Department of HEALTH & HUMAN SERVICES | Division of Public Health

Bureau of Infectious Disease Control
Infectious Disease Surveillance Section

# Weekly Surveillance Report for Influenza and Respiratory Syncytial Virus
# Week Ending December 13, 2025
# MMWR Week 50

The NH Department of Health and Human Services (DHHS) provides weekly influenza surveillance reports during the traditional influenza season, which starts at the beginning of October and continues through mid-May. The 2025–26 influenza season began on 9/28/2025.

## Summary for New Hampshire

| | Influenza-Like Illness (ILI) | Acute Respiratory Illness (ARI) | Pneumonia and Influenza-Like Illness (ILI) Related Deaths | Respiratory Specimens Submitted to the Laboratory | Flu Activity** |
|---|---|---|---|---|---|
| **Week 50** | 2.7% = Increase from previous week | 7.0% = increase from previous week | 6.6% (below threshold*) | 63 Total:<br>▪ 31 positive for A(H3)<br>▪ 5 positive for A(H1N1)pdm09<br>▪ 7 positive A/subtyping not completed<br>▪ 20 negative | Local |

**Epidemic threshold = 7.2%*

*** Flu Activity was characterized as Local for Week 50 and Widespread for Week 51 (ending 12/20/2025)*

## New Hampshire Surveillance

### Outpatient Illness Surveillance

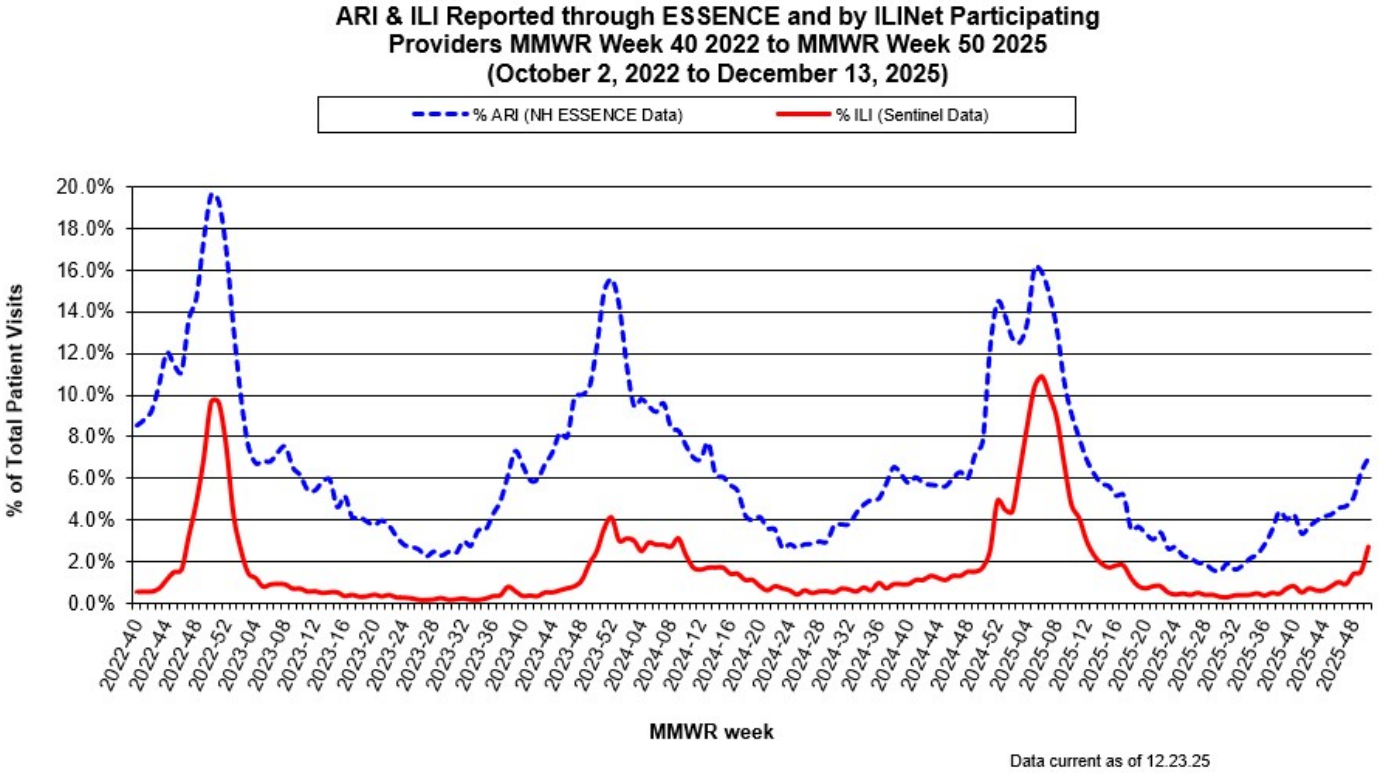
The two components of outpatient illness surveillance in New Hampshire are as follows:

