NORTH Dakota | Health & Human Services
Be Legendary.

Health Alert Network | Health Advisory | October 22, 2026

Recommendations for Respiratory Infection Season

Influenza, Respiratory Syncytial Virus (RSV), COVID-19, and other respiratory pathogens are expected to circulate this fall and winter. ND Health and Human Services (HHS) reminds clinicians to consider influenza, RSV, COVID-19, and other possible pathogens when evaluating patients with respiratory illness. As many of these pathogens may share similar symptoms, respiratory testing can be used to inform decisions on the use of antiviral treatment, the need for additional testing, isolation recommendations, and infection prevention and control practices.

Patients often have great trust in their healthcare providers and their recommendations. Evidence shows that healthcare providers making declarative recommendations about which vaccines a patient is due for and discussing any concerns raised by the patient increase the likelihood of the patient electing to take those vaccines. ND HHS encourages providers to take every opportunity to discuss respiratory vaccines with their patients, as appropriate.

Influenza:

In North Dakota, influenza activity begins to increase in the fall and typically peaks between January and March. A total of 13,799 influenza cases were reported to the state for the 2025-2026 season, along with 1,020 influenza-associated hospitalizations and 29 deaths. Four of these deaths occurred in children. Prior pediatric influenza-associated deaths were reported in North Dakota in 2011 and 2016.

Influenza – Testing and Treatment Recommendations

Influenza testing can inform decisions on the use of antiviral treatment, the need for additional testing, isolation recommendations, and infection prevention and control practices. Respiratory specimens should be collected as close to illness onset as possible, ideally within three-to-four days. Hospitalized patients with suspected influenza should be tested with high sensitivity and specificity tests such real-time polymerase chain

reaction (RT-PCR) molecular assays since prompt detection is essential to implementing appropriate infection control practices.

Antiviral treatment for patients with suspect influenza is recommended as soon as possible for hospitalized patients, and outpatients who are at high-risk for complications or those with progressive illness. See guidance on antiviral treatment of influenza.

Influenza is a reportable condition via electronic laboratory reporting. Novel influenza cases (report immediately) and pediatric influenza deaths should be reported electronically via our report card or by calling (701) 328-2378 or (800) 472-2180.

Influenza – Who and When to Immunize

Influenza vaccination is recommended for all individuals ages six months and older. Due to the unpredictability of influenza season onset and concerns about vaccine-induced immunity waning over the course of a season, flu vaccination is recommended by the end of October. It can, however, be given throughout influenza season.

Children six months through eight years old receiving influenza vaccine for the first time require two doses given at least four weeks apart, even if they turn nine between the first and second dose. Any child who has received two or more doses of influenza vaccine prior to July 1, 2026, or is nine years or older, needs only one dose of influenza vaccine. Children six months through eight years who need two doses should receive their first dose as soon as possible after vaccine becomes available, to allow the second dose (which must be administered four or more weeks later) to be received by the end of October.

Vaccination as soon as vaccine becomes available may also be considered for pregnant women during the third trimester, as vaccination of pregnant women has been shown to reduce risk of influenza illness of their infants during the first few months of life (a period during which they are too young to receive influenza vaccine).

For non-pregnant adults, influenza vaccination during July and August should be avoided unless there is concern that later vaccination might not be possible, as vaccine-induced immunity may wane while influenza viruses continue to circulate.

Influenza vaccines can be administered at the same time as any other recommended vaccines. For patients who are due for other routine immunizations, providers should follow standard practices for administration and spacing of live vaccines, when the

influenza vaccine being administered is the live attenuated influenza vaccine (LAIV) vaccine is given.

Vaccine is available from ND HHS for Vaccines for Children (VFC)-eligible children (American Indian/Alaskan Native, Medicaid-eligible, uninsured, or underinsured) and uninsured or underinsured adults presenting to providers enrolled in VFC and Vaccines for Adults (VFA) programs.

Adults 65 and older should receive one of the higher dose or adjuvanted influenza vaccines. These include the high dose inactivated influenza vaccine, recombinant influenza vaccine, and adjuvanted inactivated influenza vaccine, as well as the newly licensed mRNA influenza vaccine from Moderna, mFLUSIVA®, approved for adults ages 50 and older. If none of these vaccines is available, any other age-appropriate influenza vaccine should be used.

