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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 Feb 18, 2026)

Reporting period: Feb 8, 2026 – Feb 14, 2026 (Week 7)

- The latest surveillance data showed that the overall local activity of COVID-19 has 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 showed that XFG and NB.1.8.1 are the co-circulating variant strains in Hong Kong. XFG and NB.1.8.1 are related to the lineage JN.1. The World Health Organization (WHO) listed XFG and NB.1.8.1 as a variant under monitoring (VUM) on June 25, 2025 and May 23, 2025 respectively, and stated that the currently approved COVID-19 vaccines are expected to be effective against XFG and NB.1.8.1, and there is no evidence to suggest that XFG or NB.1.8.1 will cause more serious diseases.
- 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 7, the weekly number of newly recorded positive nucleic acid test laboratory detections for SARS-CoV-2 virus was 5 as compared to 6 in the preceding week. (Figure 1.1)

In the first 4 days of week 8 (Feb 15– Feb 18), the daily number of newly recorded positive nucleic acid test laboratory detections for SARS-CoV-2 virus was 0.

Since Jan 30, 2023, the cumulative number of positive nucleic acid test laboratory detections was 84,418 (as of Feb 18, 2026).

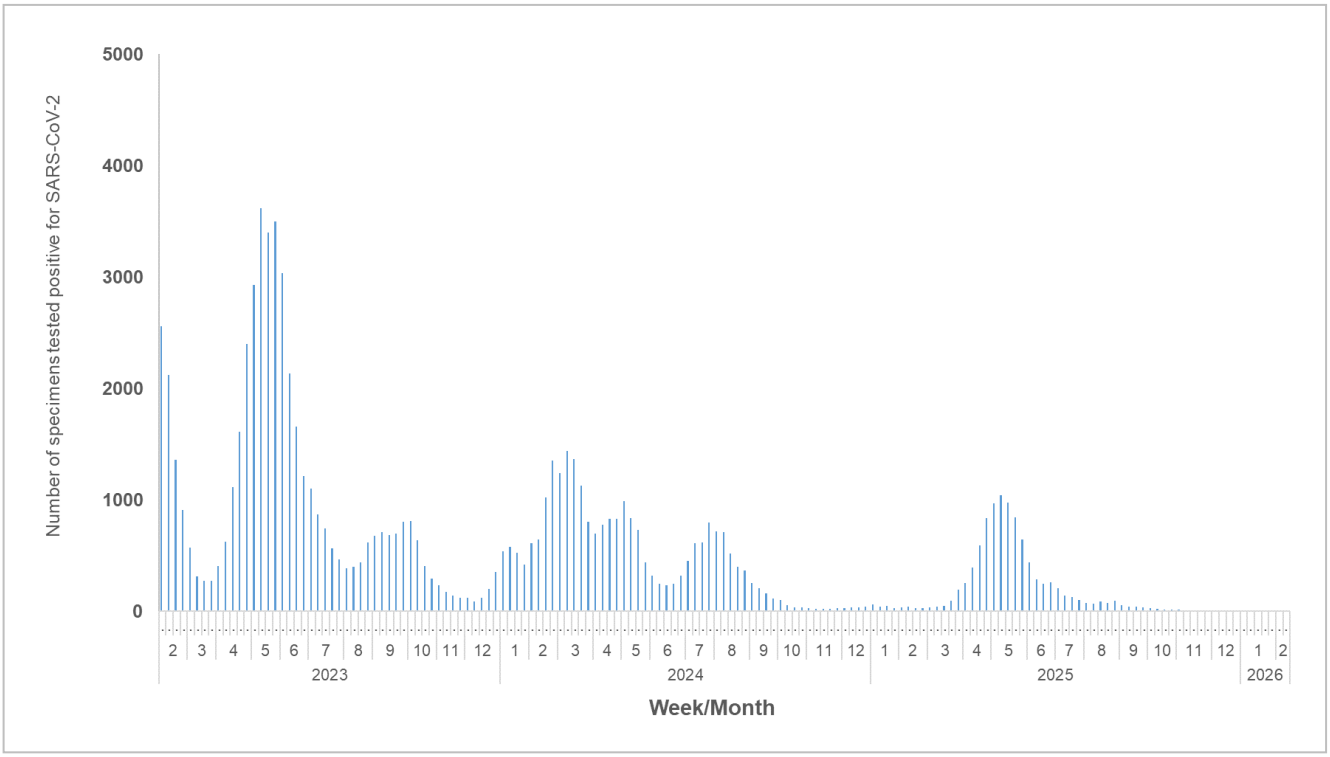

Figure 1.1 Weekly number of positive nucleic acid test laboratory detections for SARS-CoV-2 virus

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 8,126 respiratory specimens received by the Public Health Laboratory Services Branch (PHLSB) in week 7, 8 (0.10%) were tested positive for SARS-CoV-2 virus as compared to 8 (0.10%) in the preceding week. (Figure 1.2)

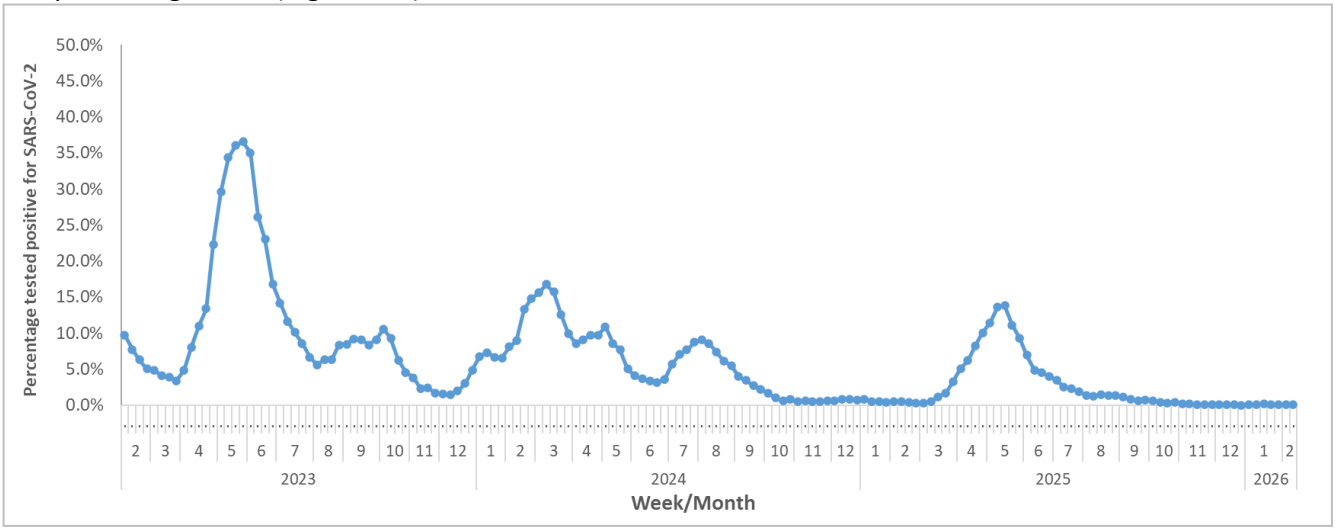

Figure 1.2 Percentage of specimens tested positive for SARS-CoV-2 virus at PHLSB

COVID-19 outbreak surveillance

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

In week 7, 1 COVID-19 outbreak occurring in schools/institutions was recorded (affecting 7 persons), as compared to 0 outbreak recorded in the previous week (affecting 0 persons). (Figure 1.3)

In the first 4 days of week 8 (Feb 15–Feb 18), 0 COVID-19 outbreaks occurring in schools/institutions were recorded (affecting 0 persons).