1. **U.S. Outpatient Influenza-like Illness Surveillance Network (ILINet)**: Beginning in 1997, NH has participated in this collaborative effort between the Centers for Disease Control and Prevention, state and local health departments, and health care providers. For the 2025-26 influenza season, 22 NH health care providers are participating. Types of ILINet providers enrolled in NH during the current season include family practices, student health services, community health centers, and emergency departments. Participating providers report the proportion of patients who present with influenza-like illness (ILI) on a weekly basis. ILI is defined as 1) a fever and 2) cough and/or sore throat. Participating providers are also asked to collect respiratory specimens from select patients and submit them to the PHL for viral subtyping.
2. **New Hampshire Electronic Surveillance System for the Early Notification of Community-based Epidemics (ESSENCE)**: This surveillance system is a collaborative effort between NH acute care hospitals and NH DHHS. During Week 50, all 26 hospitals electronically transmitted data from emergency department encounters to NH DHHS. The system is queried each week for discharge diagnosis (DD) codes related to acute respiratory illnesses that are more likely to be attributable to viral infections, such as influenza, COVID-19, and respiratory syncytial virus (RSV). While ARI includes encounters that are due to each of these respiratory viruses, it also includes encounters for other DD codes such as acute bronchitis, acute pharyngitis (with fever), certain types of pneumonia, cough with fever, and other viral respiratory illnesses.

Because these two systems collect information using different methods and represent different patient populations, it is expected that the proportions of ILI and ARI seen in these systems will differ. However, the overall trend of activity is expected to be similar.

| | Patient Visits/Encounters | Reporting Providers/Hospitals | ILI | ARI | Change from Previous Week |
|---|---|---|---|---|---|
| ILINet | 224/8,186 | 21 | 2.7% | | Increase from 1.5% |
| ESSENCE | 661/9,514 | 21 | | 7.0% | Increase from 5.1% |

Maps illustrating the degree of ARI activity for each of the ten counties for week 50 and week 51 are available on the NH DHHS influenza activity informational page at https://www.dhhs.nh.gov/programs-services/disease-prevention/infectious-disease-control/influenza-flu/influenza-activity.




**Laboratory Surveillance**

The NH Public Health Laboratories (PHL) receives respiratory specimens for influenza testing from health

**Results of Specimens Received by the PHL and Cumulative Totals for the 2025-26 Influenza Season**

| | Week 50 (12/7/25–12/13/25) | | YTD (9/28/25–12/20/25) | |
|---|---|---|---|---|
| **Results** | # specimens | % of total positive | # specimens | % of total positive |
| Influenza A (H3) | 31 | 72.1 | 108 | 51.7 |
| Influenza A (H1N1)pdm09 | 5 | 11.6 | 26 | 12.4 |
| Influenza A, subtyping not completed$^{\Omega}$ | 7 | 16.3 | 72 | 34.4 |
| Influenza B/Victoria | 0 | 0 | 3 | 1.4 |
| Influenza B/lineage not completed$^{\Omega}$ | 0 | 0 | 0 | 0 |
| Negative for influenza | 20 | | 150 | |
| Total | 63 | | 359 | |

$\Omega$ Subtyping or lineage was either not performed or unsuccessful due to low viral titer

care providers and hospitals throughout the State. Testing is important to identify circulating influenza viral subtypes and to confirm specimens that test positive by rapid test.

