VOLUME 4, NUMBER 47 (PUBLISHED ON 26 Nov 2026)

COVID-19 & FLU EXPRESS

衞生防護中心 Centre for Health Protection
保障市民健康 Protecting Hong Kong's health

COVID-19 & Flu Express *is a weekly report produced by Surveillance Division of the Communicable Disease Branch of the Centre for Health Protection. It monitors and summarises the latest local and global COVID-19 and influenza activities.*

Local Situation of COVID-19 Activity (as of Nov 25, 2026)

Reporting period: Nov 15, 2026 – Nov 21, 2026 (Week 47)

- The latest surveillance data showed that the overall local activity of COVID-19 remained at a low level.
- The Centre for Health Protection (CHP) has been closely monitoring the local prevalence of SARS-CoV-2 variants. The latest sewage surveillance data and genetic analysis of positive respiratory specimens show that PJ.2.1, XFG and PQ.16.1.1 are co-circulating. PJ.2.1 was the most prevalent variant in sewage samples, while XFG and PQ.16.1.1 were detected in clinical specimens. The World Health Organization (WHO) listed the above three variants as variants under monitoring (VUM), with PJ.2.1 designated as VUM on 19 November 2026. PJ.2.1 is a descendant lineage of JN.1. There is currently no evidence establishing greater disease severity associated with PJ.2.1, and WHO assesses the additional public health risk it poses as low at the global level.
- Members of the public are advised to maintain strict personal and environmental hygiene at all times for personal protection against COVID-19 infection and prevention of the spread of the disease in the community. High-risk people (e.g. persons with underlying medical conditions or persons who are immunocompromised) should adopt additional measures to protect themselves such as wearing mask properly when going to public places. For other details, please visit the COVID-19 information page (https://www.chp.gov.hk/en/healthtopics/content/24/102466.html).
- Members of the public are advised to take note of the latest recommendations on the use of COVID-19 vaccines in Hong Kong to protect themselves from serious outcomes of COVID-19. High-risk priority groups are recommended to receive a dose of COVID-19 vaccine at least six months since the last dose or infection, regardless of the number of doses received previously. For more details, please visit (https://www.chp.gov.hk/files/pdf/consensus_recommendations_on_the_use_of_covid-19_vaccines_in_hong_kong_oct2025.pdf).
- For the latest information on COVID-19 and prevention measures, please visit the thematic website of COVID-19 (https://www.coronavirus.gov.hk/eng/index.html).

Laboratory surveillance for COVID-19 cases

Positive nucleic acid test laboratory detections for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) virus

(Note: The data reported are provisional figures and subject to further revision.)

In week 47, the weekly number of newly recorded positive nucleic acid test laboratory detections for SARS-CoV-2 virus was 5 as compared to 4 in the preceding week. (Figure 1.1)

In the first 4 days of week 48 (Nov 22 – Nov 25), the daily number of newly recorded positive nucleic acid test laboratory detections for SARS-CoV-2 virus ranged from 0 to 2.

Since Jan 30, 2023, the cumulative number of positive nucleic acid test laboratory detections was 89,781 (as of Nov 25, 2026).

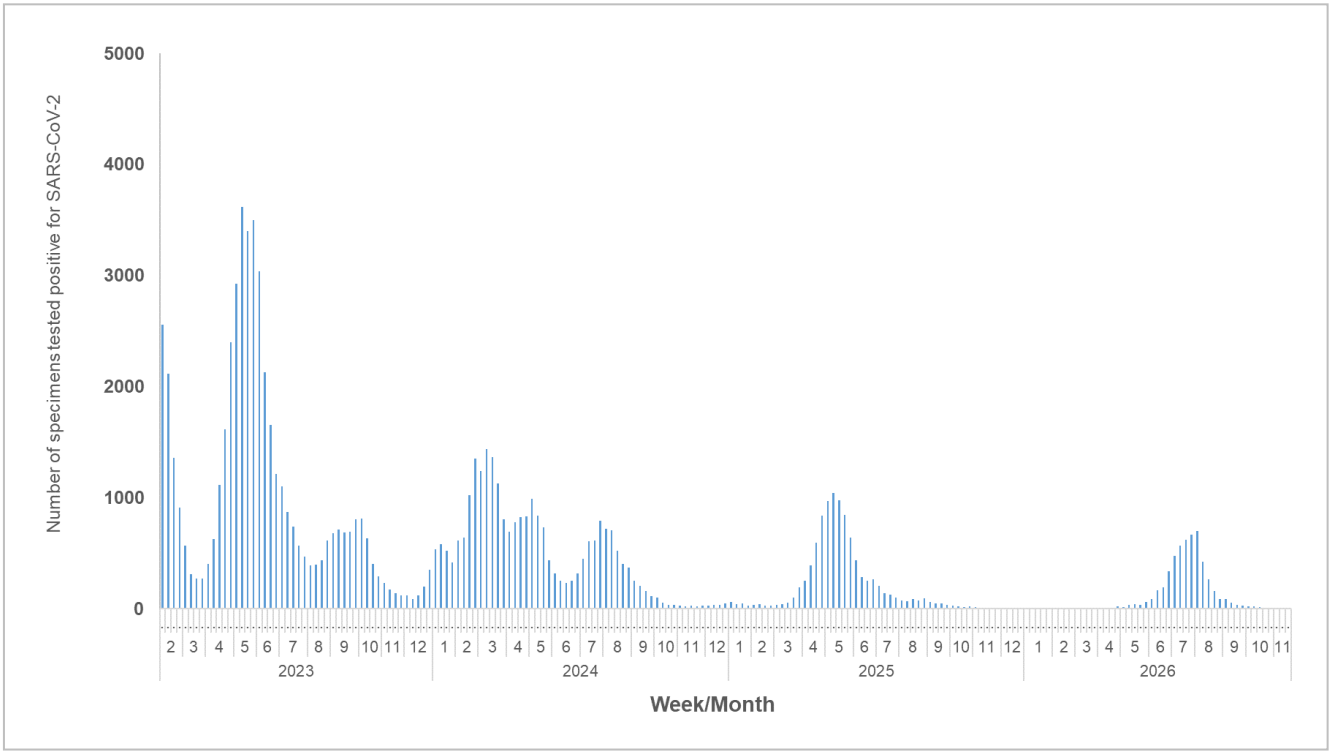


Figure 1.1 Weekly number of positive nucleic acid test laboratory detections for SARS-CoV-2 virus

Positive detection rate of specimens tested positive for SARS-CoV-2 virus at the Public Health Laboratory Services Branch, Centre for Health Protection

Among the 8,844 respiratory specimens received by the Public Health Laboratory Services Branch (PHLSB) in week 47, 10 (0.11%) were tested positive for SARS-CoV-2 virus as compared to 10 (0.12%) in the preceding week. (Figure 1.2)

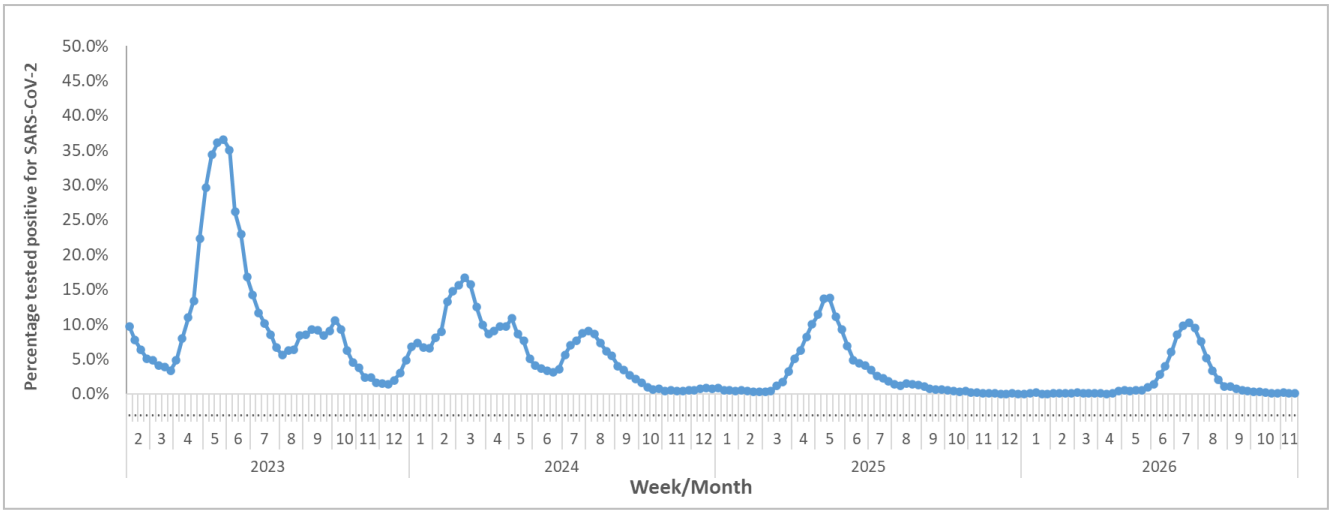


Figure 1.2 Percentage of specimens tested positive for SARS-CoV-2 virus at PHLSB

COVID-19 outbreak surveillance

(Note: The data reported are provisional figures and subject to further revision.)