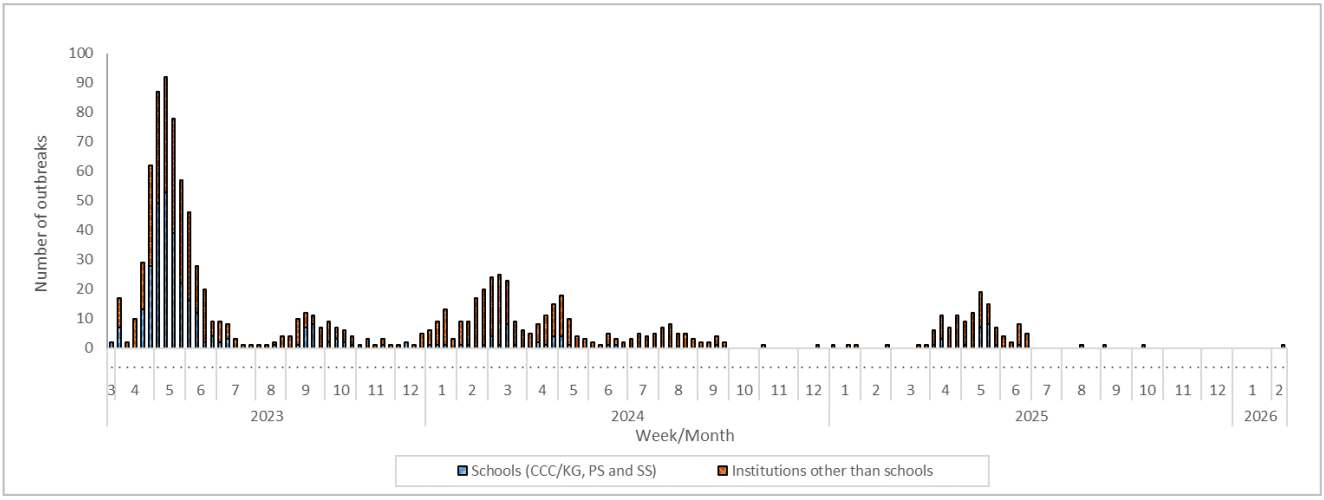

Figure 1.3 COVID-19 outbreaks in schools/institutions

Type of institutions	Week 6	Week 7	First 4 days of week 8 (Feb 15–Feb 18)
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	1	0
Residential care home for persons with disabilities	0	0	0
Others	0	0	0
Total number of outbreaks	0	1	0
Total number of persons affected	0	7	0

Surveillance of severe and fatal COVID-19 cases

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

In week 7, 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)

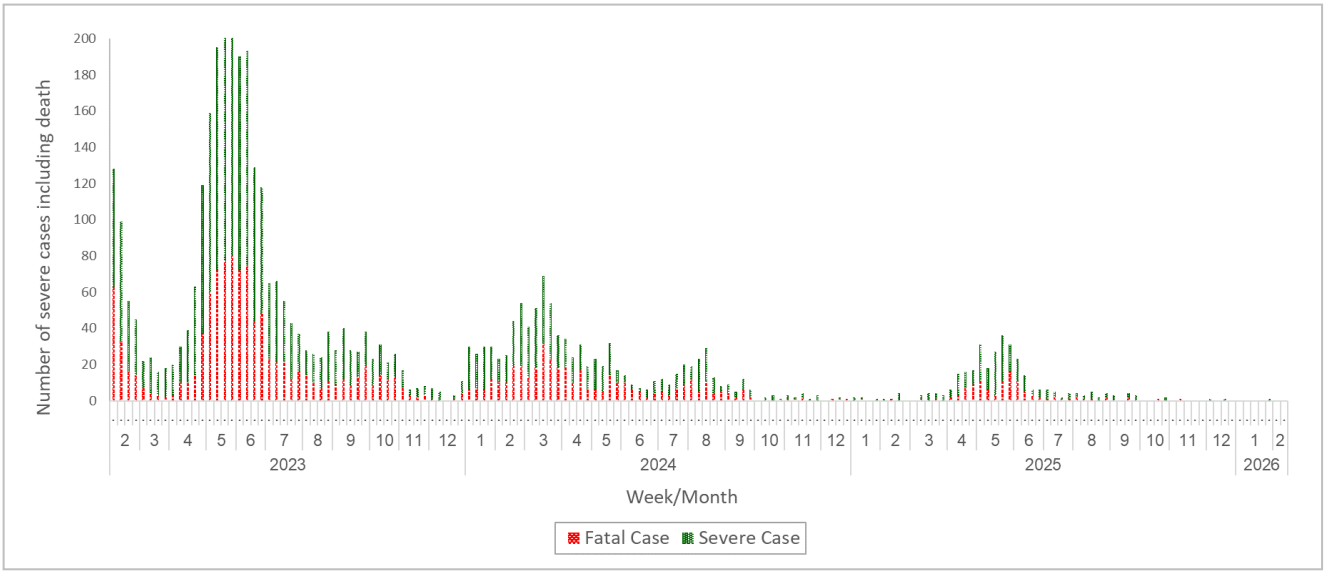

Figure 1.4 Weekly number of severe COVID-19 cases including deaths

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

Sewage surveillance of SARS-CoV-2 virus

In week 7, the 7-day geometric mean per capita viral load of SARS-CoV-2 virus from sewage surveillance was around 2,000 copy/L as compared to around 160 copy/L in the preceding week.