Solid organ transplant patients should not receive live attenuated influenza vaccine (LAIV). These patients may receive one the higher dose or adjuvanted influenza vaccine products listed above, as this group may have diminished response due to immunosuppressive regimens according to the American Society of Transplantation.

Influenza Vaccine Composition

The 2026-2027 influenza vaccine composition has been updated to better match strains anticipated to be prevalent. All vaccines this season will be trivalent.

The egg-based vaccines contain an A/Missouri/11/2025 (H1N1)pdm09-like virus, an A/Darwin/1454/2025 (H3N2)-like virus, and a B/Tokyo/EIS13-175/2025 (B/Victoria lineage)-like virus.

The cell- or recombinant-based vaccines contain an A/Missouri/11/2025 (H1N1)pdm09-like virus, an A/Darwin/1415/2025 (H3N2)-like virus, and a B/Pennsylvania/14/2025 (B/Victoria lineage)-like virus.

Influenza – Why Immunize

Influenza vaccination of individuals six months and older is recommended to reduce the prevalence of illness caused by influenza and severe outcomes, including hospitalization and death. During the 2025-2026 influenza season, there were 187 pediatric deaths in the United States due to influenza, including four children in North Dakota. Among children who were eligible for influenza vaccination and with known vaccine status,

approximately 85% of reported pediatric deaths occurred in children who were not fully vaccinated against influenza.

CDC estimates that during the 2024-2025 flu season, flu vaccination prevented 10 million flu-related illnesses, 5 million medical visits, 180,000 hospitalizations, and 12,000 deaths.

Since 2013, flu vaccinations have decreased flu hospitalizations in adults by half. Influenza vaccination will alleviate stress on the health care system because prevention of, and reduction in, the severity of influenza illness will reduce outpatient visits, hospitalizations, and intensive care unit admissions. Among vaccinated adults hospitalized with influenza, intensive care unit (ICU) admissions decreased by more than half (59%), and they spent fewer days in the ICU compared to unvaccinated hospitalized people. Children's risk of pediatric ICU admission was decreased by almost 75%. Influenza-associated hospitalizations of vaccinated pregnant women were 40% lower than of non-vaccinated pregnant women.

Influenza vaccination is highly recommended by every major medical organization, especially for children (American Academy of Pediatrics, AAP), pregnant women (the American College of Obstetricians and Gynecologists, ACOG), and those 65 or older (American Association of Family Physicians, AAFP).

Influenza Resources

For additional information, please see CDC Interim Clinical Considerations. The ND HHS influenza website is updated weekly.

Respiratory Syncytial Virus (RSV):

In North Dakota, RSV typically circulates between October and March. It is one of the most common causes of childhood respiratory illness, though annual outbreaks of RSV-associated respiratory illness are regular occurrences in all age groups. Historically, an estimated 58,000-80,000 infants and children under five years of age were hospitalized each year nationwide due to RSV infection, with some requiring oxygen, intravenous (IV) fluids, or mechanical ventilation. RSV is the leading cause of hospitalizations for infants and older babies at higher risk, with American Indian and Alaskan Native children having hospitalization rates 4-10 times higher than the average rates for U.S. children ages 12-23 months.

As of 2023, there are multiple immunization options that are important tools for preventing hospitalizations of infants and children. Prior to the introduction of the maternal RSV vaccine and infant RSV-prevention monoclonal antibody products, an estimated 100-300 children younger than five died due to RSV each year in the United States.

RSV vaccines for older adults became available in 2023 and 2024. Prior to that, RSV caused 177,000 hospitalizations and 14,000 deaths of adults 65 and older each year in the United States.

RSV – Testing and Treatment Recommendations

Clinical symptoms of RSV are nonspecific and can overlap with other viral respiratory infections, such as influenza and COVID-19, as well as some bacterial infections. Several types of laboratory tests are available to confirm RSV infection. These tests may be performed on upper and lower respiratory specimens and include RT-PCR and antigen testing (which may be more sensitive in children but less sensitive in adults).