In week 47, 0 COVID-19 outbreaks occurring in schools/institutions was recorded (affecting 0 persons), as compared to 0 outbreaks recorded in the previous week (affecting 0 persons). (Figure 1.3)

In the first 4 days of week 48 (Nov 22 – Nov 25), 0 COVID-19 outbreaks occurring in schools/institutions were recorded (affecting 0 persons).

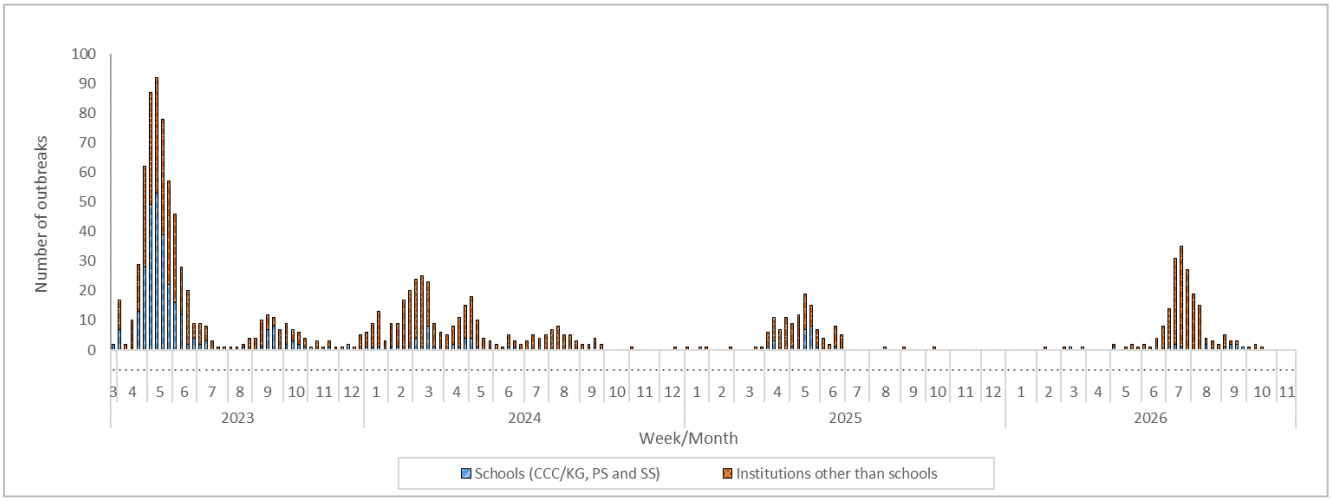


Figure 1.3 COVID-19 outbreaks in schools/institutions

Type of institutions	Week 46	Week 47	First 4 days of week 48 (Nov 22 – Nov 25)
Child care centre/ kindergarten (CCC/KG)	0	0	0
Primary school (PS)	0	0	0
Secondary school (SS)	0	0	0
Residential care home for the elderly	0	0	0
Residential care home for persons with disabilities	0	0	0
Others	0	0	0
Total number of outbreaks	0	0	0
Total number of persons affected	0	0	0

Surveillance of severe and fatal COVID-19 cases

(Note: The data reported are provisional figures and subject to further revision.)

In week 47, the weekly number of severe COVID-19 cases including deaths with cause of death preliminarily assessed to be related to COVID-19 was 0 as compared to 0 in the preceding week. (Figure 1.4)

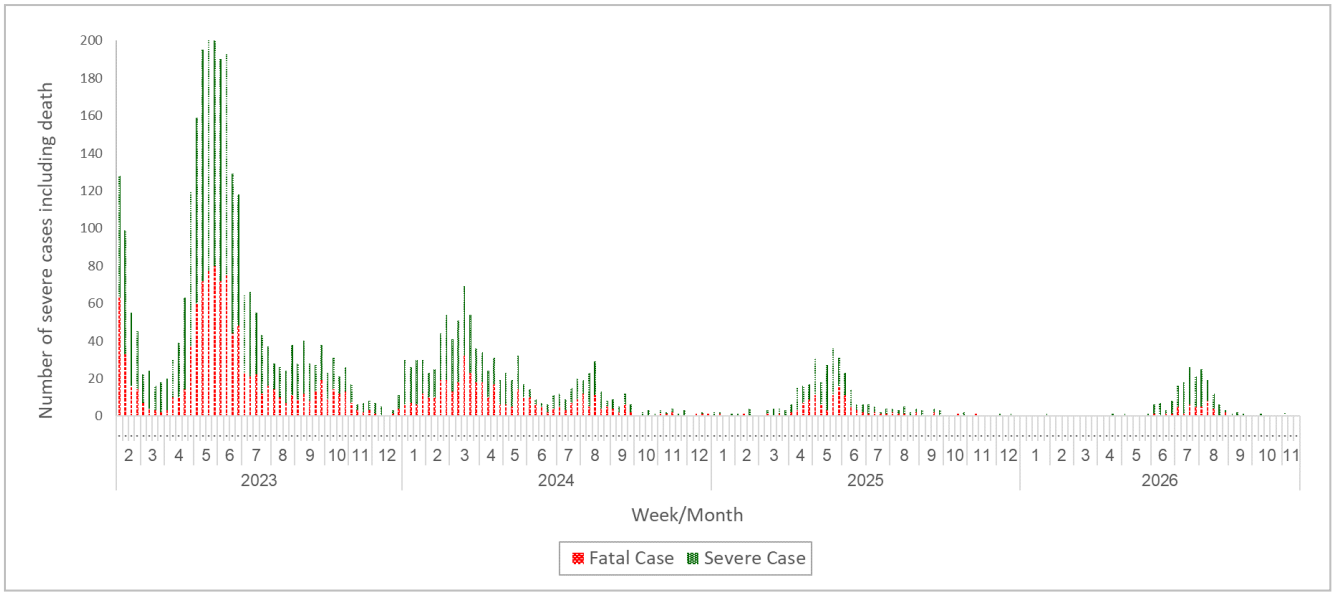


Figure 1.4 Weekly number of severe COVID-19 cases including deaths

Note: Severe and fatal cases are recorded according to their initial reporting dates.

Sewage surveillance of SARS-CoV-2 virus

In week 47, the 7-day geometric mean per capita viral load of SARS-CoV-2 virus from sewage surveillance was around 13,000 copy/L as compared to around 21,000 copy/L in the preceding week. (Figure 1.5)

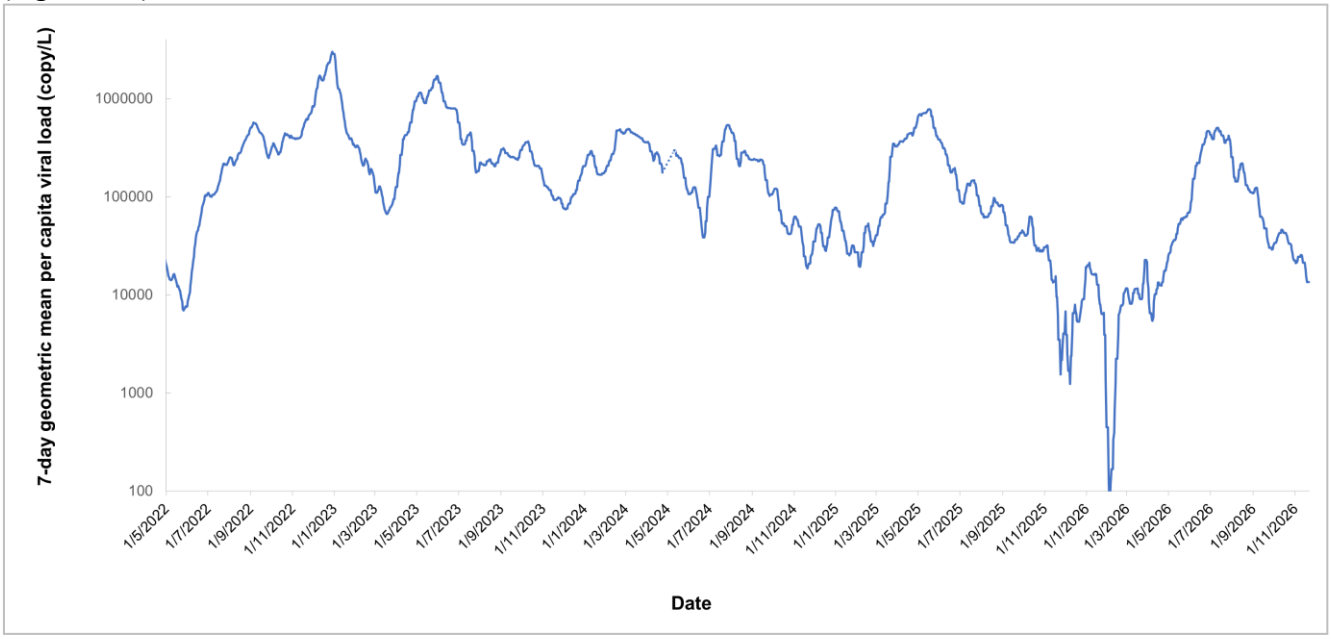


Figure 1.5 7-day geometric mean per capita viral load of SARS-CoV-2 virus from sewage surveillance since May 1, 2022

Note: The dotted line refers to the temporary sewage sampling suspension for a safety review by the Drainage Services Department.