**Hospital Clinical Laboratory Influenza Results**

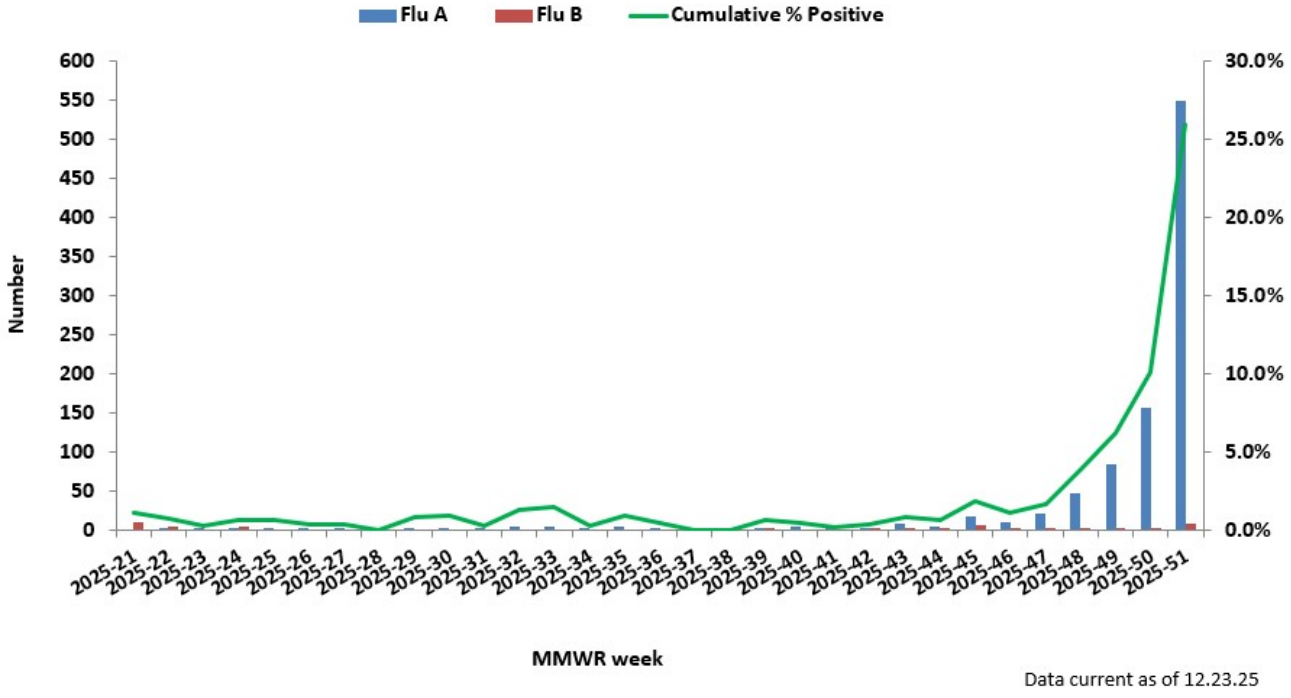
The following table reports influenza test results from participating hospital clinical laboratories throughout the state. Clinical laboratory test results are for specimens collected from patients who present with respiratory illness and may be generated by a variety of assays, including real-time polymerase chain reaction (RT-PCR) or rapid influenza diagnostic tests (RIDT). Currently there are 12 clinical laboratories that participate in submitting weekly influenza results. Results were reported for 1,558 specimens tested during week 50, and 157 (10.1%) were positive for influenza (increase compared to 6.2% the previous week).

**Results of Specimens Tested by Hospital Clinical Laboratories and Cumulative Totals for the 2025-26 Influenza Season**

| | Week 50 (12/7/25-12/13/25) PCR-based | | YTD (9/28/25–12/20/25) PCR-based | |
|---|---|---|---|---|
| **Results** | # specimens | % of positive | # specimens | % of positive |
| Influenza A | 156 | 99.4 | 908 | 97.1 |
| Influenza B | 1 | 0.6 | 27 | 2.9 |
| Influenza A/B Coinfection | 0 | 0 | 0 | 0 |
| Negative | 1,401 | | 14,474 | |
| Total tested | 1,558 | | 15,409 | |

The chart below illustrates the weekly number and percentage of specimens that have tested positive at hospital clinical laboratories that reported during the period spanning week 21 through week 51.

