19 (PIC) RELATED MORTALITY:

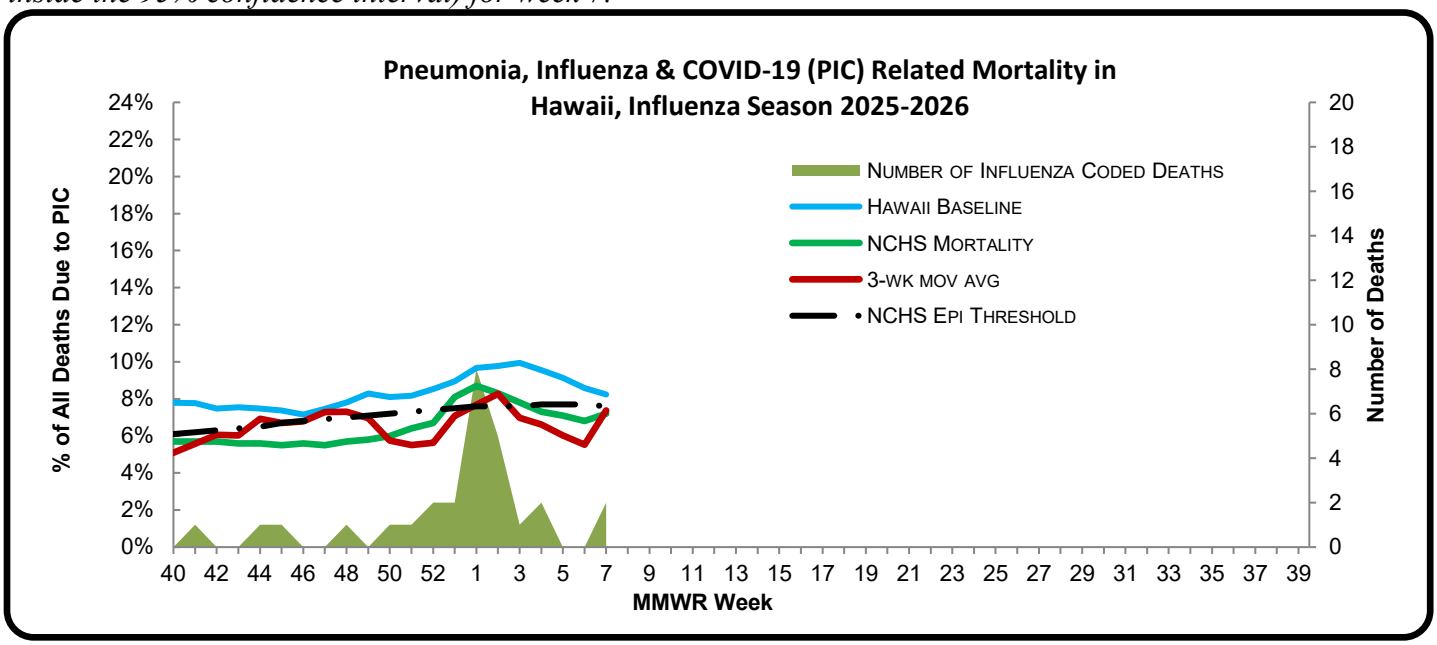
P&I mortality surveillance is collected by CDC through the National Center for Health Statistics (NCHS) using death certificate data. Each week the HDOH OHSM reports specific data from Honolulu to the CDC. CDC collects the following information by age group: the total number of deaths, total deaths from pneumonia, and total deaths related to influenza. Due to the ongoing COVID-19 pandemic, CDC included total deaths from COVID-19 by age group to the death data. Previous studies had suggested that P&I is a good indicator of influenza-related deaths; however, data has shown that pneumonia deaths associated with influenza is now being impacted by COVID-19 related pneumonia. Due to this, CDC had added COVID-19 deaths into P&I to create the PIC (pneumonia, influenza, and/or COVID-19) classification.

To standardize Hawaii's influenza surveillance with CDC influenza surveillance guidelines, PIC deaths will be reported in lieu of P&I. Hawaii's baseline will begin to include PIC deaths starting from 2019-2020 flu season.

For **week 7** of the current influenza season:

- ***12.3%*** *of all deaths that occurred in Hawaii during week 7 were related to pneumonia, influenza or COVID-19 (PIC)*[11]*. For the current season (season to date:* ***6.6%****), there have been 4,800 deaths from any cause, 318 of which were due to PIC*[12]*.*
- *The PIC rate was higher than the historical baseline in Hawaii*[13] *(i.e., outside the 95% confidence interval).*

The Hawaii PIC rate was comparable to the CDC's National Center for Health Statistics (NCHS) PIC mortality[14] *(****7.2%****) (i.e., inside the 95% confidence interval) and comparable to the national epidemic threshold (****7.6%****) (i.e., inside the 95% confidence interval) for week 7.*



[11] The percent of deaths due to PIC displayed on the graph is the 3-week moving averages.

[12] PIC data reflect 98.0% of the data reported for the MMWR week. Changes to data are expected when PIC data reaches 100% completion.

[13] The Hawaii historical baseline (%PIC) is the average of 3-week moving averages over the preceding 10 flu seasons of historical data (2014-2015, 2015-2016, 2016-2017, 2017-2018, 2018-2019, 2019-2020, 2020-2021, 2021-2022, 2022-2023, and 2023-2024).

[14] Each week, the vital statistics offices of 122 cities across the United States report the total number of death certificates processed and the number of those for which pneumonia, influenza, or COVID-19 was listed as the underlying or contributing cause of death by age group (Under 28 days, 28 days–1 year, 1–14 years, 15–24 years, 25–44 years, 45–64 years, 65–74 years, 75–84 years, and ≥85 years). The COVID-19 death counts reported by NCHS are provisional and will not match counts in other sources, such as media reports or numbers from health departments. COVID-19 deaths may be classified or defined differently in various reporting and surveillance systems. The percentage of deaths due to pneumonia, influenza, and COVID-19 (PIC) are compared with a seasonal baseline and epidemic threshold value calculated for each week.

INFLUENZA-ASSOCIATED PEDIATRIC DEATHS[15]:

- No new influenza-associated pediatric death was reported to Hawaii. There have been zero influenza-associated pediatric deaths reported in Hawaii during the 2025–2026 season.
- Nationally, eight new influenza-associated pediatric deaths were reported to CDC during week 7. (2025-2026 season total: 79).

IV. INFLUENZA WATCH: As part of a comprehensive influenza surveillance system and to prevent the spread of contagious respiratory diseases in humans, it is important to monitor all circulating influenza types. Several animal-origin influenza A subtypes are currently of interest: influenza A variant virus (H3N2v, H1N2v, and H1N1v) and Avian flu (H5N1 and H7N9). These types of influenza viruses may cause zoonotic (animal-associated) disease and are a public health concern.

A. VARIANT VIRUSES:

Influenza viruses that normally circulate in pigs are called "variant" viruses when they are found in people. These viruses were first identified in U.S. pigs in 2010. In 2011, 12 cases of H3N2v infection were detected in the United States. In 2012, 309 such cases (resulting in 16 hospitalizations and one death) across 12 states were detected, including one Hawaii case who recovered. Illness associated with H3N2v infection has been mostly mild with symptoms similar to those of seasonal flu. However, serious illness, resulting in hospitalization and death, has occurred in some cases. Most of these infections have been associated with prolonged exposure to pigs at agricultural fairs or similar settings. Limited human-to-human spread of this virus has been detected in the past, but no sustained community spread of H3N2v has been identified. More information regarding H3N2v, H1N1v, and H1N2v viruses may be found on the CDC website (*here*) and (*here*).

- *No variant or novel influenza infections have been reported to HDOH during the 2025-2026 influenza season.*
- *One new human infection with novel influenza A virus, H1N1v (0), H3N2v (0), and H1N2v (1), have been reported during the 2025-2026 influenza season.*
    - *One new human infection with influenza A(H1N1v) virus has been reported to WHO from China during the 2025-2026 influenza season.*

AVIAN (OR BIRD) INFLUENZA: These types of influenza viruses cause zoonotic (animal-associated) disease of public health concern and are therefore monitored globally by the WHO. Most avian influenza viruses do not cause disease in humans and are generally not easily transmissible between person to person, but a few subtypes may cross the species barrier and cause disease in humans. Avian influenza viruses may be of various subtypes, including H5N1, H5N2, H5N8, H7N3, H7N7, H7N8, H7N9, and H9N2. On January 15th, 2016, the USDA and APHIS reported detection of HPAI H7N8 in a commercial turkey flock in Indiana. There have been no associated human infections. This is the first detection of HPAI H7N8 in wild bird surveillance in the United States. More information, the risk assessment and recommendations for HPAI H7N8 can be found (here). The WHO, CDC, and other public health agencies have also been monitoring influenza H7N9, which represents a public health concern because of its high pandemic potential. Although H7N9 has not been detected in the United States, it remains a global concern given continuing epidemics in endemic countries. Since 2013, a total of 1,568 laboratory-confirmed cases of human infection with H7N9 viruses, including at least 613 deaths, have been reported to WHO. More information on H7N9 virus infections can be found (here). For more information regarding avian influenza, please visit the CDC (*here*) or the WHO (*here*) websites. WHO reports total number of cases and deaths related to laboratory-confirmed avian influenza viruses and posts current avian influenza case counts (*here*), which were last updated on **January 22, 2026**.

[15] Influenza-associated deaths are considered pediatric in persons aged less than 18 years. It was made a nationally notifiable condition in October, 2004. All pediatric influenza-associated deaths are laboratory confirmed.

V. INFLUENZA Vaccine: Annual influenza vaccination is recommended for all persons aged 6 months and older and is the most effective way to reduce the risk of getting sick with seasonal flu and spreading it to others. Influenza vaccination can reduce illnesses, visits to the doctor, influenza-related hospitalizations, and missed work and school days. Influenza vaccines become available by the end of October. It takes at least two weeks after vaccination to confer immunity against influenza virus infection. More information regarding influenza vaccination can be found (*here*).

A. Composition of the 2025–2026 Influenza Vaccine**:**

The composition of the 2025–2026 influenza vaccine has been updated to better match circulating influenza viruses. The Advisory Committee on Immunization Practices (ACIP) has recommended that the 2025-2026 influenza trivalent vaccine contain an influenza A/Victoria/4897/2022 (H1N1) pdm09-like virus, influenza A/Croatia/10136RV/2023 (H3N2)-like virus, and influenza B/Austria/1359417/2021 (B/Victoria lineage)-like virus. United States cell culture–based inactivated (ccIIV4) and recombinant (RIV4) influenza vaccines will contain HA derived from an influenza A/Wisconsin/67/2022 (H1N1) pdm09-like virus, an A/District of Columbia/27/2023 (H3N2)-like virus, an influenza B/Austria/1359417/2021 (B/Victoria lineage)-like virus. These vaccine recommendations were based on several factors, including global influenza virologic and epidemiologic surveillance, genetic and antigenic characterization, human serology studies, antiviral susceptibility, and the availability of candidate influenza viruses.

APPENDIX 1: ADDITIONAL INFORMATION

For more information regarding local and national influenza surveillance programs, visit the following sites.

Centers for Disease Control and Prevention	General Influenza National ILI and P&I Data Vaccine Virus Selection CDC Web Tool for Respiratory Viruses
Flu.gov	General Influenza Information
HDOH Flu and Pneumonia	General Influenza Surveillance Avian Influenza Respiratory Virus Dashboard To find out more information or join the sentinel physician program, email the Influenza Surveillance Coordinator
World Health Organization	General Global and Local Influenza Avian Influenza

APPENDIX 2: MMWR WEEK DATES

Please refer to the table below to interpret data presented by MMWR week. Week 40 is considered the traditional start for the flu season for the Northern Hemisphere.

MMWR WEEK	2022	2023	2024	2025	2026
1	1/8/2022	1/7/2023	1/6/2024	1/4/2025	1/10/2026
2	1/15/2022	1/14/2023	1/13/2024	1/11/2025	1/17/2026
3	1/22/2022	1/21/2023	1/20/2024	1/18/2025	1/24/2026
4	1/29/2022	1/28/2023	1/27/2024	1/25/2025	1/31/2026
5	2/5/2022	2/4/2023	2/3/2024	2/1/2025	2/7/2026
6	2/12/2022	2/11/2023	2/10/2024	2/8/2025	2/14/2026
7	2/19/2022	2/18/2023	2/17/2024	2/15/2025	2/21/2026
8	2/26/2022	2/25/2023	2/24/2024	2/22/2025	2/28/2026
9	3/5/2022	3/4/2023	3/2/2024	3/1/2025	3/7/2026
10	3/12/2022	3/11/2023	3/9/2024	3/8/2025	3/14/2026
11	3/19/2022	3/18/2023	3/16/2024	3/15/2025	3/21/2026
12	3/26/2022	3/25/2023	3/23/2024	3/22/2025	3/28/2026
13	4/2/2022	4/1/2023	3/30/2024	3/29/2025	4/4/2026
14	4/9/2022	4/8/2023	4/6/2024	4/5/2025	4/11/2026
15	4/16/2022	4/15/2023	4/13/2024	4/12/2025	4/18/2026
16	4/23/2022	4/22/2023	4/20/2024	4/19/2025	4/25/2026
17	4/30/2022	4/29/2023	4/27/2024	4/26/2025	5/2/2026
18	5/7/2022	5/6/2023	5/4/2024	5/3/2025	5/9/2026
19	5/14/2022	5/13/2023	5/11/2024	5/10/2025	5/16/2026
20	5/21/2022	5/20/2023	5/18/2024	5/17/2025	5/23/2026
21	5/28/2022	5/27/2023	5/25/2024	5/24/2025	5/30/2026
22	6/4/2022	6/3/2023	6/1/2024	5/31/2025	6/6/2026
23	6/11/2022	6/10/2023	6/8/2024	6/7/2025	6/13/2026
24	6/18/2022	6/17/2023	6/15/2024	6/14/2025	6/20/2026
25	6/25/2022	6/24/2023	6/22/2024	6/21/2025	6/27/2026
26	7/2/2022	7/1/2023	6/29/2024	6/28/2025	7/4/2026
27	7/9/2022	7/8/2023	7/6/2024	7/5/2025	7/11/2026
28	7/16/2022	7/15/2023	7/13/2024	7/12/2025	7/18/2026
29	7/23/2022	7/22/2023	7/20/2024	7/19/2025	7/25/2026
30	7/30/2022	7/29/2023	7/27/2024	7/26/2025	8/1/2026
31	8/6/2022	8/5/2023	8/3/2024	8/2/2025	8/8/2026
32	8/13/2022	8/12/2023	8/10/2024	8/9/2025	8/15/2026
33	8/20/2022	8/19/2023	8/17/2024	8/16/2025	8/22/2026
34	8/27/2022	8/26/2023	8/24/2024	8/23/2025	8/29/2026
35	9/3/2022	9/2/2023	8/31/2024	8/30/2025	9/5/2026
36	9/10/2022	9/9/2023	9/7/2024	9/6/2025	9/12/2026
37	9/17/2022	9/16/2023	9/14/2024	9/13/2025	9/19/2026
38	9/24/2022	9/23/2023	9/21/2024	9/20/2025	9/26/2026
39	10/1/2022	9/30/2023	9/28/2024	9/27/2025	10/3/2026
40	10/8/2022	10/7/2023	10/5/2024	10/4/2025	10/10/2026
41	10/15/2022	10/14/2023	10/12/2024	10/11/2025	10/17/2026
42	10/22/2022	10/21/2023	10/19/2024	10/18/2025	10/24/2026
43	10/29/2022	10/28/2023	10/26/2024	10/25/2025	10/31/2026
44	11/5/2022	11/4/2023	11/2/2024	11/1/2025	11/7/2026
45	11/12/2022	11/11/2023	11/9/2024	11/8/2025	11/14/2026
46	11/19/2022	11/18/2023	11/16/2024	11/15/2025	11/21/2026
47	11/26/2022	11/25/2023	11/23/2024	11/22/2025	11/28/2026
48	12/3/2022	12/2/2023	11/30/2024	11/29/2025	12/5/2026
49	12/10/2022	12/9/2023	12/7/2024	12/6/2025	12/12/2026
50	12/17/2022	12/16/2023	12/14/2024	12/13/2025	12/19/2026
51	12/24/2022	12/23/2023	12/21/2024	12/20/2025	12/26/2026
52	12/31/2022	12/30/2023	12/28/2024	12/27/2025	
53				01/03/2026	

HAWAII STATE DEPARTMENT OF HEALTH
DISEASE OUTBREAK CONTROL DIVISION

Influenza/Respiratory Disease Surveillance Report

Morbidity and Mortality Weekly Report (MMWR)[1]

WEEK 8: FEBRUARY 22, 2026– FEBRUARY 28, 2026

OVERVIEW: The Hawaii State Department of Health (HDOH) monitors influenza and other respiratory pathogens, including COVID-19, throughout the state of Hawaii. Influenza surveillance in the state of Hawaii relies upon selected sentinel health practitioners, the State Laboratories Division (SLD), private laboratories, and the Office of Health Status Monitoring (OHSM). For detailed information concerning influenza, please visit the HDOH Disease Outbreak Control Division (HDOH DOCD) website (*here*). **All data and information are conditional and may change as more reports are received.** The data in this report reflects the 2025-2026 influenza season which began the week ending October 4, 2025 (week 40[1] 2025) and will end the week ending on October 3, 2026 (week 39 2026).

REPORT SNAPSHOT FOR WEEK 8

Surveillance for Influenza-like Illness (ILI)		
Metric	*Value*	*Comment*
Outpatient visits related to influenza-like illness (ILI) from ILINet Sentinel Providers	3.0%	Lower than the previous week. Comparable to Hawaii's historical baseline and lower than the national baseline, and lower than the national ILI rate.
Number of ILI clusters reported to HDOH	1	There have been 24 clusters this season.

Laboratory Surveillance		
Percent of all respiratory specimens positive for influenza this week	12.3%	Lower than the previous week. This number means that many, if not all, of the 87.7% who tested negative for influenza had illness from another respiratory etiology.
Percent of all respiratory specimens positive for influenza this season to date	18.6%	

Surveillance for Severe Outcomes		
Pneumonia, influenza and COVID-19 (PIC) mortality rate	7.3%	Comparable to the Hawaii's historical baseline, comparable to the national epidemic threshold and comparable to the NCHS average.
Number of influenza-associated pediatric deaths reported nationwide	90	0 influenza-associated pediatric deaths have been reported from Hawaii this season to date.

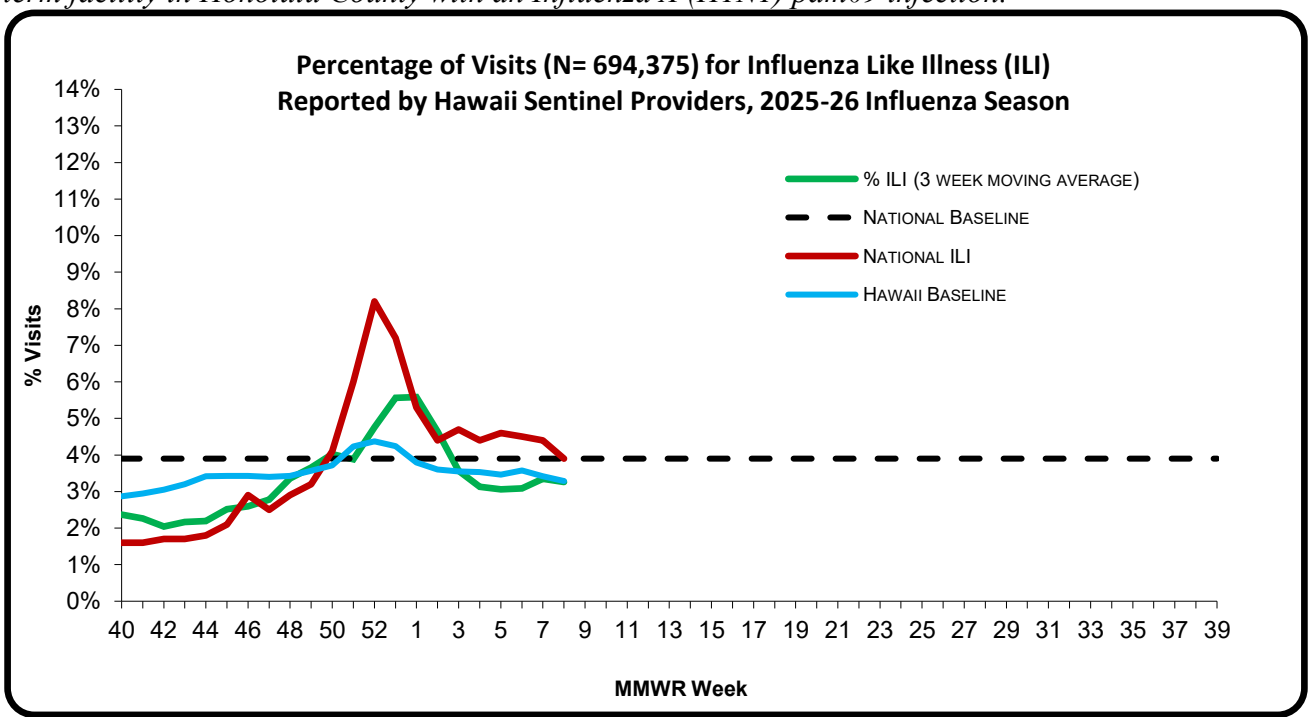
[1] MMWR stands for "Morbidity and Mortality Weekly Report," conventionally used by the Centers for Disease Control and Prevention (CDC). The weeks of a flu season are often referred to by their respective MMWR week. **See appendix 2 for interpretation of MMWR weeks.** Data reported will begin on week 40, the traditional start date of flu season.

INFLUENZA SURVEILLANCE

I. INFLUENZA-LIKE ILLNESS (ILI): HDOH collaborates with recruited doctors and healthcare providers who report the total number of outpatient visits for ILI as well as the total number of patients who complained of symptoms consistent with ILI. A patient with ILI must have the following: a fever (temperature of 100°F [37.8°C] or greater) AND a cough and/or a sore throat. ILI is based on reported symptoms and not laboratory confirmed tests; thus, ILI may represent other respiratory pathogens and not solely influenza. Further, sentinel providers report these numbers on a weekly basis; therefore, data are preliminary and may change depending on additional reporting. In combination with laboratory testing and other surveillance systems, ILI surveillance helps monitor influenza and other respiratory pathogen activity. For more information concerning ILINet and sentinel requirements, please visit the CDC website (*here*).

For **week 8** of the current influenza season:

- ***3.0**% (season to date: **3.3**%) of the outpatient visits recorded by Hawaii sentinel providers were for ILI.*
- *ILI visits were comparable to the historical baseline in Hawaii[2,3] (i.e., inside the 95% confidence interval).*
- *Hawaii's ILI outpatient visits were lower than the national baseline (**3.9%**)[4] (i.e., outside the 95% confidence interval) and lower than the national ILI rate (**3.9%**) (i.e. outside the 95% confidence interval).*
- *ILI activity level: Low[5]*
- *Geographic Spread: Sporadic Activity[6].*
- *ILI Cluster Activity: One new cluster was reported to HDOH during week 8. The cluster occurred at a long-term facility in Honolulu County with an Influenza A (H1N1) pdm09 infection.*



[2] The Hawaii historical baseline (%ILI) is the average of 3-week moving averages over the preceding 3 flu seasons of historical data (2022-2023, 2023-2024 and 2024-2025).
[3] This value is based upon comparison of actual outpatient ILI with the historical baseline, which only captures outpatient ILI. The chart above represents a 3-week moving average and not the actual ILI by week.
[4] The National Baseline is calculated by CDC as the mean percentage of visits for ILI during weeks 21–39 with two standard deviations. Because of large variability in regional ILI, comparison of the national baseline with local ILI may not be appropriate. It is provided in this report because no meaningful regional baselines are available for comparison. The national baseline combines all data reported by states to CDC, including ILI in outpatient, ER, urgent care, and inpatient settings.
[5] There are 10 activity levels classified as minimal (levels 1-3), low (levels 4-5), moderate (levels 6-7), and high (levels 8-10).
[6] The influenza activity reported by state and territorial epidemiologists indicates geographic spread of influenza viruses but does not measure the severity of influenza activity. Sporadic: no clusters reported to HDOH, Local: one or more clusters reported in one county, Regional: clusters reported two to three counties, Widespread: clusters reported in all counties. Hawaii does not report No Activity, as flu circulates year-round in Hawaii.

II. LABORATORY SURVEILLANCE: State Laboratories Division (SLD; the HDOH public health laboratory) and Hawaii's major private laboratories (DLS, CLH) report results of RT-PCR, which can be considered confirmatory (SLD may perform viral culture on select specimens). Specimens meeting priority criteria[7] are forwarded to SLD for sub-typing. Additionally, specimens meeting case definition from requesting sentinel providers are sent directly to SLD for sub-typing. Due to resource constraints, not all submitted specimens undergo sub-typing. Sub-typing at the commercial laboratories is only conducted on a case-by-case basis. The majority of specimens testing positive by rapid antigen testing or RT-PCR at the commercial laboratories do not meet criteria and are not subtyped. For more information on influenza tests and types, please visit the CDC website (*here*).

A. INFLUENZA:

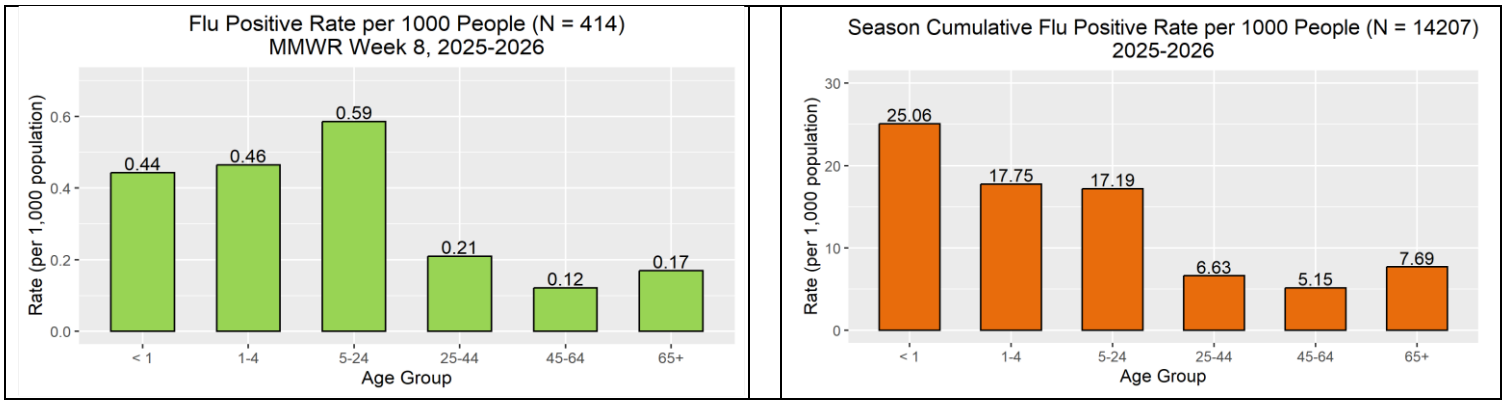
- The following reflects laboratory findings for week 8 of the 2025–26 influenza season:
  - *A total of **3,362** specimens has been tested statewide for influenza viruses (positive: 414 [**12.3%**]). (Season to date: **75,075** tested (**18.6%** positive)*
    - *1,515 (45.1%) were screened only by rapid antigen tests with no confirmatory testing.*
    - *1,847 (54.9%) underwent confirmatory testing (either RT-PCR or viral culture).*
    - *2,948 (87.7%) were negative.*
  - *Routine surveillance samples from State Laboratory Division were tested at a public health laboratory and identified as Influenza A (H3N2) subclade K.*

Influenza type	*Current week 8 (%)**	*Season to date (%)*[8]
Influenza A (H1)[9]	*1 (0.2)*	*108 (0.8)*
Influenza A (H3)	*0 (0.0)*	*999 (7.1)*
Influenza A no subtyping	*150 (36.1)*	*11,608 (83.1)*
Influenza B (Yamagata)	*0 (0.0)*	*0 (0.0)*
Influenza B (Victoria)	*0 (0.0)*	*0 (0.0)*
Influenza B no genotyping	*265 (63.7)*	*1,260 (9.0)*

**Specimens that are positive for both A and B (coinfections) are counted in both A and B totals for current and season to date*

1. AGE DISTRIBUTION

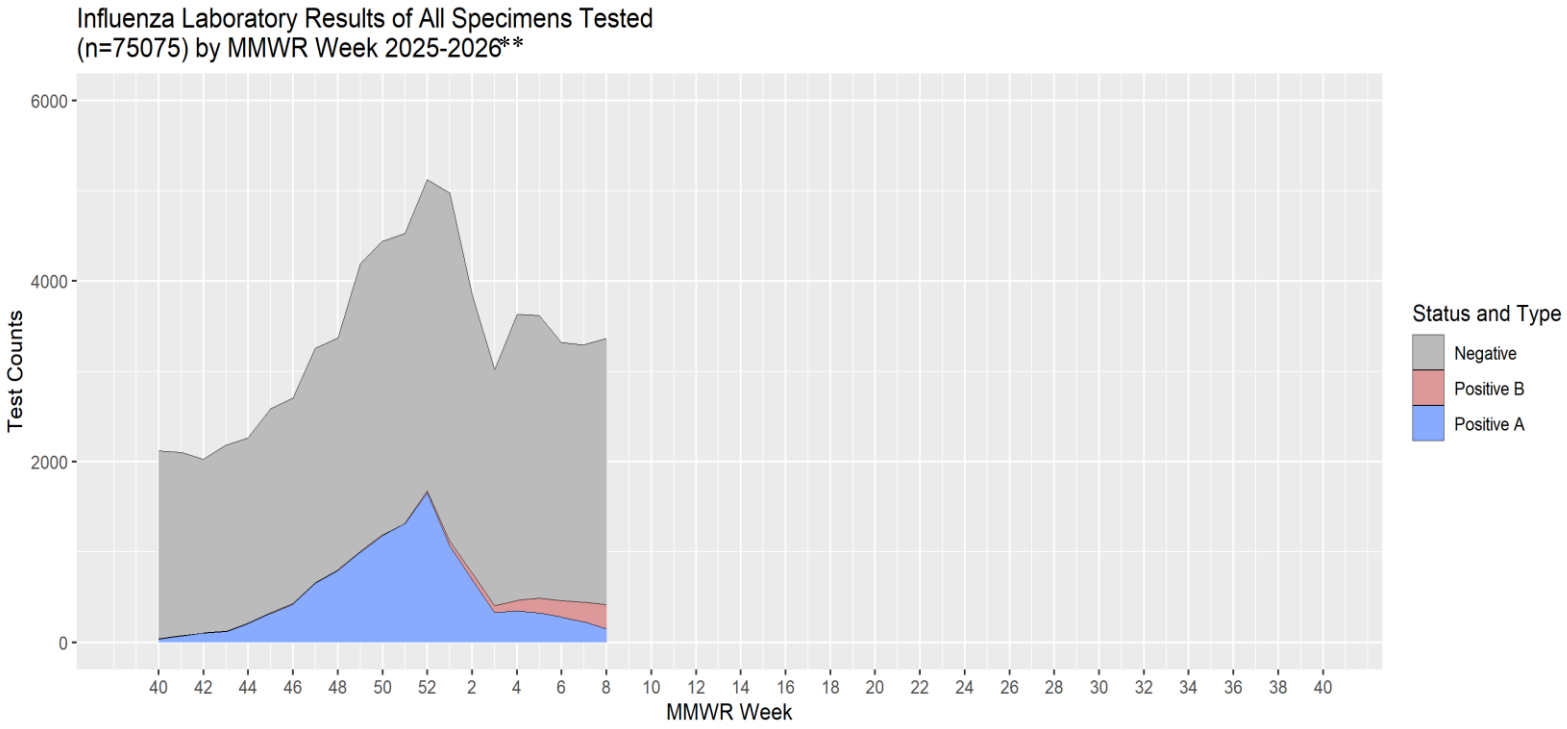
The charts below indicate the population-based rates of positive influenza cases in Hawaii by age group during the 2025–26 influenza season.[10]

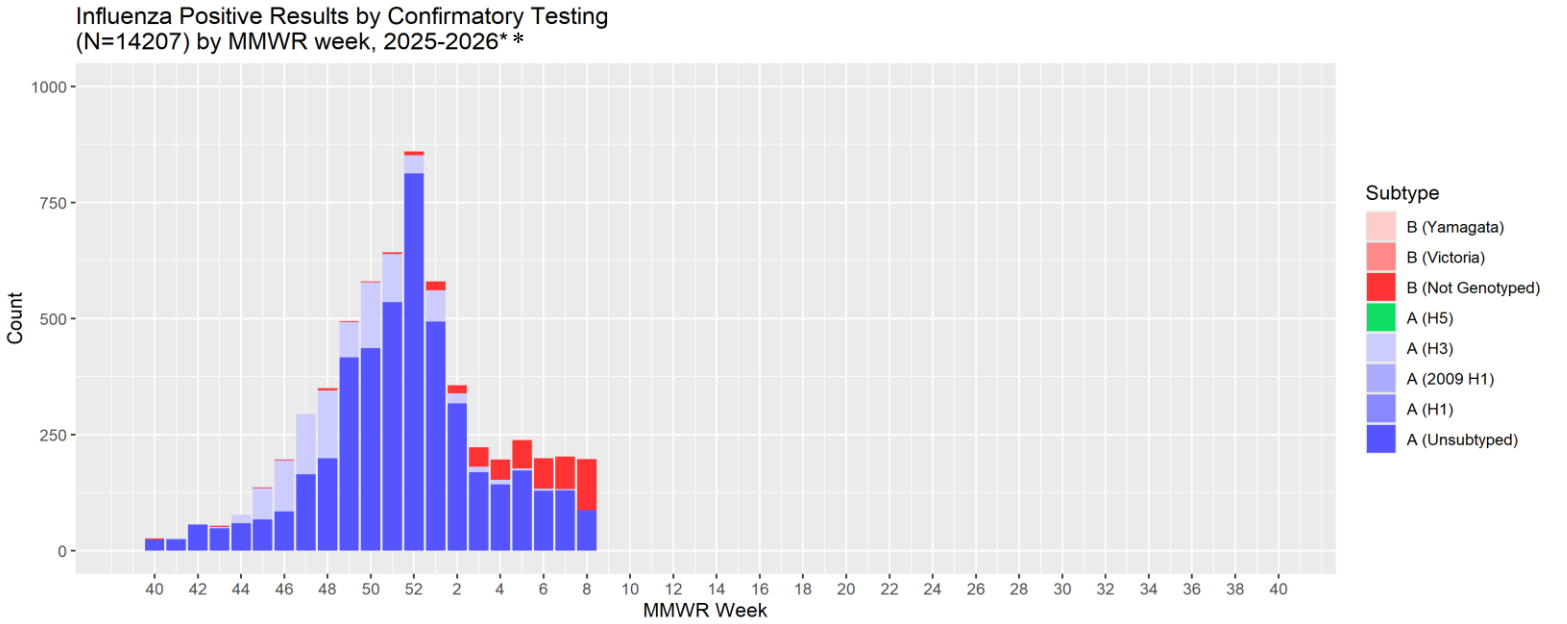


[7] Priority criteria include: hospitalized patients with acute respiratory distress syndrome [ARDS] or x-ray confirmed pneumonia; travelers with international travel history within 10 days of onset; specimens submitted by sentinel providers; specimens collected from healthcare workers, pregnant women, or women up to 6 weeks' post-partum; those with underlying medical conditions; and patients presenting with unusual or severe manifestations of influenza infection.
[8] Influenza coding was updated to reflect a more accurate count.
[9] All influenza A H1 viruses detected this season have been 2009 H1N1.
[10] This represents an estimate of population-based rates based on available data.

2. LABORATORY TESTING

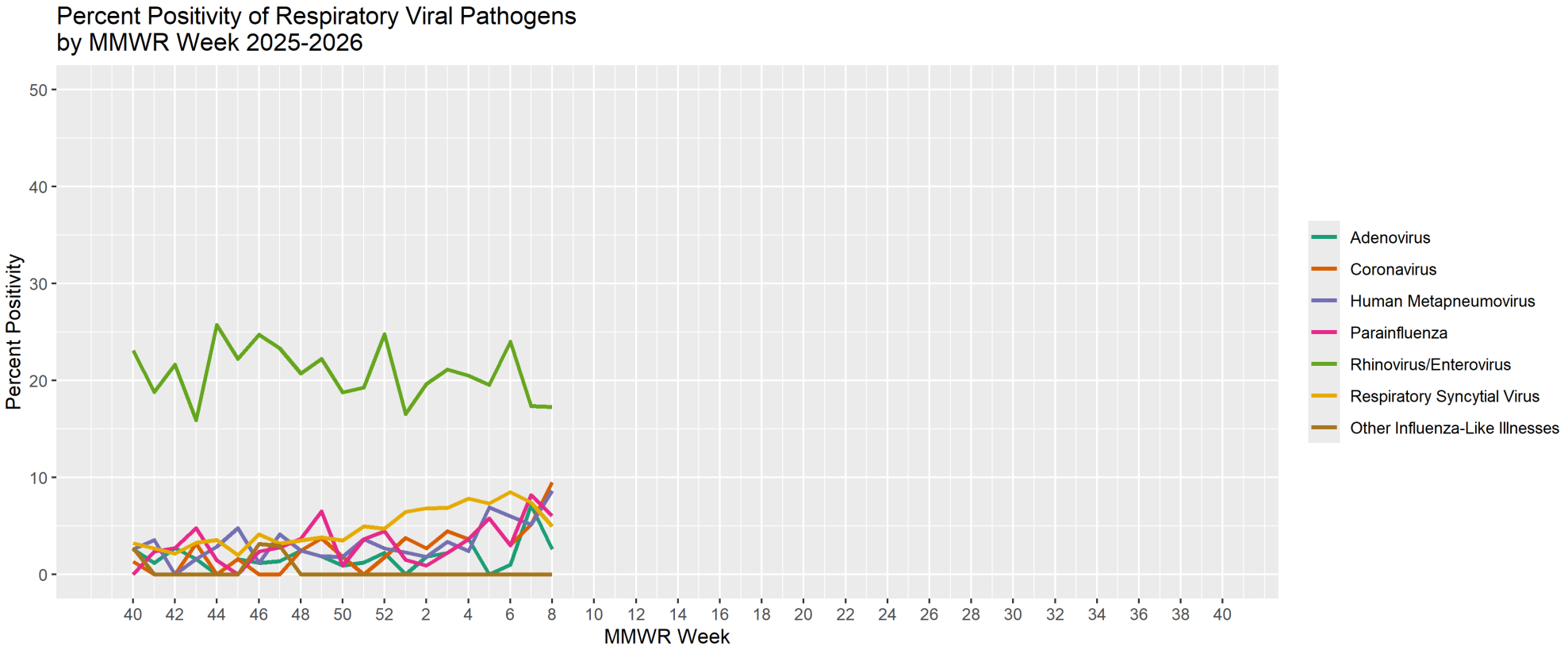
The charts below show the laboratory results of all specimens tested for influenza by MMWR week during the 2025–2026 influenza season as well as the type and subtype of positive results for influenza. Again, sub-typing is only performed on selected specimens tested by confirmatory tests (i.e., RT-PCR or viral culture).





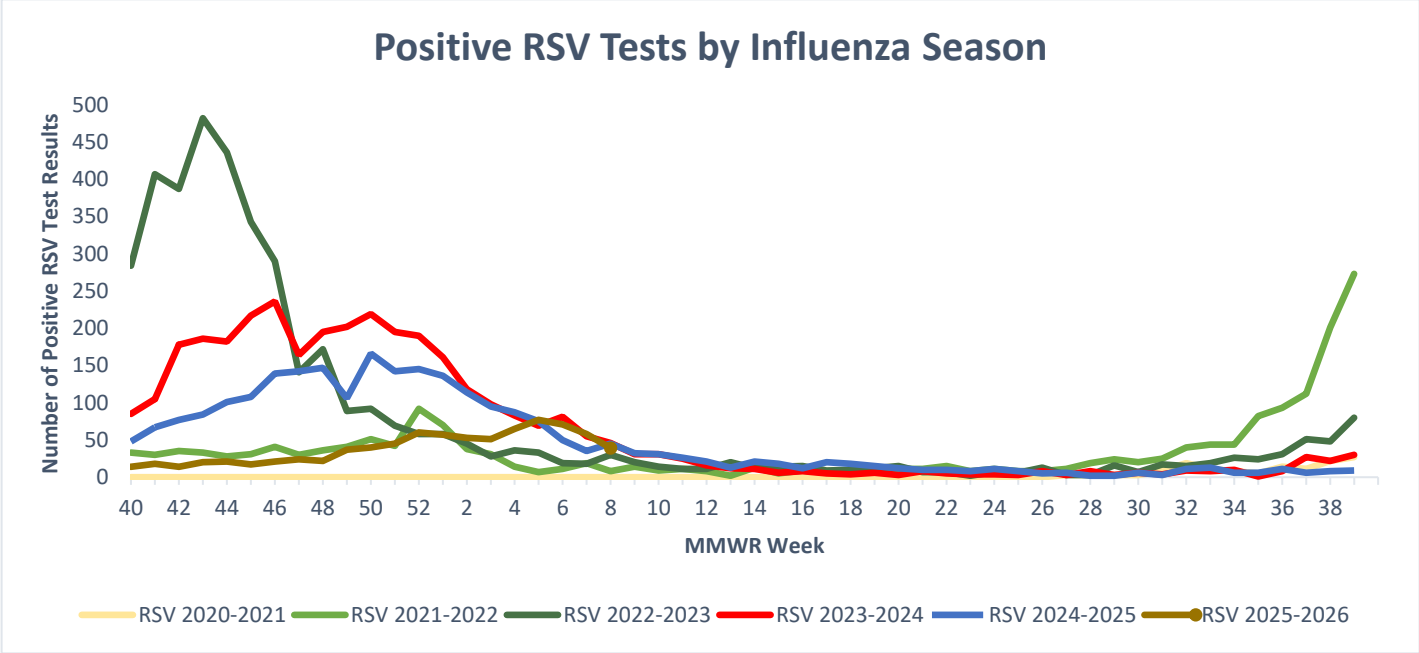
** A total of 41,718 specimens underwent confirmatory testing, but not all positive influenza specimens receive confirmatory testing that are circulating in Hawaii.*
*** For MMWR Week 53, results are reported under MMWR Week 52, where the average of Weeks 52 and 53 was calculated.*

B. **OTHER RESPIRATORY PATHOGENS:** The major clinical and commercial laboratories throughout the state of Hawaii have the testing capacity for non-influenza respiratory pathogens and report these to HDOH. However, such testing is performed as needed and when sufficient resources are available because of the high costs associated with respiratory panel tests. **Therefore, available data represent only the presence of circulating pathogens and cannot be used to determine specific trends**.

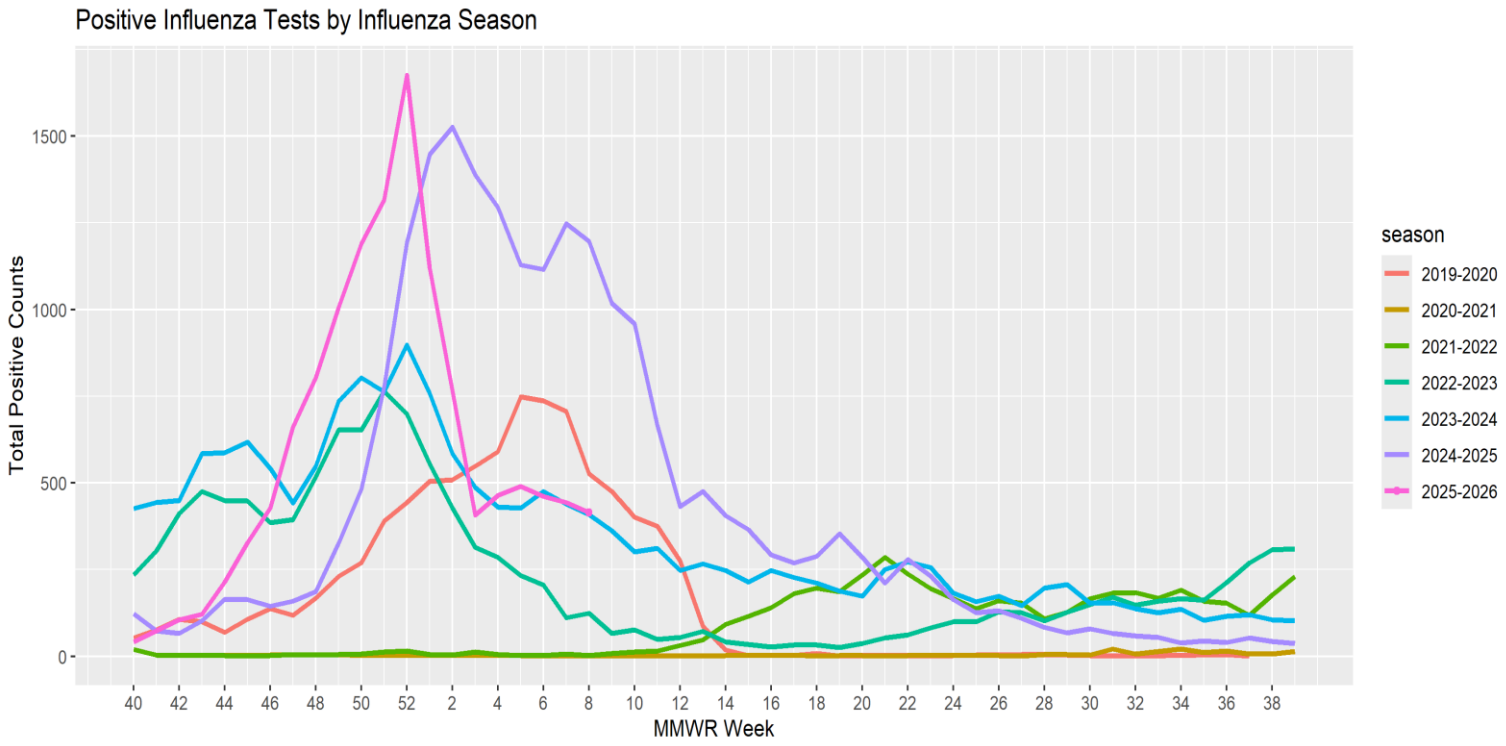


* *The coronavirus presented on this table does not indicate Severe Acute Respiratory Coronavirus-2 (i.e., COVID-19). For MMWR Week 53, results are reported under MMWR Week 52, where the average of Weeks 52 and 53 was calculated*

RESPIRATORY SYNCYTIAL VIRUS (RSV) POSITIVE TEST RESULTS BY INFLUENZA SEASON: RSV case appears to have increased later than past seasons in the 2025-2026 season. For MMWR Week 53, results are reported under MMWR Week 52, where the average of Weeks 52 and 53 was calculated.



INFLUENZA POSITIVE TEST RESULTS BY INFLUENZA SEASON: Influenza cases appear to have increased earlier than past seasons in the 2025-2026 season. For MMWR Week 53, results are reported under MMWR Week 52, where the average of Weeks 52 and 53 was calculated.



C. COVID-19 SENTINEL SURVEILLANCE: Due to the low volume of samples currently available through the influenza surveillance system, the COVID-19 sentinel surveillance data may not be accurately portraying COVID-19 activity in our communities. Reporting of the COVID-19 Sentinel Surveillance data will be paused while HODH re-evaluates the program to ensure that the reported data are accurate and representative.

HDOH is continuing to monitor COVID-19 activity throughout the state. To learn more, please visit the Hawaii's COVID-19 data website (*here*). For more information on surveillance of COVID-19 activity in the United States please visit the CDC COVIDView website (*here*).

III. PNEUMONIA, INFLUENZA, AND COVID-19 (PIC) RELATED MORTALITY:

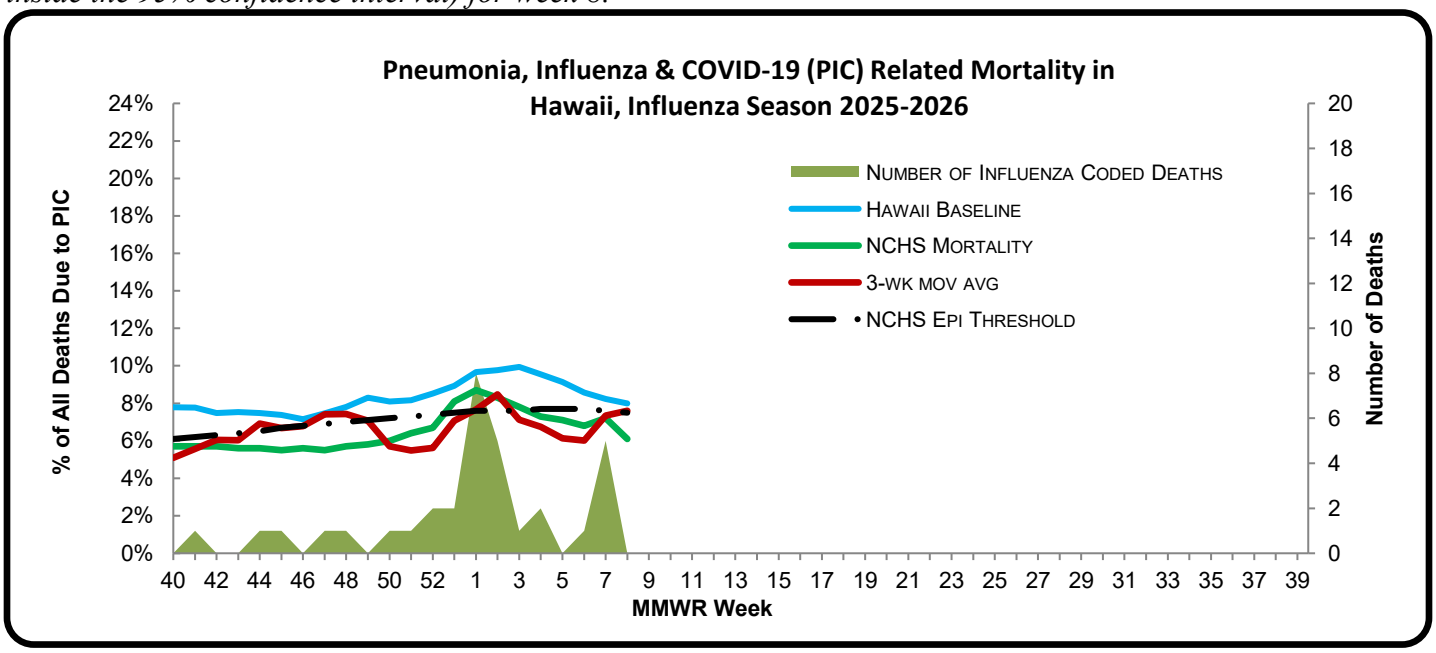
P&I mortality surveillance is collected by CDC through the National Center for Health Statistics (NCHS) using death certificate data. Each week the HDOH OHSM reports specific data from Honolulu to the CDC. CDC collects the following information by age group: the total number of deaths, total deaths from pneumonia, and total deaths related to influenza. Due to the ongoing COVID-19 pandemic, CDC included total deaths from COVID-19 by age group to the death data. Previous studies had suggested that P&I is a good indicator of influenza-related deaths; however, data has shown that pneumonia deaths associated with influenza is now being impacted by COVID-19 related pneumonia. Due to this, CDC had added COVID-19 deaths into P&I to create the PIC (pneumonia, influenza, and/or COVID-19) classification.

To standardize Hawaii's influenza surveillance with CDC influenza surveillance guidelines, PIC deaths will be reported in lieu of P&I. Hawaii's baseline will begin to include PIC deaths starting from 2019-2020 flu season.

For **week 8** of the current influenza season:

- *__7.3%__ of all deaths that occurred in Hawaii during week 8 were related to pneumonia, influenza or COVID-19 (PIC)[11]. For the current season (season to date: __6.6%__), there have been 5,195 deaths from any cause, 352 of which were due to PIC[12].*
- *The PIC rate was comparable to the historical baseline in Hawaii[13] (i.e., inside the 95% confidence interval).*

The Hawaii PIC rate was comparable to the CDC's National Center for Health Statistics (NCHS) PIC mortality[14] (__6.1%__) (i.e., inside the 95% confidence interval) and comparable to the national epidemic threshold (__7.5%__) (i.e., inside the 95% confidence interval) for week 8.



[11] The percent of deaths due to PIC displayed on the graph is the 3-week moving averages.

[12] PIC data reflect 100.0% of the data reported for the MMWR week. Changes to data are expected when PIC data reaches 100% completion.

[13] The Hawaii historical baseline (%PIC) is the average of 3-week moving averages over the preceding 10 flu seasons of historical data (2014-2015, 2015-2016, 2016-2017, 2017-2018, 2018-2019, 2019-2020, 2020-2021, 2021-2022, 2022-2023, and 2023-2024).

[14] Each week, the vital statistics offices of 122 cities across the United States report the total number of death certificates processed and the number of those for which pneumonia, influenza, or COVID-19 was listed as the underlying or contributing cause of death by age group (Under 28 days, 28 days–1 year, 1–14 years, 15–24 years, 25–44 years, 45–64 years, 65–74 years, 75–84 years, and ≥85 years). The COVID-19 death counts reported by NCHS are provisional and will not match counts in other sources, such as media reports or numbers from health departments. COVID-19 deaths may be classified or defined differently in various reporting and surveillance systems. The percentage of deaths due to pneumonia, influenza, and COVID-19 (PIC) are compared with a seasonal baseline and epidemic threshold value calculated for each week.

INFLUENZA-ASSOCIATED PEDIATRIC DEATHS[15]:

- No new influenza-associated pediatric death was reported to Hawaii. There have been zero influenza-associated pediatric deaths reported in Hawaii during the 2025–2026 season.
- Nationally, eleven new influenza-associated pediatric deaths were reported to CDC during week 8. (2025-2026 season total: 90).

IV. INFLUENZA WATCH: As part of a comprehensive influenza surveillance system and to prevent the spread of contagious respiratory diseases in humans, it is important to monitor all circulating influenza types. Several animal-origin influenza A subtypes are currently of interest: influenza A variant virus (H3N2v, H1N2v, and H1N1v) and Avian flu (H5N1 and H7N9). These types of influenza viruses may cause zoonotic (animal-associated) disease and are a public health concern.

A. VARIANT VIRUSES:

Influenza viruses that normally circulate in pigs are called "variant" viruses when they are found in people. These viruses were first identified in U.S. pigs in 2010. In 2011, 12 cases of H3N2v infection were detected in the United States. In 2012, 309 such cases (resulting in 16 hospitalizations and one death) across 12 states were detected, including one Hawaii case who recovered. Illness associated with H3N2v infection has been mostly mild with symptoms similar to those of seasonal flu. However, serious illness, resulting in hospitalization and death, has occurred in some cases. Most of these infections have been associated with prolonged exposure to pigs at agricultural fairs or similar settings. Limited human-to-human spread of this virus has been detected in the past, but no sustained community spread of H3N2v has been identified. More information regarding H3N2v, H1N1v, and H1N2v viruses may be found on the CDC website (*here*) and (*here*).

- *No variant or novel influenza infections have been reported to HDOH during the 2025-2026 influenza season.*
- *One new human infection with novel influenza A virus, H1N1v (0), H3N2v (0), and H1N2v (1), have been reported during the 2025-2026 influenza season.*
    - *One new human infection with influenza A(H1N1v) virus has been reported to WHO from China during the 2025-2026 influenza season.*

AVIAN (OR BIRD) INFLUENZA: These types of influenza viruses cause zoonotic (animal-associated) disease of public health concern and are therefore monitored globally by the WHO. Most avian influenza viruses do not cause disease in humans and are generally not easily transmissible between person to person, but a few subtypes may cross the species barrier and cause disease in humans. Avian influenza viruses may be of various subtypes, including H5N1, H5N2, H5N8, H7N3, H7N7, H7N8, H7N9, and H9N2. On January 15th, 2016, the USDA and APHIS reported detection of HPAI H7N8 in a commercial turkey flock in Indiana. There have been no associated human infections. This is the first detection of HPAI H7N8 in wild bird surveillance in the United States. More information, the risk assessment and recommendations for HPAI H7N8 can be found (here). The WHO, CDC, and other public health agencies have also been monitoring influenza H7N9, which represents a public health concern because of its high pandemic potential. Although H7N9 has not been detected in the United States, it remains a global concern given continuing epidemics in endemic countries. Since 2013, a total of 1,568 laboratory-confirmed cases of human infection with H7N9 viruses, including at least 613 deaths, have been reported to WHO. More information on H7N9 virus infections can be found (here). For more information regarding avian influenza, please visit the CDC (*here*) or the WHO (*here*) websites. WHO reports total number of cases and deaths related to laboratory-confirmed avian influenza viruses and posts current avian influenza case counts (*here*), which were last updated on **January 22, 2026**.

[15] Influenza-associated deaths are considered pediatric in persons aged less than 18 years. It was made a nationally notifiable condition in October, 2004. All pediatric influenza-associated deaths are laboratory confirmed.

V. INFLUENZA Vaccine: Annual influenza vaccination is recommended for all persons aged 6 months and older and is the most effective way to reduce the risk of getting sick with seasonal flu and spreading it to others. Influenza vaccination can reduce illnesses, visits to the doctor, influenza-related hospitalizations, and missed work and school days. Influenza vaccines become available by the end of October. It takes at least two weeks after vaccination to confer immunity against influenza virus infection. More information regarding influenza vaccination can be found (*here*).

A. Composition of the 2025–2026 Influenza Vaccine**:**

The composition of the 2025–2026 influenza vaccine has been updated to better match circulating influenza viruses. The Advisory Committee on Immunization Practices (ACIP) has recommended that the 2025-2026 influenza trivalent vaccine contain an influenza A/Victoria/4897/2022 (H1N1) pdm09-like virus, influenza A/Croatia/10136RV/2023 (H3N2)-like virus, and influenza B/Austria/1359417/2021 (B/Victoria lineage)-like virus. United States cell culture–based inactivated (ccIIV4) and recombinant (RIV4) influenza vaccines will contain HA derived from an influenza A/Wisconsin/67/2022 (H1N1) pdm09-like virus, an A/District of Columbia/27/2023 (H3N2)-like virus, an influenza B/Austria/1359417/2021 (B/Victoria lineage)-like virus. These vaccine recommendations were based on several factors, including global influenza virologic and epidemiologic surveillance, genetic and antigenic characterization, human serology studies, antiviral susceptibility, and the availability of candidate influenza viruses.

APPENDIX 1: ADDITIONAL INFORMATION

For more information regarding local and national influenza surveillance programs, visit the following sites.

Centers for Disease Control and Prevention	General Influenza National ILI and P&I Data Vaccine Virus Selection CDC Web Tool for Respiratory Viruses
Flu.gov	General Influenza Information
HDOH Flu and Pneumonia	General Influenza Surveillance Avian Influenza Respiratory Virus Dashboard To find out more information or join the sentinel physician program, email the Influenza Surveillance Coordinator
World Health Organization	General Global and Local Influenza Avian Influenza

APPENDIX 2: MMWR WEEK DATES

Please refer to the table below to interpret data presented by MMWR week. Week 40 is considered the traditional start for the flu season for the Northern Hemisphere.

MMWR WEEK	2022	2023	2024	2025	2026
1	1/8/2022	1/7/2023	1/6/2024	1/4/2025	1/10/2026
2	1/15/2022	1/14/2023	1/13/2024	1/11/2025	1/17/2026
3	1/22/2022	1/21/2023	1/20/2024	1/18/2025	1/24/2026
4	1/29/2022	1/28/2023	1/27/2024	1/25/2025	1/31/2026
5	2/5/2022	2/4/2023	2/3/2024	2/1/2025	2/7/2026
6	2/12/2022	2/11/2023	2/10/2024	2/8/2025	2/14/2026
7	2/19/2022	2/18/2023	2/17/2024	2/15/2025	2/21/2026
8	2/26/2022	2/25/2023	2/24/2024	2/22/2025	2/28/2026
9	3/5/2022	3/4/2023	3/2/2024	3/1/2025	3/7/2026
10	3/12/2022	3/11/2023	3/9/2024	3/8/2025	3/14/2026
11	3/19/2022	3/18/2023	3/16/2024	3/15/2025	3/21/2026
12	3/26/2022	3/25/2023	3/23/2024	3/22/2025	3/28/2026
13	4/2/2022	4/1/2023	3/30/2024	3/29/2025	4/4/2026
14	4/9/2022	4/8/2023	4/6/2024	4/5/2025	4/11/2026
15	4/16/2022	4/15/2023	4/13/2024	4/12/2025	4/18/2026
16	4/23/2022	4/22/2023	4/20/2024	4/19/2025	4/25/2026
17	4/30/2022	4/29/2023	4/27/2024	4/26/2025	5/2/2026
18	5/7/2022	5/6/2023	5/4/2024	5/3/2025	5/9/2026
19	5/14/2022	5/13/2023	5/11/2024	5/10/2025	5/16/2026
20	5/21/2022	5/20/2023	5/18/2024	5/17/2025	5/23/2026
21	5/28/2022	5/27/2023	5/25/2024	5/24/2025	5/30/2026
22	6/4/2022	6/3/2023	6/1/2024	5/31/2025	6/6/2026
23	6/11/2022	6/10/2023	6/8/2024	6/7/2025	6/13/2026
24	6/18/2022	6/17/2023	6/15/2024	6/14/2025	6/20/2026
25	6/25/2022	6/24/2023	6/22/2024	6/21/2025	6/27/2026
26	7/2/2022	7/1/2023	6/29/2024	6/28/2025	7/4/2026
27	7/9/2022	7/8/2023	7/6/2024	7/5/2025	7/11/2026
28	7/16/2022	7/15/2023	7/13/2024	7/12/2025	7/18/2026
29	7/23/2022	7/22/2023	7/20/2024	7/19/2025	7/25/2026
30	7/30/2022	7/29/2023	7/27/2024	7/26/2025	8/1/2026
31	8/6/2022	8/5/2023	8/3/2024	8/2/2025	8/8/2026
32	8/13/2022	8/12/2023	8/10/2024	8/9/2025	8/15/2026
33	8/20/2022	8/19/2023	8/17/2024	8/16/2025	8/22/2026
34	8/27/2022	8/26/2023	8/24/2024	8/23/2025	8/29/2026
35	9/3/2022	9/2/2023	8/31/2024	8/30/2025	9/5/2026
36	9/10/2022	9/9/2023	9/7/2024	9/6/2025	9/12/2026
37	9/17/2022	9/16/2023	9/14/2024	9/13/2025	9/19/2026
38	9/24/2022	9/23/2023	9/21/2024	9/20/2025	9/26/2026
39	10/1/2022	9/30/2023	9/28/2024	9/27/2025	10/3/2026
40	10/8/2022	10/7/2023	10/5/2024	10/4/2025	10/10/2026
41	10/15/2022	10/14/2023	10/12/2024	10/11/2025	10/17/2026
42	10/22/2022	10/21/2023	10/19/2024	10/18/2025	10/24/2026
43	10/29/2022	10/28/2023	10/26/2024	10/25/2025	10/31/2026
44	11/5/2022	11/4/2023	11/2/2024	11/1/2025	11/7/2026
45	11/12/2022	11/11/2023	11/9/2024	11/8/2025	11/14/2026
46	11/19/2022	11/18/2023	11/16/2024	11/15/2025	11/21/2026
47	11/26/2022	11/25/2023	11/23/2024	11/22/2025	11/28/2026
48	12/3/2022	12/2/2023	11/30/2024	11/29/2025	12/5/2026
49	12/10/2022	12/9/2023	12/7/2024	12/6/2025	12/12/2026
50	12/17/2022	12/16/2023	12/14/2024	12/13/2025	12/19/2026
51	12/24/2022	12/23/2023	12/21/2024	12/20/2025	12/26/2026
52	12/31/2022	12/30/2023	12/28/2024	12/27/2025	
53				01/03/2026	

HAWAII STATE DEPARTMENT OF HEALTH
DISEASE OUTBREAK CONTROL DIVISION

Influenza/Respiratory Disease Surveillance Report

Morbidity and Mortality Weekly Report (MMWR)[1]

WEEK 9: FEBRUARY 29, 2026– MARCH 7, 2026

OVERVIEW: The Hawaii State Department of Health (HDOH) monitors influenza and other respiratory pathogens, including COVID-19, throughout the state of Hawaii. Influenza surveillance in the state of Hawaii relies upon selected sentinel health practitioners, the State Laboratories Division (SLD), private laboratories, and the Office of Health Status Monitoring (OHSM). For detailed information concerning influenza, please visit the HDOH Disease Outbreak Control Division (HDOH DOCD) website (*here*). **All data and information are conditional and may change as more reports are received.** The data in this report reflects the 2025-2026 influenza season which began the week ending October 4, 2025 (week 40[1] 2025) and will end the week ending on October 3, 2026 (week 39 2026).

REPORT SNAPSHOT FOR WEEK 9

Surveillance for Influenza-like Illness (ILI)		
Metric	*Value*	*Comment*
Outpatient visits related to influenza-like illness (ILI) from ILINet Sentinel Providers	3.1%	Higher than the previous week. Comparable to Hawaii's historical baseline and lower than the national baseline, and lower than the national ILI rate.
Number of ILI clusters reported to HDOH	1	There have been 25 clusters this season.

Laboratory Surveillance		
Percent of all respiratory specimens positive for influenza this week	14.3%	Higher than the previous week. This number means that many, if not all, of the 85.7% who tested negative for influenza had illness from another respiratory etiology.
Percent of all respiratory specimens positive for influenza this season to date	18.4%	

Surveillance for Severe Outcomes		
Pneumonia, influenza and COVID-19 (PIC) mortality rate	1.8%	Lower than Hawaii's historical baseline, lower than the national epidemic threshold and lower than the NCHS average.
Number of influenza-associated pediatric deaths reported nationwide	101	0 influenza-associated pediatric deaths have been reported from Hawaii this season to date.

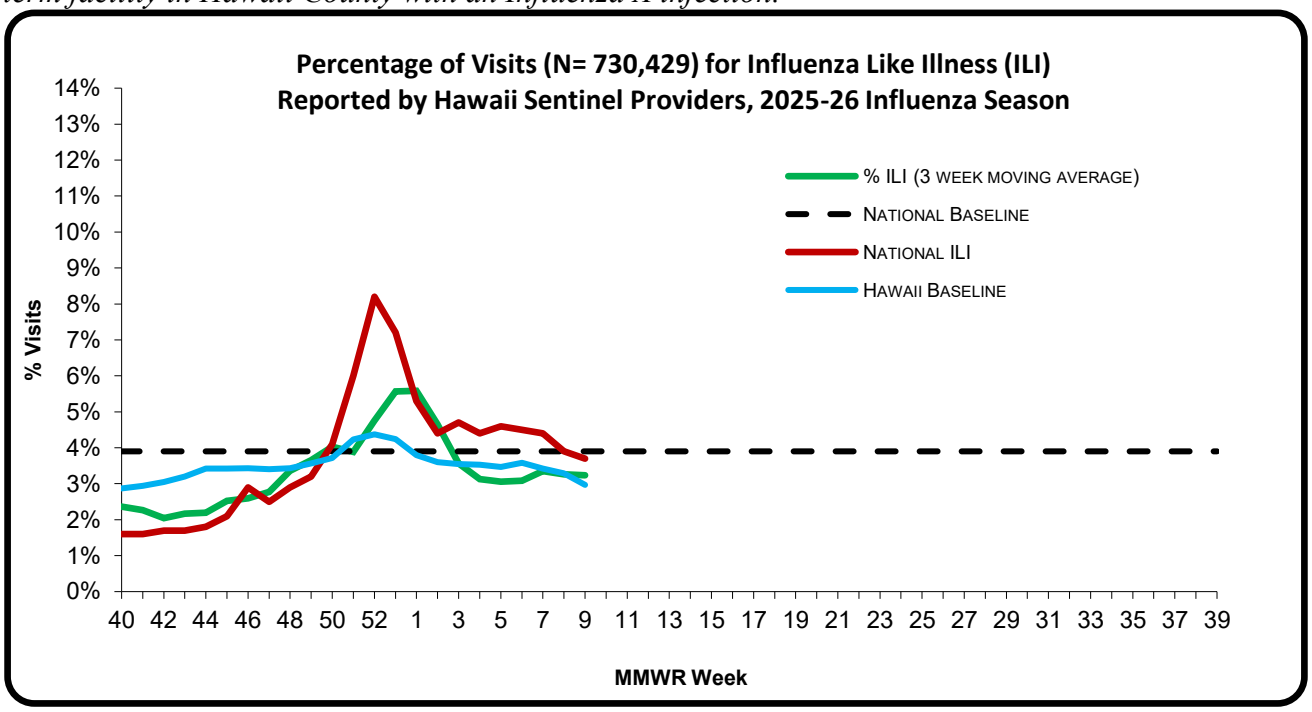
[1] MMWR stands for "Morbidity and Mortality Weekly Report," conventionally used by the Centers for Disease Control and Prevention (CDC). The weeks of a flu season are often referred to by their respective MMWR week. **See appendix 2 for interpretation of MMWR weeks.** Data reported will begin on week 40, the traditional start date of flu season.

INFLUENZA SURVEILLANCE

I. INFLUENZA-LIKE ILLNESS (ILI): HDOH collaborates with recruited doctors and healthcare providers who report the total number of outpatient visits for ILI as well as the total number of patients who complained of symptoms consistent with ILI. A patient with ILI must have the following: a fever (temperature of 100°F [37.8°C] or greater) AND a cough and/or a sore throat. ILI is based on reported symptoms and not laboratory confirmed tests; thus, ILI may represent other respiratory pathogens and not solely influenza. Further, sentinel providers report these numbers on a weekly basis; therefore, data are preliminary and may change depending on additional reporting. In combination with laboratory testing and other surveillance systems, ILI surveillance helps monitor influenza and other respiratory pathogen activity. For more information concerning ILINet and sentinel requirements, please visit the CDC website (*here*).

For **week 9** of the current influenza season:

- ***3.1****% (season to date:* ***3.3****%) of the outpatient visits recorded by Hawaii sentinel providers were for ILI.*
- *ILI visits were comparable to the historical baseline in Hawaii[2,3] (i.e., inside the 95% confidence interval).*
- *Hawaii's ILI outpatient visits were lower than the national baseline (**3.9%**)[4] (i.e., outside the 95% confidence interval) and lower than the national ILI rate (**3.7%**) (i.e. outside the 95% confidence interval).*
- *ILI activity level: Low[5]*
- *Geographic Spread: Sporadic Activity[6].*
- *ILI Cluster Activity: One new cluster was reported to HDOH during week 9. The cluster occurred at a long-term facility in Hawaii County with an Influenza A infection.*



[2] The Hawaii historical baseline (%ILI) is the average of 3-week moving averages over the preceding 3 flu seasons of historical data (2022-2023, 2023-2024 and 2024-2025).
[3] This value is based upon comparison of actual outpatient ILI with the historical baseline, which only captures outpatient ILI. The chart above represents a 3-week moving average and not the actual ILI by week.
[4] The National Baseline is calculated by CDC as the mean percentage of visits for ILI during weeks 21–39 with two standard deviations. Because of large variability in regional ILI, comparison of the national baseline with local ILI may not be appropriate. It is provided in this report because no meaningful regional baselines are available for comparison. The national baseline combines all data reported by states to CDC, including ILI in outpatient, ER, urgent care, and inpatient settings.
[5] There are 10 activity levels classified as minimal (levels 1-3), low (levels 4-5), moderate (levels 6-7), and high (levels 8-10).
[6] The influenza activity reported by state and territorial epidemiologists indicates geographic spread of influenza viruses but does not measure the severity of influenza activity. Sporadic: no clusters reported to HDOH, Local: one or more clusters reported in one county, Regional: clusters reported two to three counties, Widespread: clusters reported in all counties. Hawaii does not report No Activity, as flu circulates year-round in Hawaii.

II. LABORATORY SURVEILLANCE: State Laboratories Division (SLD; the HDOH public health laboratory) and Hawaii's major private laboratories (DLS, CLH) report results of RT-PCR, which can be considered confirmatory (SLD may perform viral culture on select specimens). Specimens meeting priority criteria[7] are forwarded to SLD for sub-typing. Additionally, specimens meeting case definition from requesting sentinel providers are sent directly to SLD for sub-typing. Due to resource constraints, not all submitted specimens undergo sub-typing. Sub-typing at the commercial laboratories is only conducted on a case-by-case basis. The majority of specimens testing positive by rapid antigen testing or RT-PCR at the commercial laboratories do not meet criteria and are not subtyped. For more information on influenza tests and types, please visit the CDC website (*here*).

A. INFLUENZA:

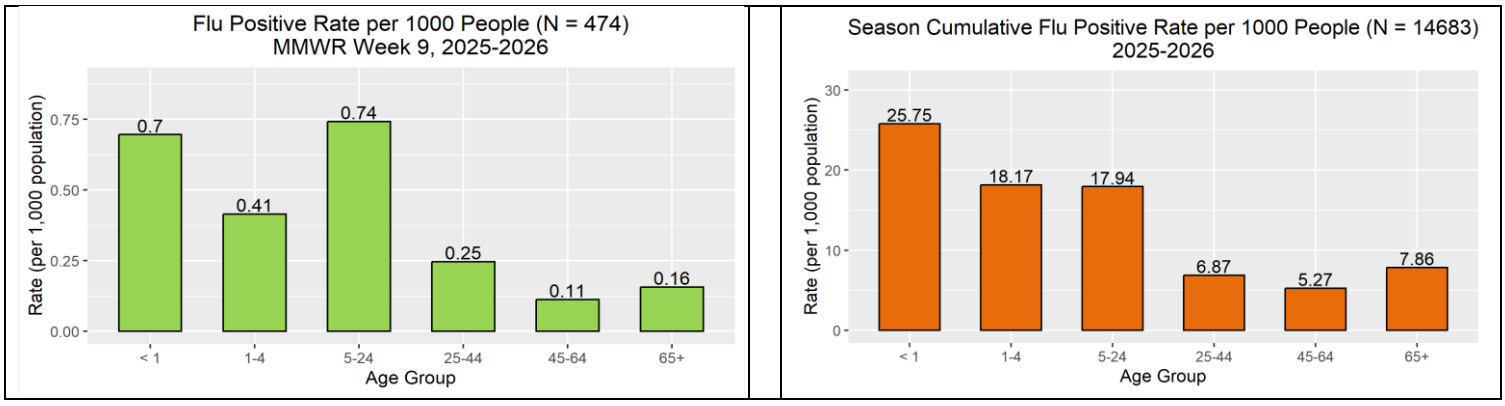
- The following reflects laboratory findings for week 9 of the 2025–26 influenza season:
  - *A total of **3,322** specimens has been tested statewide for influenza viruses (positive: 474 [**14.3%**]). (Season to date: **78,399** tested (**18.4%** positive)*
    - *1,539 (46.3%) were screened only by rapid antigen tests with no confirmatory testing.*
    - *1,783 (53.7%) underwent confirmatory testing (either RT-PCR or viral culture).*
    - *2,848 (85.7%) were negative.*
  - *Routine surveillance samples from State Laboratory Division were tested at a public health laboratory and identified as Influenza A (H3N2) subclade K.*

Influenza type	***Current week 9 (%)****	***Season to date (%)***[8]
Influenza A (H1)[9]	*1 (0.2)*	*109 (0.8)*
Influenza A (H3)	*0 (0.0)*	*999 (6.9)*
Influenza A no subtyping	*168 (35.4)*	*11,777 (81.5)*
Influenza B (Yamagata)	*0 (0.0)*	*0 (0.0)*
Influenza B (Victoria)	*0 (0.0)*	*0 (0.0)*
Influenza B no genotyping	*306 (64.4)*	*1,567 (10.8)*

**Specimens that are positive for both A and B (coinfections) are counted in both A and B totals for current and season to date*

1. AGE DISTRIBUTION

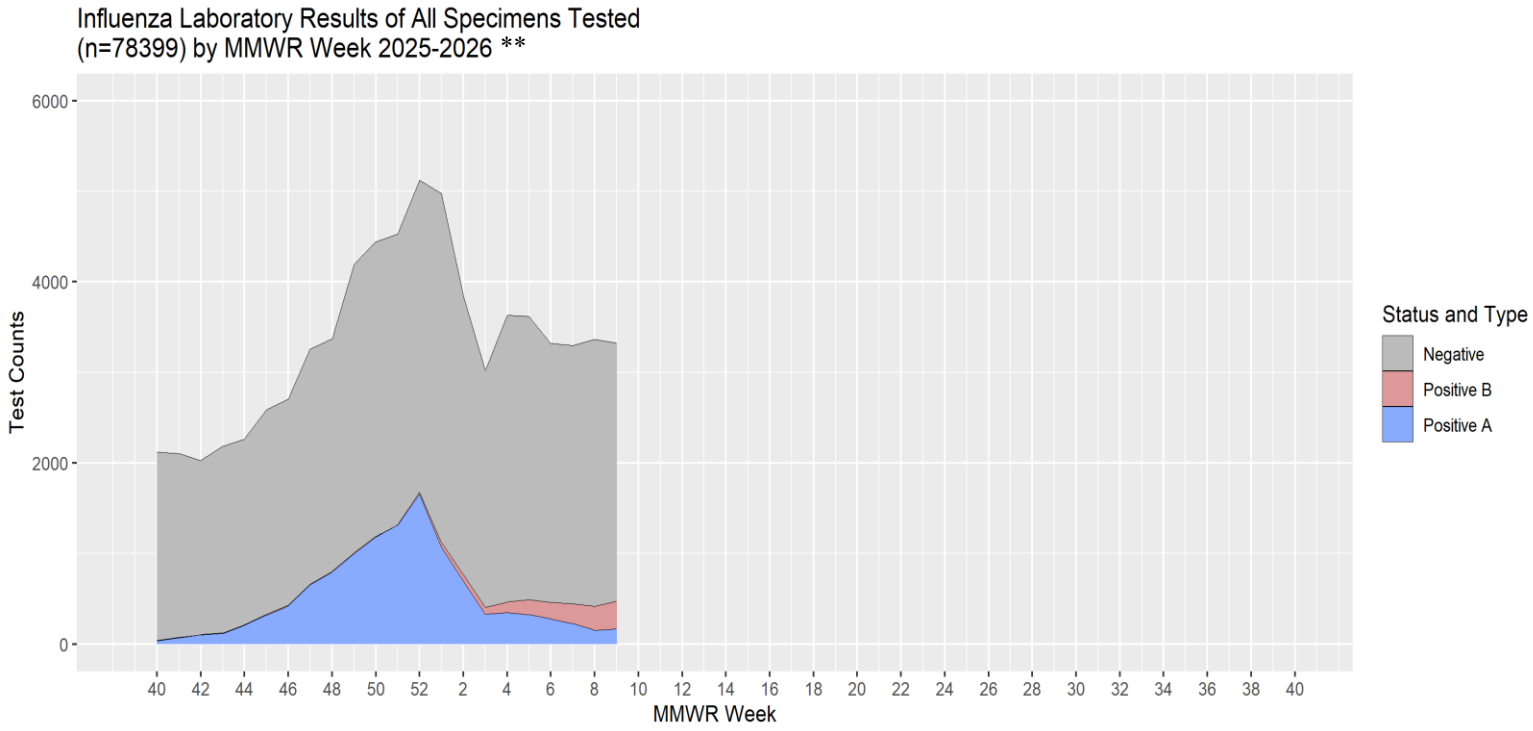
The charts below indicate the population-based rates of positive influenza cases in Hawaii by age group during the 2025–26 influenza season.[10]

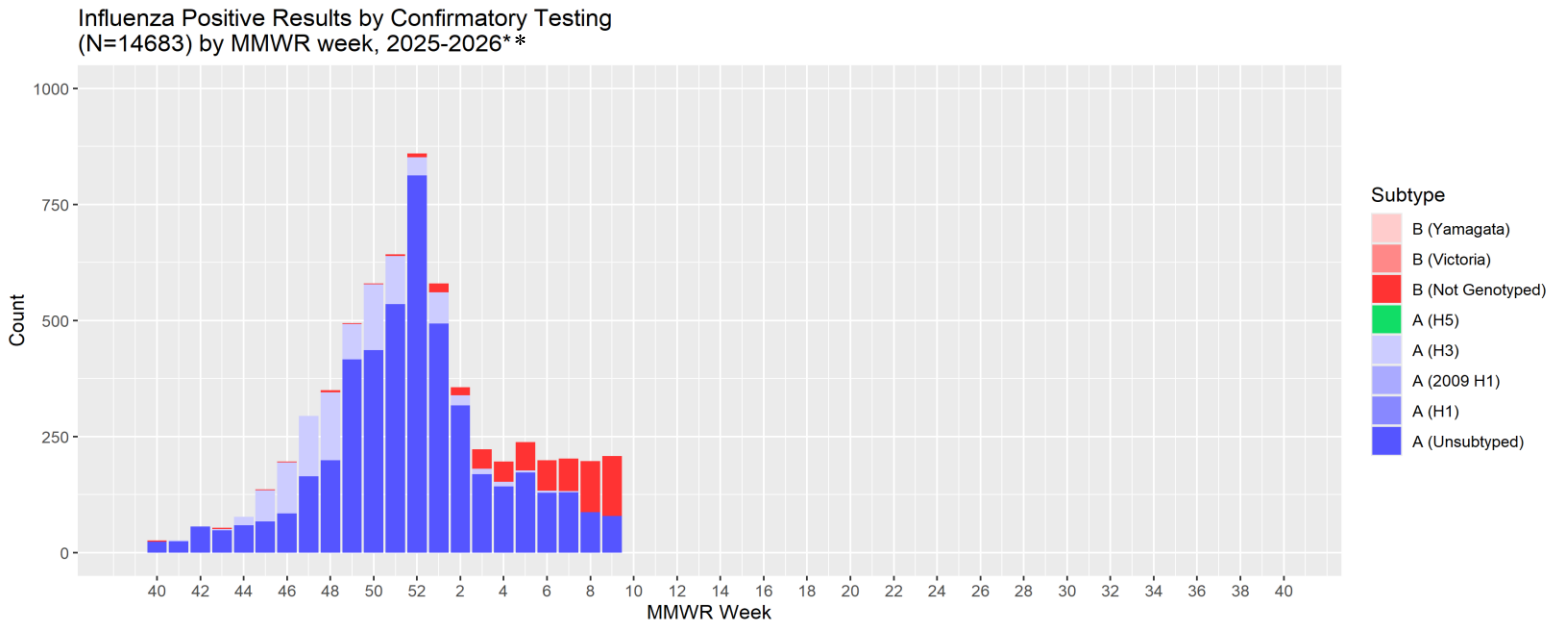


[7] Priority criteria include: hospitalized patients with acute respiratory distress syndrome [ARDS] or x-ray confirmed pneumonia; travelers with international travel history within 10 days of onset; specimens submitted by sentinel providers; specimens collected from healthcare workers, pregnant women, or women up to 6 weeks' post-partum; those with underlying medical conditions; and patients presenting with unusual or severe manifestations of influenza infection.
[8] Influenza coding was updated to reflect a more accurate count.
[9] All influenza A H1 viruses detected this season have been 2009 H1N1.
[10] This represents an estimate of population-based rates based on available data.

2. LABORATORY TESTING

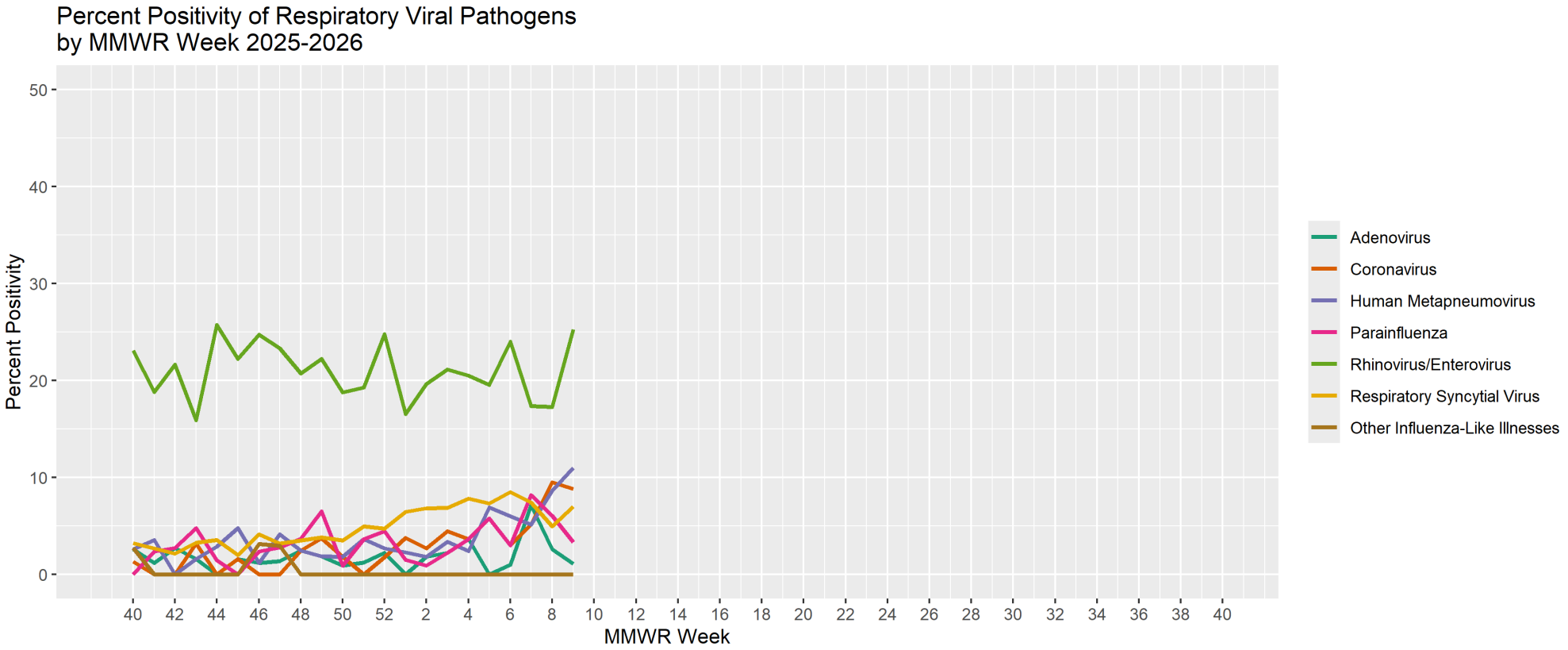
The charts below show the laboratory results of all specimens tested for influenza by MMWR week during the 2025–2026 influenza season as well as the type and subtype of positive results for influenza. Again, sub-typing is only performed on selected specimens tested by confirmatory tests (i.e., RT-PCR or viral culture).





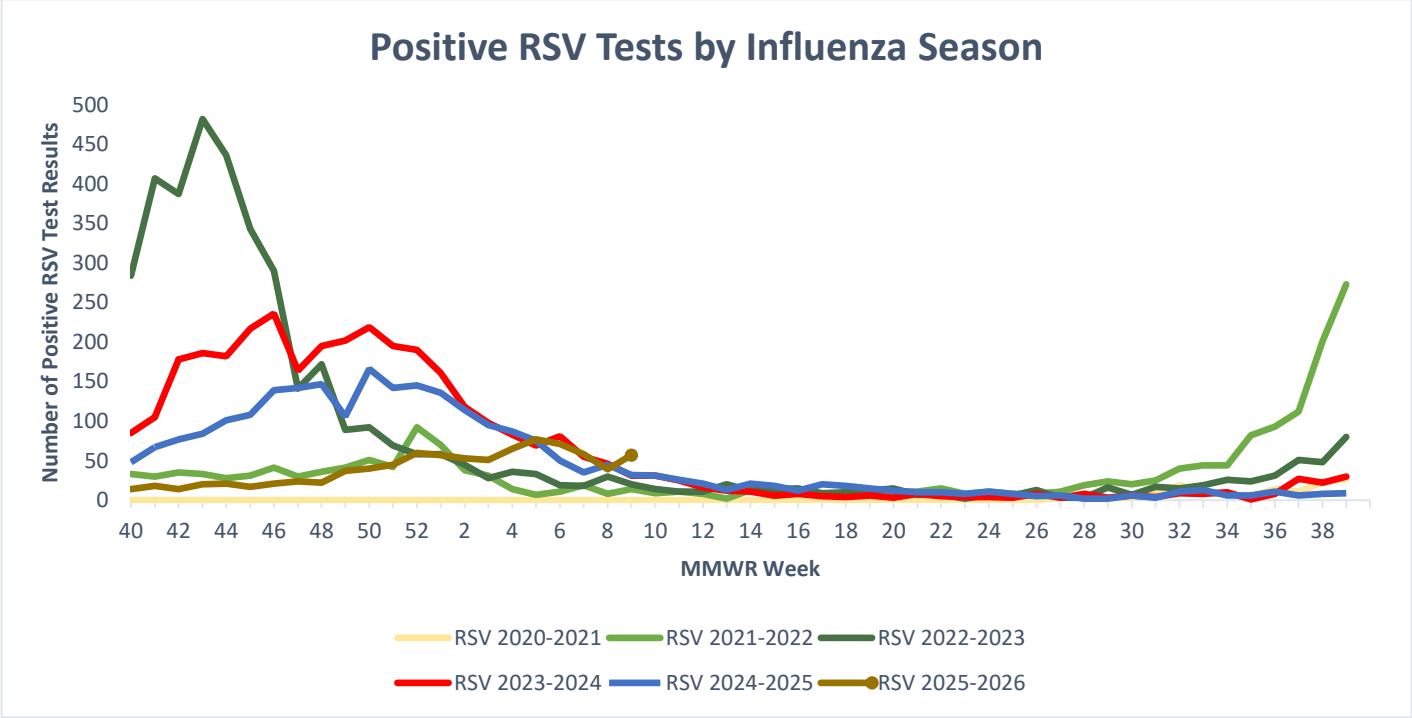
** A total of 43,501 specimens underwent confirmatory testing, but not all positive influenza specimens receive confirmatory testing that are circulating in Hawaii.*
*** For MMWR Week 53, results are reported under MMWR Week 52, where the average of Weeks 52 and 53 was calculated.*

B. **OTHER RESPIRATORY PATHOGENS:** The major clinical and commercial laboratories throughout the state of Hawaii have the testing capacity for non-influenza respiratory pathogens and report these to HDOH. However, such testing is performed as needed and when sufficient resources are available because of the high costs associated with respiratory panel tests. **Therefore, available data represent only the presence of circulating pathogens and cannot be used to determine specific trends**.