Antiviral medication is not routinely recommended to fight RSV infection, and most infections go away on their own in a week or two. Supportive care may be used to manage symptoms.

RSV is a reportable condition via electronic laboratory reporting. Pediatric RSV deaths should be reported electronically via our report card or by calling (701) 328-2378 or (800) 472-2180.

RSV – Who and When to Immunize

This fall, immunizations are available for age groups at high risk for RSV. These groups include infants, children 8-19 months who are at increased risk of severe RSV disease, and older adults.

Options for infants include nirsevimab (Beyfortus™) and clesrovimab (Enflonsia™). These immunization products protect infants born between the months of October through March from the impacts of RSV during their first RSV season. Abrysvo™ is available for pregnant women between 32-36 weeks of pregnancy during the period of September 1st through March 1st to protect infants from RSV-associated both mild and severe lower respiratory tract disease (LRTD) during their first six months of life. Other RSV vaccines, including Arexvy™ and mRESVIA™, should not be used in pregnancy. If the pregnant woman receives the maternal RSV vaccine at least 14 days prior to delivery, the infant

typically will not need to receive nirsevimab or clesrovimab. The maternal RSV vaccine is only approved to be given during one pregnancy, so if the pregnant woman received the maternal RSV vaccine during a prior pregnancy, she should not receive it again. The infant should be immunized with nirsevimab or clesrovimab within seven days of birth, as all infants under eight months of age should be immunized against RSV either via one of the infant RSV immunization products or through the mother's receipt of the maternal RSV vaccine during pregnancy.

Young children between 8-19 months of age who are at increased risk of severe RSV disease and are entering their second RSV season should receive a second dose of nirsevimab (clesrovimab is not indicated for use in children entering their second RSV season). These children include children who have severe immunocompromise, all American Indian and Alaska Native children, children with chronic lung disease of prematurity who required medical support any time during the six-month period before the start of their second RSV season, and children with cystic fibrosis who have manifestations of severe lung disease (previous hospitalization for pulmonary exacerbation in the first year of life or abnormalities on chest imaging that persist when stable) or weight-for-length <10th percentile. In addition to these groups, children with down syndrome or other chromosomal differences, children with hemodynamically significant congenital heart disease, children with anatomic pulmonary abnormalities or neuromuscular disorders, and children born at less than 32 weeks' gestation were added this year to the recommendations for a second season RSV immunization.

Healthcare providers are encouraged to conduct reminder/recall at the start of respiratory season of children under eight months of age for a dose of nirsevimab or clesrovimab and for those 8-19 months of age who are at increased risk for a dose of nirsevimab. Adequate supplies of both nirsevimab and clesrovimab are expected for the 2026-2027 season.

Options for adults ages 75 and older and adults ages 50-74 who are at increased risk of severe RSV disease due to certain comorbidities are recommended to receive one lifetime dose of one of the three available RSV vaccines, Arexvy™, Abrysvo™, or mResvia™. All residents of long-term care facilities and nursing homes are at high risk of severe RSV disease and should get vaccinated.

RSV – Why Immunize

Real world data from December 2022 through March 2025 showed that nirsevimab was at least 70% effective in preventing infant hospitalizations and no severe adverse events were reported for nirsevimab.

In clinical trials, efficacy of clesrovimab was 60.4% against medically attended lower respiratory tract infection (LRTI), as well as over 90% against RSV LRTI hospitalization through five months compared to placebo.

The three available RSV vaccines for older adults, Arexvy™, Abrysvo™, and mResvia™, were all highly effective during studies in preventing severe RSV infection.

RSV – Resources

More information about RSV immunizations can be found at https://www.cdc.gov/rsv/index.html. Additional guidance and educational materials are available at Respiratory Syncytial Virus (RSV) | Health and Human Services North Dakota.

COVID-19:

COVID-19 continues to circulate in our community, with 43 COVID-19 associated deaths in North Dakota in the last year. Nationwide, COVID-19 cases and hospitalizations have been trending upwards in recent weeks.

More than half of children hospitalized for COVID-19 in the United States do not have a comorbidity. People 75 and older have the highest rate of hospitalization, followed by infants younger than six months and adults aged 65-74.