Acknowledgement

The initiative is funded by the Hong Kong Jockey Club Charities Trust through its "Special Donation on Epidemic Preparedness" to the CHP.

COVID-19 surveillance among sentinel family medicine clinics and sentinel private medical practitioner clinics

In week 47, the average consultation rate for COVID-19 among sentinel family medicine clinics and sentinel private medical practitioner clinics were 0.3 (Figure 1.6) and 0.0 (Figure 1.7) COVID-19 cases per 1,000 consultations, respectively.

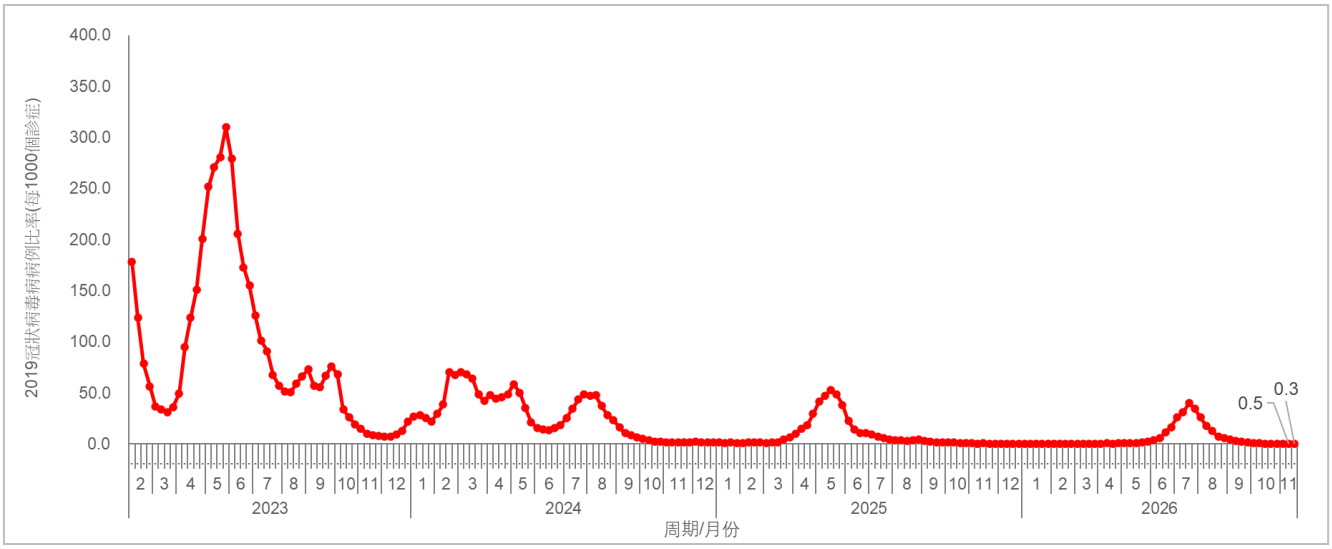


Figure 1.6 Average consultation rate of COVID-19 cases in family medicine clinics

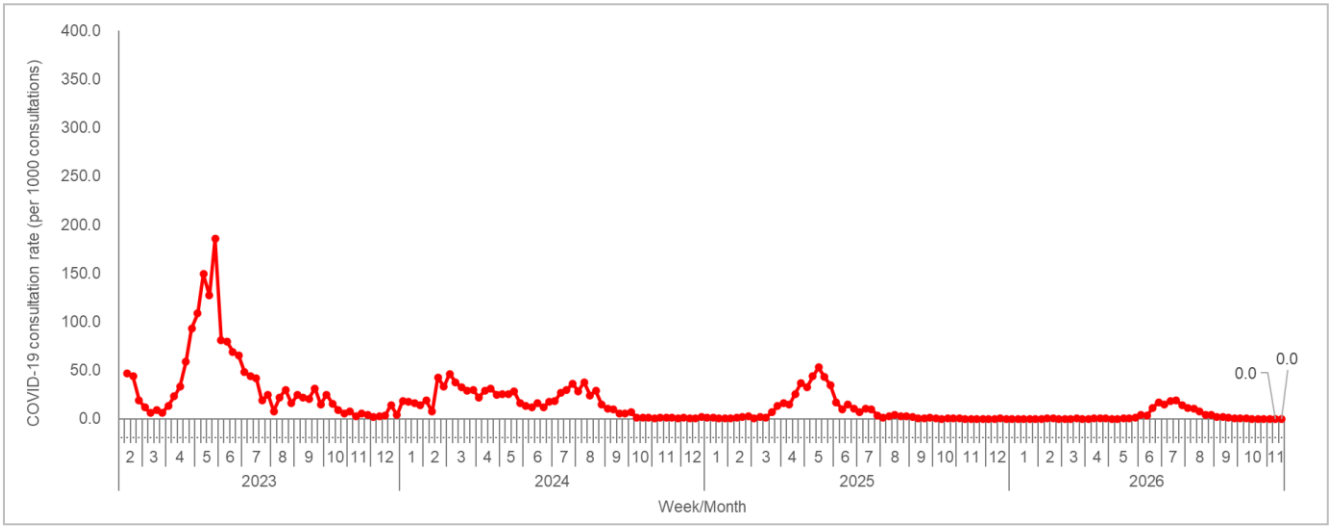


Figure 1.7 Average consultation rate of COVID-19 cases in private medical practitioner clinics

Surveillance on SARS-CoV-2 variants

Currently, WHO is monitoring one variant of interest (VOI), which is JN.1, and five VUMs, which are PQ.16.1.1, NB.1.8.1, XFG, BA.3.2 and PJ.2.1. CHP conducts surveillance on SARS-CoV-2 variants from sewage samples. The latest surveillance data (as of Nov 20, 2026) showed that PJ.2.1 was the most prevalent variant, comprising 71.4% of all characterised specimens. (Figure 1.8)

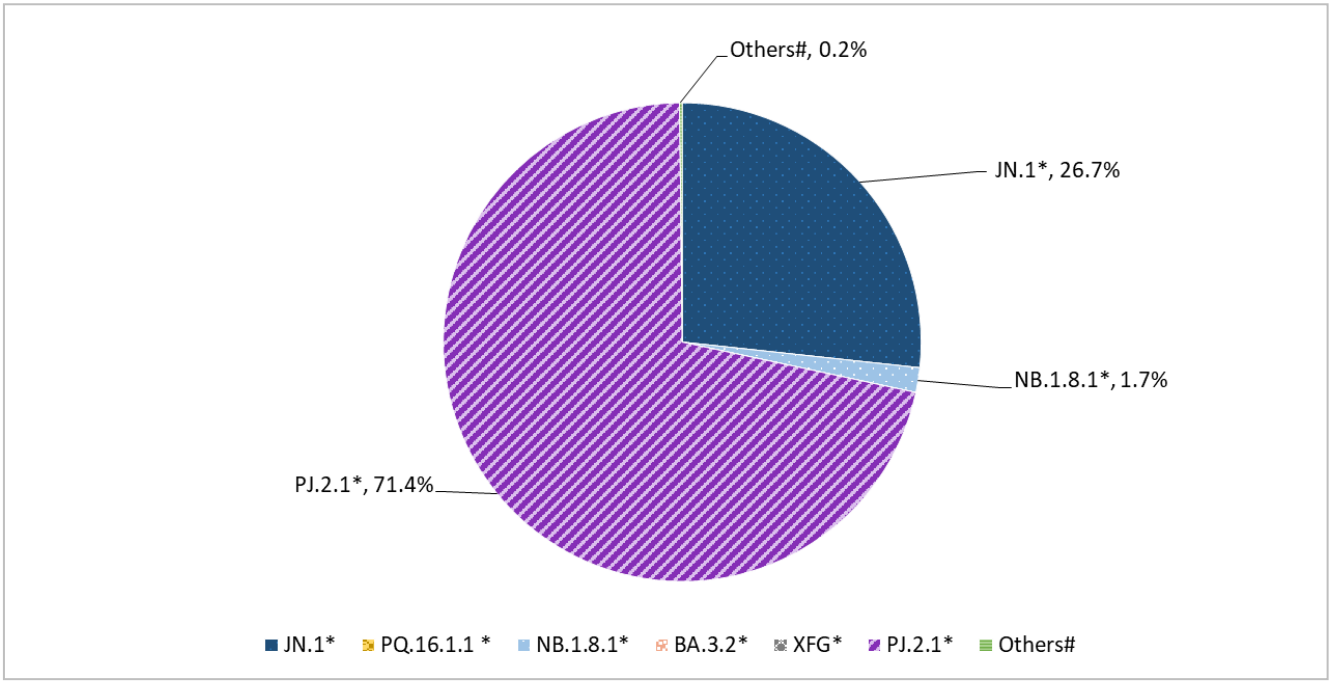


Figure 1.8 Estimated proportion of variants among sewage samples

**Including the variant's descendant lineages, except those individually specified elsewhere in the table.*

#Those SARS-CoV-2 variants not classified as VOIs/VUMs by WHO at the time of reporting.

Note: XFG is the descendant lineage of JN.1. BA.3.2 is a descendent lineage of the Omicron variant BA.3.