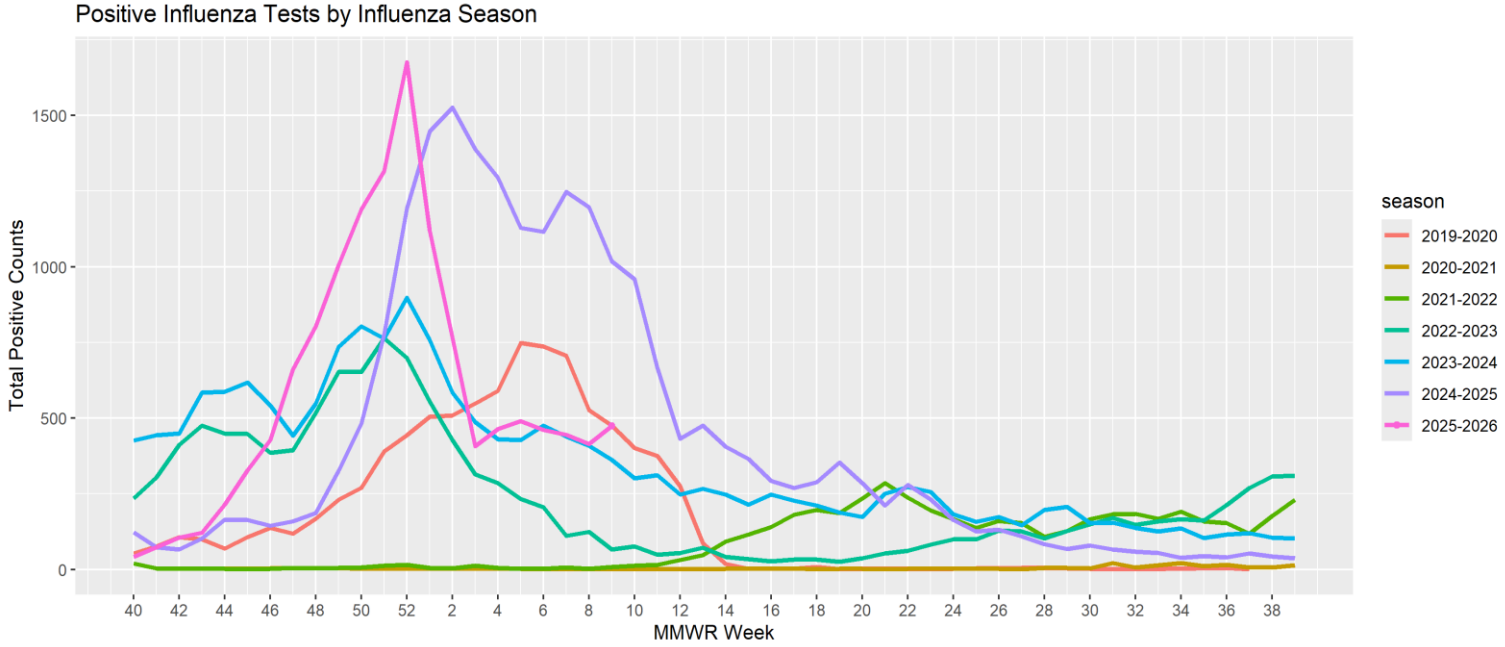


* *The coronavirus presented on this table does not indicate Severe Acute Respiratory Coronavirus-2 (i.e., COVID-19). For MMWR Week 53, results are reported under MMWR Week 52, where the average of Weeks 52 and 53 was calculated*

RESPIRATORY SYNCYTIAL VIRUS (RSV) POSITIVE TEST RESULTS BY INFLUENZA SEASON: RSV case appears to have increased later than past seasons in the 2025-2026 season. For MMWR Week 53, results are reported under MMWR Week 52, where the average of Weeks 52 and 53 was calculated.



INFLUENZA POSITIVE TEST RESULTS BY INFLUENZA SEASON: Influenza cases appear to have increased earlier than past seasons in the 2025-2026 season. For MMWR Week 53, results are reported under MMWR Week 52, where the average of Weeks 52 and 53 was calculated.



C. COVID-19 SENTINEL SURVEILLANCE: Due to the low volume of samples currently available through the influenza surveillance system, the COVID-19 sentinel surveillance data may not be accurately portraying COVID-19 activity in our communities. Reporting of the COVID-19 Sentinel Surveillance data will be paused while HODH re-evaluates the program to ensure that the reported data are accurate and representative.

HDOH is continuing to monitor COVID-19 activity throughout the state. To learn more, please visit the Hawaii's COVID-19 data website (*here*). For more information on surveillance of COVID-19 activity in the United States please visit the CDC COVIDView website (*here*).

III. PNEUMONIA, INFLUENZA, AND COVID-19 (PIC) RELATED MORTALITY:

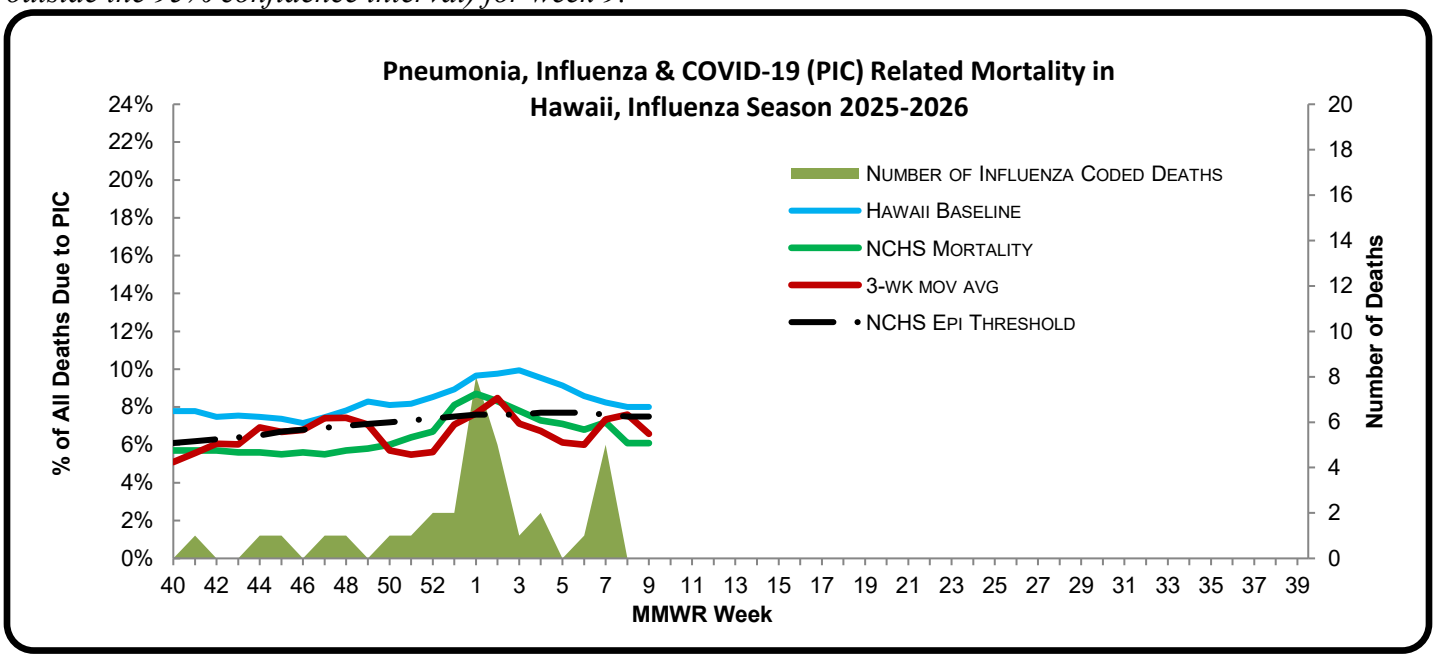
P&I mortality surveillance is collected by CDC through the National Center for Health Statistics (NCHS) using death certificate data. Each week the HDOH OHSM reports specific data from Honolulu to the CDC. CDC collects the following information by age group: the total number of deaths, total deaths from pneumonia, and total deaths related to influenza. Due to the ongoing COVID-19 pandemic, CDC included total deaths from COVID-19 by age group to the death data. Previous studies had suggested that P&I is a good indicator of influenza-related deaths; however, data has shown that pneumonia deaths associated with influenza is now being impacted by COVID-19 related pneumonia. Due to this, CDC had added COVID-19 deaths into P&I to create the PIC (pneumonia, influenza, and/or COVID-19) classification.

To standardize Hawaii's influenza surveillance with CDC influenza surveillance guidelines, PIC deaths will be reported in lieu of P&I. Hawaii's baseline will begin to include PIC deaths starting from 2019-2020 flu season.

For **week 9** of the current influenza season:

- ***1.8%*** *of all deaths that occurred in Hawaii during week 9 were related to pneumonia, influenza or COVID-19 (PIC)*[11]*. For the current season (season to date:* ***6.7%****), there have been 5,249 deaths from any cause, 353 of which were due to PIC*[12]*.*
- *The PIC rate was lower than the historical baseline in Hawaii*[13] *(i.e., outside the 95% confidence interval).*

The Hawaii PIC rate was lower than the CDC's National Center for Health Statistics (NCHS) PIC mortality[14] *(****6.1%****) (i.e., outside the 95% confidence interval) and lower than the national epidemic threshold (****7.5%****) (i.e., outside the 95% confidence interval) for week 9.*



[11] The percent of deaths due to PIC displayed on the graph is the 3-week moving averages.

[12] PIC data reflect 78.7% of the data reported for the MMWR week. Changes to data are expected when PIC data reaches 100% completion.

[13] The Hawaii historical baseline (%PIC) is the average of 3-week moving averages over the preceding 10 flu seasons of historical data (2014-2015, 2015-2016, 2016-2017, 2017-2018, 2018-2019, 2019-2020, 2020-2021, 2021-2022, 2022-2023, and 2023-2024).

[14] Each week, the vital statistics offices of 122 cities across the United States report the total number of death certificates processed and the number of those for which pneumonia, influenza, or COVID-19 was listed as the underlying or contributing cause of death by age group (Under 28 days, 28 days–1 year, 1–14 years, 15–24 years, 25–44 years, 45–64 years, 65–74 years, 75–84 years, and ≥85 years). The COVID-19 death counts reported by NCHS are provisional and will not match counts in other sources, such as media reports or numbers from health departments. COVID-19 deaths may be classified or defined differently in various reporting and surveillance systems. The percentage of deaths due to pneumonia, influenza, and COVID-19 (PIC) are compared with a seasonal baseline and epidemic threshold value calculated for each week.

INFLUENZA-ASSOCIATED PEDIATRIC DEATHS[15]:

- No new influenza-associated pediatric death was reported to Hawaii. There have been zero influenza-associated pediatric deaths reported in Hawaii during the 2025–2026 season.
- Nationally, eleven new influenza-associated pediatric deaths were reported to CDC during week 9. (2025-2026 season total: 101).

IV. INFLUENZA WATCH: As part of a comprehensive influenza surveillance system and to prevent the spread of contagious respiratory diseases in humans, it is important to monitor all circulating influenza types. Several animal-origin influenza A subtypes are currently of interest: influenza A variant virus (H3N2v, H1N2v, and H1N1v) and Avian flu (H5N1 and H7N9). These types of influenza viruses may cause zoonotic (animal-associated) disease and are a public health concern.

A. VARIANT VIRUSES:

Influenza viruses that normally circulate in pigs are called "variant" viruses when they are found in people. These viruses were first identified in U.S. pigs in 2010. In 2011, 12 cases of H3N2v infection were detected in the United States. In 2012, 309 such cases (resulting in 16 hospitalizations and one death) across 12 states were detected, including one Hawaii case who recovered. Illness associated with H3N2v infection has been mostly mild with symptoms similar to those of seasonal flu. However, serious illness, resulting in hospitalization and death, has occurred in some cases. Most of these infections have been associated with prolonged exposure to pigs at agricultural fairs or similar settings. Limited human-to-human spread of this virus has been detected in the past, but no sustained community spread of H3N2v has been identified. More information regarding H3N2v, H1N1v, and H1N2v viruses may be found on the CDC website (*here*) and (*here*).

- *No variant or novel influenza infections have been reported to HDOH during the 2025-2026 influenza season.*
- *One new human infection with novel influenza A virus, H1N1v (0), H3N2v (0), and H1N2v (1), have been reported during the 2025-2026 influenza season.*
    - *One new human infection with influenza A(H1N1v) virus has been reported to WHO from China during the 2025-2026 influenza season.*

AVIAN (OR BIRD) INFLUENZA: These types of influenza viruses cause zoonotic (animal-associated) disease of public health concern and are therefore monitored globally by the WHO. Most avian influenza viruses do not cause disease in humans and are generally not easily transmissible between person to person, but a few subtypes may cross the species barrier and cause disease in humans. Avian influenza viruses may be of various subtypes, including H5N1, H5N2, H5N8, H7N3, H7N7, H7N8, H7N9, and H9N2. On January 15th, 2016, the USDA and APHIS reported detection of HPAI H7N8 in a commercial turkey flock in Indiana. There have been no associated human infections. This is the first detection of HPAI H7N8 in wild bird surveillance in the United States. More information, the risk assessment and recommendations for HPAI H7N8 can be found (here). The WHO, CDC, and other public health agencies have also been monitoring influenza H7N9, which represents a public health concern because of its high pandemic potential. Although H7N9 has not been detected in the United States, it remains a global concern given continuing epidemics in endemic countries. Since 2013, a total of 1,568 laboratory-confirmed cases of human infection with H7N9 viruses, including at least 613 deaths, have been reported to WHO. More information on H7N9 virus infections can be found (here). For more information regarding avian influenza, please visit the CDC (*here*) or the WHO (*here*) websites. WHO reports total number of cases and deaths related to laboratory-confirmed avian influenza viruses and posts current avian influenza case counts (*here*), which were last updated on **January 22, 2026**.

[15] Influenza-associated deaths are considered pediatric in persons aged less than 18 years. It was made a nationally notifiable condition in October, 2004. All pediatric influenza-associated deaths are laboratory confirmed.

V. INFLUENZA Vaccine: Annual influenza vaccination is recommended for all persons aged 6 months and older and is the most effective way to reduce the risk of getting sick with seasonal flu and spreading it to others. Influenza vaccination can reduce illnesses, visits to the doctor, influenza-related hospitalizations, and missed work and school days. Influenza vaccines become available by the end of October. It takes at least two weeks after vaccination to confer immunity against influenza virus infection. More information regarding influenza vaccination can be found (*here*).

A. Composition of the 2025–2026 Influenza Vaccine**:**

The composition of the 2025–2026 influenza vaccine has been updated to better match circulating influenza viruses. The Advisory Committee on Immunization Practices (ACIP) has recommended that the 2025-2026 influenza trivalent vaccine contain an influenza A/Victoria/4897/2022 (H1N1) pdm09-like virus, influenza A/Croatia/10136RV/2023 (H3N2)-like virus, and influenza B/Austria/1359417/2021 (B/Victoria lineage)-like virus. United States cell culture–based inactivated (ccIIV4) and recombinant (RIV4) influenza vaccines will contain HA derived from an influenza A/Wisconsin/67/2022 (H1N1) pdm09-like virus, an A/District of Columbia/27/2023 (H3N2)-like virus, an influenza B/Austria/1359417/2021 (B/Victoria lineage)-like virus. These vaccine recommendations were based on several factors, including global influenza virologic and epidemiologic surveillance, genetic and antigenic characterization, human serology studies, antiviral susceptibility, and the availability of candidate influenza viruses.

APPENDIX 1: ADDITIONAL INFORMATION

For more information regarding local and national influenza surveillance programs, visit the following sites.

Centers for Disease Control and Prevention	General Influenza National ILI and P&I Data Vaccine Virus Selection CDC Web Tool for Respiratory Viruses
Flu.gov	General Influenza Information
HDOH Flu and Pneumonia	General Influenza Surveillance Avian Influenza Respiratory Virus Dashboard To find out more information or join the sentinel physician program, email the Influenza Surveillance Coordinator
World Health Organization	General Global and Local Influenza Avian Influenza

APPENDIX 2: MMWR WEEK DATES

Please refer to the table below to interpret data presented by MMWR week. Week 40 is considered the traditional start for the flu season for the Northern Hemisphere.

MMWR WEEK	2022	2023	2024	2025	2026
1	1/8/2022	1/7/2023	1/6/2024	1/4/2025	1/10/2026
2	1/15/2022	1/14/2023	1/13/2024	1/11/2025	1/17/2026
3	1/22/2022	1/21/2023	1/20/2024	1/18/2025	1/24/2026
4	1/29/2022	1/28/2023	1/27/2024	1/25/2025	1/31/2026
5	2/5/2022	2/4/2023	2/3/2024	2/1/2025	2/7/2026
6	2/12/2022	2/11/2023	2/10/2024	2/8/2025	2/14/2026
7	2/19/2022	2/18/2023	2/17/2024	2/15/2025	2/21/2026
8	2/26/2022	2/25/2023	2/24/2024	2/22/2025	2/28/2026
9	3/5/2022	3/4/2023	3/2/2024	3/1/2025	3/7/2026
10	3/12/2022	3/11/2023	3/9/2024	3/8/2025	3/14/2026
11	3/19/2022	3/18/2023	3/16/2024	3/15/2025	3/21/2026
12	3/26/2022	3/25/2023	3/23/2024	3/22/2025	3/28/2026
13	4/2/2022	4/1/2023	3/30/2024	3/29/2025	4/4/2026
14	4/9/2022	4/8/2023	4/6/2024	4/5/2025	4/11/2026
15	4/16/2022	4/15/2023	4/13/2024	4/12/2025	4/18/2026
16	4/23/2022	4/22/2023	4/20/2024	4/19/2025	4/25/2026
17	4/30/2022	4/29/2023	4/27/2024	4/26/2025	5/2/2026
18	5/7/2022	5/6/2023	5/4/2024	5/3/2025	5/9/2026
19	5/14/2022	5/13/2023	5/11/2024	5/10/2025	5/16/2026
20	5/21/2022	5/20/2023	5/18/2024	5/17/2025	5/23/2026
21	5/28/2022	5/27/2023	5/25/2024	5/24/2025	5/30/2026
22	6/4/2022	6/3/2023	6/1/2024	5/31/2025	6/6/2026
23	6/11/2022	6/10/2023	6/8/2024	6/7/2025	6/13/2026
24	6/18/2022	6/17/2023	6/15/2024	6/14/2025	6/20/2026
25	6/25/2022	6/24/2023	6/22/2024	6/21/2025	6/27/2026
26	7/2/2022	7/1/2023	6/29/2024	6/28/2025	7/4/2026
27	7/9/2022	7/8/2023	7/6/2024	7/5/2025	7/11/2026
28	7/16/2022	7/15/2023	7/13/2024	7/12/2025	7/18/2026
29	7/23/2022	7/22/2023	7/20/2024	7/19/2025	7/25/2026
30	7/30/2022	7/29/2023	7/27/2024	7/26/2025	8/1/2026
31	8/6/2022	8/5/2023	8/3/2024	8/2/2025	8/8/2026
32	8/13/2022	8/12/2023	8/10/2024	8/9/2025	8/15/2026
33	8/20/2022	8/19/2023	8/17/2024	8/16/2025	8/22/2026
34	8/27/2022	8/26/2023	8/24/2024	8/23/2025	8/29/2026
35	9/3/2022	9/2/2023	8/31/2024	8/30/2025	9/5/2026
36	9/10/2022	9/9/2023	9/7/2024	9/6/2025	9/12/2026
37	9/17/2022	9/16/2023	9/14/2024	9/13/2025	9/19/2026
38	9/24/2022	9/23/2023	9/21/2024	9/20/2025	9/26/2026
39	10/1/2022	9/30/2023	9/28/2024	9/27/2025	10/3/2026
40	10/8/2022	10/7/2023	10/5/2024	10/4/2025	10/10/2026
41	10/15/2022	10/14/2023	10/12/2024	10/11/2025	10/17/2026
42	10/22/2022	10/21/2023	10/19/2024	10/18/2025	10/24/2026
43	10/29/2022	10/28/2023	10/26/2024	10/25/2025	10/31/2026
44	11/5/2022	11/4/2023	11/2/2024	11/1/2025	11/7/2026
45	11/12/2022	11/11/2023	11/9/2024	11/8/2025	11/14/2026
46	11/19/2022	11/18/2023	11/16/2024	11/15/2025	11/21/2026
47	11/26/2022	11/25/2023	11/23/2024	11/22/2025	11/28/2026
48	12/3/2022	12/2/2023	11/30/2024	11/29/2025	12/5/2026
49	12/10/2022	12/9/2023	12/7/2024	12/6/2025	12/12/2026
50	12/17/2022	12/16/2023	12/14/2024	12/13/2025	12/19/2026
51	12/24/2022	12/23/2023	12/21/2024	12/20/2025	12/26/2026
52	12/31/2022	12/30/2023	12/28/2024	12/27/2025	
53				01/03/2026	

HAWAII STATE DEPARTMENT OF HEALTH
DISEASE OUTBREAK CONTROL DIVISION

Influenza/Respiratory Disease Surveillance Report

Morbidity and Mortality Weekly Report (MMWR)[1]

WEEK 10: MARCH 8, 2026– MARCH 14, 2026

OVERVIEW: The Hawaii State Department of Health (HDOH) monitors influenza and other respiratory pathogens, including COVID-19, throughout the state of Hawaii. Influenza surveillance in the state of Hawaii relies upon selected sentinel health practitioners, the State Laboratories Division (SLD), private laboratories, and the Office of Health Status Monitoring (OHSM). For detailed information concerning influenza, please visit the HDOH Disease Outbreak Control Division (HDOH DOCD) website (*here*). **All data and information are conditional and may change as more reports are received.** The data in this report reflects the 2025-2026 influenza season which began the week ending October 4, 2025 (week 40[1] 2025) and will end the week ending on October 3, 2026 (week 39 2026).

REPORT SNAPSHOT FOR WEEK 10

Surveillance for Influenza-like Illness (ILI)		
Metric	*Value*	*Comment*
Outpatient visits related to influenza-like illness (ILI) from ILINet Sentinel Providers	2.8%	Lower than the previous week. Comparable to Hawaii's historical baseline and lower than the national baseline, and lower than the national ILI rate.
Number of ILI clusters reported to HDOH	0	There have been 25 clusters this season.

Laboratory Surveillance		
Percent of all respiratory specimens positive for influenza this week	16.2%	Higher than the previous week. This number means that many, if not all, of the 83.8% who tested negative for influenza had illness from another respiratory etiology.
Percent of all respiratory specimens positive for influenza this season to date	18.3%	

Surveillance for Severe Outcomes		
Pneumonia, influenza and COVID-19 (PIC) mortality rate	3.5%	Comparable to Hawaii's historical baseline, Comparable to the national epidemic threshold and comparable to the NCHS average.
Number of influenza-associated pediatric deaths reported nationwide	115	0 influenza-associated pediatric deaths have been reported from Hawaii this season to date.

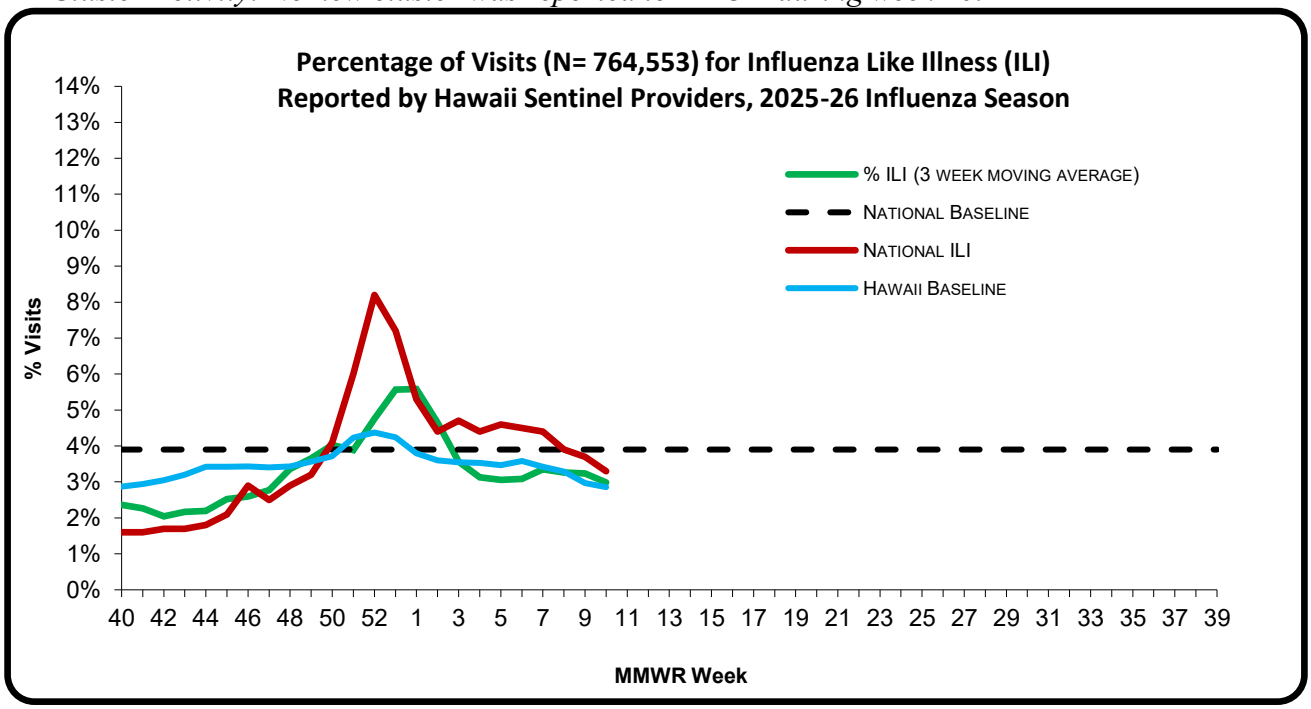
[1] MMWR stands for "Morbidity and Mortality Weekly Report," conventionally used by the Centers for Disease Control and Prevention (CDC). The weeks of a flu season are often referred to by their respective MMWR week. **See appendix 2 for interpretation of MMWR weeks.** Data reported will begin on week 40, the traditional start date of flu season.

INFLUENZA SURVEILLANCE

I. INFLUENZA-LIKE ILLNESS (ILI): HDOH collaborates with recruited doctors and healthcare providers who report the total number of outpatient visits for ILI as well as the total number of patients who complained of symptoms consistent with ILI. A patient with ILI must have the following: a fever (temperature of 100°F [37.8°C] or greater) AND a cough and/or a sore throat. ILI is based on reported symptoms and not laboratory confirmed tests; thus, ILI may represent other respiratory pathogens and not solely influenza. Further, sentinel providers report these numbers on a weekly basis; therefore, data are preliminary and may change depending on additional reporting. In combination with laboratory testing and other surveillance systems, ILI surveillance helps monitor influenza and other respiratory pathogen activity. For more information concerning ILINet and sentinel requirements, please visit the CDC website (*here*).

For **week 10** of the current influenza season:

- ***2.8**% (season to date: **3.3**%) of the outpatient visits recorded by Hawaii sentinel providers were for ILI.*
- *ILI visits were comparable to the historical baseline in Hawaii[2,3] (i.e., inside the 95% confidence interval).*
- *Hawaii's ILI outpatient visits were lower than the national baseline (**3.9%**)[4] (i.e., outside the 95% confidence interval) and lower than the national ILI rate (**3.3%**) (i.e. outside the 95% confidence interval).*
- *ILI activity level: Low[5]*
- *Geographic Spread: Sporadic Activity[6].*
- *ILI Cluster Activity: No new cluster was reported to HDOH during week 10.*



[2] The Hawaii historical baseline (%ILI) is the average of 3-week moving averages over the preceding 3 flu seasons of historical data (2022-2023, 2023-2024 and 2024-2025).
[3] This value is based upon comparison of actual outpatient ILI with the historical baseline, which only captures outpatient ILI. The chart above represents a 3-week moving average and not the actual ILI by week.
[4] The National Baseline is calculated by CDC as the mean percentage of visits for ILI during weeks 21–39 with two standard deviations. Because of large variability in regional ILI, comparison of the national baseline with local ILI may not be appropriate. It is provided in this report because no meaningful regional baselines are available for comparison. The national baseline combines all data reported by states to CDC, including ILI in outpatient, ER, urgent care, and inpatient settings.
[5] There are 10 activity levels classified as minimal (levels 1-3), low (levels 4-5), moderate (levels 6-7), and high (levels 8-10).
[6] The influenza activity reported by state and territorial epidemiologists indicates geographic spread of influenza viruses but does not measure the severity of influenza activity. Sporadic: no clusters reported to HDOH, Local: one or more clusters reported in one county, Regional: clusters reported two to three counties, Widespread: clusters reported in all counties. Hawaii does not report No Activity, as flu circulates year-round in Hawaii.

II. LABORATORY SURVEILLANCE: State Laboratories Division (SLD; the HDOH public health laboratory) and Hawaii's major private laboratories (DLS, CLH) report results of RT-PCR, which can be considered confirmatory (SLD may perform viral culture on select specimens). Specimens meeting priority criteria[7] are forwarded to SLD for sub-typing. Additionally, specimens meeting case definition from requesting sentinel providers are sent directly to SLD for sub-typing. Due to resource constraints, not all submitted specimens undergo sub-typing. Sub-typing at the commercial laboratories is only conducted on a case-by-case basis. The majority of specimens testing positive by rapid antigen testing or RT-PCR at the commercial laboratories do not meet criteria and are not subtyped. For more information on influenza tests and types, please visit the CDC website (*here*).

A. INFLUENZA:

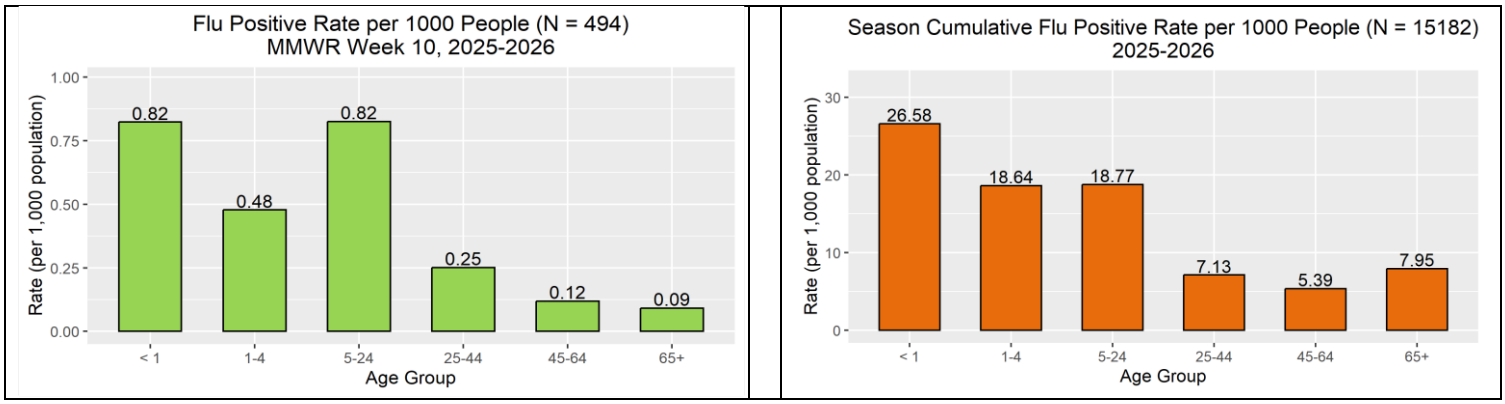
- The following reflects laboratory findings for week 10 of the 2025–26 influenza season:
  - *A total of **3,051** specimens has been tested statewide for influenza viruses (positive: 494 [**16.2%**]). (Season to date: **81,455** tested (**18.3%** positive)*
    - *1,453 (47.6%) were screened only by rapid antigen tests with no confirmatory testing.*
    - *1,598 (52.4%) underwent confirmatory testing (either RT-PCR or viral culture).*
    - *2,557 (83.8%) were negative.*
  - *Routine surveillance samples from State Laboratory Division were tested at a public health laboratory and identified as Influenza A (H3N2) subclade K.*

Influenza type	***Current week 10 (%)****	***Season to date (%)***[8]
Influenza A (H1)[9]	*0 (0.0)*	*116 (0.8)*
Influenza A (H3)	*1 (0.2)*	*1,008 (6.7)*
Influenza A no subtyping	*107 (20.5)*	*11,867 (79.4)*
Influenza B (Yamagata)	*0 (0.0)*	*0 (0.0)*
Influenza B (Victoria)	*0 (0.0)*	*0 (0.0)*
Influenza B no genotyping	*389 (78.3)*	*1,956 (13.1)*

**Specimens that are positive for both A and B (coinfections) are counted in both A and B totals for current and season to date*

1. AGE DISTRIBUTION

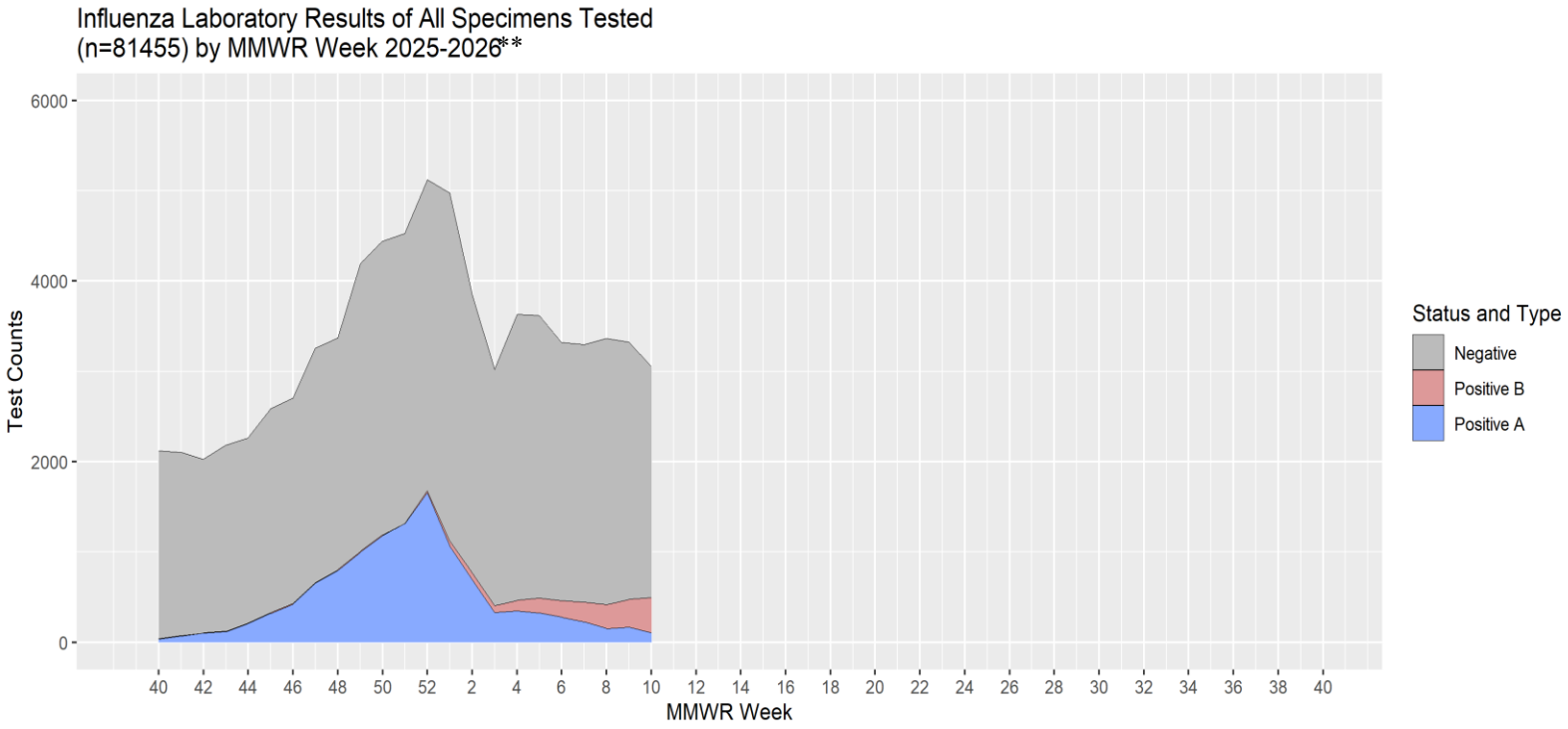
The charts below indicate the population-based rates of positive influenza cases in Hawaii by age group during the 2025–26 influenza season.[10]

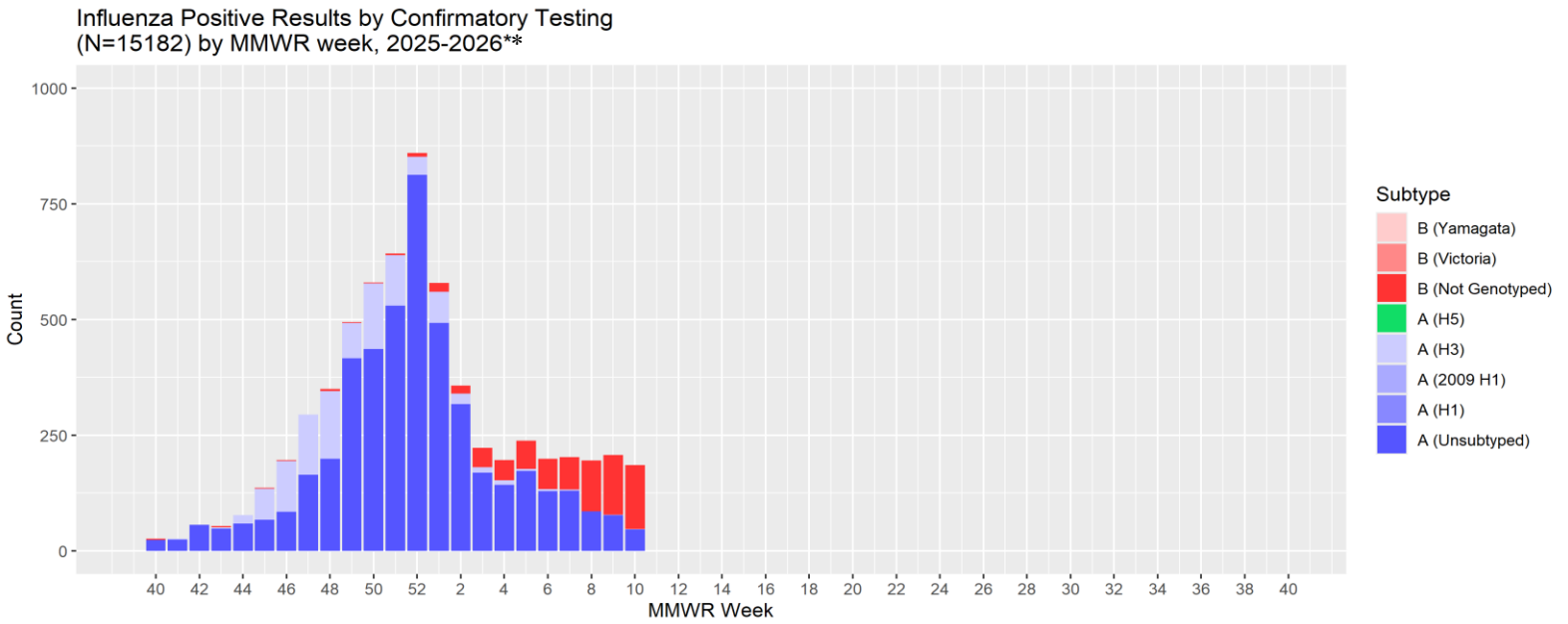


[7] Priority criteria include: hospitalized patients with acute respiratory distress syndrome [ARDS] or x-ray confirmed pneumonia; travelers with international travel history within 10 days of onset; specimens submitted by sentinel providers; specimens collected from healthcare workers, pregnant women, or women up to 6 weeks' post-partum; those with underlying medical conditions; and patients presenting with unusual or severe manifestations of influenza infection.
[8] Influenza coding was updated to reflect a more accurate count.
[9] All influenza A H1 viruses detected this season have been 2009 H1N1.
[10] This represents an estimate of population-based rates based on available data.

2. LABORATORY TESTING

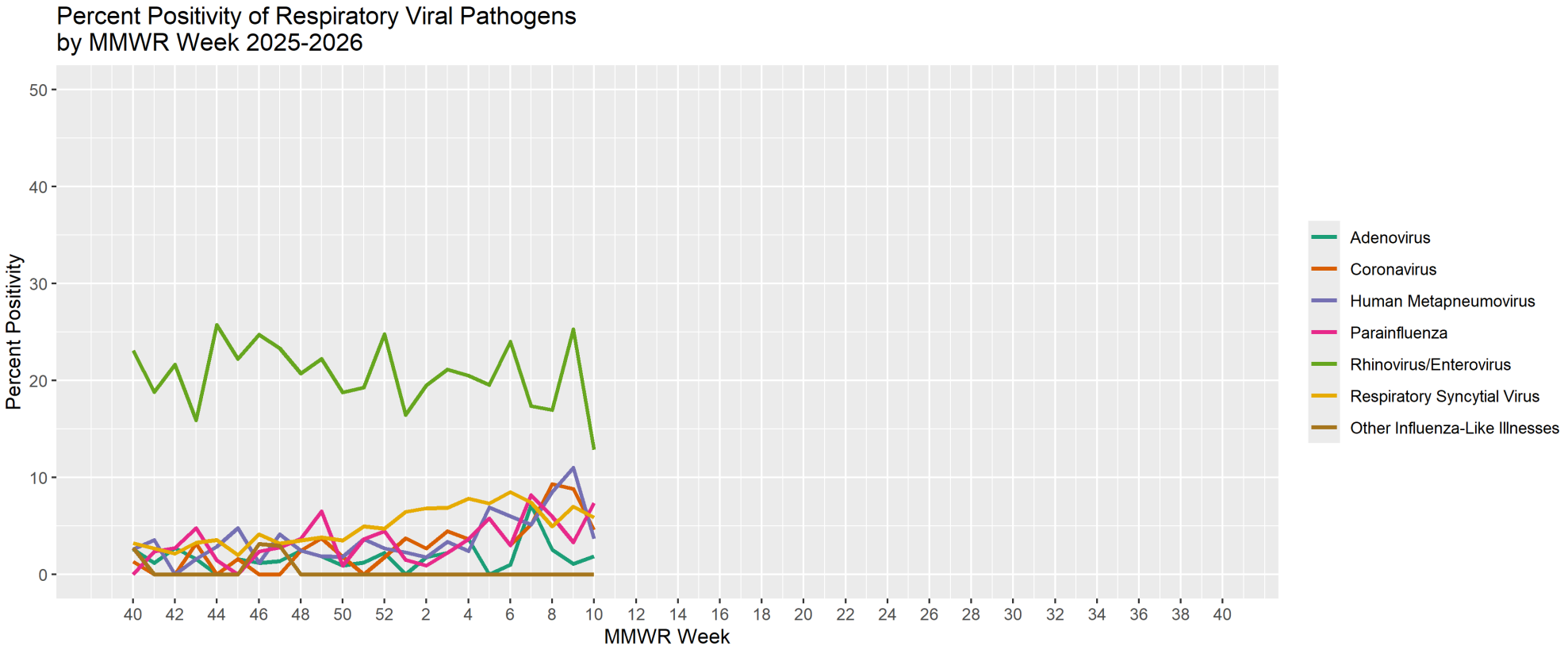
The charts below show the laboratory results of all specimens tested for influenza by MMWR week during the 2025–2026 influenza season as well as the type and subtype of positive results for influenza. Again, sub-typing is only performed on selected specimens tested by confirmatory tests (i.e., RT-PCR or viral culture).





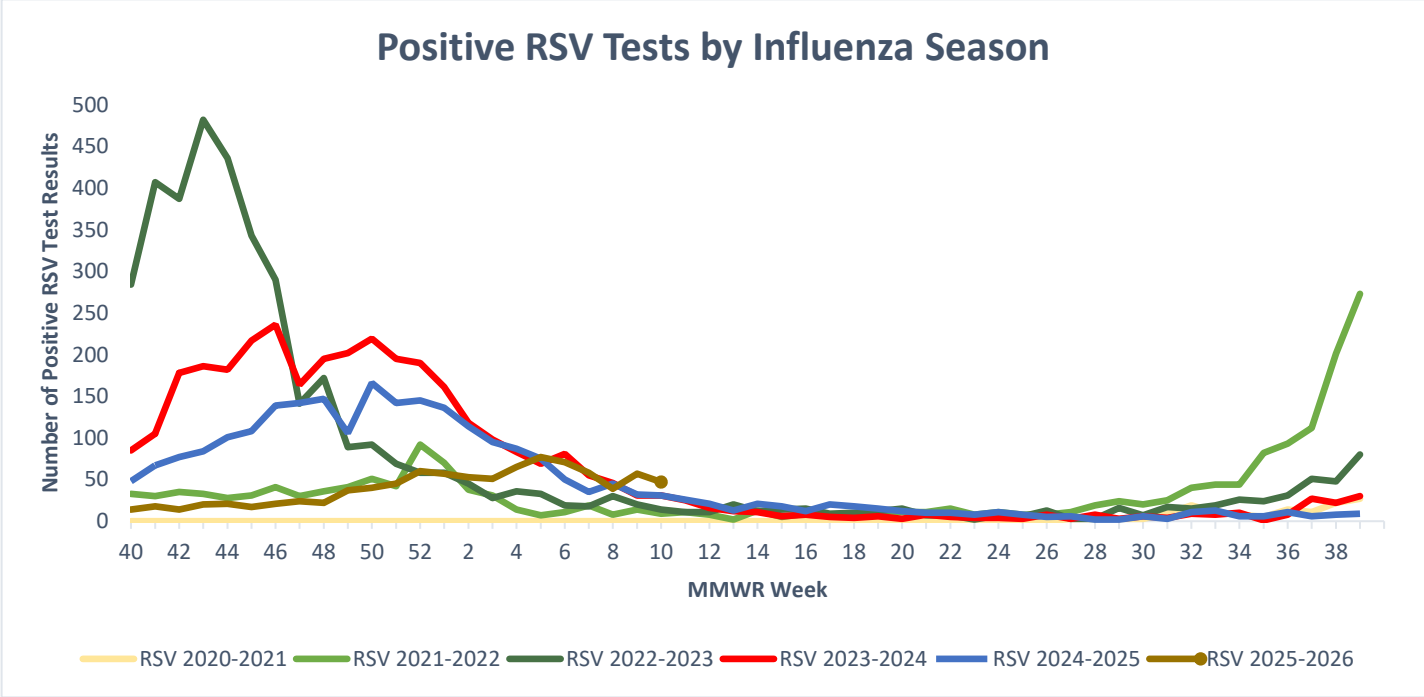
** A total of 45,104 specimens underwent confirmatory testing, but not all positive influenza specimens receive confirmatory testing that are circulating in Hawaii.*
*** For MMWR Week 53, results are reported under MMWR Week 52, where the average of Weeks 52 and 53 was calculated.*

B. **OTHER RESPIRATORY PATHOGENS:** The major clinical and commercial laboratories throughout the state of Hawaii have the testing capacity for non-influenza respiratory pathogens and report these to HDOH. However, such testing is performed as needed and when sufficient resources are available because of the high costs associated with respiratory panel tests. **Therefore, available data represent only the presence of circulating pathogens and cannot be used to determine specific trends**.

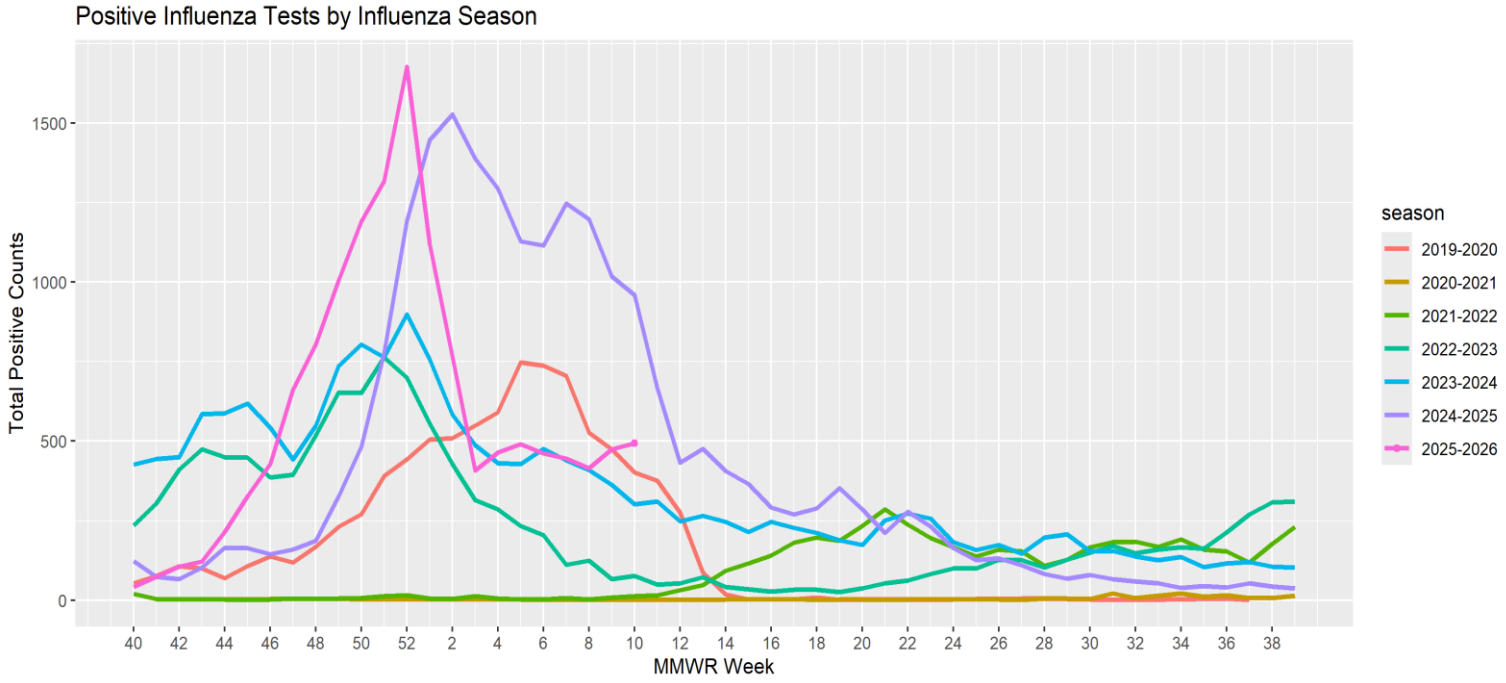


* *The coronavirus presented on this table does not indicate Severe Acute Respiratory Coronavirus-2 (i.e., COVID-19). For MMWR Week 53, results are reported under MMWR Week 52, where the average of Weeks 52 and 53 was calculated*

RESPIRATORY SYNCYTIAL VIRUS (RSV) POSITIVE TEST RESULTS BY INFLUENZA SEASON: RSV case appears to have increased later than past seasons in the 2025-2026 season. For MMWR Week 53, results are reported under MMWR Week 52, where the average of Weeks 52 and 53 was calculated.



INFLUENZA POSITIVE TEST RESULTS BY INFLUENZA SEASON: Influenza cases appear to have increased earlier than past seasons in the 2025-2026 season. For MMWR Week 53, results are reported under MMWR Week 52, where the average of Weeks 52 and 53 was calculated.



C. COVID-19 SENTINEL SURVEILLANCE: Due to the low volume of samples currently available through the influenza surveillance system, the COVID-19 sentinel surveillance data may not be accurately portraying COVID-19 activity in our communities. Reporting of the COVID-19 Sentinel Surveillance data will be paused while HODH re-evaluates the program to ensure that the reported data are accurate and representative.

HDOH is continuing to monitor COVID-19 activity throughout the state. To learn more, please visit the Hawaii's COVID-19 data website (*here*). For more information on surveillance of COVID-19 activity in the United States please visit the CDC COVIDView website (*here*).

III. PNEUMONIA, INFLUENZA, AND COVID-19 (PIC) RELATED MORTALITY:

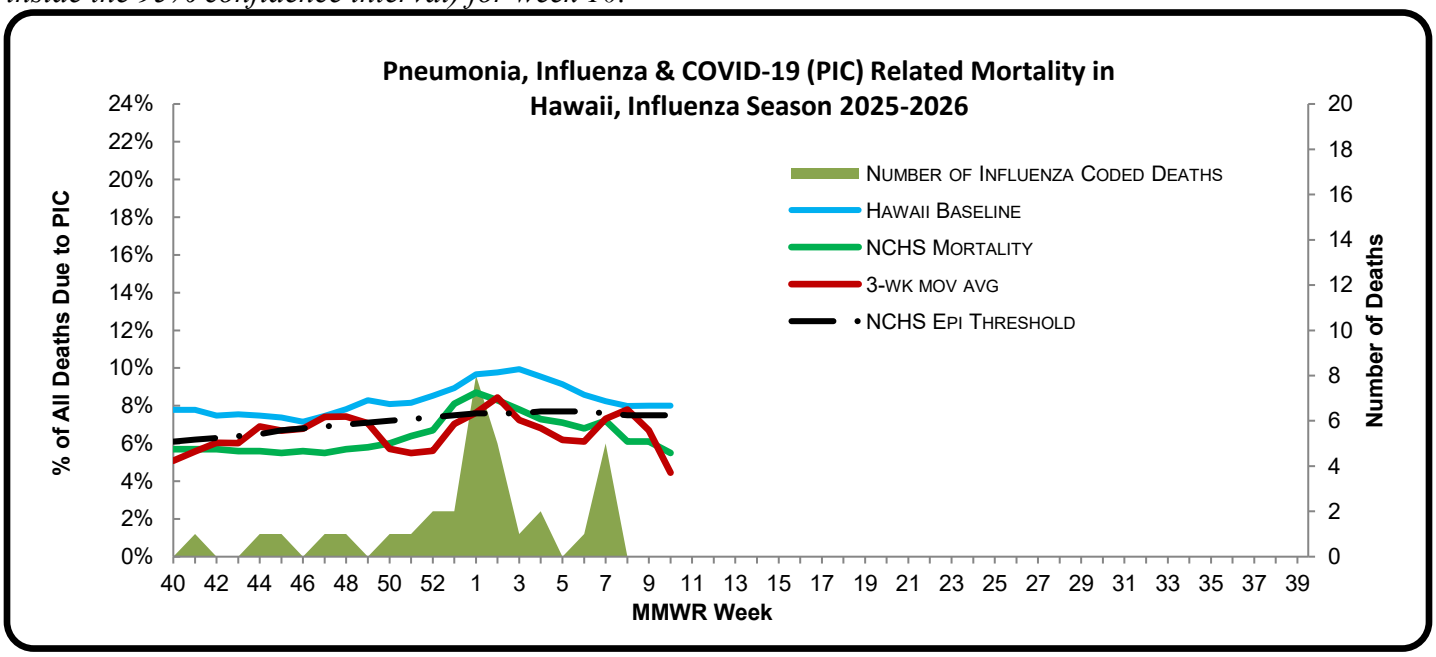
P&I mortality surveillance is collected by CDC through the National Center for Health Statistics (NCHS) using death certificate data. Each week the HDOH OHSM reports specific data from Honolulu to the CDC. CDC collects the following information by age group: the total number of deaths, total deaths from pneumonia, and total deaths related to influenza. Due to the ongoing COVID-19 pandemic, CDC included total deaths from COVID-19 by age group to the death data. Previous studies had suggested that P&I is a good indicator of influenza-related deaths; however, data has shown that pneumonia deaths associated with influenza is now being impacted by COVID-19 related pneumonia. Due to this, CDC had added COVID-19 deaths into P&I to create the PIC (pneumonia, influenza, and/or COVID-19) classification.

To standardize Hawaii's influenza surveillance with CDC influenza surveillance guidelines, PIC deaths will be reported in lieu of P&I. Hawaii's baseline will begin to include PIC deaths starting from 2019-2020 flu season.

For **week 10** of the current influenza season:

- ***3.5%*** *of all deaths that occurred in Hawaii during week 10 were related to pneumonia, influenza or COVID-19 (PIC)*[11]*. For the current season (season to date:* ***6.6%****), there have been 5,488 deaths from any cause, 365 of which were due to PIC*[12]*.*
- *The PIC rate was comparable to the historical baseline in Hawaii*[13] *(i.e., inside the 95% confidence interval).*

The Hawaii PIC rate was comparable to the CDC's National Center for Health Statistics (NCHS) PIC mortality[14] *(****5.5%****) (i.e., inside the 95% confidence interval) and comparable to the national epidemic threshold (****7.5%****) (i.e., inside the 95% confidence interval) for week 10.*



[11] The percent of deaths due to PIC displayed on the graph is the 3-week moving averages.

[12] PIC data reflect 80.2% of the data reported for the MMWR week. Changes to data are expected when PIC data reaches 100% completion.

[13] The Hawaii historical baseline (%PIC) is the average of 3-week moving averages over the preceding 10 flu seasons of historical data (2014-2015, 2015-2016, 2016-2017, 2017-2018, 2018-2019, 2019-2020, 2020-2021, 2021-2022, 2022-2023, and 2023-2024).

[14] Each week, the vital statistics offices of 122 cities across the United States report the total number of death certificates processed and the number of those for which pneumonia, influenza, or COVID-19 was listed as the underlying or contributing cause of death by age group (Under 28 days, 28 days–1 year, 1–14 years, 15–24 years, 25–44 years, 45–64 years, 65–74 years, 75–84 years, and ≥85 years). The COVID-19 death counts reported by NCHS are provisional and will not match counts in other sources, such as media reports or numbers from health departments. COVID-19 deaths may be classified or defined differently in various reporting and surveillance systems. The percentage of deaths due to pneumonia, influenza, and COVID-19 (PIC) are compared with a seasonal baseline and epidemic threshold value calculated for each week.

INFLUENZA-ASSOCIATED PEDIATRIC DEATHS[15]:

- No new influenza-associated pediatric death was reported to Hawaii. There have been zero influenza-associated pediatric deaths reported in Hawaii during the 2025–2026 season.
- Nationally, fourteen new influenza-associated pediatric deaths were reported to CDC during week 10. (2025-2026 season total: 115).

IV. INFLUENZA WATCH: As part of a comprehensive influenza surveillance system and to prevent the spread of contagious respiratory diseases in humans, it is important to monitor all circulating influenza types. Several animal-origin influenza A subtypes are currently of interest: influenza A variant virus (H3N2v, H1N2v, and H1N1v) and Avian flu (H5N1 and H7N9). These types of influenza viruses may cause zoonotic (animal-associated) disease and are a public health concern.

A. VARIANT VIRUSES:

Influenza viruses that normally circulate in pigs are called "variant" viruses when they are found in people. These viruses were first identified in U.S. pigs in 2010. In 2011, 12 cases of H3N2v infection were detected in the United States. In 2012, 309 such cases (resulting in 16 hospitalizations and one death) across 12 states were detected, including one Hawaii case who recovered. Illness associated with H3N2v infection has been mostly mild with symptoms similar to those of seasonal flu. However, serious illness, resulting in hospitalization and death, has occurred in some cases. Most of these infections have been associated with prolonged exposure to pigs at agricultural fairs or similar settings. Limited human-to-human spread of this virus has been detected in the past, but no sustained community spread of H3N2v has been identified. More information regarding H3N2v, H1N1v, and H1N2v viruses may be found on the CDC website (*here*) and (*here*).

- *No variant or novel influenza infections have been reported to HDOH during the 2025-2026 influenza season.*
- *One new human infection with novel influenza A virus, H1N1v (0), H3N2v (0), and H1N2v (1), have been reported during the 2025-2026 influenza season.*
    - *One new human infection with influenza A(H1N1v) virus has been reported to WHO from China during the 2025-2026 influenza season.*

AVIAN (OR BIRD) INFLUENZA: These types of influenza viruses cause zoonotic (animal-associated) disease of public health concern and are therefore monitored globally by the WHO. Most avian influenza viruses do not cause disease in humans and are generally not easily transmissible between person to person, but a few subtypes may cross the species barrier and cause disease in humans. Avian influenza viruses may be of various subtypes, including H5N1, H5N2, H5N8, H7N3, H7N7, H7N8, H7N9, and H9N2. On January 15th, 2016, the USDA and APHIS reported detection of HPAI H7N8 in a commercial turkey flock in Indiana. There have been no associated human infections. This is the first detection of HPAI H7N8 in wild bird surveillance in the United States. More information, the risk assessment and recommendations for HPAI H7N8 can be found (here). The WHO, CDC, and other public health agencies have also been monitoring influenza H7N9, which represents a public health concern because of its high pandemic potential. Although H7N9 has not been detected in the United States, it remains a global concern given continuing epidemics in endemic countries. Since 2013, a total of 1,568 laboratory-confirmed cases of human infection with H7N9 viruses, including at least 613 deaths, have been reported to WHO. More information on H7N9 virus infections can be found (here). For more information regarding avian influenza, please visit the CDC (*here*) or the WHO (*here*) websites. WHO reports total number of cases and deaths related to laboratory-confirmed avian influenza viruses and posts current avian influenza case counts (*here*), which were last updated on **January 22, 2026**.

[15] Influenza-associated deaths are considered pediatric in persons aged less than 18 years. It was made a nationally notifiable condition in October, 2004. All pediatric influenza-associated deaths are laboratory confirmed.

V. INFLUENZA Vaccine: Annual influenza vaccination is recommended for all persons aged 6 months and older and is the most effective way to reduce the risk of getting sick with seasonal flu and spreading it to others. Influenza vaccination can reduce illnesses, visits to the doctor, influenza-related hospitalizations, and missed work and school days. Influenza vaccines become available by the end of October. It takes at least two weeks after vaccination to confer immunity against influenza virus infection. More information regarding influenza vaccination can be found (*here*).

A. Composition of the 2025–2026 Influenza Vaccine:

The composition of the 2025–2026 influenza vaccine has been updated to better match circulating influenza viruses. The Advisory Committee on Immunization Practices (ACIP) has recommended that the 2025-2026 influenza trivalent vaccine contain an influenza A/Victoria/4897/2022 (H1N1) pdm09-like virus, influenza A/Croatia/10136RV/2023 (H3N2)-like virus, and influenza B/Austria/1359417/2021 (B/Victoria lineage)-like virus. United States cell culture–based inactivated (ccIIV4) and recombinant (RIV4) influenza vaccines will contain HA derived from an influenza A/Wisconsin/67/2022 (H1N1) pdm09-like virus, an A/District of Columbia/27/2023 (H3N2)-like virus, an influenza B/Austria/1359417/2021 (B/Victoria lineage)-like virus. These vaccine recommendations were based on several factors, including global influenza virologic and epidemiologic surveillance, genetic and antigenic characterization, human serology studies, antiviral susceptibility, and the availability of candidate influenza viruses.

APPENDIX 1: ADDITIONAL INFORMATION

For more information regarding local and national influenza surveillance programs, visit the following sites.

Centers for Disease Control and Prevention	General Influenza National ILI and P&I Data Vaccine Virus Selection CDC Web Tool for Respiratory Viruses
Flu.gov	General Influenza Information
HDOH Flu and Pneumonia	General Influenza Surveillance Avian Influenza Respiratory Virus Dashboard To find out more information or join the sentinel physician program, email the Influenza Surveillance Coordinator
World Health Organization	General Global and Local Influenza Avian Influenza

APPENDIX 2: MMWR WEEK DATES

Please refer to the table below to interpret data presented by MMWR week. Week 40 is considered the traditional start for the flu season for the Northern Hemisphere.

MMWR WEEK	2022	2023	2024	2025	2026
1	1/8/2022	1/7/2023	1/6/2024	1/4/2025	1/10/2026
2	1/15/2022	1/14/2023	1/13/2024	1/11/2025	1/17/2026
3	1/22/2022	1/21/2023	1/20/2024	1/18/2025	1/24/2026
4	1/29/2022	1/28/2023	1/27/2024	1/25/2025	1/31/2026
5	2/5/2022	2/4/2023	2/3/2024	2/1/2025	2/7/2026
6	2/12/2022	2/11/2023	2/10/2024	2/8/2025	2/14/2026
7	2/19/2022	2/18/2023	2/17/2024	2/15/2025	2/21/2026
8	2/26/2022	2/25/2023	2/24/2024	2/22/2025	2/28/2026
9	3/5/2022	3/4/2023	3/2/2024	3/1/2025	3/7/2026
10	3/12/2022	3/11/2023	3/9/2024	3/8/2025	3/14/2026
11	3/19/2022	3/18/2023	3/16/2024	3/15/2025	3/21/2026
12	3/26/2022	3/25/2023	3/23/2024	3/22/2025	3/28/2026
13	4/2/2022	4/1/2023	3/30/2024	3/29/2025	4/4/2026
14	4/9/2022	4/8/2023	4/6/2024	4/5/2025	4/11/2026
15	4/16/2022	4/15/2023	4/13/2024	4/12/2025	4/18/2026
16	4/23/2022	4/22/2023	4/20/2024	4/19/2025	4/25/2026
17	4/30/2022	4/29/2023	4/27/2024	4/26/2025	5/2/2026
18	5/7/2022	5/6/2023	5/4/2024	5/3/2025	5/9/2026
19	5/14/2022	5/13/2023	5/11/2024	5/10/2025	5/16/2026
20	5/21/2022	5/20/2023	5/18/2024	5/17/2025	5/23/2026
21	5/28/2022	5/27/2023	5/25/2024	5/24/2025	5/30/2026
22	6/4/2022	6/3/2023	6/1/2024	5/31/2025	6/6/2026
23	6/11/2022	6/10/2023	6/8/2024	6/7/2025	6/13/2026
24	6/18/2022	6/17/2023	6/15/2024	6/14/2025	6/20/2026
25	6/25/2022	6/24/2023	6/22/2024	6/21/2025	6/27/2026
26	7/2/2022	7/1/2023	6/29/2024	6/28/2025	7/4/2026
27	7/9/2022	7/8/2023	7/6/2024	7/5/2025	7/11/2026
28	7/16/2022	7/15/2023	7/13/2024	7/12/2025	7/18/2026
29	7/23/2022	7/22/2023	7/20/2024	7/19/2025	7/25/2026
30	7/30/2022	7/29/2023	7/27/2024	7/26/2025	8/1/2026
31	8/6/2022	8/5/2023	8/3/2024	8/2/2025	8/8/2026
32	8/13/2022	8/12/2023	8/10/2024	8/9/2025	8/15/2026
33	8/20/2022	8/19/2023	8/17/2024	8/16/2025	8/22/2026
34	8/27/2022	8/26/2023	8/24/2024	8/23/2025	8/29/2026
35	9/3/2022	9/2/2023	8/31/2024	8/30/2025	9/5/2026
36	9/10/2022	9/9/2023	9/7/2024	9/6/2025	9/12/2026
37	9/17/2022	9/16/2023	9/14/2024	9/13/2025	9/19/2026
38	9/24/2022	9/23/2023	9/21/2024	9/20/2025	9/26/2026
39	10/1/2022	9/30/2023	9/28/2024	9/27/2025	10/3/2026
40	10/8/2022	10/7/2023	10/5/2024	10/4/2025	10/10/2026
41	10/15/2022	10/14/2023	10/12/2024	10/11/2025	10/17/2026
42	10/22/2022	10/21/2023	10/19/2024	10/18/2025	10/24/2026
43	10/29/2022	10/28/2023	10/26/2024	10/25/2025	10/31/2026
44	11/5/2022	11/4/2023	11/2/2024	11/1/2025	11/7/2026
45	11/12/2022	11/11/2023	11/9/2024	11/8/2025	11/14/2026
46	11/19/2022	11/18/2023	11/16/2024	11/15/2025	11/21/2026
47	11/26/2022	11/25/2023	11/23/2024	11/22/2025	11/28/2026
48	12/3/2022	12/2/2023	11/30/2024	11/29/2025	12/5/2026
49	12/10/2022	12/9/2023	12/7/2024	12/6/2025	12/12/2026
50	12/17/2022	12/16/2023	12/14/2024	12/13/2025	12/19/2026
51	12/24/2022	12/23/2023	12/21/2024	12/20/2025	12/26/2026
52	12/31/2022	12/30/2023	12/28/2024	12/27/2025	
53				01/03/2026	

HAWAII STATE DEPARTMENT OF HEALTH
DISEASE OUTBREAK CONTROL DIVISION

Influenza/Respiratory Disease Surveillance Report

Morbidity and Mortality Weekly Report (MMWR)[1]

WEEK 11: MARCH 15, 2026– MARCH 21, 2026

OVERVIEW: The Hawaii State Department of Health (HDOH) monitors influenza and other respiratory pathogens, including COVID-19, throughout the state of Hawaii. Influenza surveillance in the state of Hawaii relies upon selected sentinel health practitioners, the State Laboratories Division (SLD), private laboratories, and the Office of Health Status Monitoring (OHSM). For detailed information concerning influenza, please visit the HDOH Disease Outbreak Control Division (HDOH DOCD) website (*here*). **All data and information are conditional and may change as more reports are received.** The data in this report reflects the 2025-2026 influenza season which began the week ending October 4, 2025 (week 40[1] 2025) and will end the week ending on October 3, 2026 (week 39 2026).

REPORT SNAPSHOT FOR WEEK 11

Surveillance for Influenza-like Illness (ILI)		
Metric	*Value*	*Comment*
Outpatient visits related to influenza-like illness (ILI) from ILINet Sentinel Providers	2.8%	Same as the previous week. Comparable to Hawaii's historical baseline and lower than the national baseline, and comparable to the national ILI rate.
Number of ILI clusters reported to HDOH	0	There have been 25 clusters this season.

Laboratory Surveillance		
Percent of all respiratory specimens positive for influenza this week	16.6%	Higher than the previous week. This number means that many, if not all, of the 83.4% who tested negative for influenza had illness from another respiratory etiology.
Percent of all respiratory specimens positive for influenza this season to date	18.3%	

Surveillance for Severe Outcomes		
Pneumonia, influenza and COVID-19 (PIC) mortality rate	6.0%	Comparable to Hawaii's historical baseline, Comparable to the national epidemic threshold and comparable to the NCHS average.
Number of influenza-associated pediatric deaths reported nationwide	123	0 influenza-associated pediatric deaths have been reported from Hawaii this season to date.

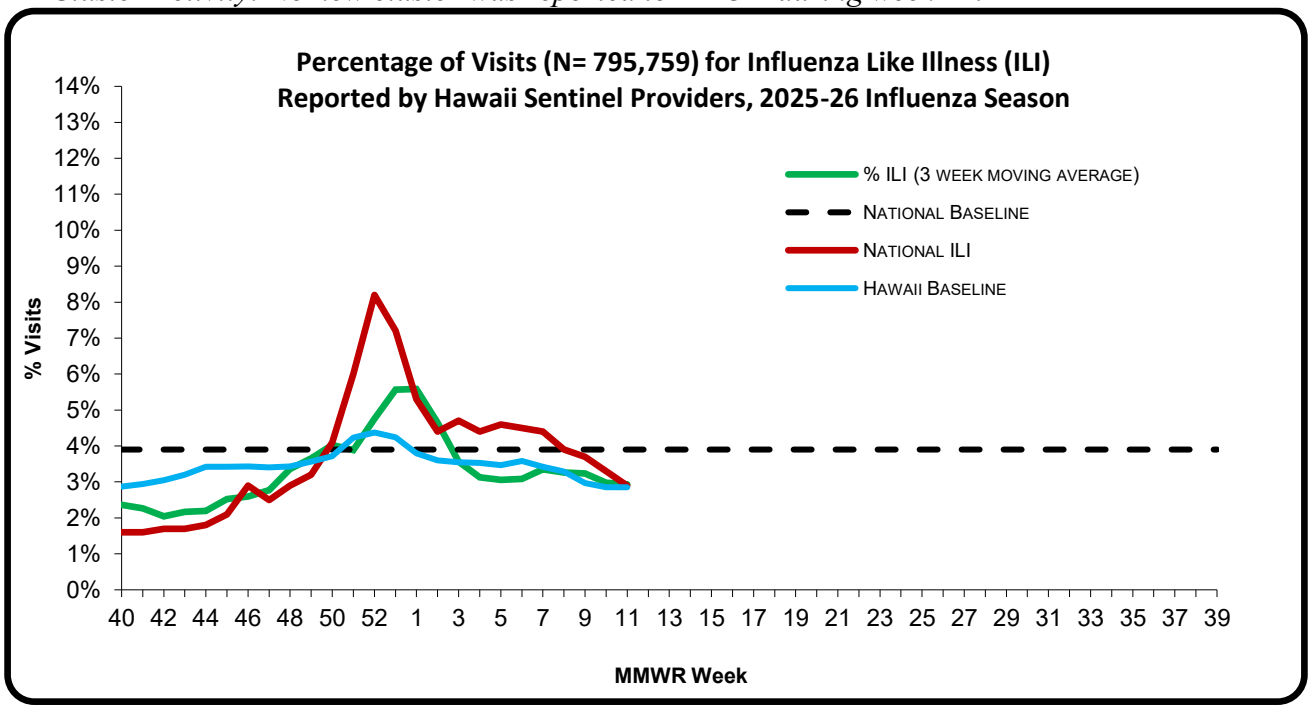
[1] MMWR stands for "Morbidity and Mortality Weekly Report," conventionally used by the Centers for Disease Control and Prevention (CDC). The weeks of a flu season are often referred to by their respective MMWR week. **See appendix 2 for interpretation of MMWR weeks.** Data reported will begin on week 40, the traditional start date of flu season.

INFLUENZA SURVEILLANCE

I. INFLUENZA-LIKE ILLNESS (ILI): HDOH collaborates with recruited doctors and healthcare providers who report the total number of outpatient visits for ILI as well as the total number of patients who complained of symptoms consistent with ILI. A patient with ILI must have the following: a fever (temperature of 100°F [37.8°C] or greater) AND a cough and/or a sore throat. ILI is based on reported symptoms and not laboratory confirmed tests; thus, ILI may represent other respiratory pathogens and not solely influenza. Further, sentinel providers report these numbers on a weekly basis; therefore, data are preliminary and may change depending on additional reporting. In combination with laboratory testing and other surveillance systems, ILI surveillance helps monitor influenza and other respiratory pathogen activity. For more information concerning ILINet and sentinel requirements, please visit the CDC website (*here*).

For **week 11** of the current influenza season:

- ***2.8**% (season to date: **3.3**%) of the outpatient visits recorded by Hawaii sentinel providers were for ILI.*
- *ILI visits were comparable to the historical baseline in Hawaii[2,3] (i.e., inside the 95% confidence interval).*
- *Hawaii's ILI outpatient visits were lower than the national baseline (**3.9%**)[4] (i.e., outside the 95% confidence interval) and comparable to the national ILI rate (**2.9%**) (i.e. inside the 95% confidence interval).*
- *ILI activity level: Low[5]*
- *Geographic Spread: Sporadic Activity[6].*
- *ILI Cluster Activity: No new cluster was reported to HDOH during week 11.*



[2] The Hawaii historical baseline (%ILI) is the average of 3-week moving averages over the preceding 3 flu seasons of historical data (2022-2023, 2023-2024 and 2024-2025).
[3] This value is based upon comparison of actual outpatient ILI with the historical baseline, which only captures outpatient ILI. The chart above represents a 3-week moving average and not the actual ILI by week.
[4] The National Baseline is calculated by CDC as the mean percentage of visits for ILI during weeks 21–39 with two standard deviations. Because of large variability in regional ILI, comparison of the national baseline with local ILI may not be appropriate. It is provided in this report because no meaningful regional baselines are available for comparison. The national baseline combines all data reported by states to CDC, including ILI in outpatient, ER, urgent care, and inpatient settings.
[5] There are 10 activity levels classified as minimal (levels 1-3), low (levels 4-5), moderate (levels 6-7), and high (levels 8-10).
[6] The influenza activity reported by state and territorial epidemiologists indicates geographic spread of influenza viruses but does not measure the severity of influenza activity. Sporadic: no clusters reported to HDOH, Local: one or more clusters reported in one county, Regional: clusters reported two to three counties, Widespread: clusters reported in all counties. Hawaii does not report No Activity, as flu circulates year-round in Hawaii.

II. LABORATORY SURVEILLANCE: State Laboratories Division (SLD; the HDOH public health laboratory) and Hawaii's major private laboratories (DLS, CLH) report results of RT-PCR, which can be considered confirmatory (SLD may perform viral culture on select specimens). Specimens meeting priority criteria[7] are forwarded to SLD for sub-typing. Additionally, specimens meeting case definition from requesting sentinel providers are sent directly to SLD for sub-typing. Due to resource constraints, not all submitted specimens undergo sub-typing. Sub-typing at the commercial laboratories is only conducted on a case-by-case basis. The majority of specimens testing positive by rapid antigen testing or RT-PCR at the commercial laboratories do not meet criteria and are not subtyped. For more information on influenza tests and types, please visit the CDC website (*here*).

A. INFLUENZA:

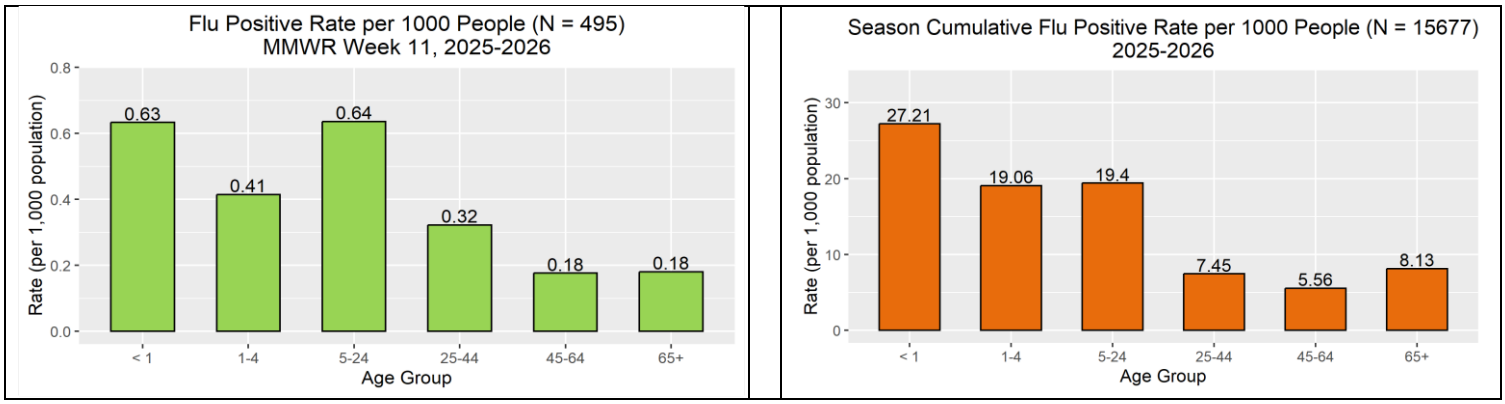
- The following reflects laboratory findings for week 11 of the 2025–26 influenza season:
  - *A total of **2,984** specimens has been tested statewide for influenza viruses (positive: 495 [**16.6%**]). (Season to date: **84,440** tested (**18.3%** positive)*
    - *1,337 (44.8%) were screened only by rapid antigen tests with no confirmatory testing.*
    - *1,647 (55.2%) underwent confirmatory testing (either RT-PCR or viral culture).*
    - *2,489 (83.4%) were negative.*
  - *Routine surveillance samples from State Laboratory Division were tested at a public health laboratory and identified as Influenza A (H3N2) subclade K.*

Influenza type	*Current week 11 (%)**	*Season to date (%)*[8]
Influenza A (H1)[9]	*2 (0.4)*	*118 (0.8)*
Influenza A (H3)	*0 (0.0)*	*1,008 (6.5)*
Influenza A no subtyping	*148 (29.8)*	*12,015 (77.8)*
Influenza B (Yamagata)	*0 (0.0)*	*0 (0.0)*
Influenza B (Victoria)	*0 (0.0)*	*0 (0.0)*
Influenza B no genotyping	*346 (69.7)*	*2,302 (14.9)*

**Specimens that are positive for both A and B (coinfections) are counted in both A and B totals for current and season to date*

1. AGE DISTRIBUTION

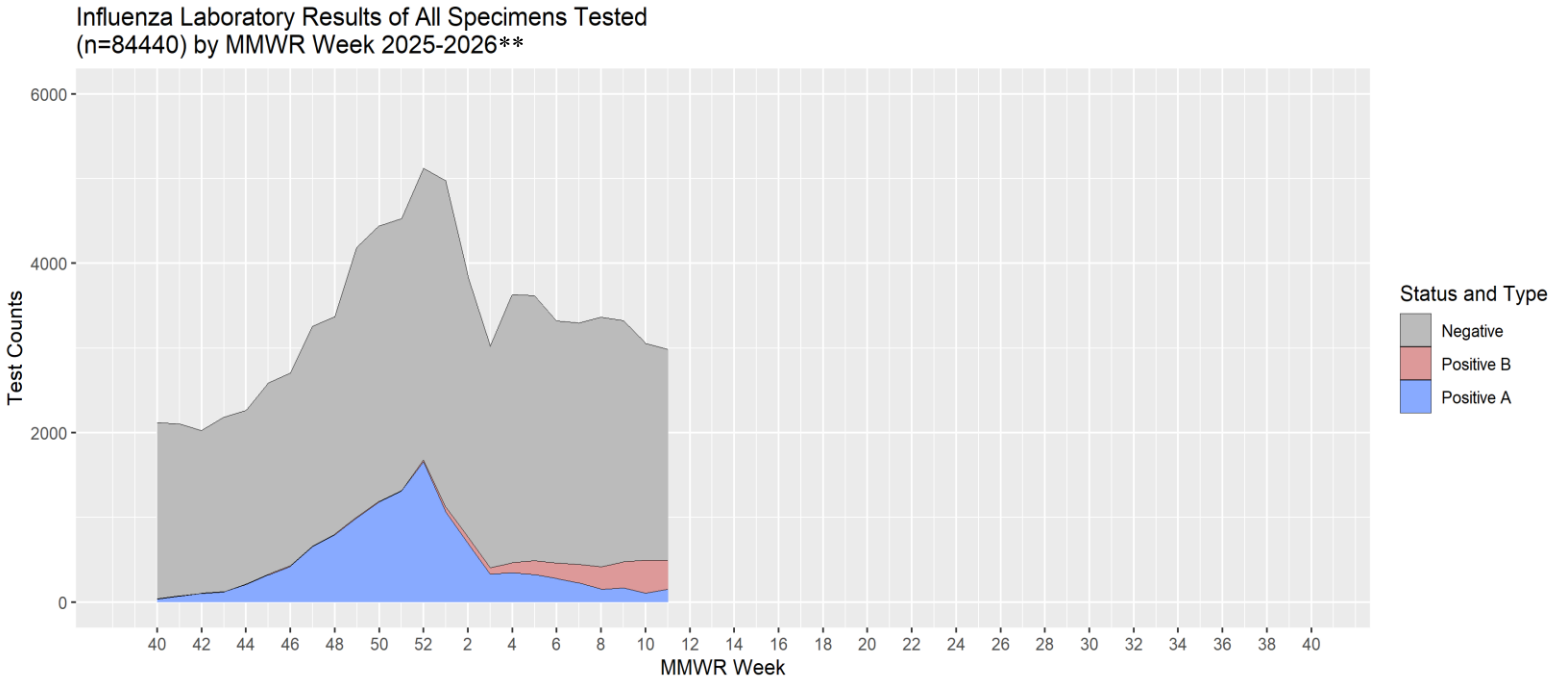
The charts below indicate the population-based rates of positive influenza cases in Hawaii by age group during the 2025–26 influenza season.[10]

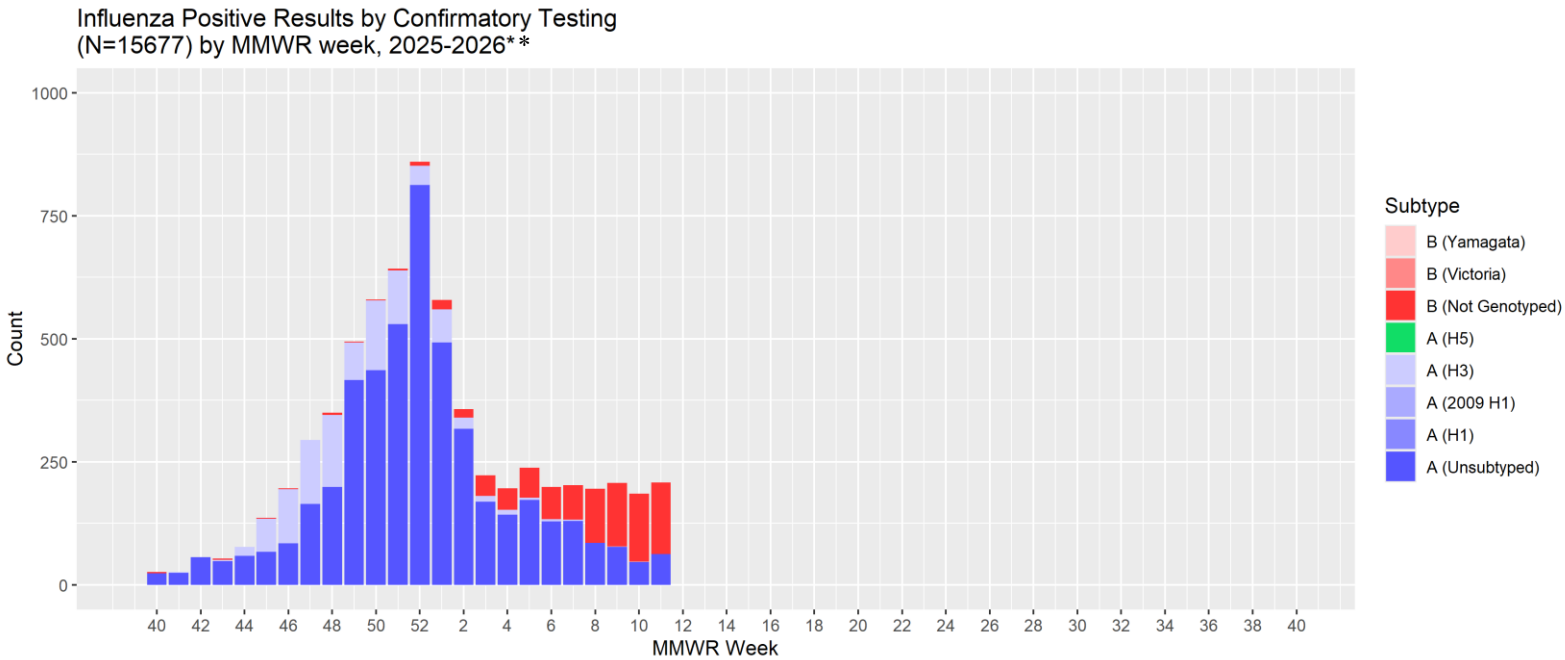


[7] Priority criteria include: hospitalized patients with acute respiratory distress syndrome [ARDS] or x-ray confirmed pneumonia; travelers with international travel history within 10 days of onset; specimens submitted by sentinel providers; specimens collected from healthcare workers, pregnant women, or women up to 6 weeks' post-partum; those with underlying medical conditions; and patients presenting with unusual or severe manifestations of influenza infection.
[8] Influenza coding was updated to reflect a more accurate count.
[9] All influenza A H1 viruses detected this season have been 2009 H1N1.
[10] This represents an estimate of population-based rates based on available data.

2. LABORATORY TESTING

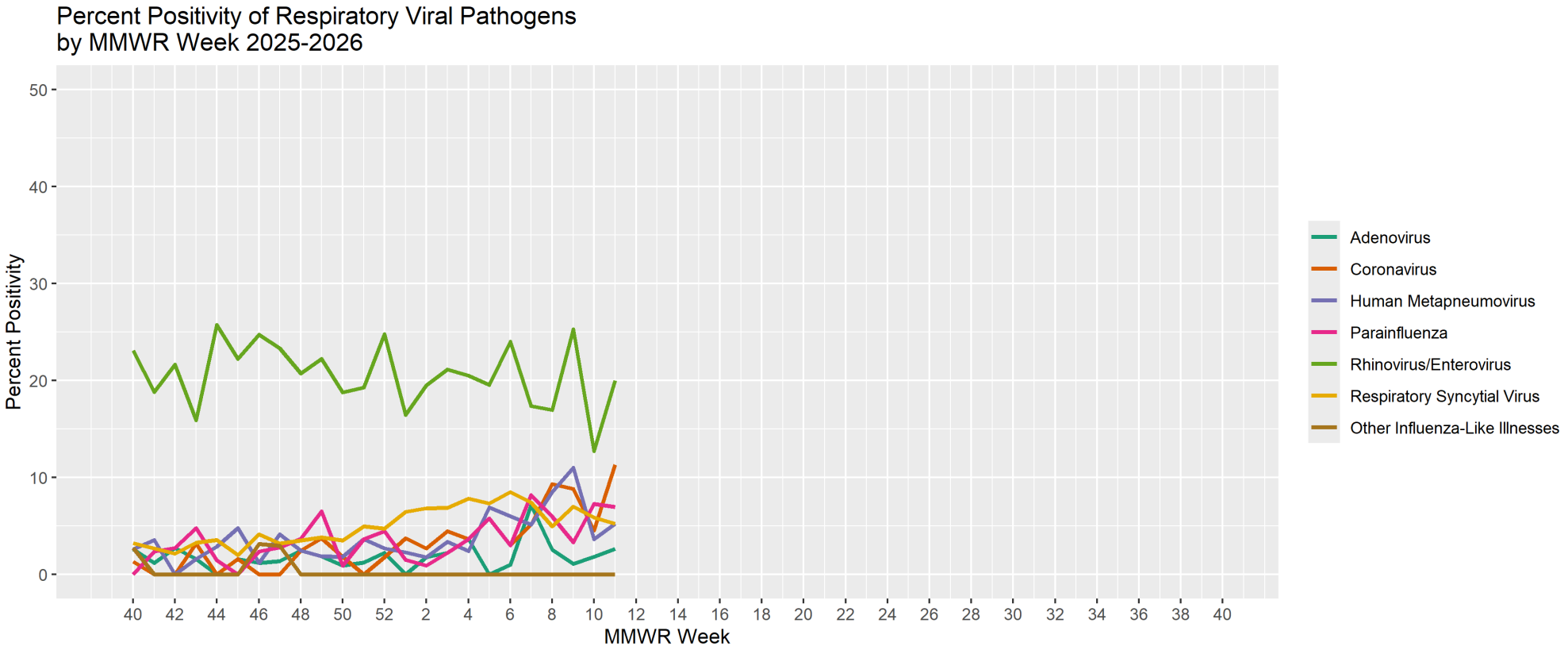
The charts below show the laboratory results of all specimens tested for influenza by MMWR week during the 2025–2026 influenza season as well as the type and subtype of positive results for influenza. Again, sub-typing is only performed on selected specimens tested by confirmatory tests (i.e., RT-PCR or viral culture).





