CDC Centers for Disease Control and Prevention
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Influenza (Flu) (/flu/index.htm)

Weekly U.S. Influenza Surveillance Report
Updated April 5, 2024

FLUVIEW
A Weekly Influenza Surveillance Report Prepared by the Influenza Division

Key Updates for Week 13, ending March 30, 2024

Seasonal influenza activity remains elevated nationally but is decreasing.

Viruses

Clinical Lab	Public Health Lab	Virus Characterization
9.1% (Trend ⬇) positive for influenza this week	Influenza A(H1N1)pdm09, A(H3N2), and B viruses were all co-circulating this week.	Genetic and antigenic characterization and antiviral susceptibility are summarized in this report.
(/flu/weekly/index.htm#ClinicalLaboratories)	(/flu/weekly/index.htm#PublicHealthLaboratories)	(/flu/weekly/index.htm#VirusCharacterization)

Illness

Outpatient Respiratory Illness

3.0% (Trend ➡)
of visits to a health care provider this week were for respiratory illness
(above baseline).

(/flu/weekly/index.htm#ILINet)

Outpatient Respiratory Illness: Activity Map

This week 5 jurisdictions experienced moderate activity and 6 jurisdictions experienced high activity.

(/flu/weekly/index.htm#ORIAM)

FluSurv-NET

74.2 per 100,000

cumulative hospitalization rate.

(/flu/weekly/index.htm#FluSurvNet)

NHSN Hospitalizations

5,299 (Trend ⬇)

patients admitted to hospitals with influenza this week.

(/flu/weekly/index.htm#NHSN)

NCHS Mortality

0.5% (Trend ➡)

of deaths attributed to influenza this week.

(/flu/weekly/index.htm#NCHSMortality)

Pediatric Deaths

7

influenza-associated deaths were reported this week for a total of 133 deaths this season.

(/flu/weekly/index.htm#PedMortality)

All data are preliminary and may change as more reports are received.

Directional arrows indicate changes between the current week and the previous week. Additional information (/flu/weekly/index.htm#Trends) on the arrows can be found at the bottom of this page.

A description of the CDC influenza surveillance system, including methodology and detailed descriptions of each data component is available on the surveillance methods (/flu/weekly/overview.htm) page.

Additional information on the current and previous influenza seasons for each surveillance component are available on FluView Interactive (/flu/weekly/fluviewinteractive.htm).

Key Points

- Seasonal influenza activity remains elevated but is decreasing nationally.

- Nationally, percent positivity for both influenza A and B decreased compared to last week.

- One human infection with a highly pathogenic avian influenza (HPAI) A(H5N1) virus was reported by the Texas Department of Health.

- Nationally, outpatient respiratory illness declined but remains above baseline.[1] Regions 2, 4, 6, 8, 9, and 10 are below their baselines, while all other HHS regions remain at or above their region-specific baselines.

- Nationally, the number of weekly flu hospital admissions has been decreasing since January.

- During Week 13, of the 329 viruses reported by public health laboratories, 201 (61.1%) were influenza A and 128 (38.9%) were influenza B. Of the 138 influenza A viruses subtyped during Week 13, 69 (50.0%) were influenza A(H1N1)pdm09 and 69 (50.0%) were A(H3N2).

- Seven influenza-associated pediatric deaths occurring during the 2023-2024 season were reported to CDC during Week 13, bringing the season total to 133 pediatric deaths.

- CDC estimates that there have been at least 32 million illnesses, 360,000 hospitalizations, and 22,000 deaths from flu so far this season.

- CDC recommends that everyone 6 months and older get an annual flu vaccine as long as influenza viruses are spreading.[2] Vaccination can still provide benefit this season.

- There also are prescription flu antiviral drugs that can treat flu illness; those should be started as early as possible and are especially important for higher risk patients.[3]

- Flu viruses are among several viruses contributing to respiratory disease activity. CDC is providing updated, integrated information (https://www.cdc.gov/respiratory-viruses/index.html) about COVID-19, flu, and RSV activity on a weekly basis.

U.S. Virologic Surveillance (https://www.cdc.gov/flu/weekly/overview.htm#LabSurveillance)

Nationally, the percentage of respiratory specimens testing positive for influenza in clinical laboratories decreased (change of >0.5 percentage points) compared to the previous week. Regions 1, 3, 4, 5, 6, 8, 9, and 10 decreased in percent positivity; region 7 remained stable, and region 2 reported an increase during Week 13 compared to Week 12. The regions with the highest percent positivity were regions 7 (19.1%), 5 (14.0%), and 2 (10.8%). Nationally, influenza A(H1N1)pdm09, A(H3N2), and B/Victoria viruses are all co-circulating. However, the distribution of circulating viruses varies by region. For regional and state level data and age group distribution, please visit FluView Interactive

(https://gis.cdc.gov/grasp/fluview/fluportaldashboard.html). Viruses known to be associated with recent receipt of live attenuated influenza vaccine (LAIV) or found upon further testing to be a vaccine virus are not included, as they are not circulating influenza viruses.