COVID-19 – Testing and Treatment Recommendations

Treatments for COVID-19 are available for individuals early in the course of their illness and can reduce the risk of hospitalization or death following infection. Treatment should be started within 5-7 days after onset of symptoms. Empiric treatment should be started as soon as possible for those at high risk of severe COVID-19 illness such as people 75 and older and people with certain medical conditions. Based on current information, tests to detect and medications to treat COVID-19 continue to be recommended for circulating variants.

COVID-19 cases should be reported through electronic laboratory reporting. Pediatric COVID-19 deaths should be reported electronically via our report card or by calling (701) 328-2378 or (800) 472-2180.

COVID-19 – Who and When to Immunize

The American Academy of Pediatrics (AAP), Association of Obstetricians and Gynecologists (ACOG), and the American Academy of Family Physicians (AAFP) have issued recommendations for use of the 2026-2027 COVID-19 vaccine, including infants six months – 23 months (AAP) (AAFP) and persons at 2-18 years old and determined to be at high risk for severe COVID-19 infection (AAP) (AAFP) which includes residents of long-term care or congregate settings (AAP) (AAFP), individuals who have never been vaccinated against COVID-19 (AAP) (AAFP), individuals who have household contacts who are high risk for severe COVID-19 infection (AAP) (AAFP), moderately or severely immunocompromised individuals (AAP) (AAFP), and any individual whose parent or guardian desires them to have protection of the vaccine, regardless of risk (AAP) (AAFP). They also made recommendations for women who are pregnant, breastfeeding a baby, trying to get pregnant now, or might become pregnant in the future (ACOG) (AAFP) and all adults 18 years and older (AAFP), especially for those who are 65 years and older (AAFP), at an increased risk for severe COVID-19 infection (AAFP), or have never received a COVID-19 Vaccine (AAFP).

The CDC recommends the 2026-2027 COVID-19 vaccine for all adults ages 18 years and older and all children ages 6 months–17 years with moderate to severe immunocompromise. For all other children in this age group, a COVID-19 vaccine is recommended through shared clinical decision making between parents or legal guardians and healthcare professionals. The recommended vaccine and number of doses are based on age, vaccination history, and immune status

COVID-19 – Immunization Access Considerations

COVID-19 vaccines are available from ND HHS for Vaccines for Children (VFC)-eligible children (American Indian/Alaskan Native, Medicaid-eligible, uninsured, or underinsured) and uninsured or underinsured adults to providers enrolled in our VFC and Vaccines for Adults (VFA) programs.

An immunization locator is available for the state of North Dakota.

COVID-19 – Why Immunize

COVID-19 variants continue to circulate, and hospitalizations are trending upward nationwide. People 75 and older have the highest rate of hospitalization, followed by infants younger than six months and people aged 65-74. More than half of pediatric COVID-19 associated hospitalizations occur in children younger than two years old, most of who do not have any underlying medical condition.

Vaccination during pregnancy provides passive immunity to the infant, protecting them from COVID-19 in the first few months of life before they can be vaccinated. Maternal COVID-19 vaccination during pregnancy results in significantly greater antibody persistence in infants when compared to infants whose mother experienced infection during pregnancy without vaccination.

COVID-19 – Resources

For additional information on COVID-19, including vaccine, testing, treatment, and current disease trends, please visit our COVID-19 website.

Summary:

Influenza, RSV, COVID-19, and other respiratory pathogens are expected to circulate this fall and winter. ND HHS reminds clinicians to consider influenza, RSV, COVID-19, and other possible pathogens when evaluating patients with respiratory illness. As many of these pathogens may share similar symptoms, respiratory testing can be used to inform decisions on use of antiviral treatment, the need for additional testing, isolation recommendations, and infection prevention and control practices.

ND HHS Laboratory Services offers several respiratory illness diagnostic tests free of charge or fee-for-service. Influenza A/B/RSV/SARS CoV-2 PCR is offered at no charge on NP swabs in VTM, and results should be available within two days after arrival at the lab.

For more information, call ND HHS Disease Control and Forensic Pathology at (701) 328-2378 or (800) 472-2180.