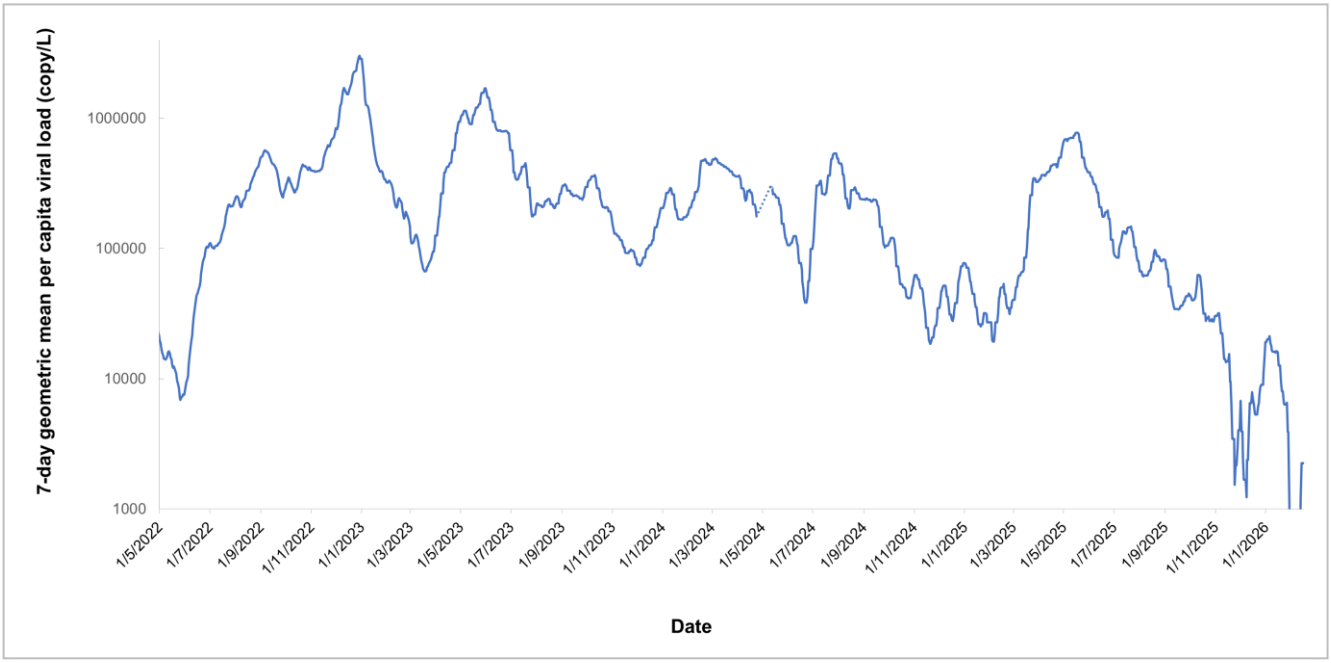

Figure 1.5 7-day geometric mean per capita viral load of SARS-CoV-2 virus from sewage surveillance since May 1, 2022

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 7, the average consultation rate for COVID-19 among sentinel family medicine clinics and sentinel private medical practitioner clinics were 0.4 (Figure 1.6) and 0.7 (Figure 1.7) COVID-19 cases per 1,000 consultations, respectively.

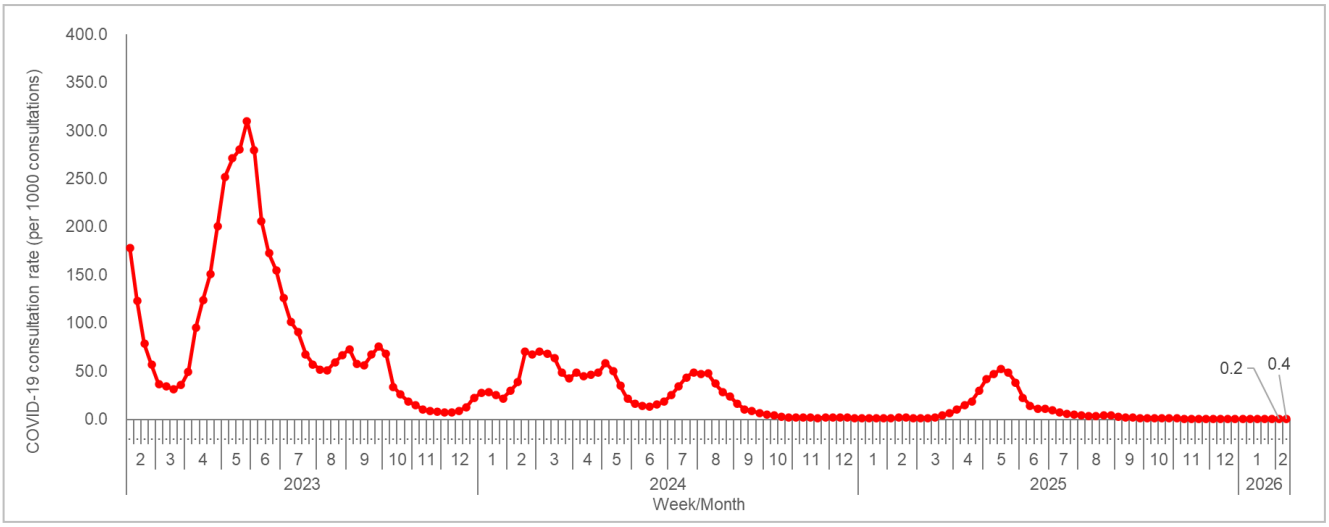

Figure 1.6 Average consultation rate of COVID-19 cases in family medicine clinics

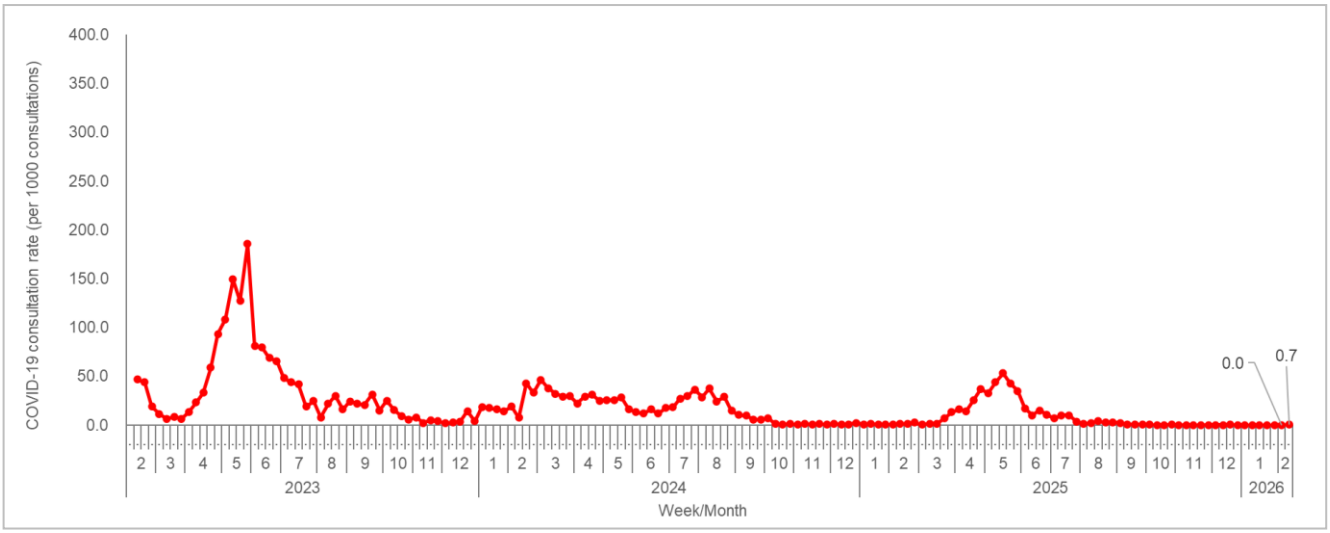

Figure 1.7 Average consultation rate of COVID-19 cases in private medical practitioner clinics

Surveillance on SARS-CoV-2 variants

Currently, WHO is monitoring one variant of interest (VOI), which is JN.1, and five VUMs, which are KP.3.1.1, LP.8.1, NB.1.8.1, XFG and BA.3.2. CHP conducts surveillance on SARS-CoV-2 variants from sewage samples. The latest surveillance data (as of Feb 4, 2026) showed that XFG is the most prevalent variant, comprising 62.0% of all characterised specimens. (Figure 1.8)