Clinical Laboratories

The results of tests performed by clinical laboratories nationwide are summarized below. Data from clinical laboratories (the percentage of specimens tested that are positive for influenza virus) are used to monitor whether influenza activity is increasing or decreasing.

	Week 13	Data Cumulative since October 1, 2023 (Week 40)
No. of specimens tested	68,989	2,773,210
No. of positive specimens (%)	6,293 (9.1%)	320,162 (11.5%)
Positive specimens by type		
Influenza A	3,081 (49.0%)	224,430 (70.1%)
Influenza B	3,212 (51.0%)	95,722 (29.9%)

Public Health Laboratories

The results of tests performed by public health laboratories nationwide are summarized below. Data from public health laboratories are used to monitor the proportion of circulating influenza viruses that belong to each influenza subtype/lineage.

	Week 13	Data Cumulative since October 1, 2023 (Week 40)
No. of specimens tested	1,785	96,345
No. of positive specimens	329	31,394
Positive specimens by type/subtype		
Influenza A	201 (61.1%)	24,500 (78%)
Subtyping Performed	138 (68.7%)	20,284 (82.8%)

(H1N1)pdm09	69 (50%)	14,449 (71.2%)
H3N2	69 (50%)	5,835 (28.8%)
H3N2v	0 (0.0%)	0 (0.0%)
Subtyping not performed	63 (31.3%)	4,216 (17.2%)
Influenza B	128 (38.9%)	6,894 (22%)
Lineage testing performed	86 (67.2%)	5,854 (84.9%)
Yamagata lineage	0 (0.0%)	0 (0.0%)
Victoria lineage	86 (100.0%)	5,854 (100.0%)
Lineage not performed	42 (32.8%)	1,040 (15.1%)

Novel Influenza A Virus:

A human infection with highly pathogenic avian influenza (HPAI) A(H5N1) virus was reported by the Texas Department of State Health Services and confirmed by CDC on March 30, 2024.

A patient aged >18 years in Texas developed conjunctivitis on approximately March 27, 2024, while working at a commercial dairy cattle farm. HPAI A(H5N1) virus has been recently detected in dairy cattle, poultry and wild birds in Texas. Respiratory and conjunctival specimens were collected on March 28, 2024, and tested at the Texas Tech University Bioterrorism Response Laboratory that same day. RT-PCR analysis indicated that both specimens were presumptive positive for influenza A(H5) virus. The specimens were then sent to CDC for further testing. They were received and tested at CDC on March 30, 2024, and confirmed as HPAI A(H5N1) virus clade 2.3.4.4b using diagnostic RT-PCR and sequencing. The patient did not report symptoms other than conjunctivitis, was not hospitalized, and is recovering. Starting on March 29, 2024, the patient was recommended to isolate and was provided with influenza antivirals per CDC guidance (https://www.cdc.gov/flu/avianflu/clinicians-evaluating-patients.htm (https://www.cdc.gov/flu/avianflu/clinicians-evaluating-patients.htm)).

Public health officials are conducting surveillance activities in the area in response to this detection. Household contacts of the patient have not reported illness and have been provided influenza antiviral prophylaxis in accordance with CDC recommendations. No additional cases of human infection with HPAI A(H5N1) associated with this case and no human-to-human transmission of HPAI A(H5N1) virus have been identified.

This is the second person to test positive for HPAI A(H5N1) virus in the United States. The first was reported in April 2022 in Colorado.

Currently in the United States, HPAI A(H5N1) virus detections among wild birds are widespread, there are sporadic outbreaks among poultry and backyard flocks, and sporadic infections in wild mammals have been reported by United States Department of Agriculture (USDA) Animal Plant Health Inspection Service (APHIS). On March 25, USDA reported the first detections of H5N1 in dairy cattle in Texas and Kansas. Since then, additional detections in dairy cattle have been reported from Idaho, Michigan, New Mexico, and Ohio. USDA is continuing to monitor and test samples collected from other farms where cattle are displaying similar symptoms.

CDC recommends that state and local public health departments monitor people who were exposed to birds or other animals (including livestock) suspected to be infected with avian influenza viruses for onset of signs and symptoms until 10 days after their last exposure and that people who develop signs or symptoms of respiratory illness and/or conjunctivitis be tested for influenza. During February 9, 2022 — March 29, 2024, over 8,000 people were actively monitored following HPAI exposure.

Information about avian influenza is available at https://www.cdc.gov/flu/avianflu/index.htm (https://www.cdc.gov/flu/avianflu/index.htm).