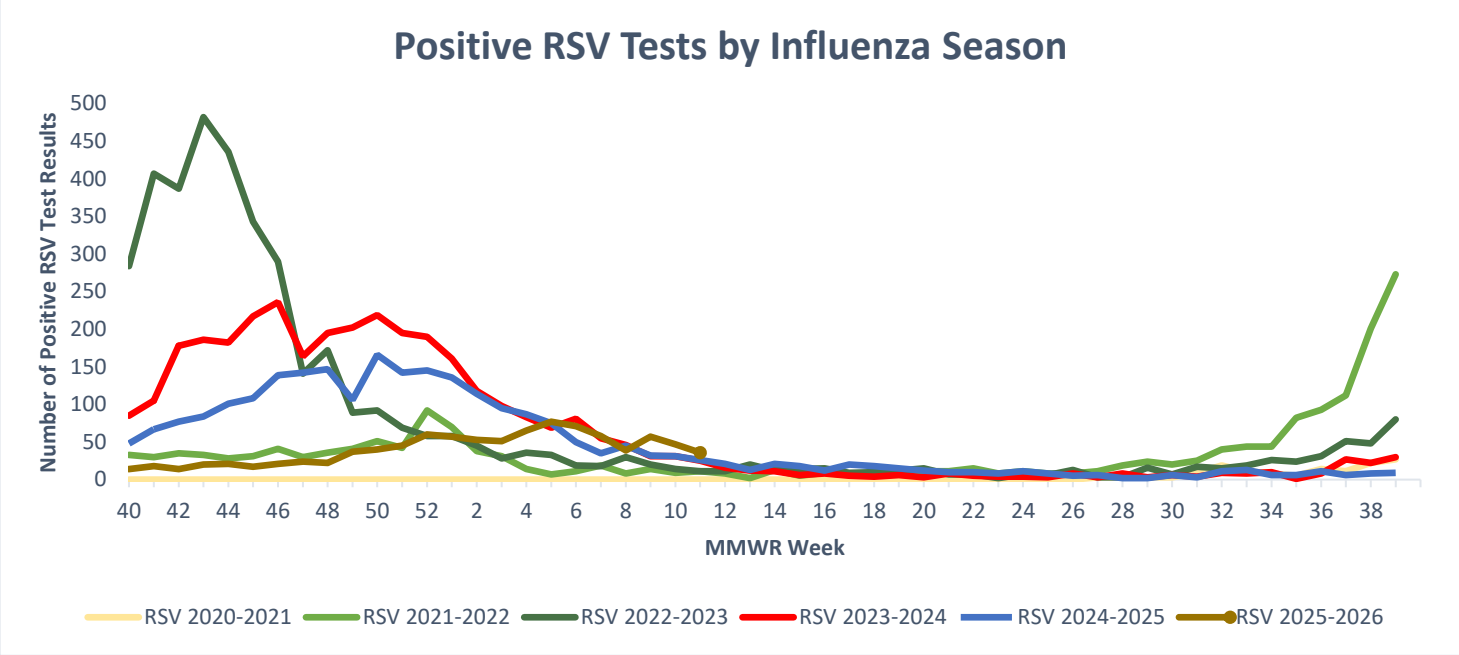
** A total of 46,752 specimens underwent confirmatory testing, but not all positive influenza specimens receive confirmatory testing that are circulating in Hawaii.*
*** For MMWR Week 53, results are reported under MMWR Week 52, where the average of Weeks 52 and 53 was calculated.*

B. **OTHER RESPIRATORY PATHOGENS:** The major clinical and commercial laboratories throughout the state of Hawaii have the testing capacity for non-influenza respiratory pathogens and report these to HDOH. However, such testing is performed as needed and when sufficient resources are available because of the high costs associated with respiratory panel tests. **Therefore, available data represent only the presence of circulating pathogens and cannot be used to determine specific trends**.

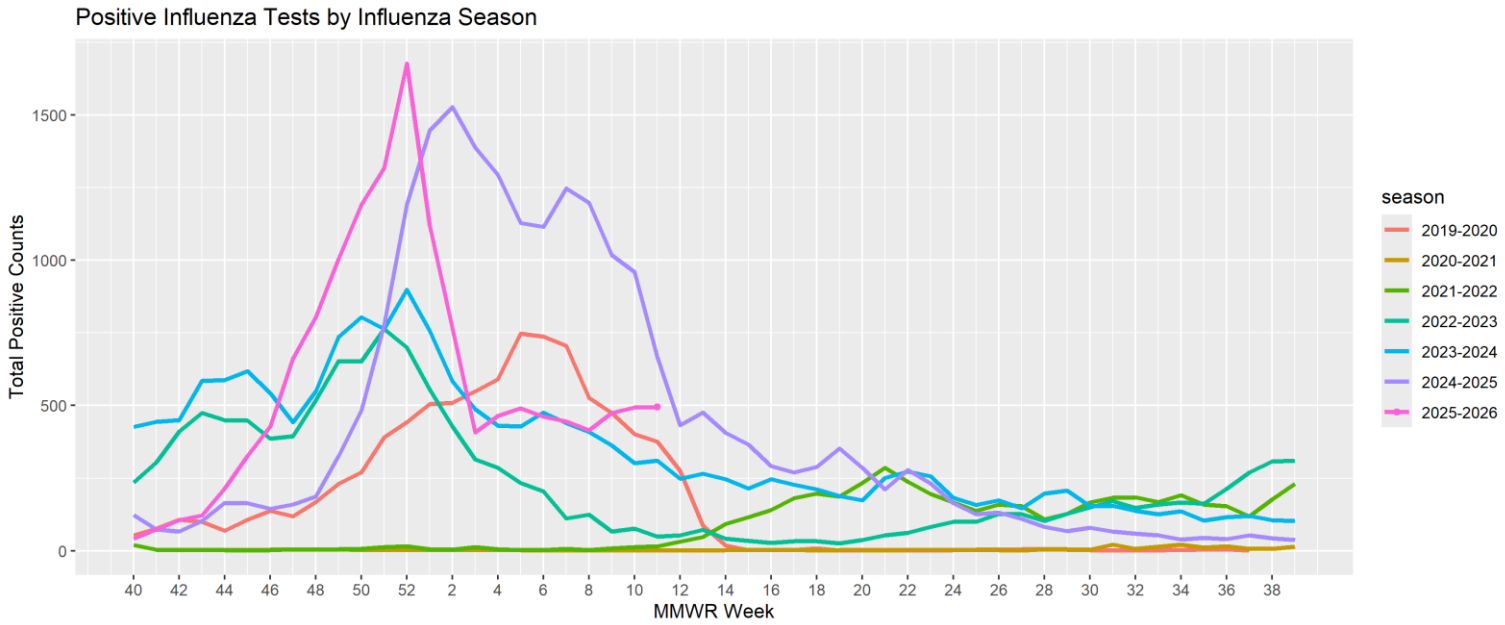


* *The coronavirus presented on this table does not indicate Severe Acute Respiratory Coronavirus-2 (i.e., COVID-19). For MMWR Week 53, results are reported under MMWR Week 52, where the average of Weeks 52 and 53 was calculated*

RESPIRATORY SYNCYTIAL VIRUS (RSV) POSITIVE TEST RESULTS BY INFLUENZA SEASON: RSV case appears to have increased later than past seasons in the 2025-2026 season. For MMWR Week 53, results are reported under MMWR Week 52, where the average of Weeks 52 and 53 was calculated.



INFLUENZA POSITIVE TEST RESULTS BY INFLUENZA SEASON: Influenza cases appear to have increased earlier than past seasons in the 2025-2026 season. For MMWR Week 53, results are reported under MMWR Week 52, where the average of Weeks 52 and 53 was calculated.



C. COVID-19 SENTINEL SURVEILLANCE: Due to the low volume of samples currently available through the influenza surveillance system, the COVID-19 sentinel surveillance data may not be accurately portraying COVID-19 activity in our communities. Reporting of the COVID-19 Sentinel Surveillance data will be paused while HODH re-evaluates the program to ensure that the reported data are accurate and representative.

HDOH is continuing to monitor COVID-19 activity throughout the state. To learn more, please visit the Hawaii's COVID-19 data website (*here*). For more information on surveillance of COVID-19 activity in the United States please visit the CDC COVIDView website (*here*).

III. PNEUMONIA, INFLUENZA, AND COVID-19 (PIC) RELATED MORTALITY:

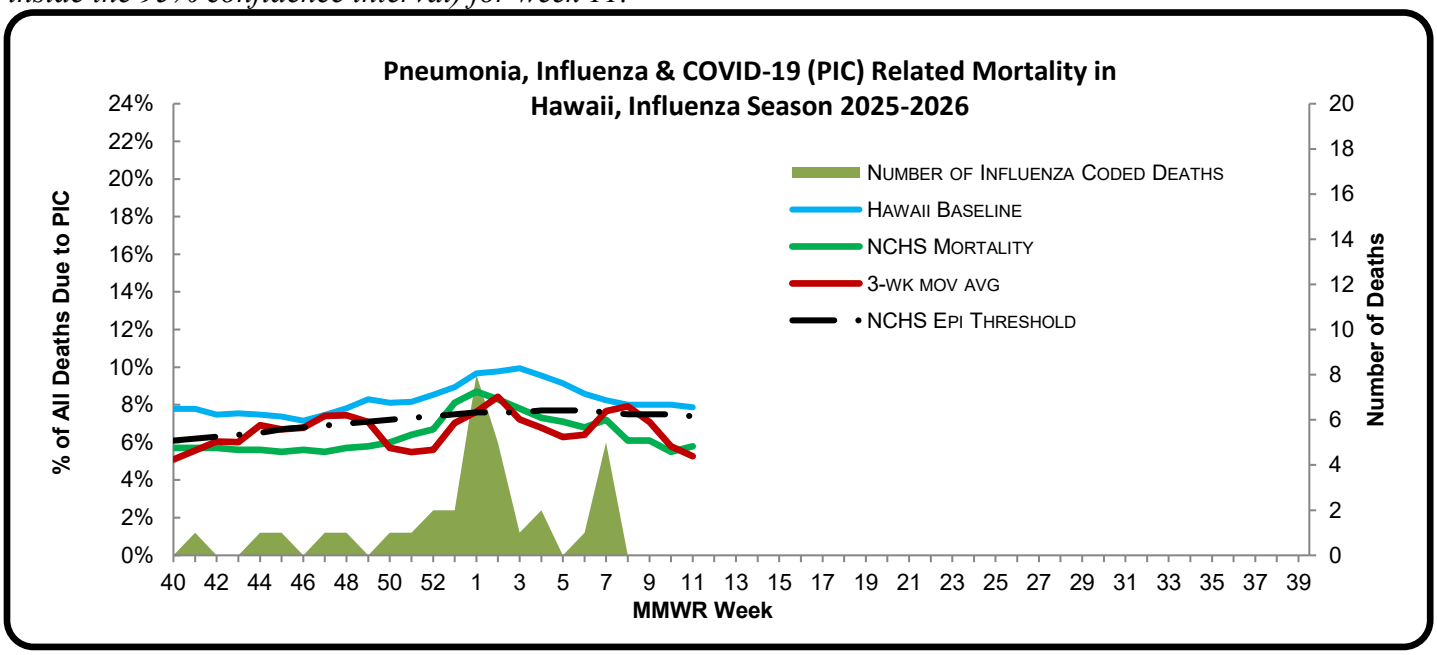
P&I mortality surveillance is collected by CDC through the National Center for Health Statistics (NCHS) using death certificate data. Each week the HDOH OHSM reports specific data from Honolulu to the CDC. CDC collects the following information by age group: the total number of deaths, total deaths from pneumonia, and total deaths related to influenza. Due to the ongoing COVID-19 pandemic, CDC included total deaths from COVID-19 by age group to the death data. Previous studies had suggested that P&I is a good indicator of influenza-related deaths; however, data has shown that pneumonia deaths associated with influenza is now being impacted by COVID-19 related pneumonia. Due to this, CDC had added COVID-19 deaths into P&I to create the PIC (pneumonia, influenza, and/or COVID-19) classification.

To standardize Hawaii's influenza surveillance with CDC influenza surveillance guidelines, PIC deaths will be reported in lieu of P&I. Hawaii's baseline will begin to include PIC deaths starting from 2019-2020 flu season.

For **week 11** of the current influenza season:

- ***6.0%*** *of all deaths that occurred in Hawaii during week 11 were related to pneumonia, influenza or COVID-19 (PIC)[11]. For the current season (season to date:* ***6.7%****), there have been 5,766 deaths from any cause, 387 of which were due to PIC[12].*
- *The PIC rate was comparable to the historical baseline in Hawaii[13] (i.e., inside the 95% confidence interval).*

*The Hawaii PIC rate was comparable to the CDC's National Center for Health Statistics (NCHS) PIC mortality[14] (**5.8%**) (i.e., inside the 95% confidence interval) and comparable to the national epidemic threshold (**7.4%**) (i.e., inside the 95% confidence interval) for week 11.*



[11] The percent of deaths due to PIC displayed on the graph is the 3-week moving averages.

[12] PIC data reflect 95.6% of the data reported for the MMWR week. Changes to data are expected when PIC data reaches 100% completion.

[13] The Hawaii historical baseline (%PIC) is the average of 3-week moving averages over the preceding 10 flu seasons of historical data (2014-2015, 2015-2016, 2016-2017, 2017-2018, 2018-2019, 2019-2020, 2020-2021, 2021-2022, 2022-2023, and 2023-2024).

[14] Each week, the vital statistics offices of 122 cities across the United States report the total number of death certificates processed and the number of those for which pneumonia, influenza, or COVID-19 was listed as the underlying or contributing cause of death by age group (Under 28 days, 28 days–1 year, 1–14 years, 15–24 years, 25–44 years, 45–64 years, 65–74 years, 75–84 years, and ≥85 years). The COVID-19 death counts reported by NCHS are provisional and will not match counts in other sources, such as media reports or numbers from health departments. COVID-19 deaths may be classified or defined differently in various reporting and surveillance systems. The percentage of deaths due to pneumonia, influenza, and COVID-19 (PIC) are compared with a seasonal baseline and epidemic threshold value calculated for each week.

INFLUENZA-ASSOCIATED PEDIATRIC DEATHS[15]:

- No new influenza-associated pediatric death was reported to Hawaii. There have been zero influenza-associated pediatric deaths reported in Hawaii during the 2025–2026 season.
- Nationally, eight new influenza-associated pediatric deaths were reported to CDC during week 11. (2025-2026 season total: 123).

IV. INFLUENZA WATCH: As part of a comprehensive influenza surveillance system and to prevent the spread of contagious respiratory diseases in humans, it is important to monitor all circulating influenza types. Several animal-origin influenza A subtypes are currently of interest: influenza A variant virus (H3N2v, H1N2v, and H1N1v) and Avian flu (H5N1 and H7N9). These types of influenza viruses may cause zoonotic (animal-associated) disease and are a public health concern.

A. VARIANT VIRUSES:

Influenza viruses that normally circulate in pigs are called "variant" viruses when they are found in people. These viruses were first identified in U.S. pigs in 2010. In 2011, 12 cases of H3N2v infection were detected in the United States. In 2012, 309 such cases (resulting in 16 hospitalizations and one death) across 12 states were detected, including one Hawaii case who recovered. Illness associated with H3N2v infection has been mostly mild with symptoms similar to those of seasonal flu. However, serious illness, resulting in hospitalization and death, has occurred in some cases. Most of these infections have been associated with prolonged exposure to pigs at agricultural fairs or similar settings. Limited human-to-human spread of this virus has been detected in the past, but no sustained community spread of H3N2v has been identified. More information regarding H3N2v, H1N1v, and H1N2v viruses may be found on the CDC website (*here*) and (*here*).

- *No variant or novel influenza infections have been reported to HDOH during the 2025-2026 influenza season.*
- *One new human infection with novel influenza A virus, H1N1v (0), H3N2v (0), and H1N2v (1), have been reported during the 2025-2026 influenza season.*
    - *One new human infection with influenza A(H1N1v) virus has been reported to WHO from China during the 2025-2026 influenza season.*

AVIAN (OR BIRD) INFLUENZA: These types of influenza viruses cause zoonotic (animal-associated) disease of public health concern and are therefore monitored globally by the WHO. Most avian influenza viruses do not cause disease in humans and are generally not easily transmissible between person to person, but a few subtypes may cross the species barrier and cause disease in humans. Avian influenza viruses may be of various subtypes, including H5N1, H5N2, H5N8, H7N3, H7N7, H7N8, H7N9, and H9N2. On January 15th, 2016, the USDA and APHIS reported detection of HPAI H7N8 in a commercial turkey flock in Indiana. There have been no associated human infections. This is the first detection of HPAI H7N8 in wild bird surveillance in the United States. More information, the risk assessment and recommendations for HPAI H7N8 can be found (here). The WHO, CDC, and other public health agencies have also been monitoring influenza H7N9, which represents a public health concern because of its high pandemic potential. Although H7N9 has not been detected in the United States, it remains a global concern given continuing epidemics in endemic countries. Since 2013, a total of 1,568 laboratory-confirmed cases of human infection with H7N9 viruses, including at least 613 deaths, have been reported to WHO. More information on H7N9 virus infections can be found (here). For more information regarding avian influenza, please visit the CDC (*here*) or the WHO (*here*) websites. WHO reports total number of cases and deaths related to laboratory-confirmed avian influenza viruses and posts current avian influenza case counts (*here*), which were last updated on **January 22, 2026**.

[15] Influenza-associated deaths are considered pediatric in persons aged less than 18 years. It was made a nationally notifiable condition in October, 2004. All pediatric influenza-associated deaths are laboratory confirmed.

V. INFLUENZA Vaccine: Annual influenza vaccination is recommended for all persons aged 6 months and older and is the most effective way to reduce the risk of getting sick with seasonal flu and spreading it to others. Influenza vaccination can reduce illnesses, visits to the doctor, influenza-related hospitalizations, and missed work and school days. Influenza vaccines become available by the end of October. It takes at least two weeks after vaccination to confer immunity against influenza virus infection. More information regarding influenza vaccination can be found (*here*).

A. Composition of the 2025–2026 Influenza Vaccine**:**

The composition of the 2025–2026 influenza vaccine has been updated to better match circulating influenza viruses. The Advisory Committee on Immunization Practices (ACIP) has recommended that the 2025-2026 influenza trivalent vaccine contain an influenza A/Victoria/4897/2022 (H1N1) pdm09-like virus, influenza A/Croatia/10136RV/2023 (H3N2)-like virus, and influenza B/Austria/1359417/2021 (B/Victoria lineage)-like virus. United States cell culture–based inactivated (ccIIV4) and recombinant (RIV4) influenza vaccines will contain HA derived from an influenza A/Wisconsin/67/2022 (H1N1) pdm09-like virus, an A/District of Columbia/27/2023 (H3N2)-like virus, an influenza B/Austria/1359417/2021 (B/Victoria lineage)-like virus. These vaccine recommendations were based on several factors, including global influenza virologic and epidemiologic surveillance, genetic and antigenic characterization, human serology studies, antiviral susceptibility, and the availability of candidate influenza viruses.

APPENDIX 1: ADDITIONAL INFORMATION

For more information regarding local and national influenza surveillance programs, visit the following sites.

Centers for Disease Control and Prevention	General Influenza National ILI and P&I Data Vaccine Virus Selection CDC Web Tool for Respiratory Viruses
Flu.gov	General Influenza Information
HDOH Flu and Pneumonia	General Influenza Surveillance Avian Influenza Respiratory Virus Dashboard To find out more information or join the sentinel physician program, email the Influenza Surveillance Coordinator
World Health Organization	General Global and Local Influenza Avian Influenza

APPENDIX 2: MMWR WEEK DATES

Please refer to the table below to interpret data presented by MMWR week. Week 40 is considered the traditional start for the flu season for the Northern Hemisphere.

MMWR WEEK	2022	2023	2024	2025	2026
1	1/8/2022	1/7/2023	1/6/2024	1/4/2025	1/10/2026
2	1/15/2022	1/14/2023	1/13/2024	1/11/2025	1/17/2026
3	1/22/2022	1/21/2023	1/20/2024	1/18/2025	1/24/2026
4	1/29/2022	1/28/2023	1/27/2024	1/25/2025	1/31/2026
5	2/5/2022	2/4/2023	2/3/2024	2/1/2025	2/7/2026
6	2/12/2022	2/11/2023	2/10/2024	2/8/2025	2/14/2026
7	2/19/2022	2/18/2023	2/17/2024	2/15/2025	2/21/2026
8	2/26/2022	2/25/2023	2/24/2024	2/22/2025	2/28/2026
9	3/5/2022	3/4/2023	3/2/2024	3/1/2025	3/7/2026
10	3/12/2022	3/11/2023	3/9/2024	3/8/2025	3/14/2026
11	3/19/2022	3/18/2023	3/16/2024	3/15/2025	3/21/2026
12	3/26/2022	3/25/2023	3/23/2024	3/22/2025	3/28/2026
13	4/2/2022	4/1/2023	3/30/2024	3/29/2025	4/4/2026
14	4/9/2022	4/8/2023	4/6/2024	4/5/2025	4/11/2026
15	4/16/2022	4/15/2023	4/13/2024	4/12/2025	4/18/2026
16	4/23/2022	4/22/2023	4/20/2024	4/19/2025	4/25/2026
17	4/30/2022	4/29/2023	4/27/2024	4/26/2025	5/2/2026
18	5/7/2022	5/6/2023	5/4/2024	5/3/2025	5/9/2026
19	5/14/2022	5/13/2023	5/11/2024	5/10/2025	5/16/2026
20	5/21/2022	5/20/2023	5/18/2024	5/17/2025	5/23/2026
21	5/28/2022	5/27/2023	5/25/2024	5/24/2025	5/30/2026
22	6/4/2022	6/3/2023	6/1/2024	5/31/2025	6/6/2026
23	6/11/2022	6/10/2023	6/8/2024	6/7/2025	6/13/2026
24	6/18/2022	6/17/2023	6/15/2024	6/14/2025	6/20/2026
25	6/25/2022	6/24/2023	6/22/2024	6/21/2025	6/27/2026
26	7/2/2022	7/1/2023	6/29/2024	6/28/2025	7/4/2026
27	7/9/2022	7/8/2023	7/6/2024	7/5/2025	7/11/2026
28	7/16/2022	7/15/2023	7/13/2024	7/12/2025	7/18/2026
29	7/23/2022	7/22/2023	7/20/2024	7/19/2025	7/25/2026
30	7/30/2022	7/29/2023	7/27/2024	7/26/2025	8/1/2026
31	8/6/2022	8/5/2023	8/3/2024	8/2/2025	8/8/2026
32	8/13/2022	8/12/2023	8/10/2024	8/9/2025	8/15/2026
33	8/20/2022	8/19/2023	8/17/2024	8/16/2025	8/22/2026
34	8/27/2022	8/26/2023	8/24/2024	8/23/2025	8/29/2026
35	9/3/2022	9/2/2023	8/31/2024	8/30/2025	9/5/2026
36	9/10/2022	9/9/2023	9/7/2024	9/6/2025	9/12/2026
37	9/17/2022	9/16/2023	9/14/2024	9/13/2025	9/19/2026
38	9/24/2022	9/23/2023	9/21/2024	9/20/2025	9/26/2026
39	10/1/2022	9/30/2023	9/28/2024	9/27/2025	10/3/2026
40	10/8/2022	10/7/2023	10/5/2024	10/4/2025	10/10/2026
41	10/15/2022	10/14/2023	10/12/2024	10/11/2025	10/17/2026
42	10/22/2022	10/21/2023	10/19/2024	10/18/2025	10/24/2026
43	10/29/2022	10/28/2023	10/26/2024	10/25/2025	10/31/2026
44	11/5/2022	11/4/2023	11/2/2024	11/1/2025	11/7/2026
45	11/12/2022	11/11/2023	11/9/2024	11/8/2025	11/14/2026
46	11/19/2022	11/18/2023	11/16/2024	11/15/2025	11/21/2026
47	11/26/2022	11/25/2023	11/23/2024	11/22/2025	11/28/2026
48	12/3/2022	12/2/2023	11/30/2024	11/29/2025	12/5/2026
49	12/10/2022	12/9/2023	12/7/2024	12/6/2025	12/12/2026
50	12/17/2022	12/16/2023	12/14/2024	12/13/2025	12/19/2026
51	12/24/2022	12/23/2023	12/21/2024	12/20/2025	12/26/2026
52	12/31/2022	12/30/2023	12/28/2024	12/27/2025	
53				01/03/2026	

HAWAII STATE DEPARTMENT OF HEALTH
DISEASE OUTBREAK CONTROL DIVISION

Influenza/Respiratory Disease Surveillance Report

Morbidity and Mortality Weekly Report (MMWR)[1]

WEEK 12: MARCH 22, 2026– MARCH 28, 2026

OVERVIEW: The Hawaii State Department of Health (HDOH) monitors influenza and other respiratory pathogens, including COVID-19, throughout the state of Hawaii. Influenza surveillance in the state of Hawaii relies upon selected sentinel health practitioners, the State Laboratories Division (SLD), private laboratories, and the Office of Health Status Monitoring (OHSM). For detailed information concerning influenza, please visit the HDOH Disease Outbreak Control Division (HDOH DOCD) website (*here*). **All data and information are conditional and may change as more reports are received.** The data in this report reflects the 2025-2026 influenza season which began the week ending October 4, 2025 (week 40[1] 2025) and will end the week ending on October 3, 2026 (week 39 2026).

REPORT SNAPSHOT FOR WEEK 12

Surveillance for Influenza-like Illness (ILI)		
Metric	*Value*	*Comment*
Outpatient visits related to influenza-like illness (ILI) from ILINet Sentinel Providers	3.4%	Higher than the previous week. Higher than Hawaii's historical baseline and lower than the national baseline, and higher than the national ILI rate.
Number of ILI clusters reported to HDOH	0	There have been 25 clusters this season.

Laboratory Surveillance		
Percent of all respiratory specimens positive for influenza this week	16.8%	Higher than the previous week. This number means that many, if not all, of the 83.2% who tested negative for influenza had illness from another respiratory etiology.
Percent of all respiratory specimens positive for influenza this season to date	18.2%	

Surveillance for Severe Outcomes		
Pneumonia, influenza and COVID-19 (PIC) mortality rate	6.7%	Comparable to Hawaii's historical baseline, Comparable to the national epidemic threshold and comparable to the NCHS average.
Number of influenza-associated pediatric deaths reported nationwide	127	0 influenza-associated pediatric deaths have been reported from Hawaii this season to date.

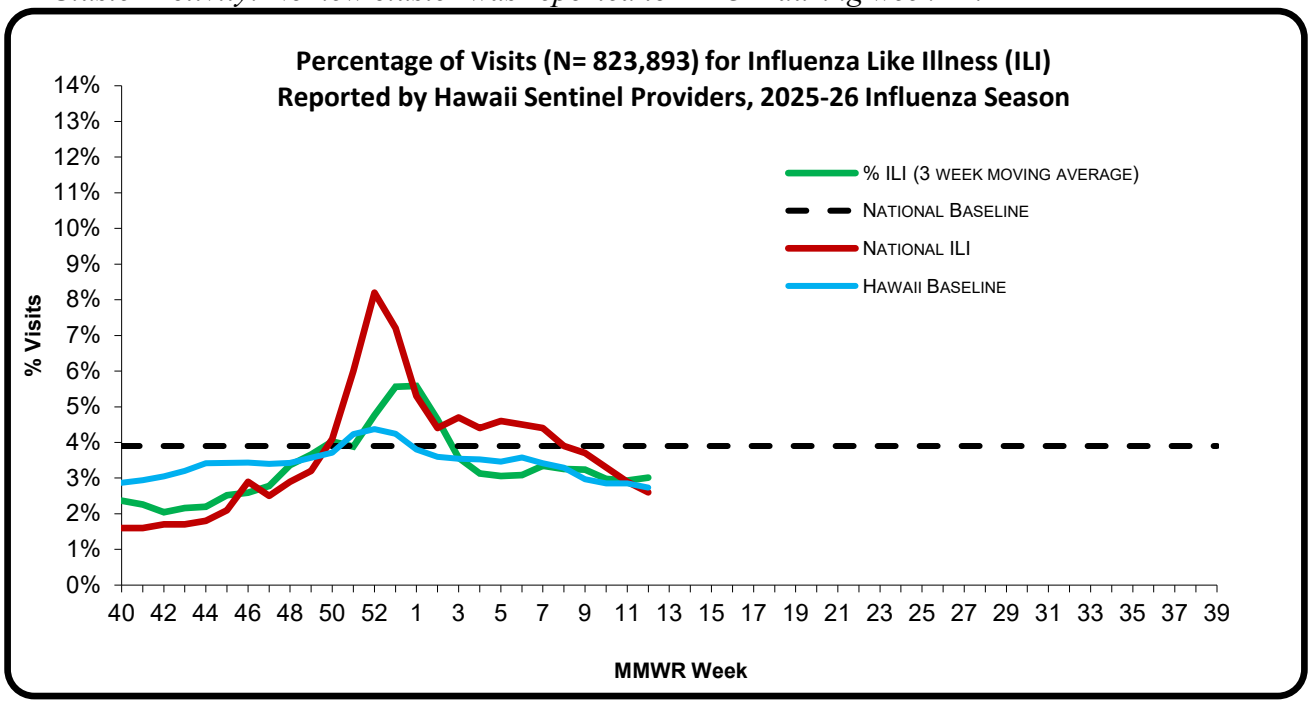
[1] MMWR stands for "Morbidity and Mortality Weekly Report," conventionally used by the Centers for Disease Control and Prevention (CDC). The weeks of a flu season are often referred to by their respective MMWR week. **See appendix 2 for interpretation of MMWR weeks.** Data reported will begin on week 40, the traditional start date of flu season.

INFLUENZA SURVEILLANCE

I. INFLUENZA-LIKE ILLNESS (ILI): HDOH collaborates with recruited doctors and healthcare providers who report the total number of outpatient visits for ILI as well as the total number of patients who complained of symptoms consistent with ILI. A patient with ILI must have the following: a fever (temperature of 100°F [37.8°C] or greater) AND a cough and/or a sore throat. ILI is based on reported symptoms and not laboratory confirmed tests; thus, ILI may represent other respiratory pathogens and not solely influenza. Further, sentinel providers report these numbers on a weekly basis; therefore, data are preliminary and may change depending on additional reporting. In combination with laboratory testing and other surveillance systems, ILI surveillance helps monitor influenza and other respiratory pathogen activity. For more information concerning ILINet and sentinel requirements, please visit the CDC website (*here*).

For **week 12** of the current influenza season:

- ***3.4%** (season to date: **3.3%**) of the outpatient visits recorded by Hawaii sentinel providers were for ILI.*
- *ILI visits were higher than the historical baseline in Hawaii[2,3] (i.e., outside the 95% confidence interval).*
- *Hawaii's ILI outpatient visits were lower than the national baseline (**3.9%**)[4] (i.e., outside the 95% confidence interval) and higher than the national ILI rate (**2.6%**) (i.e. outside the 95% confidence interval).*
- *ILI activity level: Low[5]*
- *Geographic Spread: Sporadic Activity[6].*
- *ILI Cluster Activity: No new cluster was reported to HDOH during week 12.*



[2] The Hawaii historical baseline (%ILI) is the average of 3-week moving averages over the preceding 3 flu seasons of historical data (2022-2023, 2023-2024 and 2024-2025).
[3] This value is based upon comparison of actual outpatient ILI with the historical baseline, which only captures outpatient ILI. The chart above represents a 3-week moving average and not the actual ILI by week.
[4] The National Baseline is calculated by CDC as the mean percentage of visits for ILI during weeks 21–39 with two standard deviations. Because of large variability in regional ILI, comparison of the national baseline with local ILI may not be appropriate. It is provided in this report because no meaningful regional baselines are available for comparison. The national baseline combines all data reported by states to CDC, including ILI in outpatient, ER, urgent care, and inpatient settings.
[5] There are 10 activity levels classified as minimal (levels 1-3), low (levels 4-5), moderate (levels 6-7), and high (levels 8-10).
[6] The influenza activity reported by state and territorial epidemiologists indicates geographic spread of influenza viruses but does not measure the severity of influenza activity. Sporadic: no clusters reported to HDOH, Local: one or more clusters reported in one county, Regional: clusters reported two to three counties, Widespread: clusters reported in all counties. Hawaii does not report No Activity, as flu circulates year-round in Hawaii.

II. LABORATORY SURVEILLANCE: State Laboratories Division (SLD; the HDOH public health laboratory) and Hawaii's major private laboratories (DLS, CLH) report results of RT-PCR, which can be considered confirmatory (SLD may perform viral culture on select specimens). Specimens meeting priority criteria[7] are forwarded to SLD for sub-typing. Additionally, specimens meeting case definition from requesting sentinel providers are sent directly to SLD for sub-typing. Due to resource constraints, not all submitted specimens undergo sub-typing. Sub-typing at the commercial laboratories is only conducted on a case-by-case basis. The majority of specimens testing positive by rapid antigen testing or RT-PCR at the commercial laboratories do not meet criteria and are not subtyped. For more information on influenza tests and types, please visit the CDC website (*here*).

A. INFLUENZA:

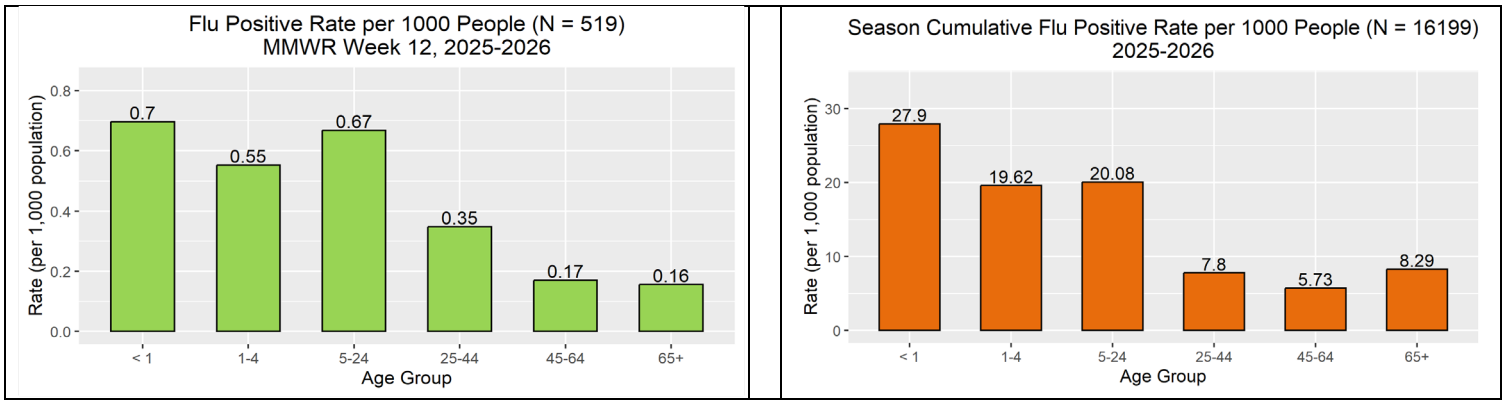
- The following reflects laboratory findings for week 12 of the 2025–26 influenza season:
  - *A total of **3,091** specimens has been tested statewide for influenza viruses (positive: 519 [**16.8%**]). (Season to date: **87,535** tested (**18.2%** positive)*
    - *1,446 (46.8%) were screened only by rapid antigen tests with no confirmatory testing.*
    - *1,645 (53.2%) underwent confirmatory testing (either RT-PCR or viral culture).*
    - *2,572 (83.2%) were negative.*
  - *Routine surveillance samples from State Laboratory Division were tested at a public health laboratory and identified as Influenza A (H3N2) subclade K.*

Influenza type	***Current week 12 (%)****	***Season to date (%)***[8]
Influenza A (H1)[9]	*0 (0.0)*	*118 (0.7)*
Influenza A (H3)	*1 (0.2)*	*1,009 (6.3)*
Influenza A no subtyping	*117 (22.5)*	*12,133 (76.0)*
Influenza B (Yamagata)	*0 (0.0)*	*0 (0.0)*
Influenza B (Victoria)	*0 (0.0)*	*0 (0.0)*
Influenza B no genotyping	*401 (77.3)*	*2,705 (16.9)*

**Specimens that are positive for both A and B (coinfections) are counted in both A and B totals for current and season to date*

1. AGE DISTRIBUTION

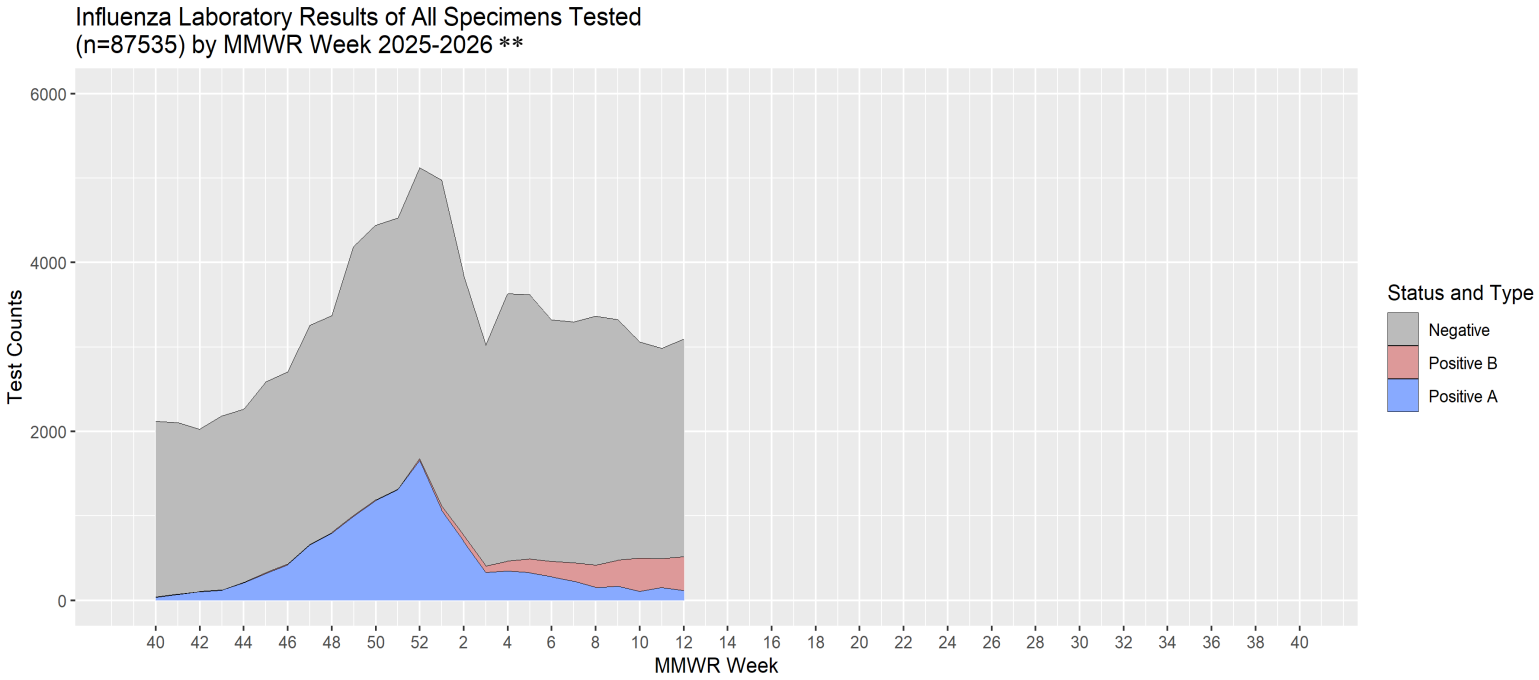
The charts below indicate the population-based rates of positive influenza cases in Hawaii by age group during the 2025–26 influenza season.[10]

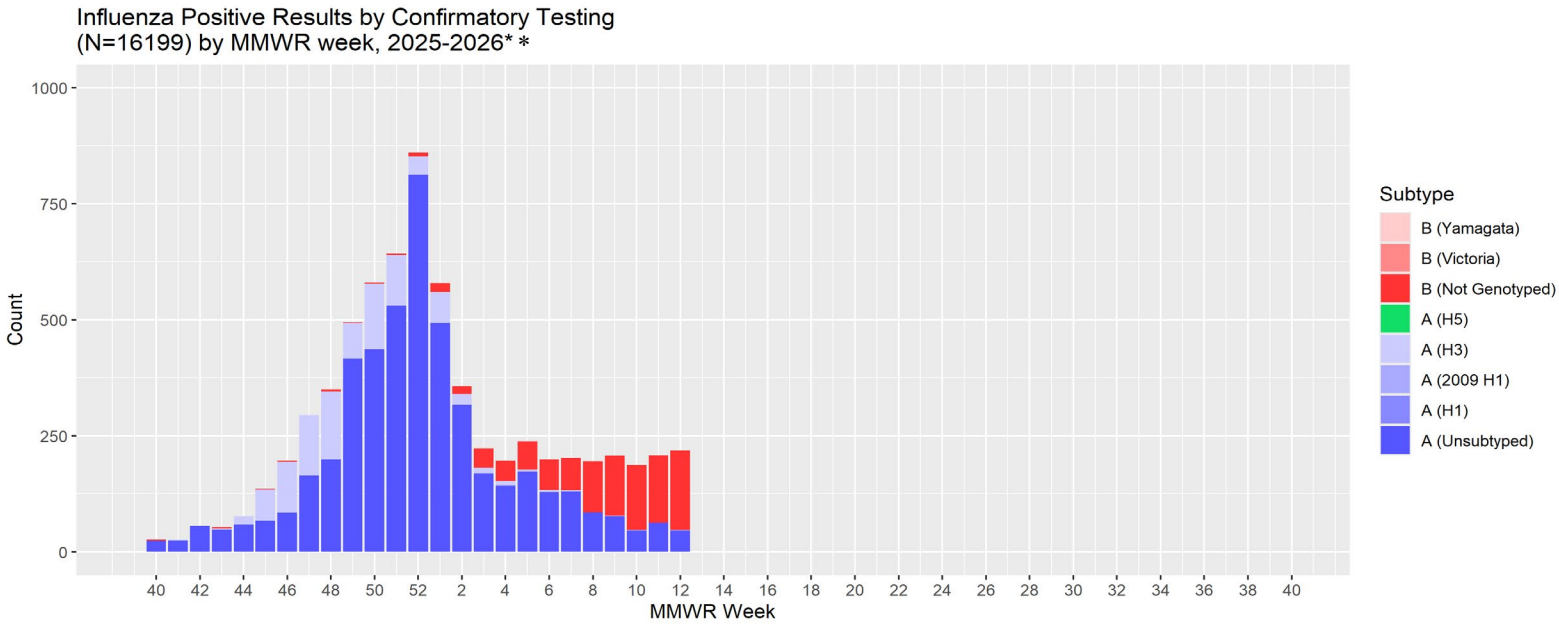


[7] Priority criteria include: hospitalized patients with acute respiratory distress syndrome [ARDS] or x-ray confirmed pneumonia; travelers with international travel history within 10 days of onset; specimens submitted by sentinel providers; specimens collected from healthcare workers, pregnant women, or women up to 6 weeks' post-partum; those with underlying medical conditions; and patients presenting with unusual or severe manifestations of influenza infection.
[8] Influenza coding was updated to reflect a more accurate count.
[9] All influenza A H1 viruses detected this season have been 2009 H1N1.
[10] This represents an estimate of population-based rates based on available data.

2. LABORATORY TESTING

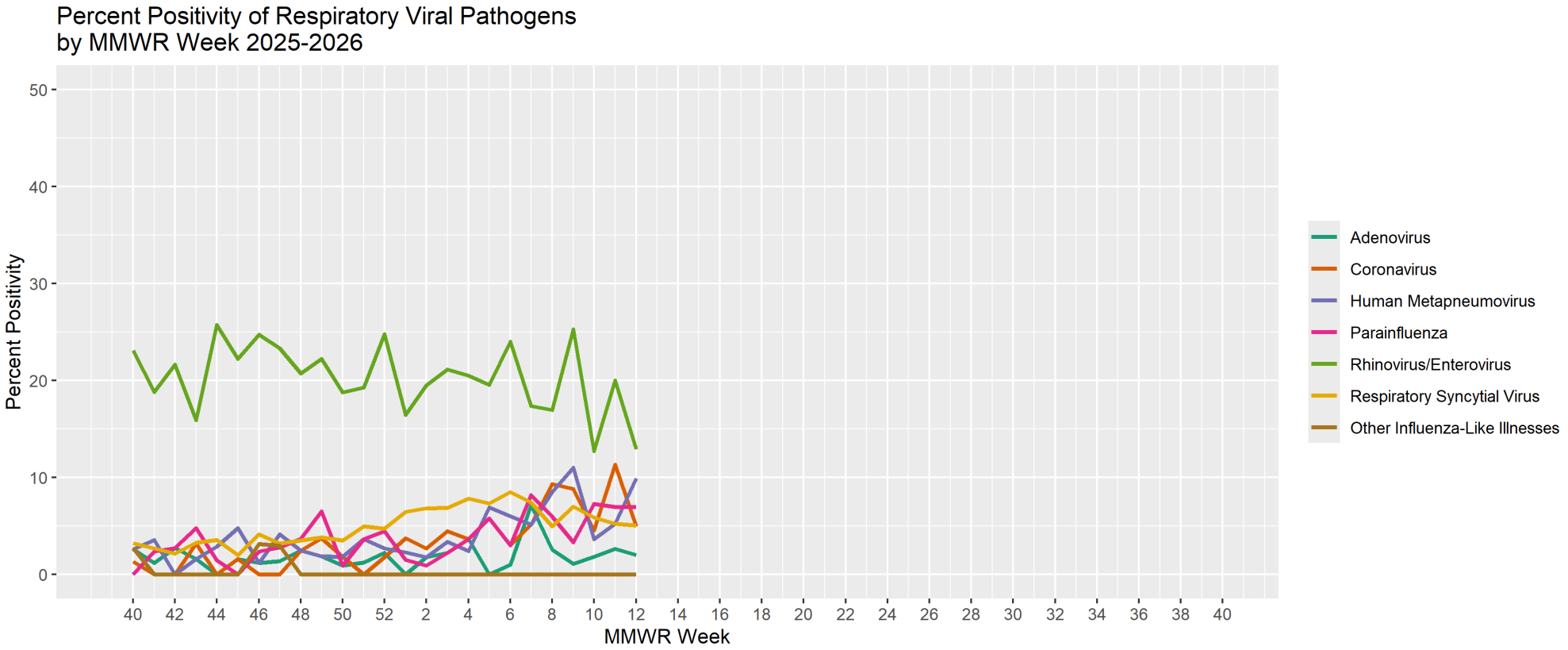
The charts below show the laboratory results of all specimens tested for influenza by MMWR week during the 2025–2026 influenza season as well as the type and subtype of positive results for influenza. Again, sub-typing is only performed on selected specimens tested by confirmatory tests (i.e., RT-PCR or viral culture).





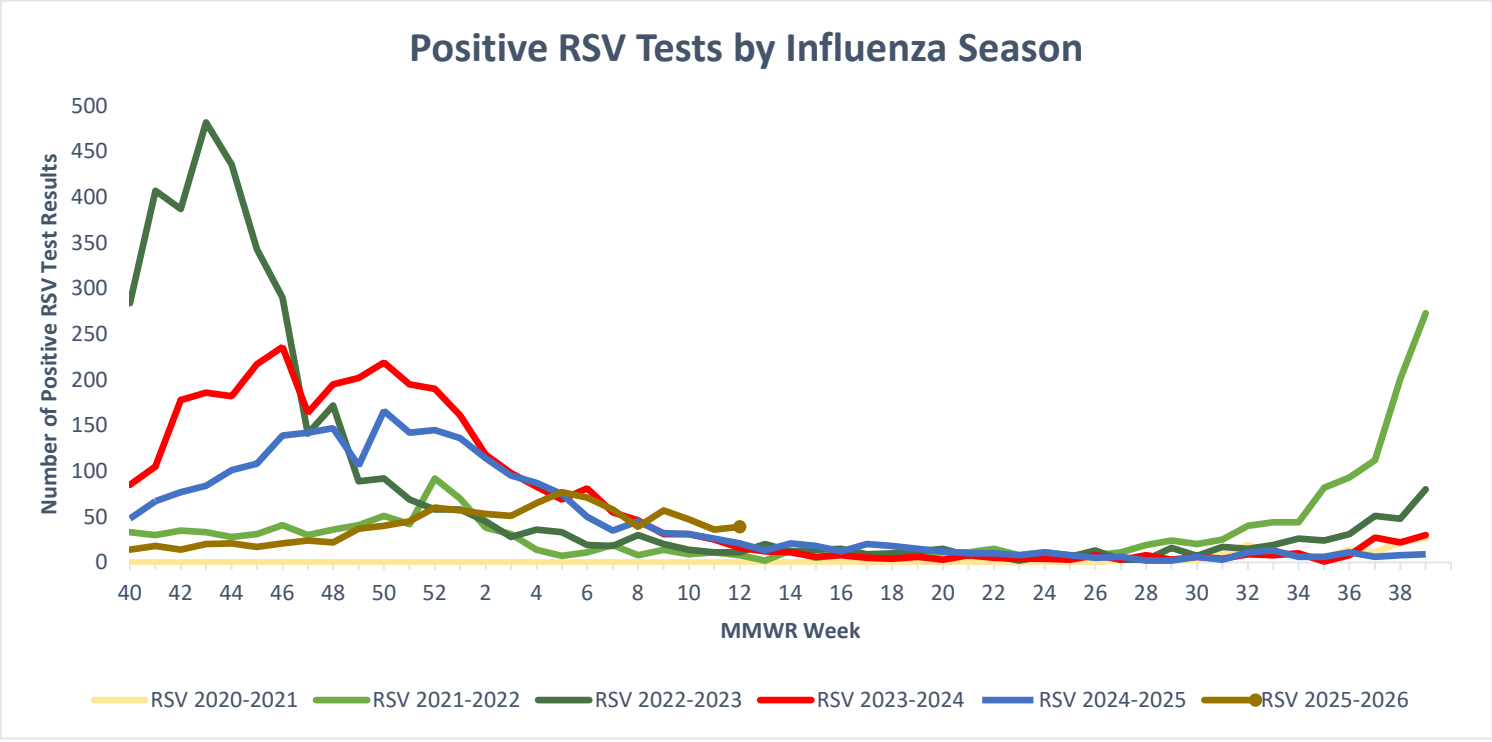
** A total of 48,400 specimens underwent confirmatory testing, but not all positive influenza specimens receive confirmatory testing that are circulating in Hawaii.*
*** For MMWR Week 53, results are reported under MMWR Week 52, where the average of Weeks 52 and 53 was calculated.*

B. **OTHER RESPIRATORY PATHOGENS:** The major clinical and commercial laboratories throughout the state of Hawaii have the testing capacity for non-influenza respiratory pathogens and report these to HDOH. However, such testing is performed as needed and when sufficient resources are available because of the high costs associated with respiratory panel tests. **Therefore, available data represent only the presence of circulating pathogens and cannot be used to determine specific trends**.

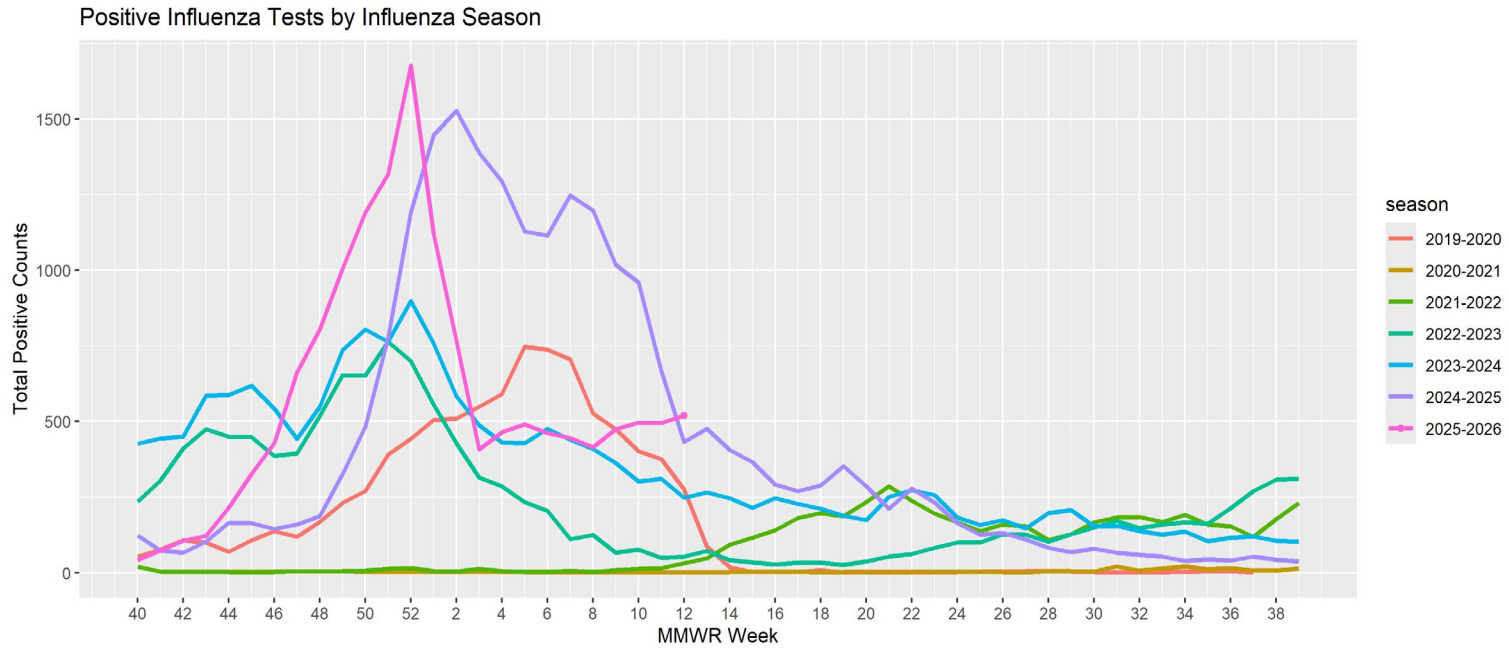


* *The coronavirus presented on this table does not indicate Severe Acute Respiratory Coronavirus-2 (i.e., COVID-19). For MMWR Week 53, results are reported under MMWR Week 52, where the average of Weeks 52 and 53 was calculated*

RESPIRATORY SYNCYTIAL VIRUS (RSV) POSITIVE TEST RESULTS BY INFLUENZA SEASON: RSV case appears to have increased later than past seasons in the 2025-2026 season. For MMWR Week 53, results are reported under MMWR Week 52, where the average of Weeks 52 and 53 was calculated.



INFLUENZA POSITIVE TEST RESULTS BY INFLUENZA SEASON: Influenza cases appear to have increased earlier than past seasons in the 2025-2026 season. For MMWR Week 53, results are reported under MMWR Week 52, where the average of Weeks 52 and 53 was calculated.



C. COVID-19 SENTINEL SURVEILLANCE: Due to the low volume of samples currently available through the influenza surveillance system, the COVID-19 sentinel surveillance data may not be accurately portraying COVID-19 activity in our communities. Reporting of the COVID-19 Sentinel Surveillance data will be paused while HODH re-evaluates the program to ensure that the reported data are accurate and representative.

HDOH is continuing to monitor COVID-19 activity throughout the state. To learn more, please visit the Hawaii's COVID-19 data website (*here*). For more information on surveillance of COVID-19 activity in the United States please visit the CDC COVIDView website (*here*).

III. PNEUMONIA, INFLUENZA, AND COVID-19 (PIC) RELATED MORTALITY:

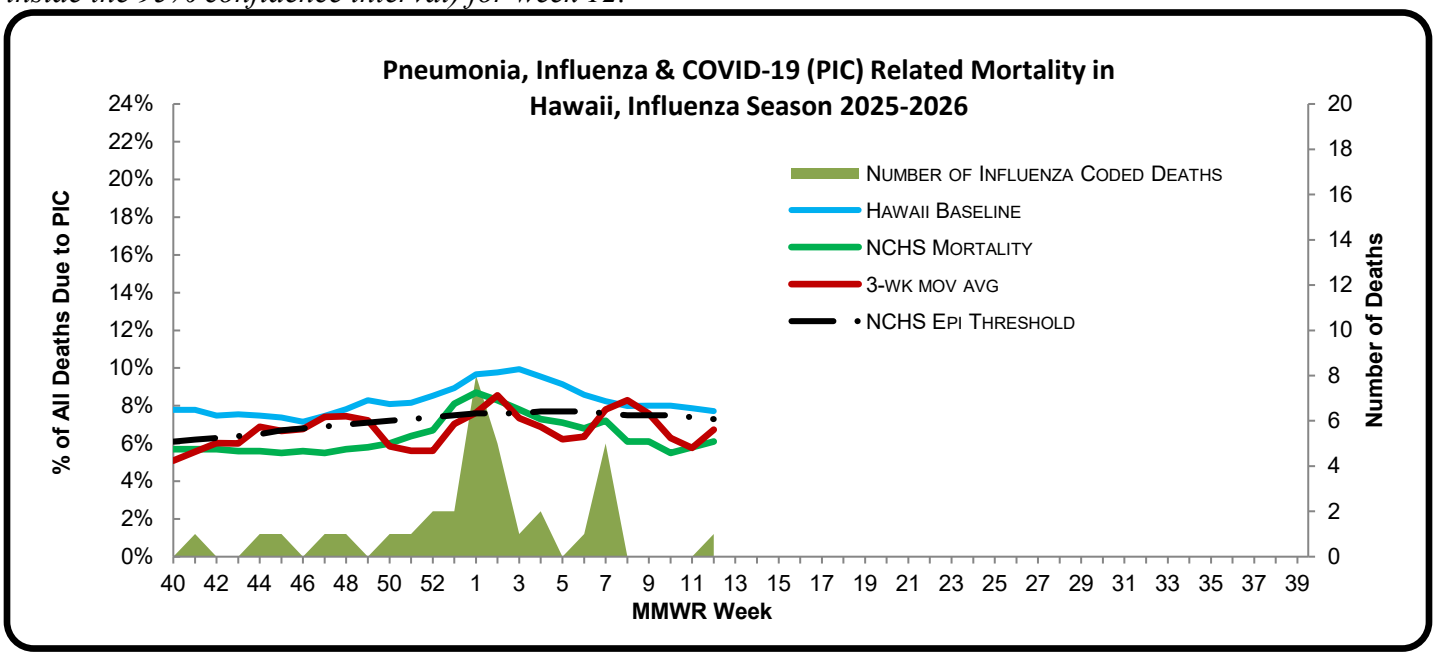
P&I mortality surveillance is collected by CDC through the National Center for Health Statistics (NCHS) using death certificate data. Each week the HDOH OHSM reports specific data from Honolulu to the CDC. CDC collects the following information by age group: the total number of deaths, total deaths from pneumonia, and total deaths related to influenza. Due to the ongoing COVID-19 pandemic, CDC included total deaths from COVID-19 by age group to the death data. Previous studies had suggested that P&I is a good indicator of influenza-related deaths; however, data has shown that pneumonia deaths associated with influenza is now being impacted by COVID-19 related pneumonia. Due to this, CDC had added COVID-19 deaths into P&I to create the PIC (pneumonia, influenza, and/or COVID-19) classification.

To standardize Hawaii's influenza surveillance with CDC influenza surveillance guidelines, PIC deaths will be reported in lieu of P&I. Hawaii's baseline will begin to include PIC deaths starting from 2019-2020 flu season.

For **week 12** of the current influenza season:

- ***6.8%*** *of all deaths that occurred in Hawaii during week 12 were related to pneumonia, influenza or COVID-19 (PIC)*[11]*. For the current season (season to date:* ***6.8%****), there have been 6,032 deaths from any cause, 410 of which were due to PIC*[12]*.*
- *The PIC rate was comparable to the historical baseline in Hawaii*[13] *(i.e., inside the 95% confidence interval).*

The Hawaii PIC rate was comparable to the CDC's National Center for Health Statistics (NCHS) PIC mortality[14] *(****6.1%****) (i.e., inside the 95% confidence interval) and comparable to the national epidemic threshold (****7.3%****) (i.e., inside the 95% confidence interval) for week 12.*



[11] The percent of deaths due to PIC displayed on the graph is the 3-week moving averages.

[12] PIC data reflect 100.0% of the data reported for the MMWR week. Changes to data are expected when PIC data reaches 100% completion.

[13] The Hawaii historical baseline (%PIC) is the average of 3-week moving averages over the preceding 10 flu seasons of historical data (2014-2015, 2015-2016, 2016-2017, 2017-2018, 2018-2019, 2019-2020, 2020-2021, 2021-2022, 2022-2023, and 2023-2024).

[14] Each week, the vital statistics offices of 122 cities across the United States report the total number of death certificates processed and the number of those for which pneumonia, influenza, or COVID-19 was listed as the underlying or contributing cause of death by age group (Under 28 days, 28 days–1 year, 1–14 years, 15–24 years, 25–44 years, 45–64 years, 65–74 years, 75–84 years, and ≥85 years). The COVID-19 death counts reported by NCHS are provisional and will not match counts in other sources, such as media reports or numbers from health departments. COVID-19 deaths may be classified or defined differently in various reporting and surveillance systems. The percentage of deaths due to pneumonia, influenza, and COVID-19 (PIC) are compared with a seasonal baseline and epidemic threshold value calculated for each week.

INFLUENZA-ASSOCIATED PEDIATRIC DEATHS[15]:

- No new influenza-associated pediatric death was reported to Hawaii. There have been zero influenza-associated pediatric deaths reported in Hawaii during the 2025–2026 season.
- Nationally, four new influenza-associated pediatric deaths were reported to CDC during week 12. (2025-2026 season total: 127).

IV. INFLUENZA WATCH: As part of a comprehensive influenza surveillance system and to prevent the spread of contagious respiratory diseases in humans, it is important to monitor all circulating influenza types. Several animal-origin influenza A subtypes are currently of interest: influenza A variant virus (H3N2v, H1N2v, and H1N1v) and Avian flu (H5N1 and H7N9). These types of influenza viruses may cause zoonotic (animal-associated) disease and are a public health concern.

A. VARIANT VIRUSES:

Influenza viruses that normally circulate in pigs are called "variant" viruses when they are found in people. These viruses were first identified in U.S. pigs in 2010. In 2011, 12 cases of H3N2v infection were detected in the United States. In 2012, 309 such cases (resulting in 16 hospitalizations and one death) across 12 states were detected, including one Hawaii case who recovered. Illness associated with H3N2v infection has been mostly mild with symptoms similar to those of seasonal flu. However, serious illness, resulting in hospitalization and death, has occurred in some cases. Most of these infections have been associated with prolonged exposure to pigs at agricultural fairs or similar settings. Limited human-to-human spread of this virus has been detected in the past, but no sustained community spread of H3N2v has been identified. More information regarding H3N2v, H1N1v, and H1N2v viruses may be found on the CDC website (*here*) and (*here*).

- *No variant or novel influenza infections have been reported to HDOH during the 2025-2026 influenza season.*
- *One new human infection with novel influenza A virus, H1N1v (0), H3N2v (0), and H1N2v (1), have been reported during the 2025-2026 influenza season.*
    - *One new human infection with influenza A(H1N1v) virus has been reported to WHO from China during the 2025-2026 influenza season.*

AVIAN (OR BIRD) INFLUENZA: These types of influenza viruses cause zoonotic (animal-associated) disease of public health concern and are therefore monitored globally by the WHO. Most avian influenza viruses do not cause disease in humans and are generally not easily transmissible between person to person, but a few subtypes may cross the species barrier and cause disease in humans. Avian influenza viruses may be of various subtypes, including H5N1, H5N2, H5N8, H7N3, H7N7, H7N8, H7N9, and H9N2. On January 15th, 2016, the USDA and APHIS reported detection of HPAI H7N8 in a commercial turkey flock in Indiana. There have been no associated human infections. This is the first detection of HPAI H7N8 in wild bird surveillance in the United States. More information, the risk assessment and recommendations for HPAI H7N8 can be found (here). The WHO, CDC, and other public health agencies have also been monitoring influenza H7N9, which represents a public health concern because of its high pandemic potential. Although H7N9 has not been detected in the United States, it remains a global concern given continuing epidemics in endemic countries. Since 2013, a total of 1,568 laboratory-confirmed cases of human infection with H7N9 viruses, including at least 613 deaths, have been reported to WHO. More information on H7N9 virus infections can be found (here). For more information regarding avian influenza, please visit the CDC (*here*) or the WHO (*here*) websites. WHO reports total number of cases and deaths related to laboratory-confirmed avian influenza viruses and posts current avian influenza case counts (*here*), which were last updated on **January 22, 2026**.

[15] Influenza-associated deaths are considered pediatric in persons aged less than 18 years. It was made a nationally notifiable condition in October, 2004. All pediatric influenza-associated deaths are laboratory confirmed.

V. INFLUENZA Vaccine: Annual influenza vaccination is recommended for all persons aged 6 months and older and is the most effective way to reduce the risk of getting sick with seasonal flu and spreading it to others. Influenza vaccination can reduce illnesses, visits to the doctor, influenza-related hospitalizations, and missed work and school days. Influenza vaccines become available by the end of October. It takes at least two weeks after vaccination to confer immunity against influenza virus infection. More information regarding influenza vaccination can be found (*here*).

A. Composition of the 2025–2026 Influenza Vaccine**:**

The composition of the 2025–2026 influenza vaccine has been updated to better match circulating influenza viruses. The Advisory Committee on Immunization Practices (ACIP) has recommended that the 2025-2026 influenza trivalent vaccine contain an influenza A/Victoria/4897/2022 (H1N1) pdm09-like virus, influenza A/Croatia/10136RV/2023 (H3N2)-like virus, and influenza B/Austria/1359417/2021 (B/Victoria lineage)-like virus. United States cell culture–based inactivated (ccIIV4) and recombinant (RIV4) influenza vaccines will contain HA derived from an influenza A/Wisconsin/67/2022 (H1N1) pdm09-like virus, an A/District of Columbia/27/2023 (H3N2)-like virus, an influenza B/Austria/1359417/2021 (B/Victoria lineage)-like virus. These vaccine recommendations were based on several factors, including global influenza virologic and epidemiologic surveillance, genetic and antigenic characterization, human serology studies, antiviral susceptibility, and the availability of candidate influenza viruses.

APPENDIX 1: ADDITIONAL INFORMATION

For more information regarding local and national influenza surveillance programs, visit the following sites.

Centers for Disease Control and Prevention	General Influenza National ILI and P&I Data Vaccine Virus Selection CDC Web Tool for Respiratory Viruses
Flu.gov	General Influenza Information
HDOH Flu and Pneumonia	General Influenza Surveillance Avian Influenza Respiratory Virus Dashboard To find out more information or join the sentinel physician program, email the Influenza Surveillance Coordinator
World Health Organization	General Global and Local Influenza Avian Influenza

APPENDIX 2: MMWR WEEK DATES

Please refer to the table below to interpret data presented by MMWR week. Week 40 is considered the traditional start for the flu season for the Northern Hemisphere.

MMWR WEEK	2022	2023	2024	2025	2026
1	1/8/2022	1/7/2023	1/6/2024	1/4/2025	1/10/2026
2	1/15/2022	1/14/2023	1/13/2024	1/11/2025	1/17/2026
3	1/22/2022	1/21/2023	1/20/2024	1/18/2025	1/24/2026
4	1/29/2022	1/28/2023	1/27/2024	1/25/2025	1/31/2026
5	2/5/2022	2/4/2023	2/3/2024	2/1/2025	2/7/2026
6	2/12/2022	2/11/2023	2/10/2024	2/8/2025	2/14/2026
7	2/19/2022	2/18/2023	2/17/2024	2/15/2025	2/21/2026
8	2/26/2022	2/25/2023	2/24/2024	2/22/2025	2/28/2026
9	3/5/2022	3/4/2023	3/2/2024	3/1/2025	3/7/2026
10	3/12/2022	3/11/2023	3/9/2024	3/8/2025	3/14/2026
11	3/19/2022	3/18/2023	3/16/2024	3/15/2025	3/21/2026
12	3/26/2022	3/25/2023	3/23/2024	3/22/2025	3/28/2026
13	4/2/2022	4/1/2023	3/30/2024	3/29/2025	4/4/2026
14	4/9/2022	4/8/2023	4/6/2024	4/5/2025	4/11/2026
15	4/16/2022	4/15/2023	4/13/2024	4/12/2025	4/18/2026
16	4/23/2022	4/22/2023	4/20/2024	4/19/2025	4/25/2026
17	4/30/2022	4/29/2023	4/27/2024	4/26/2025	5/2/2026
18	5/7/2022	5/6/2023	5/4/2024	5/3/2025	5/9/2026
19	5/14/2022	5/13/2023	5/11/2024	5/10/2025	5/16/2026
20	5/21/2022	5/20/2023	5/18/2024	5/17/2025	5/23/2026
21	5/28/2022	5/27/2023	5/25/2024	5/24/2025	5/30/2026
22	6/4/2022	6/3/2023	6/1/2024	5/31/2025	6/6/2026
23	6/11/2022	6/10/2023	6/8/2024	6/7/2025	6/13/2026
24	6/18/2022	6/17/2023	6/15/2024	6/14/2025	6/20/2026
25	6/25/2022	6/24/2023	6/22/2024	6/21/2025	6/27/2026
26	7/2/2022	7/1/2023	6/29/2024	6/28/2025	7/4/2026
27	7/9/2022	7/8/2023	7/6/2024	7/5/2025	7/11/2026
28	7/16/2022	7/15/2023	7/13/2024	7/12/2025	7/18/2026
29	7/23/2022	7/22/2023	7/20/2024	7/19/2025	7/25/2026
30	7/30/2022	7/29/2023	7/27/2024	7/26/2025	8/1/2026
31	8/6/2022	8/5/2023	8/3/2024	8/2/2025	8/8/2026
32	8/13/2022	8/12/2023	8/10/2024	8/9/2025	8/15/2026
33	8/20/2022	8/19/2023	8/17/2024	8/16/2025	8/22/2026
34	8/27/2022	8/26/2023	8/24/2024	8/23/2025	8/29/2026
35	9/3/2022	9/2/2023	8/31/2024	8/30/2025	9/5/2026
36	9/10/2022	9/9/2023	9/7/2024	9/6/2025	9/12/2026
37	9/17/2022	9/16/2023	9/14/2024	9/13/2025	9/19/2026
38	9/24/2022	9/23/2023	9/21/2024	9/20/2025	9/26/2026
39	10/1/2022	9/30/2023	9/28/2024	9/27/2025	10/3/2026
40	10/8/2022	10/7/2023	10/5/2024	10/4/2025	10/10/2026
41	10/15/2022	10/14/2023	10/12/2024	10/11/2025	10/17/2026
42	10/22/2022	10/21/2023	10/19/2024	10/18/2025	10/24/2026
43	10/29/2022	10/28/2023	10/26/2024	10/25/2025	10/31/2026
44	11/5/2022	11/4/2023	11/2/2024	11/1/2025	11/7/2026
45	11/12/2022	11/11/2023	11/9/2024	11/8/2025	11/14/2026
46	11/19/2022	11/18/2023	11/16/2024	11/15/2025	11/21/2026
47	11/26/2022	11/25/2023	11/23/2024	11/22/2025	11/28/2026
48	12/3/2022	12/2/2023	11/30/2024	11/29/2025	12/5/2026
49	12/10/2022	12/9/2023	12/7/2024	12/6/2025	12/12/2026
50	12/17/2022	12/16/2023	12/14/2024	12/13/2025	12/19/2026
51	12/24/2022	12/23/2023	12/21/2024	12/20/2025	12/26/2026
52	12/31/2022	12/30/2023	12/28/2024	12/27/2025	
53				01/03/2026	

HAWAII STATE DEPARTMENT OF HEALTH
DISEASE OUTBREAK CONTROL DIVISION

Influenza/Respiratory Disease Surveillance Report

Morbidity and Mortality Weekly Report (MMWR)[1]

WEEK 13: MARCH 29, 2026– APRIL 4, 2026

OVERVIEW: The Hawaii State Department of Health (HDOH) monitors influenza and other respiratory pathogens, including COVID-19, throughout the state of Hawaii. Influenza surveillance in the state of Hawaii relies upon selected sentinel health practitioners, the State Laboratories Division (SLD), private laboratories, and the Office of Health Status Monitoring (OHSM). For detailed information concerning influenza, please visit the HDOH Disease Outbreak Control Division (HDOH DOCD) website (*here*). **All data and information are conditional and may change as more reports are received.** The data in this report reflects the 2025-2026 influenza season which began the week ending October 4, 2025 (week 40[1] 2025) and will end the week ending on October 3, 2026 (week 39 2026).

REPORT SNAPSHOT FOR WEEK 13

Surveillance for Influenza-like Illness (ILI)		
Metric	*Value*	*Comment*
Outpatient visits related to influenza-like illness (ILI) from ILINet Sentinel Providers	2.9%	Lower than the previous week. Comparable to Hawaii's historical baseline and lower than the national baseline, and higher than the national ILI rate.
Number of ILI clusters reported to HDOH	0	There have been 25 clusters this season.

Laboratory Surveillance		
Percent of all respiratory specimens positive for influenza this week	16.2%	Lower than the previous week. This number means that many, if not all, of the 83.8% who tested negative for influenza had illness from another respiratory etiology.
Percent of all respiratory specimens positive for influenza this season to date	18.1%	

Surveillance for Severe Outcomes		
Pneumonia, influenza and COVID-19 (PIC) mortality rate	4.3%	Comparable to Hawaii's historical baseline, Comparable to the national epidemic threshold and comparable to the NCHS average.
Number of influenza-associated pediatric deaths reported nationwide	139	0 influenza-associated pediatric deaths have been reported from Hawaii this season to date.

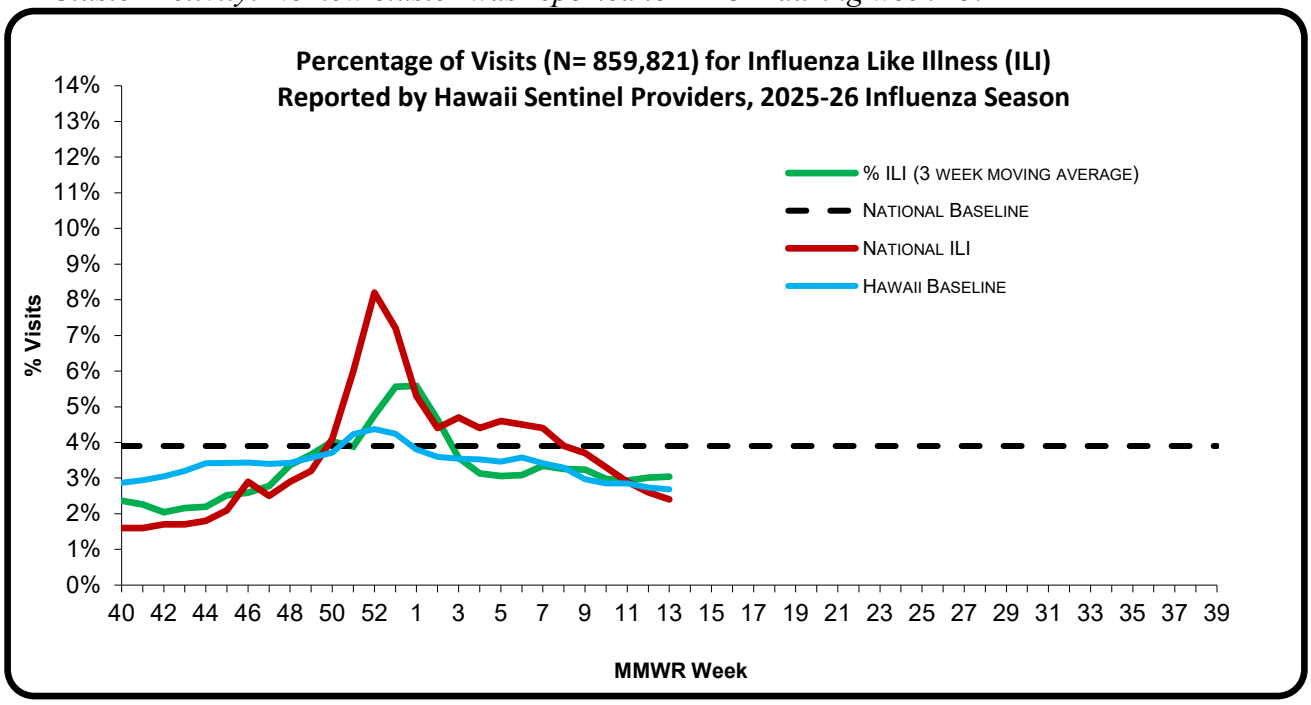
[1] MMWR stands for "Morbidity and Mortality Weekly Report," conventionally used by the Centers for Disease Control and Prevention (CDC). The weeks of a flu season are often referred to by their respective MMWR week. **See appendix 2 for interpretation of MMWR weeks.** Data reported will begin on week 40, the traditional start date of flu season.

INFLUENZA SURVEILLANCE

I. INFLUENZA-LIKE ILLNESS (ILI): HDOH collaborates with recruited doctors and healthcare providers who report the total number of outpatient visits for ILI as well as the total number of patients who complained of symptoms consistent with ILI. A patient with ILI must have the following: a fever (temperature of 100°F [37.8°C] or greater) AND a cough and/or a sore throat. ILI is based on reported symptoms and not laboratory confirmed tests; thus, ILI may represent other respiratory pathogens and not solely influenza. Further, sentinel providers report these numbers on a weekly basis; therefore, data are preliminary and may change depending on additional reporting. In combination with laboratory testing and other surveillance systems, ILI surveillance helps monitor influenza and other respiratory pathogen activity. For more information concerning ILINet and sentinel requirements, please visit the CDC website (*here*).

For **week 13** of the current influenza season:

- ***2.9%** (season to date: **3.3%**) of the outpatient visits recorded by Hawaii sentinel providers were for ILI.*
- *ILI visits were comparable to the historical baseline in Hawaii[2,3] (i.e., inside the 95% confidence interval).*
- *Hawaii's ILI outpatient visits were lower than the national baseline (**3.9%**)[4] (i.e., outside the 95% confidence interval) and higher than the national ILI rate (**2.4%**) (i.e. outside the 95% confidence interval).*
- *ILI activity level: Low[5]*
- *Geographic Spread: Sporadic Activity[6].*
- *ILI Cluster Activity: No new cluster was reported to HDOH during week 13.*



[2] The Hawaii historical baseline (%ILI) is the average of 3-week moving averages over the preceding 3 flu seasons of historical data (2022-2023, 2023-2024 and 2024-2025).
[3] This value is based upon comparison of actual outpatient ILI with the historical baseline, which only captures outpatient ILI. The chart above represents a 3-week moving average and not the actual ILI by week.
[4] The National Baseline is calculated by CDC as the mean percentage of visits for ILI during weeks 21–39 with two standard deviations. Because of large variability in regional ILI, comparison of the national baseline with local ILI may not be appropriate. It is provided in this report because no meaningful regional baselines are available for comparison. The national baseline combines all data reported by states to CDC, including ILI in outpatient, ER, urgent care, and inpatient settings.
[5] There are 10 activity levels classified as minimal (levels 1-3), low (levels 4-5), moderate (levels 6-7), and high (levels 8-10).
[6] The influenza activity reported by state and territorial epidemiologists indicates geographic spread of influenza viruses but does not measure the severity of influenza activity. Sporadic: no clusters reported to HDOH, Local: one or more clusters reported in one county, Regional: clusters reported two to three counties, Widespread: clusters reported in all counties. Hawaii does not report No Activity, as flu circulates year-round in Hawaii.

II. LABORATORY SURVEILLANCE: State Laboratories Division (SLD; the HDOH public health laboratory) and Hawaii's major private laboratories (DLS, CLH) report results of RT-PCR, which can be considered confirmatory (SLD may perform viral culture on select specimens). Specimens meeting priority criteria[7] are forwarded to SLD for sub-typing. Additionally, specimens meeting case definition from requesting sentinel providers are sent directly to SLD for sub-typing. Due to resource constraints, not all submitted specimens undergo sub-typing. Sub-typing at the commercial laboratories is only conducted on a case-by-case basis. The majority of specimens testing positive by rapid antigen testing or RT-PCR at the commercial laboratories do not meet criteria and are not subtyped. For more information on influenza tests and types, please visit the CDC website (*here*).

A. INFLUENZA:

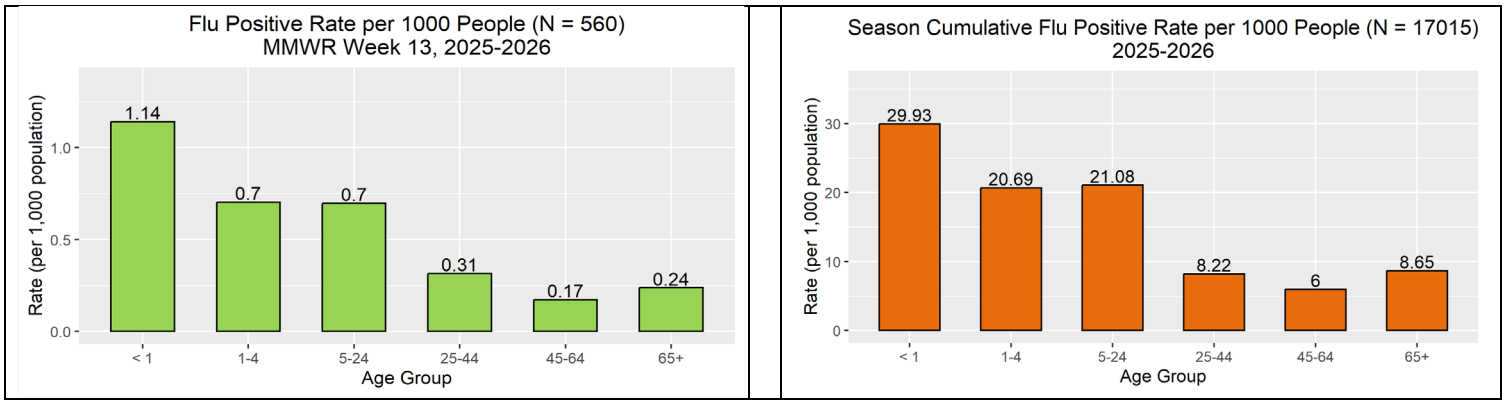
- The following reflects laboratory findings for week 13 of the 2025–26 influenza season:
  - *A total of **3,467** specimens has been tested statewide for influenza viruses (positive: 560 [**16.2%**]). (Season to date: **93,861** tested (**18.1 %** positive)*
    - *1,584 (45.7%) were screened only by rapid antigen tests with no confirmatory testing.*
    - *1,883 (54.3%) underwent confirmatory testing (either RT-PCR or viral culture).*
    - *2,907 (83.8%) were negative.*
  - *Routine surveillance samples from State Laboratory Division were tested at a public health laboratory and identified as Influenza A (H3N2) subclade K.*

Influenza type	***Current week 13 (%)****	***Season to date (%)***[8]
Influenza A (H1)[9]	*3 (0.5)*	*125 (0.7)*
Influenza A (H3)	*2 (043)*	*1,276 (7.5)*
Influenza A no subtyping	*162 (28.9)*	*12,352 (72.6)*
Influenza B (Yamagata)	*0 (0.0)*	*0 (0.0)*
Influenza B (Victoria)	*0 (0.0)*	*0 (0.0)*
Influenza B no genotyping	*394 (70.2)*	*3,260 (19.2)*

**Specimens that are positive for both A and B (coinfections) are counted in both A and B totals for current and season to date*

1. AGE DISTRIBUTION

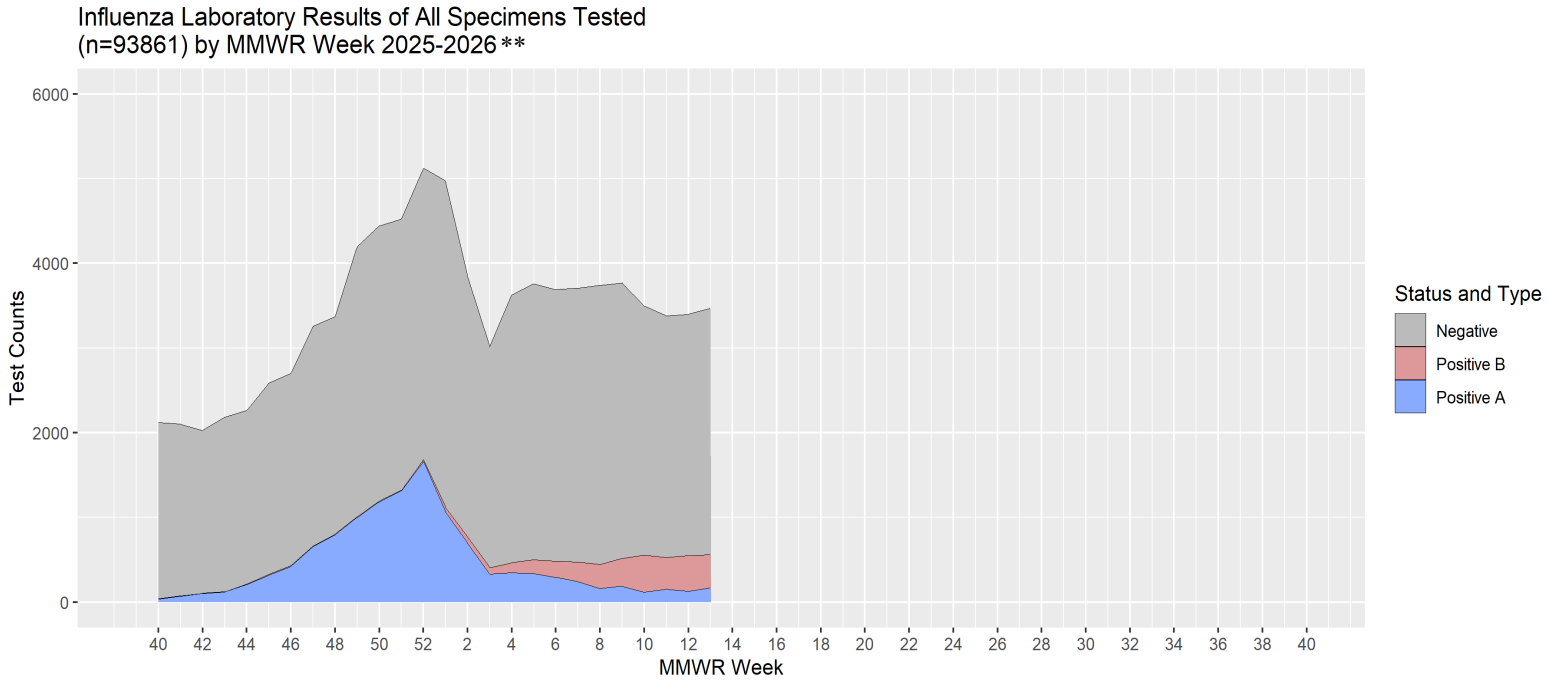
The charts below indicate the population-based rates of positive influenza cases in Hawaii by age group during the 2025–26 influenza season.[10]

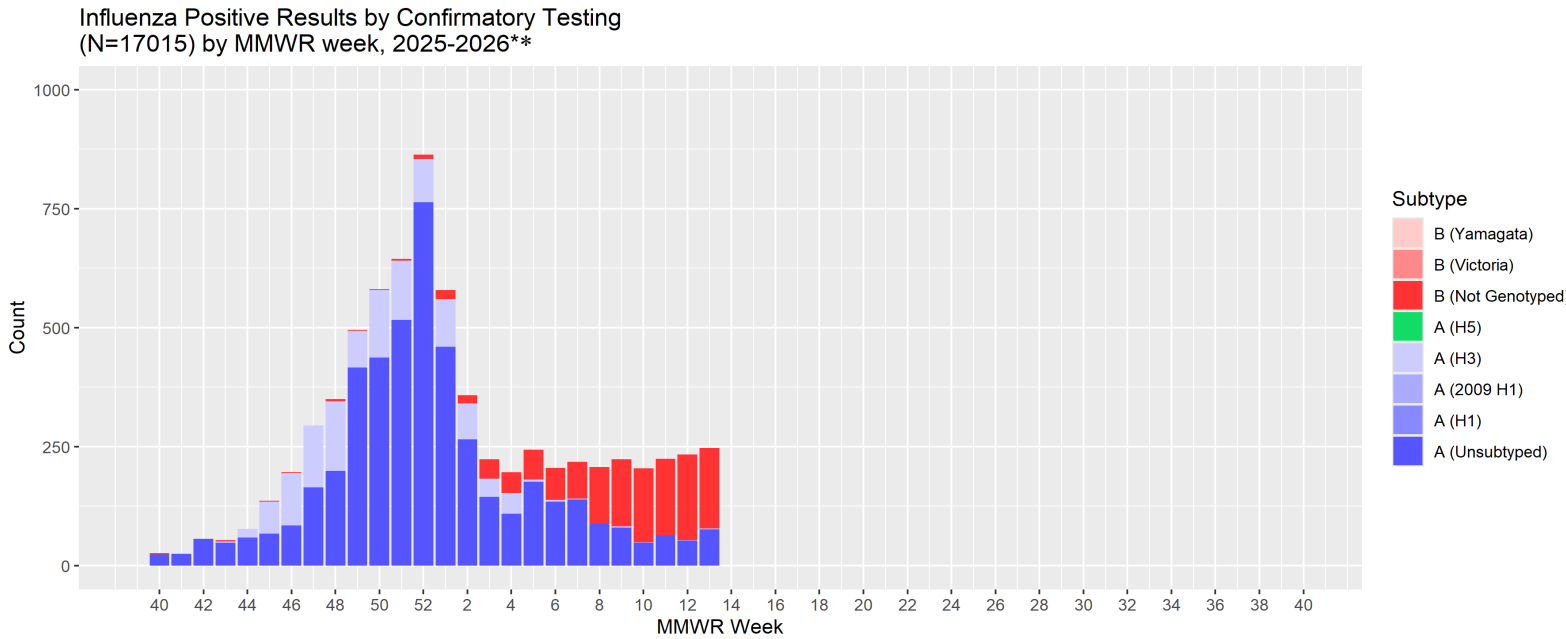


[7] Priority criteria include: hospitalized patients with acute respiratory distress syndrome [ARDS] or x-ray confirmed pneumonia; travelers with international travel history within 10 days of onset; specimens submitted by sentinel providers; specimens collected from healthcare workers, pregnant women, or women up to 6 weeks' post-partum; those with underlying medical conditions; and patients presenting with unusual or severe manifestations of influenza infection.
[8] Influenza coding was updated to reflect a more accurate count.
[9] All influenza A H1 viruses detected this season have been 2009 H1N1.
[10] This represents an estimate of population-based rates based on available data.