CHP also conducted genetic characterisation on positive respiratory specimens between Nov 11 and Nov 24, 2026. The results showed that PQ.16.1.1 accounted for 100% of all characterised specimens from reported severe or fatal cases of COVID-19, while among non-severe cases, XFG and PQ.16.1.1 accounted for 66% and 33% of the characterised specimens respectively.

Global situation of COVID-19 activity

- According to the WHO, global SARS-CoV-2 activity remained low, with variations observed across some regions.

  - In Chinese Mainland (week ending Nov 15, 2026), the percentage of specimens tested positive for SARS-CoV-2 was at a low level. The predominant variant was PQ.16.1.1 recently.
  - In Japan (week ending Nov 15, 2026), the average number of reported COVID-19 cases per sentinel site was 0.78 compared to 0.76 in the preceding week. The predominant variant was NB.1.8.1.
  - In South Korea (week ending Nov 14, 2026), the weekly detection rate for SARS-CoV-2 was 7.3% compared to 7.8% in the preceding week. The predominant variant was PQ.16.1.1.
  - In Singapore (week ending Nov 14, 2026), the positivity rate for COVID-19 among acute respiratory infection (ARI) samples in the community was 2% compared to 2% in the preceding week.
  - In the United States (week ending Nov 14, 2026), the percent positivity of COVID-19 was 3.7% compared to 3.6% in the preceding week. The predominant variants were XFG and PJ.2.1.
  - In Canada (week ending Nov 14, 2026), indicators of COVID-19 activity remained stable. The percentage of tests positive for COVID-19 was 6.4%, compared to 6.3% in the preceding week. The predominant variants were PJ.2.1.
  - In the United Kingdom (week ending Nov 15, 2026), COVID-19 activity remained at low level. COVID-19 PCR positivity in hospital settings was 7.0% compared to 7.2% in the preceding week. The predominant variant was XFG.
  - In Europe (week ending Nov 15, 2026), SARS-CoV-2 positivity from sentinel specimens was at 16.0% compared to 10.8% at the previous week. The predominant variant was XFG.
  - In Australia (fortnight ending Nov 1, 2026), test positivity for SARS-CoV-2 slightly increased. The predominant variant was NB.1.8.1.

Sources:

Information have been extracted from the following sources when updates are available: World Health Organization, Chinese Center for Disease Control and Prevention, Japan Ministry of Health, Korean Disease Control and Prevention Agency, Singapore Communicable Diseases Agency, United States Centers for Disease Control and Prevention, Public Health Agency of Canada, UK Health Security Agency, European Centre for Disease Prevention and Control (ECDC) and WHO Regional Office for Europe (WHO Euro), and Australian Department of Health and Aged Care.

Local Situation of Influenza Activity (as of Nov 25, 2026)

Reporting period: Nov 15 – 21, 2026 (Week 47)

- Hong Kong is in influenza season. The latest surveillance data showed that the overall influenza activity continued to decrease.
- Influenza can cause serious illnesses in high-risk individuals and even healthy persons. Given that seasonal influenza vaccines are safe and effective, all persons aged 6 months or above except those with known contraindications are recommended to receive influenza vaccine to prevent severe cases of seasonal influenza and its complications, as well as related hospitalisations and deaths.
- 2026/27 Seasonal Influenza Vaccination (SIV) Programmes, including the SIV School Outreach Programme (SIVSOP), the Residential Care Home Vaccination Programme and the Vaccination Subsidy Scheme (VSS), were launched on September 17. Eligible persons can receive free or subsidised vaccinations through the SIV Programmes. The public may visit the CHP's Vaccination Schemes page for more details of the vaccination programmes (https://www.chp.gov.hk/en/features/17980.html).
- Apart from getting influenza vaccination, members of the public should always maintain good personal and environmental hygiene.
- For the latest information on seasonal influenza and its prevention, please visit the Centre for Health Protection's Seasonal Influenza page (http://www.chp.gov.hk/en/view_content/14843.html).

Influenza-like-illness surveillance among sentinel family medicine clinics and sentinel private medical practitioner clinics, 2022-26

In week 47, the average consultation rate for influenza-like illness (ILI) among sentinel family medicine clinics (FMC) was 7.3 ILI cases per 1,000 consultations, which was higher than 6.6 recorded in the previous week (Figure 2.1, left). The average consultation rate for ILI among sentinel private medical practitioner (PMP) clinics was 34.1 ILI cases per 1,000 consultations, which was higher than 24.9 recorded in the previous week (Figure 2.1, right).

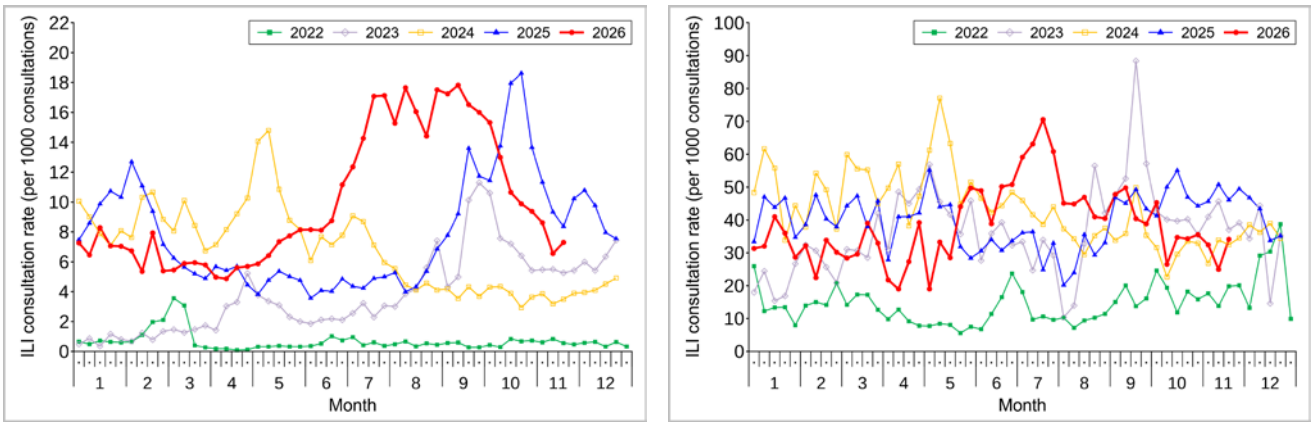


Figure 2.1 ILI consultation rates at sentinel FMC (left) and PMP clinics (right), 2022-26

Laboratory surveillance, 2022-26

Among the 9,360 respiratory specimens* received in week 47, 479 (5.12%) were tested positive for seasonal influenza A or B viruses. Among the subtyped influenza detections, there were 426 (94%) influenza A(H1), 13 (3%) influenza A(H3) and 13 (3%) influenza B viruses. The positive percentage (5.12%) was above the baseline threshold of 4.94% but was lower than 5.58% recorded in the previous week (Figure 2.2).

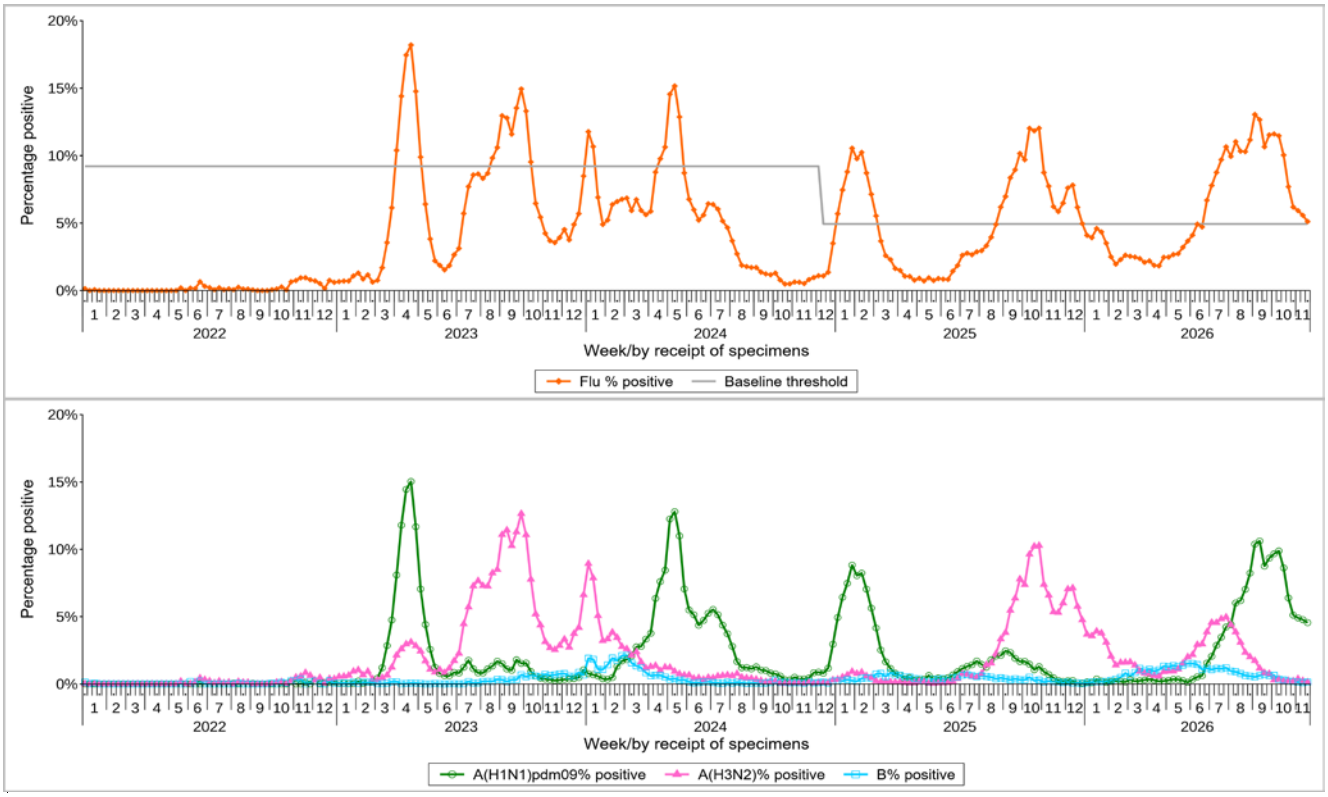


Figure 2.2 Percentage of respiratory specimens tested positive for influenza viruses, 2022-26 (upper: overall positive percentage, lower: positive percentage by subtypes)