Interim recommendations for Prevention, Monitoring, and Public Health Investigations are available at https://www.cdc.gov/flu/avianflu/hpai/hpai-interim-recommendations.html (https://www.cdc.gov/flu/avianflu/hpai/hpai-interim-recommendations.html).

The latest case reports on avian influenza outbreaks in wild birds, commercial poultry; backyard or hobbyist flocks; and mammals in the United States are available from the USDA at

https://www.aphis.usda.gov/aphis/ourfocus/animalhealth/animal-disease-information/avian/avian-influenza/2022-hpai ⬀ (https://www.aphis.usda.gov/aphis/ourfocus/animalhealth/animal-disease-information/avian/avian-influenza/2022-hpai).

Additional information regarding human infections with novel influenza A viruses:

Surveillance Methods (https://www.cdc.gov/flu/weekly/overview.htm#NovelASurveillance) | FluView Interactive (http://gis.cdc.gov/grasp/fluview/Novel_Influenza.html)

Influenza Virus Characterization (/flu/weekly/overview.htm#VirusCharacterization)

CDC performs genetic (https://www.cdc.gov/flu/about/professionals/genetic-characterization.htm) and antigenic (https://www.cdc.gov/flu/about/professionals/antigenic.htm) characterization of U.S. viruses submitted from state and local public health laboratories according to the Right Size Roadmap submission guidance. These data are used to compare how similar the currently circulating influenza viruses are to the reference viruses representing viruses contained in the current influenza vaccines. The data are also used to monitor evolutionary changes that continually occur in influenza viruses circulating in humans. CDC also tests susceptibility of circulating influenza viruses to antiviral medications including the neuraminidase inhibitors (oseltamivir, zanamivir, and peramivir) and the PA endonuclease inhibitor baloxavir.

CDC has genetically characterized 3,263 influenza viruses collected since October 1, 2023.

Virus Subtype or Lineage	Total No. of Subtype/Lineage Tested	Genetic Characterization			
		HA Clade	Number (% of subtype/lineage tested)	HA Subclade	Number (% of subtype/lineage tested)
A/H1	1,357				
		6B.1A.5a	1,357 (100%)	2a	333 (24.5%)
				2a.1	1,024 (75.5%)
A/H3	1,011				
		3C.2a1b.2a	1,011 (100%)	2a.1b	1 (0.1%)
				2a.3a	1 (0.1%)
				2a.3a.1	1,008 (99.7%)
				2b	1 (0.1%)
B/Victoria	895				
		V1A	895 (100%)	3a.2	895 (100%)
B/Yamagata	0				
		Y3	0	Y3	0 (0%)

CDC antigenically characterizes (https://www.cdc.gov/flu/about/professionals/antigenic.htm) influenza viruses by hemagglutination inhibition (HI) (H1N1pdm09, H3N2, B/Victoria, and B/Yamagata viruses) or neutralization-based HINT ⧉ (https://pubmed.ncbi.nlm.nih.gov/30804469/) (H3N2 viruses) using antisera that ferrets make after being infected with reference viruses representing the 2023-2024 Northern Hemisphere recommended cell or recombinant-based vaccine viruses. Antigenic differences between viruses are determined by comparing how well the antibodies made against the vaccine reference viruses recognize the circulating viruses that have been grown in cell culture. Ferret antisera are useful because antibodies raised against a particular virus can often recognize small changes in the surface proteins of other viruses. In HI assays, viruses with similar antigenic properties have antibody titer differences of less than or equal to 4-fold when compared to the reference (vaccine) virus. In HINT, viruses with similar antigenic properties have antibody neutralization titer differences of less than or equal to 8-fold. Viruses selected for antigenic characterization are a subset representing the genetic changes in the surface proteins seen in genetically characterized viruses.

Influenza A Viruses

- **A (H1N1)pdm09:** 217 A(H1N1)pdm09 viruses were antigenically characterized by HI, and all were well-recognized (reacting at titers that were within 4-fold of the homologous virus titer) by ferret antisera to cell-grown

A/Wisconsin/67/2022-like reference viruses representing the A(H1N1)pdm09 component for the cell- and recombinant-based influenza vaccines.

- **A (H3N2):** 249 A(H3N2) viruses were antigenically characterized by HI or HINT, and 246 (99%) were well-recognized (reacting at titers that were within 4-fold of the homologous virus titer in HI or reacting at titers that were less than or equal to 8-fold of the homologous virus in HINT) by ferret antisera to cell-grown A/Darwin/6/2021-like reference viruses representing the A(H3N2) component for the cell- and recombinant-based influenza vaccines.

Influenza B Viruses

- **B/Victoria:** 180 influenza B/Victoria-lineage virus were antigenically characterized by HI, and all were well-recognized (reacting at titers that were within 4-fold of the homologous virus titer) by ferret antisera to cell-grown B/Austria/1359417/2021-like reference viruses representing the B/Victoria component for the cell- and recombinant-based influenza vaccines.
- **B/Yamagata:** No influenza B/Yamagata-lineage viruses were available for antigenic characterization.