**Influenza Positive Tests Reported to NH DHHS by Hospital Clinical Laboratories, Weeks 21 - 51 of 2025**

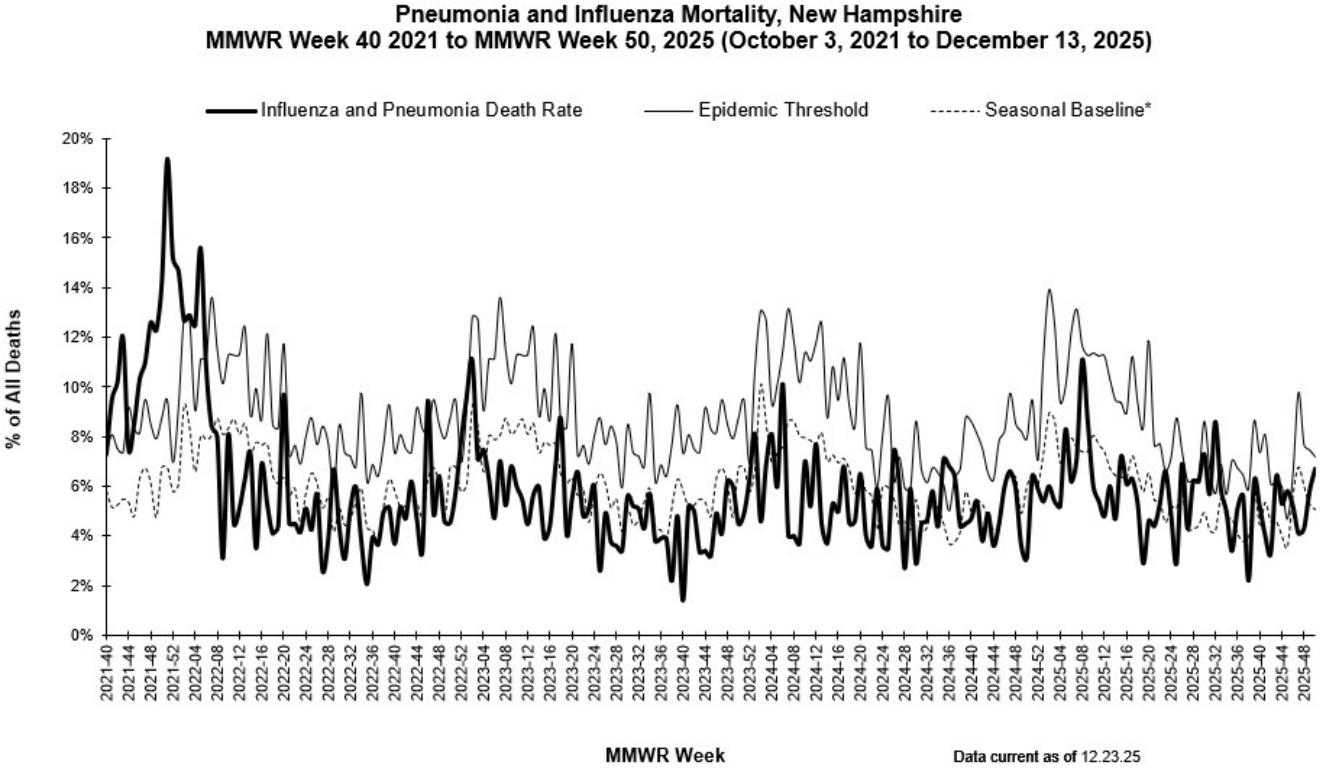



Data current as of 12.23.25

## Pneumonia and Influenza (P&I) Mortality

Pneumonia and Influenza (P&I) deaths in New Hampshire are identified through review of electronically filed death certificates by looking at the causes of death listed on each death certificate. The graph below, which shows the proportion of deaths attributed to P&I, represents all deaths recorded by NH's Division of Vital Records Administration. This includes resident and non-resident deaths that occurred within the State, and may not include deaths of NH residents that occurred out-of-state, or cases being investigated by the Medical Examiner's Office.