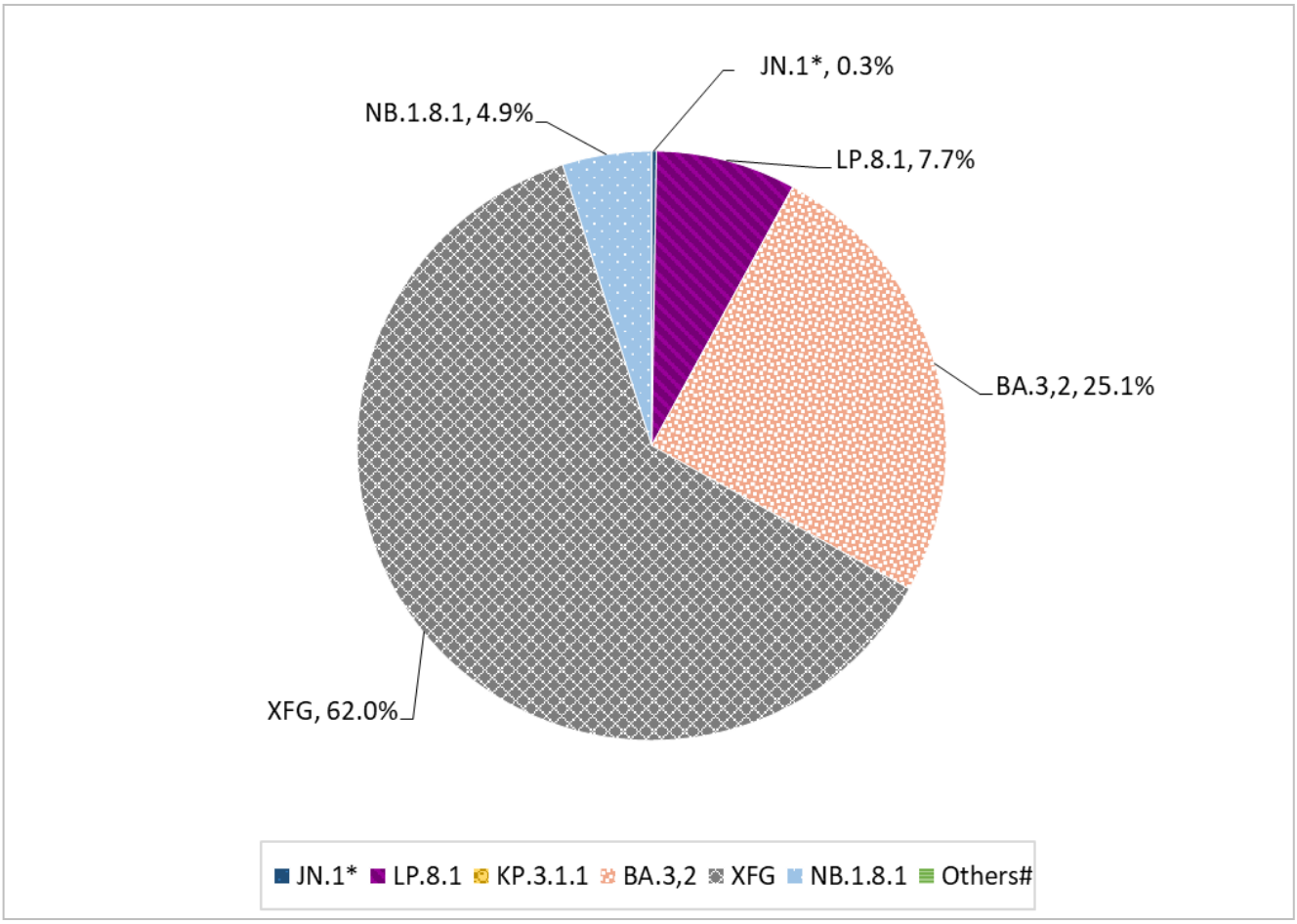

Figure 1.8 Estimated proportion of variants among sewage samples

**Including JN.1 and its 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: KP.3.1.1, LP.8.1 and XFG are the descendant lineages of JN.1. BA.3.2 is a descendent lineage of the Omicron variant BA.3.

CHP also conducted genetic characterisation on reported severe and fatal cases of COVID-19. No related specimens were collected for testing between Jan 14, 2026 and Feb 10, 2026.

Besides, CHP conducted genetic characterisation for the specimens obtained from some non-severe cases of COVID-19 during the same period. The results showed that NB.1.8.1 and XFG were the most prevalent variants, respectively comprising 46% and 40% of all characterised specimens.

Global situation of COVID-19 activity

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

- The COVID-19 activity in most of the following regions decreased gradually or remained stable at low levels.
  - In Chinese Mainland (week ending Feb 8, 2026), the overall percentage of specimens tested positive for SARS-CoV-2 remained at low level. The predominant variant was NB.1.8.1 recently. In Taiwan region (week ending Feb 7, 2026), the COVID-19 activity remained at low level. The predominant variant was XFG.
  - In Japan (week ending Feb 8, 2026), the average number of reported COVID-19 cases per sentinel site was 2.71 compared to 2.49 in the preceding week. The predominant variant was NB.1.8.1.
  - In South Korea (week ending Feb 7, 2026), the weekly detection rate for SARS-CoV-2 was 1.4% compared to 1.3% in the preceding week. The predominant variant was NB.1.8.1.
  - In Singapore (week ending Feb 7, 2026), the positivity rate for COVID-19 among acute respiratory infection (ARI) samples in the community was 1% compared to 1% in the preceding week.
  - In the United States (week ending Jan 10, 2026), the percent positivity of COVID-19 was 5.2% compared to 5.0% in the preceding week. The predominant variant was XFG.
  - In Canada (week ending Feb 7, 2026), some indicators of COVID-19 activity remained stable. The percentage of tests positive for COVID-19 was 5.2%, compared to 5.2% in the preceding week. The predominant variants were NB.1.8.1 and XFG.
  - In the United Kingdom (week ending Feb 8, 2026), COVID-19 activity remained stable. COVID-19 PCR positivity in hospital settings was 2.5% compared to 2.1% in the preceding week. The predominant variants were NB.1.8.1 and XFG.
  - In Europe (week ending Feb 8, 2026), SARS-CoV-2 positivity from sentinel specimens was 3.0% compared to 3.0% in the preceding week. The predominant variant was XFG.
  - In Australia (month ending Jan 25, 2026), test positivity for SARS-CoV-2 remained at low level. The predominant variant was XFG.

Sources:

Information have been extracted from the following sources when updates are available: World Health Organization, Chinese Center for Disease Control and Prevention, Taiwan Centers for Disease Control, 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 Feb 18, 2026)

Reporting period: Feb 8 – 14, 2026 (Week 7)

- The latest surveillance data showed that the local influenza activity was at low level.
- 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 protect themselves against seasonal influenza and its complications, as well as related hospitalisations and deaths.
- 2025/26 Seasonal Influenza Vaccination (SIV) Programmes, including the SIV School Outreach Programme and the Residential Care Home Vaccination Programme, have been commenced on September 25, 2025, and the Vaccination Subsidy Scheme has also been commenced on September 22, 2025. Eligible high-risk groups can receive a free or subsidised SIV through various vaccination 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 7, the average consultation rate for influenza-like illness (ILI) among sentinel family medicine clinics (FMC) was 5.4 ILI cases per 1,000 consultations, which was lower than 6.7 recorded in the previous week (Figure 2.1, left). The average consultation rate for ILI among sentinel private medical practitioner (PMP) clinics was 22.4 ILI cases per 1,000 consultations, which was lower than 32.2 recorded in the previous week (Figure 2.1, right).