Assessment of Virus Susceptibility to Antiviral Medications

CDC assesses susceptibility of influenza viruses to the antiviral medications including the neuraminidase inhibitors (oseltamivir, zanamivir, and peramivir) and the PA endonuclease inhibitor baloxavir using next generation sequence analysis supplemented by laboratory assays. Information about antiviral susceptibility test methods can be found at U.S. Influenza Surveillance: Purpose and (https://www.cdc.gov/flu/weekly/overview.htm) Methods | CDC (https://www.cdc.gov/flu/weekly/overview.htm).

Viruses collected in the U.S. since October 01, 2023, were tested for antiviral susceptibility as follows:

Antiviral Medication			Total Viruses	A/H1	A/H3	B/Victoria
Neuraminidase Inhibitors	Oseltamivir	Viruses Tested	3,255	1,358	1,008	889
		Reduced Inhibition	1 (0.03%)	1 (0.07%)	0 (0.0%)	0 (0.0%)
		Highly Reduced Inhibition	2 (0.06%)	2 (0.1%)	0 (0.0%)	0 (0.0%)
	Peramivir	Viruses Tested	3,255	1,358	1,008	889
		Reduced Inhibition	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
		Highly Reduced Inhibition	2 (0.06%)	2 (0.1%)	0 (0.0%)	0 (0.0%)
	Zanamivir	Viruses Tested	3,255	1,358	1,008	889
		Reduced Inhibition	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
		Highly Reduced Inhibition	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
PA Cap-Dependent Endonuclease Inhibitor	Baloxavir	Viruses Tested	3,163	1,319	982	862
		Decreased Susceptibility	1 (0.03%)	0 (0.0%)	1 (0.1%)	0 (0.0%)

Two A(H1N1)pdm09 viruses had NA-H275Y amino acid substitution and showed highly reduced inhibition by oseltamivir and peramivir. One (H1N1)pdm09 virus had NA-I223V and NA-S247N amino acid substitutions and showed reduced inhibition by oseltamivir. One A(H3N2) virus had PA-I38T amino acid substitution and showed reduced susceptibility to baloxavir.

High levels of resistance to the adamantanes (amantadine and rimantadine) persist among influenza A(H1N1)pdm09 and influenza A(H3N2) viruses (the adamantanes are not effective against influenza B viruses). Therefore, use of these antivirals for treatment and prevention of influenza A virus infection is not recommended and data from adamantane resistance testing are not presented.

Outpatient Respiratory Illness Surveillance (https://www.cdc.gov/flu/weekly/overview.htm#ILINet)

The U.S. Outpatient Influenza-like Illness Surveillance Network (ILINet) monitors outpatient visits for respiratory illness referred to as influenza-like illness [ILI (fever plus cough or sore throat)], not laboratory-confirmed influenza and will therefore capture respiratory illness visits due to infection with pathogens that can present with similar symptoms, including influenza viruses, SARS-CoV-2, and RSV. It is important to evaluate syndromic surveillance data, including that from ILINet, in the context of other sources of surveillance data to obtain a more complete and accurate picture of influenza, SARS-CoV-2, and other respiratory virus activity. CDC is providing integrated information about COVID-19, influenza, and RSV activity on a website (https://www.cdc.gov/respiratory-viruses/index.html) that is updated weekly. Information about other respiratory virus activity can be found on CDC's National Respiratory and Enteric Virus Surveillance System (NREVSS) website (https://www.cdc.gov/surveillance/nrevss/index.html).

Outpatient Respiratory Illness Visits

Nationally, during Week 13, 3.0% of patient visits reported through ILINet were due to respiratory illness that included fever plus a cough or sore throat, also referred to as ILI. This has remained stable (change of ≤ 0.1 percentage points) since Week 12 and remains above the national baseline. The percentage of visits for ILI decreased in regions 2, 3, 8, and 10, and remained stable in all other regions in Week 13 compared to Week 12. Regions 1, 3, 5, and 7 are at or above their baseline, and all other regions are below their respective baselines. Multiple respiratory viruses are co-circulating, and the relative contribution of influenza virus infection to ILI varies by location.

Outpatient Respiratory Illness Visits by Age Group

About 70% of ILINet participants provide both the number of patient visits for respiratory illness and the total number of patient visits for the week broken out by age group. Data from this subset of providers are used to calculate the percentages of patient visits for respiratory illness by age group.

The percentage of visits for respiratory illness reported in ILINet decreased in the 0-4 years and 5-24 years age groups, and remained stable in the 25-49 years, 50-64 years, and the 65+ years age groups in Week 13 compared to Week 12.

Outpatient Respiratory Illness Activity Map

Data collected in ILINet are used to produce a measure of ILI activity* (/flu/weekly/overview.htm#ILINet) by state/jurisdiction and Core Based Statistical Areas (CBSA).