- ❑ 6.6% of all deaths recorded in NH were reported as due to P&I. This is below the epidemic threshold of 7.2%.
- ❑ Five adult influenza-related deaths have been identified so far this influenza season. The counties of residence for the persons with an identified influenza-related death are Belknap, Cheshire, Hillsborough, and Rockingham. No pediatric influenza related deaths have been identified this influenza season. Due to delays in electronic filing of death certificates, newly identified deaths in the last week may have occurred at any point during the flu season and not necessarily within the last week.




**Seasonal baseline is calculated using the previous 5 years of data. If the proportion of P&I deaths for a given week exceeds the baseline value for that week by a statistically significant amount (1.645 standard deviations), then P&I deaths are said to be above the epidemic threshold, and the proportion of deaths above threshold are considered attributable to influenza.*

## Influenza Activity in New Hampshire as Assessed by the State Epidemiologist

The weekly reporting to the CDC of Geographic Spread of influenza Activity has been discontinued. Although the flu activity level will not be reported weekly to CDC, the DHHS will continue to characterize this variable and include it in these NH weekly influenza reports.

- ❑ Overall influenza activity in NH for week 50 was **local**.
- ❑ Influenza activity in NH for week 51 was **widespread**.

Reported flu activity level is based on ILI reported by the participating providers and ESSENCE surveillance systems, reported outbreaks in facilities, and reports of laboratory confirmed influenza.

Influenza activity levels are defined by CDC as follows:

- **No Activity:** Low ILI activity and no laboratory-confirmed cases of influenza.
- **Sporadic:** Low ILI activity and isolated laboratory-confirmed influenza cases or a single influenza outbreak has been reported.
- **Local:** Increased ILI activity or influenza outbreaks in a single region of the state, and recent laboratory-confirmed influenza in that region.
- **Regional:** Increased ILI activity or influenza outbreaks in ≥ 2, but less than half of state regions, and recent laboratory-confirmed influenza in affected regions.
- **Widespread:** Increased ILI activity or influenza outbreaks in at least half of state regions, and recent laboratory-confirmed influenza in the state.

## National Surveillance

- ❑ Seasonal influenza activity continues to increase across the country.
- ❑ Influenza A(H1N1)pdm09 and A(H3N2) viruses were co-circulating this week, however, the most frequently reported was A(H3N2).
- ❑ The proportion of outpatient visits for influenza-like illness (ILI) was 4.1%, which is above the national baseline of 3.1%. All of the 10 HHS regions are either at or above their respective baselines during week 50, including Region 1 (New England).
- ❑ The percentage of deaths due to pneumonia, influenza, and/or COVID-19 (PIC) in the National Center for Health Statistics (NCHS) Mortality Surveillance System was at 5.9%, which is below threshold (7.2%).
- ❑ Two influenza-associated pediatric deaths occurring during the 2025-2026 season were reported to CDC during Week 50. Both deaths were associated with influenza A(H3) viruses. A total of three influenza-associated pediatric deaths occurring during the 2025-2026 season have been reported to CDC.

## Laboratory Surveillance

Public Health laboratories located in all 50 states and Washington D.C. reported specimens testing positive during week 50 for influenza viruses, as follows:

| Flu Season | Influenza A (H1N1) pdm09 | Influenza A (H3N2) | Influenza A(H5) | Influenza A - Subtyping not performed | Influenza B – Victoria lineage | Influenza B – lineage not performed | Percentage of Specimens Testing Positive |
|---|---|---|---|---|---|---|---|
| **Week 50 2025-26** | 71 (7.7%) | 635 (68.5%) | 0 (0%) | 205 (22.1%) | 6 (0.6%) | 10 (1.1%) | **927/1,414 (65.6%)** |

**Novel Influenza A Virus Infections**

No new confirmed human infections with avian influenza A(H5) virus were reported to CDC this week. To date, person-to-person transmission of avian influenza A(H5) virus (H5 bird flu) has not been identified in the United States. An up-to-date human case summary during the current A(H5) outbreak by state and exposure source is available at www.cdc.gov/bird-flu/situation-summary/index.html