[Notes: The Centre for Health Protection (CHP) of the Department of Health closely monitors the local seasonal influenza activity through a series of surveillance systems. Among them, the CHP sets threshold levels for two important influenza indicators, including the positive percentage of influenza detections among respiratory specimens and the admission rate of patients diagnosed with influenza in public hospitals. These threshold levels are calculated statistically based on data collected for both indicators in the past years during non-season periods. Using these thresholds, the CHP assesses the current local situation of seasonal influenza with higher accuracy and determines whether Hong Kong enters influenza season. The CHP annually reviews and analyses the latest surveillance data, and updates these threshold levels where appropriate. The sensitivity of the surveillance system is enhanced with the updated thresholds of positive percentage of influenza detection and admission rate of higher coherence.]

Remarks: Some specimens may contain vaccine strains from people with recent history of receiving live-attenuated influenza vaccine

* Including 8,844 specimens received by Public Health Laboratory Services Branch, Centre for Health Protection and 516 specimens received by the Hospital Authority

Surveillance of antiviral susceptibility of influenza A and B viruses

- The Public Health Laboratory Services Branch of the Centre for Health Protection tests virus isolates of influenza viruses obtained from cell culture for reduced antiviral susceptibility. For influenza A(H1) viruses, genotypic assay for H275Y substitution (which confers resistance to oseltamivir) is also performed on selected clinical specimens.
- In October 2026, there was one report of influenza A(H1) virus with reduced susceptibility to oseltamivir and one with reduced susceptibility to baloxavir. There were no new reports of influenza A(H3) or B viruses with reduced susceptibility to oseltamivir, nor any influenza A(H1) virus with the H275Y substitution.
- For the results of previous months, please refer to the following webpage: https://www.chp.gov.hk/en/statistics/data/10/641/695/7124.html
- The detection rates of oseltamivir-resistant influenza A and B viruses remain low (less than 5%) according to latest surveillance data of overseas countries.

Influenza-like illness outbreak surveillance, 2022-26

In week 47, 19 ILI outbreaks occurring in schools/institutions were recorded (affecting 95 persons), as compared to 26 outbreaks recorded in the previous week (affecting 145 persons) (Figure 2.3). The overall number was at the low intensity level currently (Figure 2.4*). In the first 4 days of week 48 (Nov 22 to 25), 14 ILI outbreaks in schools/institutions were recorded (affecting 58 persons). Since the start of the influenza season in week 26, 1,010 outbreaks were recorded (as of Nov 25).

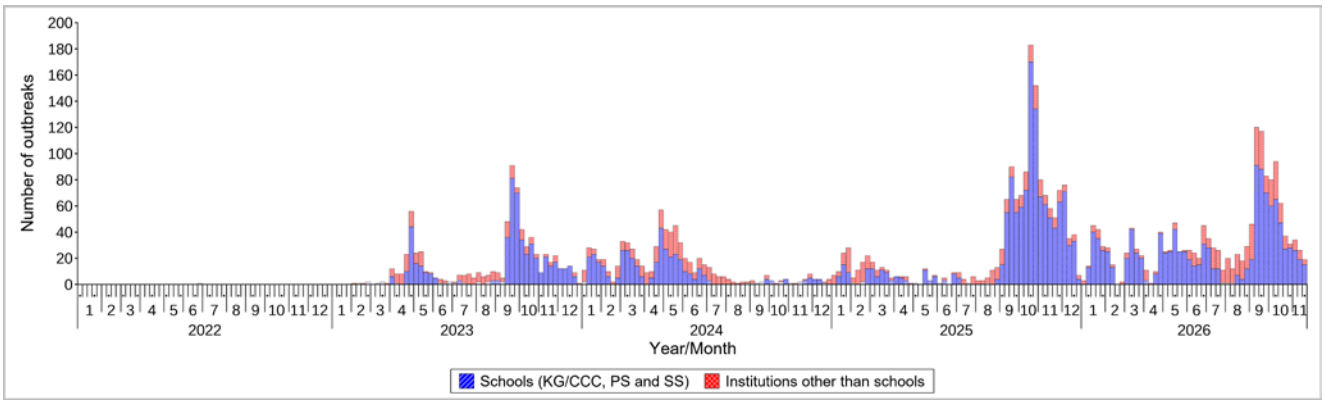


Figure 2.3 ILI outbreaks in schools/institutions, 2022-26

Type of institutions	Week 46	Week 47	Cumulative number of outbreaks during influenza season
Child care centre/kindergarten (CCC/KG)	2	0	105
Primary school (PS)	14	9	405
Secondary school (SS)	3	6	164
Residential care home for the elderly	3	1	202
Residential care home for persons with disabilities	3	1	66
Others	1	2	68
Total number of outbreaks	26	19	1010
Total number of persons affected	145	95	7254

In comparison, 545 outbreaks were recorded in the same duration of surveillance (22 complete weeks) in the 2024 season, as compared with 996 outbreaks in the current season (Figure 2.5).

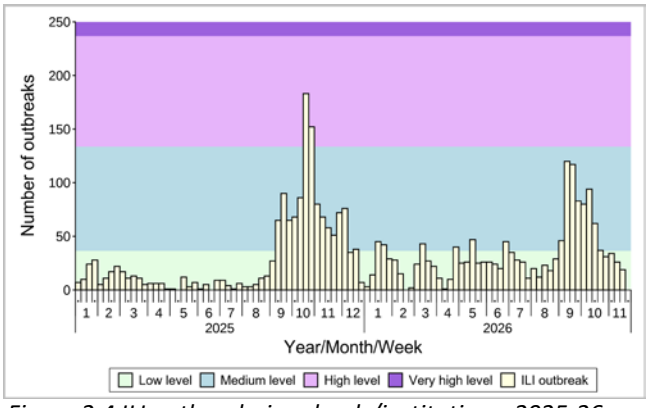


Figure 2.4 ILI outbreaks in schools/institutions, 2025-26

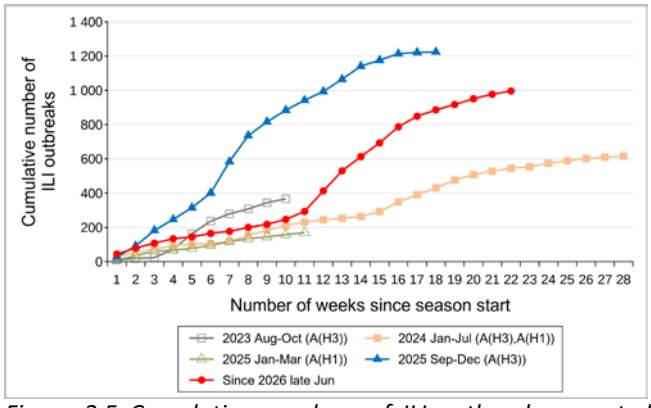


Figure 2.5 Cumulative numbers of ILI outbreaks reported during major influenza seasons, 2023–26
Note: The predominating virus was shown in bracket.

** Various intensity levels applicable for this year were calculated with the moving epidemic method (MEM). For details, please refer to this webpage: https://www.chp.gov.hk/files/pdf/explanatory_note_for_flux_mem_eng.pdf*

Influenza-associated hospital admission rates in public hospitals based on discharge coding, 2022-26

In week 47, the overall admission rate in public hospitals with principal diagnosis of influenza was 0.26 (per 10,000 population) as compared to 0.30 recorded in the previous week (Figure 2.6). It was below the baseline threshold of 0.27 and at the low intensity level (Figure 2.7*). The influenza-associated admission rates for persons aged 0-5 years, 6-11 years, 12-17 years, 18-49 years, 50-64 years and 65 years or above were 1.18, 0.51, 0.33, 0.06, 0.17 and 0.55 cases (per 10,000 people in the age group) respectively, as compared to 0.95, 0.38, 0.35, 0.09, 0.15 and 0.70 cases in the previous week (Figure 2.6).