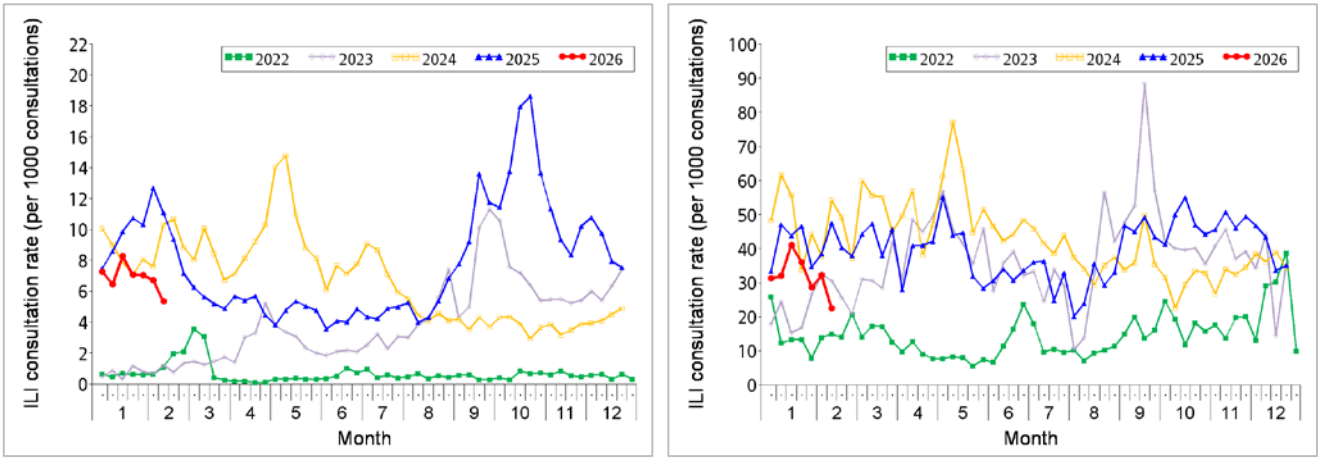

Figure 2.1 ILI consultation rates at sentinel FMC (left) and PMP clinics (right), 2022-26

Laboratory surveillance, 2022-26

Among the 8,705 respiratory specimens* received in week 7, 169 (1.94%) were tested positive for seasonal influenza A or B viruses. Among the subtyped influenza detections, there were 17 (10%) influenza A(H1), 120 (71%) influenza A(H3) and 31 (19%) influenza B viruses. The positive percentage (1.94%) was below the baseline threshold of 4.94% and was lower than 2.50% recorded in the previous week (Figure 2.2).

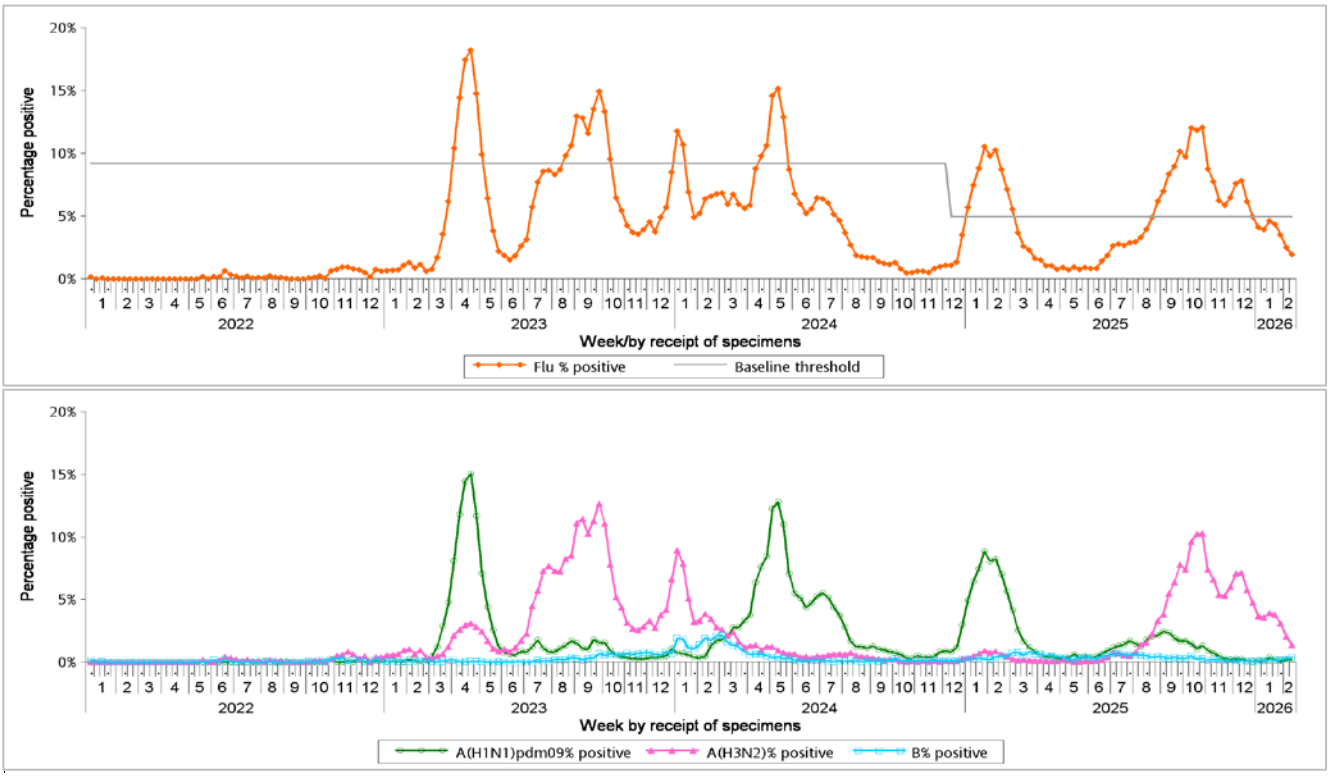

Figure 2.2 Percentage of respiratory specimens tested positive for influenza viruses, 2022-26 (upper: overall positive percentage, lower: positive percentage by subtypes)

[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 8,126 specimens received by Public Health Laboratory Services Branch, Centre for Health Protection and 579 specimens received by the Hospital Authority

Surveillance of oseltamivir (Tamiflu) resistant influenza A and B viruses

- The Public Health Laboratory Services Branch of the Centre for Health Protection tests virus isolates of influenza A(H3) and B viruses obtained from cell culture for antiviral susceptibility to oseltamivir. For influenza A(H1) viruses, genotypic assay for H275Y substitution (which confers resistance to oseltamivir) is also performed on selected clinical specimens.
- In December 2025, there were no new reports of influenza A(H3) and B viruses with reduced susceptibility to oseltamivir, nor any influenza A(H1) virus with H275Y substitution in December 2025.
- For the results of previous months, please refer to the following webpage: https://www.chp.gov.hk/en/statistics/data/10/641/695/7088.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 7, 15 ILI outbreaks occurring in schools/institutions were recorded (affecting 93 persons), as compared to 28 outbreaks recorded in the previous week (affecting 171 persons) (Figure 2.3). In the first 4 days of week 8 (Feb 15 to 18), no ILI outbreaks in schools/institutions were recorded.