More information about avian influenza is available at https://www.cdc.gov/flu/avianflu/index.htm

**Antigenic Characterization**

CDC has antigenically characterized 70 influenza viruses since September 28, 2025, including 23 A(H1N1)pdm09 viruses, 35 A(H3N2) viruses, and 12 B/Victoria lineage viruses. No B/Yamagata lineage viruses were available for antigenic characterization. The CDC characterizes antigenicity by how well antibodies made against the vaccine strains recognize circulating virus that have been grown in cell culture. Of the characterized viruses, the vaccine antibodies recognized:

- 100% of influenza A(H1N1)pdm09 samples with cell-grown and recombinant-based vaccine antibodies
- 9% of influenza A(H3N2) samples with cell-grown and recombinant-based vaccine antibodies
- 67% of influenza B/Victoria samples with cell-grown and recombinant-based vaccine antibodies

**Antiviral Resistance**

CDC assesses susceptibility of influenza viruses to antiviral medications including the neuraminidase inhibitors (oseltamivir, zanamivir, and peramivir) and the PA endonuclease inhibitor baloxavir. Viruses collected in the United States since September 28, 2025, were tested for antiviral susceptibility as follows:

| | N* | Resistant Viruses, Number (%) Oseltamivir | N* | Resistant Viruses, Number (%) Peramivir | N* | Resistant Viruses, Number (%) Zanamivir | N* | Resistant Viruses, Number (%) Baloxavir |
|---|---|---|---|---|---|---|---|---|
| InfluenzaA(H1N1)pdm09 | 116 | 0 (0%) | 116 | 0 (0%) | 116 | 0 (0%) | 107 | 0 (0%) |
| Influenza A (H3N2) | 208 | 0 (0%) | 208 | 0 (0%) | 208 | 0 (0%) | 204 | 0 (0%) |
| Influenza B/Victoria | 30 | 0 (0%) | 30 | 0 (0%) | 30 | 0 (0%) | 30 | 0 (0%) |

*N equals the number of viruses tested.

## Respiratory syncytial virus

Respiratory syncytial virus, or RSV, is a common respiratory virus that usually causes mild, cold-like symptoms. Most people recover in a week or two, but RSV can be serious, especially for infants and older adults. Virtually all children get an RSV infection by the time they are 2 years old, and it is the most common cause of bronchiolitis (inflammation of the small airways in the lung) and pneumonia (infection of the lungs) in children younger than 1 year of age in the United States.