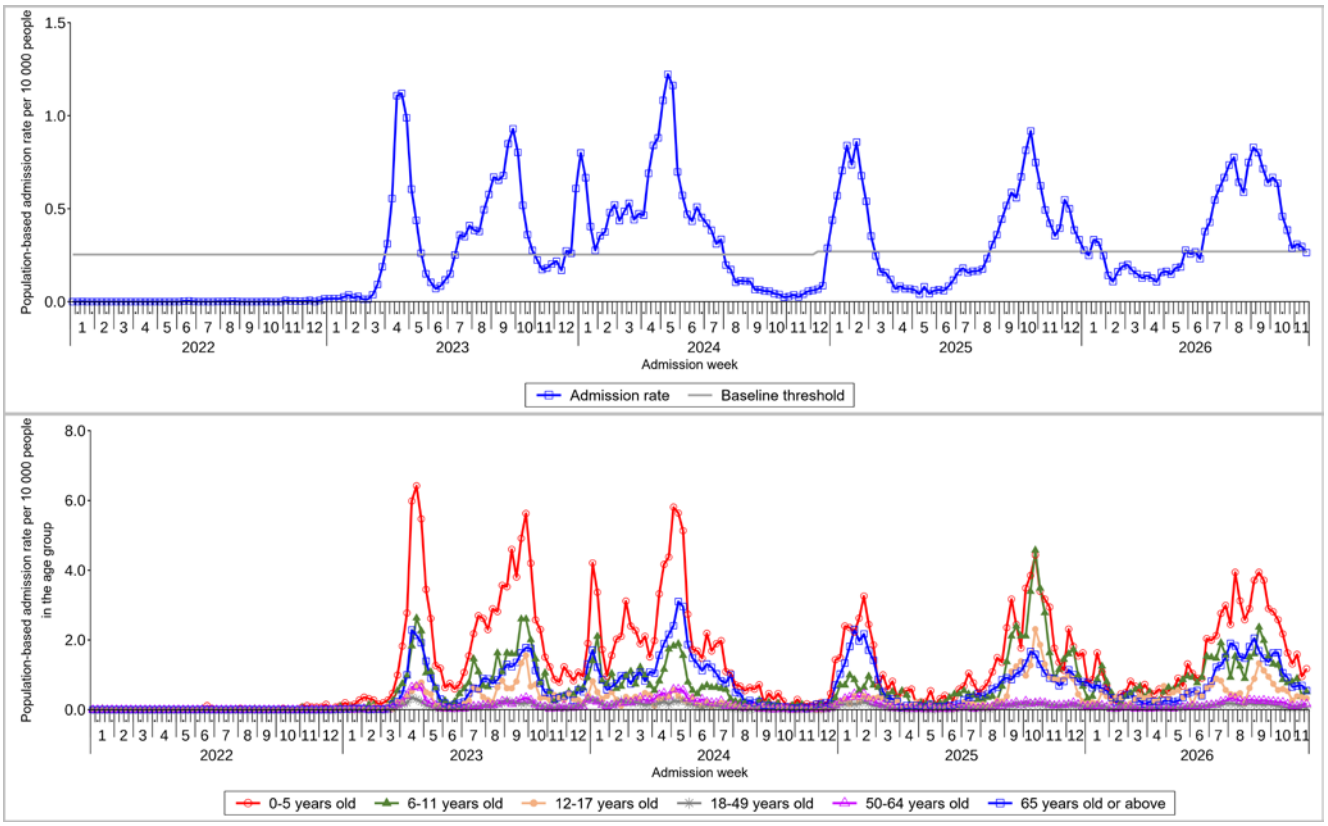


Figure 2.6 Influenza-associated hospital admission rates, 2022-26 (upper: overall rate, lower: rates by age groups)

[Notes: The Centre for Health Protection (CHP) of the Department of Health closely monitors the local seasonal influenza activity through a series of surveillance systems. Among them, the CHP sets threshold levels for two important influenza indicators, including the positive percentage of influenza detections among respiratory specimens and the admission rate of patients diagnosed with influenza in public hospitals. These threshold levels are calculated statistically based on data collected for both indicators in the past years during non-season periods. Using these thresholds, the CHP assesses the current local situation of seasonal influenza with higher accuracy and determines whether Hong Kong enters influenza season. The CHP annually reviews and analyses the latest surveillance data, and updates these threshold levels where appropriate. The sensitivity of the surveillance system is enhanced with the updated thresholds of positive percentage of influenza detection and admission rate of higher coherence.]

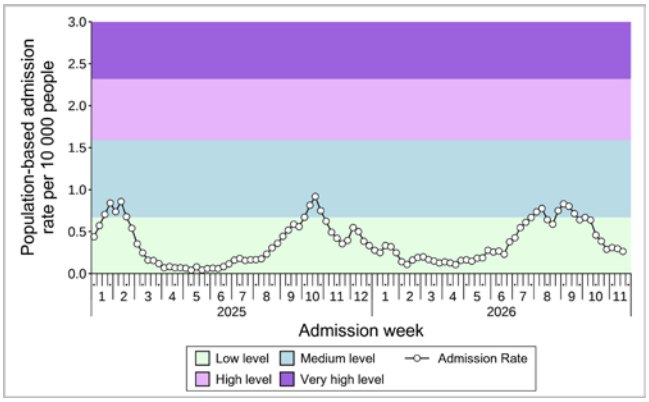


Figure 2.7 Influenza-associated hospital admission rates, 2025-26

Various intensity levels applicable for this year were calculated with the moving epidemic method (MEM). For details, please refer to this webpage: https://www.chp.gov.hk/files/pdf/explanatory_note_for_flux_mem_eng.pdf

Rate of ILI syndrome group in accident and emergency departments, 2022-26#

In week 47, the rate of the ILI syndrome group in the accident and emergency departments (AEDs) was 114.9 (per 1,000 coded cases), which was lower than the rate of 119.1 in the previous week (Figure 2.8).

#Note: This syndrome group includes codes related to ILI such as influenza, upper respiratory tract infection, fever, cough, throat pain, and pneumonia.

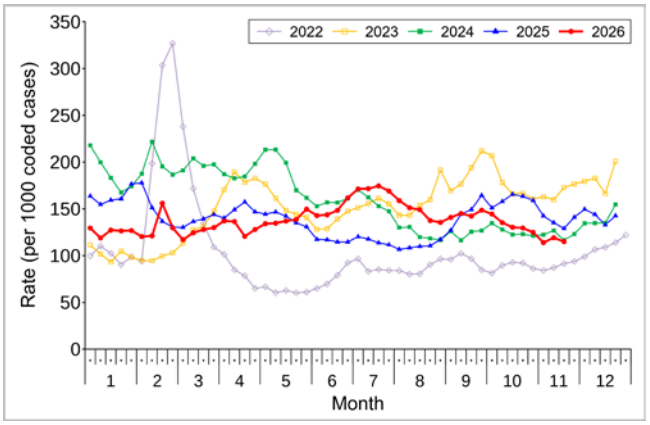


Figure 2.8 Rate of ILI syndrome group in AEDs, 2022-26

Fever surveillance at sentinel child care centres/kindergartens, 2022-26

In week 47, 0.75% of children in the sentinel child care centres / kindergartens (CCCs/KGs) had fever (38°C or above) as compared to 0.74% recorded in the previous week (Figure 2.9).

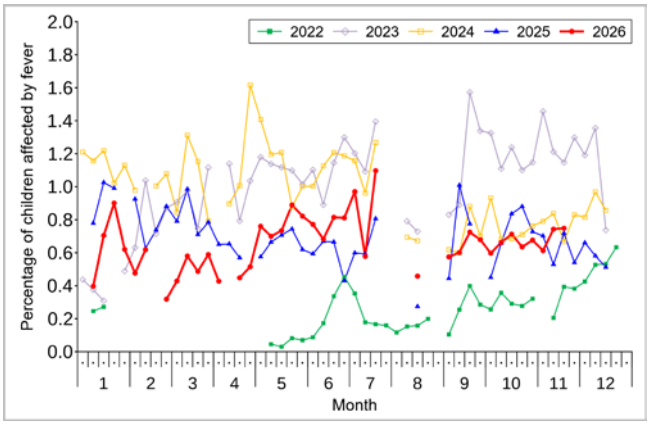


Figure 2.9 Percentage of children with fever at sentinel CCCs/KGs, 2022-26

Fever surveillance at sentinel residential care homes for the elderly, 2022-26

In week 47, 0.11% of residents in the sentinel residential care homes for the elderly (RCHEs) had fever (38°C or above), compared to 0.10% recorded in the previous week (Figure 2.10).

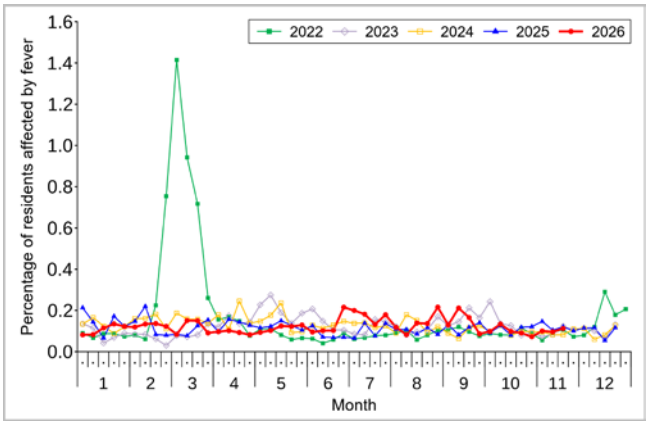


Figure 2.10 Percentage of residents with fever at sentinel RCHEs, 2022-26

Influenza-like illness surveillance among sentinel Chinese medicine practitioners, 2022-26

In week 47, the average consultation rate for ILI among Chinese medicine practitioners (CMPs) was 1.04 ILI cases per 1,000 consultations as compared to 0.24 recorded in the previous week (Figure 2.11).