	Number of Jurisdictions		Number of CBSAs	
Activity Level	**Week 13 (Week ending Mar. 30, 2024)**	**Week 12 (Week ending Mar. 23, 2024)**	**Week 13 (Week ending Mar. 30, 2024)**	**Week 12 (Week ending Mar. 23, 2024)**

Very High	0	0	1	2
High	6	10	20	28
Moderate	5	3	53	52
Low	21	19	138	160
Minimal	23	23	480	466
Insufficient Data	0	0	237	221

*Data collected in ILINet may disproportionally represent certain populations within a jurisdiction or CBSA, and therefore, may not accurately depict the full picture of influenza activity for the entire jurisdiction or CBSA. Differences in the data presented here by CDC and independently by some health departments likely represent differing levels of data completeness with data presented by the health department likely being the more complete.

Additional information about medically attended visits for ILI for current and past seasons:
Surveillance Methods (/flu/weekly/overview.htm#ILINet) | FluView Interactive: National, Regional, and State Data (http://gis.cdc.gov/grasp/fluview/fluportaldashboard.html) or ILI Activity Map (https://gis.cdc.gov/grasp/fluview/main.html)

Hospitalization Surveillance
(http://www.cdc.gov/flu/weekly/overview.htm#HospitalizationSurv)

FluSurv-NET

The Influenza Hospitalization Surveillance Network (FluSurv-NET) conducts population-based surveillance for laboratory-confirmed influenza-related hospitalizations in select counties in 14 states and represents approximately 9% of the U.S. population. FluSurv-NET hospitalization data are preliminary. As data are received each week, prior case counts and rates are updated accordingly.

A total of 22,684 laboratory-confirmed influenza-associated hospitalizations were reported by FluSurv-NET sites between October 1, 2023, and March 30, 2024. The weekly hospitalization rate observed in Week 13 was 1.3 per 100,000 population. The weekly hospitalization rate observed during Week 52 is the third highest peak weekly rate observed during all seasons going back to 2010-2011 following the 2014-2015 and 2017-2018 seasons. The overall cumulative hospitalization rate was 74.2 per 100,000 population. This cumulative hospitalization rate is the second highest cumulative hospitalization rate when compared against previous end-of-season rates for Week 13, and it is the second highest cumulative in-season hospitalization rate observed in Week 13, following the 2017-2018 season (99.9). Cumulative in-season hospitalization rates observed in Week 13 from 2010-2011 through 2022-2023 ranged from 0.7 to 67.9.

When examining rates by age, the highest cumulative hospitalization rate per 100,000 population was among adults aged 65 years and older (202.6), followed by adults aged 50-64 years (88.2) and children aged 0-4 years (76.5). When examining age-adjusted rates by race and ethnicity, the highest rate of hospitalization per 100,000 population was among non-Hispanic Black persons (138.4), followed by non-Hispanic American Indian or Alaska Native persons (102.7), Hispanic persons (69.3), non-Hispanic White persons (57.1), and non-Hispanic Asian/Pacific Islander persons (38.9).

Among 22,684 hospitalizations, 19,347 (85.3%) were associated with influenza A virus, 3,178 (14.0%) with influenza B virus, 43 (0.2%) with influenza A virus and influenza B virus co-infection, and 116 (0.5%) with influenza virus for which the type was not determined. Among those with influenza A subtype information, 3,249 (71.5%) were A(H1N1) pdm09 and 1,298 (28.5%) were A(H3N2).

Among 2,758 hospitalized adults with information on underlying medical conditions, 95.3% had at least one reported underlying medical condition, the most commonly reported were hypertension, cardiovascular disease, obesity, and metabolic disease. Among 1,316 hospitalized women of childbearing age (15-49 years) with information on pregnancy status, 22.6% were pregnant. Among 853 hospitalized children with information on underlying medical conditions, 69.2% had at least one reported underlying medical condition; the most commonly reported was asthma, followed by obesity and neurologic disease.

In these figures, cumulative and weekly rates for all seasons prior to the 2023-2024 season reflect end-of-season rates. For the 2023-2024 season, rates for recent hospitals admissions are subject to reporting delays. As hospitalization data are reviewed each week, prior case counts and rates are updated accordingly.