2. LABORATORY TESTING

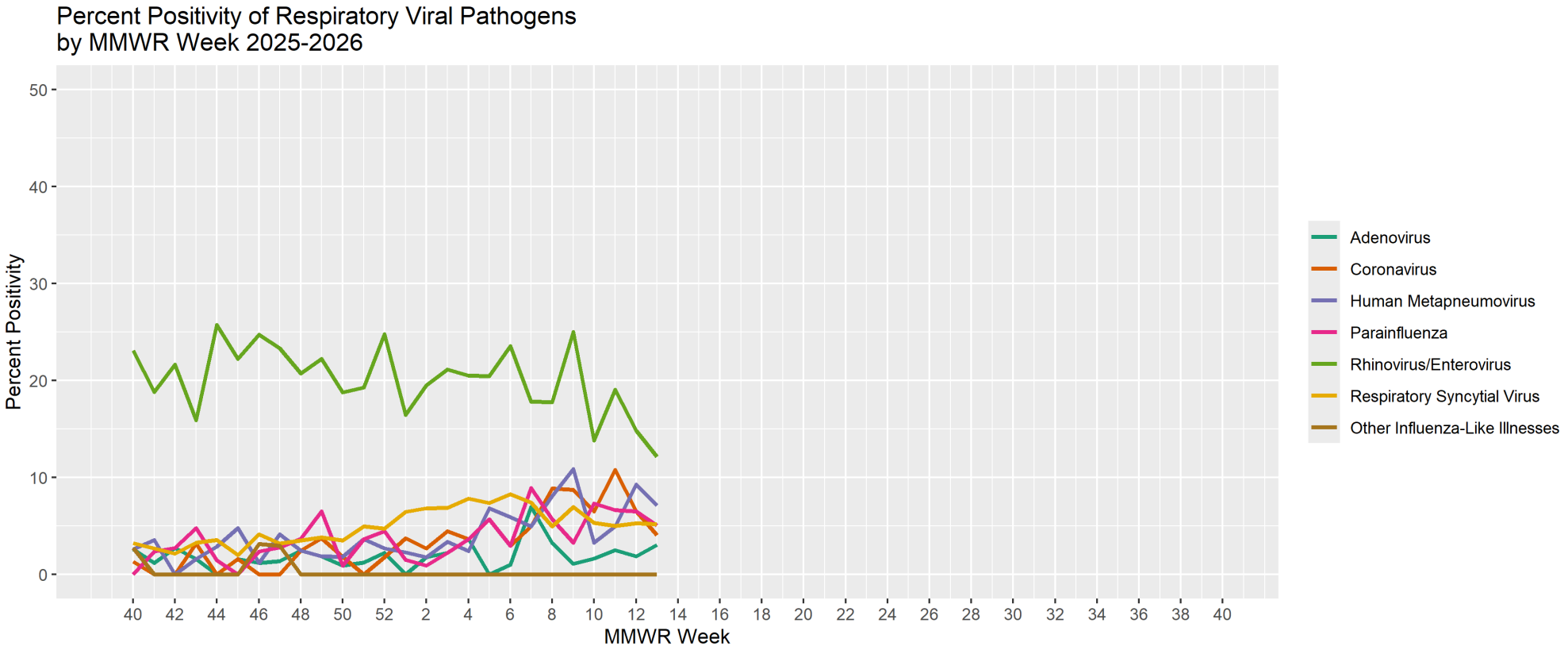
The charts below show the laboratory results of all specimens tested for influenza by MMWR week during the 2025–2026 influenza season as well as the type and subtype of positive results for influenza. Again, sub-typing is only performed on selected specimens tested by confirmatory tests (i.e., RT-PCR or viral culture).





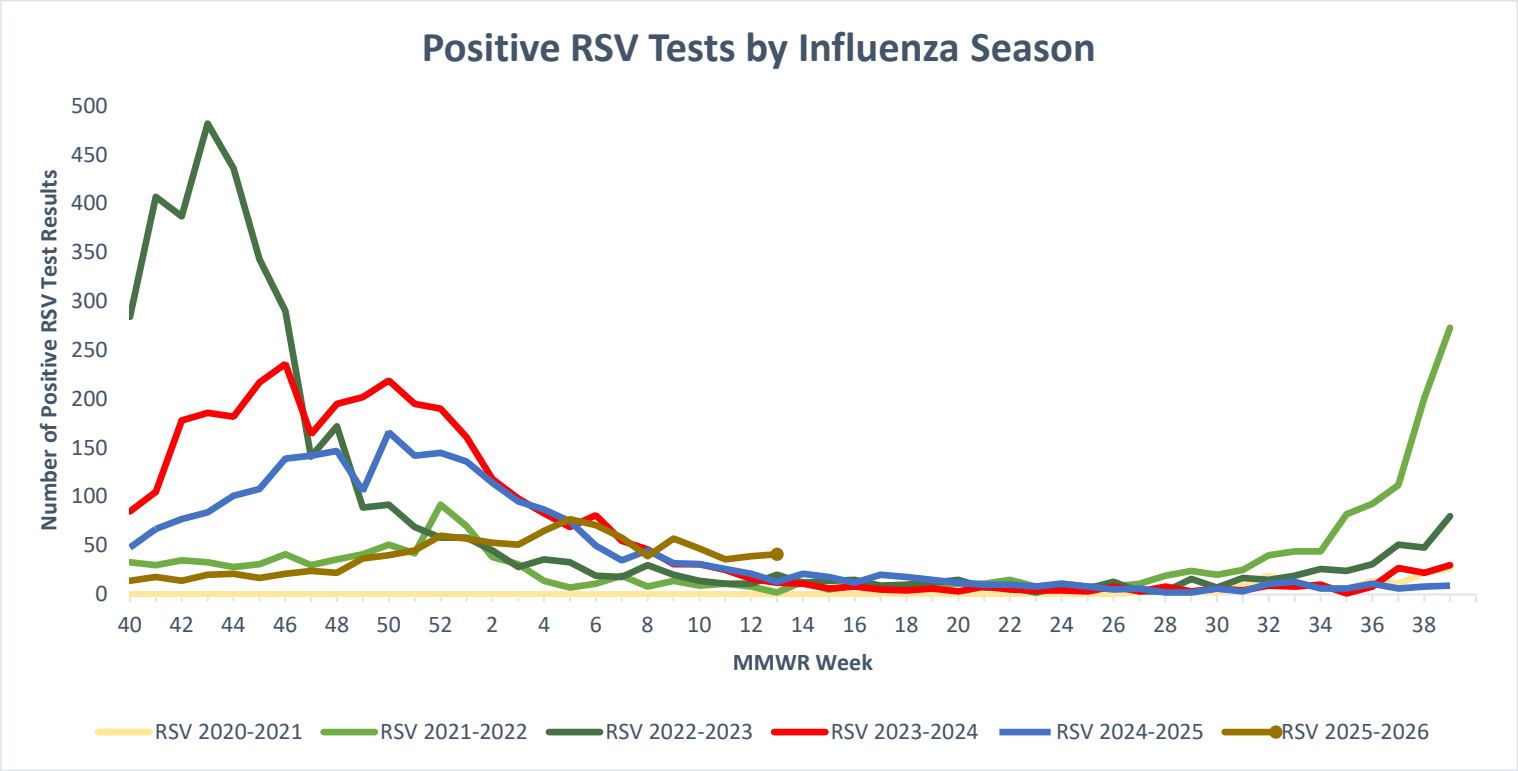
** A total of 51,941 specimens underwent confirmatory testing, but not all positive influenza specimens receive confirmatory testing that are circulating in Hawaii.*
*** For MMWR Week 53, results are reported under MMWR Week 52, where the average of Weeks 52 and 53 was calculated.*

B. **OTHER RESPIRATORY PATHOGENS:** The major clinical and commercial laboratories throughout the state of Hawaii have the testing capacity for non-influenza respiratory pathogens and report these to HDOH. However, such testing is performed as needed and when sufficient resources are available because of the high costs associated with respiratory panel tests. **Therefore, available data represent only the presence of circulating pathogens and cannot be used to determine specific trends**.

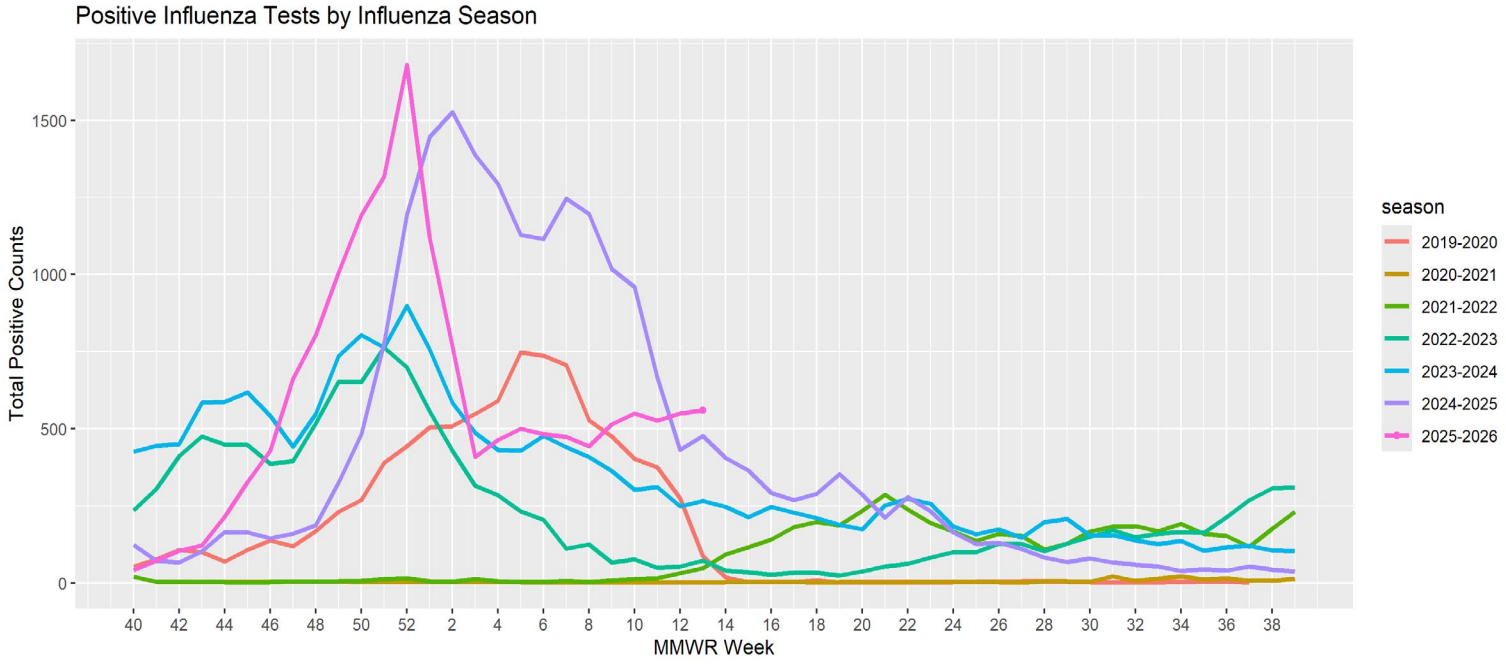


* *The coronavirus presented on this table does not indicate Severe Acute Respiratory Coronavirus-2 (i.e., COVID-19). For MMWR Week 53, results are reported under MMWR Week 52, where the average of Weeks 52 and 53 was calculated*

RESPIRATORY SYNCYTIAL VIRUS (RSV) POSITIVE TEST RESULTS BY INFLUENZA SEASON: RSV case appears to have increased later than past seasons in the 2025-2026 season. For MMWR Week 53, results are reported under MMWR Week 52, where the average of Weeks 52 and 53 was calculated.



INFLUENZA POSITIVE TEST RESULTS BY INFLUENZA SEASON: Influenza cases appear to have increased earlier than past seasons in the 2025-2026 season. For MMWR Week 53, results are reported under MMWR Week 52, where the average of Weeks 52 and 53 was calculated.



C. COVID-19 SENTINEL SURVEILLANCE: Due to the low volume of samples currently available through the influenza surveillance system, the COVID-19 sentinel surveillance data may not be accurately portraying COVID-19 activity in our communities. Reporting of the COVID-19 Sentinel Surveillance data will be paused while HODH re-evaluates the program to ensure that the reported data are accurate and representative.

HDOH is continuing to monitor COVID-19 activity throughout the state. To learn more, please visit the Hawaii's COVID-19 data website (*here*). For more information on surveillance of COVID-19 activity in the United States please visit the CDC COVIDView website (*here*).

III. PNEUMONIA, INFLUENZA, AND COVID-19 (PIC) RELATED MORTALITY:

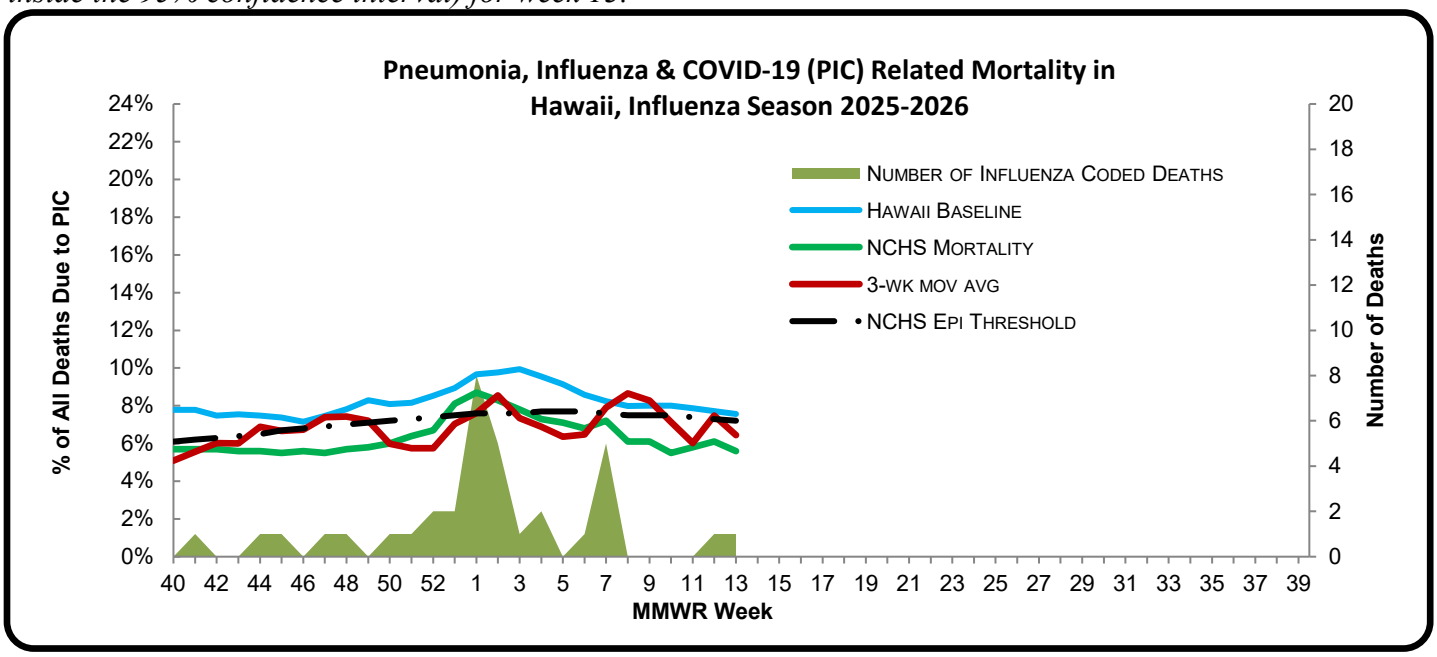
P&I mortality surveillance is collected by CDC through the National Center for Health Statistics (NCHS) using death certificate data. Each week the HDOH OHSM reports specific data from Honolulu to the CDC. CDC collects the following information by age group: the total number of deaths, total deaths from pneumonia, and total deaths related to influenza. Due to the ongoing COVID-19 pandemic, CDC included total deaths from COVID-19 by age group to the death data. Previous studies had suggested that P&I is a good indicator of influenza-related deaths; however, data has shown that pneumonia deaths associated with influenza is now being impacted by COVID-19 related pneumonia. Due to this, CDC had added COVID-19 deaths into P&I to create the PIC (pneumonia, influenza, and/or COVID-19) classification.

To standardize Hawaii's influenza surveillance with CDC influenza surveillance guidelines, PIC deaths will be reported in lieu of P&I. Hawaii's baseline will begin to include PIC deaths starting from 2019-2020 flu season.

For **week 13** of the current influenza season:

- ***4.3%*** *of all deaths that occurred in Hawaii during week 13 were related to pneumonia, influenza or COVID-19 (PIC)*[11]*. For the current season (season to date:* ***6.9%****), there have been 6,279 deaths from any cause, 435 of which were due to PIC*[12]*.*
- *The PIC rate was comparable to the historical baseline in Hawaii*[13] *(i.e., inside the 95% confidence interval).*

The Hawaii PIC rate was comparable to the CDC's National Center for Health Statistics (NCHS) PIC mortality[14] *(****5.6%****) (i.e., inside the 95% confidence interval) and comparable to the national epidemic threshold (****7.2%****) (i.e., inside the 95% confidence interval) for week 13.*



[11] The percent of deaths due to PIC displayed on the graph is the 3-week moving averages.

[12] PIC data reflect 100.0% of the data reported for the MMWR week. Changes to data are expected when PIC data reaches 100% completion.

[13] The Hawaii historical baseline (%PIC) is the average of 3-week moving averages over the preceding 10 flu seasons of historical data (2014-2015, 2015-2016, 2016-2017, 2017-2018, 2018-2019, 2019-2020, 2020-2021, 2021-2022, 2022-2023, and 2023-2024).

[14] Each week, the vital statistics offices of 122 cities across the United States report the total number of death certificates processed and the number of those for which pneumonia, influenza, or COVID-19 was listed as the underlying or contributing cause of death by age group (Under 28 days, 28 days–1 year, 1–14 years, 15–24 years, 25–44 years, 45–64 years, 65–74 years, 75–84 years, and ≥85 years). The COVID-19 death counts reported by NCHS are provisional and will not match counts in other sources, such as media reports or numbers from health departments. COVID-19 deaths may be classified or defined differently in various reporting and surveillance systems. The percentage of deaths due to pneumonia, influenza, and COVID-19 (PIC) are compared with a seasonal baseline and epidemic threshold value calculated for each week.

INFLUENZA-ASSOCIATED PEDIATRIC DEATHS[15]:

- No new influenza-associated pediatric death was reported to Hawaii. There have been zero influenza-associated pediatric deaths reported in Hawaii during the 2025–2026 season.
- Nationally, twelve new influenza-associated pediatric deaths were reported to CDC during week 13. (2025-2026 season total: 139).

IV. INFLUENZA WATCH: As part of a comprehensive influenza surveillance system and to prevent the spread of contagious respiratory diseases in humans, it is important to monitor all circulating influenza types. Several animal-origin influenza A subtypes are currently of interest: influenza A variant virus (H3N2v, H1N2v, and H1N1v) and Avian flu (H5N1 and H7N9). These types of influenza viruses may cause zoonotic (animal-associated) disease and are a public health concern.

A. VARIANT VIRUSES:

Influenza viruses that normally circulate in pigs are called "variant" viruses when they are found in people. These viruses were first identified in U.S. pigs in 2010. In 2011, 12 cases of H3N2v infection were detected in the United States. In 2012, 309 such cases (resulting in 16 hospitalizations and one death) across 12 states were detected, including one Hawaii case who recovered. Illness associated with H3N2v infection has been mostly mild with symptoms similar to those of seasonal flu. However, serious illness, resulting in hospitalization and death, has occurred in some cases. Most of these infections have been associated with prolonged exposure to pigs at agricultural fairs or similar settings. Limited human-to-human spread of this virus has been detected in the past, but no sustained community spread of H3N2v has been identified. More information regarding H3N2v, H1N1v, and H1N2v viruses may be found on the CDC website (*here*) and (*here*).

- *No variant or novel influenza infections have been reported to HDOH during the 2025-2026 influenza season.*
- *One new human infection with novel influenza A virus, H1N1v (0), H3N2v (0), and H1N2v (1), have been reported during the 2025-2026 influenza season.*
    - *One new human infection with influenza A(H1N1v) virus has been reported to WHO from China during the 2025-2026 influenza season.*

AVIAN (OR BIRD) INFLUENZA: These types of influenza viruses cause zoonotic (animal-associated) disease of public health concern and are therefore monitored globally by the WHO. Most avian influenza viruses do not cause disease in humans and are generally not easily transmissible between person to person, but a few subtypes may cross the species barrier and cause disease in humans. Avian influenza viruses may be of various subtypes, including H5N1, H5N2, H5N8, H7N3, H7N7, H7N8, H7N9, and H9N2. On January 15th, 2016, the USDA and APHIS reported detection of HPAI H7N8 in a commercial turkey flock in Indiana. There have been no associated human infections. This is the first detection of HPAI H7N8 in wild bird surveillance in the United States. More information, the risk assessment and recommendations for HPAI H7N8 can be found (here). The WHO, CDC, and other public health agencies have also been monitoring influenza H7N9, which represents a public health concern because of its high pandemic potential. Although H7N9 has not been detected in the United States, it remains a global concern given continuing epidemics in endemic countries. Since 2013, a total of 1,568 laboratory-confirmed cases of human infection with H7N9 viruses, including at least 613 deaths, have been reported to WHO. More information on H7N9 virus infections can be found (here). For more information regarding avian influenza, please visit the CDC (*here*) or the WHO (*here*) websites. WHO reports total number of cases and deaths related to laboratory-confirmed avian influenza viruses and posts current avian influenza case counts (*here*), which were last updated on **January 22, 2026**.

[15] Influenza-associated deaths are considered pediatric in persons aged less than 18 years. It was made a nationally notifiable condition in October, 2004. All pediatric influenza-associated deaths are laboratory confirmed.

V. INFLUENZA Vaccine: Annual influenza vaccination is recommended for all persons aged 6 months and older and is the most effective way to reduce the risk of getting sick with seasonal flu and spreading it to others. Influenza vaccination can reduce illnesses, visits to the doctor, influenza-related hospitalizations, and missed work and school days. Influenza vaccines become available by the end of October. It takes at least two weeks after vaccination to confer immunity against influenza virus infection. More information regarding influenza vaccination can be found (*here*).

A. Composition of the 2025–2026 Influenza Vaccine**:**

The composition of the 2025–2026 influenza vaccine has been updated to better match circulating influenza viruses. The Advisory Committee on Immunization Practices (ACIP) has recommended that the 2025-2026 influenza trivalent vaccine contain an influenza A/Victoria/4897/2022 (H1N1) pdm09-like virus, influenza A/Croatia/10136RV/2023 (H3N2)-like virus, and influenza B/Austria/1359417/2021 (B/Victoria lineage)-like virus. United States cell culture–based inactivated (ccIIV4) and recombinant (RIV4) influenza vaccines will contain HA derived from an influenza A/Wisconsin/67/2022 (H1N1) pdm09-like virus, an A/District of Columbia/27/2023 (H3N2)-like virus, an influenza B/Austria/1359417/2021 (B/Victoria lineage)-like virus. These vaccine recommendations were based on several factors, including global influenza virologic and epidemiologic surveillance, genetic and antigenic characterization, human serology studies, antiviral susceptibility, and the availability of candidate influenza viruses.

APPENDIX 1: ADDITIONAL INFORMATION

For more information regarding local and national influenza surveillance programs, visit the following sites.

Centers for Disease Control and Prevention	General Influenza National ILI and P&I Data Vaccine Virus Selection CDC Web Tool for Respiratory Viruses
Flu.gov	General Influenza Information
HDOH Flu and Pneumonia	General Influenza Surveillance Avian Influenza Respiratory Virus Dashboard To find out more information or join the sentinel physician program, email the Influenza Surveillance Coordinator
World Health Organization	General Global and Local Influenza Avian Influenza

APPENDIX 2: MMWR WEEK DATES

Please refer to the table below to interpret data presented by MMWR week. Week 40 is considered the traditional start for the flu season for the Northern Hemisphere.

MMWR WEEK	2022	2023	2024	2025	2026
1	1/8/2022	1/7/2023	1/6/2024	1/4/2025	1/10/2026
2	1/15/2022	1/14/2023	1/13/2024	1/11/2025	1/17/2026
3	1/22/2022	1/21/2023	1/20/2024	1/18/2025	1/24/2026
4	1/29/2022	1/28/2023	1/27/2024	1/25/2025	1/31/2026
5	2/5/2022	2/4/2023	2/3/2024	2/1/2025	2/7/2026
6	2/12/2022	2/11/2023	2/10/2024	2/8/2025	2/14/2026
7	2/19/2022	2/18/2023	2/17/2024	2/15/2025	2/21/2026
8	2/26/2022	2/25/2023	2/24/2024	2/22/2025	2/28/2026
9	3/5/2022	3/4/2023	3/2/2024	3/1/2025	3/7/2026
10	3/12/2022	3/11/2023	3/9/2024	3/8/2025	3/14/2026
11	3/19/2022	3/18/2023	3/16/2024	3/15/2025	3/21/2026
12	3/26/2022	3/25/2023	3/23/2024	3/22/2025	3/28/2026
13	4/2/2022	4/1/2023	3/30/2024	3/29/2025	4/4/2026
14	4/9/2022	4/8/2023	4/6/2024	4/5/2025	4/11/2026
15	4/16/2022	4/15/2023	4/13/2024	4/12/2025	4/18/2026
16	4/23/2022	4/22/2023	4/20/2024	4/19/2025	4/25/2026
17	4/30/2022	4/29/2023	4/27/2024	4/26/2025	5/2/2026
18	5/7/2022	5/6/2023	5/4/2024	5/3/2025	5/9/2026
19	5/14/2022	5/13/2023	5/11/2024	5/10/2025	5/16/2026
20	5/21/2022	5/20/2023	5/18/2024	5/17/2025	5/23/2026
21	5/28/2022	5/27/2023	5/25/2024	5/24/2025	5/30/2026
22	6/4/2022	6/3/2023	6/1/2024	5/31/2025	6/6/2026
23	6/11/2022	6/10/2023	6/8/2024	6/7/2025	6/13/2026
24	6/18/2022	6/17/2023	6/15/2024	6/14/2025	6/20/2026
25	6/25/2022	6/24/2023	6/22/2024	6/21/2025	6/27/2026
26	7/2/2022	7/1/2023	6/29/2024	6/28/2025	7/4/2026
27	7/9/2022	7/8/2023	7/6/2024	7/5/2025	7/11/2026
28	7/16/2022	7/15/2023	7/13/2024	7/12/2025	7/18/2026
29	7/23/2022	7/22/2023	7/20/2024	7/19/2025	7/25/2026
30	7/30/2022	7/29/2023	7/27/2024	7/26/2025	8/1/2026
31	8/6/2022	8/5/2023	8/3/2024	8/2/2025	8/8/2026
32	8/13/2022	8/12/2023	8/10/2024	8/9/2025	8/15/2026
33	8/20/2022	8/19/2023	8/17/2024	8/16/2025	8/22/2026
34	8/27/2022	8/26/2023	8/24/2024	8/23/2025	8/29/2026
35	9/3/2022	9/2/2023	8/31/2024	8/30/2025	9/5/2026
36	9/10/2022	9/9/2023	9/7/2024	9/6/2025	9/12/2026
37	9/17/2022	9/16/2023	9/14/2024	9/13/2025	9/19/2026
38	9/24/2022	9/23/2023	9/21/2024	9/20/2025	9/26/2026
39	10/1/2022	9/30/2023	9/28/2024	9/27/2025	10/3/2026
40	10/8/2022	10/7/2023	10/5/2024	10/4/2025	10/10/2026
41	10/15/2022	10/14/2023	10/12/2024	10/11/2025	10/17/2026
42	10/22/2022	10/21/2023	10/19/2024	10/18/2025	10/24/2026
43	10/29/2022	10/28/2023	10/26/2024	10/25/2025	10/31/2026
44	11/5/2022	11/4/2023	11/2/2024	11/1/2025	11/7/2026
45	11/12/2022	11/11/2023	11/9/2024	11/8/2025	11/14/2026
46	11/19/2022	11/18/2023	11/16/2024	11/15/2025	11/21/2026
47	11/26/2022	11/25/2023	11/23/2024	11/22/2025	11/28/2026
48	12/3/2022	12/2/2023	11/30/2024	11/29/2025	12/5/2026
49	12/10/2022	12/9/2023	12/7/2024	12/6/2025	12/12/2026
50	12/17/2022	12/16/2023	12/14/2024	12/13/2025	12/19/2026
51	12/24/2022	12/23/2023	12/21/2024	12/20/2025	12/26/2026
52	12/31/2022	12/30/2023	12/28/2024	12/27/2025	
53				01/03/2026	

HAWAII STATE DEPARTMENT OF HEALTH
DISEASE OUTBREAK CONTROL DIVISION

Influenza/Respiratory Disease Surveillance Report

Morbidity and Mortality Weekly Report (MMWR)[1]

WEEK 14: APRIL 5, 2026– APRIL 11, 2026

OVERVIEW: The Hawaii State Department of Health (HDOH) monitors influenza and other respiratory pathogens, including COVID-19, throughout the state of Hawaii. Influenza surveillance in the state of Hawaii relies upon selected sentinel health practitioners, the State Laboratories Division (SLD), private laboratories, and the Office of Health Status Monitoring (OHSM). For detailed information concerning influenza, please visit the HDOH Disease Outbreak Control Division (HDOH DOCD) website (*here*). **All data and information are conditional and may change as more reports are received.** The data in this report reflects the 2025-2026 influenza season which began the week ending October 4, 2025 (week 40[1] 2025) and will end the week ending on October 3, 2026 (week 39 2026).

REPORT SNAPSHOT FOR WEEK 14

Surveillance for Influenza-like Illness (ILI)		
Metric	*Value*	*Comment*
Outpatient visits related to influenza-like illness (ILI) from ILINet Sentinel Providers	3.2%	Higher than the previous week. Higher than Hawaii's historical baseline and lower than the national baseline, and higher than the national ILI rate.
Number of ILI clusters reported to HDOH	0	There have been 25 clusters this season.

Laboratory Surveillance		
Percent of all respiratory specimens positive for influenza this week	16.4%	Higher than the previous week. This number means that many, if not all, of the 83.6% who tested negative for influenza had illness from another respiratory etiology.
Percent of all respiratory specimens positive for influenza this season to date	18.0%	

Surveillance for Severe Outcomes		
Pneumonia, influenza and COVID-19 (PIC) mortality rate	8.2%	Comparable to Hawaii's historical baseline, Comparable to the national epidemic threshold and comparable to the NCHS average.
Number of influenza-associated pediatric deaths reported nationwide	143	0 influenza-associated pediatric deaths have been reported from Hawaii this season to date.

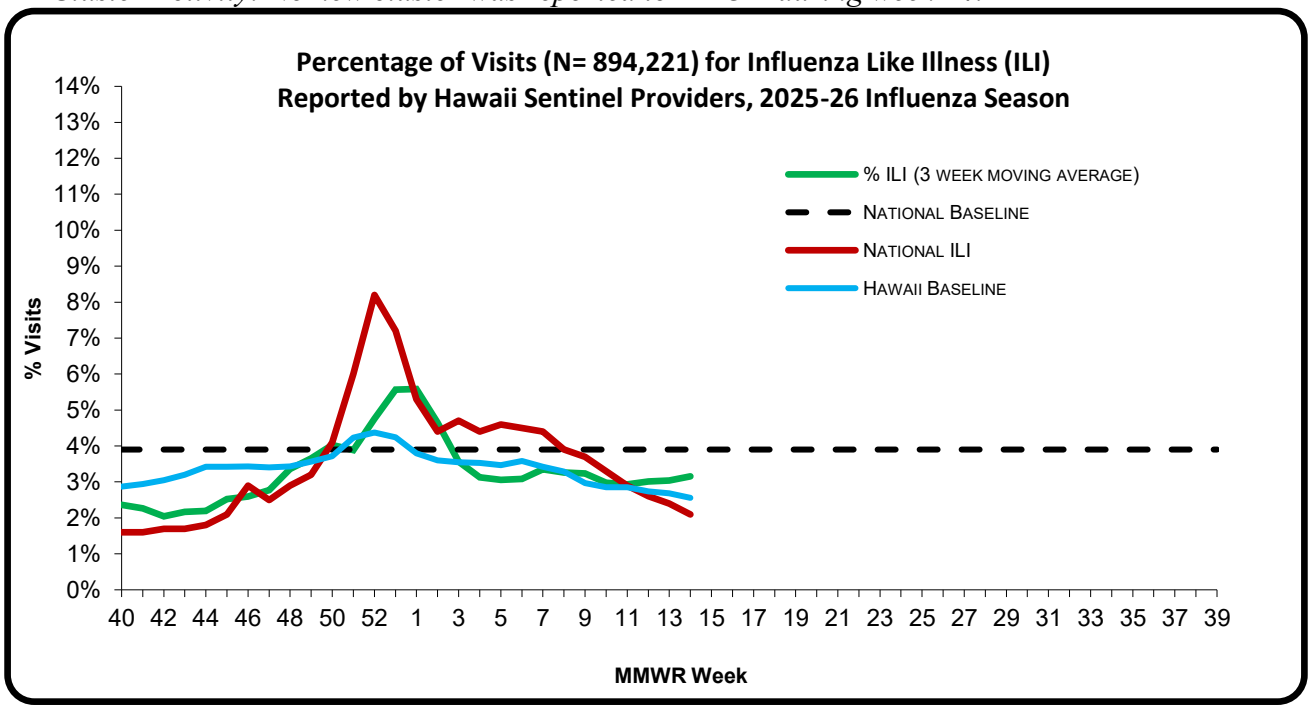
[1] MMWR stands for "Morbidity and Mortality Weekly Report," conventionally used by the Centers for Disease Control and Prevention (CDC). The weeks of a flu season are often referred to by their respective MMWR week. **See appendix 2 for interpretation of MMWR weeks.** Data reported will begin on week 40, the traditional start date of flu season.

INFLUENZA SURVEILLANCE

I. INFLUENZA-LIKE ILLNESS (ILI): HDOH collaborates with recruited doctors and healthcare providers who report the total number of outpatient visits for ILI as well as the total number of patients who complained of symptoms consistent with ILI. A patient with ILI must have the following: a fever (temperature of 100°F [37.8°C] or greater) AND a cough and/or a sore throat. ILI is based on reported symptoms and not laboratory confirmed tests; thus, ILI may represent other respiratory pathogens and not solely influenza. Further, sentinel providers report these numbers on a weekly basis; therefore, data are preliminary and may change depending on additional reporting. In combination with laboratory testing and other surveillance systems, ILI surveillance helps monitor influenza and other respiratory pathogen activity. For more information concerning ILINet and sentinel requirements, please visit the CDC website (*here*).

For **week 14** of the current influenza season:

- ***3.2%** (season to date: **3.3%**) of the outpatient visits recorded by Hawaii sentinel providers were for ILI.*
- *ILI visits were higher than the historical baseline in Hawaii[2,3] (i.e., outside the 95% confidence interval).*
- *Hawaii's ILI outpatient visits were lower than the national baseline (**3.9%**)[4] (i.e., outside the 95% confidence interval) and higher than the national ILI rate (**2.1%**) (i.e. outside the 95% confidence interval).*
- *ILI activity level: Low[5]*
- *Geographic Spread: Sporadic Activity[6].*
- *ILI Cluster Activity: No new cluster was reported to HDOH during week 14.*



[2] The Hawaii historical baseline (%ILI) is the average of 3-week moving averages over the preceding 3 flu seasons of historical data (2022-2023, 2023-2024 and 2024-2025).
[3] This value is based upon comparison of actual outpatient ILI with the historical baseline, which only captures outpatient ILI. The chart above represents a 3-week moving average and not the actual ILI by week.
[4] The National Baseline is calculated by CDC as the mean percentage of visits for ILI during weeks 21–39 with two standard deviations. Because of large variability in regional ILI, comparison of the national baseline with local ILI may not be appropriate. It is provided in this report because no meaningful regional baselines are available for comparison. The national baseline combines all data reported by states to CDC, including ILI in outpatient, ER, urgent care, and inpatient settings.
[5] There are 10 activity levels classified as minimal (levels 1-3), low (levels 4-5), moderate (levels 6-7), and high (levels 8-10).
[6] The influenza activity reported by state and territorial epidemiologists indicates geographic spread of influenza viruses but does not measure the severity of influenza activity. Sporadic: no clusters reported to HDOH, Local: one or more clusters reported in one county, Regional: clusters reported two to three counties, Widespread: clusters reported in all counties. Hawaii does not report No Activity, as flu circulates year-round in Hawaii.

II. LABORATORY SURVEILLANCE: State Laboratories Division (SLD; the HDOH public health laboratory) and Hawaii's major private laboratories (DLS, CLH) report results of RT-PCR, which can be considered confirmatory (SLD may perform viral culture on select specimens). Specimens meeting priority criteria[7] are forwarded to SLD for sub-typing. Additionally, specimens meeting case definition from requesting sentinel providers are sent directly to SLD for sub-typing. Due to resource constraints, not all submitted specimens undergo sub-typing. Sub-typing at the commercial laboratories is only conducted on a case-by-case basis. The majority of specimens testing positive by rapid antigen testing or RT-PCR at the commercial laboratories do not meet criteria and are not subtyped. For more information on influenza tests and types, please visit the CDC website (*here*).

A. INFLUENZA:

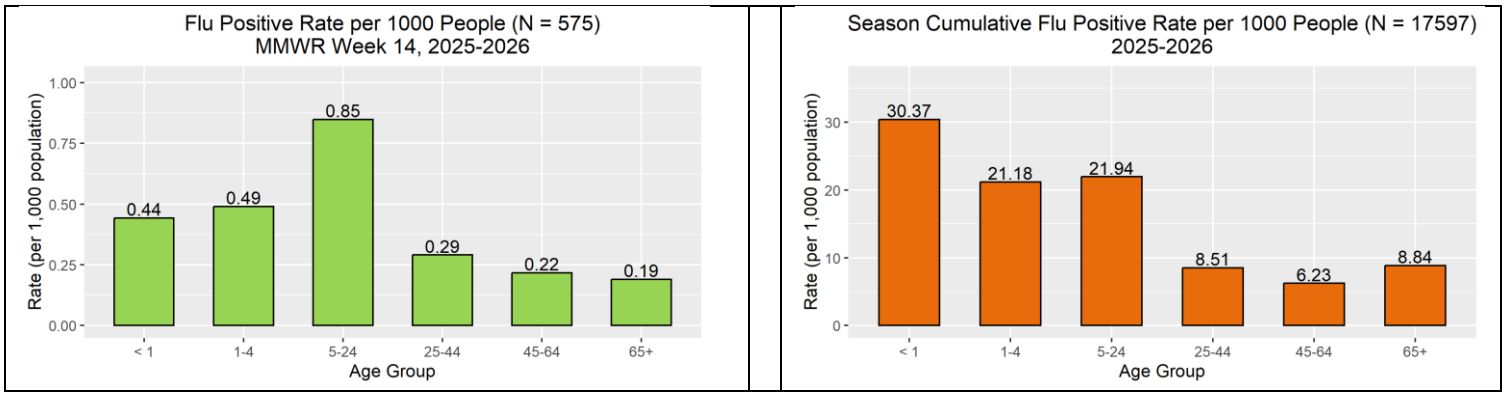
- The following reflects laboratory findings for week 14 of the 2025–26 influenza season:
  - *A total of **3,499** specimens has been tested statewide for influenza viruses (positive: 575 [**16.4%**]). (Season to date: **97,371** tested (**18.0 %** positive)*
    - *1,653 (47.2%) were screened only by rapid antigen tests with no confirmatory testing.*
    - *1,846 (52.8%) underwent confirmatory testing (either RT-PCR or viral culture).*
    - *2,924 (83.6%) were negative.*
  - *Routine surveillance samples from State Laboratory Division were tested at a public health laboratory and identified as Influenza A (H3N2) subclade K.*

Influenza type	*Current week 14 (%)**	*Season to date (%)*[8]
Influenza A (H1)[9]	*6 (1.0)*	*143 (0.8)*
Influenza A (H3)	*0 (0.0)*	*1,282 (7.3)*
Influenza A no subtyping	*146 (25.3)*	*12,464 (70.9)*
Influenza B (Yamagata)	*0 (0.0)*	*0 (0.0)*
Influenza B (Victoria)	*0 (0.0)*	*0 (0.0)*
Influenza B no genotyping	*424 (73.6)*	*3,688 (21.0)*

**Specimens that are positive for both A and B (coinfections) are counted in both A and B totals for current and season to date*

1. AGE DISTRIBUTION

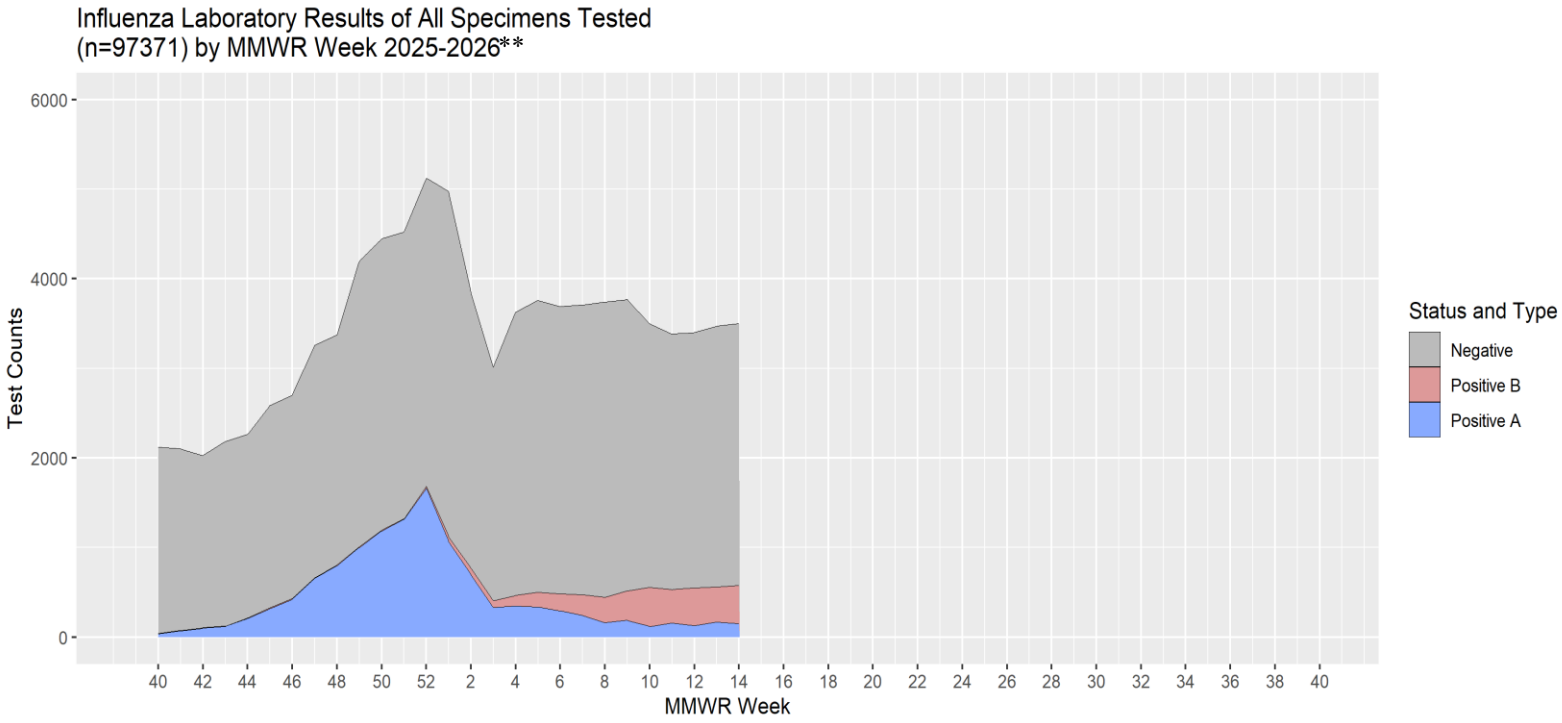
The charts below indicate the population-based rates of positive influenza cases in Hawaii by age group during the 2025–26 influenza season.[10]

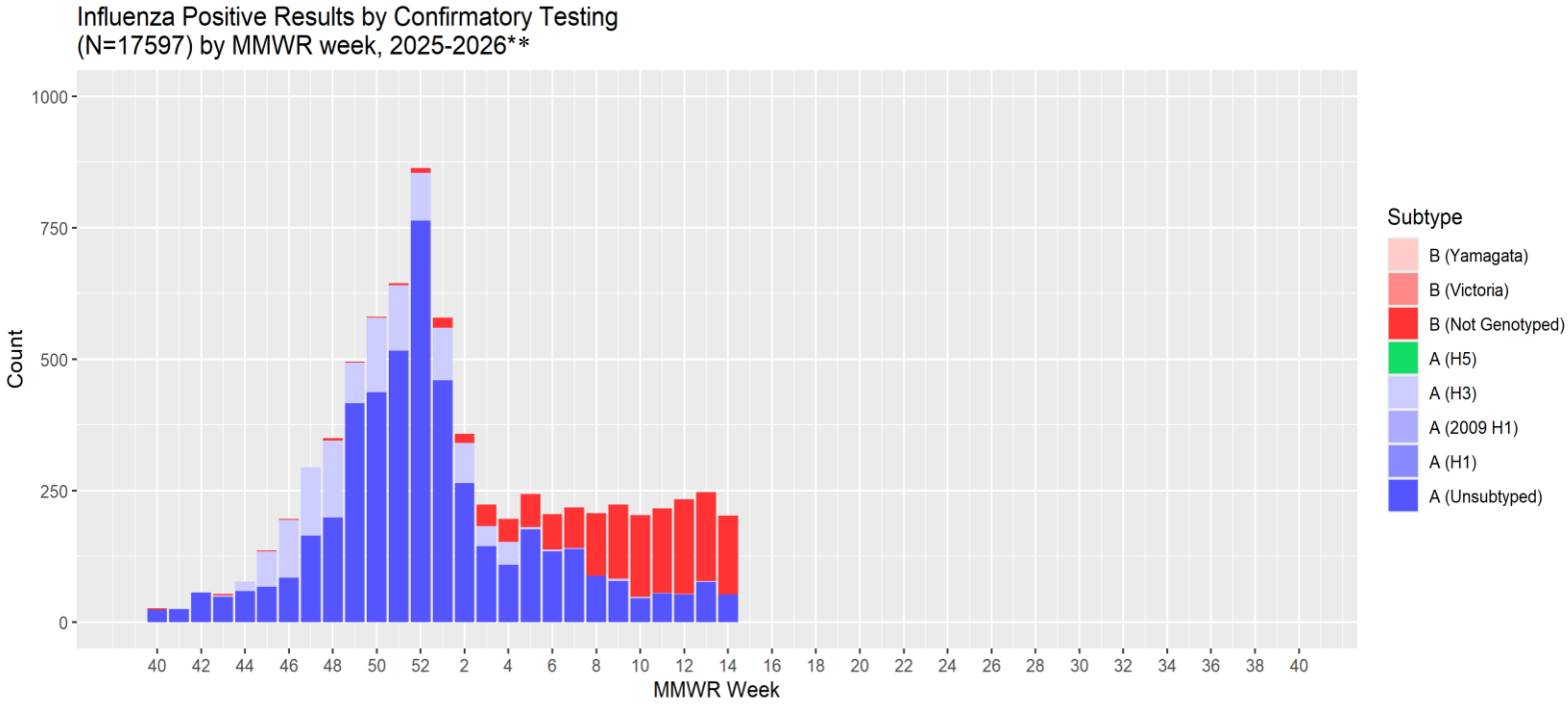


[7] Priority criteria include: hospitalized patients with acute respiratory distress syndrome [ARDS] or x-ray confirmed pneumonia; travelers with international travel history within 10 days of onset; specimens submitted by sentinel providers; specimens collected from healthcare workers, pregnant women, or women up to 6 weeks' post-partum; those with underlying medical conditions; and patients presenting with unusual or severe manifestations of influenza infection.
[8] Influenza coding was updated to reflect a more accurate count.
[9] All influenza A H1 viruses detected this season have been 2009 H1N1.
[10] This represents an estimate of population-based rates based on available data.

2. LABORATORY TESTING

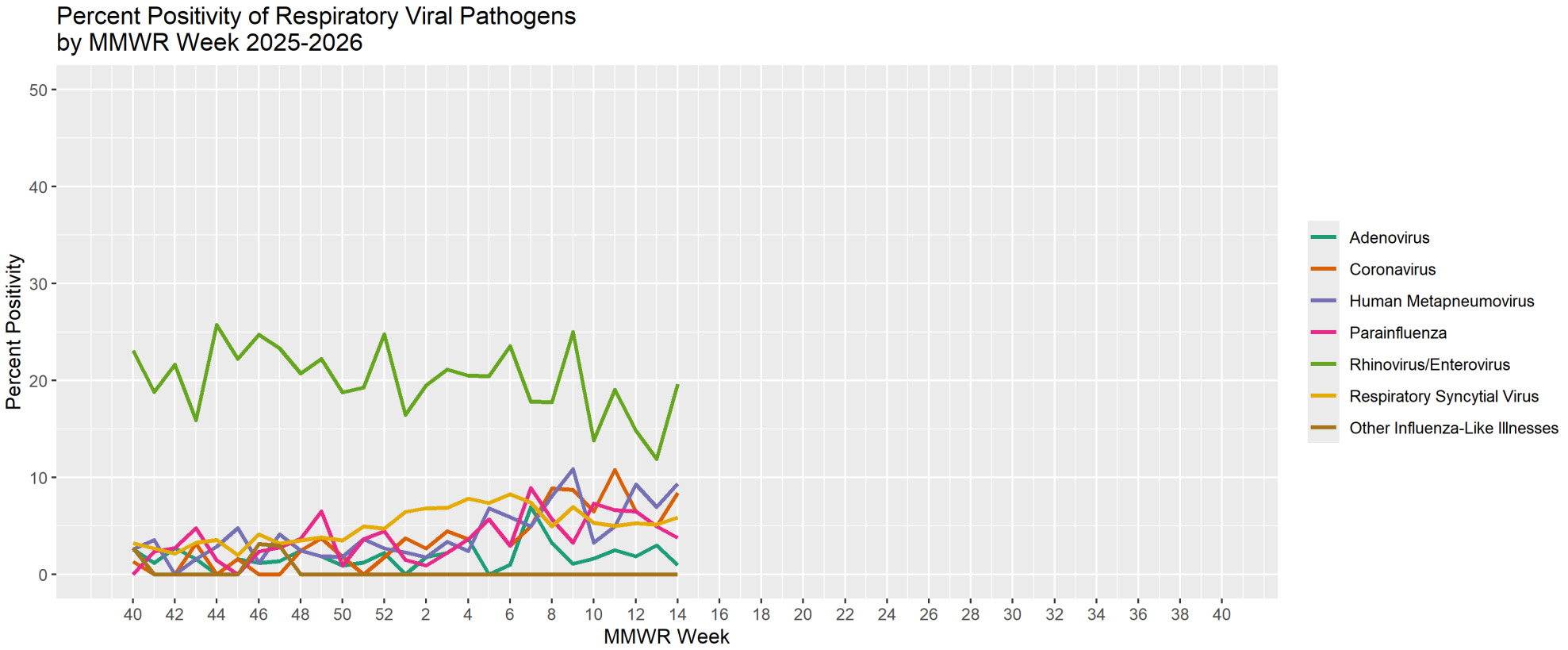
The charts below show the laboratory results of all specimens tested for influenza by MMWR week during the 2025–2026 influenza season as well as the type and subtype of positive results for influenza. Again, sub-typing is only performed on selected specimens tested by confirmatory tests (i.e., RT-PCR or viral culture).





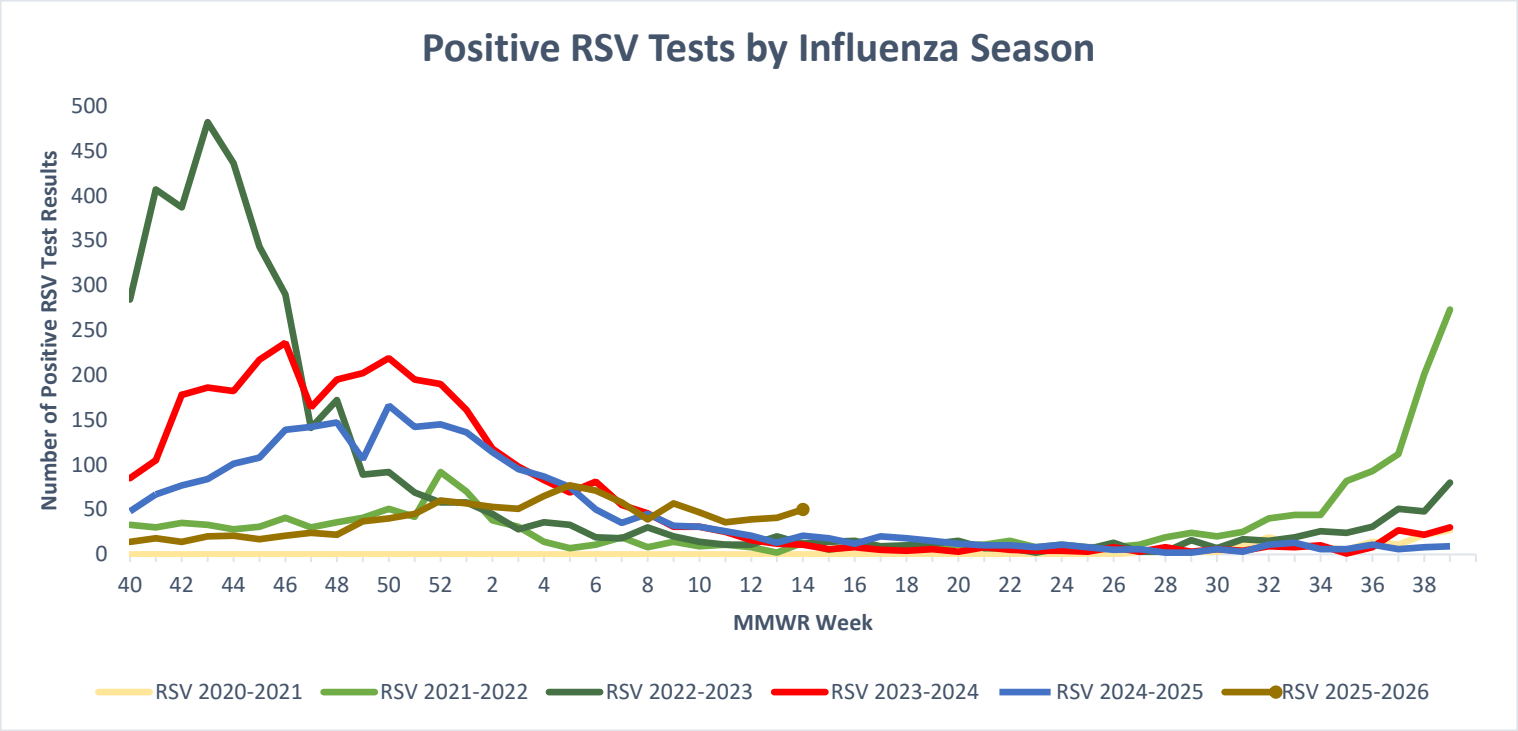
** A total of 53,794 specimens underwent confirmatory testing, but not all positive influenza specimens receive confirmatory testing that are circulating in Hawaii.*
*** For MMWR Week 53, results are reported under MMWR Week 52, where the average of Weeks 52 and 53 was calculated.*

B. **OTHER RESPIRATORY PATHOGENS:** The major clinical and commercial laboratories throughout the state of Hawaii have the testing capacity for non-influenza respiratory pathogens and report these to HDOH. However, such testing is performed as needed and when sufficient resources are available because of the high costs associated with respiratory panel tests. **Therefore, available data represent only the presence of circulating pathogens and cannot be used to determine specific trends**.

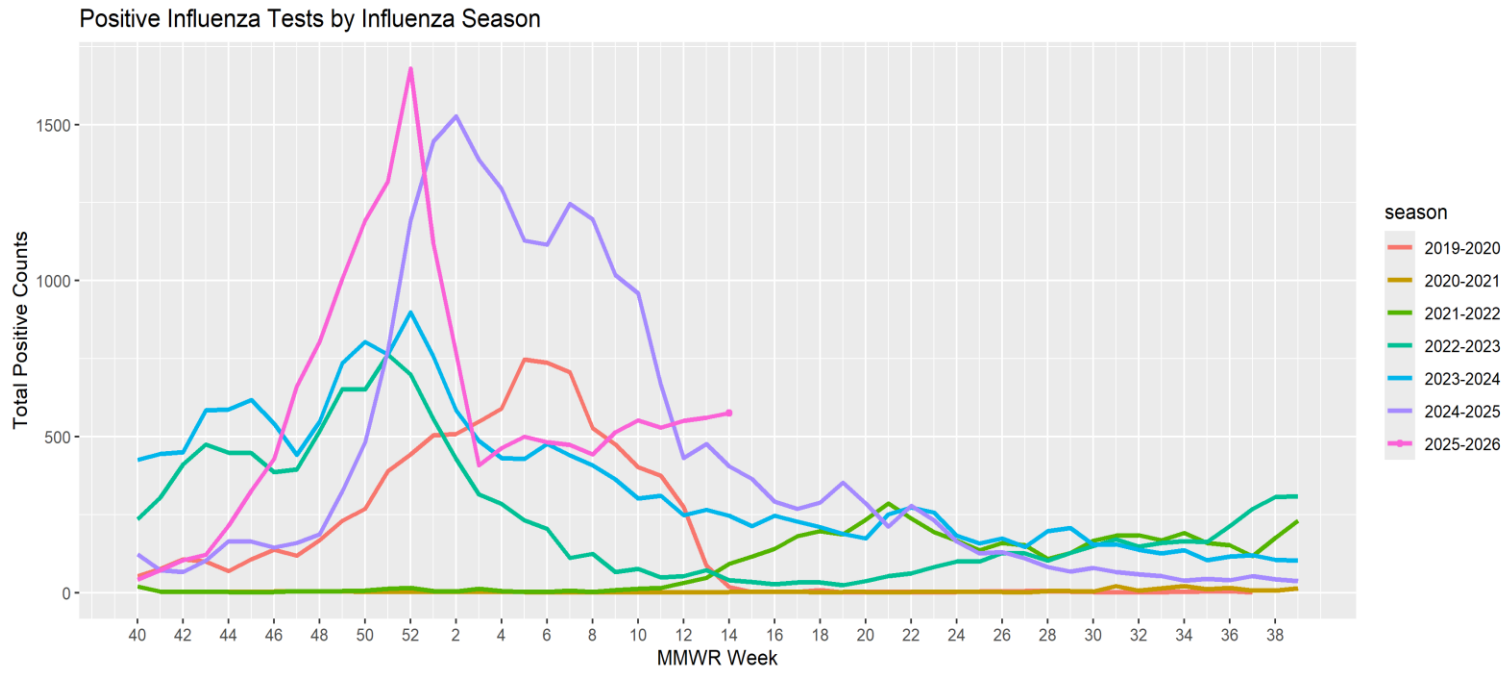


* *The coronavirus presented on this table does not indicate Severe Acute Respiratory Coronavirus-2 (i.e., COVID-19). For MMWR Week 53, results are reported under MMWR Week 52, where the average of Weeks 52 and 53 was calculated*

RESPIRATORY SYNCYTIAL VIRUS (RSV) POSITIVE TEST RESULTS BY INFLUENZA SEASON: RSV case appears to have increased later than past seasons in the 2025-2026 season. For MMWR Week 53, results are reported under MMWR Week 52, where the average of Weeks 52 and 53 was calculated.



INFLUENZA POSITIVE TEST RESULTS BY INFLUENZA SEASON: Influenza cases appear to have increased earlier than past seasons in the 2025-2026 season. For MMWR Week 53, results are reported under MMWR Week 52, where the average of Weeks 52 and 53 was calculated.



C. COVID-19 SENTINEL SURVEILLANCE: Due to the low volume of samples currently available through the influenza surveillance system, the COVID-19 sentinel surveillance data may not be accurately portraying COVID-19 activity in our communities. Reporting of the COVID-19 Sentinel Surveillance data will be paused while HODH re-evaluates the program to ensure that the reported data are accurate and representative.

HDOH is continuing to monitor COVID-19 activity throughout the state. To learn more, please visit the Hawaii's COVID-19 data website (*here*). For more information on surveillance of COVID-19 activity in the United States please visit the CDC COVIDView website (*here*).

III. PNEUMONIA, INFLUENZA, AND COVID-19 (PIC) RELATED MORTALITY:

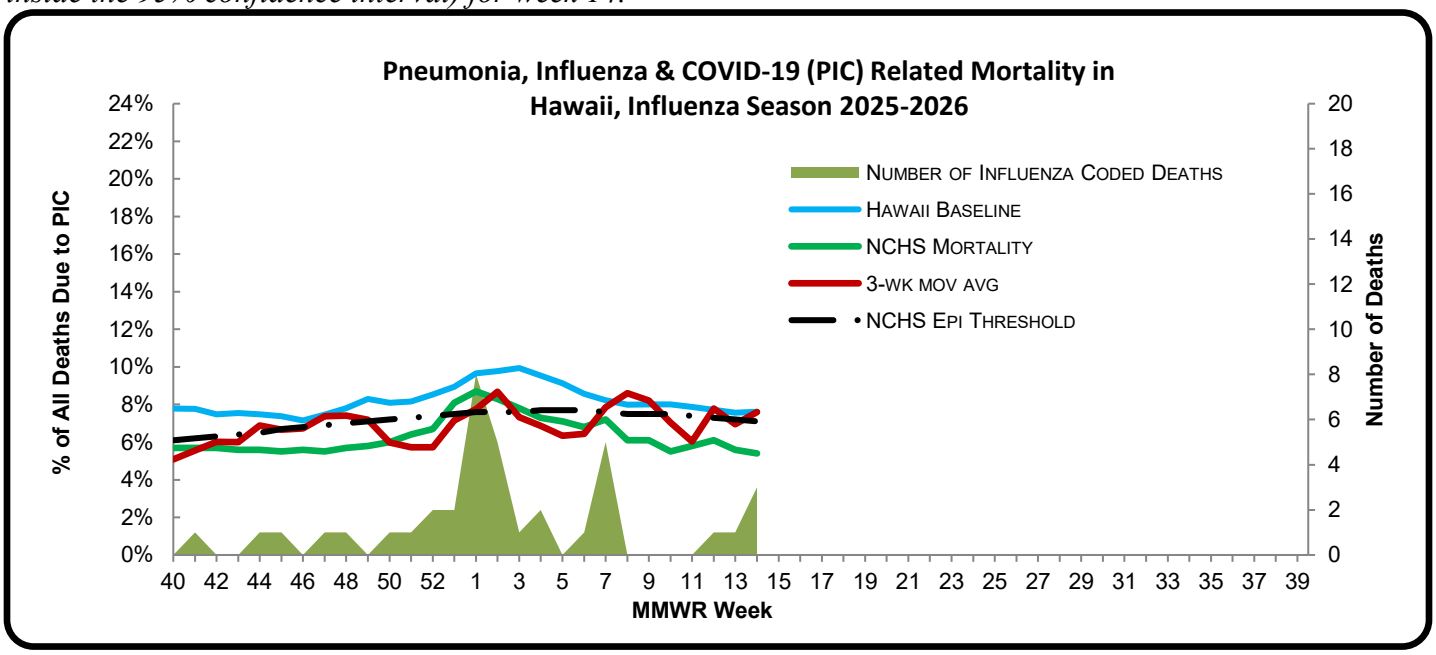
P&I mortality surveillance is collected by CDC through the National Center for Health Statistics (NCHS) using death certificate data. Each week the HDOH OHSM reports specific data from Honolulu to the CDC. CDC collects the following information by age group: the total number of deaths, total deaths from pneumonia, and total deaths related to influenza. Due to the ongoing COVID-19 pandemic, CDC included total deaths from COVID-19 by age group to the death data. Previous studies had suggested that P&I is a good indicator of influenza-related deaths; however, data has shown that pneumonia deaths associated with influenza is now being impacted by COVID-19 related pneumonia. Due to this, CDC had added COVID-19 deaths into P&I to create the PIC (pneumonia, influenza, and/or COVID-19) classification.

To standardize Hawaii's influenza surveillance with CDC influenza surveillance guidelines, PIC deaths will be reported in lieu of P&I. Hawaii's baseline will begin to include PIC deaths starting from 2019-2020 flu season.

For **week 14** of the current influenza season:

- ***8.2%*** *of all deaths that occurred in Hawaii during week 14 were related to pneumonia, influenza or COVID-19 (PIC)*[11]*. For the current season (season to date:* ***6.9%****), there have been 6,516 deaths from any cause, 453 of which were due to PIC*[12]*.*
- *The PIC rate was comparable to the historical baseline in Hawaii*[13] *(i.e., inside the 95% confidence interval).*

The Hawaii PIC rate was comparable to the CDC's National Center for Health Statistics (NCHS) PIC mortality[14] *(**5.4%**) (i.e., inside the 95% confidence interval) and comparable to the national epidemic threshold (**7.1%**) (i.e., inside the 95% confidence interval) for week 14.*



[11] The percent of deaths due to PIC displayed on the graph is the 3-week moving averages.

[12] PIC data reflect 100.0% of the data reported for the MMWR week. Changes to data are expected when PIC data reaches 100% completion.

[13] The Hawaii historical baseline (%PIC) is the average of 3-week moving averages over the preceding 10 flu seasons of historical data (2014-2015, 2015-2016, 2016-2017, 2017-2018, 2018-2019, 2019-2020, 2020-2021, 2021-2022, 2022-2023, and 2023-2024).

[14] Each week, the vital statistics offices of 122 cities across the United States report the total number of death certificates processed and the number of those for which pneumonia, influenza, or COVID-19 was listed as the underlying or contributing cause of death by age group (Under 28 days, 28 days–1 year, 1–14 years, 15–24 years, 25–44 years, 45–64 years, 65–74 years, 75–84 years, and ≥85 years). The COVID-19 death counts reported by NCHS are provisional and will not match counts in other sources, such as media reports or numbers from health departments. COVID-19 deaths may be classified or defined differently in various reporting and surveillance systems. The percentage of deaths due to pneumonia, influenza, and COVID-19 (PIC) are compared with a seasonal baseline and epidemic threshold value calculated for each week.

INFLUENZA-ASSOCIATED PEDIATRIC DEATHS[15]:

- No new influenza-associated pediatric death was reported to Hawaii. There have been zero influenza-associated pediatric deaths reported in Hawaii during the 2025–2026 season.
- Nationally, four new influenza-associated pediatric deaths were reported to CDC during week 14. (2025-2026 season total: 143).

IV. INFLUENZA WATCH: As part of a comprehensive influenza surveillance system and to prevent the spread of contagious respiratory diseases in humans, it is important to monitor all circulating influenza types. Several animal-origin influenza A subtypes are currently of interest: influenza A variant virus (H3N2v, H1N2v, and H1N1v) and Avian flu (H5N1 and H7N9). These types of influenza viruses may cause zoonotic (animal-associated) disease and are a public health concern.

A. VARIANT VIRUSES:

Influenza viruses that normally circulate in pigs are called "variant" viruses when they are found in people. These viruses were first identified in U.S. pigs in 2010. In 2011, 12 cases of H3N2v infection were detected in the United States. In 2012, 309 such cases (resulting in 16 hospitalizations and one death) across 12 states were detected, including one Hawaii case who recovered. Illness associated with H3N2v infection has been mostly mild with symptoms similar to those of seasonal flu. However, serious illness, resulting in hospitalization and death, has occurred in some cases. Most of these infections have been associated with prolonged exposure to pigs at agricultural fairs or similar settings. Limited human-to-human spread of this virus has been detected in the past, but no sustained community spread of H3N2v has been identified. More information regarding H3N2v, H1N1v, and H1N2v viruses may be found on the CDC website (*here*) and (*here*).

- *No variant or novel influenza infections have been reported to HDOH during the 2025-2026 influenza season.*
- *One new human infection with novel influenza A virus, H1N1v (0), H3N2v (0), and H1N2v (1), have been reported during the 2025-2026 influenza season.*
    - *One new human infection with influenza A(H1N1v) virus has been reported to WHO from China during the 2025-2026 influenza season.*

AVIAN (OR BIRD) INFLUENZA: These types of influenza viruses cause zoonotic (animal-associated) disease of public health concern and are therefore monitored globally by the WHO. Most avian influenza viruses do not cause disease in humans and are generally not easily transmissible between person to person, but a few subtypes may cross the species barrier and cause disease in humans. Avian influenza viruses may be of various subtypes, including H5N1, H5N2, H5N8, H7N3, H7N7, H7N8, H7N9, and H9N2. On January 15th, 2016, the USDA and APHIS reported detection of HPAI H7N8 in a commercial turkey flock in Indiana. There have been no associated human infections. This is the first detection of HPAI H7N8 in wild bird surveillance in the United States. More information, the risk assessment and recommendations for HPAI H7N8 can be found (here). The WHO, CDC, and other public health agencies have also been monitoring influenza H7N9, which represents a public health concern because of its high pandemic potential. Although H7N9 has not been detected in the United States, it remains a global concern given continuing epidemics in endemic countries. Since 2013, a total of 1,568 laboratory-confirmed cases of human infection with H7N9 viruses, including at least 613 deaths, have been reported to WHO. More information on H7N9 virus infections can be found (here). For more information regarding avian influenza, please visit the CDC (*here*) or the WHO (*here*) websites. WHO reports total number of cases and deaths related to laboratory-confirmed avian influenza viruses and posts current avian influenza case counts (*here*), which were last updated on **January 22, 2026**.

[15] Influenza-associated deaths are considered pediatric in persons aged less than 18 years. It was made a nationally notifiable condition in October, 2004. All pediatric influenza-associated deaths are laboratory confirmed.

V. INFLUENZA Vaccine: Annual influenza vaccination is recommended for all persons aged 6 months and older and is the most effective way to reduce the risk of getting sick with seasonal flu and spreading it to others. Influenza vaccination can reduce illnesses, visits to the doctor, influenza-related hospitalizations, and missed work and school days. Influenza vaccines become available by the end of October. It takes at least two weeks after vaccination to confer immunity against influenza virus infection. More information regarding influenza vaccination can be found (*here*).

A. Composition of the 2025–2026 Influenza Vaccine**:**

The composition of the 2025–2026 influenza vaccine has been updated to better match circulating influenza viruses. The Advisory Committee on Immunization Practices (ACIP) has recommended that the 2025-2026 influenza trivalent vaccine contain an influenza A/Victoria/4897/2022 (H1N1) pdm09-like virus, influenza A/Croatia/10136RV/2023 (H3N2)-like virus, and influenza B/Austria/1359417/2021 (B/Victoria lineage)-like virus. United States cell culture–based inactivated (ccIIV4) and recombinant (RIV4) influenza vaccines will contain HA derived from an influenza A/Wisconsin/67/2022 (H1N1) pdm09-like virus, an A/District of Columbia/27/2023 (H3N2)-like virus, an influenza B/Austria/1359417/2021 (B/Victoria lineage)-like virus. These vaccine recommendations were based on several factors, including global influenza virologic and epidemiologic surveillance, genetic and antigenic characterization, human serology studies, antiviral susceptibility, and the availability of candidate influenza viruses.

APPENDIX 1: ADDITIONAL INFORMATION

For more information regarding local and national influenza surveillance programs, visit the following sites.

Centers for Disease Control and Prevention	General Influenza National ILI and P&I Data Vaccine Virus Selection CDC Web Tool for Respiratory Viruses
Flu.gov	General Influenza Information
HDOH Flu and Pneumonia	General Influenza Surveillance Avian Influenza Respiratory Virus Dashboard To find out more information or join the sentinel physician program, email the Influenza Surveillance Coordinator
World Health Organization	General Global and Local Influenza Avian Influenza

APPENDIX 2: MMWR WEEK DATES

Please refer to the table below to interpret data presented by MMWR week. Week 40 is considered the traditional start for the flu season for the Northern Hemisphere.

MMWR WEEK	2022	2023	2024	2025	2026
1	1/8/2022	1/7/2023	1/6/2024	1/4/2025	1/10/2026
2	1/15/2022	1/14/2023	1/13/2024	1/11/2025	1/17/2026
3	1/22/2022	1/21/2023	1/20/2024	1/18/2025	1/24/2026
4	1/29/2022	1/28/2023	1/27/2024	1/25/2025	1/31/2026
5	2/5/2022	2/4/2023	2/3/2024	2/1/2025	2/7/2026
6	2/12/2022	2/11/2023	2/10/2024	2/8/2025	2/14/2026
7	2/19/2022	2/18/2023	2/17/2024	2/15/2025	2/21/2026
8	2/26/2022	2/25/2023	2/24/2024	2/22/2025	2/28/2026
9	3/5/2022	3/4/2023	3/2/2024	3/1/2025	3/7/2026
10	3/12/2022	3/11/2023	3/9/2024	3/8/2025	3/14/2026
11	3/19/2022	3/18/2023	3/16/2024	3/15/2025	3/21/2026
12	3/26/2022	3/25/2023	3/23/2024	3/22/2025	3/28/2026
13	4/2/2022	4/1/2023	3/30/2024	3/29/2025	4/4/2026
14	4/9/2022	4/8/2023	4/6/2024	4/5/2025	4/11/2026
15	4/16/2022	4/15/2023	4/13/2024	4/12/2025	4/18/2026
16	4/23/2022	4/22/2023	4/20/2024	4/19/2025	4/25/2026
17	4/30/2022	4/29/2023	4/27/2024	4/26/2025	5/2/2026
18	5/7/2022	5/6/2023	5/4/2024	5/3/2025	5/9/2026
19	5/14/2022	5/13/2023	5/11/2024	5/10/2025	5/16/2026
20	5/21/2022	5/20/2023	5/18/2024	5/17/2025	5/23/2026
21	5/28/2022	5/27/2023	5/25/2024	5/24/2025	5/30/2026
22	6/4/2022	6/3/2023	6/1/2024	5/31/2025	6/6/2026
23	6/11/2022	6/10/2023	6/8/2024	6/7/2025	6/13/2026
24	6/18/2022	6/17/2023	6/15/2024	6/14/2025	6/20/2026
25	6/25/2022	6/24/2023	6/22/2024	6/21/2025	6/27/2026
26	7/2/2022	7/1/2023	6/29/2024	6/28/2025	7/4/2026
27	7/9/2022	7/8/2023	7/6/2024	7/5/2025	7/11/2026
28	7/16/2022	7/15/2023	7/13/2024	7/12/2025	7/18/2026
29	7/23/2022	7/22/2023	7/20/2024	7/19/2025	7/25/2026
30	7/30/2022	7/29/2023	7/27/2024	7/26/2025	8/1/2026
31	8/6/2022	8/5/2023	8/3/2024	8/2/2025	8/8/2026
32	8/13/2022	8/12/2023	8/10/2024	8/9/2025	8/15/2026
33	8/20/2022	8/19/2023	8/17/2024	8/16/2025	8/22/2026
34	8/27/2022	8/26/2023	8/24/2024	8/23/2025	8/29/2026
35	9/3/2022	9/2/2023	8/31/2024	8/30/2025	9/5/2026
36	9/10/2022	9/9/2023	9/7/2024	9/6/2025	9/12/2026
37	9/17/2022	9/16/2023	9/14/2024	9/13/2025	9/19/2026
38	9/24/2022	9/23/2023	9/21/2024	9/20/2025	9/26/2026
39	10/1/2022	9/30/2023	9/28/2024	9/27/2025	10/3/2026
40	10/8/2022	10/7/2023	10/5/2024	10/4/2025	10/10/2026
41	10/15/2022	10/14/2023	10/12/2024	10/11/2025	10/17/2026
42	10/22/2022	10/21/2023	10/19/2024	10/18/2025	10/24/2026
43	10/29/2022	10/28/2023	10/26/2024	10/25/2025	10/31/2026
44	11/5/2022	11/4/2023	11/2/2024	11/1/2025	11/7/2026
45	11/12/2022	11/11/2023	11/9/2024	11/8/2025	11/14/2026
46	11/19/2022	11/18/2023	11/16/2024	11/15/2025	11/21/2026
47	11/26/2022	11/25/2023	11/23/2024	11/22/2025	11/28/2026
48	12/3/2022	12/2/2023	11/30/2024	11/29/2025	12/5/2026
49	12/10/2022	12/9/2023	12/7/2024	12/6/2025	12/12/2026
50	12/17/2022	12/16/2023	12/14/2024	12/13/2025	12/19/2026
51	12/24/2022	12/23/2023	12/21/2024	12/20/2025	12/26/2026
52	12/31/2022	12/30/2023	12/28/2024	12/27/2025	
53				01/03/2026	

HAWAII STATE DEPARTMENT OF HEALTH
DISEASE OUTBREAK CONTROL DIVISION

Influenza/Respiratory Disease Surveillance Report

Morbidity and Mortality Weekly Report (MMWR)[1]

WEEK 15: APRIL 12, 2026– APRIL 18, 2026

OVERVIEW: The Hawaii State Department of Health (HDOH) monitors influenza and other respiratory pathogens, including COVID-19, throughout the state of Hawaii. Influenza surveillance in the state of Hawaii relies upon selected sentinel health practitioners, the State Laboratories Division (SLD), private laboratories, and the Office of Health Status Monitoring (OHSM). For detailed information concerning influenza, please visit the HDOH Disease Outbreak Control Division (HDOH DOCD) website (*here*). **All data and information are conditional and may change as more reports are received.** The data in this report reflects the 2025-2026 influenza season which began the week ending October 4, 2025 (week 40[1] 2025) and will end the week ending on October 3, 2026 (week 39 2026).

REPORT SNAPSHOT FOR WEEK 15

Surveillance for Influenza-like Illness (ILI)		
Metric	*Value*	*Comment*
Outpatient visits related to influenza-like illness (ILI) from ILINet Sentinel Providers	3.5%	Higher than the previous week. Higher than Hawaii's historical baseline and lower than the national baseline, and higher than the national ILI rate.
Number of ILI clusters reported to HDOH	2	There have been 27 clusters this season.

Laboratory Surveillance		
Percent of all respiratory specimens positive for influenza this week	15.9%	Lower than the previous week. This number means that many, if not all, of the 84.1% who tested negative for influenza had illness from another respiratory etiology.
Percent of all respiratory specimens positive for influenza this season to date	18.0%	

Surveillance for Severe Outcomes		
Pneumonia, influenza and COVID-19 (PIC) mortality rate		No new data for PIC mortality rates was available to include in this week's report.
Number of influenza-associated pediatric deaths reported nationwide	149	0 influenza-associated pediatric deaths have been reported from Hawaii this season to date.

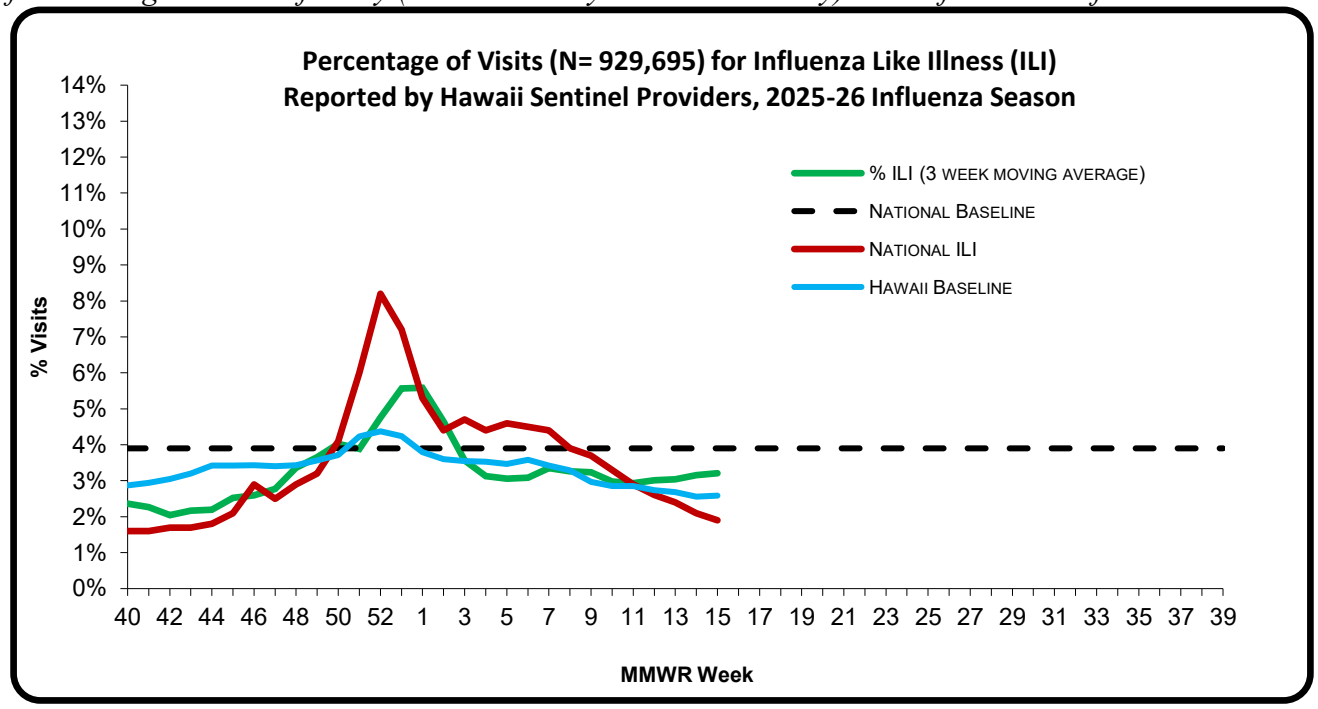
[1] MMWR stands for "Morbidity and Mortality Weekly Report," conventionally used by the Centers for Disease Control and Prevention (CDC). The weeks of a flu season are often referred to by their respective MMWR week. **See appendix 2 for interpretation of MMWR weeks.** Data reported will begin on week 40, the traditional start date of flu season.

INFLUENZA SURVEILLANCE

I. INFLUENZA-LIKE ILLNESS (ILI): HDOH collaborates with recruited doctors and healthcare providers who report the total number of outpatient visits for ILI as well as the total number of patients who complained of symptoms consistent with ILI. A patient with ILI must have the following: a fever (temperature of 100°F [37.8°C] or greater) AND a cough and/or a sore throat. ILI is based on reported symptoms and not laboratory confirmed tests; thus, ILI may represent other respiratory pathogens and not solely influenza. Further, sentinel providers report these numbers on a weekly basis; therefore, data are preliminary and may change depending on additional reporting. In combination with laboratory testing and other surveillance systems, ILI surveillance helps monitor influenza and other respiratory pathogen activity. For more information concerning ILINet and sentinel requirements, please visit the CDC website (*here*).

For **week 15** of the current influenza season:

- ***3.5%** (season to date: **3.3%**) of the outpatient visits recorded by Hawaii sentinel providers were for ILI.*
- *ILI visits were higher than the historical baseline in Hawaii[2,3] (i.e., outside the 95% confidence interval).*
- *Hawaii's ILI outpatient visits were lower than the national baseline (**3.9%**)[4] (i.e., outside the 95% confidence interval) and higher than the national ILI rate (**1.9%**) (i.e. outside the 95% confidence interval).*
- *ILI activity level: Low[5]*
- *Geographic Spread: Sporadic Activity[6].*
- *ILI Cluster Activity: Two new clusters were reported to HDOH during week 15. Both clusters were reported from a long-term care facility (Hawaii County and Maui County) with influenza A infections.*



[2] The Hawaii historical baseline (%ILI) is the average of 3-week moving averages over the preceding 3 flu seasons of historical data (2022-2023, 2023-2024 and 2024-2025).
[3] This value is based upon comparison of actual outpatient ILI with the historical baseline, which only captures outpatient ILI. The chart above represents a 3-week moving average and not the actual ILI by week.
[4] The National Baseline is calculated by CDC as the mean percentage of visits for ILI during weeks 21–39 with two standard deviations. Because of large variability in regional ILI, comparison of the national baseline with local ILI may not be appropriate. It is provided in this report because no meaningful regional baselines are available for comparison. The national baseline combines all data reported by states to CDC, including ILI in outpatient, ER, urgent care, and inpatient settings.
[5] There are 10 activity levels classified as minimal (levels 1-3), low (levels 4-5), moderate (levels 6-7), and high (levels 8-10).
[6] The influenza activity reported by state and territorial epidemiologists indicates geographic spread of influenza viruses but does not measure the severity of influenza activity. Sporadic: no clusters reported to HDOH, Local: one or more clusters reported in one county, Regional: clusters reported two to three counties, Widespread: clusters reported in all counties. Hawaii does not report No Activity, as flu circulates year-round in Hawaii.

II. LABORATORY SURVEILLANCE: State Laboratories Division (SLD; the HDOH public health laboratory) and Hawaii's major private laboratories (DLS, CLH) report results of RT-PCR, which can be considered confirmatory (SLD may perform viral culture on select specimens). Specimens meeting priority criteria[7] are forwarded to SLD for sub-typing. Additionally, specimens meeting case definition from requesting sentinel providers are sent directly to SLD for sub-typing. Due to resource constraints, not all submitted specimens undergo sub-typing. Sub-typing at the commercial laboratories is only conducted on a case-by-case basis. The majority of specimens testing positive by rapid antigen testing or RT-PCR at the commercial laboratories do not meet criteria and are not subtyped. For more information on influenza tests and types, please visit the CDC website (*here*).