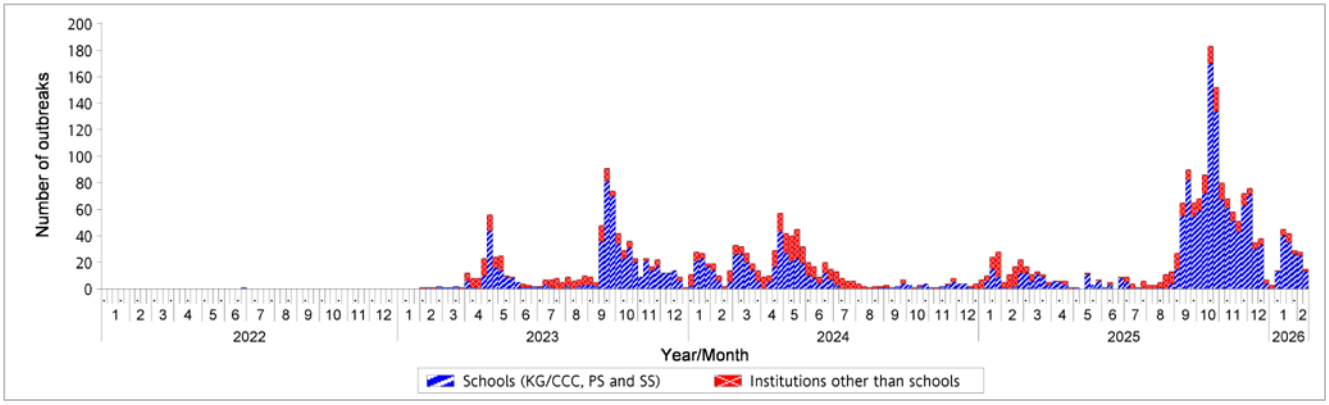

Figure 2.3 ILI outbreaks in schools/institutions, 2022-26

Type of institutions	Week 6	Week 7	First 4 days of week 8 (Feb 15 to 18)
Child care centre/ kindergarten (CCC/KG)	2	1	0
Primary school (PS)	16	7	0
Secondary school (SS)	7	5	0
Residential care home for the elderly	1	1	0
Residential care home for persons with disabilities	0	0	0
Others	2	1	0
Total number of outbreaks	28	15	0
Total number of persons affected	171	93	0

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

In week 7, the overall admission rates in public hospitals with principal diagnosis of influenza was 0.09 (per 10,000 population), which was below the baseline threshold of 0.27 and was lower than 0.14 recorded in the previous week. 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 0.32, 0.35, 0.33, 0.03, 0.03 and 0.15 cases (per 10,000 people in the age group) respectively, as compared to 0.45, 0.48, 0.24, 0.02, 0.03 and 0.32 cases in the previous week (Figure 2.4).

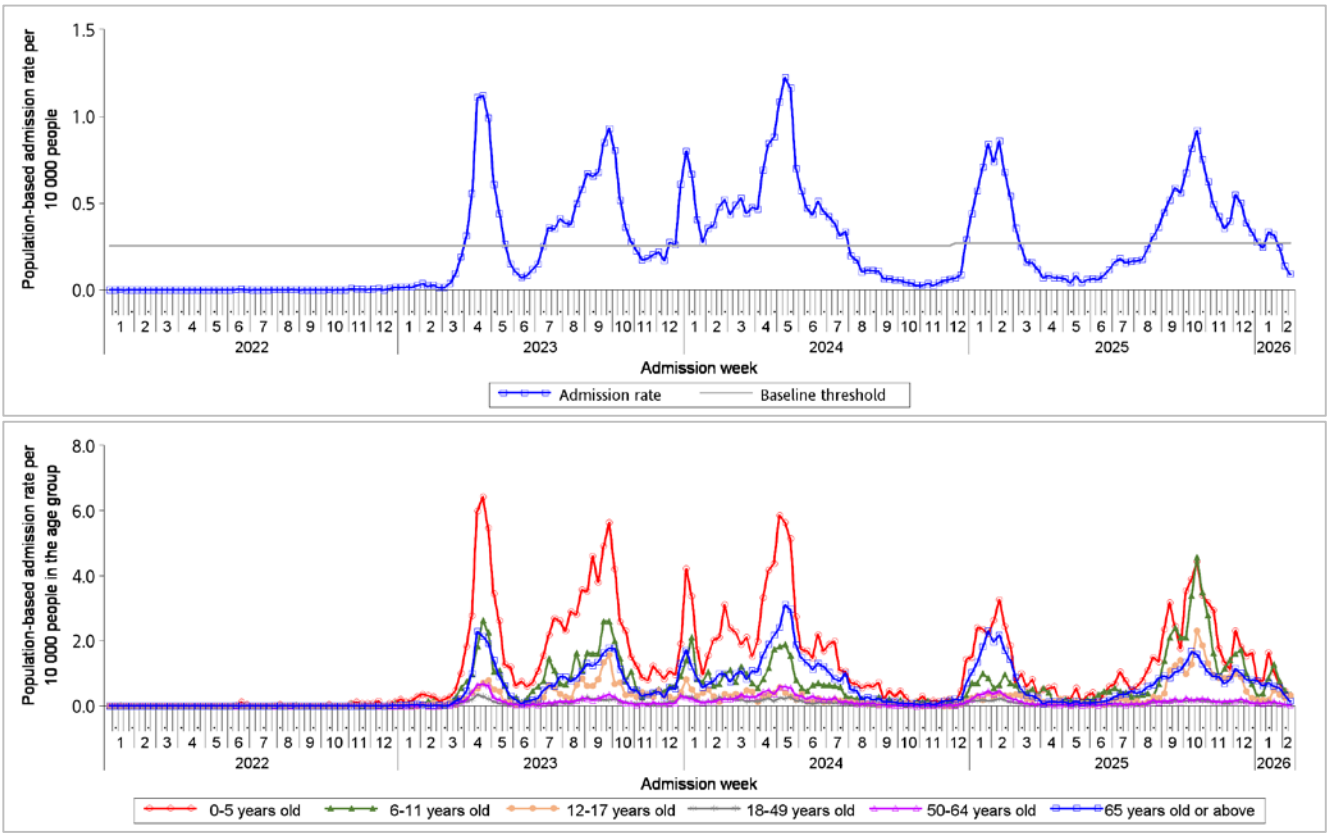

Figure 2.4 Influenza-associated hospital admission rates, 2022-26 (upper: overall rate, lower: rates by age groups)

[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.]

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

In week 7, the rate of the ILI syndrome group in the accident and emergency departments (AEDs) was 121.1 (per 1,000 coded cases), which was higher than the rate of 120.3 in the previous week (Figure 2.5).