Additional FluSurv-NET hospitalization surveillance information for current and past seasons and additional age groups:

Surveillance Methods (https://www.cdc.gov/flu/weekly/overview.htm#FluSurvNet) |FluView Interactive: Rates by Age, Sex, and Race/Ethnicity (http://gis.cdc.gov/GRASP/Fluview/FluHospRates.html) or Data on Patient Characteristics (http://gis.cdc.gov/grasp/fluview/FluHospChars.html) | RESP-NET Interactive (https://www.cdc.gov/surveillance/resp-net/dashboard.html)

National Healthcare Safety Network (NHSN) Hospitalization Surveillance

Hospitals report to NHSN the weekly number of patients admitted with laboratory-confirmed influenza. During Week 13, 5,299 patients with laboratory-confirmed influenza were admitted to a hospital. Nationally and in regions 1, 3, 4, 5, 6, 8, 9, and 10, the number of patients admitted to a hospital with laboratory-confirmed influenza for Week 13 decreased (change of >5%) compared to Week 12. The number of hospitalizations with laboratory-confirmed influenza remained stable in regions 2 and 7.

Additional NHSN Hospitalization Surveillance information:

Surveillance Methods (https://www.cdc.gov/flu/weekly/overview.htm#NHSN) | Additional Data (https://data.cdc.gov/Public-Health-Surveillance/Respiratory-Virus-Response-RVR-United-States-Hospi/9t9r-e5a3) | FluView Interactive (http://gis.cdc.gov/grasp/fluview/FluView12.html)

National Center for Health Statistics (NCHS) Mortality Surveillance

Based on NCHS mortality surveillance data available on April 4, 2024, 0.5% of the deaths that occurred during the week ending March 30, 2024 (Week 13), were due to influenza. This percentage remained stable (< 0.1 percentage point change) compared to Week 12. The data presented are preliminary and may change as more data are received and processed.
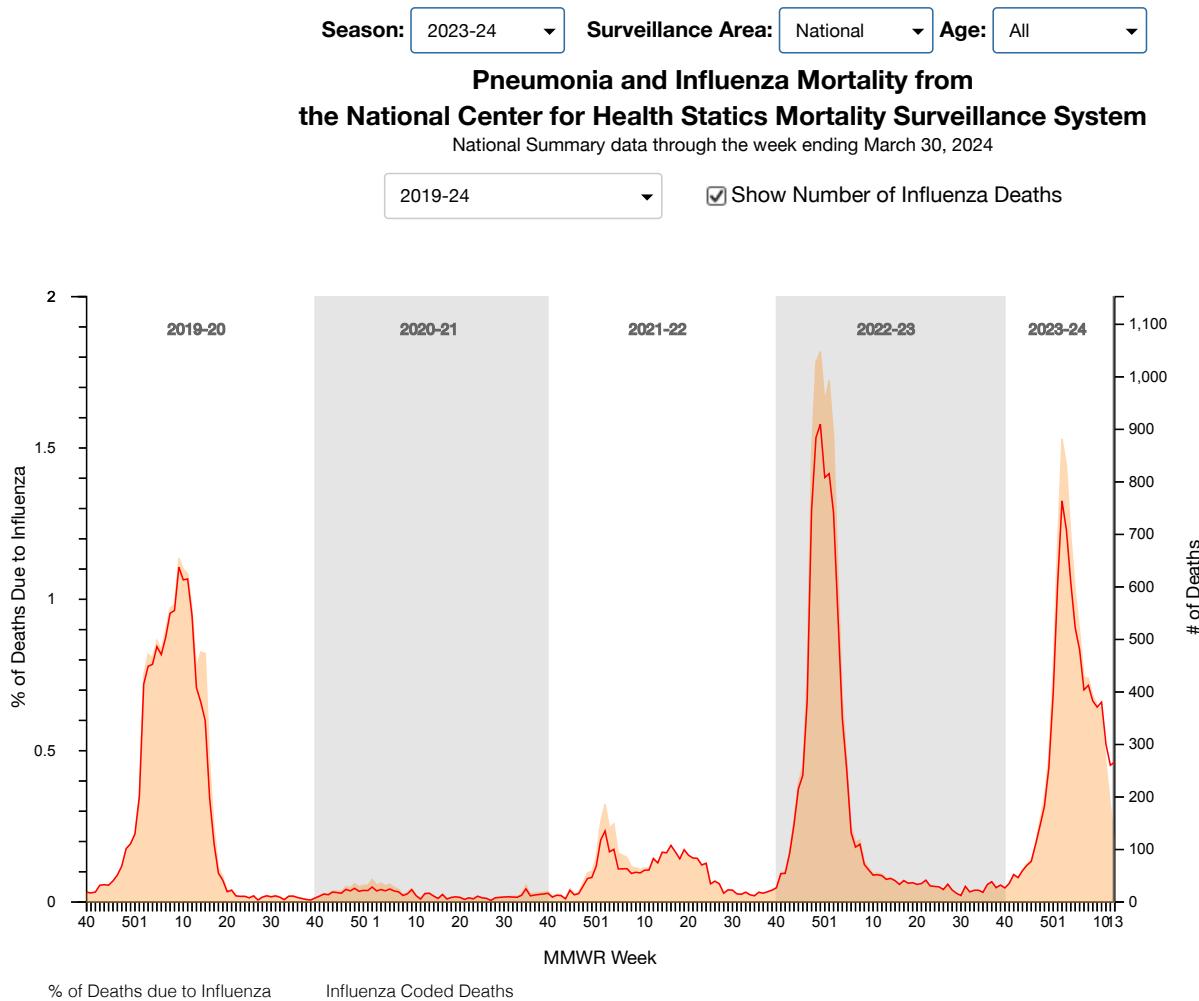
Season:	2023-24 ▼	Surveillance Area:	National ▼	Age:	All ▼