A. INFLUENZA:

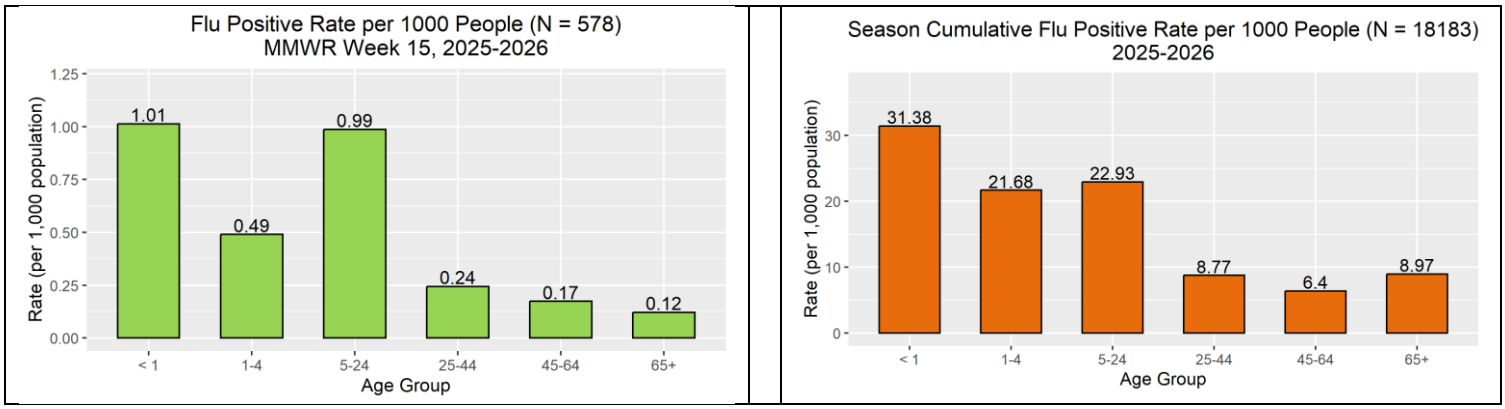
- The following reflects laboratory findings for week 15 of the 2025–26 influenza season:
  - *A total of **3,641** specimens has been tested statewide for influenza viruses (positive: 578 [**15.9%**]). (Season to date: **101,023** tested (**18.0 %** positive)*
    - *1,683 (46.2%) were screened only by rapid antigen tests with no confirmatory testing.*
    - *1,958 (53.8%) underwent confirmatory testing (either RT-PCR or viral culture).*
    - *3,063 (84.1%) were negative.*
  - *Routine surveillance samples from State Laboratory Division were tested at a public health laboratory and identified as Influenza A (H3N2) subclade K.*

Influenza type	***Current week 15 (%)****	***Season to date (%)***[8]
Influenza A (H1)[9]	*1 (0.2)*	*171 (0.9)*
Influenza A (H3)	*0 (0.0)*	*1,292 (7.1)*
Influenza A no subtyping	*81 (14.0)*	*12,502 (68.9)*
Influenza B (Yamagata)	*0 (0.0)*	*0 (0.0)*
Influenza B (Victoria)	*0 (0.0)*	*0 (0.0)*
Influenza B no genotyping	*496 (85.8)*	*4,184 (23.1)*

**Specimens that are positive for both A and B (coinfections) are counted in both A and B totals for current and season to date*

1. AGE DISTRIBUTION

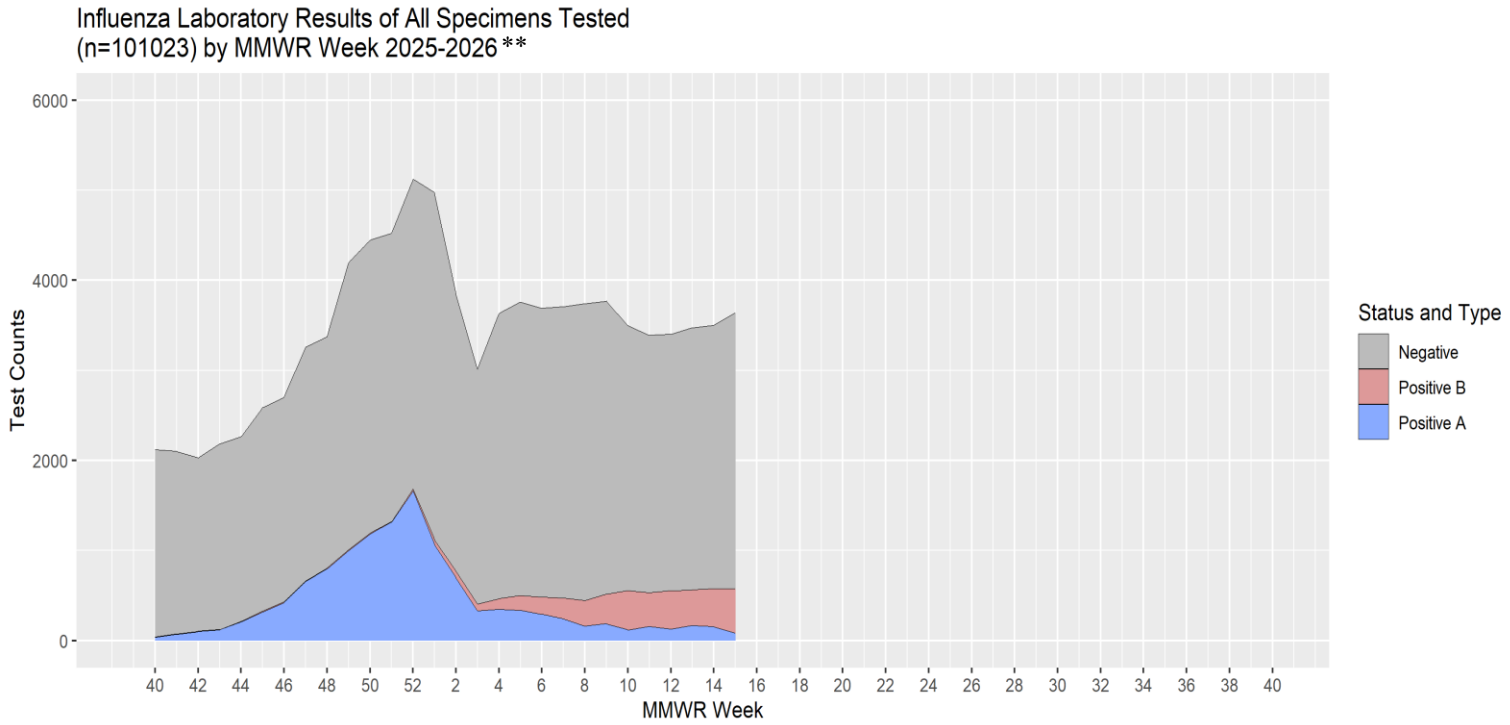
The charts below indicate the population-based rates of positive influenza cases in Hawaii by age group during the 2025–26 influenza season.[10]

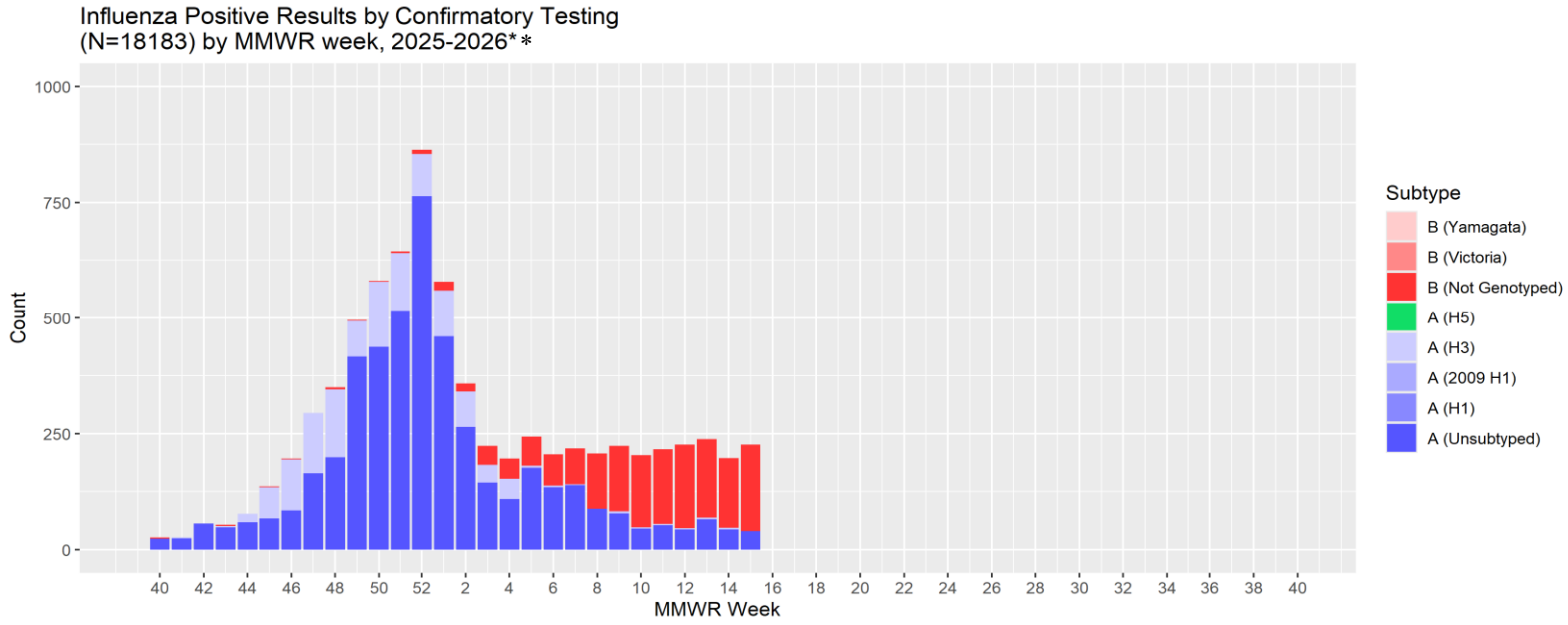


[7] Priority criteria include: hospitalized patients with acute respiratory distress syndrome [ARDS] or x-ray confirmed pneumonia; travelers with international travel history within 10 days of onset; specimens submitted by sentinel providers; specimens collected from healthcare workers, pregnant women, or women up to 6 weeks' post-partum; those with underlying medical conditions; and patients presenting with unusual or severe manifestations of influenza infection.
[8] Influenza coding was updated to reflect a more accurate count.
[9] All influenza A H1 viruses detected this season have been 2009 H1N1.
[10] This represents an estimate of population-based rates based on available data.

2. LABORATORY TESTING

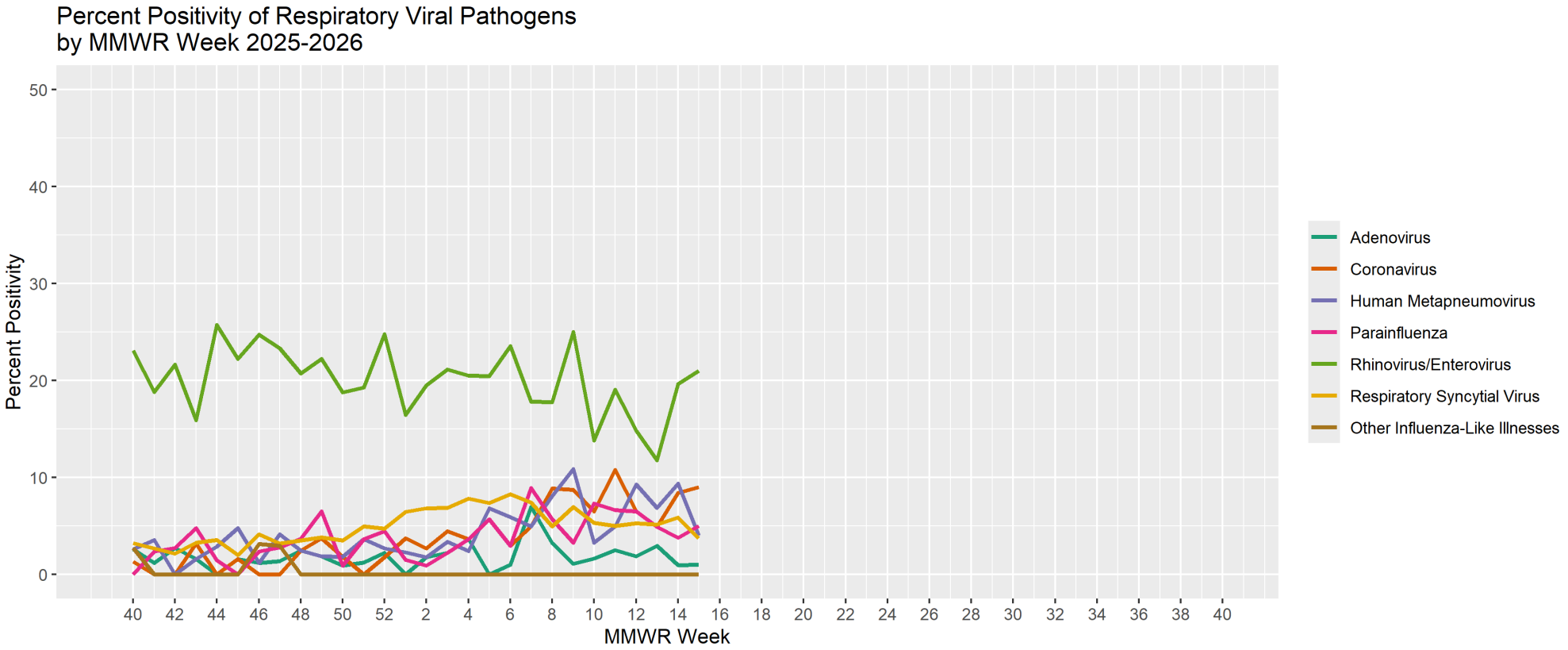
The charts below show the laboratory results of all specimens tested for influenza by MMWR week during the 2025–2026 influenza season as well as the type and subtype of positive results for influenza. Again, sub-typing is only performed on selected specimens tested by confirmatory tests (i.e., RT-PCR or viral culture).





** A total of 55,760 specimens underwent confirmatory testing, but not all positive influenza specimens receive confirmatory testing that are circulating in Hawaii.*
*** For MMWR Week 53, results are reported under MMWR Week 52, where the average of Weeks 52 and 53 was calculated.*

B. **OTHER RESPIRATORY PATHOGENS:** The major clinical and commercial laboratories throughout the state of Hawaii have the testing capacity for non-influenza respiratory pathogens and report these to HDOH. However, such testing is performed as needed and when sufficient resources are available because of the high costs associated with respiratory panel tests. **Therefore, available data represents only the presence of circulating pathogens and cannot be used to determine specific trends**.



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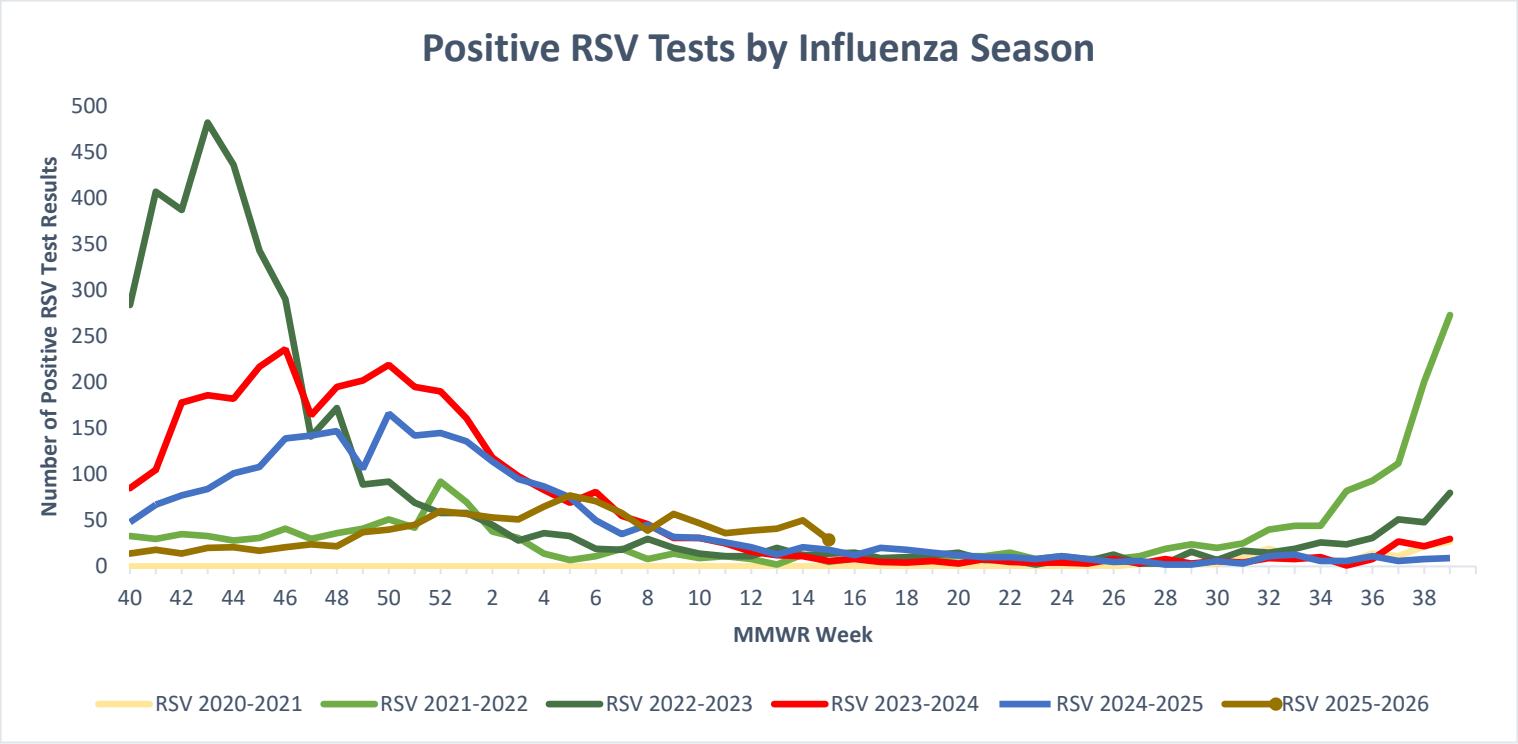

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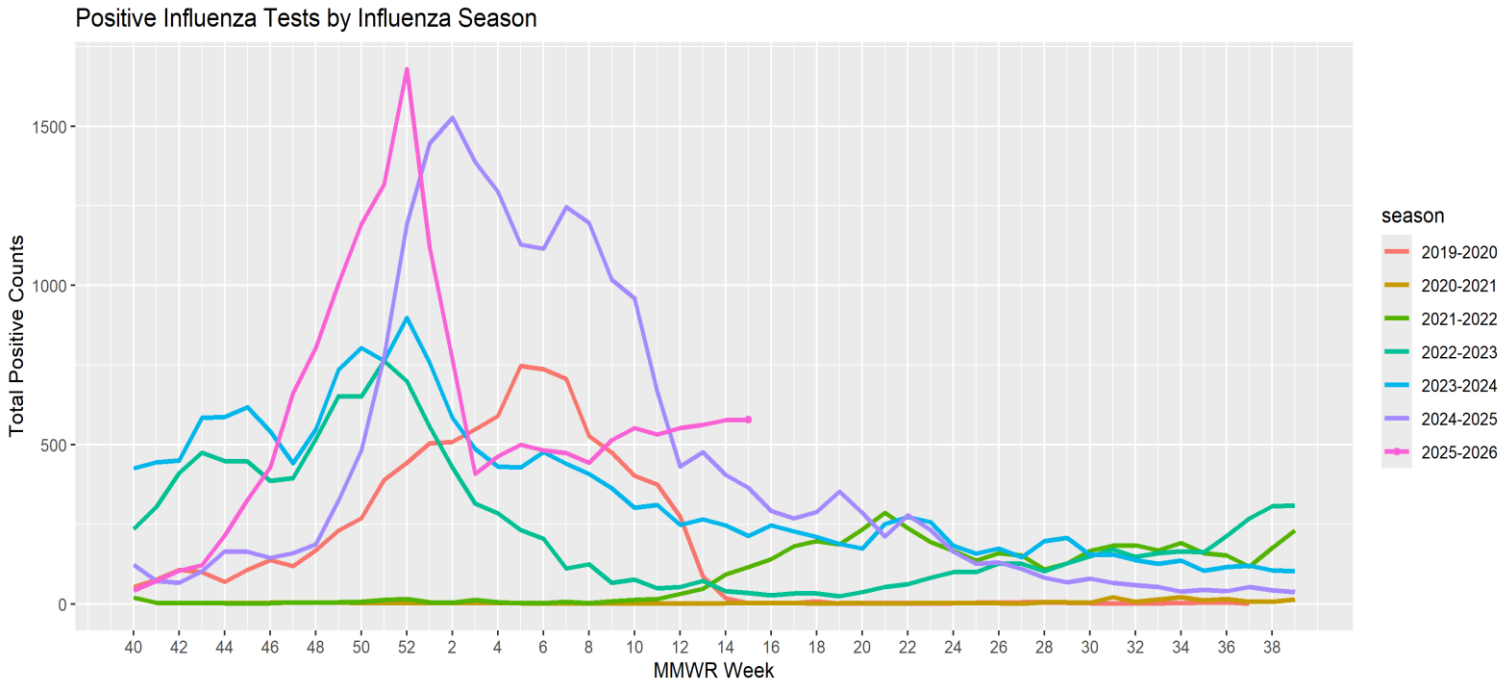

C. COVID-19 SENTINEL SURVEILLANCE: Due to the low volume of samples currently available through the influenza surveillance system, the COVID-19 sentinel surveillance data may not be accurately portraying COVID-19 activity in our communities. Reporting of the COVID-19 Sentinel Surveillance data will be paused while HODH re-evaluates the program to ensure that the reported data are accurate and representative.

HDOH is continuing to monitor COVID-19 activity throughout the state. To learn more, please visit the Hawaii's COVID-19 data website (*here*). For more information on surveillance of COVID-19 activity in the United States please visit the CDC COVIDView website (*here*).

III. PNEUMONIA, INFLUENZA, AND COVID-19 (PIC) RELATED MORTALITY:

P&I mortality surveillance is collected by CDC through the National Center for Health Statistics (NCHS) using death certificate data. Each week the HDOH OHSM reports specific data from Honolulu to the CDC. CDC collects the following information by age group: the total number of deaths, total deaths from pneumonia, and total deaths related to influenza. Due to the ongoing COVID-19 pandemic, CDC included total deaths from COVID-19 by age group to the death data. Previous studies had suggested that P&I is a good indicator of influenza-related deaths; however, data has shown that pneumonia deaths associated with influenza is now being impacted by COVID-19 related pneumonia. Due to this, CDC had added COVID-19 deaths into P&I to create the PIC (pneumonia, influenza, and/or COVID-19) classification.

To standardize Hawaii's influenza surveillance with CDC influenza surveillance guidelines, PIC deaths will be reported in lieu of P&I. Hawaii's baseline will begin to include PIC deaths starting from 2019-2020 flu season.

The National Vital Statistic System (NVSS) surveillance datasets and reports had been paused temporarily, including those used to evaluate pneumonia, influenza, and COVID-19 deaths. HDOH PIC mortality data will not be published in the Influenza/Respiratory Disease Surveillance Report for week 15.

INFLUENZA-ASSOCIATED PEDIATRIC DEATHS[11]:

- No new influenza-associated pediatric death was reported to Hawaii. There have been zero influenza-associated pediatric deaths reported in Hawaii during the 2025–2026 season.
- Nationally, six new influenza-associated pediatric deaths were reported to CDC during week 15. (2025-2026 season total: 149).

IV. INFLUENZA WATCH: As part of a comprehensive influenza surveillance system and to prevent the spread of contagious respiratory diseases in humans, it is important to monitor all circulating influenza types. Several animal-origin influenza A subtypes are currently of interest: influenza A variant virus (H3N2v, H1N2v, and H1N1v) and Avian flu (H5N1 and H7N9). These types of influenza viruses may cause zoonotic (animal-associated) disease and are a public health concern.

A. VARIANT VIRUSES:

Influenza viruses that normally circulate in pigs are called "variant" viruses when they are found in people. These viruses were first identified in U.S. pigs in 2010. In 2011, 12 cases of H3N2v infection were detected in the United States. In 2012, 309 such cases (resulting in 16 hospitalizations and one death) across 12 states were detected, including one Hawaii case who recovered. Illness associated with H3N2v infection has been mostly mild with symptoms similar to those of seasonal flu. However, serious illness, resulting in hospitalization and death, has occurred in some cases. Most of these infections have been associated with prolonged exposure to pigs at agricultural fairs or similar settings. Limited human-to-human spread of this virus has been detected in the past, but no sustained community spread of H3N2v has been identified. More information regarding H3N2v, H1N1v, and H1N2v viruses may be found on the CDC website (*here*) and (*here*).

- *No variant or novel influenza infections have been reported to HDOH during the 2025-2026 influenza season.*
- *One new human infection with novel influenza A virus, H1N1v (0), H3N2v (0), and H1N2v (1), have been reported during the 2025-2026 influenza season.*
    - *One new human infection with influenza A(H1N1v) virus has been reported to WHO from China during the 2025-2026 influenza season.*

AVIAN (OR BIRD) INFLUENZA: These types of influenza viruses cause zoonotic (animal-associated) disease of public health concern and are therefore monitored globally by the WHO. Most avian influenza viruses do not cause disease in humans and are generally not easily transmissible between person to person, but a few subtypes may cross the species barrier and cause disease in humans. Avian influenza viruses may be of various subtypes, including H5N1, H5N2, H5N8, H7N3, H7N7, H7N8, H7N9, and H9N2. On January 15th, 2016, the USDA and APHIS reported detection of HPAI H7N8 in a commercial turkey flock in Indiana. There have been no associated human infections. This is the first detection of HPAI H7N8 in wild bird surveillance in the United States. More information, the risk assessment and recommendations for HPAI H7N8 can be found (here). The WHO, CDC, and other public health agencies have also been monitoring influenza H7N9, which represents a public health concern because of its high pandemic potential. Although H7N9 has not been detected in the United States, it remains a global concern given continuing epidemics in endemic countries. Since 2013, a total of 1,568 laboratory-confirmed cases of human infection with H7N9 viruses, including at least 613 deaths, have been reported to WHO. More information on H7N9 virus infections can be found (here). For more information regarding avian influenza, please visit the CDC (*here*) or the WHO (*here*) websites. WHO reports total number of cases and deaths related to laboratory-confirmed avian influenza viruses and posts current avian influenza case counts (*here*), which were last updated on **January 22, 2026**.

[11] Influenza-associated deaths are considered pediatric in persons aged less than 18 years. It was made a nationally notifiable condition in October, 2004. All pediatric influenza-associated deaths are laboratory confirmed.

V. INFLUENZA Vaccine: Annual influenza vaccination is recommended for all persons aged 6 months and older and is the most effective way to reduce the risk of getting sick with seasonal flu and spreading it to others. Influenza vaccination can reduce illnesses, visits to the doctor, influenza-related hospitalizations, and missed work and school days. Influenza vaccines become available by the end of October. It takes at least two weeks after vaccination to confer immunity against influenza virus infection. More information regarding influenza vaccination can be found (*here*).

A. Composition of the 2025–2026 Influenza Vaccine:

The composition of the 2025–2026 influenza vaccine has been updated to better match circulating influenza viruses. The Advisory Committee on Immunization Practices (ACIP) has recommended that the 2025-2026 influenza trivalent vaccine contain an influenza A/Victoria/4897/2022 (H1N1) pdm09-like virus, influenza A/Croatia/10136RV/2023 (H3N2)-like virus, and influenza B/Austria/1359417/2021 (B/Victoria lineage)-like virus. United States cell culture–based inactivated (ccIIV4) and recombinant (RIV4) influenza vaccines will contain HA derived from an influenza A/Wisconsin/67/2022 (H1N1) pdm09-like virus, an A/District of Columbia/27/2023 (H3N2)-like virus, an influenza B/Austria/1359417/2021 (B/Victoria lineage)-like virus. These vaccine recommendations were based on several factors, including global influenza virologic and epidemiologic surveillance, genetic and antigenic characterization, human serology studies, antiviral susceptibility, and the availability of candidate influenza viruses.

APPENDIX 1: ADDITIONAL INFORMATION

For more information regarding local and national influenza surveillance programs, visit the following sites.

Centers for Disease Control and Prevention	General Influenza National ILI and P&I Data Vaccine Virus Selection CDC Web Tool for Respiratory Viruses
Flu.gov	General Influenza Information
HDOH Flu and Pneumonia	General Influenza Surveillance Avian Influenza Respiratory Virus Dashboard To find out more information or join the sentinel physician program, email the Influenza Surveillance Coordinator
World Health Organization	General Global and Local Influenza Avian Influenza

APPENDIX 2: MMWR WEEK DATES

Please refer to the table below to interpret data presented by MMWR week. Week 40 is considered the traditional start for the flu season for the Northern Hemisphere.

MMWR WEEK	2022	2023	2024	2025	2026
1	1/8/2022	1/7/2023	1/6/2024	1/4/2025	1/10/2026
2	1/15/2022	1/14/2023	1/13/2024	1/11/2025	1/17/2026
3	1/22/2022	1/21/2023	1/20/2024	1/18/2025	1/24/2026
4	1/29/2022	1/28/2023	1/27/2024	1/25/2025	1/31/2026
5	2/5/2022	2/4/2023	2/3/2024	2/1/2025	2/7/2026
6	2/12/2022	2/11/2023	2/10/2024	2/8/2025	2/14/2026
7	2/19/2022	2/18/2023	2/17/2024	2/15/2025	2/21/2026
8	2/26/2022	2/25/2023	2/24/2024	2/22/2025	2/28/2026
9	3/5/2022	3/4/2023	3/2/2024	3/1/2025	3/7/2026
10	3/12/2022	3/11/2023	3/9/2024	3/8/2025	3/14/2026
11	3/19/2022	3/18/2023	3/16/2024	3/15/2025	3/21/2026
12	3/26/2022	3/25/2023	3/23/2024	3/22/2025	3/28/2026
13	4/2/2022	4/1/2023	3/30/2024	3/29/2025	4/4/2026
14	4/9/2022	4/8/2023	4/6/2024	4/5/2025	4/11/2026
15	4/16/2022	4/15/2023	4/13/2024	4/12/2025	4/18/2026
16	4/23/2022	4/22/2023	4/20/2024	4/19/2025	4/25/2026
17	4/30/2022	4/29/2023	4/27/2024	4/26/2025	5/2/2026
18	5/7/2022	5/6/2023	5/4/2024	5/3/2025	5/9/2026
19	5/14/2022	5/13/2023	5/11/2024	5/10/2025	5/16/2026
20	5/21/2022	5/20/2023	5/18/2024	5/17/2025	5/23/2026
21	5/28/2022	5/27/2023	5/25/2024	5/24/2025	5/30/2026
22	6/4/2022	6/3/2023	6/1/2024	5/31/2025	6/6/2026
23	6/11/2022	6/10/2023	6/8/2024	6/7/2025	6/13/2026
24	6/18/2022	6/17/2023	6/15/2024	6/14/2025	6/20/2026
25	6/25/2022	6/24/2023	6/22/2024	6/21/2025	6/27/2026
26	7/2/2022	7/1/2023	6/29/2024	6/28/2025	7/4/2026
27	7/9/2022	7/8/2023	7/6/2024	7/5/2025	7/11/2026
28	7/16/2022	7/15/2023	7/13/2024	7/12/2025	7/18/2026
29	7/23/2022	7/22/2023	7/20/2024	7/19/2025	7/25/2026
30	7/30/2022	7/29/2023	7/27/2024	7/26/2025	8/1/2026
31	8/6/2022	8/5/2023	8/3/2024	8/2/2025	8/8/2026
32	8/13/2022	8/12/2023	8/10/2024	8/9/2025	8/15/2026
33	8/20/2022	8/19/2023	8/17/2024	8/16/2025	8/22/2026
34	8/27/2022	8/26/2023	8/24/2024	8/23/2025	8/29/2026
35	9/3/2022	9/2/2023	8/31/2024	8/30/2025	9/5/2026
36	9/10/2022	9/9/2023	9/7/2024	9/6/2025	9/12/2026
37	9/17/2022	9/16/2023	9/14/2024	9/13/2025	9/19/2026
38	9/24/2022	9/23/2023	9/21/2024	9/20/2025	9/26/2026
39	10/1/2022	9/30/2023	9/28/2024	9/27/2025	10/3/2026
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41	10/15/2022	10/14/2023	10/12/2024	10/11/2025	10/17/2026
42	10/22/2022	10/21/2023	10/19/2024	10/18/2025	10/24/2026
43	10/29/2022	10/28/2023	10/26/2024	10/25/2025	10/31/2026
44	11/5/2022	11/4/2023	11/2/2024	11/1/2025	11/7/2026
45	11/12/2022	11/11/2023	11/9/2024	11/8/2025	11/14/2026
46	11/19/2022	11/18/2023	11/16/2024	11/15/2025	11/21/2026
47	11/26/2022	11/25/2023	11/23/2024	11/22/2025	11/28/2026
48	12/3/2022	12/2/2023	11/30/2024	11/29/2025	12/5/2026
49	12/10/2022	12/9/2023	12/7/2024	12/6/2025	12/12/2026
50	12/17/2022	12/16/2023	12/14/2024	12/13/2025	12/19/2026
51	12/24/2022	12/23/2023	12/21/2024	12/20/2025	12/26/2026
52	12/31/2022	12/30/2023	12/28/2024	12/27/2025	
53				01/03/2026	

HAWAII STATE DEPARTMENT OF HEALTH
DISEASE OUTBREAK CONTROL DIVISION

Influenza/Respiratory Disease Surveillance Report

Morbidity and Mortality Weekly Report (MMWR)[1]

WEEK 16: APRIL 19, 2026– APRIL 25, 2026

OVERVIEW: The Hawaii State Department of Health (HDOH) monitors influenza and other respiratory pathogens, including COVID-19, throughout the state of Hawaii. Influenza surveillance in the state of Hawaii relies upon selected sentinel health practitioners, the State Laboratories Division (SLD), private laboratories, and the Office of Health Status Monitoring (OHSM). For detailed information concerning influenza, please visit the HDOH Disease Outbreak Control Division (HDOH DOCD) website (*here*). **All data and information are conditional and may change as more reports are received.** The data in this report reflects the 2025-2026 influenza season which began the week ending October 4, 2025 (week 40[1] 2025) and will end the week ending on October 3, 2026 (week 39 2026).

REPORT SNAPSHOT FOR WEEK 16

Surveillance for Influenza-like Illness (ILI)		
Metric	*Value*	*Comment*
Outpatient visits related to influenza-like illness (ILI) from ILINet Sentinel Providers	3.4%	Lower than the previous week. Higher than Hawaii's historical baseline and lower than the national baseline, and higher than the national ILI rate.
Number of ILI clusters reported to HDOH	0	There have been 27 clusters this season.

Laboratory Surveillance		
Percent of all respiratory specimens positive for influenza this week	16.8%	Higher than the previous week. This number means that many, if not all, of the 83.2% who tested negative for influenza had illness from another respiratory etiology.
Percent of all respiratory specimens positive for influenza this season to date	17.9%	

Surveillance for Severe Outcomes		
Pneumonia, influenza and COVID-19 (PIC) mortality rate		No new data for PIC mortality rates was available to include in this week's report.
Number of influenza-associated pediatric deaths reported nationwide	155	0 influenza-associated pediatric deaths have been reported from Hawaii this season to date.

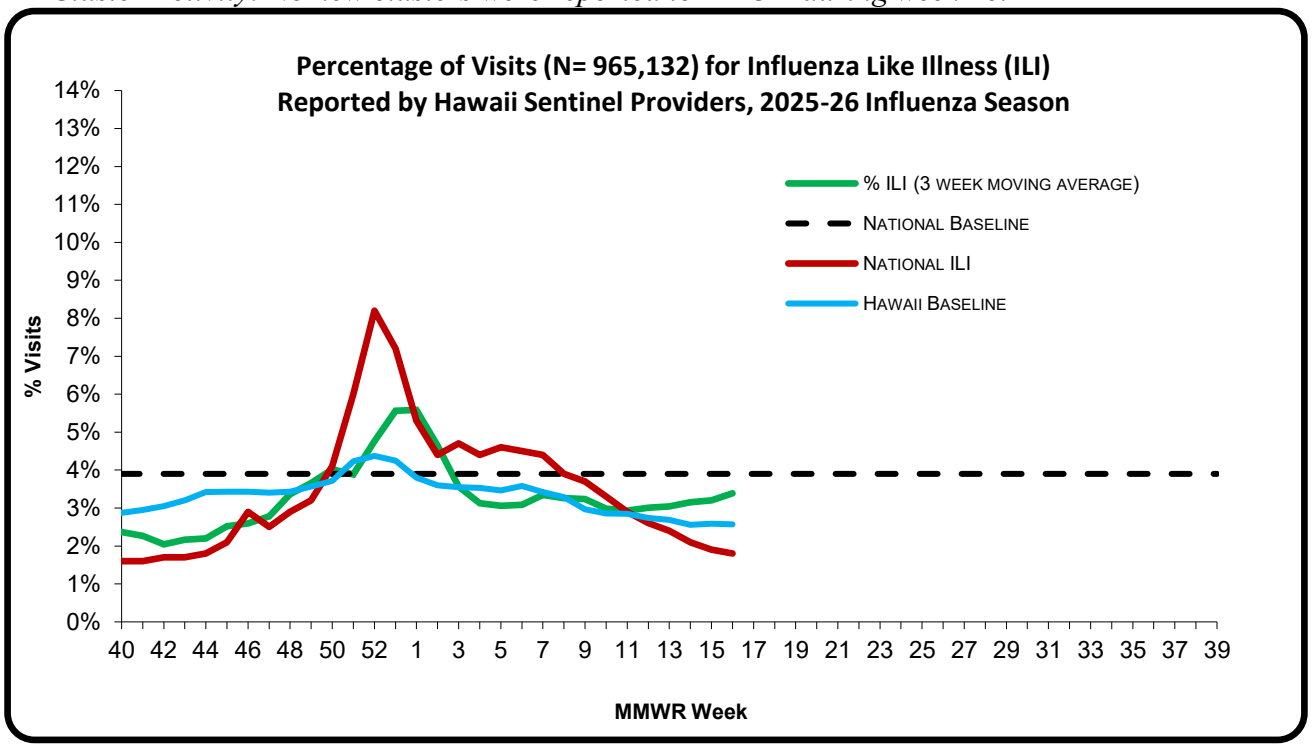
[1] MMWR stands for "Morbidity and Mortality Weekly Report," conventionally used by the Centers for Disease Control and Prevention (CDC). The weeks of a flu season are often referred to by their respective MMWR week. **See appendix 2 for interpretation of MMWR weeks.** Data reported will begin on week 40, the traditional start date of flu season.

INFLUENZA SURVEILLANCE

I. INFLUENZA-LIKE ILLNESS (ILI): HDOH collaborates with recruited doctors and healthcare providers who report the total number of outpatient visits for ILI as well as the total number of patients who complained of symptoms consistent with ILI. A patient with ILI must have the following: a fever (temperature of 100°F [37.8°C] or greater) AND a cough and/or a sore throat. ILI is based on reported symptoms and not laboratory confirmed tests; thus, ILI may represent other respiratory pathogens and not solely influenza. Further, sentinel providers report these numbers on a weekly basis; therefore, data are preliminary and may change depending on additional reporting. In combination with laboratory testing and other surveillance systems, ILI surveillance helps monitor influenza and other respiratory pathogen activity. For more information concerning ILINet and sentinel requirements, please visit the CDC website (*here*).

For **week 16** of the current influenza season:

- ***3.4%** (season to date: **3.3%**) of the outpatient visits recorded by Hawaii sentinel providers were for ILI.*
- *ILI visits were higher than the historical baseline in Hawaii[2,3] (i.e., outside the 95% confidence interval).*
- *Hawaii's ILI outpatient visits were lower than the national baseline (**3.9%**)[4] (i.e., outside the 95% confidence interval) and higher than the national ILI rate (**1.8%**) (i.e. outside the 95% confidence interval).*
- *ILI activity level: Low[5]*
- *Geographic Spread: Sporadic Activity[6].*
- *ILI Cluster Activity: No new clusters were reported to HDOH during week 16.*



[2] The Hawaii historical baseline (%ILI) is the average of 3-week moving averages over the preceding 3 flu seasons of historical data (2022-2023, 2023-2024 and 2024-2025).
[3] This value is based upon comparison of actual outpatient ILI with the historical baseline, which only captures outpatient ILI. The chart above represents a 3-week moving average and not the actual ILI by week.
[4] The National Baseline is calculated by CDC as the mean percentage of visits for ILI during weeks 21–39 with two standard deviations. Because of large variability in regional ILI, comparison of the national baseline with local ILI may not be appropriate. It is provided in this report because no meaningful regional baselines are available for comparison. The national baseline combines all data reported by states to CDC, including ILI in outpatient, ER, urgent care, and inpatient settings.
[5] There are 10 activity levels classified as minimal (levels 1-3), low (levels 4-5), moderate (levels 6-7), and high (levels 8-10).
[6] The influenza activity reported by state and territorial epidemiologists indicates geographic spread of influenza viruses but does not measure the severity of influenza activity. Sporadic: no clusters reported to HDOH, Local: one or more clusters reported in one county, Regional: clusters reported two to three counties, Widespread: clusters reported in all counties. Hawaii does not report No Activity, as flu circulates year-round in Hawaii.

II. LABORATORY SURVEILLANCE: State Laboratories Division (SLD; the HDOH public health laboratory) and Hawaii's major private laboratories (DLS, CLH) report results of RT-PCR, which can be considered confirmatory (SLD may perform viral culture on select specimens). Specimens meeting priority criteria[7] are forwarded to SLD for sub-typing. Additionally, specimens meeting case definition from requesting sentinel providers are sent directly to SLD for sub-typing. Due to resource constraints, not all submitted specimens undergo sub-typing. Sub-typing at the commercial laboratories is only conducted on a case-by-case basis. The majority of specimens testing positive by rapid antigen testing or RT-PCR at the commercial laboratories do not meet criteria and are not subtyped. For more information on influenza tests and types, please visit the CDC website (*here*).

A. INFLUENZA:

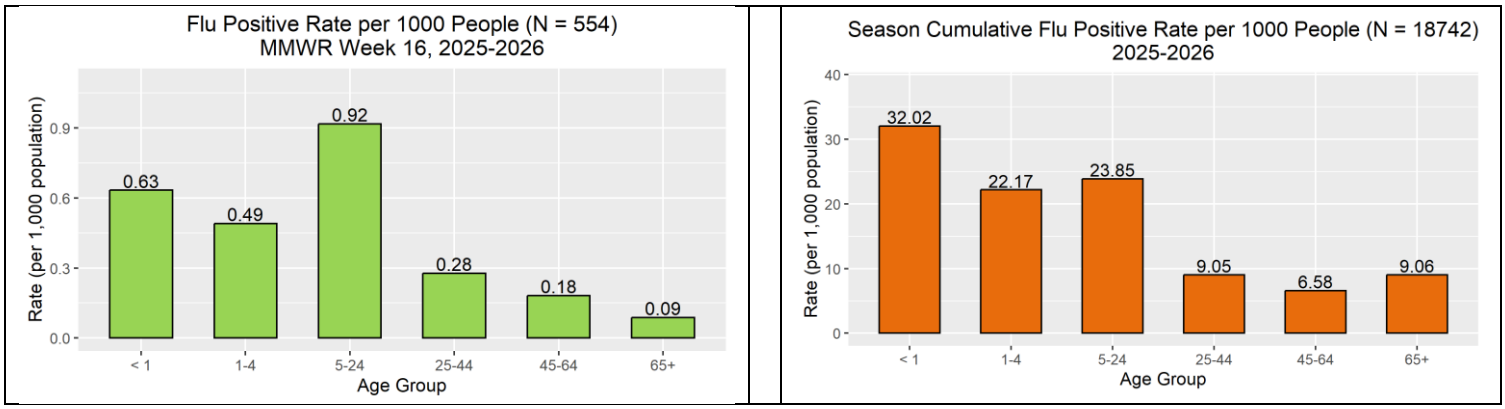
- The following reflects laboratory findings for week 16 of the 2025–26 influenza season:
  - *A total of **3,297** specimens has been tested statewide for influenza viruses (positive: 554 [**16.8%**]). (Season to date: **104,326** tested (**17.9%** positive)*
    - *1,591 (48.2%) were screened only by rapid antigen tests with no confirmatory testing.*
    - *1,706 (51.8%) underwent confirmatory testing (either RT-PCR or viral culture).*
    - *2,743 (83.2) were negative.*
  - *Routine surveillance samples from State Laboratory Division were tested at a public health laboratory and identified as Influenza A (H3N2) subclade K.*

Influenza type	***Current week 16 (%)****	***Season to date (%)***[8]
Influenza A (H1)[9]	*0 (0.0)*	*188 (1.0)*
Influenza A (H3)	*0 (0.0)*	*1,293 (6.9)*
Influenza A no subtyping	*68 (12.3)*	*12,552 (67.1)*
Influenza B (Yamagata)	*0 (0.0)*	*0 (0.0)*
Influenza B (Victoria)	*0 (0.0)*	*0 (0.0)*
Influenza B no genotyping	*486 (87.7)*	*4,673 (25.0)*

**Specimens that are positive for both A and B (coinfections) are counted in both A and B totals for current and season to date*

1. AGE DISTRIBUTION

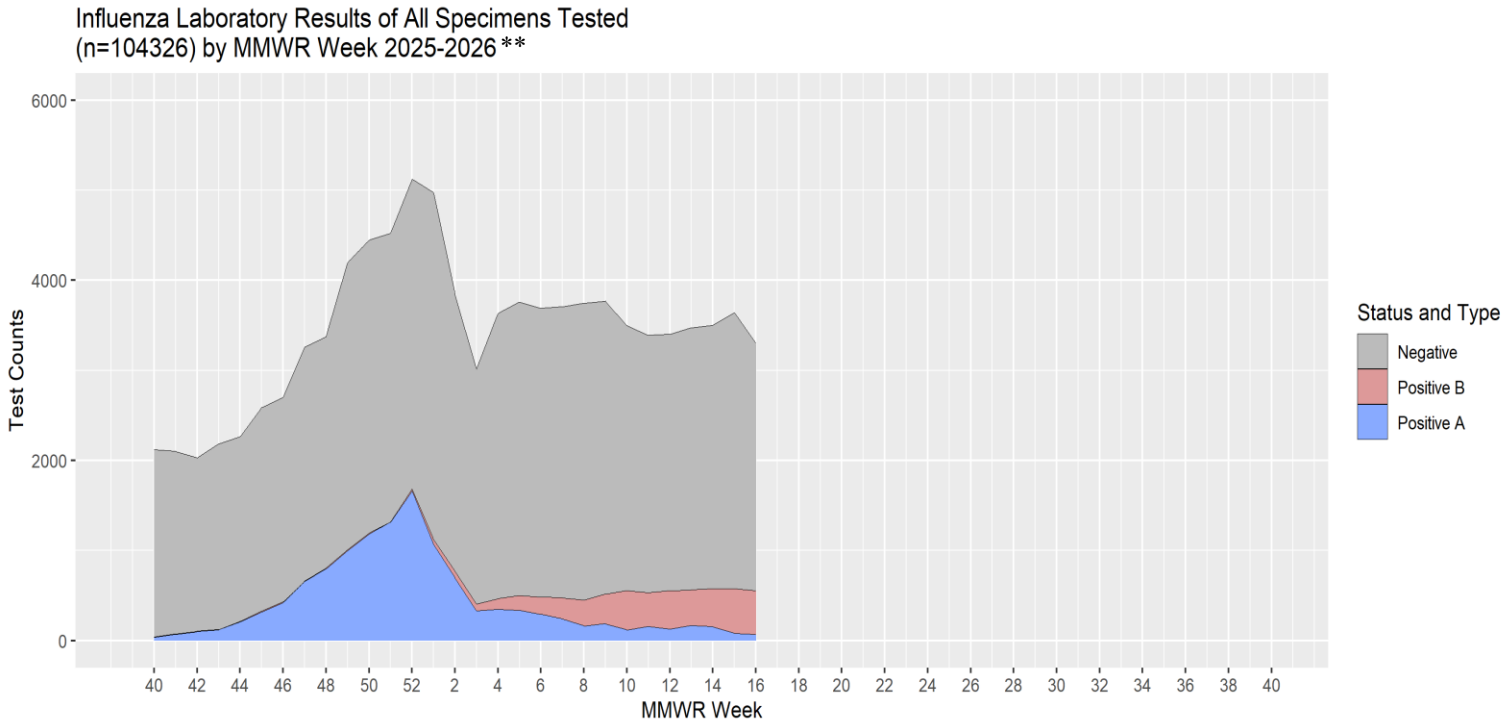
The charts below indicate the population-based rates of positive influenza cases in Hawaii by age group during the 2025–26 influenza season.[10]

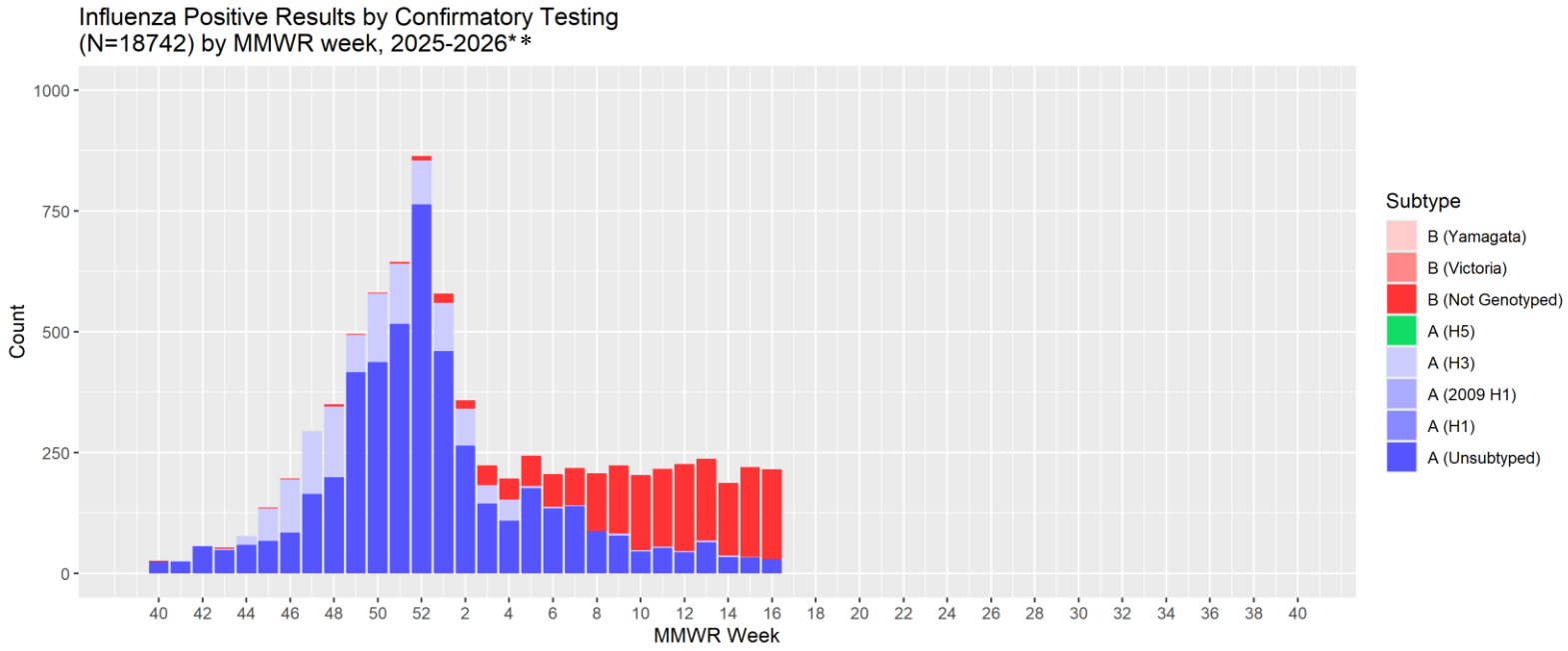


[7] Priority criteria include: hospitalized patients with acute respiratory distress syndrome [ARDS] or x-ray confirmed pneumonia; travelers with international travel history within 10 days of onset; specimens submitted by sentinel providers; specimens collected from healthcare workers, pregnant women, or women up to 6 weeks' post-partum; those with underlying medical conditions; and patients presenting with unusual or severe manifestations of influenza infection.
[8] Influenza coding was updated to reflect a more accurate count.
[9] All influenza A H1 viruses detected this season have been 2009 H1N1.
[10] This represents an estimate of population-based rates based on available data.

2. LABORATORY TESTING

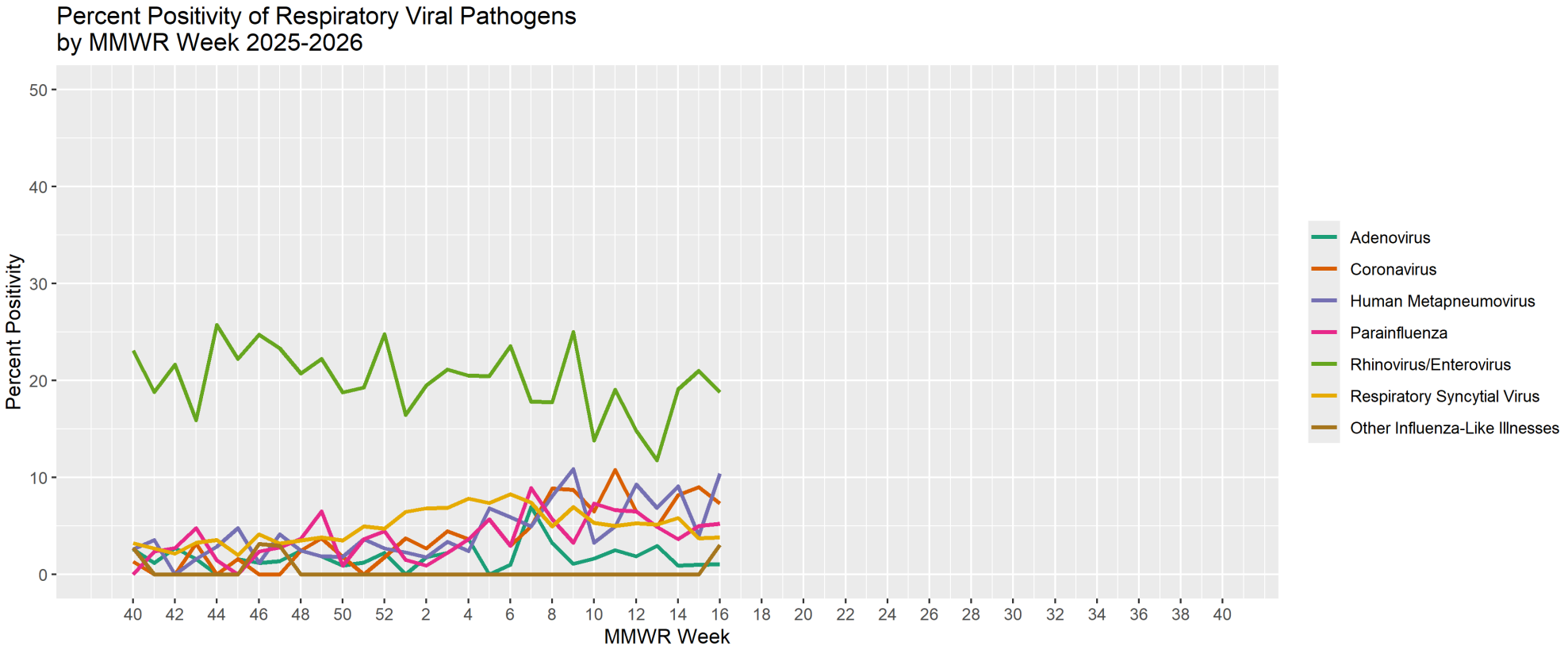
The charts below show the laboratory results of all specimens tested for influenza by MMWR week during the 2025–2026 influenza season as well as the type and subtype of positive results for influenza. Again, sub-typing is only performed on selected specimens tested by confirmatory tests (i.e., RT-PCR or viral culture).





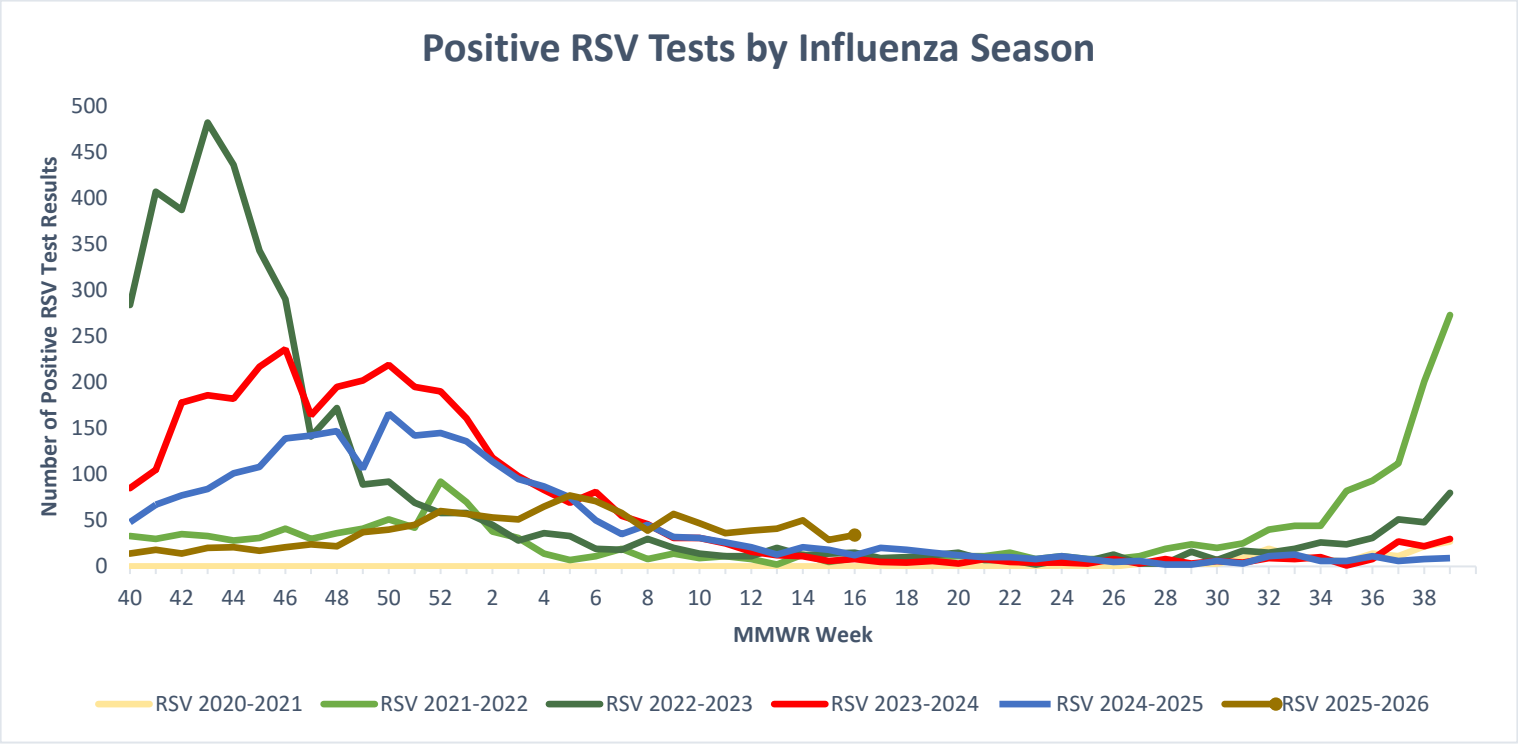
** A total of 57,467 specimens underwent confirmatory testing, but not all positive influenza specimens receive confirmatory testing that are circulating in Hawaii.*
*** For MMWR Week 53, results are reported under MMWR Week 52, where the average of Weeks 52 and 53 was calculated.*

B. **OTHER RESPIRATORY PATHOGENS:** The major clinical and commercial laboratories throughout the state of Hawaii have the testing capacity for non-influenza respiratory pathogens and report these to HDOH. However, such testing is performed as needed and when sufficient resources are available because of the high costs associated with respiratory panel tests. **Therefore, available data represents only the presence of circulating pathogens and cannot be used to determine specific trends**.

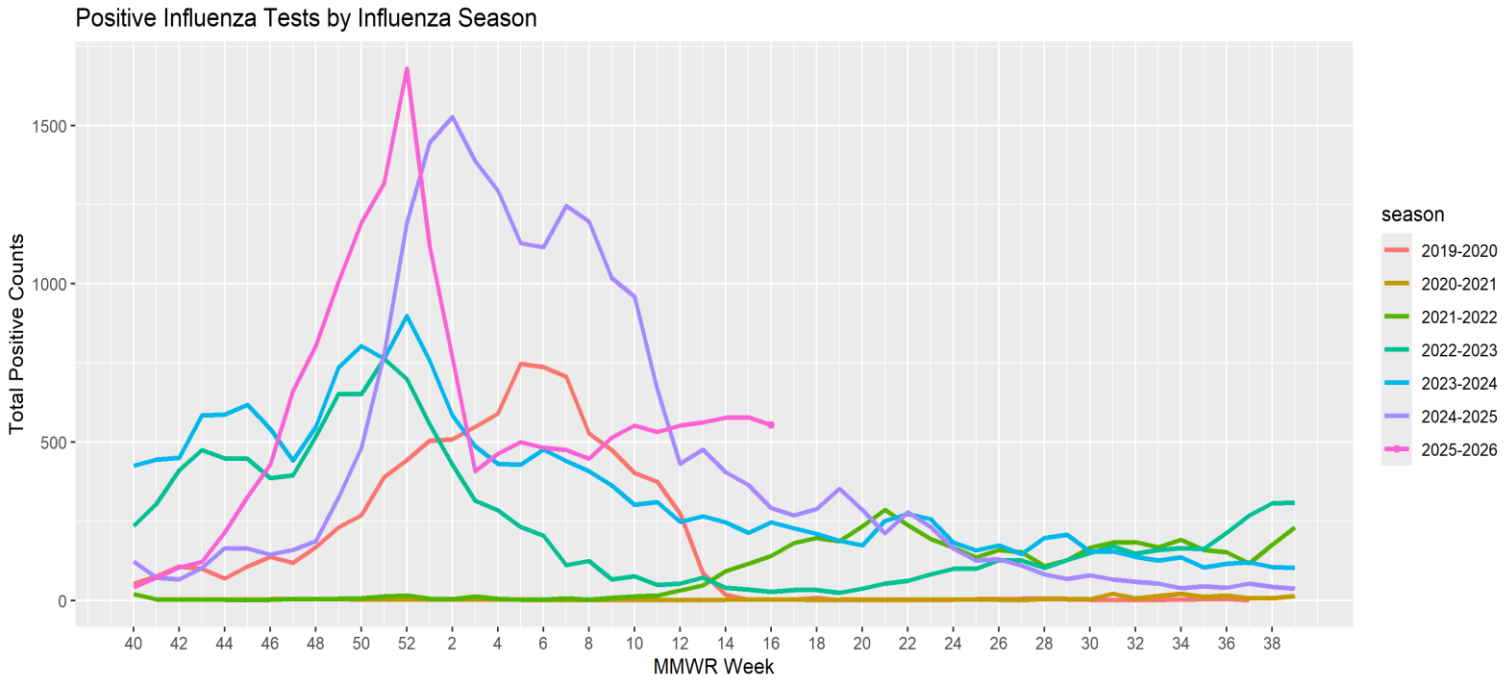


* *The coronavirus presented on this table does not indicate Severe Acute Respiratory Coronavirus-2 (i.e., COVID-19). For MMWR Week 53, results are reported under MMWR Week 52, where the average of Weeks 52 and 53 was calculated*

RESPIRATORY SYNCYTIAL VIRUS (RSV) POSITIVE TEST RESULTS BY INFLUENZA SEASON: RSV case appears to have increased later than past seasons in the 2025-2026 season. For MMWR Week 53, results are reported under MMWR Week 52, where the average of Weeks 52 and 53 was calculated.



INFLUENZA POSITIVE TEST RESULTS BY INFLUENZA SEASON: Influenza cases appear to have increased earlier than past seasons in the 2025-2026 season. For MMWR Week 53, results are reported under MMWR Week 52, where the average of Weeks 52 and 53 was calculated.



C. COVID-19 SENTINEL SURVEILLANCE: Due to the low volume of samples currently available through the influenza surveillance system, the COVID-19 sentinel surveillance data may not be accurately portraying COVID-19 activity in our communities. Reporting of the COVID-19 Sentinel Surveillance data will be paused while HODH re-evaluates the program to ensure that the reported data are accurate and representative.

HDOH is continuing to monitor COVID-19 activity throughout the state. To learn more, please visit the Hawaii's COVID-19 data website (*here*). For more information on surveillance of COVID-19 activity in the United States please visit the CDC COVIDView website (*here*).

III. PNEUMONIA, INFLUENZA, AND COVID-19 (PIC) RELATED MORTALITY:

P&I mortality surveillance is collected by CDC through the National Center for Health Statistics (NCHS) using death certificate data. Each week the HDOH OHSM reports specific data from Honolulu to the CDC. CDC collects the following information by age group: the total number of deaths, total deaths from pneumonia, and total deaths related to influenza. Due to the ongoing COVID-19 pandemic, CDC included total deaths from COVID-19 by age group to the death data. Previous studies had suggested that P&I is a good indicator of influenza-related deaths; however, data has shown that pneumonia deaths associated with influenza is now being impacted by COVID-19 related pneumonia. Due to this, CDC had added COVID-19 deaths into P&I to create the PIC (pneumonia, influenza, and/or COVID-19) classification.

To standardize Hawaii's influenza surveillance with CDC influenza surveillance guidelines, PIC deaths will be reported in lieu of P&I. Hawaii's baseline will begin to include PIC deaths starting from 2019-2020 flu season.

The National Vital Statistic System (NVSS) surveillance datasets and reports had been paused temporarily, including those used to evaluate pneumonia, influenza, and COVID-19 deaths. HDOH PIC mortality data will not be published in the Influenza/Respiratory Disease Surveillance Report for week 16.

INFLUENZA-ASSOCIATED PEDIATRIC DEATHS[11]:

- No new influenza-associated pediatric death was reported to Hawaii. There have been zero influenza-associated pediatric deaths reported in Hawaii during the 2025–2026 season.
- Nationally, six new influenza-associated pediatric deaths were reported to CDC during week 16. (2025-2026 season total: 155).

IV. INFLUENZA WATCH: As part of a comprehensive influenza surveillance system and to prevent the spread of contagious respiratory diseases in humans, it is important to monitor all circulating influenza types. Several animal-origin influenza A subtypes are currently of interest: influenza A variant virus (H3N2v, H1N2v, and H1N1v) and Avian flu (H5N1 and H7N9). These types of influenza viruses may cause zoonotic (animal-associated) disease and are a public health concern.

A. VARIANT VIRUSES:

Influenza viruses that normally circulate in pigs are called "variant" viruses when they are found in people. These viruses were first identified in U.S. pigs in 2010. In 2011, 12 cases of H3N2v infection were detected in the United States. In 2012, 309 such cases (resulting in 16 hospitalizations and one death) across 12 states were detected, including one Hawaii case who recovered. Illness associated with H3N2v infection has been mostly mild with symptoms similar to those of seasonal flu. However, serious illness, resulting in hospitalization and death, has occurred in some cases. Most of these infections have been associated with prolonged exposure to pigs at agricultural fairs or similar settings. Limited human-to-human spread of this virus has been detected in the past, but no sustained community spread of H3N2v has been identified. More information regarding H3N2v, H1N1v, and H1N2v viruses may be found on the CDC website (*here*) and (*here*).

- *No variant or novel influenza infections have been reported to HDOH during the 2025-2026 influenza season.*
- *One new human infection with novel influenza A virus, H1N1v (0), H3N2v (0), and H1N2v (1), have been reported during the 2025-2026 influenza season.*
    - *One new human infection with influenza A(H1N1v) virus has been reported to WHO from China during the 2025-2026 influenza season.*

AVIAN (OR BIRD) INFLUENZA: These types of influenza viruses cause zoonotic (animal-associated) disease of public health concern and are therefore monitored globally by the WHO. Most avian influenza viruses do not cause disease in humans and are generally not easily transmissible between person to person, but a few subtypes may cross the species barrier and cause disease in humans. Avian influenza viruses may be of various subtypes, including H5N1, H5N2, H5N8, H7N3, H7N7, H7N8, H7N9, and H9N2. On January 15th, 2016, the USDA and APHIS reported detection of HPAI H7N8 in a commercial turkey flock in Indiana. There have been no associated human infections. This is the first detection of HPAI H7N8 in wild bird surveillance in the United States. More information, the risk assessment and recommendations for HPAI H7N8 can be found (here). The WHO, CDC, and other public health agencies have also been monitoring influenza H7N9, which represents a public health concern because of its high pandemic potential. Although H7N9 has not been detected in the United States, it remains a global concern given continuing epidemics in endemic countries. Since 2013, a total of 1,568 laboratory-confirmed cases of human infection with H7N9 viruses, including at least 613 deaths, have been reported to WHO. More information on H7N9 virus infections can be found (here). For more information regarding avian influenza, please visit the CDC (*here*) or the WHO (*here*) websites. WHO reports total number of cases and deaths related to laboratory-confirmed avian influenza viruses and posts current avian influenza case counts (*here*), which were last updated on **January 22, 2026**.

[11] Influenza-associated deaths are considered pediatric in persons aged less than 18 years. It was made a nationally notifiable condition in October, 2004. All pediatric influenza-associated deaths are laboratory confirmed.

V. INFLUENZA Vaccine: Annual influenza vaccination is recommended for all persons aged 6 months and older and is the most effective way to reduce the risk of getting sick with seasonal flu and spreading it to others. Influenza vaccination can reduce illnesses, visits to the doctor, influenza-related hospitalizations, and missed work and school days. Influenza vaccines become available by the end of October. It takes at least two weeks after vaccination to confer immunity against influenza virus infection. More information regarding influenza vaccination can be found (*here*).

A. Composition of the 2025–2026 Influenza Vaccine:

The composition of the 2025–2026 influenza vaccine has been updated to better match circulating influenza viruses. The Advisory Committee on Immunization Practices (ACIP) has recommended that the 2025-2026 influenza trivalent vaccine contain an influenza A/Victoria/4897/2022 (H1N1) pdm09-like virus, influenza A/Croatia/10136RV/2023 (H3N2)-like virus, and influenza B/Austria/1359417/2021 (B/Victoria lineage)-like virus. United States cell culture–based inactivated (ccIIV4) and recombinant (RIV4) influenza vaccines will contain HA derived from an influenza A/Wisconsin/67/2022 (H1N1) pdm09-like virus, an A/District of Columbia/27/2023 (H3N2)-like virus, an influenza B/Austria/1359417/2021 (B/Victoria lineage)-like virus. These vaccine recommendations were based on several factors, including global influenza virologic and epidemiologic surveillance, genetic and antigenic characterization, human serology studies, antiviral susceptibility, and the availability of candidate influenza viruses.

APPENDIX 1: ADDITIONAL INFORMATION

For more information regarding local and national influenza surveillance programs, visit the following sites.

Centers for Disease Control and Prevention	General Influenza National ILI and P&I Data Vaccine Virus Selection CDC Web Tool for Respiratory Viruses
Flu.gov	General Influenza Information
HDOH Flu and Pneumonia	General Influenza Surveillance Avian Influenza Respiratory Virus Dashboard To find out more information or join the sentinel physician program, email the Influenza Surveillance Coordinator
World Health Organization	General Global and Local Influenza Avian Influenza

APPENDIX 2: MMWR WEEK DATES

Please refer to the table below to interpret data presented by MMWR week. Week 40 is considered the traditional start for the flu season for the Northern Hemisphere.

MMWR WEEK	2022	2023	2024	2025	2026
1	1/8/2022	1/7/2023	1/6/2024	1/4/2025	1/10/2026
2	1/15/2022	1/14/2023	1/13/2024	1/11/2025	1/17/2026
3	1/22/2022	1/21/2023	1/20/2024	1/18/2025	1/24/2026
4	1/29/2022	1/28/2023	1/27/2024	1/25/2025	1/31/2026
5	2/5/2022	2/4/2023	2/3/2024	2/1/2025	2/7/2026
6	2/12/2022	2/11/2023	2/10/2024	2/8/2025	2/14/2026
7	2/19/2022	2/18/2023	2/17/2024	2/15/2025	2/21/2026
8	2/26/2022	2/25/2023	2/24/2024	2/22/2025	2/28/2026
9	3/5/2022	3/4/2023	3/2/2024	3/1/2025	3/7/2026
10	3/12/2022	3/11/2023	3/9/2024	3/8/2025	3/14/2026
11	3/19/2022	3/18/2023	3/16/2024	3/15/2025	3/21/2026
12	3/26/2022	3/25/2023	3/23/2024	3/22/2025	3/28/2026
13	4/2/2022	4/1/2023	3/30/2024	3/29/2025	4/4/2026
14	4/9/2022	4/8/2023	4/6/2024	4/5/2025	4/11/2026
15	4/16/2022	4/15/2023	4/13/2024	4/12/2025	4/18/2026
16	4/23/2022	4/22/2023	4/20/2024	4/19/2025	4/25/2026
17	4/30/2022	4/29/2023	4/27/2024	4/26/2025	5/2/2026
18	5/7/2022	5/6/2023	5/4/2024	5/3/2025	5/9/2026
19	5/14/2022	5/13/2023	5/11/2024	5/10/2025	5/16/2026
20	5/21/2022	5/20/2023	5/18/2024	5/17/2025	5/23/2026
21	5/28/2022	5/27/2023	5/25/2024	5/24/2025	5/30/2026
22	6/4/2022	6/3/2023	6/1/2024	5/31/2025	6/6/2026
23	6/11/2022	6/10/2023	6/8/2024	6/7/2025	6/13/2026
24	6/18/2022	6/17/2023	6/15/2024	6/14/2025	6/20/2026
25	6/25/2022	6/24/2023	6/22/2024	6/21/2025	6/27/2026
26	7/2/2022	7/1/2023	6/29/2024	6/28/2025	7/4/2026
27	7/9/2022	7/8/2023	7/6/2024	7/5/2025	7/11/2026
28	7/16/2022	7/15/2023	7/13/2024	7/12/2025	7/18/2026
29	7/23/2022	7/22/2023	7/20/2024	7/19/2025	7/25/2026
30	7/30/2022	7/29/2023	7/27/2024	7/26/2025	8/1/2026
31	8/6/2022	8/5/2023	8/3/2024	8/2/2025	8/8/2026
32	8/13/2022	8/12/2023	8/10/2024	8/9/2025	8/15/2026
33	8/20/2022	8/19/2023	8/17/2024	8/16/2025	8/22/2026
34	8/27/2022	8/26/2023	8/24/2024	8/23/2025	8/29/2026
35	9/3/2022	9/2/2023	8/31/2024	8/30/2025	9/5/2026
36	9/10/2022	9/9/2023	9/7/2024	9/6/2025	9/12/2026
37	9/17/2022	9/16/2023	9/14/2024	9/13/2025	9/19/2026
38	9/24/2022	9/23/2023	9/21/2024	9/20/2025	9/26/2026
39	10/1/2022	9/30/2023	9/28/2024	9/27/2025	10/3/2026
40	10/8/2022	10/7/2023	10/5/2024	10/4/2025	10/10/2026
41	10/15/2022	10/14/2023	10/12/2024	10/11/2025	10/17/2026
42	10/22/2022	10/21/2023	10/19/2024	10/18/2025	10/24/2026
43	10/29/2022	10/28/2023	10/26/2024	10/25/2025	10/31/2026
44	11/5/2022	11/4/2023	11/2/2024	11/1/2025	11/7/2026
45	11/12/2022	11/11/2023	11/9/2024	11/8/2025	11/14/2026
46	11/19/2022	11/18/2023	11/16/2024	11/15/2025	11/21/2026
47	11/26/2022	11/25/2023	11/23/2024	11/22/2025	11/28/2026
48	12/3/2022	12/2/2023	11/30/2024	11/29/2025	12/5/2026
49	12/10/2022	12/9/2023	12/7/2024	12/6/2025	12/12/2026
50	12/17/2022	12/16/2023	12/14/2024	12/13/2025	12/19/2026
51	12/24/2022	12/23/2023	12/21/2024	12/20/2025	12/26/2026
52	12/31/2022	12/30/2023	12/28/2024	12/27/2025	
53				01/03/2026	

HAWAII STATE DEPARTMENT OF HEALTH
DISEASE OUTBREAK CONTROL DIVISION

Influenza/Respiratory Disease Surveillance Report

Morbidity and Mortality Weekly Report (MMWR)[1]

WEEK 17: APRIL 26, 2026– MAY 2, 2026

OVERVIEW: The Hawaii State Department of Health (HDOH) monitors influenza and other respiratory pathogens, including COVID-19, throughout the state of Hawaii. Influenza surveillance in the state of Hawaii relies upon selected sentinel health practitioners, the State Laboratories Division (SLD), private laboratories, and the Office of Health Status Monitoring (OHSM). For detailed information concerning influenza, please visit the HDOH Disease Outbreak Control Division (HDOH DOCD) website (*here*). **All data and information are conditional and may change as more reports are received.** The data in this report reflects the 2025-2026 influenza season which began the week ending October 4, 2025 (week 40[1] 2025) and will end the week ending on October 3, 2026 (week 39 2026).

REPORT SNAPSHOT FOR WEEK 17

Surveillance for Influenza-like Illness (ILI)		
Metric	*Value*	*Comment*
Outpatient visits related to influenza-like illness (ILI) from ILINet Sentinel Providers	3.3%	Lower than the previous week. Higher than Hawaii's historical baseline and lower than the national baseline, and higher than the national ILI rate.
Number of ILI clusters reported to HDOH	0	There have been 27 clusters this season.

Laboratory Surveillance		
Percent of all respiratory specimens positive for influenza this week	13.8%	Lower than the previous week. This number means that many, if not all, of the 86.2% who tested negative for influenza had illness from another respiratory etiology.
Percent of all respiratory specimens positive for influenza this season to date	17.8%	

Surveillance for Severe Outcomes		
Pneumonia, influenza and COVID-19 (PIC) mortality rate	2.0	Lower than Hawaii's historical baseline, lower than the national epidemic threshold and comparable to the NCHS average.
Number of influenza-associated pediatric deaths reported nationwide	158	0 influenza-associated pediatric deaths have been reported from Hawaii this season to date.

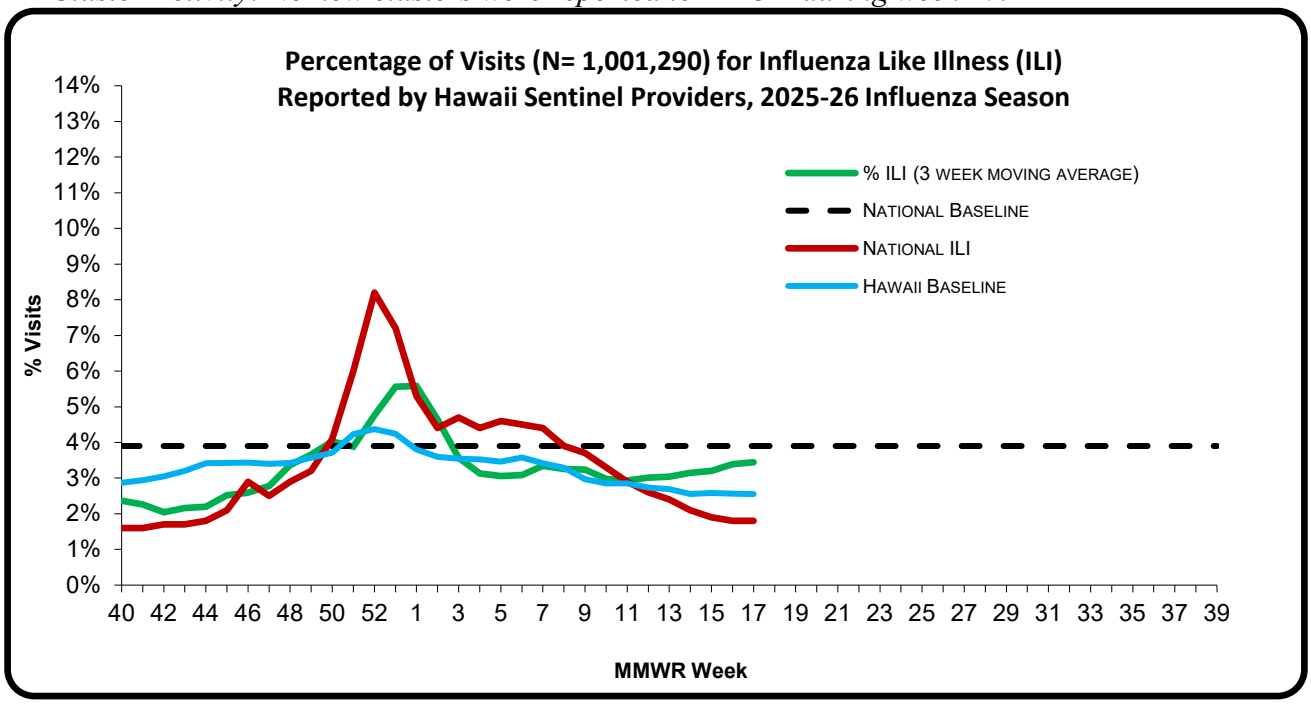
[1] MMWR stands for "Morbidity and Mortality Weekly Report," conventionally used by the Centers for Disease Control and Prevention (CDC). The weeks of a flu season are often referred to by their respective MMWR week. **See appendix 2 for interpretation of MMWR weeks.** Data reported will begin on week 40, the traditional start date of flu season.

INFLUENZA SURVEILLANCE

I. INFLUENZA-LIKE ILLNESS (ILI): HDOH collaborates with recruited doctors and healthcare providers who report the total number of outpatient visits for ILI as well as the total number of patients who complained of symptoms consistent with ILI. A patient with ILI must have the following: a fever (temperature of 100°F [37.8°C] or greater) AND a cough and/or a sore throat. ILI is based on reported symptoms and not laboratory confirmed tests; thus, ILI may represent other respiratory pathogens and not solely influenza. Further, sentinel providers report these numbers on a weekly basis; therefore, data are preliminary and may change depending on additional reporting. In combination with laboratory testing and other surveillance systems, ILI surveillance helps monitor influenza and other respiratory pathogen activity. For more information concerning ILINet and sentinel requirements, please visit the CDC website (*here*).

For **week 17** of the current influenza season:

- ***3.3**% (season to date: **3.3**%) of the outpatient visits recorded by Hawaii sentinel providers were for ILI.*
- *ILI visits were higher than the historical baseline in Hawaii[2,3] (i.e., outside the 95% confidence interval).*
- *Hawaii's ILI outpatient visits were lower than the national baseline (**3.9%**)[4] (i.e., outside the 95% confidence interval) and higher than the national ILI rate (**1.8%**) (i.e. outside the 95% confidence interval).*
- *ILI activity level: Low[5]*
- *Geographic Spread: Sporadic Activity[6].*
- *ILI Cluster Activity: No new clusters were reported to HDOH during week 17.*



[2] The Hawaii historical baseline (%ILI) is the average of 3-week moving averages over the preceding 3 flu seasons of historical data (2022-2023, 2023-2024 and 2024-2025).
[3] This value is based upon comparison of actual outpatient ILI with the historical baseline, which only captures outpatient ILI. The chart above represents a 3-week moving average and not the actual ILI by week.
[4] The National Baseline is calculated by CDC as the mean percentage of visits for ILI during weeks 21–39 with two standard deviations. Because of large variability in regional ILI, comparison of the national baseline with local ILI may not be appropriate. It is provided in this report because no meaningful regional baselines are available for comparison. The national baseline combines all data reported by states to CDC, including ILI in outpatient, ER, urgent care, and inpatient settings.
[5] There are 10 activity levels classified as minimal (levels 1-3), low (levels 4-5), moderate (levels 6-7), and high (levels 8-10).
[6] The influenza activity reported by state and territorial epidemiologists indicates geographic spread of influenza viruses but does not measure the severity of influenza activity. Sporadic: no clusters reported to HDOH, Local: one or more clusters reported in one county, Regional: clusters reported two to three counties, Widespread: clusters reported in all counties. Hawaii does not report No Activity, as flu circulates year-round in Hawaii.

II. LABORATORY SURVEILLANCE: State Laboratories Division (SLD; the HDOH public health laboratory) and Hawaii's major private laboratories (DLS, CLH) report results of RT-PCR, which can be considered confirmatory (SLD may perform viral culture on select specimens). Specimens meeting priority criteria[7] are forwarded to SLD for sub-typing. Additionally, specimens meeting case definition from requesting sentinel providers are sent directly to SLD for sub-typing. Due to resource constraints, not all submitted specimens undergo sub-typing. Sub-typing at the commercial laboratories is only conducted on a case-by-case basis. The majority of specimens testing positive by rapid antigen testing or RT-PCR at the commercial laboratories do not meet criteria and are not subtyped. For more information on influenza tests and types, please visit the CDC website (*here*).

A. INFLUENZA:

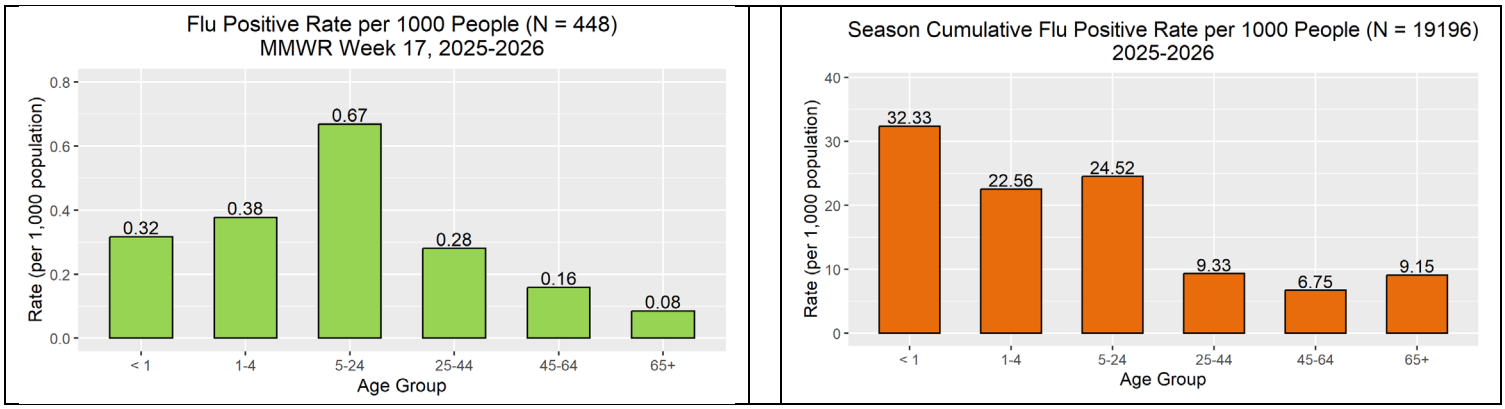
- The following reflects laboratory findings for week 17 of the 2025–26 influenza season:
  - *A total of **3,250** specimens has been tested statewide for influenza viruses (positive: 448 [**13.8%**]). (Season to date: **107,582** tested (**17.8%** positive)*
    - *1,528 (47.0%) were screened only by rapid antigen tests with no confirmatory testing.*
    - *1,722 (53.0%) underwent confirmatory testing (either RT-PCR or viral culture).*
    - *2,802 (86.2) were negative.*
  - *Routine surveillance samples from State Laboratory Division were tested at a public health laboratory and identified as Influenza A (H3N2) subclade K.*

Influenza type	***Current week 17 (%)****	***Season to date (%)***[8]
Influenza A (H1)[9]	*2 (0.4)*	*199 (1.0)*
Influenza A (H3)	*1 (0.2)*	*1,300 (6.8)*
Influenza A no subtyping	*47 (10.5)*	*12,582 (65.7)*
Influenza B (Yamagata)	*0 (0.0)*	*0 (0.0)*
Influenza B (Victoria)	*0 (0.0)*	*0 (0.0)*
Influenza B no genotyping	*398 (88.8)*	*5,072 (26.5)*

**Specimens that are positive for both A and B (coinfections) are counted in both A and B totals for current and season to date*

1. AGE DISTRIBUTION

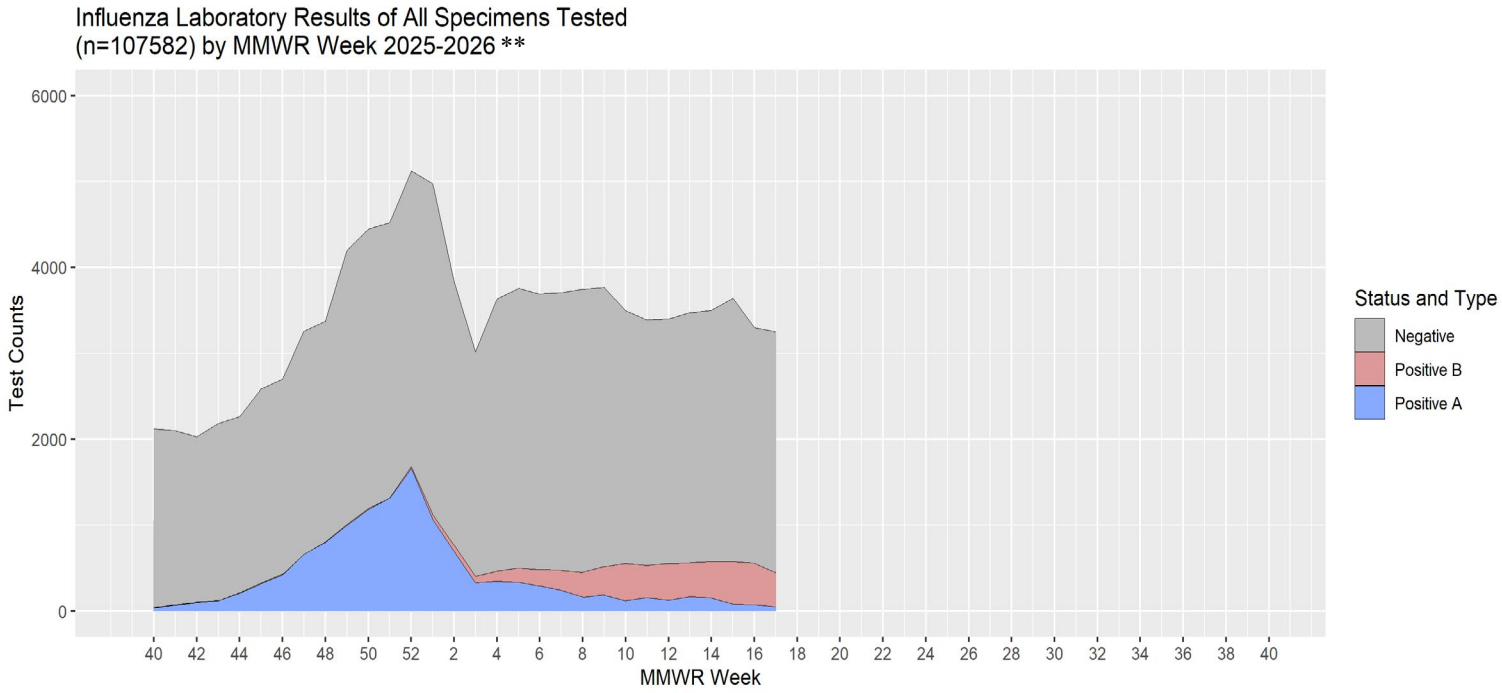
The charts below indicate the population-based rates of positive influenza cases in Hawaii by age group during the 2025–26 influenza season.[10]

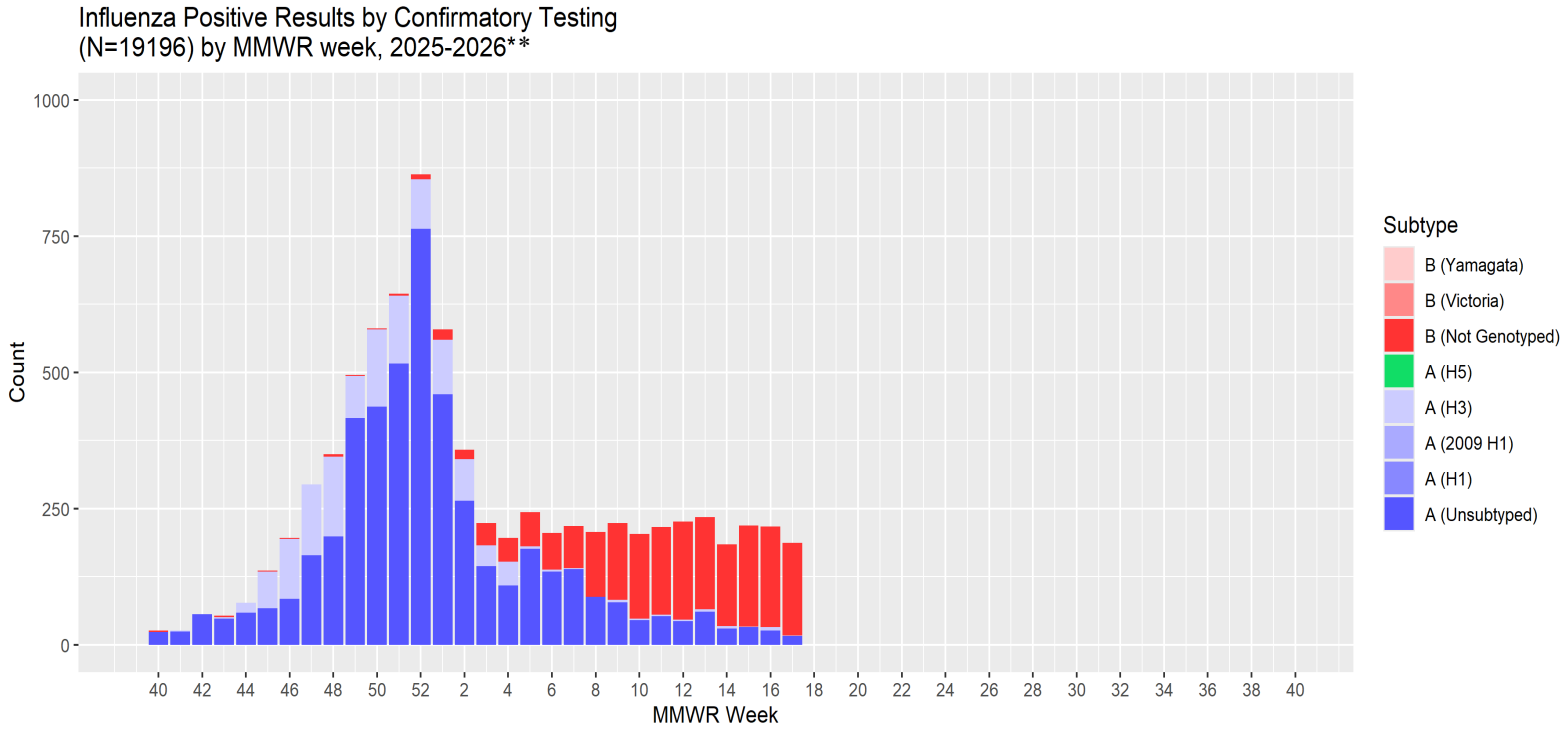


[7] Priority criteria include: hospitalized patients with acute respiratory distress syndrome [ARDS] or x-ray confirmed pneumonia; travelers with international travel history within 10 days of onset; specimens submitted by sentinel providers; specimens collected from healthcare workers, pregnant women, or women up to 6 weeks' post-partum; those with underlying medical conditions; and patients presenting with unusual or severe manifestations of influenza infection.
[8] Influenza coding was updated to reflect a more accurate count.
[9] All influenza A H1 viruses detected this season have been 2009 H1N1.
[10] This represents an estimate of population-based rates based on available data.