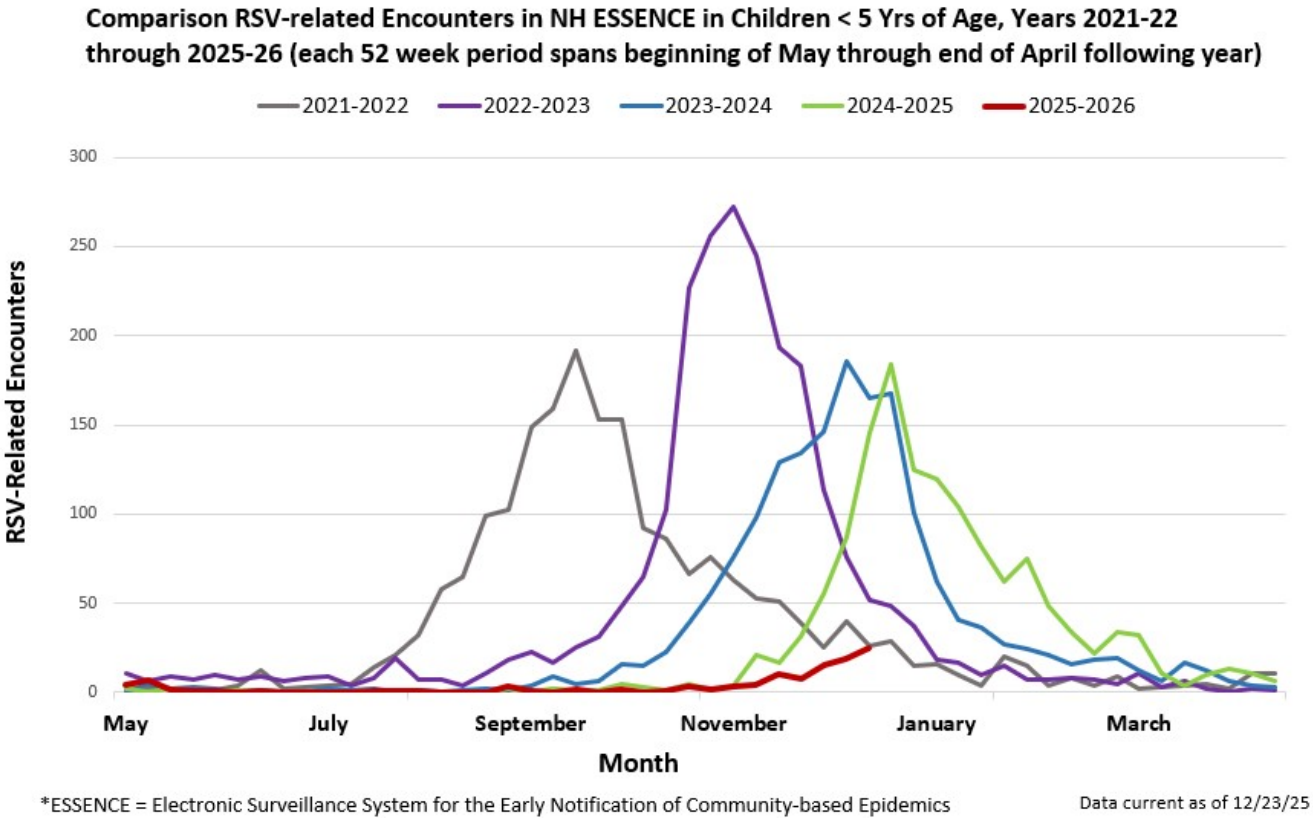
RSV is a common cause of hospitalization in children younger than 5 years old, and each year an estimated 58,000-80,000 children in this age group are hospitalized due to RSV. Those at greatest risk for severe illness from RSV include:

- premature infants
- infants, especially those 6 months and younger
- children younger than 2 years old with chronic lung disease or congenital heart disease
- children with weakened immune systems
- children who have neuromuscular disorders, including those who have difficulty swallowing or clearing mucus secretions

Prior to 2020, seasonal patterns for RSV in the United States were very consistent, typically beginning in the fall, peaking in the winter, and decreasing to inter-seasonal levels in the spring. However, the patterns of circulation for RSV and other common respiratory viruses have been disrupted since the start of the COVID-19 pandemic early in 2020.

The NH DHHS conducts syndromic surveillance to help characterize RSV activity in children younger than 5 years, by querying chief complaint text for patient emergency department encounters in NH's 26 acute care hospitals that transmit data into NH ESSENCE (see page 1 for description). To identify such

encounters, each week chief complaint text field is queried for the terms “RSV”, “respiratory sync”, and “syncy”. This query also identifies patient encounters with ICD-10 discharge diagnosis codes that are specific to RSV*. The weekly number of RSV-related encounters identified in children < 5 years of age




across all 26 acute care hospitals is displayed in the chart above. Each uniquely colored line represents a 52 week period spanning from MMWR Week 18 (beginning of May) of the first year through MMWR Week 17 (end of April) of the following year. Data are displayed for the current 2025-26 period as well as the 4 previous 52-week periods (beginning with 2021-22).

Additional resources for RSV can be found on the CDC website at the following URLs.