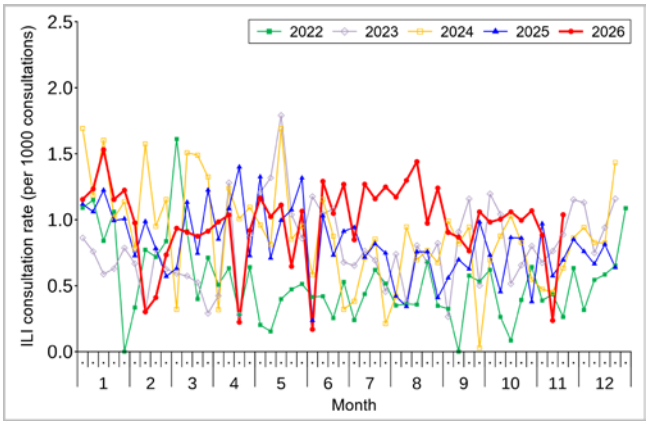


Figure 2.11 ILI consultation rate at sentinel CMPs, 2022-26

Surveillance of severe influenza cases

(Note: The data reported are provisional figures and subject to further revision.)

Surveillance for intensive care unit (ICU) admission/death with laboratory confirmation of influenza among adult patients (Aged 18 years or above)

Since 2018, the Centre for Health Protection (CHP) has collaborated with the Hospital Authority and private hospitals to monitor ICU admissions and deaths with laboratory confirmation of influenza among adult patients regularly. For surveillance purposes, the cases refer to laboratory-confirmed influenza patients who required ICU admission or died within the same admission of influenza infection. Their causes of ICU admission or death may be due to other acute medical conditions or underlying diseases.

- In week 47, 18 adult cases of ICU admission/death with laboratory confirmation of influenza (including 10 deaths) were recorded, as compared to 37 cases (including 27 deaths) in the previous week. Among the 18 adult cases, 15 were not known to have received the SIV. In the first 4 days of week 48 (Nov 22 to 25), 9 cases were recorded, in which 5 of them were fatal.

Week	Influenza type					
	A(H1)	A(H3)	A (pending subtype)	B	A and B	C
Week 47	17	1	0	0	0	0
First 4 days of week 48 (Nov 22 to 25)	8	0	0	1	0	0

- During the influenza season, 1004 adult cases of ICU admission/death with laboratory confirmation of influenza were recorded, in which 706 of them were fatal (as of Nov 25). Among them, 674 patients had influenza A(H1) infection, 210 patients had influenza A(H3), 80 patients had influenza A (subtype pending), 38 patients had influenza B and 2 had influenza C.

- In comparison, 952 adult cases were recorded in the same duration of surveillance (22 complete weeks) in the 2024 season, as compared with 995 cases in the current season (Figure 2.12, left). The corresponding figure for deaths was 632 in the above season, as compared with 701 deaths in the current season (Figure 2.12, right).

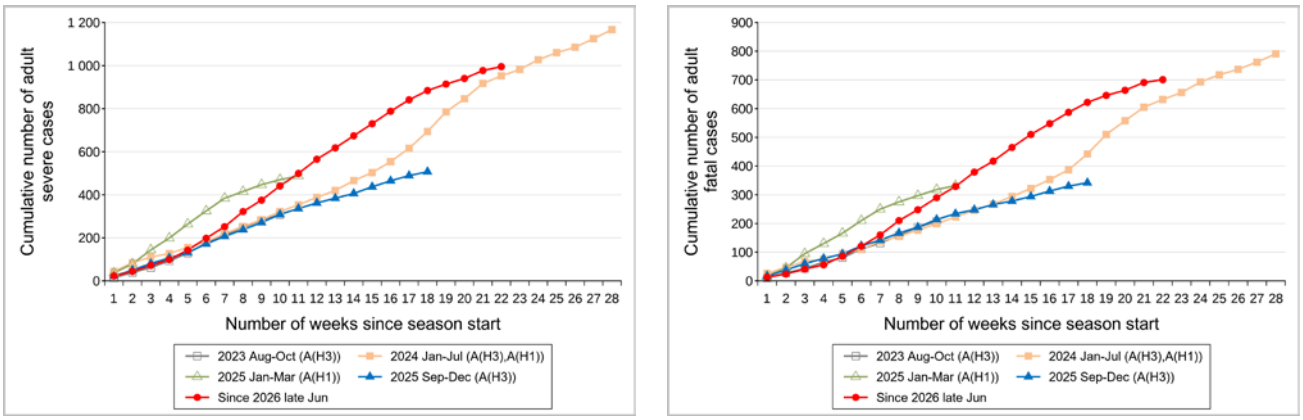


Figure 2.12 Cumulative numbers of adult severe influenza cases reported during major influenza seasons, 2023–26 (left: ICU admission/death cases; right: deaths)

Note: The predominating virus was shown in bracket.

Surveillance of severe paediatric influenza-associated complication/death (Aged below 18 years)

- In week 47 and the first 4 days of week 48 (Nov 22 to 25), there were no cases of severe paediatric influenza-associated complication/death.
- During the influenza season, 29 paediatric cases of influenza-associated complication/death were reported, in which three of them were fatal. Twenty-one cases had infections with influenza A(H1), six with influenza A(H3) and two with influenza B. Nineteen cases had not received SIV. In 2026, 37 paediatric cases of influenza-associated complication/death were reported, in which three of them were fatal (as of Nov 25).
- In comparison, 29 paediatric cases of influenza-associated complication/death were recorded in the same duration of surveillance (22 complete weeks) in the 2024 season, as compared with 29 cases in the current season (Figure 2.13, left). The corresponding figure for deaths was 4 in the above season, as compared with 3 deaths in the current season (Figure 2.13, right).

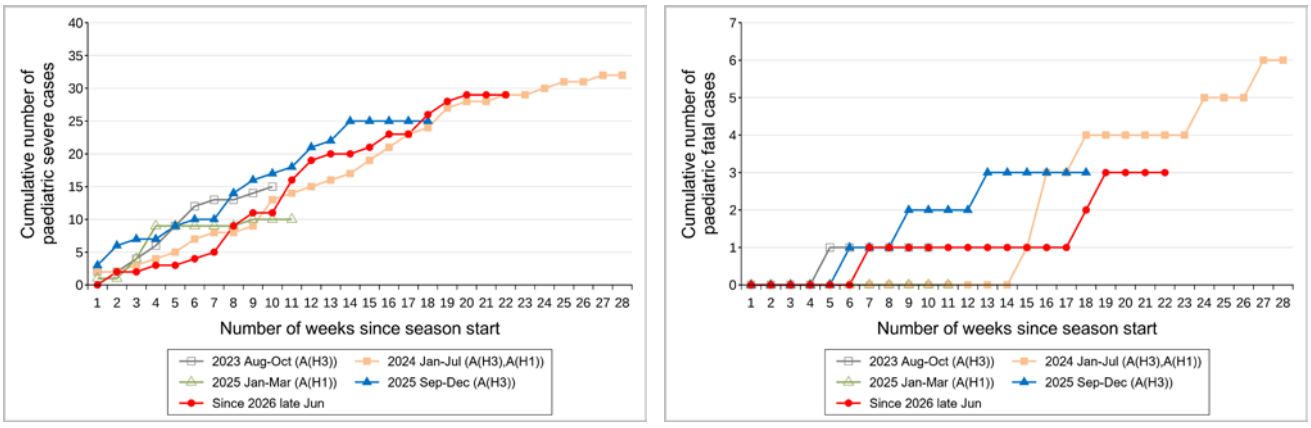


Figure 2.13 Cumulative numbers of cases of paediatric influenza-associated complication/death reported during major influenza seasons, 2023–26 (left: complication/death cases; right: deaths)

Note: The predominating virus was shown in bracket.

Severe influenza cases of all ages

- During the influenza season, 1033 severe influenza cases among all ages have been reported, including 709 deaths (as of Nov 25).

Age group	Cumulative number of cases (death)
0-5	10 (1)
6-11	13 (1)
12-17	6 (1)
18-49	61 (12)
50-64	126 (48)
>=65	817 (646)

- Among the adult fatal cases with available clinical information, about 85% had chronic diseases.
- Among patients with laboratory confirmation of influenza admitted to public hospitals in this season, 3.3% of admitted cases died during the same episode of admission. It was within the historical range of 2.5% to 4.5%.