2. LABORATORY TESTING

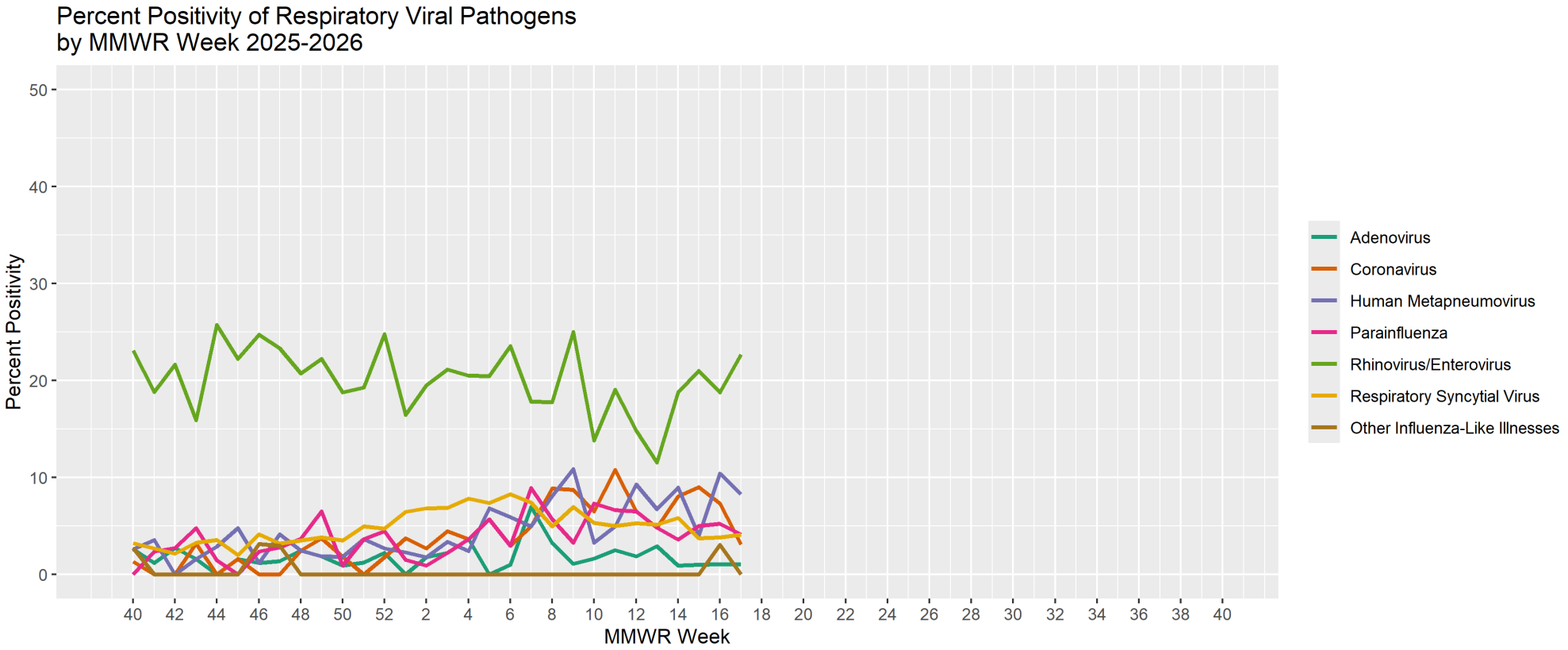
The charts below show the laboratory results of all specimens tested for influenza by MMWR week during the 2025–2026 influenza season as well as the type and subtype of positive results for influenza. Again, sub-typing is only performed on selected specimens tested by confirmatory tests (i.e., RT-PCR or viral culture).





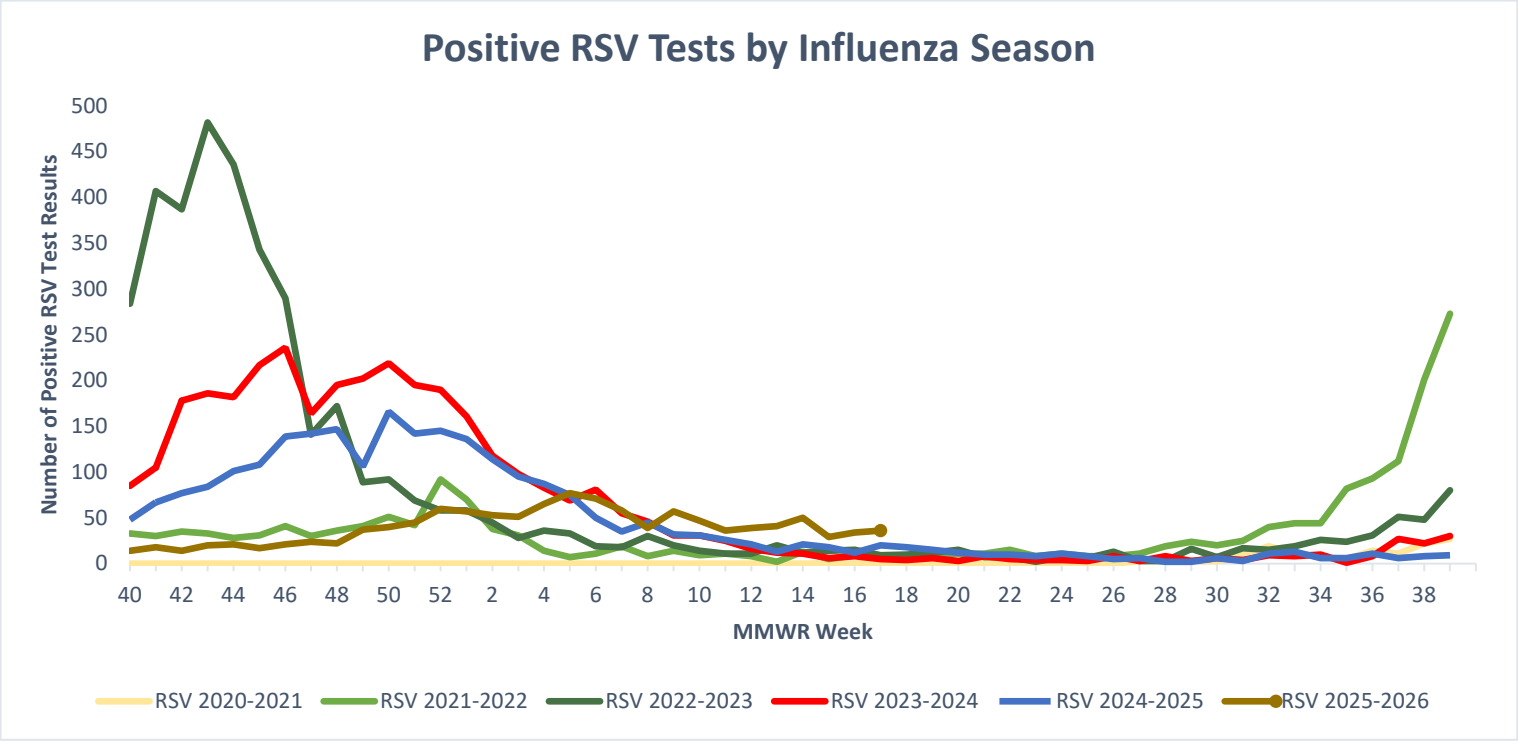
** A total of 59,193 specimens underwent confirmatory testing, but not all positive influenza specimens receive confirmatory testing that are circulating in Hawaii.*
*** For MMWR Week 53, results are reported under MMWR Week 52, where the average of Weeks 52 and 53 was calculated.*

B. **OTHER RESPIRATORY PATHOGENS:** The major clinical and commercial laboratories throughout the state of Hawaii have the testing capacity for non-influenza respiratory pathogens and report these to HDOH. However, such testing is performed as needed and when sufficient resources are available because of the high costs associated with respiratory panel tests. **Therefore, available data represents only the presence of circulating pathogens and cannot be used to determine specific trends**.



* *The coronavirus presented on this table does not indicate Severe Acute Respiratory Coronavirus-2 (i.e., COVID-19). For MMWR Week 53, results are reported under MMWR Week 52, where the average of Weeks 52 and 53 was calculated*

RESPIRATORY SYNCYTIAL VIRUS (RSV) POSITIVE TEST RESULTS BY INFLUENZA SEASON: RSV case appears to have increased later than past seasons in the 2025-2026 season. For MMWR Week 53, results are reported under MMWR Week 52, where the average of Weeks 52 and 53 was calculated.



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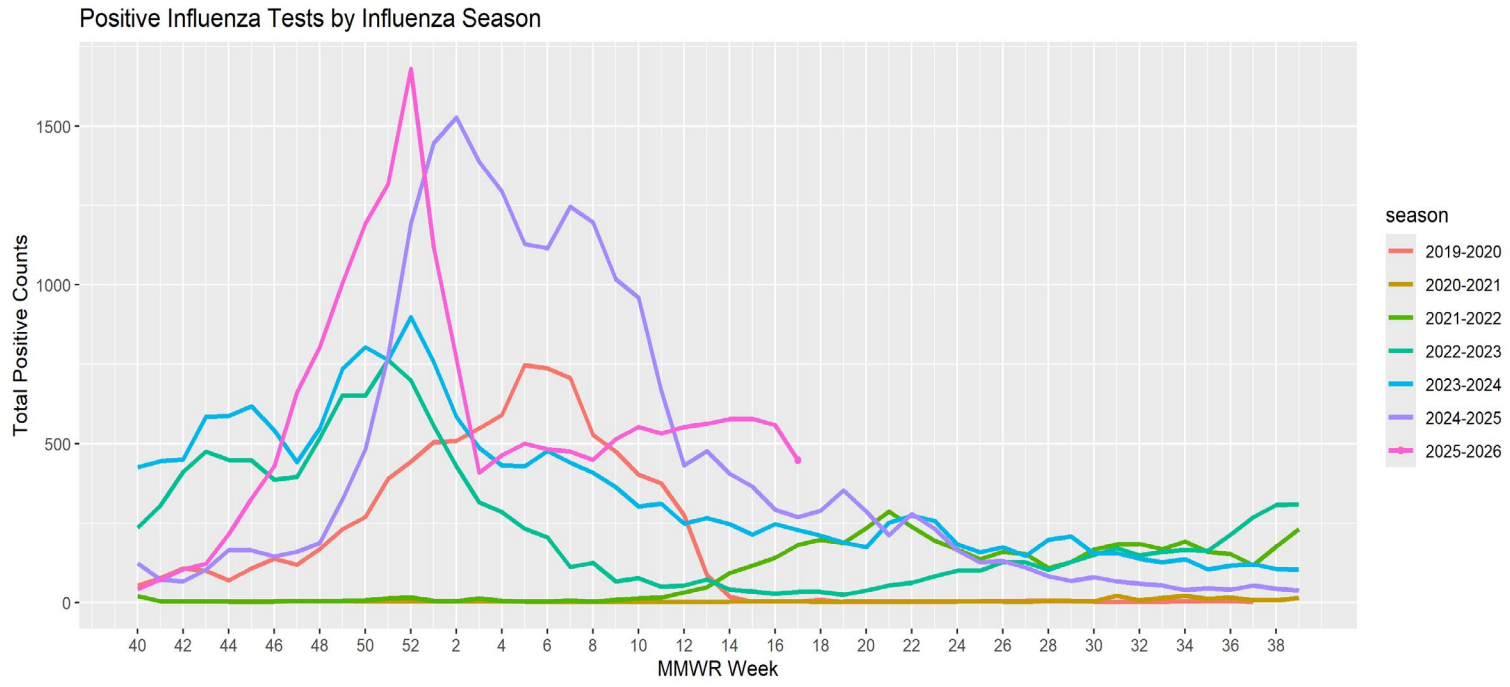


C. COVID-19 SENTINEL SURVEILLANCE: Due to the low volume of samples currently available through the influenza surveillance system, the COVID-19 sentinel surveillance data may not be accurately portraying COVID-19 activity in our communities. Reporting of the COVID-19 Sentinel Surveillance data will be paused while HODH re-evaluates the program to ensure that the reported data are accurate and representative.

HDOH is continuing to monitor COVID-19 activity throughout the state. To learn more, please visit the Hawaii's COVID-19 data website (*here*). For more information on surveillance of COVID-19 activity in the United States please visit the CDC COVIDView website (*here*).

III. PNEUMONIA, INFLUENZA, AND COVID-19 (PIC) RELATED MORTALITY:

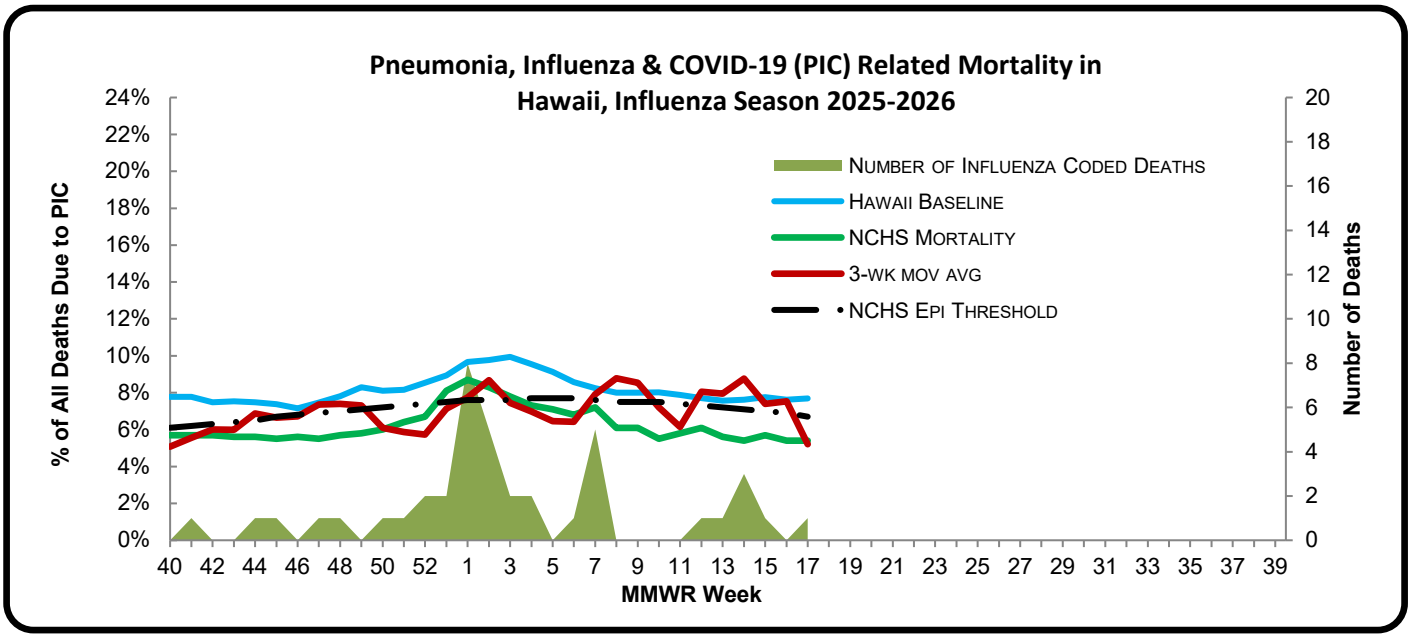
P&I mortality surveillance is collected by CDC through the National Center for Health Statistics (NCHS) using death certificate data. Each week the HDOH OHSM reports specific data from Honolulu to the CDC. CDC collects the following information by age group: the total number of deaths, total deaths from pneumonia, and total deaths related to influenza. Due to the ongoing COVID-19 pandemic, CDC included total deaths from COVID-19 by age group to the death data. Previous studies had suggested that P&I is a good indicator of influenza-related deaths; however, data has shown that pneumonia deaths associated with influenza is now being impacted by COVID-19 related pneumonia. Due to this, CDC had added COVID-19 deaths into P&I to create the PIC (pneumonia, influenza, and/or COVID-19) classification.

To standardize Hawaii's influenza surveillance with CDC influenza surveillance guidelines, PIC deaths will be reported in lieu of P&I. Hawaii's baseline will begin to include PIC deaths starting from 2019-2020 flu season.

For **week 17** of the current influenza season:

- ***2.0%*** *of all deaths that occurred in Hawaii during week 17 were related to pneumonia, influenza or COVID-19 (PIC)*[11]*. For the current season (season to date:* ***7.1%****), there have been 7,265 deaths from any cause, 515 of which were due to PIC*[12]*.*
- *The PIC rate was lower than the historical baseline in Hawaii*[13] *(i.e., outside the 95% confidence interval).*

The Hawaii PIC rate was comparable to the CDC's National Center for Health Statistics (NCHS) PIC mortality[14] ***(5.4%)*** *(i.e., inside the 95% confidence interval) and lower than the national epidemic threshold (****6.7****%) (i.e., inside the 95% confidence interval) for week 17.*



[11] The percent of deaths due to PIC displayed on the graph is the 3-week moving averages.

[12] PIC data reflect 71.2% of the data reported for the MMWR week. Changes to data are expected when PIC data reaches 100% completion.

[13] The Hawaii historical baseline (%PIC) is the average of 3-week moving averages over the preceding 10 flu seasons of historical data (2014-2015, 2015-2016, 2016-2017, 2017-2018, 2018-2019, 2019-2020, 2020-2021, 2021-2022, 2022-2023, and 2023-2024).

[14] Each week, the vital statistics offices of 122 cities across the United States report the total number of death certificates processed and the number of those for which pneumonia, influenza, or COVID-19 was listed as the underlying or contributing cause of death by age group (Under 28 days, 28 days–1 year, 1–14 years, 15–24 years, 25–44 years, 45–64 years, 65–74 years, 75–84 years, and ≥85 years). The COVID-19 death counts reported by NCHS are provisional and will not match counts in other sources, such as media reports or numbers from health departments. COVID-19 deaths may be classified or defined differently in various reporting and surveillance systems. The percentage of deaths due to pneumonia, influenza, and COVID-19 (PIC) are compared with a seasonal baseline and epidemic threshold value calculated for each week.

INFLUENZA-ASSOCIATED PEDIATRIC DEATHS[15]:

- No new influenza-associated pediatric death was reported to Hawaii. There have been zero influenza-associated pediatric deaths reported in Hawaii during the 2025–2026 season.
- Nationally, three new influenza-associated pediatric deaths were reported to CDC during week 17. (2025-2026 season total: 158).

IV. INFLUENZA WATCH: As part of a comprehensive influenza surveillance system and to prevent the spread of contagious respiratory diseases in humans, it is important to monitor all circulating influenza types. Several animal-origin influenza A subtypes are currently of interest: influenza A variant virus (H3N2v, H1N2v, and H1N1v) and Avian flu (H5N1 and H7N9). These types of influenza viruses may cause zoonotic (animal-associated) disease and are a public health concern.

A. VARIANT VIRUSES:

Influenza viruses that normally circulate in pigs are called "variant" viruses when they are found in people. These viruses were first identified in U.S. pigs in 2010. In 2011, 12 cases of H3N2v infection were detected in the United States. In 2012, 309 such cases (resulting in 16 hospitalizations and one death) across 12 states were detected, including one Hawaii case who recovered. Illness associated with H3N2v infection has been mostly mild with symptoms similar to those of seasonal flu. However, serious illness, resulting in hospitalization and death, has occurred in some cases. Most of these infections have been associated with prolonged exposure to pigs at agricultural fairs or similar settings. Limited human-to-human spread of this virus has been detected in the past, but no sustained community spread of H3N2v has been identified. More information regarding H3N2v, H1N1v, and H1N2v viruses may be found on the CDC website (*here*) and (*here*).

- *No variant or novel influenza infections have been reported to HDOH during the 2025-2026 influenza season.*
- *One new human infection with novel influenza A virus, H1N1v (0), H3N2v (0), and H1N2v (1), have been reported during the 2025-2026 influenza season.*
    - *One new human infection with influenza A(H1N1v) virus has been reported to WHO from China during the 2025-2026 influenza season.*

AVIAN (OR BIRD) INFLUENZA: These types of influenza viruses cause zoonotic (animal-associated) disease of public health concern and are therefore monitored globally by the WHO. Most avian influenza viruses do not cause disease in humans and are generally not easily transmissible between person to person, but a few subtypes may cross the species barrier and cause disease in humans. Avian influenza viruses may be of various subtypes, including H5N1, H5N2, H5N8, H7N3, H7N7, H7N8, H7N9, and H9N2. On January 15th, 2016, the USDA and APHIS reported detection of HPAI H7N8 in a commercial turkey flock in Indiana. There have been no associated human infections. This is the first detection of HPAI H7N8 in wild bird surveillance in the United States. More information, the risk assessment and recommendations for HPAI H7N8 can be found (here). The WHO, CDC, and other public health agencies have also been monitoring influenza H7N9, which represents a public health concern because of its high pandemic potential. Although H7N9 has not been detected in the United States, it remains a global concern given continuing epidemics in endemic countries. Since 2013, a total of 1,568 laboratory-confirmed cases of human infection with H7N9 viruses, including at least 613 deaths, have been reported to WHO. More information on H7N9 virus infections can be found (here). For more information regarding avian influenza, please visit the CDC (*here*) or the WHO (*here*) websites. WHO reports total number of cases and deaths related to laboratory-confirmed avian influenza viruses and posts current avian influenza case counts (*here*), which were last updated on **January 22, 2026**.

[15] Influenza-associated deaths are considered pediatric in persons aged less than 18 years. It was made a nationally notifiable condition in October, 2004. All pediatric influenza-associated deaths are laboratory confirmed.

V. INFLUENZA Vaccine: Annual influenza vaccination is recommended for all persons aged 6 months and older and is the most effective way to reduce the risk of getting sick with seasonal flu and spreading it to others. Influenza vaccination can reduce illnesses, visits to the doctor, influenza-related hospitalizations, and missed work and school days. Influenza vaccines become available by the end of October. It takes at least two weeks after vaccination to confer immunity against influenza virus infection. More information regarding influenza vaccination can be found (*here*).

A. Composition of the 2025–2026 Influenza Vaccine**:**

The composition of the 2025–2026 influenza vaccine has been updated to better match circulating influenza viruses. The Advisory Committee on Immunization Practices (ACIP) has recommended that the 2025-2026 influenza trivalent vaccine contain an influenza A/Victoria/4897/2022 (H1N1) pdm09-like virus, influenza A/Croatia/10136RV/2023 (H3N2)-like virus, and influenza B/Austria/1359417/2021 (B/Victoria lineage)-like virus. United States cell culture–based inactivated (ccIIV4) and recombinant (RIV4) influenza vaccines will contain HA derived from an influenza A/Wisconsin/67/2022 (H1N1) pdm09-like virus, an A/District of Columbia/27/2023 (H3N2)-like virus, an influenza B/Austria/1359417/2021 (B/Victoria lineage)-like virus. These vaccine recommendations were based on several factors, including global influenza virologic and epidemiologic surveillance, genetic and antigenic characterization, human serology studies, antiviral susceptibility, and the availability of candidate influenza viruses.

APPENDIX 1: ADDITIONAL INFORMATION

For more information regarding local and national influenza surveillance programs, visit the following sites.

Centers for Disease Control and Prevention	General Influenza National ILI and P&I Data Vaccine Virus Selection CDC Web Tool for Respiratory Viruses
Flu.gov	General Influenza Information
HDOH Flu and Pneumonia	General Influenza Surveillance Avian Influenza Respiratory Virus Dashboard To find out more information or join the sentinel physician program, email the Influenza Surveillance Coordinator
World Health Organization	General Global and Local Influenza Avian Influenza

APPENDIX 2: MMWR WEEK DATES

Please refer to the table below to interpret data presented by MMWR week. Week 40 is considered the traditional start for the flu season for the Northern Hemisphere.

MMWR WEEK	2022	2023	2024	2025	2026
1	1/8/2022	1/7/2023	1/6/2024	1/4/2025	1/10/2026
2	1/15/2022	1/14/2023	1/13/2024	1/11/2025	1/17/2026
3	1/22/2022	1/21/2023	1/20/2024	1/18/2025	1/24/2026
4	1/29/2022	1/28/2023	1/27/2024	1/25/2025	1/31/2026
5	2/5/2022	2/4/2023	2/3/2024	2/1/2025	2/7/2026
6	2/12/2022	2/11/2023	2/10/2024	2/8/2025	2/14/2026
7	2/19/2022	2/18/2023	2/17/2024	2/15/2025	2/21/2026
8	2/26/2022	2/25/2023	2/24/2024	2/22/2025	2/28/2026
9	3/5/2022	3/4/2023	3/2/2024	3/1/2025	3/7/2026
10	3/12/2022	3/11/2023	3/9/2024	3/8/2025	3/14/2026
11	3/19/2022	3/18/2023	3/16/2024	3/15/2025	3/21/2026
12	3/26/2022	3/25/2023	3/23/2024	3/22/2025	3/28/2026
13	4/2/2022	4/1/2023	3/30/2024	3/29/2025	4/4/2026
14	4/9/2022	4/8/2023	4/6/2024	4/5/2025	4/11/2026
15	4/16/2022	4/15/2023	4/13/2024	4/12/2025	4/18/2026
16	4/23/2022	4/22/2023	4/20/2024	4/19/2025	4/25/2026
17	4/30/2022	4/29/2023	4/27/2024	4/26/2025	5/2/2026
18	5/7/2022	5/6/2023	5/4/2024	5/3/2025	5/9/2026
19	5/14/2022	5/13/2023	5/11/2024	5/10/2025	5/16/2026
20	5/21/2022	5/20/2023	5/18/2024	5/17/2025	5/23/2026
21	5/28/2022	5/27/2023	5/25/2024	5/24/2025	5/30/2026
22	6/4/2022	6/3/2023	6/1/2024	5/31/2025	6/6/2026
23	6/11/2022	6/10/2023	6/8/2024	6/7/2025	6/13/2026
24	6/18/2022	6/17/2023	6/15/2024	6/14/2025	6/20/2026
25	6/25/2022	6/24/2023	6/22/2024	6/21/2025	6/27/2026
26	7/2/2022	7/1/2023	6/29/2024	6/28/2025	7/4/2026
27	7/9/2022	7/8/2023	7/6/2024	7/5/2025	7/11/2026
28	7/16/2022	7/15/2023	7/13/2024	7/12/2025	7/18/2026
29	7/23/2022	7/22/2023	7/20/2024	7/19/2025	7/25/2026
30	7/30/2022	7/29/2023	7/27/2024	7/26/2025	8/1/2026
31	8/6/2022	8/5/2023	8/3/2024	8/2/2025	8/8/2026
32	8/13/2022	8/12/2023	8/10/2024	8/9/2025	8/15/2026
33	8/20/2022	8/19/2023	8/17/2024	8/16/2025	8/22/2026
34	8/27/2022	8/26/2023	8/24/2024	8/23/2025	8/29/2026
35	9/3/2022	9/2/2023	8/31/2024	8/30/2025	9/5/2026
36	9/10/2022	9/9/2023	9/7/2024	9/6/2025	9/12/2026
37	9/17/2022	9/16/2023	9/14/2024	9/13/2025	9/19/2026
38	9/24/2022	9/23/2023	9/21/2024	9/20/2025	9/26/2026
39	10/1/2022	9/30/2023	9/28/2024	9/27/2025	10/3/2026
40	10/8/2022	10/7/2023	10/5/2024	10/4/2025	10/10/2026
41	10/15/2022	10/14/2023	10/12/2024	10/11/2025	10/17/2026
42	10/22/2022	10/21/2023	10/19/2024	10/18/2025	10/24/2026
43	10/29/2022	10/28/2023	10/26/2024	10/25/2025	10/31/2026
44	11/5/2022	11/4/2023	11/2/2024	11/1/2025	11/7/2026
45	11/12/2022	11/11/2023	11/9/2024	11/8/2025	11/14/2026
46	11/19/2022	11/18/2023	11/16/2024	11/15/2025	11/21/2026
47	11/26/2022	11/25/2023	11/23/2024	11/22/2025	11/28/2026
48	12/3/2022	12/2/2023	11/30/2024	11/29/2025	12/5/2026
49	12/10/2022	12/9/2023	12/7/2024	12/6/2025	12/12/2026
50	12/17/2022	12/16/2023	12/14/2024	12/13/2025	12/19/2026
51	12/24/2022	12/23/2023	12/21/2024	12/20/2025	12/26/2026
52	12/31/2022	12/30/2023	12/28/2024	12/27/2025	
53				01/03/2026	

HAWAII STATE DEPARTMENT OF HEALTH
DISEASE OUTBREAK CONTROL DIVISION

Influenza/Respiratory Disease Surveillance Report

Morbidity and Mortality Weekly Report (MMWR)[1]

WEEK 18: MAY 3, 2026– MAY 9, 2026

OVERVIEW: The Hawaii State Department of Health (HDOH) monitors influenza and other respiratory pathogens, including COVID-19, throughout the state of Hawaii. Influenza surveillance in the state of Hawaii relies upon selected sentinel health practitioners, the State Laboratories Division (SLD), private laboratories, and the Office of Health Status Monitoring (OHSM). For detailed information concerning influenza, please visit the HDOH Disease Outbreak Control Division (HDOH DOCD) website (*here*). **All data and information are conditional and may change as more reports are received.** The data in this report reflects the 2025-2026 influenza season which began the week ending October 4, 2025 (week 40[1] 2025) and will end the week ending on October 3, 2026 (week 39 2026).

REPORT SNAPSHOT FOR WEEK 18

Surveillance for Influenza-like Illness (ILI)		
Metric	*Value*	*Comment*
Outpatient visits related to influenza-like illness (ILI) from ILINet Sentinel Providers	3.1%	Lower than the previous week. Comparable to Hawaii's historical baseline and lower than the national baseline, and higher than the national ILI rate.
Number of ILI clusters reported to HDOH	0	There have been 27 clusters this season.

Laboratory Surveillance		
Percent of all respiratory specimens positive for influenza this week	13.3%	Lower than the previous week. This number means that many, if not all, of the 86.7% who tested negative for influenza had illness from another respiratory etiology.
Percent of all respiratory specimens positive for influenza this season to date	17.7%	

Surveillance for Severe Outcomes		
Pneumonia, influenza and COVID-19 (PIC) mortality rate	1.8	Lower than Hawaii's historical baseline, lower than the national epidemic threshold and comparable to the NCHS average.
Number of influenza-associated pediatric deaths reported nationwide	166	0 influenza-associated pediatric deaths have been reported from Hawaii this season to date.

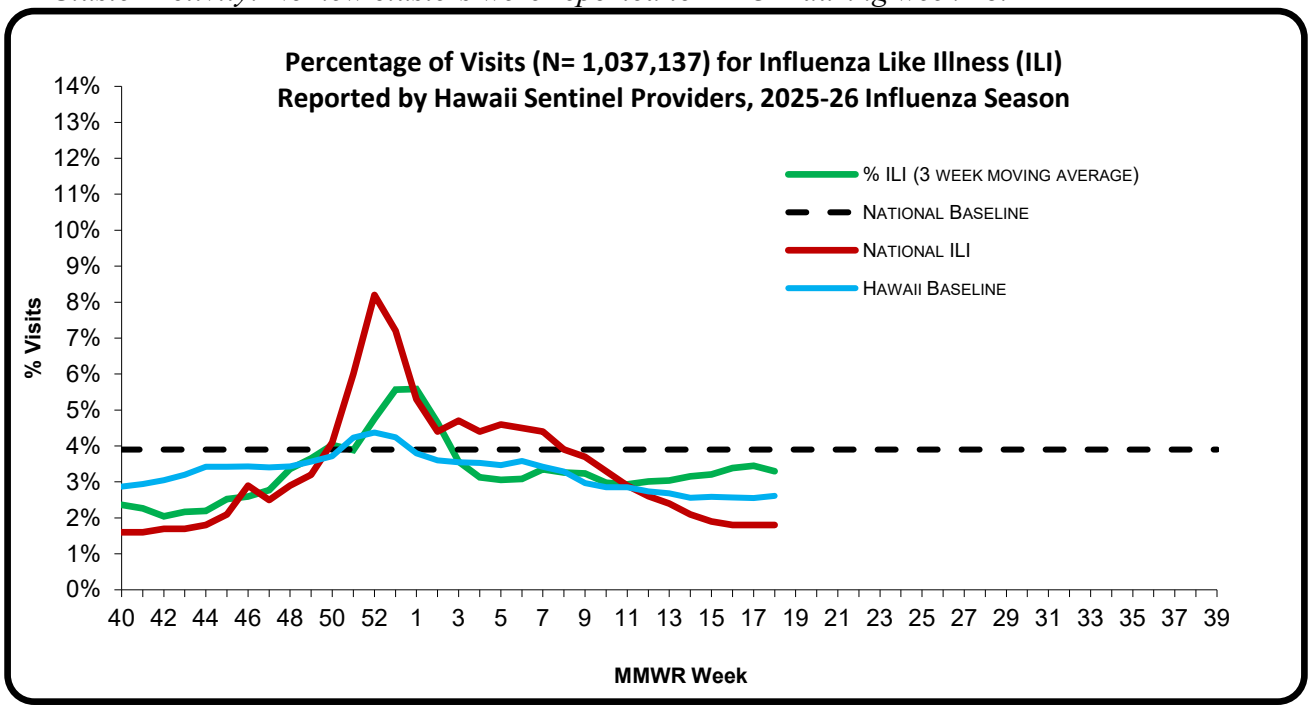
[1] MMWR stands for "Morbidity and Mortality Weekly Report," conventionally used by the Centers for Disease Control and Prevention (CDC). The weeks of a flu season are often referred to by their respective MMWR week. **See appendix 2 for interpretation of MMWR weeks.** Data reported will begin on week 40, the traditional start date of flu season.

INFLUENZA SURVEILLANCE

I. INFLUENZA-LIKE ILLNESS (ILI): HDOH collaborates with recruited doctors and healthcare providers who report the total number of outpatient visits for ILI as well as the total number of patients who complained of symptoms consistent with ILI. A patient with ILI must have the following: a fever (temperature of 100°F [37.8°C] or greater) AND a cough and/or a sore throat. ILI is based on reported symptoms and not laboratory confirmed tests; thus, ILI may represent other respiratory pathogens and not solely influenza. Further, sentinel providers report these numbers on a weekly basis; therefore, data are preliminary and may change depending on additional reporting. In combination with laboratory testing and other surveillance systems, ILI surveillance helps monitor influenza and other respiratory pathogen activity. For more information concerning ILINet and sentinel requirements, please visit the CDC website (*here*).

For **week 18** of the current influenza season:

- ***3.1****% (season to date:* ***3.3****%) of the outpatient visits recorded by Hawaii sentinel providers were for ILI.*
- *ILI visits were comparable to the historical baseline in Hawaii[2,3] (i.e., inside the 95% confidence interval).*
- *Hawaii's ILI outpatient visits were lower than the national baseline (**3.9%**)[4] (i.e., outside the 95% confidence interval) and higher than the national ILI rate (**1.8%**) (i.e. outside the 95% confidence interval).*
- *ILI activity level: Low[5]*
- *Geographic Spread: Sporadic Activity[6].*
- *ILI Cluster Activity: No new clusters were reported to HDOH during week 18.*



[2] The Hawaii historical baseline (%ILI) is the average of 3-week moving averages over the preceding 3 flu seasons of historical data (2022-2023, 2023-2024 and 2024-2025).
[3] This value is based upon comparison of actual outpatient ILI with the historical baseline, which only captures outpatient ILI. The chart above represents a 3-week moving average and not the actual ILI by week.
[4] The National Baseline is calculated by CDC as the mean percentage of visits for ILI during weeks 21–39 with two standard deviations. Because of large variability in regional ILI, comparison of the national baseline with local ILI may not be appropriate. It is provided in this report because no meaningful regional baselines are available for comparison. The national baseline combines all data reported by states to CDC, including ILI in outpatient, ER, urgent care, and inpatient settings.
[5] There are 10 activity levels classified as minimal (levels 1-3), low (levels 4-5), moderate (levels 6-7), and high (levels 8-10).
[6] The influenza activity reported by state and territorial epidemiologists indicates geographic spread of influenza viruses but does not measure the severity of influenza activity. Sporadic: no clusters reported to HDOH, Local: one or more clusters reported in one county, Regional: clusters reported two to three counties, Widespread: clusters reported in all counties. Hawaii does not report No Activity, as flu circulates year-round in Hawaii.

II. LABORATORY SURVEILLANCE: State Laboratories Division (SLD; the HDOH public health laboratory) and Hawaii's major private laboratories (DLS, CLH) report results of RT-PCR, which can be considered confirmatory (SLD may perform viral culture on select specimens). Specimens meeting priority criteria[7] are forwarded to SLD for sub-typing. Additionally, specimens meeting case definition from requesting sentinel providers are sent directly to SLD for sub-typing. Due to resource constraints, not all submitted specimens undergo sub-typing. Sub-typing at the commercial laboratories is only conducted on a case-by-case basis. The majority of specimens testing positive by rapid antigen testing or RT-PCR at the commercial laboratories do not meet criteria and are not subtyped. For more information on influenza tests and types, please visit the CDC website (*here*).

A. INFLUENZA:

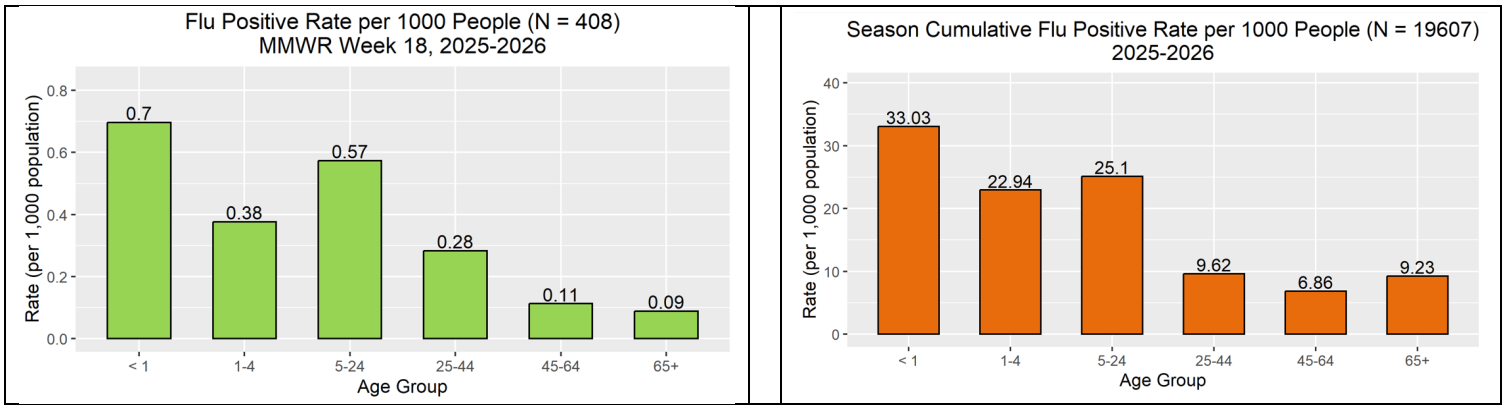
- The following reflects laboratory findings for week 18 of the 2025–26 influenza season:
  - *A total of **3,071** specimens has been tested statewide for influenza viruses (positive: 408 [**13.3%**]). (Season to date: **110,656** tested (**17.7%** positive)*
    - *1,496 (48.7%) were screened only by rapid antigen tests with no confirmatory testing.*
    - *1,575 (51.3%) underwent confirmatory testing (either RT-PCR or viral culture).*
    - *2,663 (86.7%) were negative.*
  - *Routine surveillance samples from State Laboratory Division were tested at a public health laboratory and identified as Influenza A (H3N2) subclade K.*

Influenza type	***Current week 18 (%)****	***Season to date (%)***[8]
Influenza A (H1)[9]	*0 (0.0)*	*199 (1.0)*
Influenza A (H3)	*0 (0.0)*	*1,300 (6.6)*
Influenza A no subtyping	*50 (12.3)*	*12,634 (64.6)*
Influenza B (Yamagata)	*0 (0.0)*	*0 (0.0)*
Influenza B (Victoria)	*0 (0.0)*	*0 (0.0)*
Influenza B no genotyping	*358 (87.7)*	*5,431 (27.8)*

**Specimens that are positive for both A and B (coinfections) are counted in both A and B totals for current and season to date*

1. AGE DISTRIBUTION

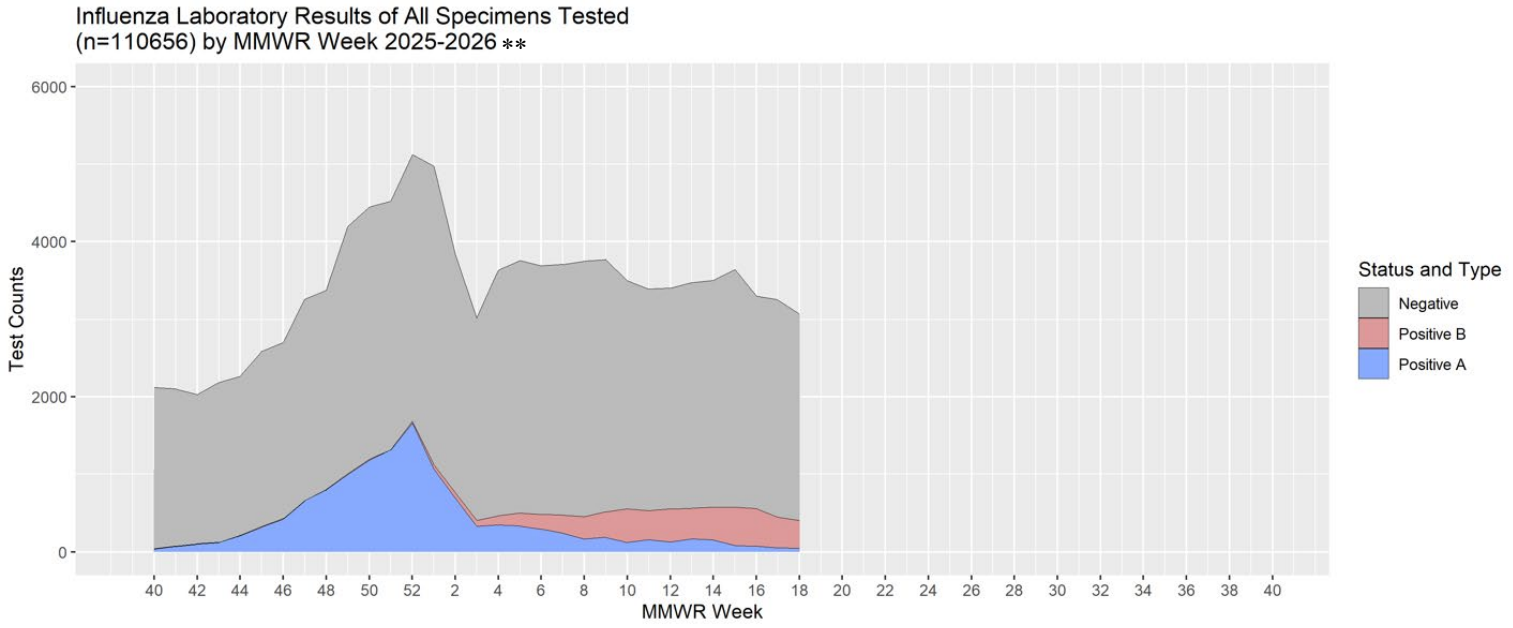
The charts below indicate the population-based rates of positive influenza cases in Hawaii by age group during the 2025–26 influenza season.[10]

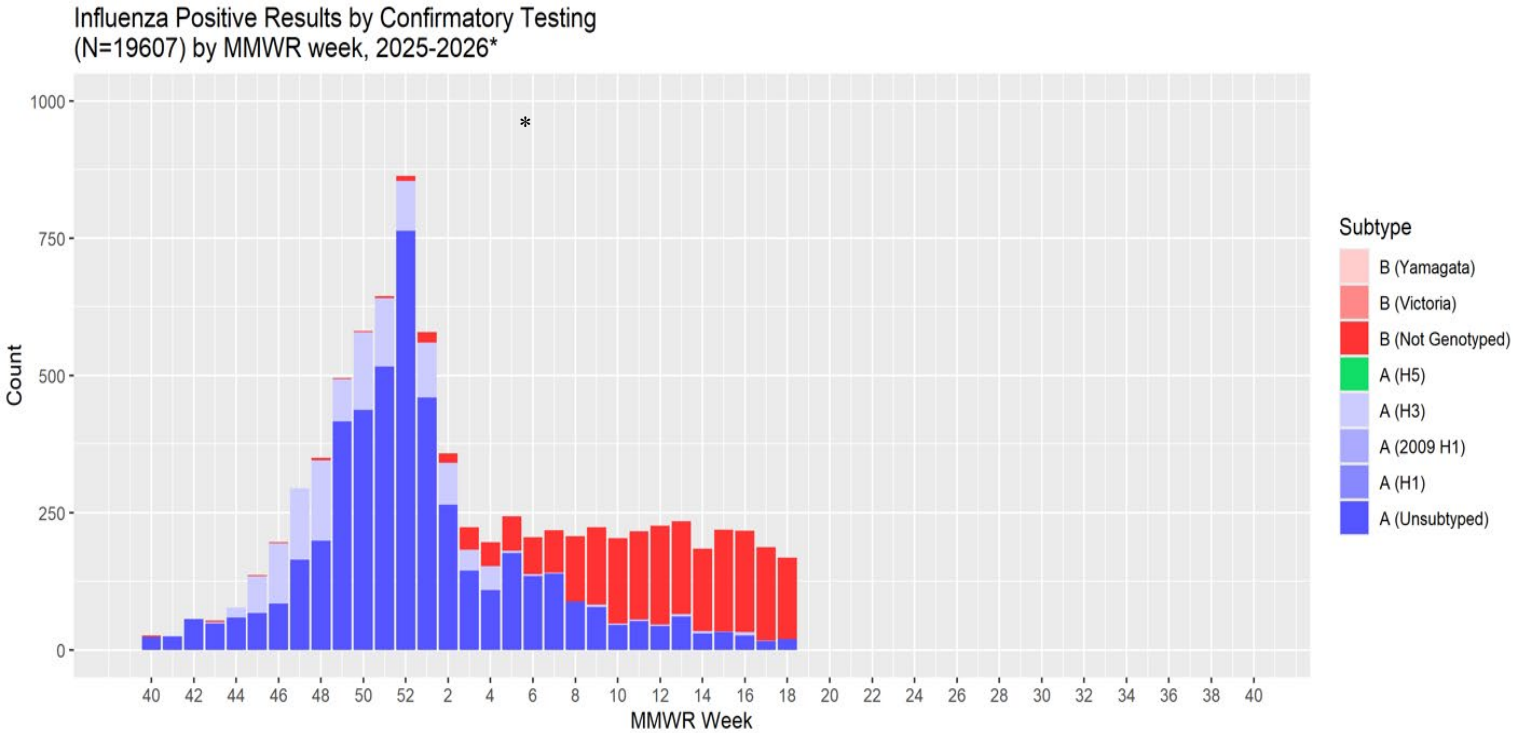


[7] Priority criteria include: hospitalized patients with acute respiratory distress syndrome [ARDS] or x-ray confirmed pneumonia; travelers with international travel history within 10 days of onset; specimens submitted by sentinel providers; specimens collected from healthcare workers, pregnant women, or women up to 6 weeks' post-partum; those with underlying medical conditions; and patients presenting with unusual or severe manifestations of influenza infection.
[8] Influenza coding was updated to reflect a more accurate count.
[9] All influenza A H1 viruses detected this season have been 2009 H1N1.
[10] This represents an estimate of population-based rates based on available data.

2. LABORATORY TESTING

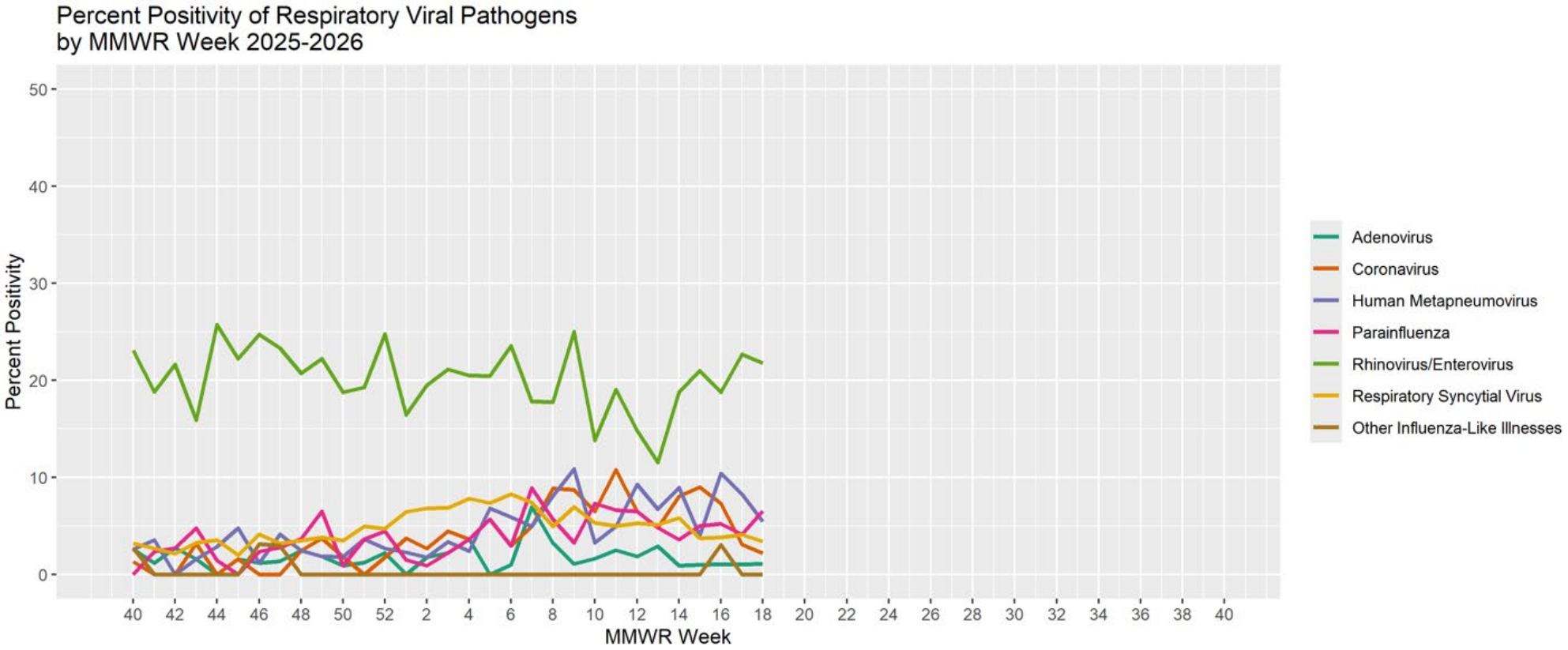
The charts below show the laboratory results of all specimens tested for influenza by MMWR week during the 2025–2026 influenza season as well as the type and subtype of positive results for influenza. Again, sub-typing is only performed on selected specimens tested by confirmatory tests (i.e., RT-PCR or viral culture).





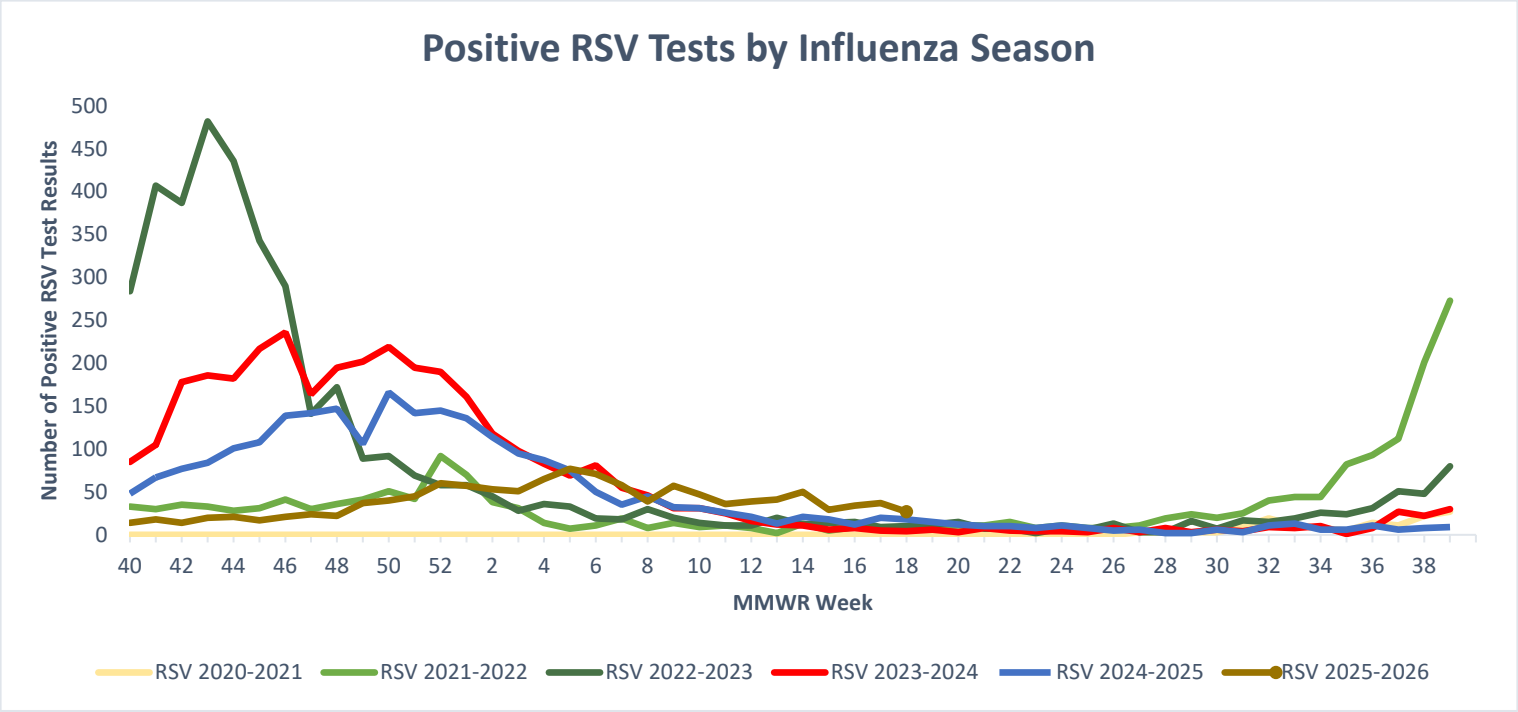
** A total of 60,768 specimens underwent confirmatory testing, but not all positive influenza specimens receive confirmatory testing that are circulating in Hawaii.*
*** For MMWR Week 53, results are reported under MMWR Week 52, where the average of Weeks 52 and 53 was calculated.*

B. **OTHER RESPIRATORY PATHOGENS:** The major clinical and commercial laboratories throughout the state of Hawaii have the testing capacity for non-influenza respiratory pathogens and report these to HDOH. However, such testing is performed as needed and when sufficient resources are available because of the high costs associated with respiratory panel tests. **Therefore, available data represents only the presence of circulating pathogens and cannot be used to determine specific trends**.

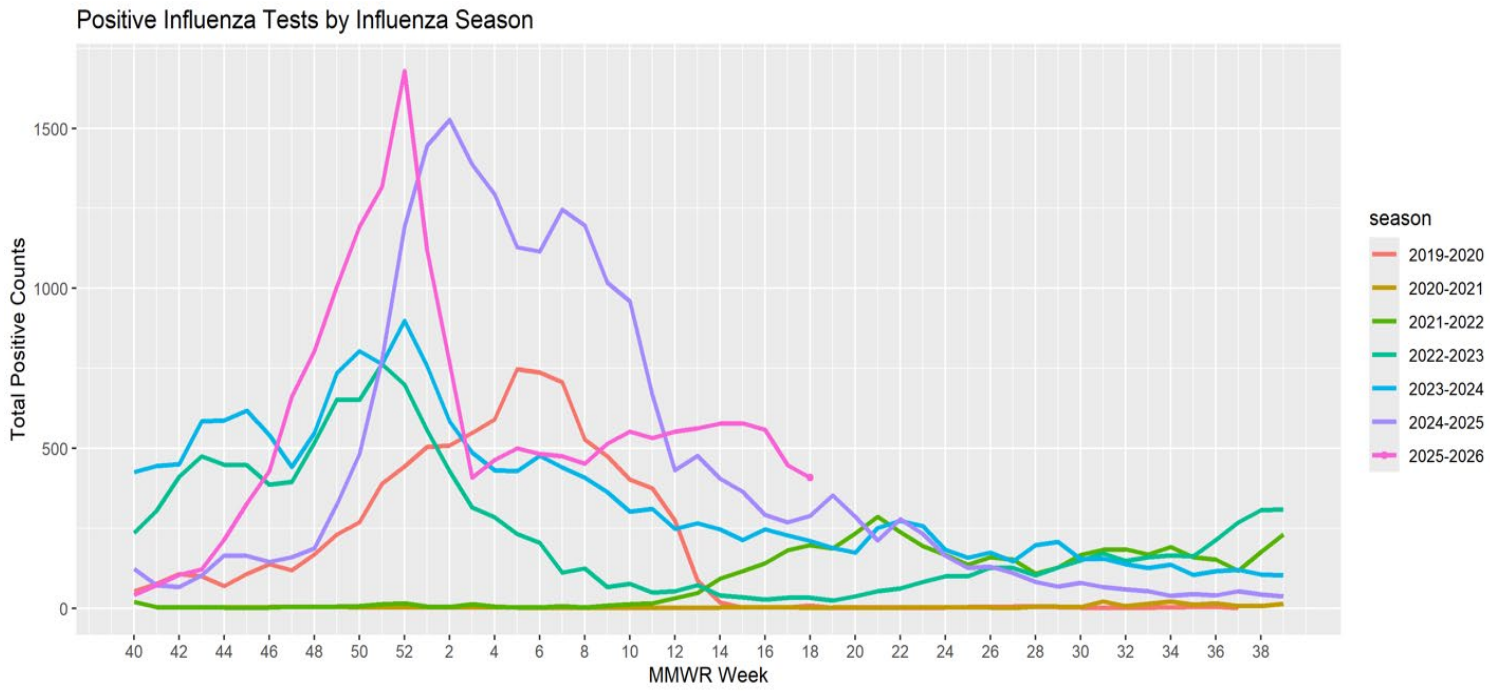


* *The coronavirus presented on this table does not indicate Severe Acute Respiratory Coronavirus-2 (i.e., COVID-19). For MMWR Week 53, results are reported under MMWR Week 52, where the average of Weeks 52 and 53 was calculated*

RESPIRATORY SYNCYTIAL VIRUS (RSV) POSITIVE TEST RESULTS BY INFLUENZA SEASON: RSV case appears to have increased later than past seasons in the 2025-2026 season. For MMWR Week 53, results are reported under MMWR Week 52, where the average of Weeks 52 and 53 was calculated.



INFLUENZA POSITIVE TEST RESULTS BY INFLUENZA SEASON: Influenza cases appear to have increased earlier than past seasons in the 2025-2026 season. For MMWR Week 53, results are reported under MMWR Week 52, where the average of Weeks 52 and 53 was calculated.



C. COVID-19 SENTINEL SURVEILLANCE: Due to the low volume of samples currently available through the influenza surveillance system, the COVID-19 sentinel surveillance data may not be accurately portraying COVID-19 activity in our communities. Reporting of the COVID-19 Sentinel Surveillance data will be paused while HODH re-evaluates the program to ensure that the reported data are accurate and representative.

HDOH is continuing to monitor COVID-19 activity throughout the state. To learn more, please visit the Hawaii's COVID-19 data website (*here*). For more information on surveillance of COVID-19 activity in the United States please visit the CDC COVIDView website (*here*).

III. PNEUMONIA, INFLUENZA, AND COVID-19 (PIC) RELATED MORTALITY:

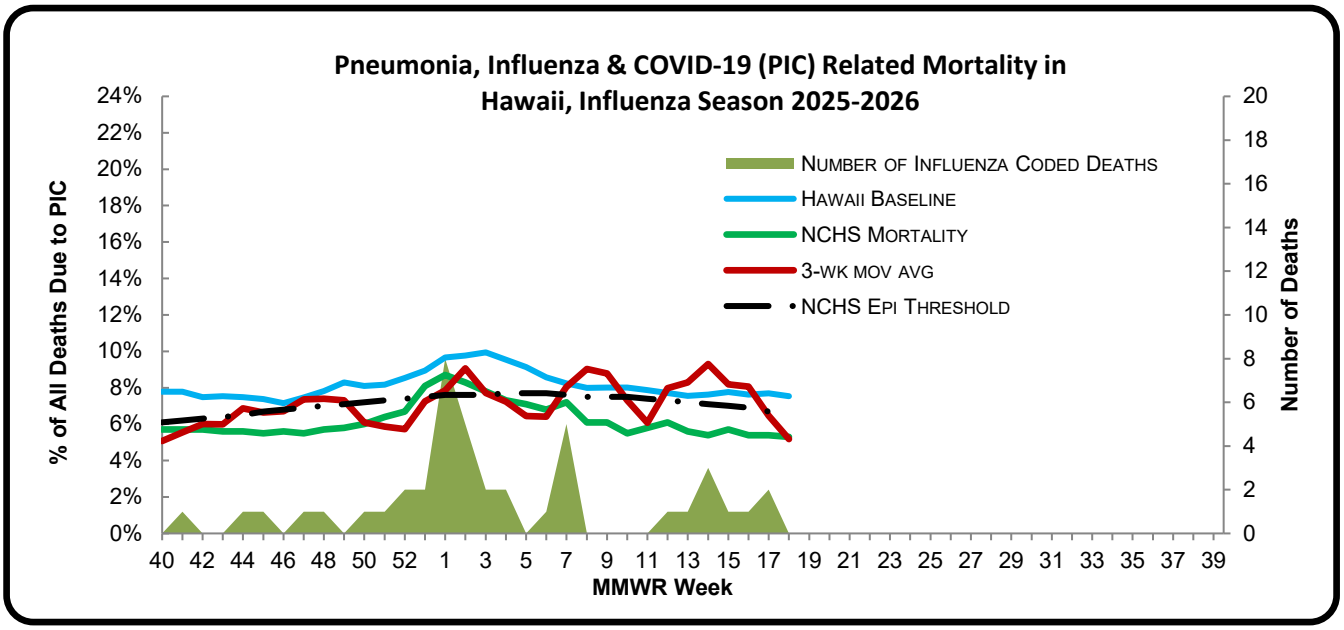
P&I mortality surveillance is collected by CDC through the National Center for Health Statistics (NCHS) using death certificate data. Each week the HDOH OHSM reports specific data from Honolulu to the CDC. CDC collects the following information by age group: the total number of deaths, total deaths from pneumonia, and total deaths related to influenza. Due to the ongoing COVID-19 pandemic, CDC included total deaths from COVID-19 by age group to the death data. Previous studies had suggested that P&I is a good indicator of influenza-related deaths; however, data has shown that pneumonia deaths associated with influenza is now being impacted by COVID-19 related pneumonia. Due to this, CDC had added COVID-19 deaths into P&I to create the PIC (pneumonia, influenza, and/or COVID-19) classification.

To standardize Hawaii's influenza surveillance with CDC influenza surveillance guidelines, PIC deaths will be reported in lieu of P&I. Hawaii's baseline will begin to include PIC deaths starting from 2019-2020 flu season.

For **week 18** of the current influenza season:

- ***1.8%*** *of all deaths that occurred in Hawaii during week 18 were related to pneumonia, influenza or COVID-19 (PIC)*[11]*. For the current season (season to date:* ***7.1%****), there have been 7,762 deaths from any cause, 552 of which were due to PIC*[12]*.*
- *The PIC rate was lower than the historical baseline in Hawaii*[13] *(i.e., outside the 95% confidence interval).*

The Hawaii PIC rate was comparable to the CDC's National Center for Health Statistics (NCHS) PIC mortality[14] ***(5.3%)*** *(i.e., inside the 95% confidence interval) and lower than the national epidemic threshold (****6.6****%) (i.e., outside the 95% confidence interval) for week 18.*



[11] The percent of deaths due to PIC displayed on the graph is the 3-week moving averages.

[12] PIC data reflect 100% of the data reported for the MMWR week. Changes to data are expected when PIC data reaches 100% completion.

[13] The Hawaii historical baseline (%PIC) is the average of 3-week moving averages over the preceding 10 flu seasons of historical data (2014-2015, 2015-2016, 2016-2017, 2017-2018, 2018-2019, 2019-2020, 2020-2021, 2021-2022, 2022-2023, and 2023-2024).

[14] Each week, the vital statistics offices of 122 cities across the United States report the total number of death certificates processed and the number of those for which pneumonia, influenza, or COVID-19 was listed as the underlying or contributing cause of death by age group (Under 28 days, 28 days–1 year, 1–14 years, 15–24 years, 25–44 years, 45–64 years, 65–74 years, 75–84 years, and ≥85 years). The COVID-19 death counts reported by NCHS are provisional and will not match counts in other sources, such as media reports or numbers from health departments. COVID-19 deaths may be classified or defined differently in various reporting and surveillance systems. The percentage of deaths due to pneumonia, influenza, and COVID-19 (PIC) are compared with a seasonal baseline and epidemic threshold value calculated for each week.

INFLUENZA-ASSOCIATED PEDIATRIC DEATHS[15]:

- No new influenza-associated pediatric death was reported to Hawaii. There have been zero influenza-associated pediatric deaths reported in Hawaii during the 2025–2026 season.
- Nationally, eight new influenza-associated pediatric deaths were reported to CDC during week 18. (2025-2026 season total: 166).

IV. INFLUENZA WATCH: As part of a comprehensive influenza surveillance system and to prevent the spread of contagious respiratory diseases in humans, it is important to monitor all circulating influenza types. Several animal-origin influenza A subtypes are currently of interest: influenza A variant virus (H3N2v, H1N2v, and H1N1v) and Avian flu (H5N1 and H7N9). These types of influenza viruses may cause zoonotic (animal-associated) disease and are a public health concern.

A. VARIANT VIRUSES:

Influenza viruses that normally circulate in pigs are called "variant" viruses when they are found in people. These viruses were first identified in U.S. pigs in 2010. In 2011, 12 cases of H3N2v infection were detected in the United States. In 2012, 309 such cases (resulting in 16 hospitalizations and one death) across 12 states were detected, including one Hawaii case who recovered. Illness associated with H3N2v infection has been mostly mild with symptoms similar to those of seasonal flu. However, serious illness, resulting in hospitalization and death, has occurred in some cases. Most of these infections have been associated with prolonged exposure to pigs at agricultural fairs or similar settings. Limited human-to-human spread of this virus has been detected in the past, but no sustained community spread of H3N2v has been identified. More information regarding H3N2v, H1N1v, and H1N2v viruses may be found on the CDC website (*here*) and (*here*).

- *No variant or novel influenza infections have been reported to HDOH during the 2025-2026 influenza season.*
- *One new human infection with novel influenza A virus, H1N1v (0), H3N2v (0), and H1N2v (1), have been reported during the 2025-2026 influenza season.*
    - *One new human infection with influenza A(H1N1v) virus has been reported to WHO from China during the 2025-2026 influenza season.*

AVIAN (OR BIRD) INFLUENZA: These types of influenza viruses cause zoonotic (animal-associated) disease of public health concern and are therefore monitored globally by the WHO. Most avian influenza viruses do not cause disease in humans and are generally not easily transmissible between person to person, but a few subtypes may cross the species barrier and cause disease in humans. Avian influenza viruses may be of various subtypes, including H5N1, H5N2, H5N8, H7N3, H7N7, H7N8, H7N9, and H9N2. On January 15th, 2016, the USDA and APHIS reported detection of HPAI H7N8 in a commercial turkey flock in Indiana. There have been no associated human infections. This is the first detection of HPAI H7N8 in wild bird surveillance in the United States. More information, the risk assessment and recommendations for HPAI H7N8 can be found (here). The WHO, CDC, and other public health agencies have also been monitoring influenza H7N9, which represents a public health concern because of its high pandemic potential. Although H7N9 has not been detected in the United States, it remains a global concern given continuing epidemics in endemic countries. Since 2013, a total of 1,568 laboratory-confirmed cases of human infection with H7N9 viruses, including at least 613 deaths, have been reported to WHO. More information on H7N9 virus infections can be found (here). For more information regarding avian influenza, please visit the CDC (*here*) or the WHO (*here*) websites. WHO reports total number of cases and deaths related to laboratory-confirmed avian influenza viruses and posts current avian influenza case counts (*here*), which were last updated on **January 22, 2026**.

[15] Influenza-associated deaths are considered pediatric in persons aged less than 18 years. It was made a nationally notifiable condition in October, 2004. All pediatric influenza-associated deaths are laboratory confirmed.

V. INFLUENZA Vaccine: Annual influenza vaccination is recommended for all persons aged 6 months and older and is the most effective way to reduce the risk of getting sick with seasonal flu and spreading it to others. Influenza vaccination can reduce illnesses, visits to the doctor, influenza-related hospitalizations, and missed work and school days. Influenza vaccines become available by the end of October. It takes at least two weeks after vaccination to confer immunity against influenza virus infection. More information regarding influenza vaccination can be found (*here*).

A. Composition of the 2025–2026 Influenza Vaccine**:**

The composition of the 2025–2026 influenza vaccine has been updated to better match circulating influenza viruses. The Advisory Committee on Immunization Practices (ACIP) has recommended that the 2025-2026 influenza trivalent vaccine contain an influenza A/Victoria/4897/2022 (H1N1) pdm09-like virus, influenza A/Croatia/10136RV/2023 (H3N2)-like virus, and influenza B/Austria/1359417/2021 (B/Victoria lineage)-like virus. United States cell culture–based inactivated (ccIIV4) and recombinant (RIV4) influenza vaccines will contain HA derived from an influenza A/Wisconsin/67/2022 (H1N1) pdm09-like virus, an A/District of Columbia/27/2023 (H3N2)-like virus, an influenza B/Austria/1359417/2021 (B/Victoria lineage)-like virus. These vaccine recommendations were based on several factors, including global influenza virologic and epidemiologic surveillance, genetic and antigenic characterization, human serology studies, antiviral susceptibility, and the availability of candidate influenza viruses.

APPENDIX 1: ADDITIONAL INFORMATION

For more information regarding local and national influenza surveillance programs, visit the following sites.

Centers for Disease Control and Prevention	General Influenza National ILI and P&I Data Vaccine Virus Selection CDC Web Tool for Respiratory Viruses
Flu.gov	General Influenza Information
HDOH Flu and Pneumonia	General Influenza Surveillance Avian Influenza Respiratory Virus Dashboard To find out more information or join the sentinel physician program, email the Influenza Surveillance Coordinator
World Health Organization	General Global and Local Influenza Avian Influenza

APPENDIX 2: MMWR WEEK DATES

Please refer to the table below to interpret data presented by MMWR week. Week 40 is considered the traditional start for the flu season for the Northern Hemisphere.

MMWR WEEK	2022	2023	2024	2025	2026
1	1/8/2022	1/7/2023	1/6/2024	1/4/2025	1/10/2026
2	1/15/2022	1/14/2023	1/13/2024	1/11/2025	1/17/2026
3	1/22/2022	1/21/2023	1/20/2024	1/18/2025	1/24/2026
4	1/29/2022	1/28/2023	1/27/2024	1/25/2025	1/31/2026
5	2/5/2022	2/4/2023	2/3/2024	2/1/2025	2/7/2026
6	2/12/2022	2/11/2023	2/10/2024	2/8/2025	2/14/2026
7	2/19/2022	2/18/2023	2/17/2024	2/15/2025	2/21/2026
8	2/26/2022	2/25/2023	2/24/2024	2/22/2025	2/28/2026
9	3/5/2022	3/4/2023	3/2/2024	3/1/2025	3/7/2026
10	3/12/2022	3/11/2023	3/9/2024	3/8/2025	3/14/2026
11	3/19/2022	3/18/2023	3/16/2024	3/15/2025	3/21/2026
12	3/26/2022	3/25/2023	3/23/2024	3/22/2025	3/28/2026
13	4/2/2022	4/1/2023	3/30/2024	3/29/2025	4/4/2026
14	4/9/2022	4/8/2023	4/6/2024	4/5/2025	4/11/2026
15	4/16/2022	4/15/2023	4/13/2024	4/12/2025	4/18/2026
16	4/23/2022	4/22/2023	4/20/2024	4/19/2025	4/25/2026
17	4/30/2022	4/29/2023	4/27/2024	4/26/2025	5/2/2026
18	5/7/2022	5/6/2023	5/4/2024	5/3/2025	5/9/2026
19	5/14/2022	5/13/2023	5/11/2024	5/10/2025	5/16/2026
20	5/21/2022	5/20/2023	5/18/2024	5/17/2025	5/23/2026
21	5/28/2022	5/27/2023	5/25/2024	5/24/2025	5/30/2026
22	6/4/2022	6/3/2023	6/1/2024	5/31/2025	6/6/2026
23	6/11/2022	6/10/2023	6/8/2024	6/7/2025	6/13/2026
24	6/18/2022	6/17/2023	6/15/2024	6/14/2025	6/20/2026
25	6/25/2022	6/24/2023	6/22/2024	6/21/2025	6/27/2026
26	7/2/2022	7/1/2023	6/29/2024	6/28/2025	7/4/2026
27	7/9/2022	7/8/2023	7/6/2024	7/5/2025	7/11/2026
28	7/16/2022	7/15/2023	7/13/2024	7/12/2025	7/18/2026
29	7/23/2022	7/22/2023	7/20/2024	7/19/2025	7/25/2026
30	7/30/2022	7/29/2023	7/27/2024	7/26/2025	8/1/2026
31	8/6/2022	8/5/2023	8/3/2024	8/2/2025	8/8/2026
32	8/13/2022	8/12/2023	8/10/2024	8/9/2025	8/15/2026
33	8/20/2022	8/19/2023	8/17/2024	8/16/2025	8/22/2026
34	8/27/2022	8/26/2023	8/24/2024	8/23/2025	8/29/2026
35	9/3/2022	9/2/2023	8/31/2024	8/30/2025	9/5/2026
36	9/10/2022	9/9/2023	9/7/2024	9/6/2025	9/12/2026
37	9/17/2022	9/16/2023	9/14/2024	9/13/2025	9/19/2026
38	9/24/2022	9/23/2023	9/21/2024	9/20/2025	9/26/2026
39	10/1/2022	9/30/2023	9/28/2024	9/27/2025	10/3/2026
40	10/8/2022	10/7/2023	10/5/2024	10/4/2025	10/10/2026
41	10/15/2022	10/14/2023	10/12/2024	10/11/2025	10/17/2026
42	10/22/2022	10/21/2023	10/19/2024	10/18/2025	10/24/2026
43	10/29/2022	10/28/2023	10/26/2024	10/25/2025	10/31/2026
44	11/5/2022	11/4/2023	11/2/2024	11/1/2025	11/7/2026
45	11/12/2022	11/11/2023	11/9/2024	11/8/2025	11/14/2026
46	11/19/2022	11/18/2023	11/16/2024	11/15/2025	11/21/2026
47	11/26/2022	11/25/2023	11/23/2024	11/22/2025	11/28/2026
48	12/3/2022	12/2/2023	11/30/2024	11/29/2025	12/5/2026
49	12/10/2022	12/9/2023	12/7/2024	12/6/2025	12/12/2026
50	12/17/2022	12/16/2023	12/14/2024	12/13/2025	12/19/2026
51	12/24/2022	12/23/2023	12/21/2024	12/20/2025	12/26/2026
52	12/31/2022	12/30/2023	12/28/2024	12/27/2025	
53				01/03/2026	

HAWAII STATE DEPARTMENT OF HEALTH
DISEASE OUTBREAK CONTROL DIVISION

Influenza/Respiratory Disease Surveillance Report

Morbidity and Mortality Weekly Report (MMWR)[1]

WEEK 19: MAY 10, 2026– MAY 16, 2026

OVERVIEW: The Hawaii State Department of Health (HDOH) monitors influenza and other respiratory pathogens, including COVID-19, throughout the state of Hawaii. Influenza surveillance in the state of Hawaii relies upon selected sentinel health practitioners, the State Laboratories Division (SLD), private laboratories, and the Office of Health Status Monitoring (OHSM). For detailed information concerning influenza, please visit the HDOH Disease Outbreak Control Division (HDOH DOCD) website (*here*). **All data and information are conditional and may change as more reports are received.** The data in this report reflects the 2025-2026 influenza season which began the week ending October 4, 2025 (week 40[1] 2025) and will end the week ending on October 3, 2026 (week 39 2026).

REPORT SNAPSHOT FOR WEEK 19

Surveillance for Influenza-like Illness (ILI)		
Metric	*Value*	*Comment*
Outpatient visits related to influenza-like illness (ILI) from ILINet Sentinel Providers	3.2%	Higher than the previous week. Comparable to Hawaii's historical baseline and lower than the national baseline, and higher than the national ILI rate.
Number of ILI clusters reported to HDOH	2	There have been 29 clusters this season.

Laboratory Surveillance		
Percent of all respiratory specimens positive for influenza this week	12.8%	Lower than the previous week. This number means that many, if not all, of the 87.1% who tested negative for influenza had illness from another respiratory etiology.
Percent of all respiratory specimens positive for influenza this season to date	17.6%	

Surveillance for Severe Outcomes		
Pneumonia, influenza and COVID-19 (PIC) mortality rate	9.8	Comparable to Hawaii's historical baseline, lower than the national epidemic threshold and comparable to the NCHS average.
Number of influenza-associated pediatric deaths reported nationwide	172	0 influenza-associated pediatric deaths have been reported from Hawaii this season to date.

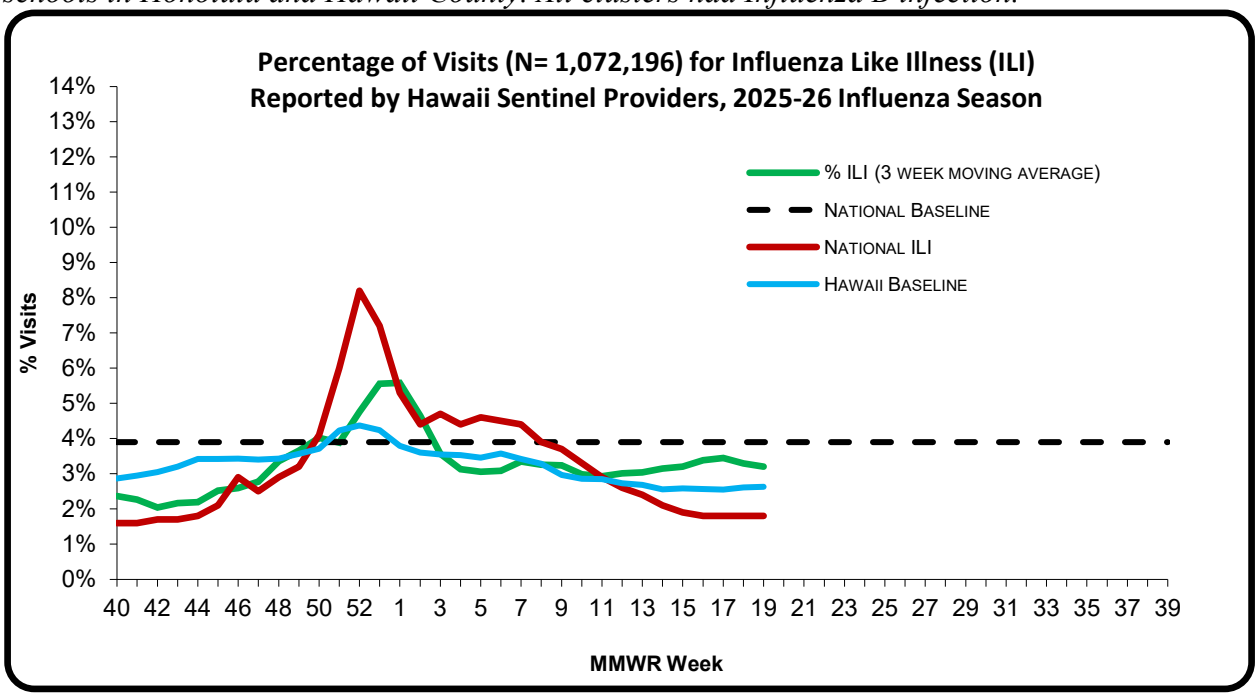
[1] MMWR stands for "Morbidity and Mortality Weekly Report," conventionally used by the Centers for Disease Control and Prevention (CDC). The weeks of a flu season are often referred to by their respective MMWR week. **See appendix 2 for interpretation of MMWR weeks.** Data reported will begin on week 40, the traditional start date of flu season.

INFLUENZA SURVEILLANCE

I. INFLUENZA-LIKE ILLNESS (ILI): HDOH collaborates with recruited doctors and healthcare providers who report the total number of outpatient visits for ILI as well as the total number of patients who complained of symptoms consistent with ILI. A patient with ILI must have the following: a fever (temperature of 100°F [37.8°C] or greater) AND a cough and/or a sore throat. ILI is based on reported symptoms and not laboratory confirmed tests; thus, ILI may represent other respiratory pathogens and not solely influenza. Further, sentinel providers report these numbers on a weekly basis; therefore, data are preliminary and may change depending on additional reporting. In combination with laboratory testing and other surveillance systems, ILI surveillance helps monitor influenza and other respiratory pathogen activity. For more information concerning ILINet and sentinel requirements, please visit the CDC website (*here*).

For **week 19** of the current influenza season:

- ***3.2%** (season to date: **3.3%**) of the outpatient visits recorded by Hawaii sentinel providers were for ILI.*
- *ILI visits were comparable to the historical baseline in Hawaii[2,3] (i.e., inside the 95% confidence interval).*
- *Hawaii's ILI outpatient visits were lower than the national baseline (**3.9%**)[4] (i.e., outside the 95% confidence interval) and higher than the national ILI rate (**1.8%**) (i.e. outside the 95% confidence interval).*
- *ILI activity level: Low[5]*
- *Geographic Spread: Sporadic Activity[6].*
- *ILI Cluster Activity: Two new clusters were reported to HDOH during week 19. Both clusters were from schools in Honolulu and Hawaii County. All clusters had Influenza B infection.*



[2] The Hawaii historical baseline (%ILI) is the average of 3-week moving averages over the preceding 3 flu seasons of historical data (2022-2023, 2023-2024 and 2024-2025).
[3] This value is based upon comparison of actual outpatient ILI with the historical baseline, which only captures outpatient ILI. The chart above represents a 3-week moving average and not the actual ILI by week.
[4] The National Baseline is calculated by CDC as the mean percentage of visits for ILI during weeks 21–39 with two standard deviations. Because of large variability in regional ILI, comparison of the national baseline with local ILI may not be appropriate. It is provided in this report because no meaningful regional baselines are available for comparison. The national baseline combines all data reported by states to CDC, including ILI in outpatient, ER, urgent care, and inpatient settings.
[5] There are 10 activity levels classified as minimal (levels 1-3), low (levels 4-5), moderate (levels 6-7), and high (levels 8-10).
[6] The influenza activity reported by state and territorial epidemiologists indicates geographic spread of influenza viruses but does not measure the severity of influenza activity. Sporadic: no clusters reported to HDOH, Local: one or more clusters reported in one county, Regional: clusters reported two to three counties, Widespread: clusters reported in all counties. Hawaii does not report No Activity, as flu circulates year-round in Hawaii.

II. LABORATORY SURVEILLANCE: State Laboratories Division (SLD; the HDOH public health laboratory) and Hawaii's major private laboratories (DLS, CLH) report results of RT-PCR, which can be considered confirmatory (SLD may perform viral culture on select specimens). Specimens meeting priority criteria[7] are forwarded to SLD for sub-typing. Additionally, specimens meeting case definition from requesting sentinel providers are sent directly to SLD for sub-typing. Due to resource constraints, not all submitted specimens undergo sub-typing. Sub-typing at the commercial laboratories is only conducted on a case-by-case basis. The majority of specimens testing positive by rapid antigen testing or RT-PCR at the commercial laboratories do not meet criteria and are not subtyped. For more information on influenza tests and types, please visit the CDC website (*here*).