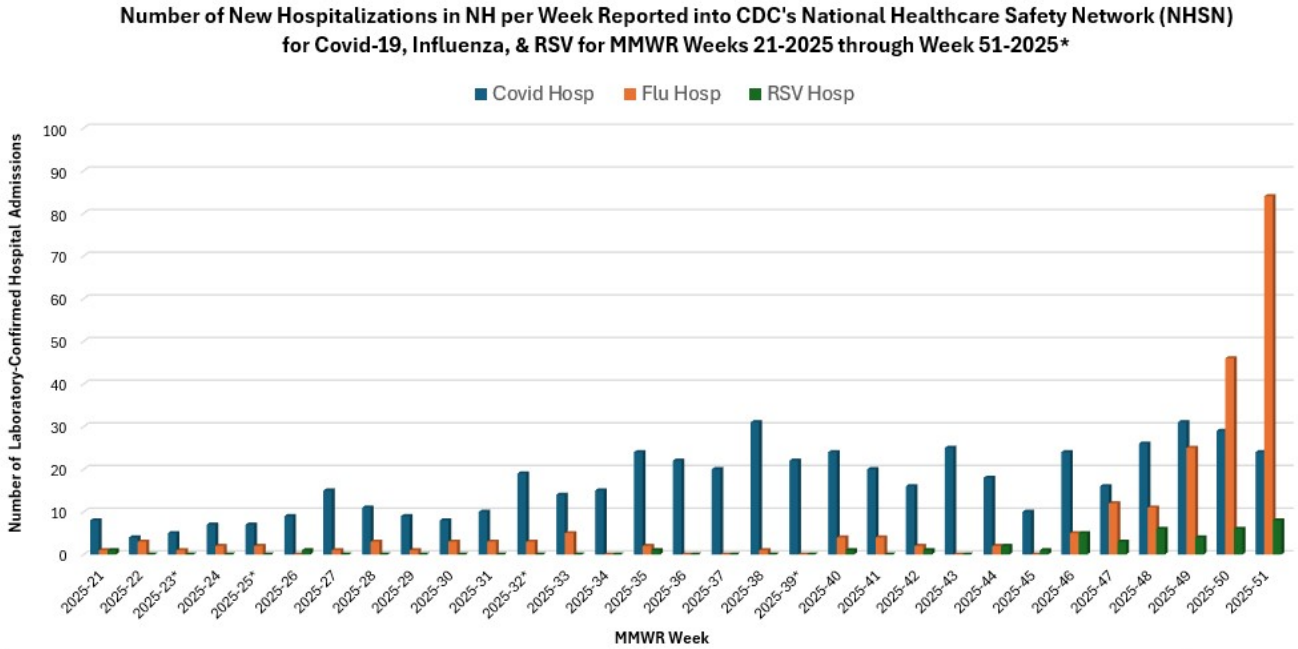
https://www.cdc.gov/rsv/index.html

https://www.cdc.gov/rsv/php/surveillance/rsv-net.html

* ICD-10 codes used to identify RSV-related encounters include: J21.0 (acute bronchiolitis due to respiratory syncytial virus), J20.5 (acute bronchitis due to respiratory syncytial virus), B97.4 (respiratory syncytial virus as the cause of diseases classified elsewhere), and J12.1 (respiratory syncytial virus pneumonia).

## Hospital Respiratory Data Reported in NH to National Healthcare Safety Network (NHSN)

Each of the 26 acute care hospitals in NH report weekly to the National Healthcare Safety Network (NHSN) the number of patients with laboratory-confirmed Covid-19, influenza, and RSV who were admitted to the hospital. The weekly number of new hospitalizations reported for patients who tested positive for each of these three viruses during the period spanning week 21 through week 51 of 2025 is displayed in the chart below.




* Data displayed for each week is self-reported by each individual hospital into NHSN. With the exception of MMWR Weeks 23, 25, 32, 39, & 51 each week includes data for all 26 acute care hospitals in NH. Weeks 23, 25, 32, 39, & 51 included data for 23, 22, 25, 22, & 24 hospitals, respectively. NH DPHS does not perform any additional quality assurance to verify the accuracy of these reported hospitalization data.

Data current as of 12/23/25

**Report Date:** 12/23/25
**Prepared by:** John J. Dreisig, MPH
**John.J.Dreisig@dhhs.nh.gov** 603-271-6585

All data in this report are based upon information provided to the New Hampshire Department of Health and Human Services under specific legislative authority. The numbers reported may represent an underestimate of the true absolute number and incidence rate of cases in the state. The unauthorized disclosure of any confidential medical or scientific data is a misdemeanor under New Hampshire law. The department is not responsible for any duplication or misrepresentation of surveillance data released in accordance with this guideline.