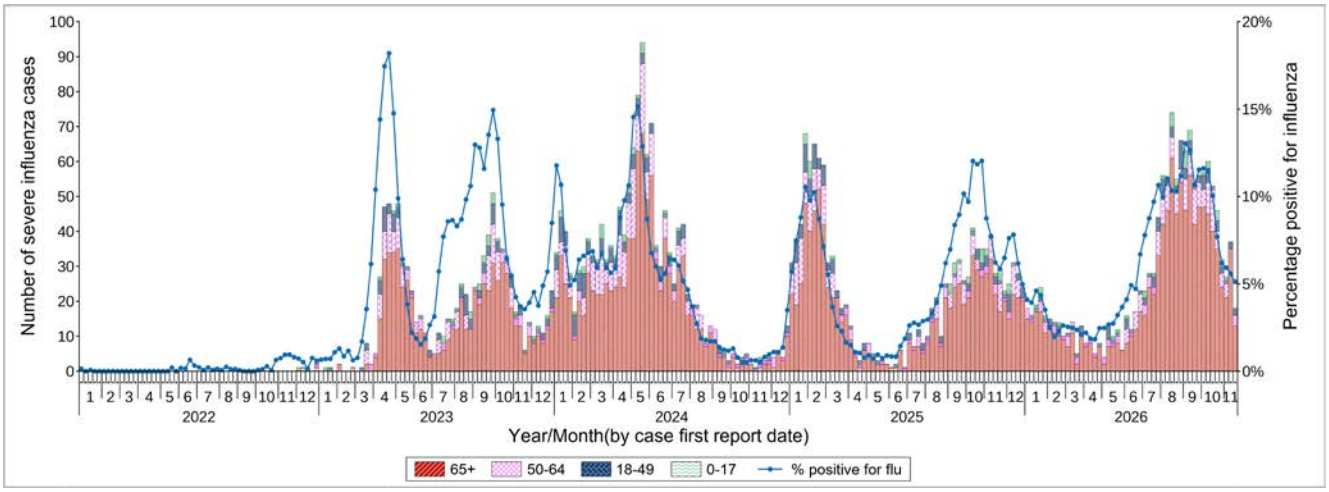


Figure 2.14 Weekly number of severe influenza cases by age groups, 2022-26 (the percentage positive for influenza viruses in Figure 2.2 is also shown in this graph)

Sewage surveillance for seasonal influenza

CHP has leveraged established infrastructure to launch a new sewage-based surveillance indicator for tracking local seasonal influenza activity in the community as a complement to the conventional systems. Starting from late October 2025, CHP publishes sewage surveillance results on seasonal influenza viruses.

In week 47, viral load of influenza A and B viruses from sewage surveillance was 2.83 copies (unit adjusted for population)*, which was lower than 2.91 copies* recorded in the previous week (Figure 2.15).

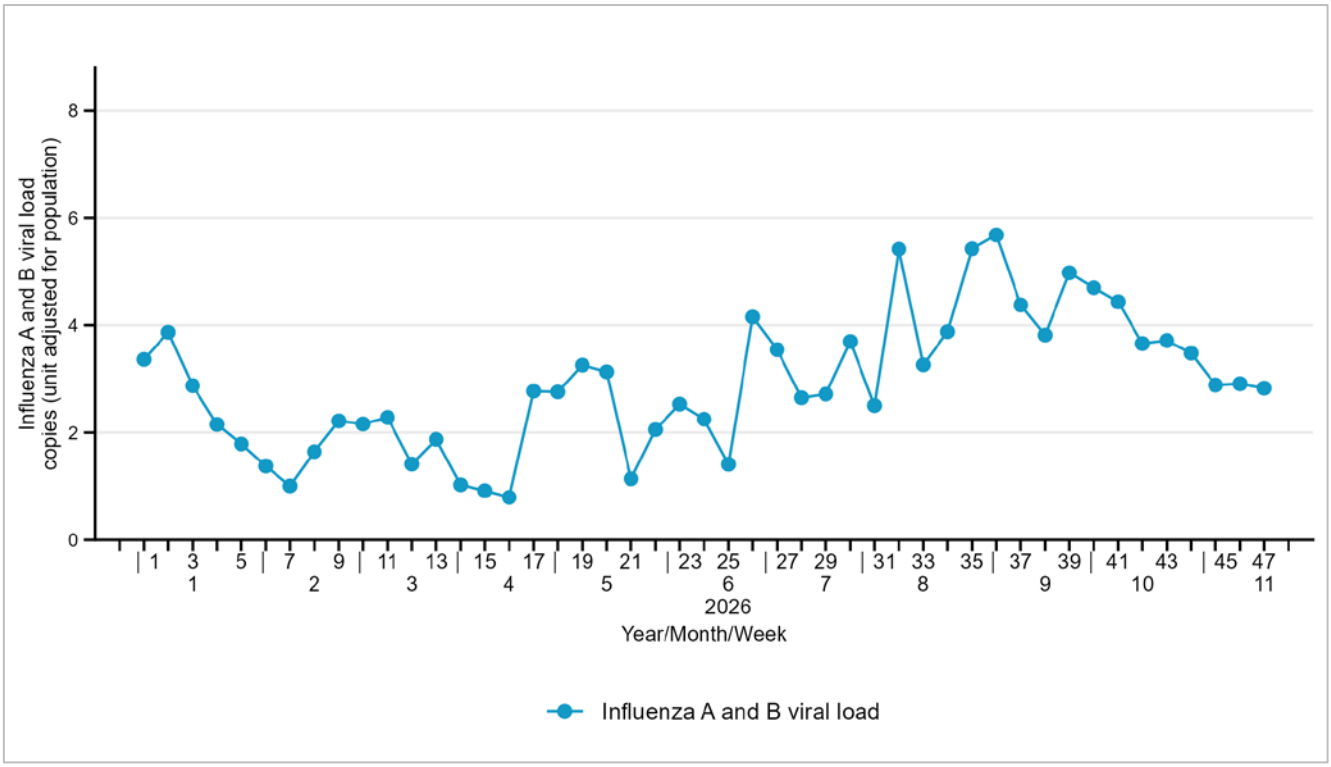


Figure 2.15 Viral load of influenza A and B viruses from sewage surveillance, 2026

**Note: The unit for influenza viral load in sewage is the number of influenza virus copies per 1,000 copies of Pepper Mild Mottle Virus (PMMoV), which is a standardised unit. PMMoV is a plant virus primarily found in peppers and their products. It is harmless to humans and does not cause disease. It enters the human body through food ingestion and is excreted in faeces, making it a common biomarker for estimating the size of the population catchment of the sampling sites. Normalising viral load data with PMMoV can reduce the influence of population fluctuations, thereby making the monitoring more accurate and reliable.*

Acknowledgement
The initiative is funded by the Hong Kong Jockey Club Charities Trust through its "Special Donation on Epidemic Preparedness" to the CHP.

Global Situation of Influenza Activity

Globally, influenza detections continued to increase in week 46, with influenza A viruses predominant. Among subtyped influenza A detections, A(H1) predominated (data up to Nov 15, 2026).

- In the United States (week ending Nov 14, 2026), influenza activity continued to increase nationally. The percentage of specimens tested positive for influenza increased to 11.8%. Influenza A(H1) viruses predominated.
- In Canada (week ending Nov 14, 2026), influenza activity was at moderate levels and had generally increased over the past 4 weeks, although it remained stable in the most recent reporting week. The percentage of specimens that tested positive for influenza increased to 14.5%. Influenza A(H1) viruses predominated.
- In Europe (week ending Nov 15, 2026), influenza positivity has exceeded 10% for more than 2 consecutive weeks, marking the start of seasonal epidemic at the regional level. Influenza test positivity remained above the 10% epidemic threshold at 11% compared to 11% in the prior week. The majority of influenza detections were influenza A(H1) viruses.
- In the United Kingdom (week ending Nov 15, 2026), influenza activity increased and was circulating at low levels. Influenza positivity was 11.4% as compared with 8.3% in the preceding week.
- In Chinese Mainland (week ending Nov 15, 2026), influenza test positivity decreased slightly in the southern provinces but increased in the northern provinces. In week 46, influenza test positivity in the southern and northern provinces was 17.4% and 16.3%, respectively. Influenza A viruses predominated. In Macao (week ending Nov 14, 2026), influenza-like illness activity increased overall. The influenza virus positivity rate rose from 10.3% in the previous week to 13.6%, with influenza A(H1) being the predominant circulating virus. In Taiwan (week ending Nov 14, 2026), influenza activity decreased in recent weeks but the number of severe influenza cases remained high. Influenza A(H1) viruses predominated in the community.
- In Japan (week ending Nov 15, 2026), the average number of reported ILI cases per sentinel site continued to increase to 11.94 from 11.00 in the preceding week, higher than the epidemic baseline threshold of 1.0. Influenza A(H1) was the predominant virus detected.
- In South Korea (week ending Nov 14, 2026), the weekly ILI consultation rate continued to increase to 37.0 from 28.9 cases per 1,000 consultations in the preceding week. The influenza positivity rate increased to 33.1% as compared to 27.7% in the preceding week. Influenza A(H1) was the predominant virus detected.

Sources:
Information has been extracted from the following sources when updates are available: World Health Organization, United States Centers for Disease Control and Prevention, Public Health Agency of Canada, European Centre for Disease Prevention and Control (ECDC) and WHO Regional Office for Europe (WHO Euro), UK Health Security Agency and Chinese National Influenza Center, Japan Ministry of Health and Korean Disease Control and Prevention Agency.