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

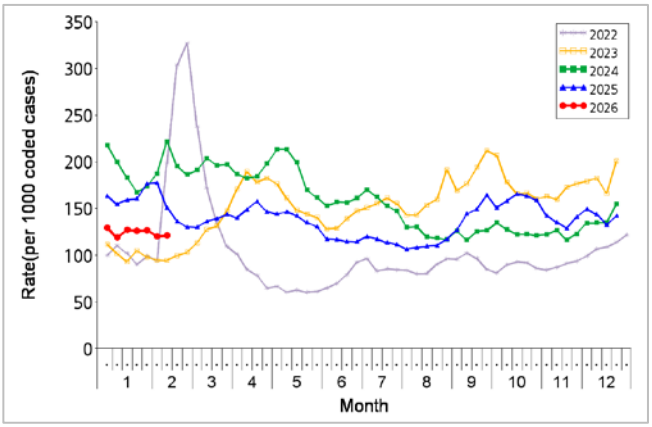

Figure 2.5 Rate of ILI syndrome group in AEDs, 2022-26

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

In week 7, 0.62% of children in the sentinel child care centres / kindergartens (CCCs/KGs) had fever (38°C or above) as compared to 0.48% recorded in the previous week (Figure 2.6).

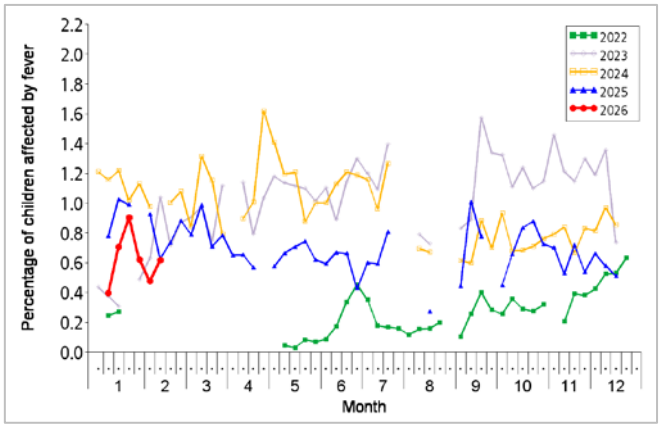

Figure 2.6 Percentage of children with fever at sentinel CCCs/KGs, 2022-26

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

In week 7, 0.13% of residents in the sentinel residential care homes for the elderly (RCHEs) had fever (38°C or above), compared to 0.12% recorded in the previous week (Figure 2.7).

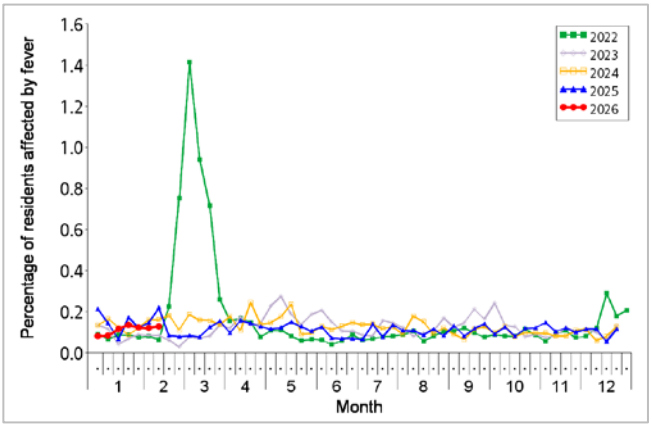

Figure 2.7 Percentage of residents with fever at sentinel RCHEs, 2022-26

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

In week 7, the average consultation rate for ILI among Chinese medicine practitioners (CMPs) was 0.30 ILI cases per 1,000 consultations as compared to 0.98 recorded in the previous week (Figure 2.8).

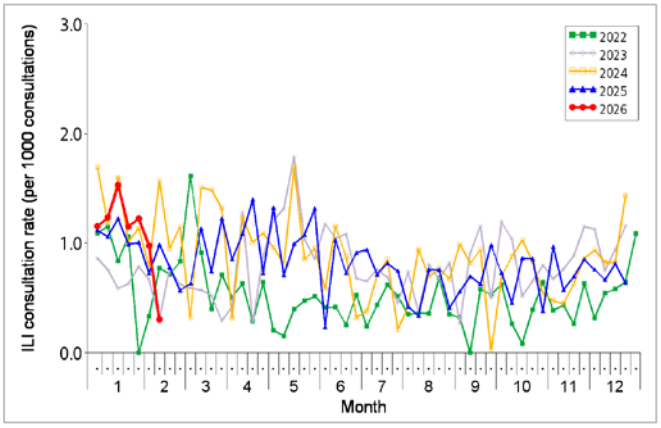

Figure 2.8 ILI consultation rate at sentinel CMPs, 2022-26

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 purpose, 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 7, 14 adult cases of ICU admission/death with laboratory confirmation of influenza (including 11 deaths) were recorded, as compared to 15 cases (including 9 deaths) in the previous week.

Week	Influenza type					
	A(H1)	A(H3)	A (pending subtype)	B	H1 and H3	C
Week 6	1	9	5	0	0	0
Week 7	1	9	2	1	0	1

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

- In week 7 and the first 4 days of week 8 (Feb 15 to 18), there was one case of severe paediatric influenza-associated complication/death.

Reporting week	Age	Sex	Complication	Fatal case?	Influenza subtype	History of receiving 2025/26 influenza vaccine
8	15 years	Male	Pneumonia and heart failure	No	Influenza A(H3)	No

- In 2026, 5 paediatric cases of influenza-associated complication/death were reported, in which none of them were fatal (as of Feb 18).

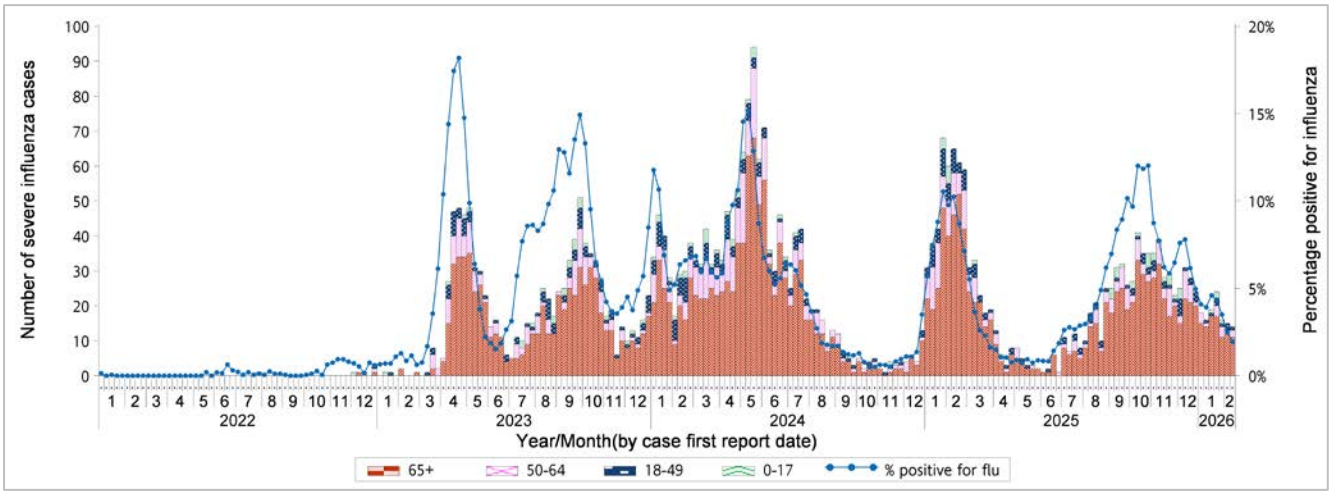

Figure 2.9 Weekly number of severe influenza cases by age groups, 2022-26 (the percentage positive for influenza viruses in Figure 2.2 is also shown in this graph)

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 7, viral load of influenza A and B viruses from sewage surveillance was 1.01 copies (unit adjusted for population)*, which was lower than the 1.38 copies* recorded in the previous week but remained above the baseline threshold# (0.79) (Figure 2.10).