A. INFLUENZA:

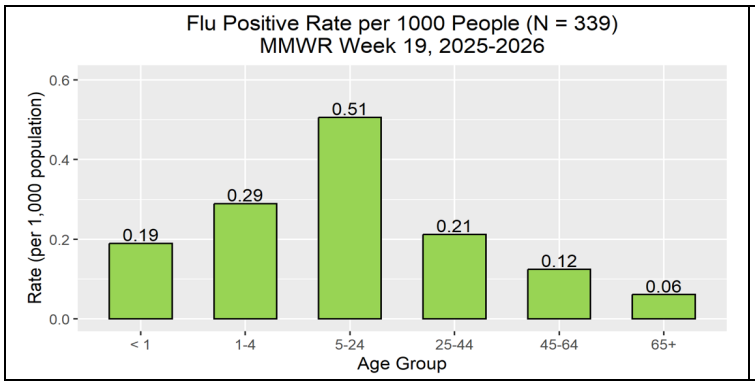
- The following reflects laboratory findings for week 19 of the 2025–26 influenza season:
  - *A total of **2,631** specimens has been tested statewide for influenza viruses (positive: 339 [**12.8%**]). (Season to date: **113,287** tested (**17.6%** positive)*
    - *1,032 (39.2%) were screened only by rapid antigen tests with no confirmatory testing.*
    - *1,599 (60.8%) underwent confirmatory testing (either RT-PCR or viral culture).*
    - *2,292 (87.1%) were negative.*
  - *Routine surveillance samples from State Laboratory Division were tested at a public health laboratory and identified as Influenza A (H3N2) subclade K.*

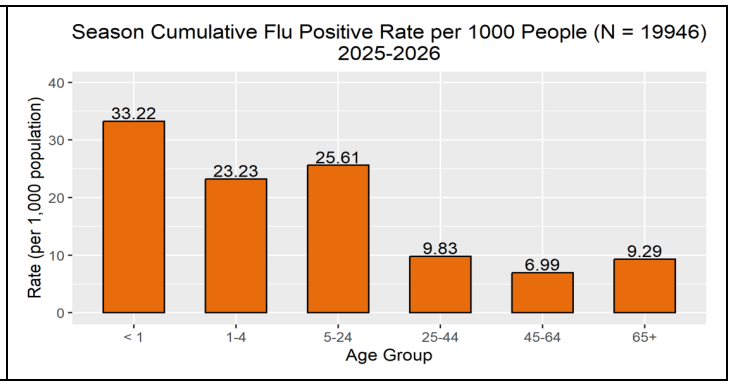
Influenza type	*Current week 19 (%)**	*Season to date (%)*[8]
Influenza A (H1)[9]	*1 (0.3)*	*200 (1.0)*
Influenza A (H3)	*0 (0.0)*	*1,300 (6.5)*
Influenza A no subtyping	*44 (13.0)*	*12,678 (63.7)*
Influenza B (Yamagata)	*0 (0.0)*	*0 (0.0)*
Influenza B (Victoria)	*0 (0.0)*	*0 (0.0)*
Influenza B no genotyping	*294 (86.7)*	*5,725 (28.8)*

**Specimens that are positive for both A and B (coinfections) are counted in both A and B totals for current and season to date*

1. AGE DISTRIBUTION

The charts below indicate the population-based rates of positive influenza cases in Hawaii by age group during the 2025–26 influenza season.[10]

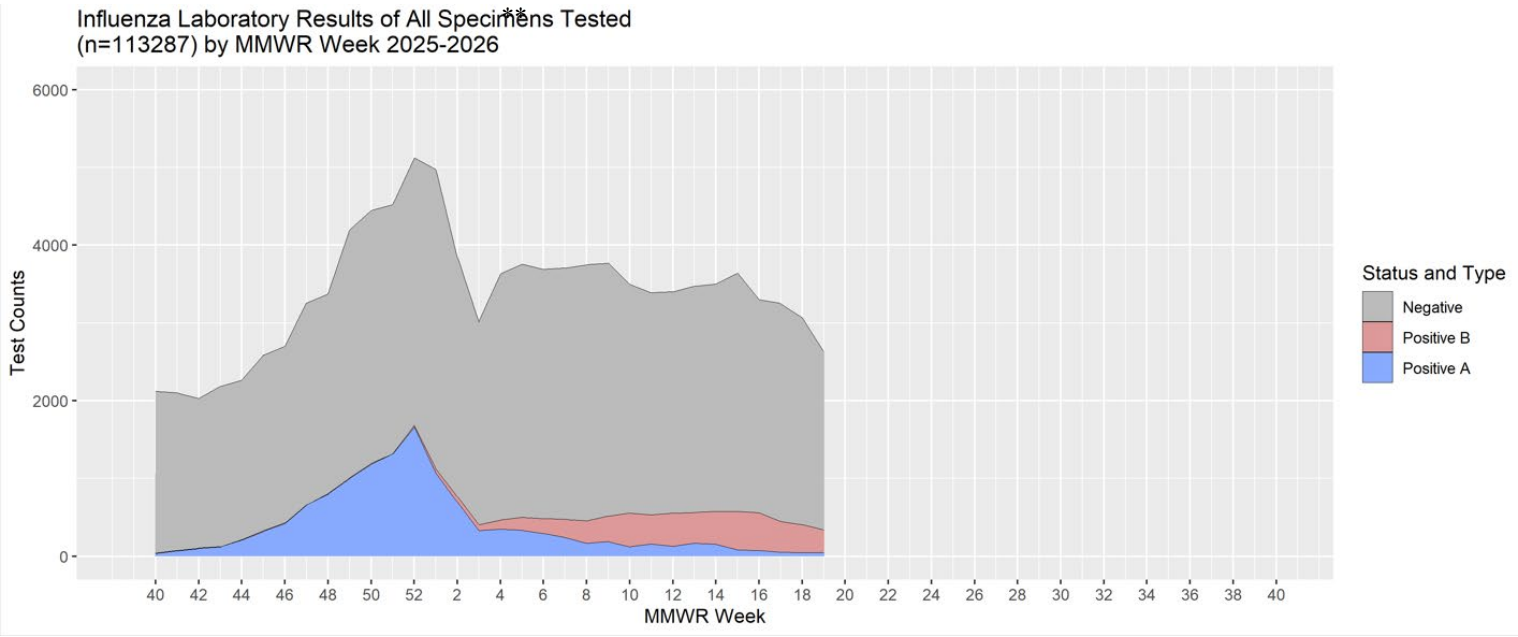


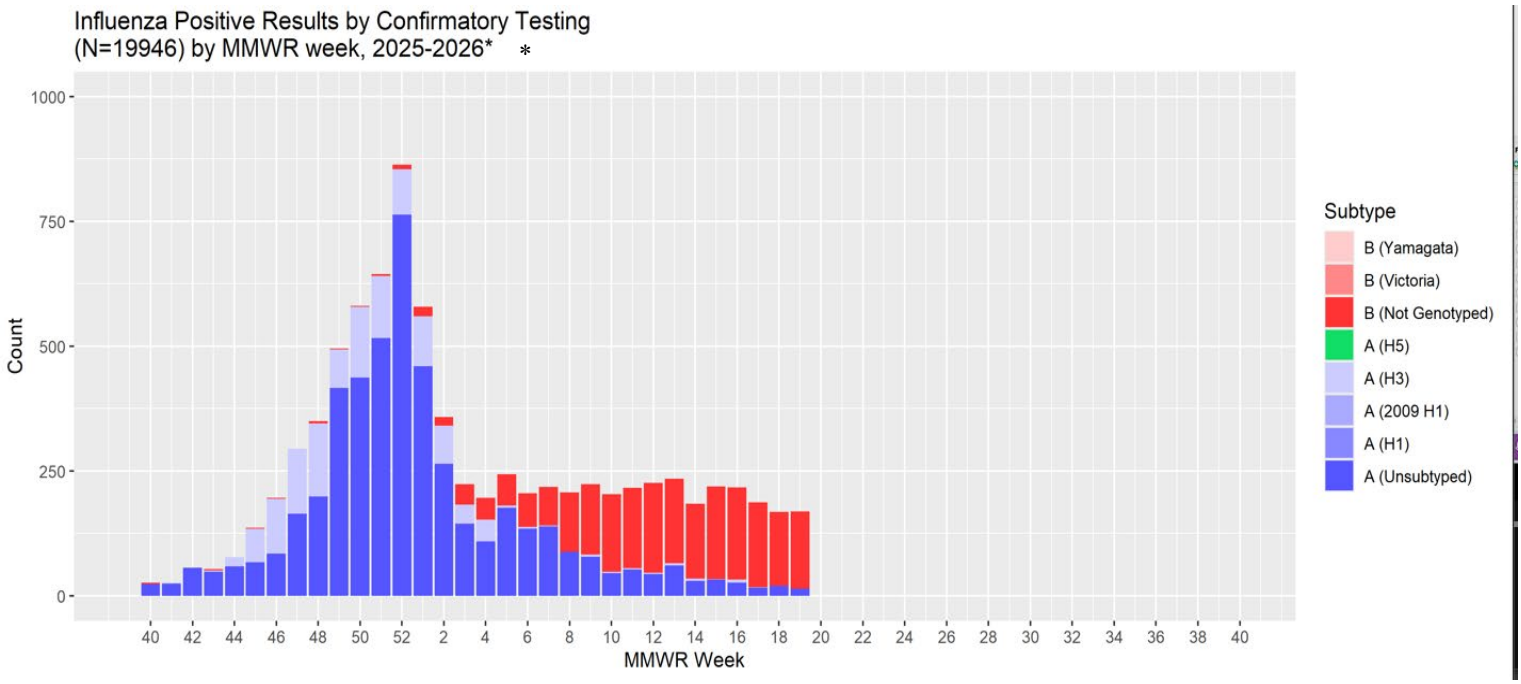


[7] Priority criteria include: hospitalized patients with acute respiratory distress syndrome [ARDS] or x-ray confirmed pneumonia; travelers with international travel history within 10 days of onset; specimens submitted by sentinel providers; specimens collected from healthcare workers, pregnant women, or women up to 6 weeks' post-partum; those with underlying medical conditions; and patients presenting with unusual or severe manifestations of influenza infection.
[8] Influenza coding was updated to reflect a more accurate count.
[9] All influenza A H1 viruses detected this season have been 2009 H1N1.
[10] This represents an estimate of population-based rates based on available data.

2. LABORATORY TESTING

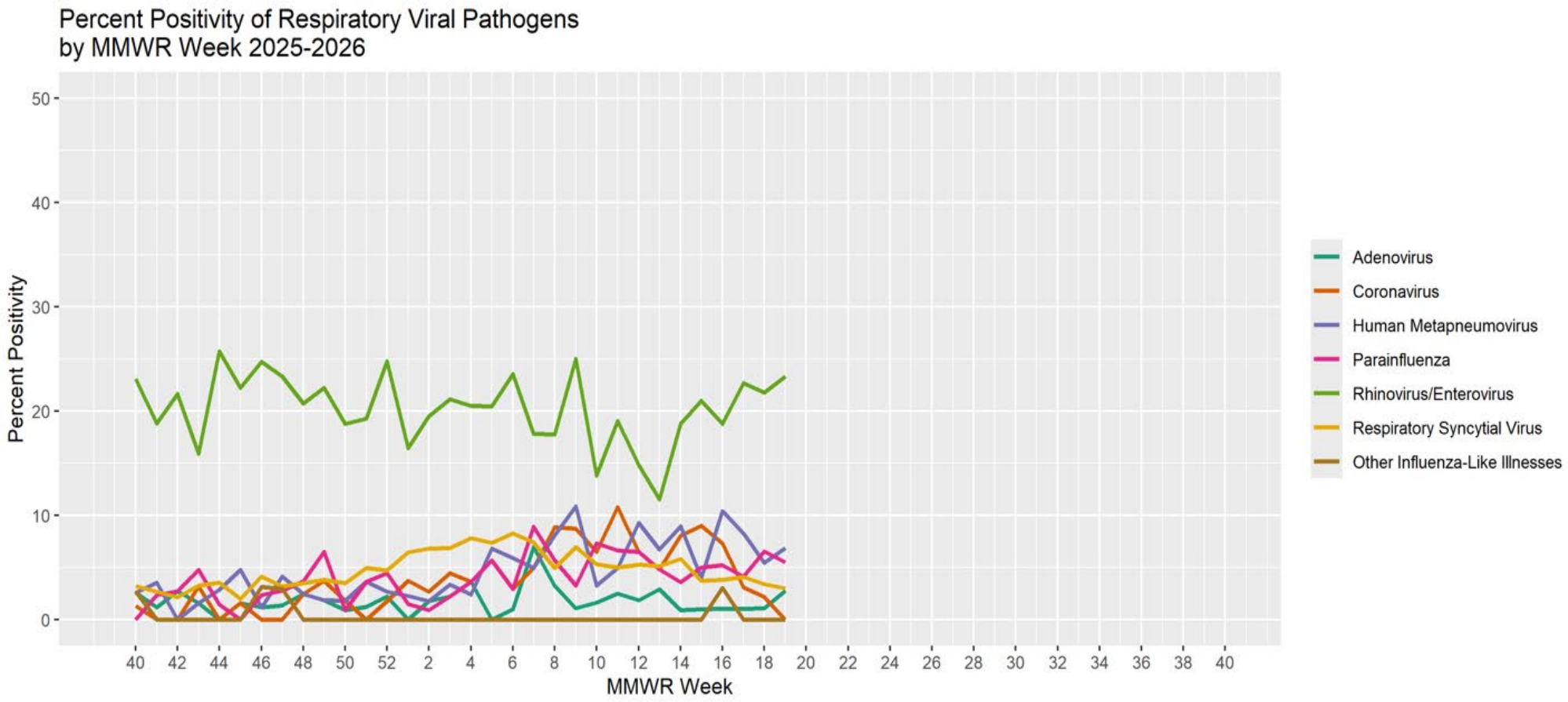
The charts below show the laboratory results of all specimens tested for influenza by MMWR week during the 2025–2026 influenza season as well as the type and subtype of positive results for influenza. Again, sub-typing is only performed on selected specimens tested by confirmatory tests (i.e., RT-PCR or viral culture).





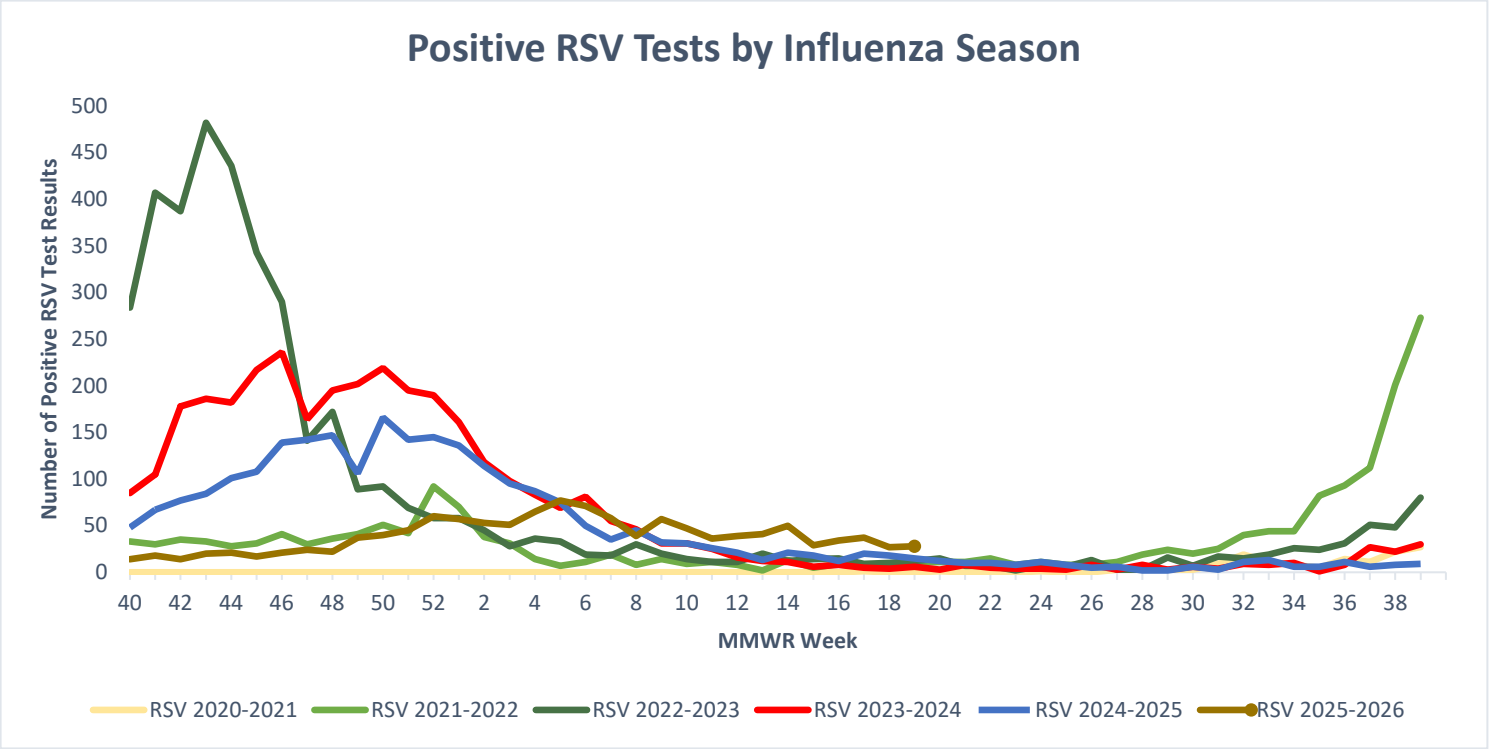
** A total of 62,367 specimens underwent confirmatory testing, but not all positive influenza specimens receive confirmatory testing that are circulating in Hawaii.*
*** For MMWR Week 53, results are reported under MMWR Week 52, where the average of Weeks 52 and 53 was calculated.*

B. **OTHER RESPIRATORY PATHOGENS:** The major clinical and commercial laboratories throughout the state of Hawaii have the testing capacity for non-influenza respiratory pathogens and report these to HDOH. However, such testing is performed as needed and when sufficient resources are available because of the high costs associated with respiratory panel tests. **Therefore, available data represents only the presence of circulating pathogens and cannot be used to determine specific trends**.

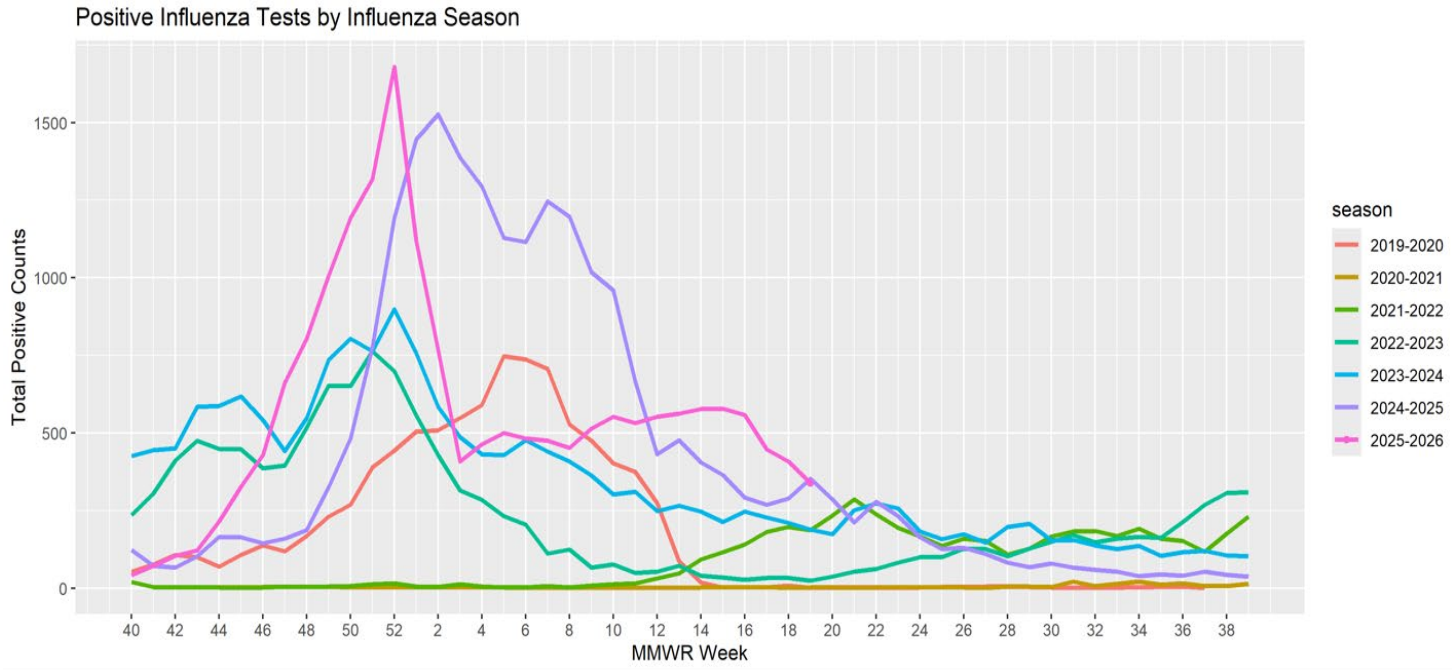


* *The coronavirus presented on this table does not indicate Severe Acute Respiratory Coronavirus-2 (i.e., COVID-19). For MMWR Week 53, results are reported under MMWR Week 52, where the average of Weeks 52 and 53 was calculated*

RESPIRATORY SYNCYTIAL VIRUS (RSV) POSITIVE TEST RESULTS BY INFLUENZA SEASON: RSV case appears to have increased later than past seasons in the 2025-2026 season. For MMWR Week 53, results are reported under MMWR Week 52, where the average of Weeks 52 and 53 was calculated.



INFLUENZA POSITIVE TEST RESULTS BY INFLUENZA SEASON: Influenza cases appear to have increased earlier than past seasons in the 2025-2026 season. For MMWR Week 53, results are reported under MMWR Week 52, where the average of Weeks 52 and 53 was calculated.



C. COVID-19 SENTINEL SURVEILLANCE: Due to the low volume of samples currently available through the influenza surveillance system, the COVID-19 sentinel surveillance data may not be accurately portraying COVID-19 activity in our communities. Reporting of the COVID-19 Sentinel Surveillance data will be paused while HODH re-evaluates the program to ensure that the reported data are accurate and representative.

HDOH is continuing to monitor COVID-19 activity throughout the state. To learn more, please visit the Hawaii's COVID-19 data website (*here*). For more information on surveillance of COVID-19 activity in the United States please visit the CDC COVIDView website (*here*).

III. PNEUMONIA, INFLUENZA, AND COVID-19 (PIC) RELATED MORTALITY:

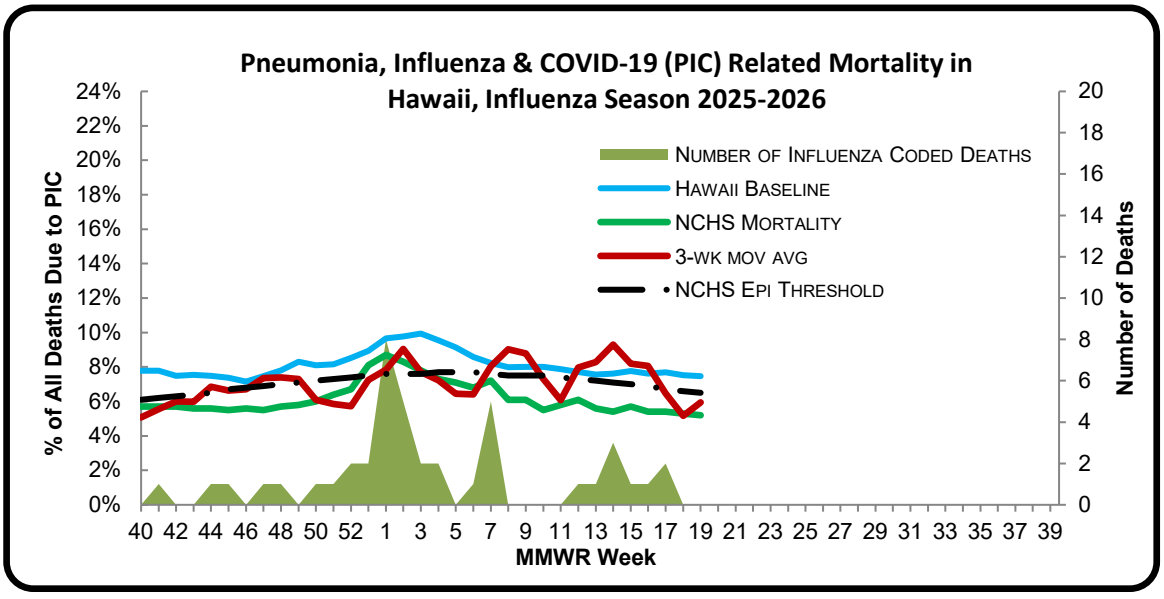
P&I mortality surveillance is collected by CDC through the National Center for Health Statistics (NCHS) using death certificate data. Each week the HDOH OHSM reports specific data from Honolulu to the CDC. CDC collects the following information by age group: the total number of deaths, total deaths from pneumonia, and total deaths related to influenza. Due to the ongoing COVID-19 pandemic, CDC included total deaths from COVID-19 by age group to the death data. Previous studies had suggested that P&I is a good indicator of influenza-related deaths; however, data has shown that pneumonia deaths associated with influenza is now being impacted by COVID-19 related pneumonia. Due to this, CDC had added COVID-19 deaths into P&I to create the PIC (pneumonia, influenza, and/or COVID-19) classification.

To standardize Hawaii's influenza surveillance with CDC influenza surveillance guidelines, PIC deaths will be reported in lieu of P&I. Hawaii's baseline will begin to include PIC deaths starting from 2019-2020 flu season.

For **week 19** of the current influenza season:

- ***9.8%*** *of all deaths that occurred in Hawaii during week 19 were related to pneumonia, influenza or COVID-19 (PIC)[11]. For the current season (season to date:* ***7.1%****), there have been 7,854 deaths from any cause, 561 of which were due to PIC[12].*
- *The PIC rate was comparable to the historical baseline in Hawaii[13] (i.e., inside the 95% confidence interval).*

*The Hawaii PIC rate was comparable to the CDC's National Center for Health Statistics (NCHS) PIC mortality[14] (****5.2%****) (i.e., inside the 95% confidence interval) and comparable to the national epidemic threshold (****6.5****%) (i.e., inside the 95% confidence interval) for week 19.*



[11] The percent of deaths due to PIC displayed on the graph is the 3-week moving averages.

[12] PIC data reflect 100% of the data reported for the MMWR week. Changes to data are expected when PIC data reaches 100% completion.

[13] The Hawaii historical baseline (%PIC) is the average of 3-week moving averages over the preceding 10 flu seasons of historical data (2014-2015, 2015-2016, 2016-2017, 2017-2018, 2018-2019, 2019-2020, 2020-2021, 2021-2022, 2022-2023, and 2023-2024).

[14] Each week, the vital statistics offices of 122 cities across the United States report the total number of death certificates processed and the number of those for which pneumonia, influenza, or COVID-19 was listed as the underlying or contributing cause of death by age group (Under 28 days, 28 days–1 year, 1–14 years, 15–24 years, 25–44 years, 45–64 years, 65–74 years, 75–84 years, and ≥85 years). The COVID-19 death counts reported by NCHS are provisional and will not match counts in other sources, such as media reports or numbers from health departments. COVID-19 deaths may be classified or defined differently in various reporting and surveillance systems. The percentage of deaths due to pneumonia, influenza, and COVID-19 (PIC) are compared with a seasonal baseline and epidemic threshold value calculated for each week.

INFLUENZA-ASSOCIATED PEDIATRIC DEATHS[15]:

- No new influenza-associated pediatric death was reported to Hawaii. There have been zero influenza-associated pediatric deaths reported in Hawaii during the 2025–2026 season.
- Nationally, six new influenza-associated pediatric deaths were reported to CDC during week 19. (2025-2026 season total: 172).

IV. INFLUENZA WATCH: As part of a comprehensive influenza surveillance system and to prevent the spread of contagious respiratory diseases in humans, it is important to monitor all circulating influenza types. Several animal-origin influenza A subtypes are currently of interest: influenza A variant virus (H3N2v, H1N2v, and H1N1v) and Avian flu (H5N1 and H7N9). These types of influenza viruses may cause zoonotic (animal-associated) disease and are a public health concern.

A. VARIANT VIRUSES:

Influenza viruses that normally circulate in pigs are called "variant" viruses when they are found in people. These viruses were first identified in U.S. pigs in 2010. In 2011, 12 cases of H3N2v infection were detected in the United States. In 2012, 309 such cases (resulting in 16 hospitalizations and one death) across 12 states were detected, including one Hawaii case who recovered. Illness associated with H3N2v infection has been mostly mild with symptoms similar to those of seasonal flu. However, serious illness, resulting in hospitalization and death, has occurred in some cases. Most of these infections have been associated with prolonged exposure to pigs at agricultural fairs or similar settings. Limited human-to-human spread of this virus has been detected in the past, but no sustained community spread of H3N2v has been identified. More information regarding H3N2v, H1N1v, and H1N2v viruses may be found on the CDC website (*here*) and (*here*).

- *No variant or novel influenza infections have been reported to HDOH during the 2025-2026 influenza season.*
- *One new human infection with novel influenza A virus, H1N1v (0), H3N2v (0), and H1N2v (1), have been reported during the 2025-2026 influenza season.*
    - *One new human infection with influenza A(H1N1v) virus has been reported to WHO from China during the 2025-2026 influenza season.*

AVIAN (OR BIRD) INFLUENZA: These types of influenza viruses cause zoonotic (animal-associated) disease of public health concern and are therefore monitored globally by the WHO. Most avian influenza viruses do not cause disease in humans and are generally not easily transmissible between person to person, but a few subtypes may cross the species barrier and cause disease in humans. Avian influenza viruses may be of various subtypes, including H5N1, H5N2, H5N8, H7N3, H7N7, H7N8, H7N9, and H9N2. On January 15th, 2016, the USDA and APHIS reported detection of HPAI H7N8 in a commercial turkey flock in Indiana. There have been no associated human infections. This is the first detection of HPAI H7N8 in wild bird surveillance in the United States. More information, the risk assessment and recommendations for HPAI H7N8 can be found (here). The WHO, CDC, and other public health agencies have also been monitoring influenza H7N9, which represents a public health concern because of its high pandemic potential. Although H7N9 has not been detected in the United States, it remains a global concern given continuing epidemics in endemic countries. Since 2013, a total of 1,568 laboratory-confirmed cases of human infection with H7N9 viruses, including at least 613 deaths, have been reported to WHO. More information on H7N9 virus infections can be found (here). For more information regarding avian influenza, please visit the CDC (*here*) or the WHO (*here*) websites. WHO reports total number of cases and deaths related to laboratory-confirmed avian influenza viruses and posts current avian influenza case counts (*here*), which were last updated on **January 22, 2026**.

[15] Influenza-associated deaths are considered pediatric in persons aged less than 18 years. It was made a nationally notifiable condition in October, 2004. All pediatric influenza-associated deaths are laboratory confirmed.

V. INFLUENZA Vaccine: Annual influenza vaccination is recommended for all persons aged 6 months and older and is the most effective way to reduce the risk of getting sick with seasonal flu and spreading it to others. Influenza vaccination can reduce illnesses, visits to the doctor, influenza-related hospitalizations, and missed work and school days. Influenza vaccines become available by the end of October. It takes at least two weeks after vaccination to confer immunity against influenza virus infection. More information regarding influenza vaccination can be found (*here*).

A. Composition of the 2025–2026 Influenza Vaccine**:**

The composition of the 2025–2026 influenza vaccine has been updated to better match circulating influenza viruses. The Advisory Committee on Immunization Practices (ACIP) has recommended that the 2025-2026 influenza trivalent vaccine contain an influenza A/Victoria/4897/2022 (H1N1) pdm09-like virus, influenza A/Croatia/10136RV/2023 (H3N2)-like virus, and influenza B/Austria/1359417/2021 (B/Victoria lineage)-like virus. United States cell culture–based inactivated (ccIIV4) and recombinant (RIV4) influenza vaccines will contain HA derived from an influenza A/Wisconsin/67/2022 (H1N1) pdm09-like virus, an A/District of Columbia/27/2023 (H3N2)-like virus, an influenza B/Austria/1359417/2021 (B/Victoria lineage)-like virus. These vaccine recommendations were based on several factors, including global influenza virologic and epidemiologic surveillance, genetic and antigenic characterization, human serology studies, antiviral susceptibility, and the availability of candidate influenza viruses.

APPENDIX 1: ADDITIONAL INFORMATION

For more information regarding local and national influenza surveillance programs, visit the following sites.

Centers for Disease Control and Prevention	General Influenza National ILI and P&I Data Vaccine Virus Selection CDC Web Tool for Respiratory Viruses
Flu.gov	General Influenza Information
HDOH Flu and Pneumonia	General Influenza Surveillance Avian Influenza Respiratory Virus Dashboard To find out more information or join the sentinel physician program, email the Influenza Surveillance Coordinator
World Health Organization	General Global and Local Influenza Avian Influenza

APPENDIX 2: MMWR WEEK DATES

Please refer to the table below to interpret data presented by MMWR week. Week 40 is considered the traditional start for the flu season for the Northern Hemisphere.

MMWR WEEK	2022	2023	2024	2025	2026
1	1/8/2022	1/7/2023	1/6/2024	1/4/2025	1/10/2026
2	1/15/2022	1/14/2023	1/13/2024	1/11/2025	1/17/2026
3	1/22/2022	1/21/2023	1/20/2024	1/18/2025	1/24/2026
4	1/29/2022	1/28/2023	1/27/2024	1/25/2025	1/31/2026
5	2/5/2022	2/4/2023	2/3/2024	2/1/2025	2/7/2026
6	2/12/2022	2/11/2023	2/10/2024	2/8/2025	2/14/2026
7	2/19/2022	2/18/2023	2/17/2024	2/15/2025	2/21/2026
8	2/26/2022	2/25/2023	2/24/2024	2/22/2025	2/28/2026
9	3/5/2022	3/4/2023	3/2/2024	3/1/2025	3/7/2026
10	3/12/2022	3/11/2023	3/9/2024	3/8/2025	3/14/2026
11	3/19/2022	3/18/2023	3/16/2024	3/15/2025	3/21/2026
12	3/26/2022	3/25/2023	3/23/2024	3/22/2025	3/28/2026
13	4/2/2022	4/1/2023	3/30/2024	3/29/2025	4/4/2026
14	4/9/2022	4/8/2023	4/6/2024	4/5/2025	4/11/2026
15	4/16/2022	4/15/2023	4/13/2024	4/12/2025	4/18/2026
16	4/23/2022	4/22/2023	4/20/2024	4/19/2025	4/25/2026
17	4/30/2022	4/29/2023	4/27/2024	4/26/2025	5/2/2026
18	5/7/2022	5/6/2023	5/4/2024	5/3/2025	5/9/2026
19	5/14/2022	5/13/2023	5/11/2024	5/10/2025	5/16/2026
20	5/21/2022	5/20/2023	5/18/2024	5/17/2025	5/23/2026
21	5/28/2022	5/27/2023	5/25/2024	5/24/2025	5/30/2026
22	6/4/2022	6/3/2023	6/1/2024	5/31/2025	6/6/2026
23	6/11/2022	6/10/2023	6/8/2024	6/7/2025	6/13/2026
24	6/18/2022	6/17/2023	6/15/2024	6/14/2025	6/20/2026
25	6/25/2022	6/24/2023	6/22/2024	6/21/2025	6/27/2026
26	7/2/2022	7/1/2023	6/29/2024	6/28/2025	7/4/2026
27	7/9/2022	7/8/2023	7/6/2024	7/5/2025	7/11/2026
28	7/16/2022	7/15/2023	7/13/2024	7/12/2025	7/18/2026
29	7/23/2022	7/22/2023	7/20/2024	7/19/2025	7/25/2026
30	7/30/2022	7/29/2023	7/27/2024	7/26/2025	8/1/2026
31	8/6/2022	8/5/2023	8/3/2024	8/2/2025	8/8/2026
32	8/13/2022	8/12/2023	8/10/2024	8/9/2025	8/15/2026
33	8/20/2022	8/19/2023	8/17/2024	8/16/2025	8/22/2026
34	8/27/2022	8/26/2023	8/24/2024	8/23/2025	8/29/2026
35	9/3/2022	9/2/2023	8/31/2024	8/30/2025	9/5/2026
36	9/10/2022	9/9/2023	9/7/2024	9/6/2025	9/12/2026
37	9/17/2022	9/16/2023	9/14/2024	9/13/2025	9/19/2026
38	9/24/2022	9/23/2023	9/21/2024	9/20/2025	9/26/2026
39	10/1/2022	9/30/2023	9/28/2024	9/27/2025	10/3/2026
40	10/8/2022	10/7/2023	10/5/2024	10/4/2025	10/10/2026
41	10/15/2022	10/14/2023	10/12/2024	10/11/2025	10/17/2026
42	10/22/2022	10/21/2023	10/19/2024	10/18/2025	10/24/2026
43	10/29/2022	10/28/2023	10/26/2024	10/25/2025	10/31/2026
44	11/5/2022	11/4/2023	11/2/2024	11/1/2025	11/7/2026
45	11/12/2022	11/11/2023	11/9/2024	11/8/2025	11/14/2026
46	11/19/2022	11/18/2023	11/16/2024	11/15/2025	11/21/2026
47	11/26/2022	11/25/2023	11/23/2024	11/22/2025	11/28/2026
48	12/3/2022	12/2/2023	11/30/2024	11/29/2025	12/5/2026
49	12/10/2022	12/9/2023	12/7/2024	12/6/2025	12/12/2026
50	12/17/2022	12/16/2023	12/14/2024	12/13/2025	12/19/2026
51	12/24/2022	12/23/2023	12/21/2024	12/20/2025	12/26/2026
52	12/31/2022	12/30/2023	12/28/2024	12/27/2025	
53				01/03/2026	

HAWAII STATE DEPARTMENT OF HEALTH
DISEASE OUTBREAK CONTROL DIVISION

Influenza/Respiratory Disease Surveillance Report

Morbidity and Mortality Weekly Report (MMWR)[1]

WEEK 20: MAY 17, 2026– MAY 23, 2026

OVERVIEW: The Hawaii State Department of Health (HDOH) monitors influenza and other respiratory pathogens, including COVID-19, throughout the state of Hawaii. Influenza surveillance in the state of Hawaii relies upon selected sentinel health practitioners, the State Laboratories Division (SLD), private laboratories, and the Office of Health Status Monitoring (OHSM). For detailed information concerning influenza, please visit the HDOH Disease Outbreak Control Division (HDOH DOCD) website (*here*). **All data and information are conditional and may change as more reports are received.** The data in this report reflects the 2025-2026 influenza season which began the week ending October 4, 2025 (week 40[1] 2025) and will end the week ending on October 3, 2026 (week 39 2026).

REPORT SNAPSHOT FOR WEEK 20

Surveillance for Influenza-like Illness (ILI)		
Metric	*Value*	*Comment*
Outpatient visits related to influenza-like illness (ILI) from ILINet Sentinel Providers	2.8%	Lower than the previous week. Comparable to Hawaii's historical baseline and lower than the national baseline, and higher than the national ILI rate.
Number of ILI clusters reported to HDOH	2	There have been 31 clusters this season.

Laboratory Surveillance		
Percent of all respiratory specimens positive for influenza this week	11.3%	Lower than the previous week. This number means that many, if not all, of the 88.7% who tested negative for influenza had illness from another respiratory etiology.
Percent of all respiratory specimens positive for influenza this season to date	17.5%	

Surveillance for Severe Outcomes		
Pneumonia, influenza and COVID-20 (PIC) mortality rate	0.0%	Lower than Hawaii's historical baseline, lower than the national epidemic threshold and lower than the NCHS average.
Number of influenza-associated pediatric deaths reported nationwide	174	0 influenza-associated pediatric deaths have been reported from Hawaii this season to date.

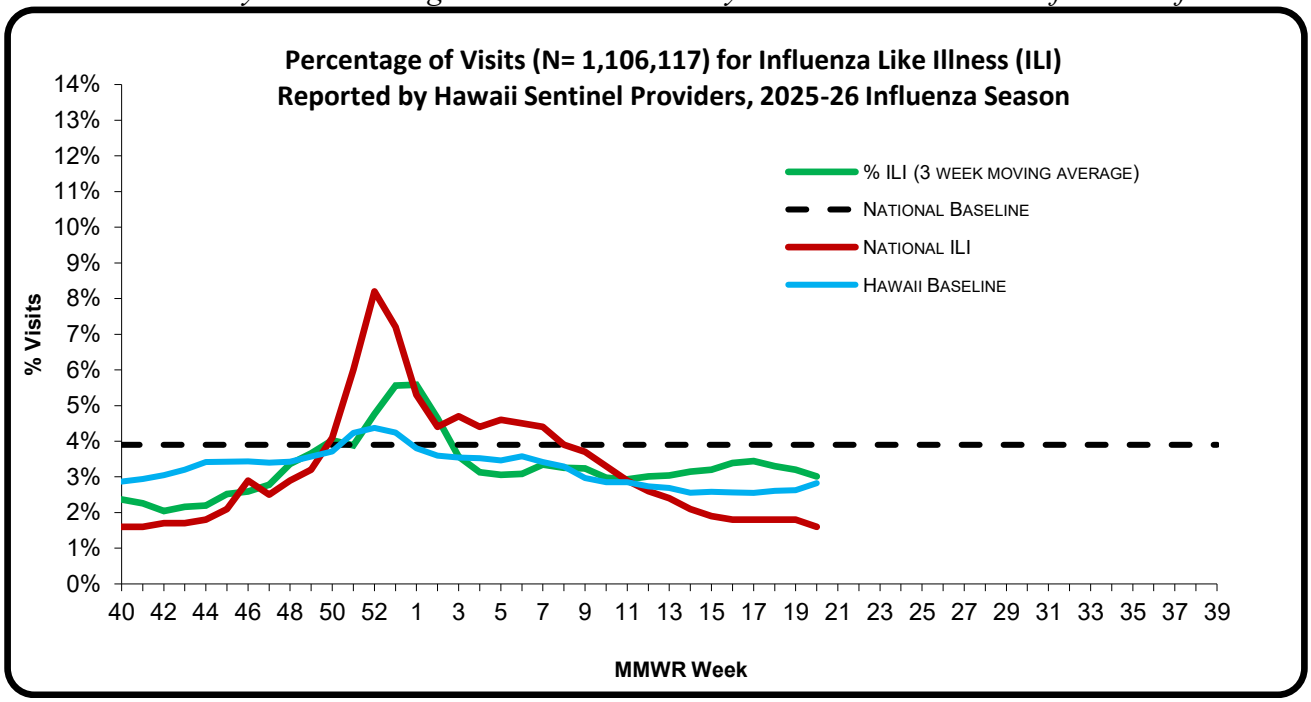
[1] MMWR stands for "Morbidity and Mortality Weekly Report," conventionally used by the Centers for Disease Control and Prevention (CDC). The weeks of a flu season are often referred to by their respective MMWR week. **See appendix 2 for interpretation of MMWR weeks.** Data reported will begin on week 40, the traditional start date of flu season.

INFLUENZA SURVEILLANCE

I. INFLUENZA-LIKE ILLNESS (ILI): HDOH collaborates with recruited doctors and healthcare providers who report the total number of outpatient visits for ILI as well as the total number of patients who complained of symptoms consistent with ILI. A patient with ILI must have the following: a fever (temperature of 100°F [37.8°C] or greater) AND a cough and/or a sore throat. ILI is based on reported symptoms and not laboratory confirmed tests; thus, ILI may represent other respiratory pathogens and not solely influenza. Further, sentinel providers report these numbers on a weekly basis; therefore, data are preliminary and may change depending on additional reporting. In combination with laboratory testing and other surveillance systems, ILI surveillance helps monitor influenza and other respiratory pathogen activity. For more information concerning ILINet and sentinel requirements, please visit the CDC website (*here*).

For **week 20** of the current influenza season:

- ***2.8****% (season to date:* ***3.2****%) of the outpatient visits recorded by Hawaii sentinel providers were for ILI.*
- *ILI visits were comparable to the historical baseline in Hawaii[2,3] (i.e., inside the 95% confidence interval).*
- *Hawaii's ILI outpatient visits were lower than the national baseline (**3.9%**)[4] (i.e., outside the 95% confidence interval) and higher than the national ILI rate (**1.6%**) (i.e. outside the 95% confidence interval).*
- *ILI activity level: Low[5]*
- *Geographic Spread: Sporadic Activity[6].*
- *ILI Cluster Activity: Two new clusters were reported to HDOH during week 20. Clusters were from a school in Honolulu County and a nursing home in Kauai County. Both clusters had an influenza infection.*



[2] The Hawaii historical baseline (%ILI) is the average of 3-week moving averages over the preceding 3 flu seasons of historical data (2022-2023, 2023-2024 and 2024-2025).
[3] This value is based upon comparison of actual outpatient ILI with the historical baseline, which only captures outpatient ILI. The chart above represents a 3-week moving average and not the actual ILI by week.
[4] The National Baseline is calculated by CDC as the mean percentage of visits for ILI during weeks 21–39 with two standard deviations. Because of large variability in regional ILI, comparison of the national baseline with local ILI may not be appropriate. It is provided in this report because no meaningful regional baselines are available for comparison. The national baseline combines all data reported by states to CDC, including ILI in outpatient, ER, urgent care, and inpatient settings.
[5] There are 10 activity levels classified as minimal (levels 1-3), low (levels 4-5), moderate (levels 6-7), and high (levels 8-10).
[6] The influenza activity reported by state and territorial epidemiologists indicates geographic spread of influenza viruses but does not measure the severity of influenza activity. Sporadic: no clusters reported to HDOH, Local: one or more clusters reported in one county, Regional: clusters reported two to three counties, Widespread: clusters reported in all counties. Hawaii does not report No Activity, as flu circulates year-round in Hawaii.

II. LABORATORY SURVEILLANCE: State Laboratories Division (SLD; the HDOH public health laboratory) and Hawaii's major private laboratories (DLS, CLH) report results of RT-PCR, which can be considered confirmatory (SLD may perform viral culture on select specimens). Specimens meeting priority criteria[7] are forwarded to SLD for sub-typing. Additionally, specimens meeting case definition from requesting sentinel providers are sent directly to SLD for sub-typing. Due to resource constraints, not all submitted specimens undergo sub-typing. Sub-typing at the commercial laboratories is only conducted on a case-by-case basis. The majority of specimens testing positive by rapid antigen testing or RT-PCR at the commercial laboratories do not meet criteria and are not subtyped. For more information on influenza tests and types, please visit the CDC website (*here*).

A. INFLUENZA:

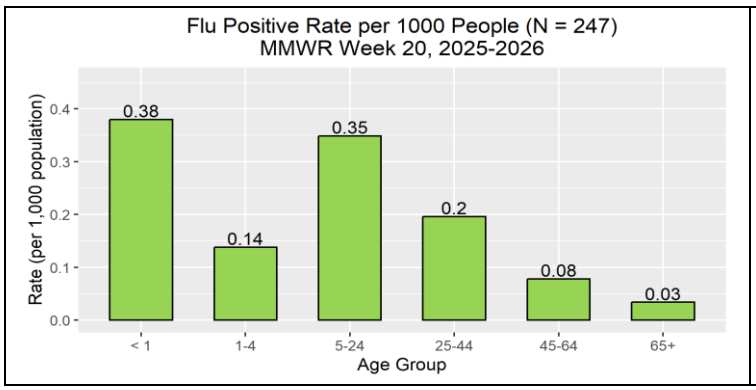
- The following reflects laboratory findings for week 20 of the 2025–26 influenza season:
  - *A total of **2,192** specimens has been tested statewide for influenza viruses (positive: 247 [**11.3%**]). (Season to date: **115,479** tested (**17.5%** positive)*
    - *765 (34.9%) were screened only by rapid antigen tests with no confirmatory testing.*
    - *1,436 (65.1%) underwent confirmatory testing (either RT-PCR or viral culture).*
    - *1,945 (88.7%) were negative.*
  - *Routine surveillance samples from State Laboratory Division were tested at a public health laboratory and identified as Influenza A (H3N2) subclade K.*

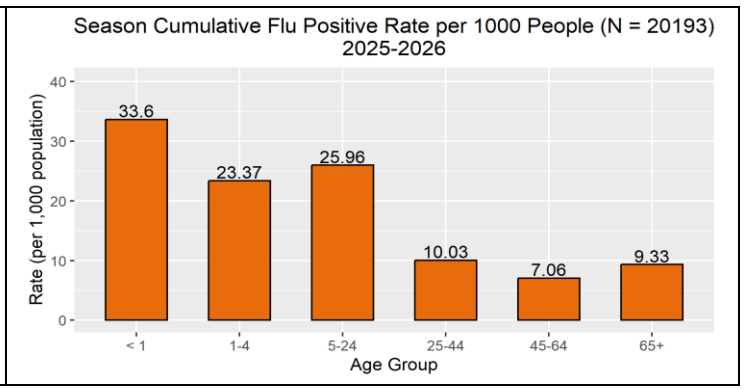
Influenza type	*Current week 20 (%)**	*Season to date (%)[8]*
Influenza A (H1)[9]	*2 (0.8)*	*202 (1.0)*
Influenza A (H3)	*1 (0.4)*	*1,301 (6.5)*
Influenza A no subtyping	*39 (15.7)*	*12,717 (63.1)*
Influenza B (Yamagata)	*0 (0.0)*	*0 (0.0)*
Influenza B (Victoria)	*0 (0.0)*	*0 (0.0)*
Influenza B no genotyping	*206 (83.0)*	*5,932 (29.4)*

**Specimens that are positive for both A and B (coinfections) are counted in both A and B totals for current and season to date*

1. AGE DISTRIBUTION

The charts below indicate the population-based rates of positive influenza cases in Hawaii by age group during the 2025–26 influenza season.[10]

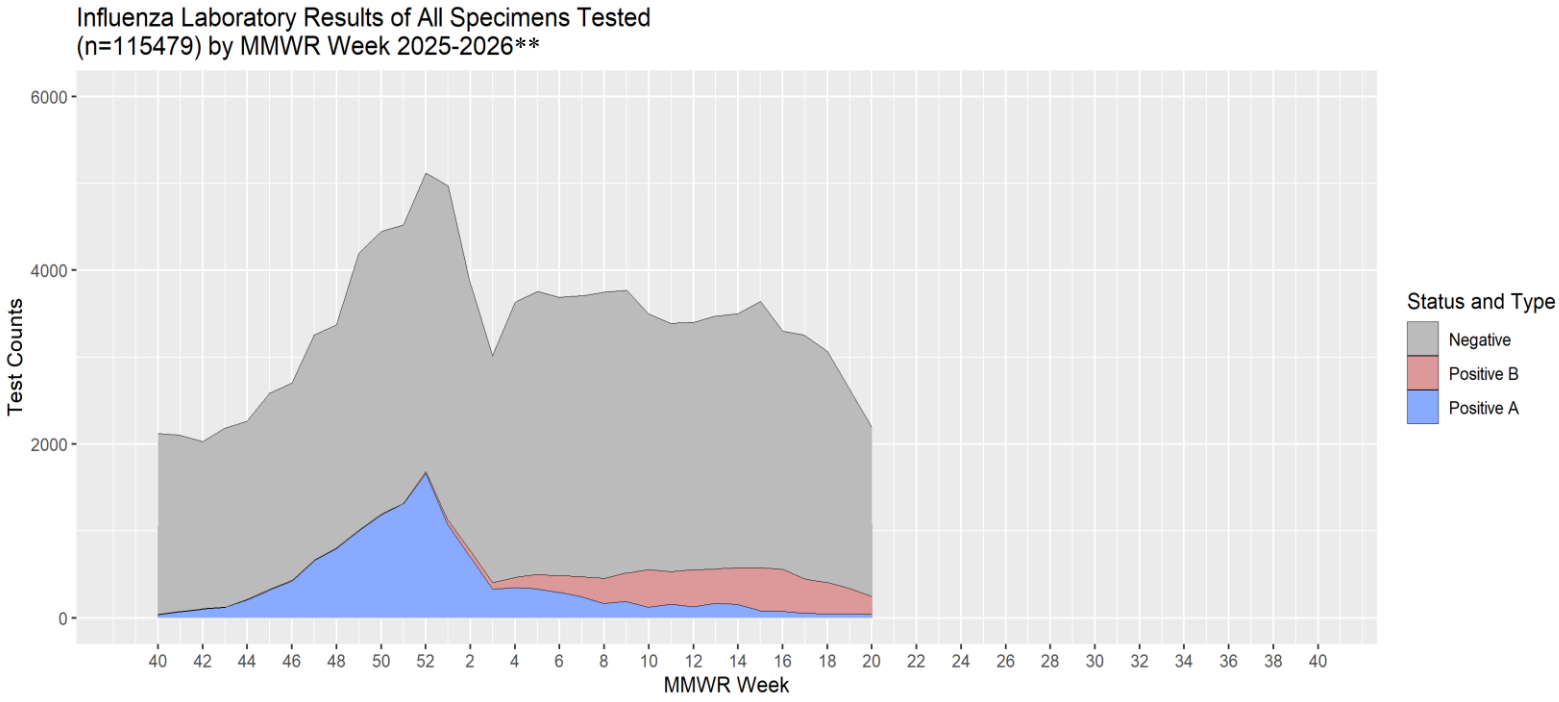


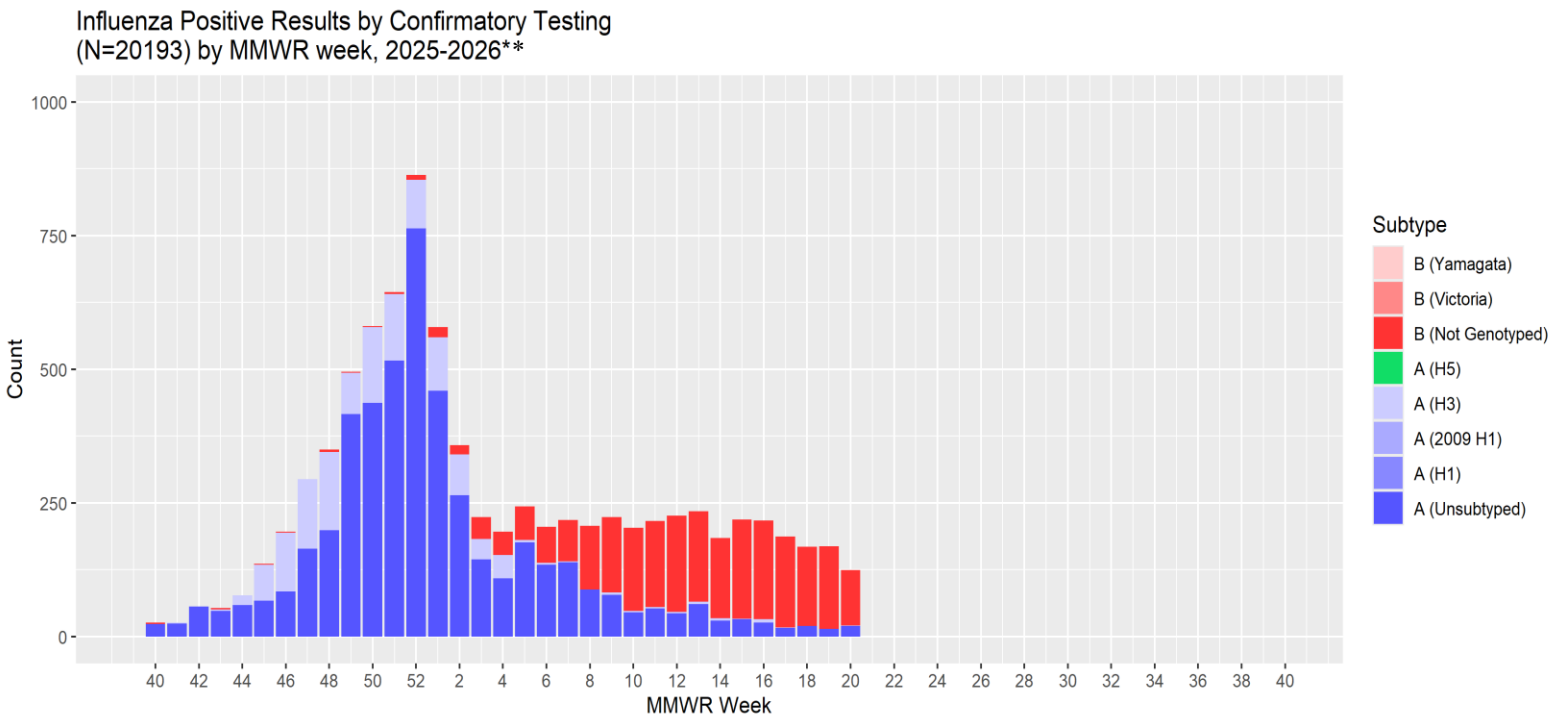


[7] Priority criteria include: hospitalized patients with acute respiratory distress syndrome [ARDS] or x-ray confirmed pneumonia; travelers with international travel history within 10 days of onset; specimens submitted by sentinel providers; specimens collected from healthcare workers, pregnant women, or women up to 6 weeks' post-partum; those with underlying medical conditions; and patients presenting with unusual or severe manifestations of influenza infection.
[8] Influenza coding was updated to reflect a more accurate count.
[9] All influenza A H1 viruses detected this season have been 2009 H1N1.
[10] This represents an estimate of population-based rates based on available data.

2. LABORATORY TESTING

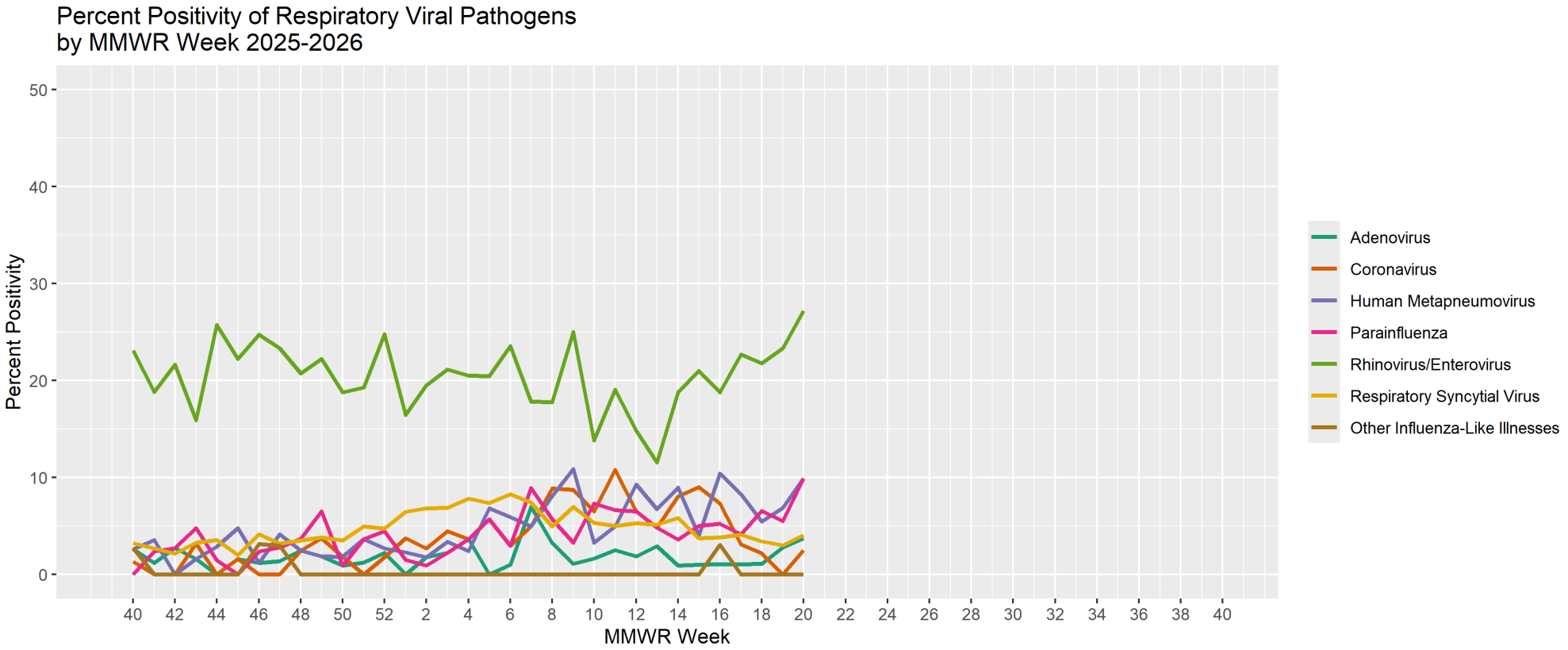
The charts below show the laboratory results of all specimens tested for influenza by MMWR week during the 2025–2026 influenza season as well as the type and subtype of positive results for influenza. Again, sub-typing is only performed on selected specimens tested by confirmatory tests (i.e., RT-PCR or viral culture).





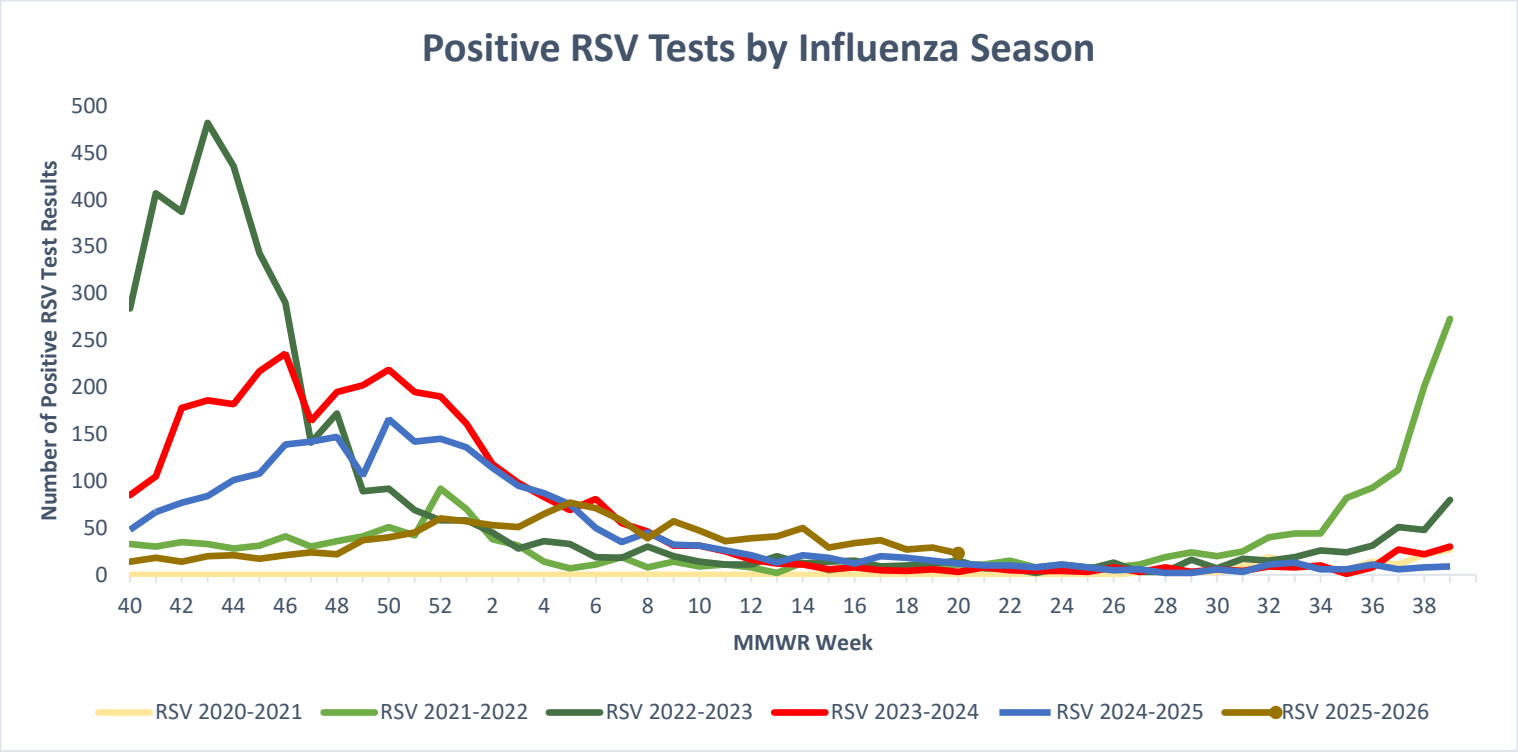
** A total of 63,803 specimens underwent confirmatory testing, but not all positive influenza specimens receive confirmatory testing that are circulating in Hawaii.*
*** For MMWR Week 53, results are reported under MMWR Week 52, where the average of Weeks 52 and 53 was calculated.*

B. **OTHER RESPIRATORY PATHOGENS:** The major clinical and commercial laboratories throughout the state of Hawaii have the testing capacity for non-influenza respiratory pathogens and report these to HDOH. However, such testing is performed as needed and when sufficient resources are available because of the high costs associated with respiratory panel tests. **Therefore, available data represents only the presence of circulating pathogens and cannot be used to determine specific trends**.

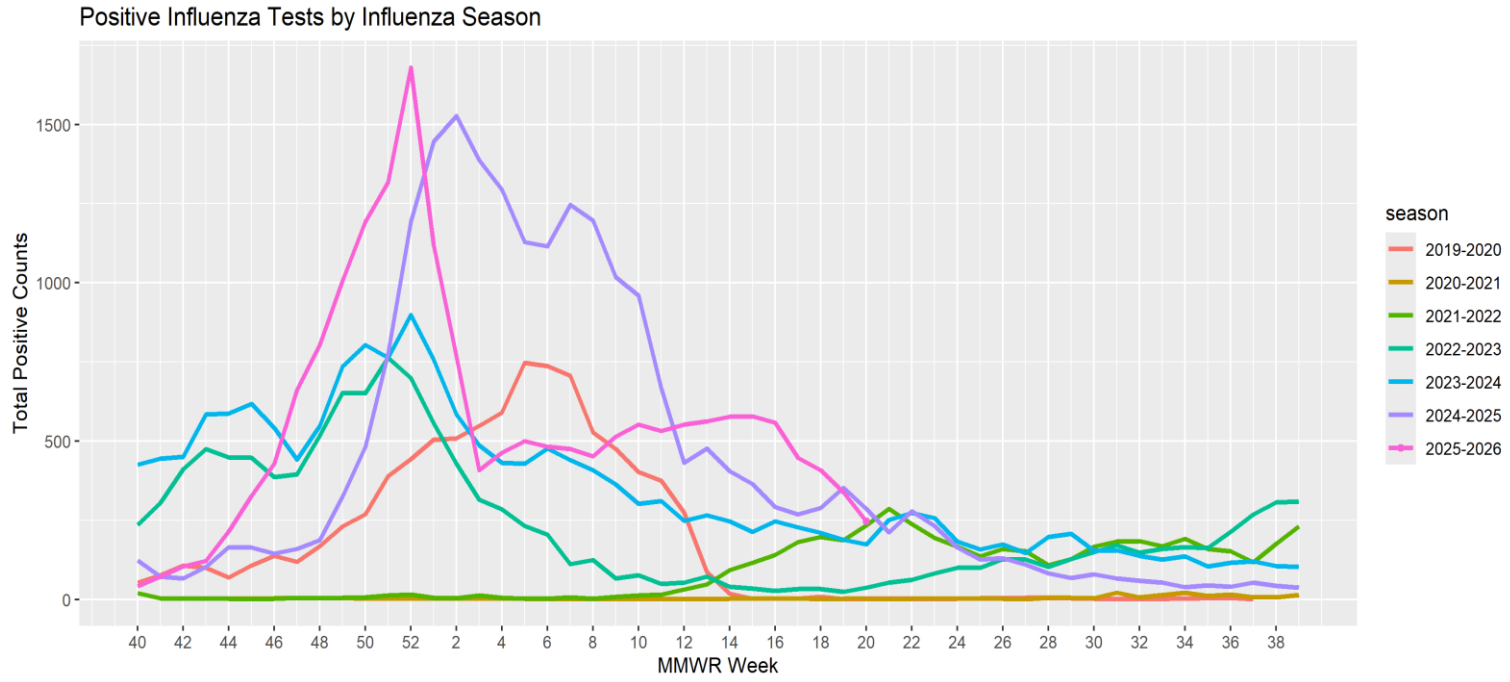


* *The coronavirus presented on this table does not indicate Severe Acute Respiratory Coronavirus-2 (i.e., COVID-19). For MMWR Week 53, results are reported under MMWR Week 52, where the average of Weeks 52 and 53 was calculated*

RESPIRATORY SYNCYTIAL VIRUS (RSV) POSITIVE TEST RESULTS BY INFLUENZA SEASON: RSV case appears to have increased later than past seasons in the 2025-2026 season. For MMWR Week 53, results are reported under MMWR Week 52, where the average of Weeks 52 and 53 was calculated.



INFLUENZA POSITIVE TEST RESULTS BY INFLUENZA SEASON: Influenza cases appear to have increased earlier than past seasons in the 2025-2026 season. For MMWR Week 53, results are reported under MMWR Week 52, where the average of Weeks 52 and 53 was calculated.



C. COVID-19 SENTINEL SURVEILLANCE: Due to the low volume of samples currently available through the influenza surveillance system, the COVID-19 sentinel surveillance data may not be accurately portraying COVID-19 activity in our communities. Reporting of the COVID-19 Sentinel Surveillance data will be paused while HODH re-evaluates the program to ensure that the reported data are accurate and representative.

HDOH is continuing to monitor COVID-19 activity throughout the state. To learn more, please visit the Hawaii's COVID-19 data website (*here*). For more information on surveillance of COVID-19 activity in the United States please visit the CDC COVIDView website (*here*).

III. PNEUMONIA, INFLUENZA, AND COVID-19 (PIC) RELATED MORTALITY:

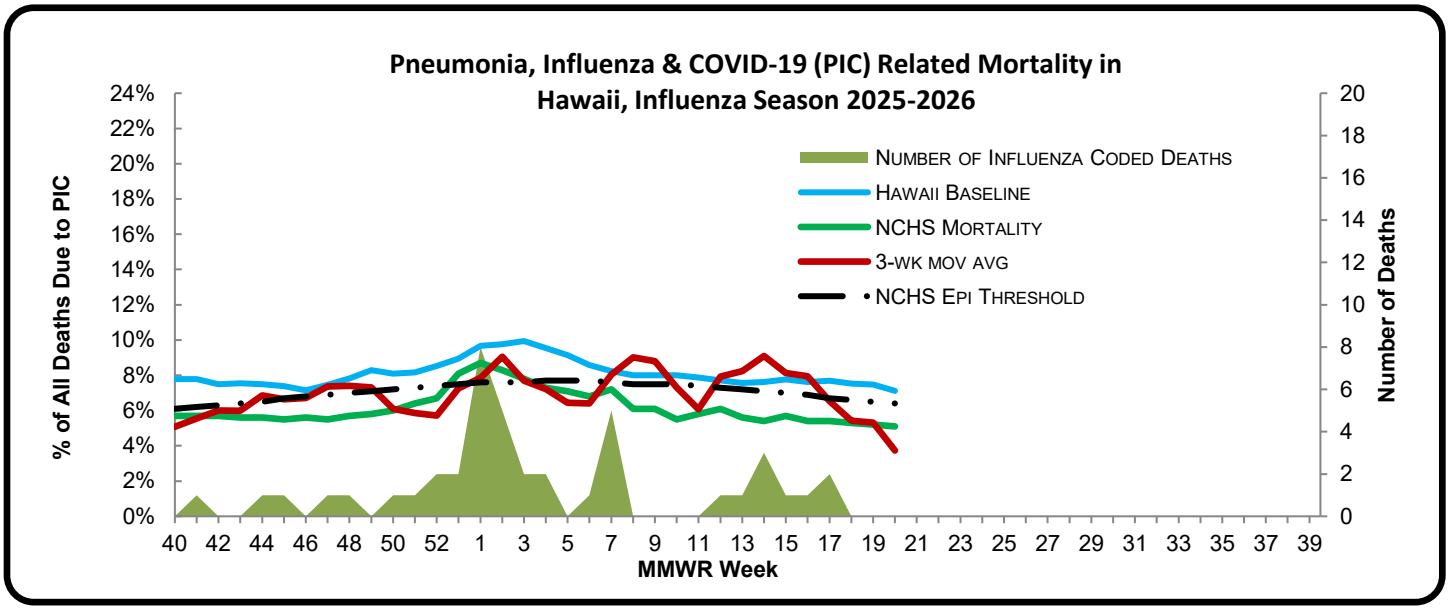
P&I mortality surveillance is collected by CDC through the National Center for Health Statistics (NCHS) using death certificate data. Each week the HDOH OHSM reports specific data from Honolulu to the CDC. CDC collects the following information by age group: the total number of deaths, total deaths from pneumonia, and total deaths related to influenza. Due to the ongoing COVID-19 pandemic, CDC included total deaths from COVID-19 by age group to the death data. Previous studies had suggested that P&I is a good indicator of influenza-related deaths; however, data has shown that pneumonia deaths associated with influenza is now being impacted by COVID-19 related pneumonia. Due to this, CDC had added COVID-19 deaths into P&I to create the PIC (pneumonia, influenza, and/or COVID-19) classification.

To standardize Hawaii's influenza surveillance with CDC influenza surveillance guidelines, PIC deaths will be reported in lieu of P&I. Hawaii's baseline will begin to include PIC deaths starting from 2019-2020 flu season.

For **week 20** of the current influenza season:

- ***0.0%*** *of all deaths that occurred in Hawaii during week 20 were related to pneumonia, influenza or COVID-19 (PIC)[11]. For the current season (season to date:* ***7.0%****), there have been 8,065 deaths from any cause, 568 of which were due to PIC[12].*
- *The PIC rate was lower than the historical baseline in Hawaii[13] (i.e., outside the 95% confidence interval).*

*The Hawaii PIC rate was lower than the CDC's National Center for Health Statistics (NCHS) PIC mortality[14] (**5.1%**) (i.e., outside the 95% confidence interval) and lower than the national epidemic threshold (**6.4**%) (i.e., outside the 95% confidence interval) for week 20.*



[11] The percent of deaths due to PIC displayed on the graph is the 3-week moving averages.

[12] PIC data reflect 100% of the data reported for the MMWR week. Changes to data are expected when PIC data reaches 100% completion.

[13] The Hawaii historical baseline (%PIC) is the average of 3-week moving averages over the preceding 10 flu seasons of historical data (2014-2015, 2015-2016, 2016-2017, 2017-2018, 2018-2019, 2019-2020, 2020-2021, 2021-2022, 2022-2023, and 2023-2024).

[14] Each week, the vital statistics offices of 122 cities across the United States report the total number of death certificates processed and the number of those for which pneumonia, influenza, or COVID-19 was listed as the underlying or contributing cause of death by age group (Under 28 days, 28 days–1 year, 1–14 years, 15–24 years, 25–44 years, 45–64 years, 65–74 years, 75–84 years, and ≥85 years). The COVID-19 death counts reported by NCHS are provisional and will not match counts in other sources, such as media reports or numbers from health departments. COVID-19 deaths may be classified or defined differently in various reporting and surveillance systems. The percentage of deaths due to pneumonia, influenza, and COVID-19 (PIC) are compared with a seasonal baseline and epidemic threshold value calculated for each week.

INFLUENZA-ASSOCIATED PEDIATRIC DEATHS[15]:

- No new influenza-associated pediatric death was reported to Hawaii. There have been zero influenza-associated pediatric deaths reported in Hawaii during the 2025–2026 season.
- Nationally, two new influenza-associated pediatric deaths were reported to CDC during week 20. (2025-2026 season total: 174).

IV. INFLUENZA WATCH: As part of a comprehensive influenza surveillance system and to prevent the spread of contagious respiratory diseases in humans, it is important to monitor all circulating influenza types. Several animal-origin influenza A subtypes are currently of interest: influenza A variant virus (H3N2v, H1N2v, and H1N1v) and Avian flu (H5N1 and H7N9). These types of influenza viruses may cause zoonotic (animal-associated) disease and are a public health concern.

A. VARIANT VIRUSES:

Influenza viruses that normally circulate in pigs are called "variant" viruses when they are found in people. These viruses were first identified in U.S. pigs in 2010. In 2011, 12 cases of H3N2v infection were detected in the United States. In 2012, 309 such cases (resulting in 16 hospitalizations and one death) across 12 states were detected, including one Hawaii case who recovered. Illness associated with H3N2v infection has been mostly mild with symptoms similar to those of seasonal flu. However, serious illness, resulting in hospitalization and death, has occurred in some cases. Most of these infections have been associated with prolonged exposure to pigs at agricultural fairs or similar settings. Limited human-to-human spread of this virus has been detected in the past, but no sustained community spread of H3N2v has been identified. More information regarding H3N2v, H1N1v, and H1N2v viruses may be found on the CDC website (*here*) and (*here*).

- *No variant or novel influenza infections have been reported to HDOH during the 2025-2026 influenza season.*
- *One new human infection with novel influenza A virus, H1N1v (0), H3N2v (0), and H1N2v (1), have been reported during the 2025-2026 influenza season.*
    - *One new human infection with influenza A(H1N1v) virus has been reported to WHO from China during the 2025-2026 influenza season.*

AVIAN (OR BIRD) INFLUENZA: These types of influenza viruses cause zoonotic (animal-associated) disease of public health concern and are therefore monitored globally by the WHO. Most avian influenza viruses do not cause disease in humans and are generally not easily transmissible between person to person, but a few subtypes may cross the species barrier and cause disease in humans. Avian influenza viruses may be of various subtypes, including H5N1, H5N2, H5N8, H7N3, H7N7, H7N8, H7N9, and H9N2. On January 15th, 2016, the USDA and APHIS reported detection of HPAI H7N8 in a commercial turkey flock in Indiana. There have been no associated human infections. This is the first detection of HPAI H7N8 in wild bird surveillance in the United States. More information, the risk assessment and recommendations for HPAI H7N8 can be found (here). The WHO, CDC, and other public health agencies have also been monitoring influenza H7N9, which represents a public health concern because of its high pandemic potential. Although H7N9 has not been detected in the United States, it remains a global concern given continuing epidemics in endemic countries. Since 2013, a total of 1,568 laboratory-confirmed cases of human infection with H7N9 viruses, including at least 613 deaths, have been reported to WHO. More information on H7N9 virus infections can be found (here). For more information regarding avian influenza, please visit the CDC (*here*) or the WHO (*here*) websites. WHO reports total number of cases and deaths related to laboratory-confirmed avian influenza viruses and posts current avian influenza case counts (*here*), which were last updated on **January 22, 2026**.

[15] Influenza-associated deaths are considered pediatric in persons aged less than 18 years. It was made a nationally notifiable condition in October, 2004. All pediatric influenza-associated deaths are laboratory confirmed.

V. INFLUENZA Vaccine: Annual influenza vaccination is recommended for all persons aged 6 months and older and is the most effective way to reduce the risk of getting sick with seasonal flu and spreading it to others. Influenza vaccination can reduce illnesses, visits to the doctor, influenza-related hospitalizations, and missed work and school days. Influenza vaccines become available by the end of October. It takes at least two weeks after vaccination to confer immunity against influenza virus infection. More information regarding influenza vaccination can be found (*here*).

A. Composition of the 2025–2026 Influenza Vaccine**:**

The composition of the 2025–2026 influenza vaccine has been updated to better match circulating influenza viruses. The Advisory Committee on Immunization Practices (ACIP) has recommended that the 2025-2026 influenza trivalent vaccine contain an influenza A/Victoria/4897/2022 (H1N1) pdm09-like virus, influenza A/Croatia/10136RV/2023 (H3N2)-like virus, and influenza B/Austria/1359417/2021 (B/Victoria lineage)-like virus. United States cell culture–based inactivated (ccIIV4) and recombinant (RIV4) influenza vaccines will contain HA derived from an influenza A/Wisconsin/67/2022 (H1N1) pdm09-like virus, an A/District of Columbia/27/2023 (H3N2)-like virus, an influenza B/Austria/1359417/2021 (B/Victoria lineage)-like virus. These vaccine recommendations were based on several factors, including global influenza virologic and epidemiologic surveillance, genetic and antigenic characterization, human serology studies, antiviral susceptibility, and the availability of candidate influenza viruses.

APPENDIX 1: ADDITIONAL INFORMATION

For more information regarding local and national influenza surveillance programs, visit the following sites.

Centers for Disease Control and Prevention	General Influenza National ILI and P&I Data Vaccine Virus Selection CDC Web Tool for Respiratory Viruses
Flu.gov	General Influenza Information
HDOH Flu and Pneumonia	General Influenza Surveillance Avian Influenza Respiratory Virus Dashboard To find out more information or join the sentinel physician program, email the Influenza Surveillance Coordinator
World Health Organization	General Global and Local Influenza Avian Influenza

APPENDIX 2: MMWR WEEK DATES

Please refer to the table below to interpret data presented by MMWR week. Week 40 is considered the traditional start for the flu season for the Northern Hemisphere.

MMWR WEEK	2022	2023	2024	2025	2026
1	1/8/2022	1/7/2023	1/6/2024	1/4/2025	1/10/2026
2	1/15/2022	1/14/2023	1/13/2024	1/11/2025	1/17/2026
3	1/22/2022	1/21/2023	1/20/2024	1/18/2025	1/24/2026
4	1/29/2022	1/28/2023	1/27/2024	1/25/2025	1/31/2026
5	2/5/2022	2/4/2023	2/3/2024	2/1/2025	2/7/2026
6	2/12/2022	2/11/2023	2/10/2024	2/8/2025	2/14/2026
7	2/19/2022	2/18/2023	2/17/2024	2/15/2025	2/21/2026
8	2/26/2022	2/25/2023	2/24/2024	2/22/2025	2/28/2026
9	3/5/2022	3/4/2023	3/2/2024	3/1/2025	3/7/2026
10	3/12/2022	3/11/2023	3/9/2024	3/8/2025	3/14/2026
11	3/19/2022	3/18/2023	3/16/2024	3/15/2025	3/21/2026
12	3/26/2022	3/25/2023	3/23/2024	3/22/2025	3/28/2026
13	4/2/2022	4/1/2023	3/30/2024	3/29/2025	4/4/2026
14	4/9/2022	4/8/2023	4/6/2024	4/5/2025	4/11/2026
15	4/16/2022	4/15/2023	4/13/2024	4/12/2025	4/18/2026
16	4/23/2022	4/22/2023	4/20/2024	4/19/2025	4/25/2026
17	4/30/2022	4/29/2023	4/27/2024	4/26/2025	5/2/2026
18	5/7/2022	5/6/2023	5/4/2024	5/3/2025	5/9/2026
19	5/14/2022	5/13/2023	5/11/2024	5/10/2025	5/16/2026
20	5/21/2022	5/20/2023	5/18/2024	5/17/2025	5/23/2026
21	5/28/2022	5/27/2023	5/25/2024	5/24/2025	5/30/2026
22	6/4/2022	6/3/2023	6/1/2024	5/31/2025	6/6/2026
23	6/11/2022	6/10/2023	6/8/2024	6/7/2025	6/13/2026
24	6/18/2022	6/17/2023	6/15/2024	6/14/2025	6/20/2026
25	6/25/2022	6/24/2023	6/22/2024	6/21/2025	6/27/2026
26	7/2/2022	7/1/2023	6/29/2024	6/28/2025	7/4/2026
27	7/9/2022	7/8/2023	7/6/2024	7/5/2025	7/11/2026
28	7/16/2022	7/15/2023	7/13/2024	7/12/2025	7/18/2026
29	7/23/2022	7/22/2023	7/20/2024	7/19/2025	7/25/2026
30	7/30/2022	7/29/2023	7/27/2024	7/26/2025	8/1/2026
31	8/6/2022	8/5/2023	8/3/2024	8/2/2025	8/8/2026
32	8/13/2022	8/12/2023	8/10/2024	8/9/2025	8/15/2026
33	8/20/2022	8/19/2023	8/17/2024	8/16/2025	8/22/2026
34	8/27/2022	8/26/2023	8/24/2024	8/23/2025	8/29/2026
35	9/3/2022	9/2/2023	8/31/2024	8/30/2025	9/5/2026
36	9/10/2022	9/9/2023	9/7/2024	9/6/2025	9/12/2026
37	9/17/2022	9/16/2023	9/14/2024	9/13/2025	9/19/2026
38	9/24/2022	9/23/2023	9/21/2024	9/20/2025	9/26/2026
39	10/1/2022	9/30/2023	9/28/2024	9/27/2025	10/3/2026
40	10/8/2022	10/7/2023	10/5/2024	10/4/2025	10/10/2026
41	10/15/2022	10/14/2023	10/12/2024	10/11/2025	10/17/2026
42	10/22/2022	10/21/2023	10/19/2024	10/18/2025	10/24/2026
43	10/29/2022	10/28/2023	10/26/2024	10/25/2025	10/31/2026
44	11/5/2022	11/4/2023	11/2/2024	11/1/2025	11/7/2026
45	11/12/2022	11/11/2023	11/9/2024	11/8/2025	11/14/2026
46	11/19/2022	11/18/2023	11/16/2024	11/15/2025	11/21/2026
47	11/26/2022	11/25/2023	11/23/2024	11/22/2025	11/28/2026
48	12/3/2022	12/2/2023	11/30/2024	11/29/2025	12/5/2026
49	12/10/2022	12/9/2023	12/7/2024	12/6/2025	12/12/2026
50	12/17/2022	12/16/2023	12/14/2024	12/13/2025	12/19/2026
51	12/24/2022	12/23/2023	12/21/2024	12/20/2025	12/26/2026
52	12/31/2022	12/30/2023	12/28/2024	12/27/2025	
53				01/03/2026	

HAWAII STATE DEPARTMENT OF HEALTH
DISEASE OUTBREAK CONTROL DIVISION

Influenza/Respiratory Disease Surveillance Report

Morbidity and Mortality Weekly Report (MMWR)[1]

WEEK 21: MAY 24, 2026– MAY 30, 2026

OVERVIEW: The Hawaii State Department of Health (HDOH) monitors influenza and other respiratory pathogens, including COVID-19, throughout the state of Hawaii. Influenza surveillance in the state of Hawaii relies upon selected sentinel health practitioners, the State Laboratories Division (SLD), private laboratories, and the Office of Health Status Monitoring (OHSM). For detailed information concerning influenza, please visit the HD OH Disease Outbreak Control Division (HDOH DOCD) website (*here*). **All data and information are conditional and may change as more reports are received.** The data in this report reflects the 2025-2026 influenza season which began the week ending October 4, 2025 (week 40[1] 2025) and will end the week ending on October 3, 2026 (week 39 2026).

REPORT SNAPSHOT FOR WEEK 21

Surveillance for Influenza-like Illness (ILI)		
Metric	*Value*	*Comment*
Outpatient visits related to influenza-like illness (ILI) from ILINet Sentinel Providers	3.1%	Higher than the previous week. Comparable to Hawaii's historical baseline and lower than the national baseline, and higher than the national ILI rate.
Number of ILI clusters reported to HDOH	0	There have been 31 clusters this season.

Laboratory Surveillance		
Percent of all respiratory specimens positive for influenza this week	11.3%	Same as the previous week. This number means that many, if not all, of the 88.7% who tested negative for influenza had illness from another respiratory etiology.
Percent of all respiratory specimens positive for influenza this season to date	17.3%	

Surveillance for Severe Outcomes		
Pneumonia, influenza and COVID-20 (PIC) mortality rate	3.3%	Lower than Hawaii's historical baseline, lower than the national epidemic threshold and comparable to the NCHS average.
Number of influenza-associated pediatric deaths reported nationwide	179	0 influenza-associated pediatric deaths have been reported from Hawaii this season to date.

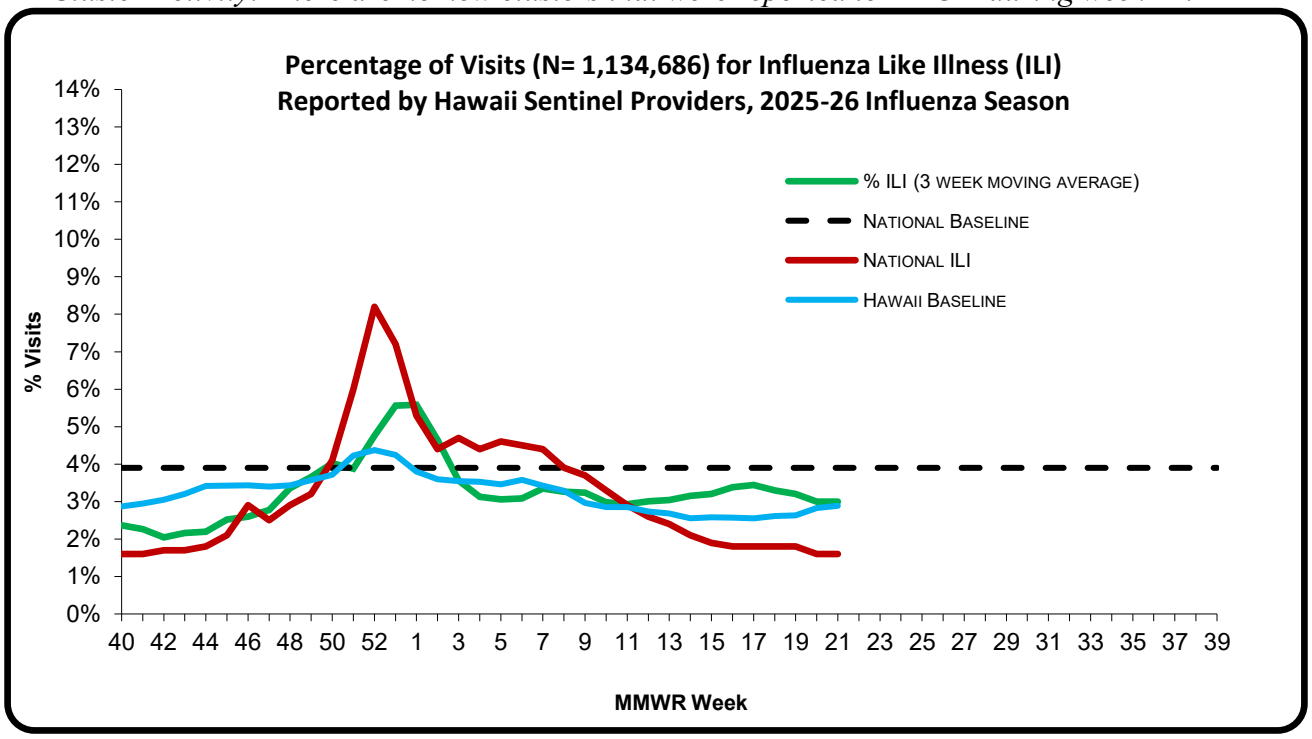
[1] MMWR stands for "Morbidity and Mortality Weekly Report," conventionally used by the Centers for Disease Control and Prevention (CDC). The weeks of a flu season are often referred to by their respective MMWR week. **See appendix 2 for interpretation of MMWR weeks.** Data reported will begin on week 40, the traditional start date of flu season.

INFLUENZA SURVEILLANCE

I. INFLUENZA-LIKE ILLNESS (ILI): HDOH collaborates with recruited doctors and healthcare providers who report the total number of outpatient visits for ILI as well as the total number of patients who complained of symptoms consistent with ILI. A patient with ILI must have the following: a fever (temperature of 100°F [37.8°C] or greater) AND a cough and/or a sore throat. ILI is based on reported symptoms and not laboratory confirmed tests; thus, ILI may represent other respiratory pathogens and not solely influenza. Further, sentinel providers report these numbers on a weekly basis; therefore, data are preliminary and may change depending on additional reporting. In combination with laboratory testing and other surveillance systems, ILI surveillance helps monitor influenza and other respiratory pathogen activity. For more information concerning ILINet and sentinel requirements, please visit the CDC website (*here*).