**Pneumonia and Influenza Mortality from
the National Center for Health Statics Mortality Surveillance System**
National Summary data through the week ending March 30, 2024

2019-24 ▼	☑ Show Number of Influenza Deaths

% of Deaths due to Influenza   Influenza Coded Deaths

View Regional and State Level Data (https://gis.cdc.gov/grasp/fluview/Mortality.html) | Download Chart Data | Download PowerPoint Presentation

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Additional pneumonia, influenza and COVID-19 mortality surveillance information for current and past seasons:

Surveillance Methods (https://www.cdc.gov/flu/weekly/overview.htm#NCHSMortality) | FluView Interactive (https://gis.cdc.gov/grasp/fluview/mortality.html)

Influenza-Associated Pediatric Mortality

Seven influenza-associated pediatric deaths occurring during the 2023-2024 season were reported to CDC during Week 13. The deaths occurred during weeks 2, 6, 12 and 13 (the weeks ending January 13, February 10, March 23, and March 30 of 2024, respectively). Two deaths were associated with influenza A viruses. One of the influenza A viruses had subtyping performed and it was an A(H1N1) virus. Five deaths were associated with influenza B viruses. Two of the influenza B viruses had lineage determined and both were B/Victoria viruses.

**Influenza-Associated Pediatric Deaths
by Week of Death, 2020-21 season to 2023-24 season**
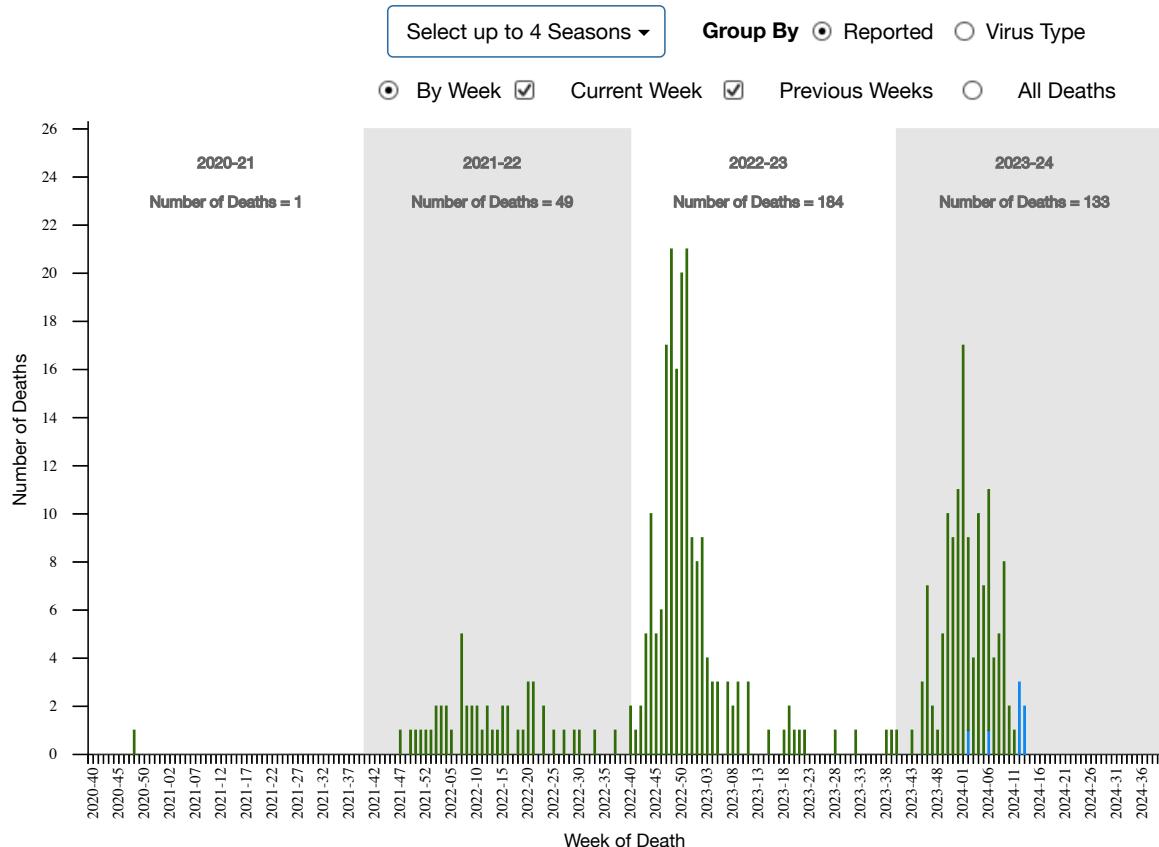
View FluView Interactive (https://gis.cdc.gov/grasp/fluview/PedFluDeath.html) | Download Chart Data | Download PowerPoint Presentation