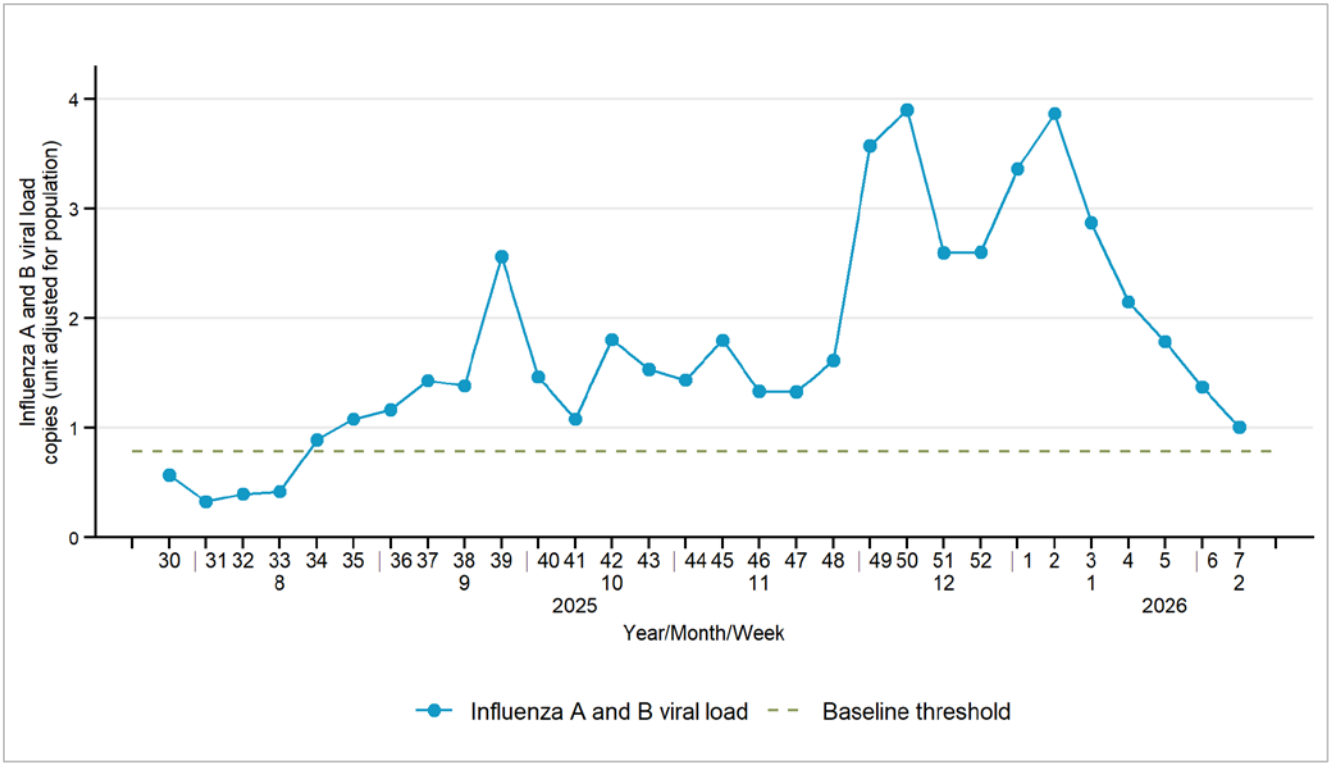

Figure 2.10 Viral load of influenza A and B viruses from sewage surveillance from week 30, 2025 onwards

**Note: The unit for influenza viral load in sewage is the number of influenza virus copies per 1,000 copies of Pepper Mild Molt 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.*

#Since there are only a few months of historical data on sewage surveillance for seasonal influenza, the current baseline threshold level is temporary. It is derived through a statistical model, which projects the baseline level for sewage surveillance from the corresponding baseline level of the percentage of respiratory specimens tested positive for influenza viruses (i.e. 4.94%).

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 decline in week 6 2026. Influenza A viruses were predominant among influenza detections, with a slight increase in the proportion of influenza B virus detections in recent weeks (data up to Feb 8, 2026).

- In the United States (week ending Feb 7, 2026), influenza activity remained elevated nationally. The percentage of specimens tested positive for influenza was 18.6% as compared to 17.5% in preceding week. Influenza A activity is decreasing while influenza B activity is increasing.
- In Canada (week ending Feb 7, 2026), all indicators of influenza activity continued to decrease. The percentage of tests positive for influenza decreased to 6.4% from 7.6% in the preceding week, still above the 5% seasonal threshold. Laboratory detections remain predominantly influenza A, and influenza B detections are increasing slowly but remain at low levels.
- In Europe (week ending Feb 8, 2026), influenza activity continued to decrease. Influenza positivity remained elevated at 28%, but lower than 34% in the preceding week, which was above the 10% epidemic threshold. Influenza A(H3) remained the dominant circulating virus.
- In the United Kingdom (week ending Feb 8, 2026), influenza activity continued to decrease. The positivity rate decreased to 3.9% from 5.5% in the preceding week. Most of the influenza viruses were influenza A(H3N2).
- In Chinese Mainland (week ending Feb 8, 2026), influenza activity continued to decrease in southern and northern provinces. The percentages of specimens that tested positive for influenza in southern and northern provinces were 15.0% and 8.7% in week 6, respectively. In Guangdong (week ending Feb 8, 2026), influenza activity gradually decreased, and decreased to below baseline level last week. The percentage of specimens tested positive for influenza decreased to 11.08% from 15.07% in previous week, still higher than the baseline of 12.44%. Influenza A(H3N2) viruses predominated. In Macao (week ending Feb 7, 2026), influenza detection rate remained below its alert level. Most of the influenza detection were influenza A (H3), followed by influenza B viruses.
- In Japan (week ending Feb 8, 2026), influenza activity continue to increase in the past few weeks. The average number of reported ILI cases per sentinel site further increased to 43.34 from 30.03 in the preceding week. Influenza B has become predominating in past 3 weeks.
- In South Korea (week ending Feb 7, 2026), influenza activity increased. The weekly proportion of influenza-like illness per 1,000 outpatients increased to 52.6 from 47.5 recorded in the preceding week. Influenza positivity was 38.4%, as compared to 40.6% in the preceding week. Influenza B has become predominating since mid-January.

Sources:
Information have 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, Chinese National Influenza Center, Japan Ministry of Health and Korean Disease Control and Prevention Agency.