For **week 21** of the current influenza season:

- ***3.1****% (season to date:* ***3.2****%) of the outpatient visits recorded by Hawaii sentinel providers were for ILI.*
- *ILI visits were comparable to the historical baseline in Hawaii[2,3] (i.e., inside the 95% confidence interval).*
- *Hawaii's ILI outpatient visits were lower than the national baseline (**3.9%**)[4] (i.e., outside the 95% confidence interval) and higher than the national ILI rate (**1.6%**) (i.e. outside the 95% confidence interval).*
- *ILI activity level: Low[5]*
- *Geographic Spread: Sporadic Activity[6].*
- *ILI Cluster Activity: There are no new clusters that were reported to HDOH during week 21.*



[2] The Hawaii historical baseline (%ILI) is the average of 3-week moving averages over the preceding 3 flu seasons of historical data (2022-2023, 2023-2024 and 2024-2025).
[3] This value is based upon comparison of actual outpatient ILI with the historical baseline, which only captures outpatient ILI. The chart above represents a 3-week moving average and not the actual ILI by week.
[4] The National Baseline is calculated by CDC as the mean percentage of visits for ILI during weeks 21–39 with two standard deviations. Because of large variability in regional ILI, comparison of the national baseline with local ILI may not be appropriate. It is provided in this report because no meaningful regional baselines are available for comparison. The national baseline combines all data reported by states to CDC, including ILI in outpatient, ER, urgent care, and inpatient settings.
[5] There are 10 activity levels classified as minimal (levels 1-3), low (levels 4-5), moderate (levels 6-7), and high (levels 8-10).
[6] The influenza activity reported by state and territorial epidemiologists indicates geographic spread of influenza viruses but does not measure the severity of influenza activity. Sporadic: no clusters reported to HDOH, Local: one or more clusters reported in one county, Regional: clusters reported two to three counties, Widespread: clusters reported in all counties. Hawaii does not report No Activity, as flu circulates year-round in Hawaii.

II. LABORATORY SURVEILLANCE: State Laboratories Division (SLD; the HDOH public health laboratory) and Hawaii's major private laboratories (DLS, CLH) report results of RT-PCR, which can be considered confirmatory (SLD may perform viral culture on select specimens). Specimens meeting priority criteria[7] are forwarded to SLD for sub-typing. Additionally, specimens meeting case definition from requesting sentinel providers are sent directly to SLD for sub-typing. Due to resource constraints, not all submitted specimens undergo sub-typing. Sub-typing at the commercial laboratories is only conducted on a case-by-case basis. The majority of specimens testing positive by rapid antigen testing or RT-PCR at the commercial laboratories do not meet criteria and are not subtyped. For more information on influenza tests and types, please visit the CDC website (*here*).

A. INFLUENZA:

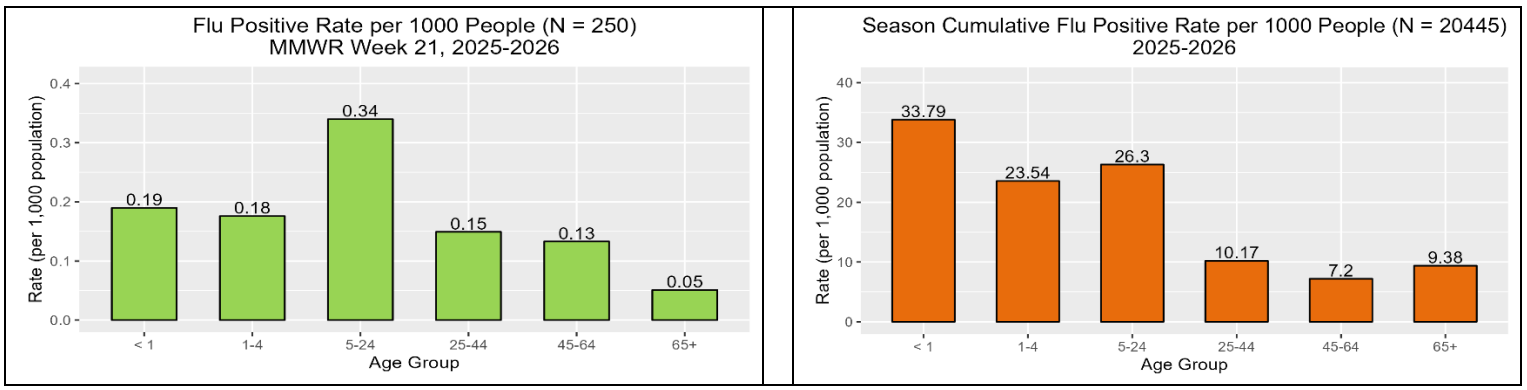
- The following reflects laboratory findings for week 21 of the 2025–26 influenza season:
  - *A total of **2,217** specimens has been tested statewide for influenza viruses (positive: 250 [**11.3%**]). (Season to date: **117,710** tested (**17.3%** positive)*
    - *724 (32.6%) were screened only by rapid antigen tests with no confirmatory testing.*
    - *1,493 (67.4%) underwent confirmatory testing (either RT-PCR or viral culture).*
    - *1,967 (88.7%) were negative.*
  - *Routine surveillance samples from State Laboratory Division were tested at a public health laboratory and identified as Influenza A (H3N2) subclade K.*

Influenza type	*Current week 21 (%)**	*Season to date (%)*[8]
Influenza A (H1)[9]	*2 (0.8)*	*204 (1.0)*
Influenza A (H3)	*0 (0.0)*	*1,302 (6.4)*
Influenza A no subtyping	*33 (13.2)*	*12,742 (62.5)*
Influenza B (Yamagata)	*0 (0.0)*	*0 (0.0)*
Influenza B (Victoria)	*0 (0.0)*	*0 (0.0)*
Influenza B no genotyping	*215 (86.0)*	*6,146 (30.1)*

**Specimens that are positive for both A and B (coinfections) are counted in both A and B totals for current and season to date*

1. AGE DISTRIBUTION

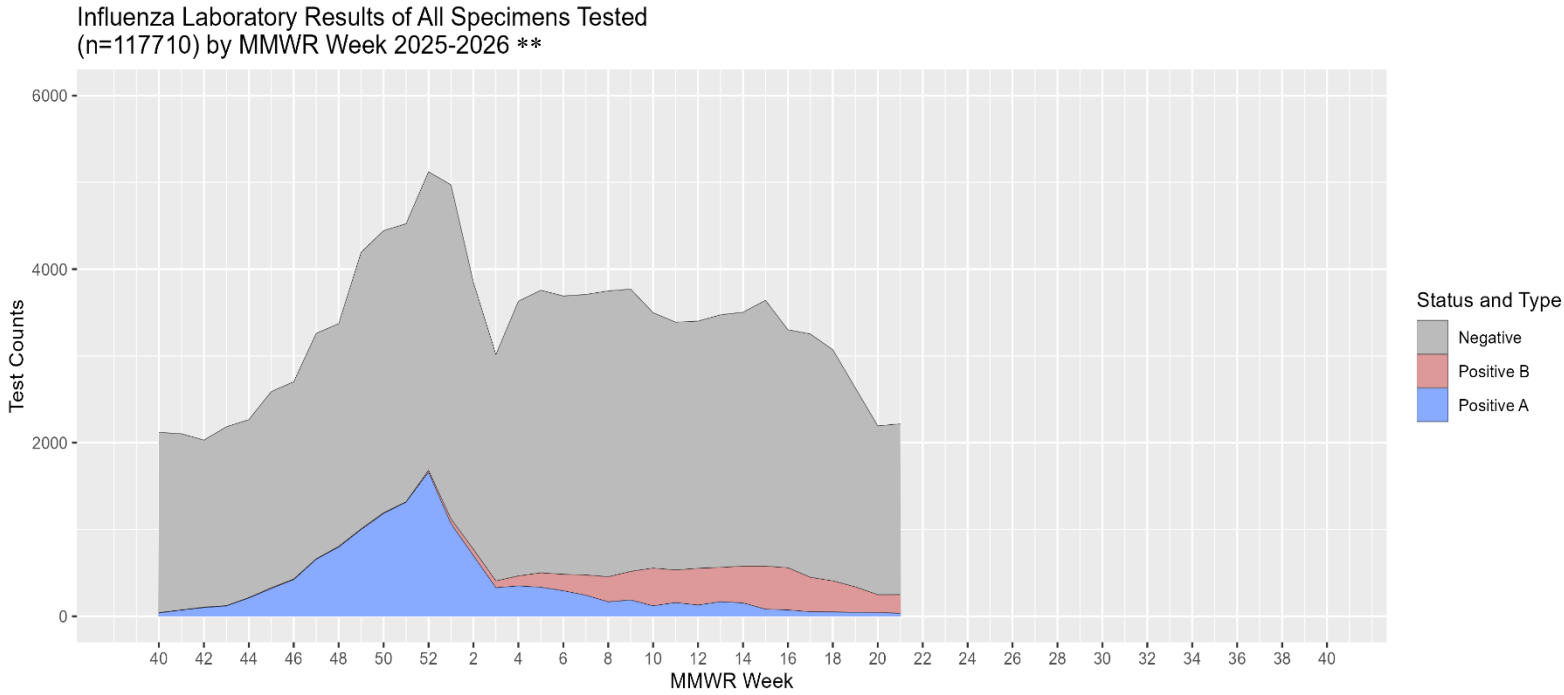
The charts below indicate the population-based rates of positive influenza cases in Hawaii by age group during the 2025–26 influenza season.[10]

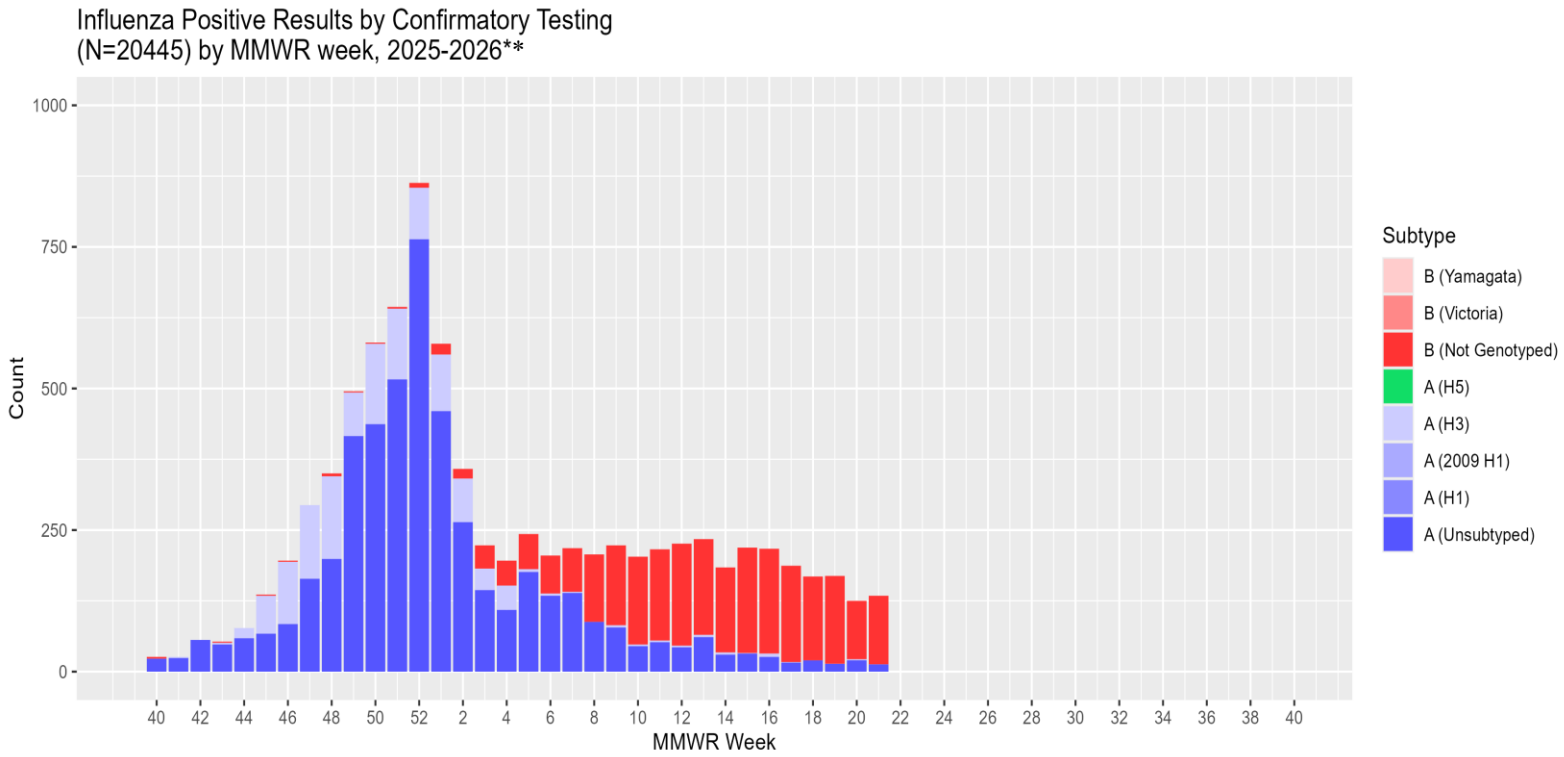


[7] Priority criteria include: hospitalized patients with acute respiratory distress syndrome [ARDS] or x-ray confirmed pneumonia; travelers with international travel history within 10 days of onset; specimens submitted by sentinel providers; specimens collected from healthcare workers, pregnant women, or women up to 6 weeks' post-partum; those with underlying medical conditions; and patients presenting with unusual or severe manifestations of influenza infection.
[8] Influenza coding was updated to reflect a more accurate count.
[9] All influenza A H1 viruses detected this season have been 2009 H1N1.
[10] This represents an estimate of population-based rates based on available data.

2. LABORATORY TESTING

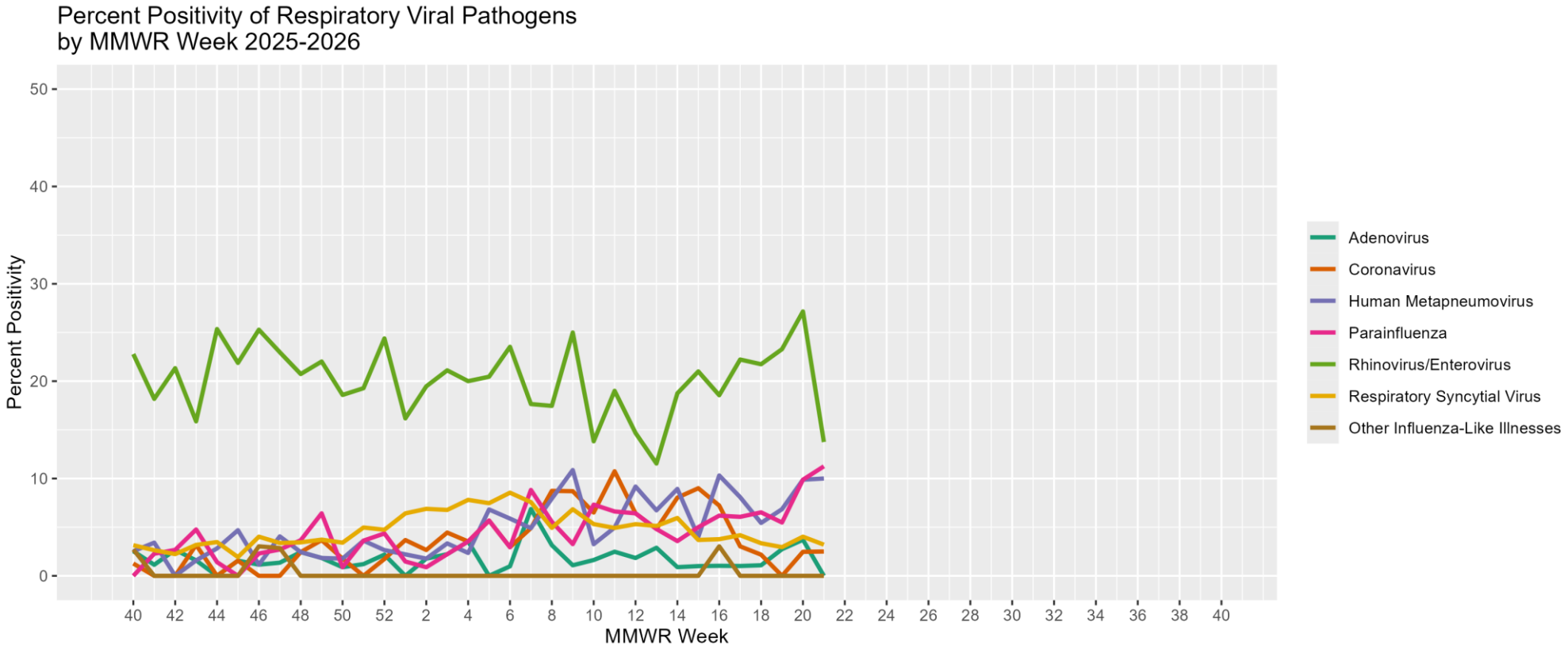
The charts below show the laboratory results of all specimens tested for influenza by MMWR week during the 2025–2026 influenza season as well as the type and subtype of positive results for influenza. Again, sub-typing is only performed on selected specimens tested by confirmatory tests (i.e., RT-PCR or viral culture).





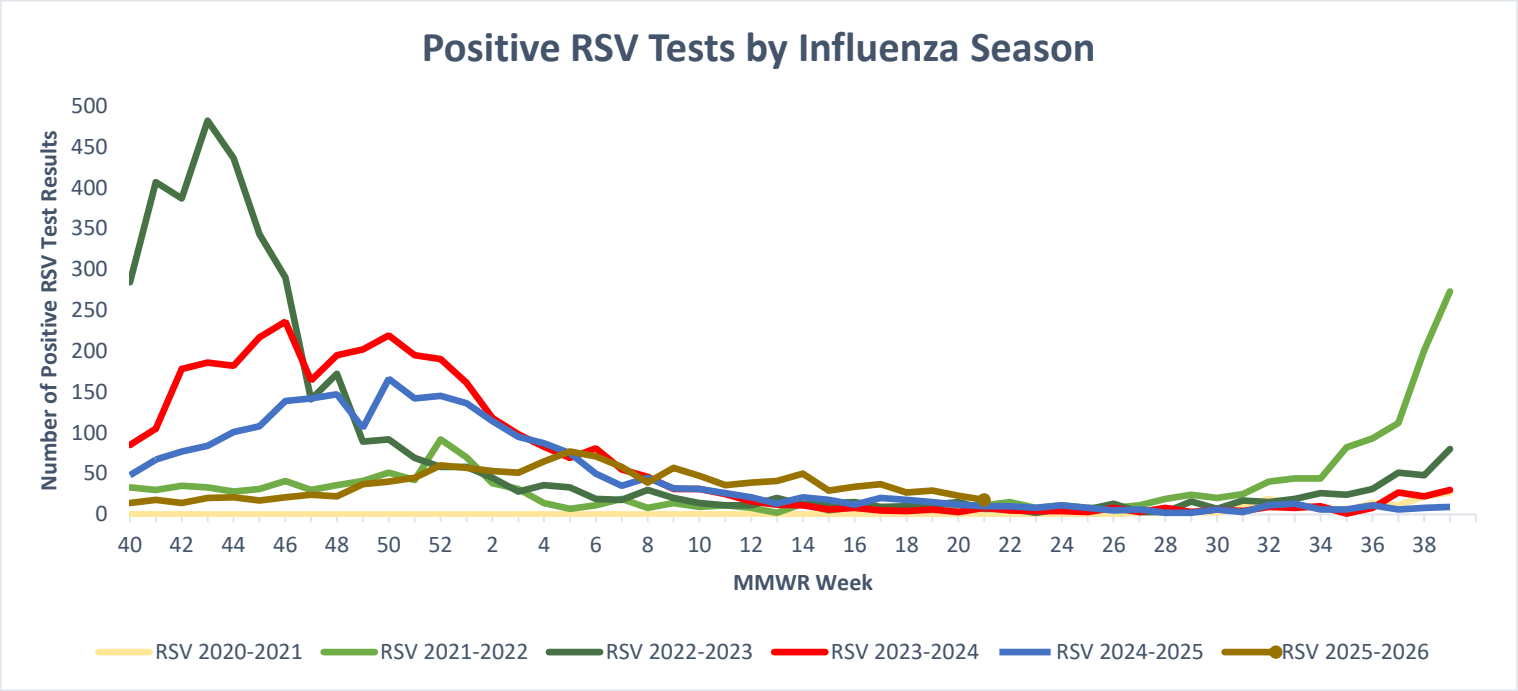
** A total of 65,309 specimens underwent confirmatory testing, but not all positive influenza specimens receive confirmatory testing that are circulating in Hawaii.*
*** For MMWR Week 53, results are reported under MMWR Week 52, where the average of Weeks 52 and 53 was calculated.*

B. **OTHER RESPIRATORY PATHOGENS:** The major clinical and commercial laboratories throughout the state of Hawaii have the testing capacity for non-influenza respiratory pathogens and report these to HDOH. However, such testing is performed as needed and when sufficient resources are available because of the high costs associated with respiratory panel tests. **Therefore, available data represents only the presence of circulating pathogens and cannot be used to determine specific trends**.

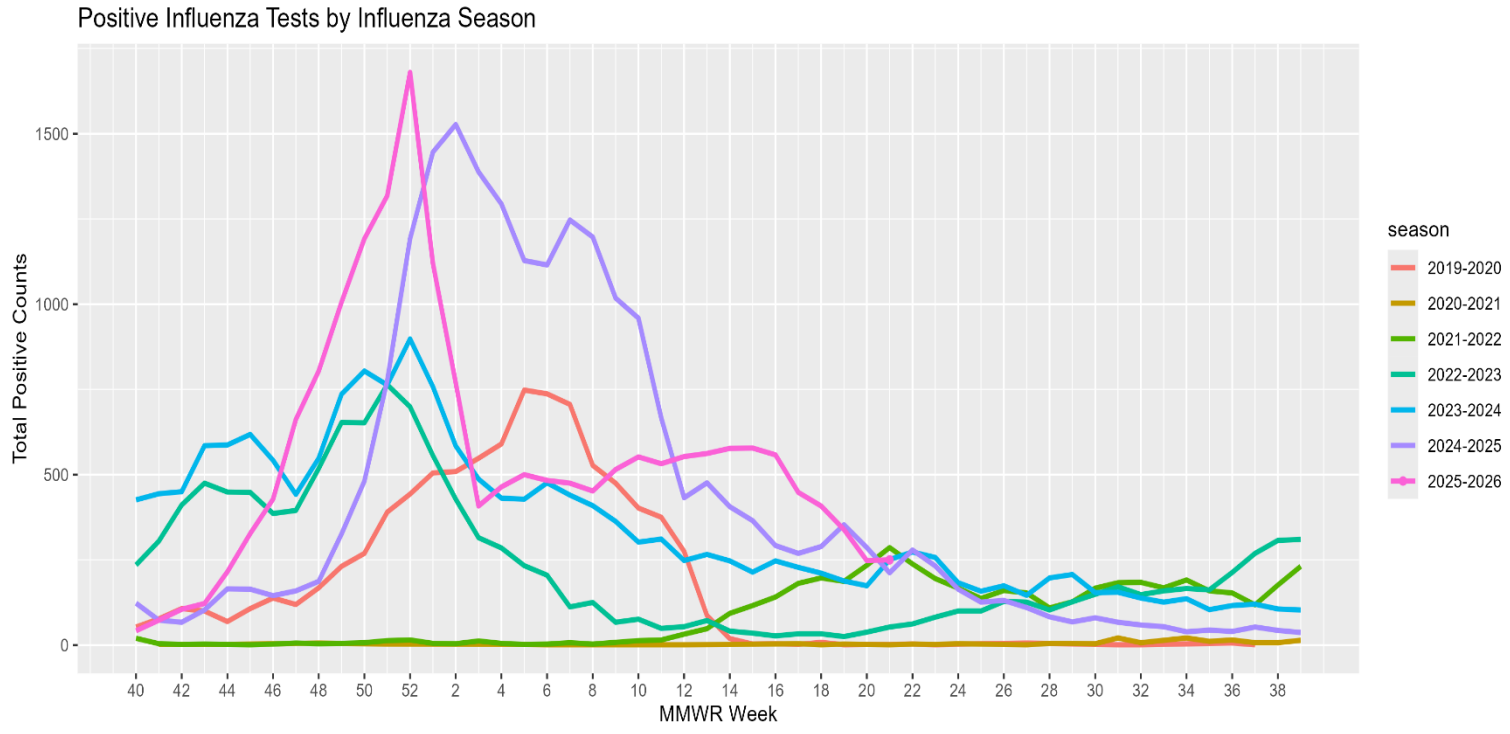


* *The coronavirus presented on this table does not indicate Severe Acute Respiratory Coronavirus-2 (i.e., COVID-19). For MMWR Week 53, results are reported under MMWR Week 52, where the average of Weeks 52 and 53 was calculated*

RESPIRATORY SYNCYTIAL VIRUS (RSV) POSITIVE TEST RESULTS BY INFLUENZA SEASON: RSV case appears to have increased later than past seasons in the 2025-2026 season. For MMWR Week 53, results are reported under MMWR Week 52, where the average of Weeks 52 and 53 was calculated.



INFLUENZA POSITIVE TEST RESULTS BY INFLUENZA SEASON: Influenza cases appear to have increased earlier than past seasons in the 2025-2026 season. For MMWR Week 53, results are reported under MMWR Week 52, where the average of Weeks 52 and 53 was calculated.



C. COVID-19 SENTINEL SURVEILLANCE: Due to the low volume of samples currently available through the influenza surveillance system, the COVID-19 sentinel surveillance data may not be accurately portraying COVID-19 activity in our communities. Reporting of the COVID-19 Sentinel Surveillance data will be paused while HODH re-evaluates the program to ensure that the reported data are accurate and representative.

HDOH is continuing to monitor COVID-19 activity throughout the state. To learn more, please visit the Hawaii's COVID-19 data website (*here*). For more information on surveillance of COVID-19 activity in the United States please visit the CDC COVIDView website (*here*).

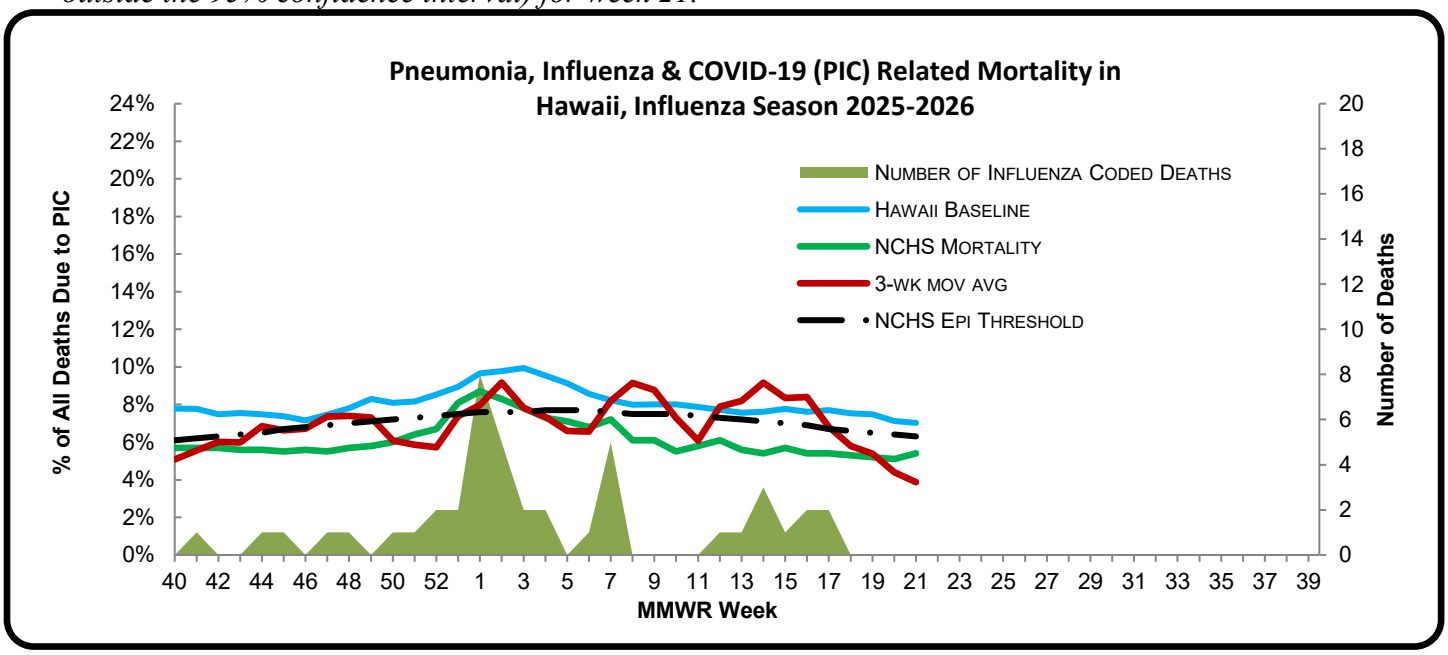
III. PNEUMONIA, INFLUENZA, AND COVID-19 (PIC) RELATED MORTALITY:

P&I mortality surveillance is collected by CDC through the National Center for Health Statistics (NCHS) using death certificate data. Each week the HDOH OHSM reports specific data from Honolulu to the CDC. CDC collects the following information by age group: the total number of deaths, total deaths from pneumonia, and total deaths related to influenza. Due to the ongoing COVID-19 pandemic, CDC included total deaths from COVID-19 by age group to the death data. Previous studies had suggested that P&I is a good indicator of influenza-related deaths; however, data has shown that pneumonia deaths associated with influenza is now being impacted by COVID-19 related pneumonia. Due to this, CDC had added COVID-19 deaths into P&I to create the PIC (pneumonia, influenza, and/or COVID-19) classification.

To standardize Hawaii's influenza surveillance with CDC influenza surveillance guidelines, PIC deaths will be reported in lieu of P&I. Hawaii's baseline will begin to include PIC deaths starting from 2019-2020 flu season.

For **week 21** of the current influenza season:

- ***3.3%*** *of all deaths that occurred in Hawaii during week 21 were related to pneumonia, influenza or COVID-19 (PIC)*[11]*. For the current season (season to date:* ***7.0%****), there have been 8,408 deaths from any cause, 587 of which were due to PIC*[12]*.*
- *The PIC rate was lower than the historical baseline in Hawaii*[13] *(i.e., outside the 95% confidence interval). The Hawaii PIC rate was comparable to the CDC's National Center for Health Statistics (NCHS) PIC mortality*[14] ***(5.4%)*** *(i.e., inside the 95% confidence interval) and lower than the national epidemic threshold (****6.3****%) (i.e., outside the 95% confidence interval) for week 21.*



[11] The percent of deaths due to PIC displayed on the graph is the 3-week moving averages.

[12] PIC data reflect 100% of the data reported for the MMWR week. Changes to data are expected when PIC data reaches 100% completion.

[13] The Hawaii historical baseline (%PIC) is the average of 3-week moving averages over the preceding 10 flu seasons of historical data (2014-2015, 2015-2016, 2016-2017, 2017-2018, 2018-2019, 2019-2020, 2020-2021, 2021-2022, 2022-2023, and 2023-2024).

[14] Each week, the vital statistics offices of 122 cities across the United States report the total number of death certificates processed and the number of those for which pneumonia, influenza, or COVID-19 was listed as the underlying or contributing cause of death by age group (Under 28 days, 28 days–1 year, 1–14 years, 15–24 years, 25–44 years, 45–64 years, 65–74 years, 75–84 years, and ≥85 years). The COVID-19 death counts reported by NCHS are provisional and will not match counts in other sources, such as media reports or numbers from health departments. COVID-19 deaths may be classified or defined differently in various reporting and surveillance systems. The percentage of deaths due to pneumonia, influenza, and COVID-19 (PIC) are compared with a seasonal baseline and epidemic threshold value calculated for each week.

INFLUENZA-ASSOCIATED PEDIATRIC DEATHS[15]:

- No new influenza-associated pediatric death was reported to Hawaii. There have been zero influenza-associated pediatric deaths reported in Hawaii during the 2025–2026 season.
- Nationally, five new influenza-associated pediatric deaths were reported to CDC during week 21. (2025-2026 season total: 179).

IV. INFLUENZA WATCH: As part of a comprehensive influenza surveillance system and to prevent the spread of contagious respiratory diseases in humans, it is important to monitor all circulating influenza types. Several animal-origin influenza A subtypes are currently of interest: influenza A variant virus (H3N2v, H1N2v, and H1N1v) and Avian flu (H5N1 and H7N9). These types of influenza viruses may cause zoonotic (animal-associated) disease and are a public health concern.

A. VARIANT VIRUSES:

Influenza viruses that normally circulate in pigs are called "variant" viruses when they are found in people. These viruses were first identified in U.S. pigs in 2010. In 2011, 12 cases of H3N2v infection were detected in the United States. In 2012, 309 such cases (resulting in 16 hospitalizations and one death) across 12 states were detected, including one Hawaii case who recovered. Illness associated with H3N2v infection has been mostly mild with symptoms similar to those of seasonal flu. However, serious illness, resulting in hospitalization and death, has occurred in some cases. Most of these infections have been associated with prolonged exposure to pigs at agricultural fairs or similar settings. Limited human-to-human spread of this virus has been detected in the past, but no sustained community spread of H3N2v has been identified. More information regarding H3N2v, H1N1v, and H1N2v viruses may be found on the CDC website (*here*) and (*here*).

- *No variant or novel influenza infections have been reported to HDOH during the 2025-2026 influenza season.*
- *One new human infection with novel influenza A virus, H1N1v (0), H3N2v (0), and H1N2v (1), have been reported during the 2025-2026 influenza season.*
    - *One new human infection with influenza A(H1N1v) virus has been reported to WHO from China during the 2025-2026 influenza season.*

AVIAN (OR BIRD) INFLUENZA: These types of influenza viruses cause zoonotic (animal-associated) disease of public health concern and are therefore monitored globally by the WHO. Most avian influenza viruses do not cause disease in humans and are generally not easily transmissible between person to person, but a few subtypes may cross the species barrier and cause disease in humans. Avian influenza viruses may be of various subtypes, including H5N1, H5N2, H5N8, H7N3, H7N7, H7N8, H7N9, and H9N2. On January 15th, 2016, the USDA and APHIS reported detection of HPAI H7N8 in a commercial turkey flock in Indiana. There have been no associated human infections. This is the first detection of HPAI H7N8 in wild bird surveillance in the United States. More information, the risk assessment and recommendations for HPAI H7N8 can be found (here). The WHO, CDC, and other public health agencies have also been monitoring influenza H7N9, which represents a public health concern because of its high pandemic potential. Although H7N9 has not been detected in the United States, it remains a global concern given continuing epidemics in endemic countries. Since 2013, a total of 1,568 laboratory-confirmed cases of human infection with H7N9 viruses, including at least 613 deaths, have been reported to WHO. More information on H7N9 virus infections can be found (here). For more information regarding avian influenza, please visit the CDC (*here*) or the WHO (*here*) websites. WHO reports total number of cases and deaths related to laboratory-confirmed avian influenza viruses and posts current avian influenza case counts (*here*), which were last updated on **January 22, 2026**.

[15] Influenza-associated deaths are considered pediatric in persons aged less than 18 years. It was made a nationally notifiable condition in October, 2004. All pediatric influenza-associated deaths are laboratory confirmed.

V. INFLUENZA Vaccine: Annual influenza vaccination is recommended for all persons aged 6 months and older and is the most effective way to reduce the risk of getting sick with seasonal flu and spreading it to others. Influenza vaccination can reduce illnesses, visits to the doctor, influenza-related hospitalizations, and missed work and school days. Influenza vaccines become available by the end of October. It takes at least two weeks after vaccination to confer immunity against influenza virus infection. More information regarding influenza vaccination can be found (*here*).

A. Composition of the 2025–2026 Influenza Vaccine**:**

The composition of the 2025–2026 influenza vaccine has been updated to better match circulating influenza viruses. The Advisory Committee on Immunization Practices (ACIP) has recommended that the 2025-2026 influenza trivalent vaccine contain an influenza A/Victoria/4897/2022 (H1N1) pdm09-like virus, influenza A/Croatia/10136RV/2023 (H3N2)-like virus, and influenza B/Austria/1359417/2021 (B/Victoria lineage)-like virus. United States cell culture–based inactivated (ccIIV4) and recombinant (RIV4) influenza vaccines will contain HA derived from an influenza A/Wisconsin/67/2022 (H1N1) pdm09-like virus, an A/District of Columbia/27/2023 (H3N2)-like virus, an influenza B/Austria/1359417/2021 (B/Victoria lineage)-like virus. These vaccine recommendations were based on several factors, including global influenza virologic and epidemiologic surveillance, genetic and antigenic characterization, human serology studies, antiviral susceptibility, and the availability of candidate influenza viruses.

APPENDIX 1: ADDITIONAL INFORMATION

For more information regarding local and national influenza surveillance programs, visit the following sites.

Centers for Disease Control and Prevention	General Influenza National ILI and P&I Data Vaccine Virus Selection CDC Web Tool for Respiratory Viruses
Flu.gov	General Influenza Information
HDOH Flu and Pneumonia	General Influenza Surveillance Avian Influenza Respiratory Virus Dashboard To find out more information or join the sentinel physician program, email the Influenza Surveillance Coordinator
World Health Organization	General Global and Local Influenza Avian Influenza

APPENDIX 2: MMWR WEEK DATES

Please refer to the table below to interpret data presented by MMWR week. Week 40 is considered the traditional start for the flu season for the Northern Hemisphere.

MMWR WEEK	2022	2023	2024	2025	2026
1	1/8/2022	1/7/2023	1/6/2024	1/4/2025	1/10/2026
2	1/15/2022	1/14/2023	1/13/2024	1/11/2025	1/17/2026
3	1/22/2022	1/21/2023	1/20/2024	1/18/2025	1/24/2026
4	1/29/2022	1/28/2023	1/27/2024	1/25/2025	1/31/2026
5	2/5/2022	2/4/2023	2/3/2024	2/1/2025	2/7/2026
6	2/12/2022	2/11/2023	2/10/2024	2/8/2025	2/14/2026
7	2/19/2022	2/18/2023	2/17/2024	2/15/2025	2/21/2026
8	2/26/2022	2/25/2023	2/24/2024	2/22/2025	2/28/2026
9	3/5/2022	3/4/2023	3/2/2024	3/1/2025	3/7/2026
10	3/12/2022	3/11/2023	3/9/2024	3/8/2025	3/14/2026
11	3/19/2022	3/18/2023	3/16/2024	3/15/2025	3/21/2026
12	3/26/2022	3/25/2023	3/23/2024	3/22/2025	3/28/2026
13	4/2/2022	4/1/2023	3/30/2024	3/29/2025	4/4/2026
14	4/9/2022	4/8/2023	4/6/2024	4/5/2025	4/11/2026
15	4/16/2022	4/15/2023	4/13/2024	4/12/2025	4/18/2026
16	4/23/2022	4/22/2023	4/20/2024	4/19/2025	4/25/2026
17	4/30/2022	4/29/2023	4/27/2024	4/26/2025	5/2/2026
18	5/7/2022	5/6/2023	5/4/2024	5/3/2025	5/9/2026
19	5/14/2022	5/13/2023	5/11/2024	5/10/2025	5/16/2026
20	5/21/2022	5/20/2023	5/18/2024	5/17/2025	5/23/2026
21	5/28/2022	5/27/2023	5/25/2024	5/24/2025	5/30/2026
22	6/4/2022	6/3/2023	6/1/2024	5/31/2025	6/6/2026
23	6/11/2022	6/10/2023	6/8/2024	6/7/2025	6/13/2026
24	6/18/2022	6/17/2023	6/15/2024	6/14/2025	6/20/2026
25	6/25/2022	6/24/2023	6/22/2024	6/21/2025	6/27/2026
26	7/2/2022	7/1/2023	6/29/2024	6/28/2025	7/4/2026
27	7/9/2022	7/8/2023	7/6/2024	7/5/2025	7/11/2026
28	7/16/2022	7/15/2023	7/13/2024	7/12/2025	7/18/2026
29	7/23/2022	7/22/2023	7/20/2024	7/19/2025	7/25/2026
30	7/30/2022	7/29/2023	7/27/2024	7/26/2025	8/1/2026
31	8/6/2022	8/5/2023	8/3/2024	8/2/2025	8/8/2026
32	8/13/2022	8/12/2023	8/10/2024	8/9/2025	8/15/2026
33	8/20/2022	8/19/2023	8/17/2024	8/16/2025	8/22/2026
34	8/27/2022	8/26/2023	8/24/2024	8/23/2025	8/29/2026
35	9/3/2022	9/2/2023	8/31/2024	8/30/2025	9/5/2026
36	9/10/2022	9/9/2023	9/7/2024	9/6/2025	9/12/2026
37	9/17/2022	9/16/2023	9/14/2024	9/13/2025	9/19/2026
38	9/24/2022	9/23/2023	9/21/2024	9/20/2025	9/26/2026
39	10/1/2022	9/30/2023	9/28/2024	9/27/2025	10/3/2026
40	10/8/2022	10/7/2023	10/5/2024	10/4/2025	10/10/2026
41	10/15/2022	10/14/2023	10/12/2024	10/11/2025	10/17/2026
42	10/22/2022	10/21/2023	10/19/2024	10/18/2025	10/24/2026
43	10/29/2022	10/28/2023	10/26/2024	10/25/2025	10/31/2026
44	11/5/2022	11/4/2023	11/2/2024	11/1/2025	11/7/2026
45	11/12/2022	11/11/2023	11/9/2024	11/8/2025	11/14/2026
46	11/19/2022	11/18/2023	11/16/2024	11/15/2025	11/21/2026
47	11/26/2022	11/25/2023	11/23/2024	11/22/2025	11/28/2026
48	12/3/2022	12/2/2023	11/30/2024	11/29/2025	12/5/2026
49	12/10/2022	12/9/2023	12/7/2024	12/6/2025	12/12/2026
50	12/17/2022	12/16/2023	12/14/2024	12/13/2025	12/19/2026
51	12/24/2022	12/23/2023	12/21/2024	12/20/2025	12/26/2026
52	12/31/2022	12/30/2023	12/28/2024	12/27/2025	
53				01/03/2026	

HAWAII STATE DEPARTMENT OF HEALTH
DISEASE OUTBREAK CONTROL DIVISION

Influenza/Respiratory Disease Surveillance Report

Morbidity and Mortality Weekly Report (MMWR)[1]

WEEK 22: MAY 31, 2026– JUNE 6, 2026

OVERVIEW: The Hawaii State Department of Health (HDOH) monitors influenza and other respiratory pathogens, including COVID-19, throughout the state of Hawaii. Influenza surveillance in the state of Hawaii relies upon selected sentinel health practitioners, the State Laboratories Division (SLD), private laboratories, and the Office of Health Status Monitoring (OHSM). For detailed information concerning influenza, please visit the HD OH Disease Outbreak Control Division (HDOH DOCD) website (*here*). **All data and information are conditional and may change as more reports are received.** The data in this report reflects the 2025-2026 influenza season which began the week ending October 4, 2025 (week 40[1] 2025) and will end the week ending on October 3, 2026 (week 39 2026).

REPORT SNAPSHOT FOR WEEK 22

Surveillance for Influenza-like Illness (ILI)		
Metric	*Value*	*Comment*
Outpatient visits related to influenza-like illness (ILI) from ILINet Sentinel Providers	2.5%	Lower than the previous week. Comparable to Hawaii's historical baseline and lower than the national baseline, and higher than the national ILI rate.
Number of ILI clusters reported to HDOH	1	There have been 32 clusters this season.

Laboratory Surveillance		
Percent of all respiratory specimens positive for influenza this week	8.8%	Lower than the previous week. This number means that many, if not all, of the 91.2% who tested negative for influenza had illness from another respiratory etiology.
Percent of all respiratory specimens positive for influenza this season to date	17.1%	

Surveillance for Severe Outcomes		
Pneumonia, influenza and COVID-20 (PIC) mortality rate	7.5%	Comparable to Hawaii's historical baseline, comparable to the national epidemic threshold and comparable to the NCHS average.
Number of influenza-associated pediatric deaths reported nationwide	179	0 influenza-associated pediatric deaths have been reported from Hawaii this season to date.

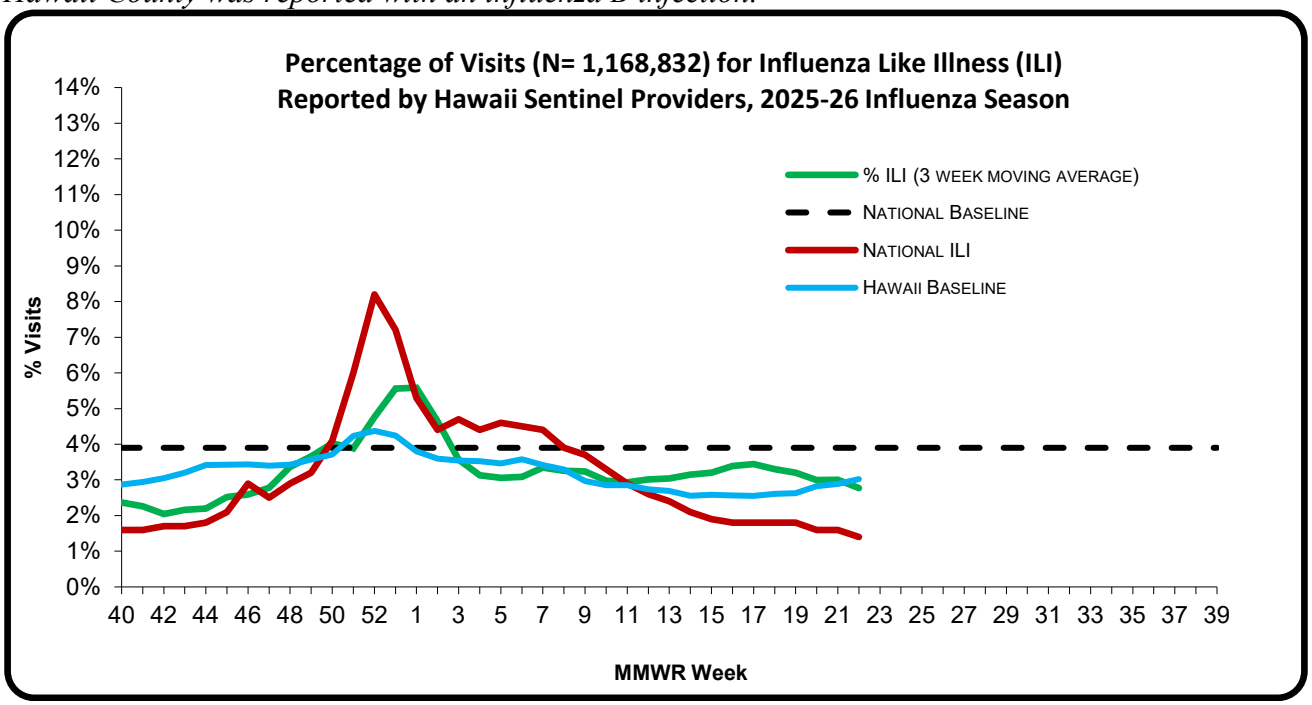
[1] MMWR stands for "Morbidity and Mortality Weekly Report," conventionally used by the Centers for Disease Control and Prevention (CDC). The weeks of a flu season are often referred to by their respective MMWR week. **See appendix 2 for interpretation of MMWR weeks.** Data reported will begin on week 40, the traditional start date of flu season.

INFLUENZA SURVEILLANCE

I. INFLUENZA-LIKE ILLNESS (ILI): HDOH collaborates with recruited doctors and healthcare providers who report the total number of outpatient visits for ILI as well as the total number of patients who complained of symptoms consistent with ILI. A patient with ILI must have the following: a fever (temperature of 100°F [37.8°C] or greater) AND a cough and/or a sore throat. ILI is based on reported symptoms and not laboratory confirmed tests; thus, ILI may represent other respiratory pathogens and not solely influenza. Further, sentinel providers report these numbers on a weekly basis; therefore, data are preliminary and may change depending on additional reporting. In combination with laboratory testing and other surveillance systems, ILI surveillance helps monitor influenza and other respiratory pathogen activity. For more information concerning ILINet and sentinel requirements, please visit the CDC website (*here*).

For **week 22** of the current influenza season:

- ***2.5%** (season to date: **3.2%**) of the outpatient visits recorded by Hawaii sentinel providers were for ILI.*
- *ILI visits were comparable to the historical baseline in Hawaii[2,3] (i.e., inside the 95% confidence interval).*
- *Hawaii's ILI outpatient visits were lower than the national baseline (**3.9%**)[4] (i.e., outside the 95% confidence interval) and higher than the national ILI rate (**1.4%**) (i.e. outside the 95% confidence interval).*
- *ILI activity level: Low[5]*
- *Geographic Spread: Sporadic Activity[6].*
- *ILI Cluster Activity: There is one new cluster that was reported to HDOH during week 22. A long-term care in Hawaii County was reported with an influenza B infection.*



[2] The Hawaii historical baseline (%ILI) is the average of 3-week moving averages over the preceding 3 flu seasons of historical data (2022-2023, 2023-2024 and 2024-2025).
[3] This value is based upon comparison of actual outpatient ILI with the historical baseline, which only captures outpatient ILI. The chart above represents a 3-week moving average and not the actual ILI by week.
[4] The National Baseline is calculated by CDC as the mean percentage of visits for ILI during weeks 21–39 with two standard deviations. Because of large variability in regional ILI, comparison of the national baseline with local ILI may not be appropriate. It is provided in this report because no meaningful regional baselines are available for comparison. The national baseline combines all data reported by states to CDC, including ILI in outpatient, ER, urgent care, and inpatient settings.
[5] There are 10 activity levels classified as minimal (levels 1-3), low (levels 4-5), moderate (levels 6-7), and high (levels 8-10).
[6] The influenza activity reported by state and territorial epidemiologists indicates geographic spread of influenza viruses but does not measure the severity of influenza activity. Sporadic: no clusters reported to HDOH, Local: one or more clusters reported in one county, Regional: clusters reported two to three counties, Widespread: clusters reported in all counties. Hawaii does not report No Activity, as flu circulates year-round in Hawaii.

II. LABORATORY SURVEILLANCE: State Laboratories Division (SLD; the HDOH public health laboratory) and Hawaii's major private laboratories (DLS, CLH) report results of RT-PCR, which can be considered confirmatory (SLD may perform viral culture on select specimens). Specimens meeting priority criteria[7] are forwarded to SLD for sub-typing. Additionally, specimens meeting case definition from requesting sentinel providers are sent directly to SLD for sub-typing. Due to resource constraints, not all submitted specimens undergo sub-typing. Sub-typing at the commercial laboratories is only conducted on a case-by-case basis. The majority of specimens testing positive by rapid antigen testing or RT-PCR at the commercial laboratories do not meet criteria and are not subtyped. For more information on influenza tests and types, please visit the CDC website (*here*).

A. INFLUENZA:

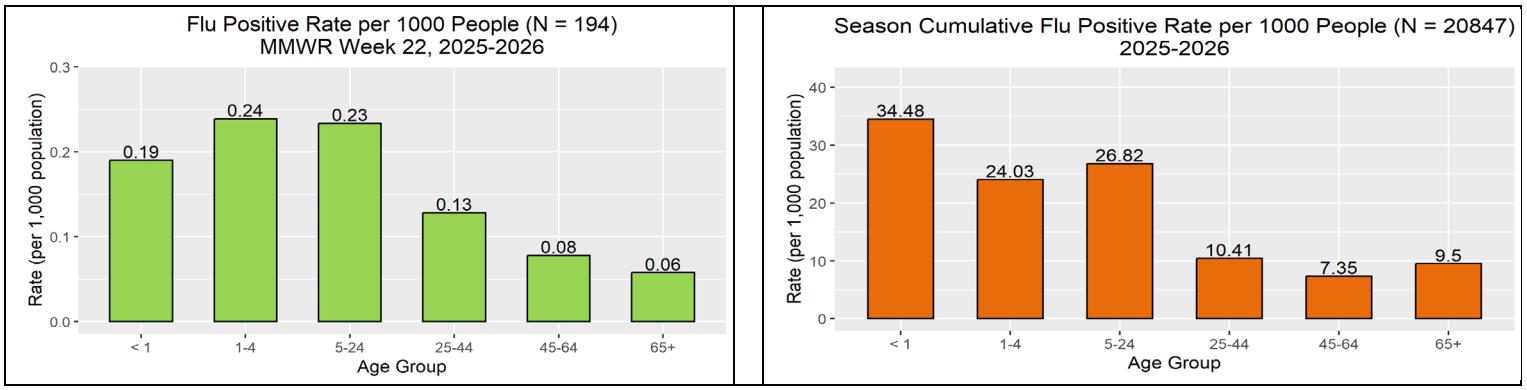
- The following reflects laboratory findings for week 22 of the 2025–26 influenza season:
  - *A total of **2,206** specimens has been tested statewide for influenza viruses (positive: 194 [**8.8%**]). (Season to date: **122,122** tested (**17.1%** positive)*
    - *647 (29.3%) were screened only by rapid antigen tests with no confirmatory testing.*
    - *1,559 (70.7%) underwent confirmatory testing (either RT-PCR or viral culture).*
    - *2,012 (91.2%) were negative.*
  - *Routine surveillance samples from State Laboratory Division were tested at a public health laboratory and identified as Influenza A (H3N2) subclade K.*

Influenza type	*Current week 22 (%)**	*Season to date (%)*[8]
Influenza A (H1)[9]	*5 (2.6)*	*230 (1.1)*
Influenza A (H3)	*1 (0.5)*	*1,347 (6.5)*
Influenza A no subtyping	*28 (14.4)*	*12,774 (61.3)*
Influenza B (Yamagata)	*0 (0.0)*	*0 (0.0)*
Influenza B (Victoria)	*0 (0.0)*	*0 (0.0)*
Influenza B no genotyping	*160 (82.5)*	*6,491 (31.1)*

**Specimens that are positive for both A and B (coinfections) are counted in both A and B totals for current and season to date*

1. AGE DISTRIBUTION

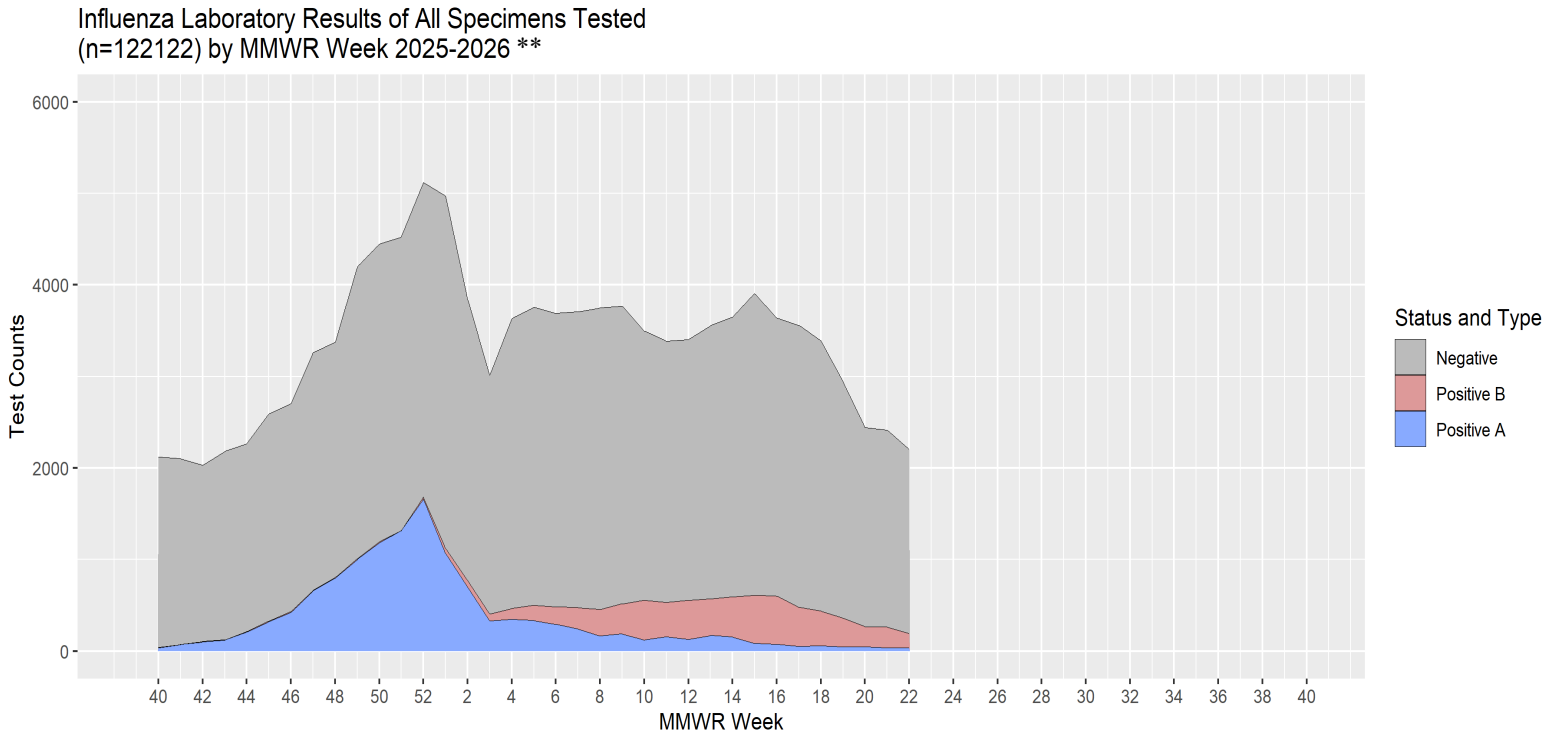
The charts below indicate the population-based rates of positive influenza cases in Hawaii by age group during the 2025–26 influenza season.[10]

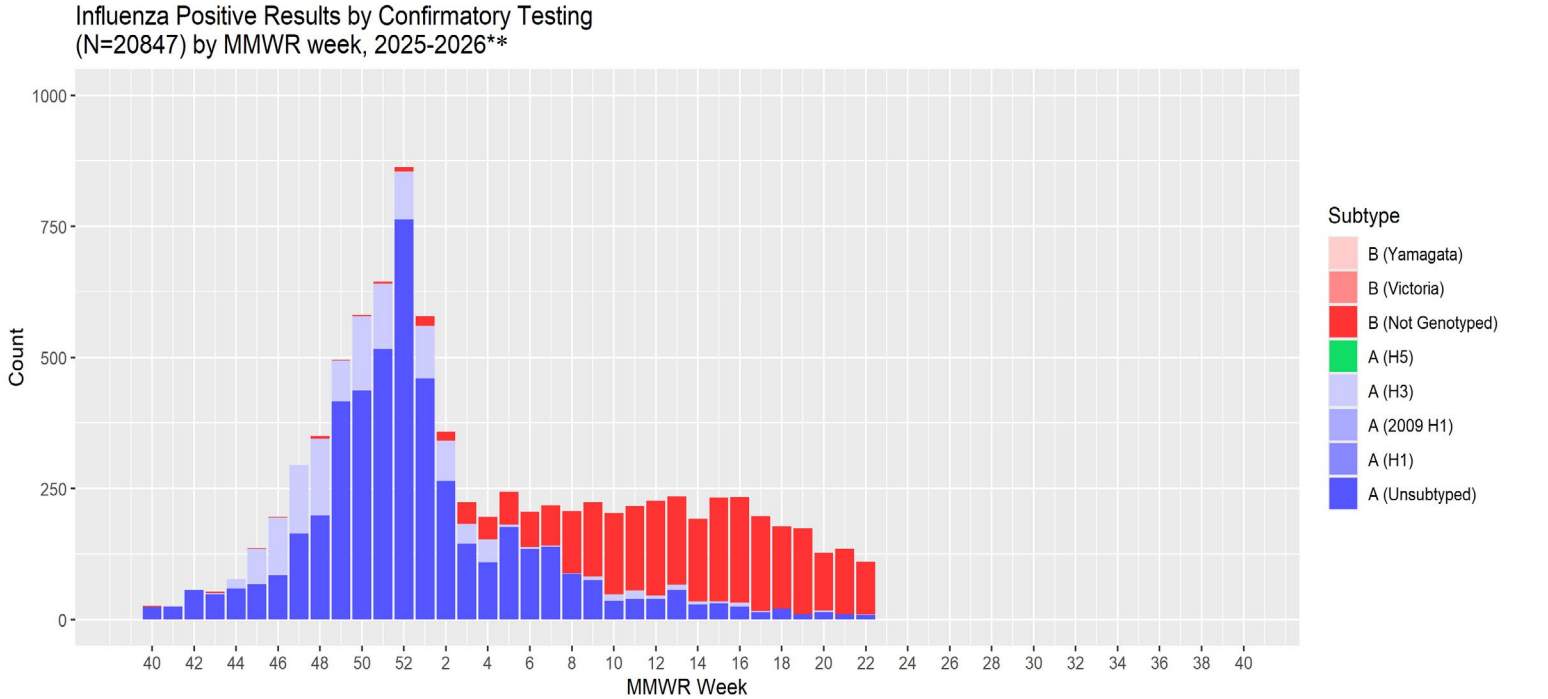


[7] Priority criteria include: hospitalized patients with acute respiratory distress syndrome [ARDS] or x-ray confirmed pneumonia; travelers with international travel history within 10 days of onset; specimens submitted by sentinel providers; specimens collected from healthcare workers, pregnant women, or women up to 6 weeks' post-partum; those with underlying medical conditions; and patients presenting with unusual or severe manifestations of influenza infection.
[8] Influenza coding was updated to reflect a more accurate count.
[9] All influenza A H1 viruses detected this season have been 2009 H1N1.
[10] This represents an estimate of population-based rates based on available data.

2. LABORATORY TESTING

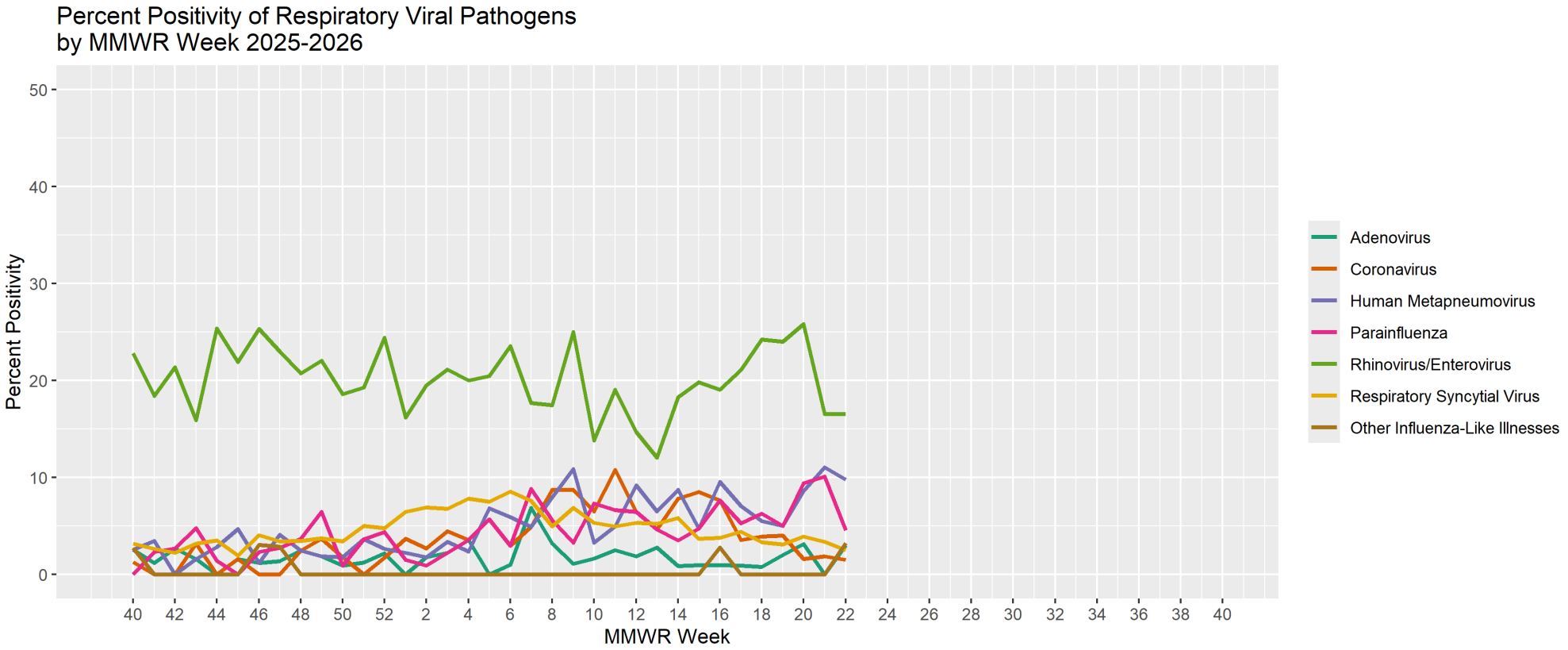
The charts below show the laboratory results of all specimens tested for influenza by MMWR week during the 2025–2026 influenza season as well as the type and subtype of positive results for influenza. Again, sub-typing is only performed on selected specimens tested by confirmatory tests (i.e., RT-PCR or viral culture).





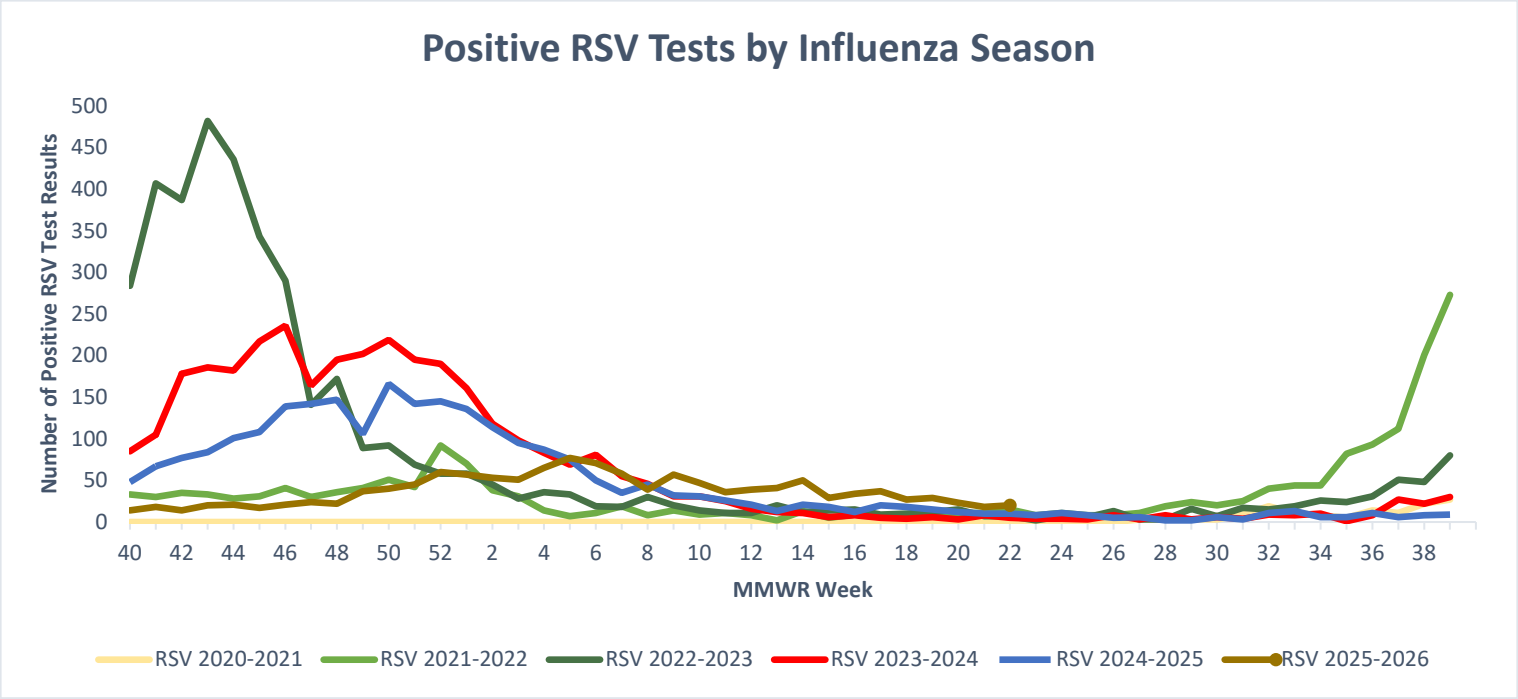
** A total of 68,221specimens underwent confirmatory testing, but not all positive influenza specimens receive confirmatory testing that are circulating in Hawaii.*
*** For MMWR Week 53, results are reported under MMWR Week 52, where the average of Weeks 52 and 53 was calculated.*

B. **OTHER RESPIRATORY PATHOGENS:** The major clinical and commercial laboratories throughout the state of Hawaii have the testing capacity for non-influenza respiratory pathogens and report these to HDOH. However, such testing is performed as needed and when sufficient resources are available because of the high costs associated with respiratory panel tests. **Therefore, available data represents only the presence of circulating pathogens and cannot be used to determine specific trends**.

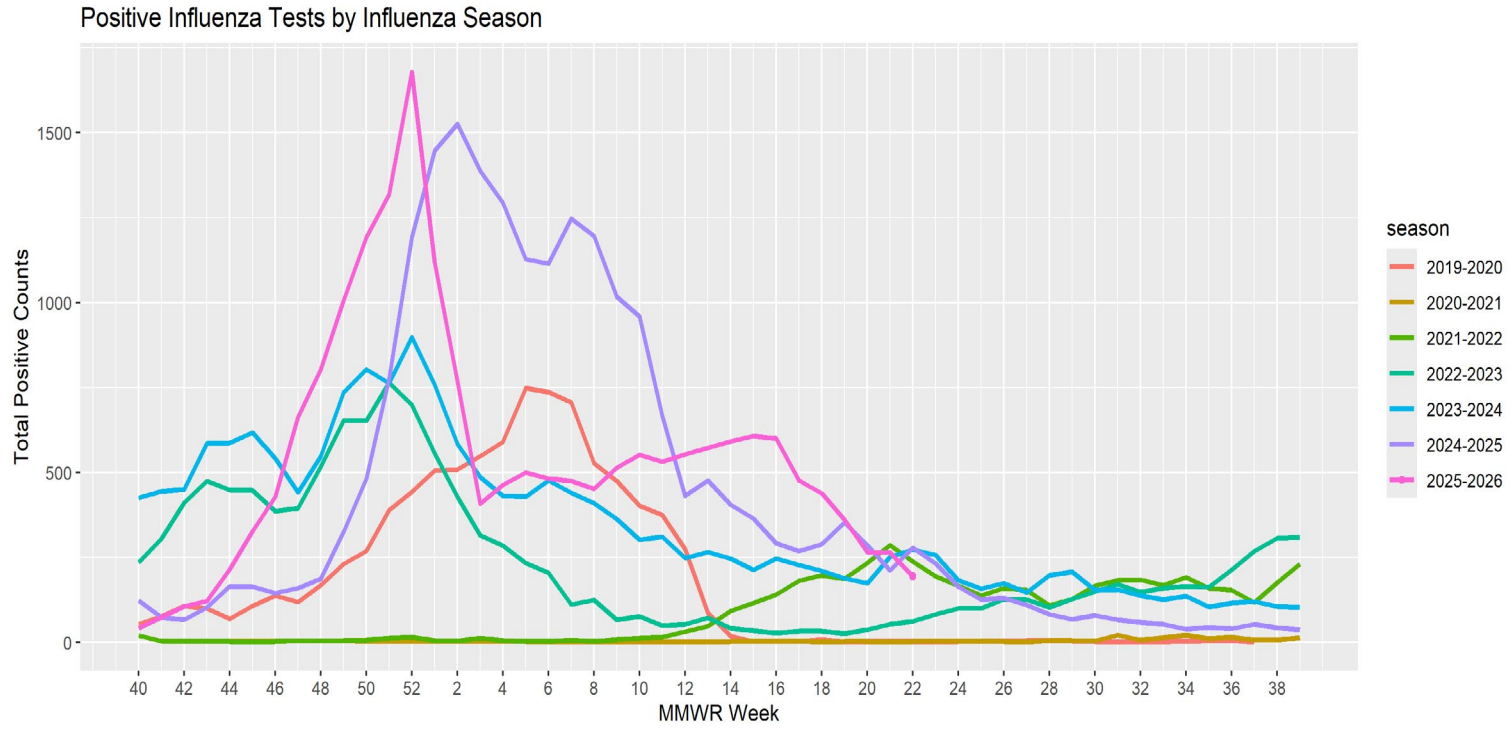


* *The coronavirus presented on this table does not indicate Severe Acute Respiratory Coronavirus-2 (i.e., COVID-19). For MMWR Week 53, results are reported under MMWR Week 52, where the average of Weeks 52 and 53 was calculated*

RESPIRATORY SYNCYTIAL VIRUS (RSV) POSITIVE TEST RESULTS BY INFLUENZA SEASON: RSV case appears to have increased later than past seasons in the 2025-2026 season. For MMWR Week 53, results are reported under MMWR Week 52, where the average of Weeks 52 and 53 was calculated.



INFLUENZA POSITIVE TEST RESULTS BY INFLUENZA SEASON: Influenza cases appear to have increased earlier than past seasons in the 2025-2026 season. For MMWR Week 53, results are reported under MMWR Week 52, where the average of Weeks 52 and 53 was calculated.



C. COVID-19 SENTINEL SURVEILLANCE: Due to the low volume of samples currently available through the influenza surveillance system, the COVID-19 sentinel surveillance data may not be accurately portraying COVID-19 activity in our communities. Reporting of the COVID-19 Sentinel Surveillance data will be paused while HODH re-evaluates the program to ensure that the reported data are accurate and representative.

HDOH is continuing to monitor COVID-19 activity throughout the state. To learn more, please visit the Hawaii's COVID-19 data website (*here*). For more information on surveillance of COVID-19 activity in the United States please visit the CDC COVIDView website (*here*).

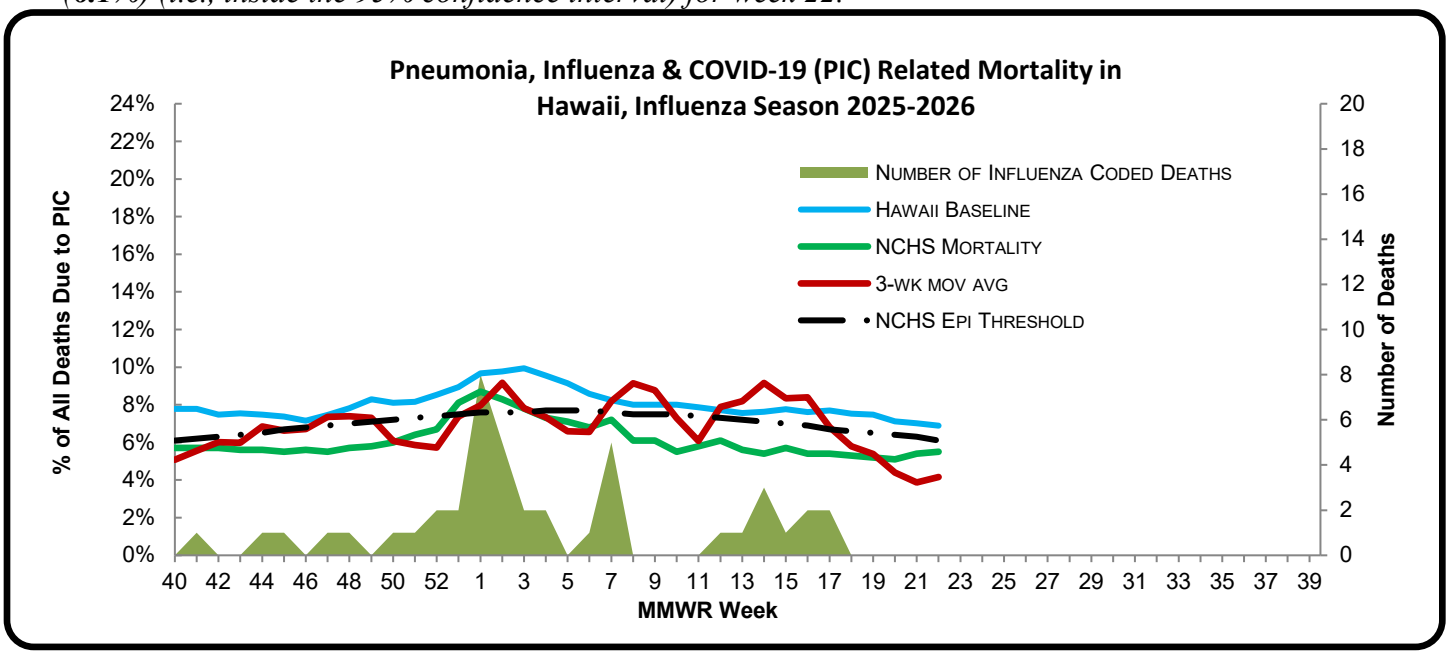
III. PNEUMONIA, INFLUENZA, AND COVID-19 (PIC) RELATED MORTALITY:

P&I mortality surveillance is collected by CDC through the National Center for Health Statistics (NCHS) using death certificate data. Each week the HDOH OHSM reports specific data from Honolulu to the CDC. CDC collects the following information by age group: the total number of deaths, total deaths from pneumonia, and total deaths related to influenza. Due to the ongoing COVID-19 pandemic, CDC included total deaths from COVID-19 by age group to the death data. Previous studies had suggested that P&I is a good indicator of influenza-related deaths; however, data has shown that pneumonia deaths associated with influenza is now being impacted by COVID-19 related pneumonia. Due to this, CDC had added COVID-19 deaths into P&I to create the PIC (pneumonia, influenza, and/or COVID-19) classification.

To standardize Hawaii's influenza surveillance with CDC influenza surveillance guidelines, PIC deaths will be reported in lieu of P&I. Hawaii's baseline will begin to include PIC deaths starting from 2019-2020 flu season.

For **week 22** of the current influenza season:

- ***7.5%*** *of all deaths that occurred in Hawaii during week 22 were related to pneumonia, influenza or COVID-19 (PIC)*[11]*. For the current season (season to date:* ***7.0%****), there have been 8,501 deaths from any cause, 594 of which were due to PIC*[12]*.*
- *The PIC rate was comparable to the historical baseline in Hawaii*[13] *(i.e., inside the 95% confidence interval). The Hawaii PIC rate was comparable to the CDC's National Center for Health Statistics (NCHS) PIC mortality*[14] ***(5.5%)*** *(i.e., inside the 95% confidence interval) and comparable to the national epidemic threshold (****6.1****%) (i.e., inside the 95% confidence interval) for week 22.*



[11] The percent of deaths due to PIC displayed on the graph is the 3-week moving averages.

[12] PIC data reflect 100% of the data reported for the MMWR week. Changes to data are expected when PIC data reaches 100% completion.

[13] The Hawaii historical baseline (%PIC) is the average of 3-week moving averages over the preceding 10 flu seasons of historical data (2014-2015, 2015-2016, 2016-2017, 2017-2018, 2018-2019, 2019-2020, 2020-2021, 2021-2022, 2022-2023, and 2023-2024).

[14] Each week, the vital statistics offices of 122 cities across the United States report the total number of death certificates processed and the number of those for which pneumonia, influenza, or COVID-19 was listed as the underlying or contributing cause of death by age group (Under 28 days, 28 days–1 year, 1–14 years, 15–24 years, 25–44 years, 45–64 years, 65–74 years, 75–84 years, and ≥85 years). The COVID-19 death counts reported by NCHS are provisional and will not match counts in other sources, such as media reports or numbers from health departments. COVID-19 deaths may be classified or defined differently in various reporting and surveillance systems. The percentage of deaths due to pneumonia, influenza, and COVID-19 (PIC) are compared with a seasonal baseline and epidemic threshold value calculated for each week.

INFLUENZA-ASSOCIATED PEDIATRIC DEATHS[15]:

- No new influenza-associated pediatric death was reported to Hawaii. There have been zero influenza-associated pediatric deaths reported in Hawaii during the 2025–2026 season.
- Nationally, no new influenza-associated pediatric deaths were reported to CDC during week 22. (2025-2026 season total: 179).

IV. INFLUENZA WATCH: As part of a comprehensive influenza surveillance system and to prevent the spread of contagious respiratory diseases in humans, it is important to monitor all circulating influenza types. Several animal-origin influenza A subtypes are currently of interest: influenza A variant virus (H3N2v, H1N2v, and H1N1v) and Avian flu (H5N1 and H7N9). These types of influenza viruses may cause zoonotic (animal-associated) disease and are a public health concern.

A. VARIANT VIRUSES:

Influenza viruses that normally circulate in pigs are called "variant" viruses when they are found in people. These viruses were first identified in U.S. pigs in 2010. In 2011, 12 cases of H3N2v infection were detected in the United States. In 2012, 309 such cases (resulting in 16 hospitalizations and one death) across 12 states were detected, including one Hawaii case who recovered. Illness associated with H3N2v infection has been mostly mild with symptoms similar to those of seasonal flu. However, serious illness, resulting in hospitalization and death, has occurred in some cases. Most of these infections have been associated with prolonged exposure to pigs at agricultural fairs or similar settings. Limited human-to-human spread of this virus has been detected in the past, but no sustained community spread of H3N2v has been identified. More information regarding H3N2v, H1N1v, and H1N2v viruses may be found on the CDC website (*here*) and (*here*).

- *No variant or novel influenza infections have been reported to HDOH during the 2025-2026 influenza season.*
- *One new human infection with novel influenza A virus, H1N1v (0), H3N2v (0), and H1N2v (1), have been reported during the 2025-2026 influenza season.*
    - *One new human infection with influenza A(H1N1v) virus has been reported to WHO from China during the 2025-2026 influenza season.*

AVIAN (OR BIRD) INFLUENZA: These types of influenza viruses cause zoonotic (animal-associated) disease of public health concern and are therefore monitored globally by the WHO. Most avian influenza viruses do not cause disease in humans and are generally not easily transmissible between person to person, but a few subtypes may cross the species barrier and cause disease in humans. Avian influenza viruses may be of various subtypes, including H5N1, H5N2, H5N8, H7N3, H7N7, H7N8, H7N9, and H9N2. On January 15th, 2016, the USDA and APHIS reported detection of HPAI H7N8 in a commercial turkey flock in Indiana. There have been no associated human infections. This is the first detection of HPAI H7N8 in wild bird surveillance in the United States. More information, the risk assessment and recommendations for HPAI H7N8 can be found (here). The WHO, CDC, and other public health agencies have also been monitoring influenza H7N9, which represents a public health concern because of its high pandemic potential. Although H7N9 has not been detected in the United States, it remains a global concern given continuing epidemics in endemic countries. Since 2013, a total of 1,568 laboratory-confirmed cases of human infection with H7N9 viruses, including at least 613 deaths, have been reported to WHO. More information on H7N9 virus infections can be found (here). For more information regarding avian influenza, please visit the CDC (*here*) or the WHO (*here*) websites. WHO reports total number of cases and deaths related to laboratory-confirmed avian influenza viruses and posts current avian influenza case counts (*here*), which were last updated on **January 22, 2026**.

[15] Influenza-associated deaths are considered pediatric in persons aged less than 18 years. It was made a nationally notifiable condition in October, 2004. All pediatric influenza-associated deaths are laboratory confirmed.

V. INFLUENZA Vaccine: Annual influenza vaccination is recommended for all persons aged 6 months and older and is the most effective way to reduce the risk of getting sick with seasonal flu and spreading it to others. Influenza vaccination can reduce illnesses, visits to the doctor, influenza-related hospitalizations, and missed work and school days. Influenza vaccines become available by the end of October. It takes at least two weeks after vaccination to confer immunity against influenza virus infection. More information regarding influenza vaccination can be found (*here*).

A. Composition of the 2025–2026 Influenza Vaccine**:**

The composition of the 2025–2026 influenza vaccine has been updated to better match circulating influenza viruses. The Advisory Committee on Immunization Practices (ACIP) has recommended that the 2025-2026 influenza trivalent vaccine contain an influenza A/Victoria/4897/2022 (H1N1) pdm09-like virus, influenza A/Croatia/10136RV/2023 (H3N2)-like virus, and influenza B/Austria/1359417/2021 (B/Victoria lineage)-like virus. United States cell culture–based inactivated (ccIIV4) and recombinant (RIV4) influenza vaccines will contain HA derived from an influenza A/Wisconsin/67/2022 (H1N1) pdm09-like virus, an A/District of Columbia/27/2023 (H3N2)-like virus, an influenza B/Austria/1359417/2021 (B/Victoria lineage)-like virus. These vaccine recommendations were based on several factors, including global influenza virologic and epidemiologic surveillance, genetic and antigenic characterization, human serology studies, antiviral susceptibility, and the availability of candidate influenza viruses.

APPENDIX 1: ADDITIONAL INFORMATION

For more information regarding local and national influenza surveillance programs, visit the following sites.

Centers for Disease Control and Prevention	General Influenza National ILI and P&I Data Vaccine Virus Selection CDC Web Tool for Respiratory Viruses
Flu.gov	General Influenza Information
HDOH Flu and Pneumonia	General Influenza Surveillance Avian Influenza Respiratory Virus Dashboard To find out more information or join the sentinel physician program, email the Influenza Surveillance Coordinator
World Health Organization	General Global and Local Influenza Avian Influenza

APPENDIX 2: MMWR WEEK DATES

Please refer to the table below to interpret data presented by MMWR week. Week 40 is considered the traditional start for the flu season for the Northern Hemisphere.

MMWR WEEK	2022	2023	2024	2025	2026
1	1/8/2022	1/7/2023	1/6/2024	1/4/2025	1/10/2026
2	1/15/2022	1/14/2023	1/13/2024	1/11/2025	1/17/2026
3	1/22/2022	1/21/2023	1/20/2024	1/18/2025	1/24/2026
4	1/29/2022	1/28/2023	1/27/2024	1/25/2025	1/31/2026
5	2/5/2022	2/4/2023	2/3/2024	2/1/2025	2/7/2026
6	2/12/2022	2/11/2023	2/10/2024	2/8/2025	2/14/2026
7	2/19/2022	2/18/2023	2/17/2024	2/15/2025	2/21/2026
8	2/26/2022	2/25/2023	2/24/2024	2/22/2025	2/28/2026
9	3/5/2022	3/4/2023	3/2/2024	3/1/2025	3/7/2026
10	3/12/2022	3/11/2023	3/9/2024	3/8/2025	3/14/2026
11	3/19/2022	3/18/2023	3/16/2024	3/15/2025	3/21/2026
12	3/26/2022	3/25/2023	3/23/2024	3/22/2025	3/28/2026
13	4/2/2022	4/1/2023	3/30/2024	3/29/2025	4/4/2026
14	4/9/2022	4/8/2023	4/6/2024	4/5/2025	4/11/2026
15	4/16/2022	4/15/2023	4/13/2024	4/12/2025	4/18/2026
16	4/23/2022	4/22/2023	4/20/2024	4/19/2025	4/25/2026
17	4/30/2022	4/29/2023	4/27/2024	4/26/2025	5/2/2026
18	5/7/2022	5/6/2023	5/4/2024	5/3/2025	5/9/2026
19	5/14/2022	5/13/2023	5/11/2024	5/10/2025	5/16/2026
20	5/21/2022	5/20/2023	5/18/2024	5/17/2025	5/23/2026
21	5/28/2022	5/27/2023	5/25/2024	5/24/2025	5/30/2026
22	6/4/2022	6/3/2023	6/1/2024	5/31/2025	6/6/2026
23	6/11/2022	6/10/2023	6/8/2024	6/7/2025	6/13/2026
24	6/18/2022	6/17/2023	6/15/2024	6/14/2025	6/20/2026
25	6/25/2022	6/24/2023	6/22/2024	6/21/2025	6/27/2026
26	7/2/2022	7/1/2023	6/29/2024	6/28/2025	7/4/2026
27	7/9/2022	7/8/2023	7/6/2024	7/5/2025	7/11/2026
28	7/16/2022	7/15/2023	7/13/2024	7/12/2025	7/18/2026
29	7/23/2022	7/22/2023	7/20/2024	7/19/2025	7/25/2026
30	7/30/2022	7/29/2023	7/27/2024	7/26/2025	8/1/2026
31	8/6/2022	8/5/2023	8/3/2024	8/2/2025	8/8/2026
32	8/13/2022	8/12/2023	8/10/2024	8/9/2025	8/15/2026
33	8/20/2022	8/19/2023	8/17/2024	8/16/2025	8/22/2026
34	8/27/2022	8/26/2023	8/24/2024	8/23/2025	8/29/2026
35	9/3/2022	9/2/2023	8/31/2024	8/30/2025	9/5/2026
36	9/10/2022	9/9/2023	9/7/2024	9/6/2025	9/12/2026
37	9/17/2022	9/16/2023	9/14/2024	9/13/2025	9/19/2026
38	9/24/2022	9/23/2023	9/21/2024	9/20/2025	9/26/2026
39	10/1/2022	9/30/2023	9/28/2024	9/27/2025	10/3/2026
40	10/8/2022	10/7/2023	10/5/2024	10/4/2025	10/10/2026
41	10/15/2022	10/14/2023	10/12/2024	10/11/2025	10/17/2026
42	10/22/2022	10/21/2023	10/19/2024	10/18/2025	10/24/2026
43	10/29/2022	10/28/2023	10/26/2024	10/25/2025	10/31/2026
44	11/5/2022	11/4/2023	11/2/2024	11/1/2025	11/7/2026
45	11/12/2022	11/11/2023	11/9/2024	11/8/2025	11/14/2026
46	11/19/2022	11/18/2023	11/16/2024	11/15/2025	11/21/2026
47	11/26/2022	11/25/2023	11/23/2024	11/22/2025	11/28/2026
48	12/3/2022	12/2/2023	11/30/2024	11/29/2025	12/5/2026
49	12/10/2022	12/9/2023	12/7/2024	12/6/2025	12/12/2026
50	12/17/2022	12/16/2023	12/14/2024	12/13/2025	12/19/2026
51	12/24/2022	12/23/2023	12/21/2024	12/20/2025	12/26/2026
52	12/31/2022	12/30/2023	12/28/2024	12/27/2025	
53				01/03/2026	