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Additional pediatric mortality surveillance information for current and past seasons:

Surveillance Methods (https://www.cdc.gov/flu/weekly/overview.htm#PediatricMortality) | FluView Interactive (https://gis.cdc.gov/GRASP/Fluview/PedFluDeath.html)

Trend Indicators

Increasing: 🔺
Decreasing: 🔻
Stable: ➡️

Indicators Status by System

Clinical Labs: Up or down arrows indicate a change of greater than or equal to 0.5 percentage points in the percent of specimens positive for influenza compared to the previous week.

Outpatient Respiratory Illness (ILINet): Up or down arrows indicate a change of greater than 0.1 percentage points in the percent of visits due to respiratory illness (ILI) compared to the previous week.

NHSN Hospitalizations: Up or down arrows indicate change of greater than or equal to 5% of the number of patients admitted with laboratory-confirmed influenza compared to the previous week.

NCHS Mortality: Up or down arrows indicate change of greater than 0.1 percentage points of the percent of deaths due to influenza compared to the previous week.

Reference Footnotes

[1]U.S. Influenza Surveillance: Purpose and Methods (2023 Oct). Centers for Disease Control and Prevention. https://www.cdc.gov/flu/weekly/overview.htm#ILINet (https://www.cdc.gov/flu/weekly/overview.htm#ILINet).

[2]Grohskopf LA, Blanton LH, Ferdinands JM, Chung JR, Broder KR, Talbot HK. Prevention and Control of Seasonal Influenza with Vaccines: Recommendations of the Advisory Committee on Immunization Practices — United States, 2023–24 Influenza Season. MMWR Recomm Rep 2023;72(No. RR-2):1–25. DOI: http://dx.doi.org/10.15585/mmwr.rr7202a1 ⧉ (http://dx.doi.org/10.15585/mmwr.rr7202a1)

[3]Influenza Antiviral Medications: Summary for Clinicians (2023 Sept). Centers for Disease Control and Prevention. https://www.cdc.gov/flu/professionals/antivirals/summary-clinicians.htm (https://www.cdc.gov/flu/professionals/antivirals/summary-clinicians.htm).

Additional National and International Influenza Surveillance Information

FluView Interactive: FluView includes enhanced web-based interactive applications that can provide dynamic visuals of the influenza data collected and analyzed by CDC. These FluView Interactive applications (http://www.cdc.gov/flu/weekly/fluviewinteractive.htm) allow people to create customized, visual interpretations of influenza data, as well as make comparisons across flu seasons, regions, age groups and a variety of other demographics.

National Institute for Occupational Safety and Health: Monthly surveillance data on the prevalence of health-related workplace absenteeism among full-time workers in the United States are available from NIOSH (https://www.cdc.gov/niosh/topics/absences/default.html).

U.S. State and local influenza surveillance: Select a jurisdiction below to access the latest local influenza information.

Alabama (http://adph.org/influenza/)	Alaska (http://dhss.alaska.gov/dph/Epi/id/Pages/influenza/fluinfo.
Colorado (https://www.mass.gov/info-details/influenza-reporting)	Connecticut (https://portal.ct.gov/DPH/Epidemiology-ar Emerging-Infections/Influenza-Surveillance-and-Statistics)
Georgia (https://dph.georgia.gov/flu-activity-georgia)	Hawaii (http://health.hawaii.gov/docd/resources/reports/influenza reports/)

Iowa (https://idph.iowa.gov/influenza/reports) Kansas (http://www.kdheks.gov/flu/surveillance.htm)

Maryland (https://phpa.health.maryland.gov/influenza/fluwatch/) Massachusetts (https://www.mass.gov/info-details/infl reporting)

Missouri (http://health.mo.gov/living/healthcondiseases/communicable/influenza/reports.php) Montana (https://dphhs.mt.gov/publichealth/cdepi/diseases/influen

New Jersey (http://www.nj.gov/health/cd/topics/flu.shtml) New Mexico (https://nmhealth.org/about/erd/ideb/isp/

Ohio (http://www.flu.ohio.gov) Oklahoma (https://oklahoma.gov/health/health-education/acute-disease-service/disease-information/influ home-page.html)

South Carolina (http://www.scdhec.gov/Health/DiseasesandConditions/InfectiousDiseases/Flu/FluData/) South Dakota (https://doh.sd.gov/health-data-reports/ dashboards/influenza-dashboard/)

Vermont (http://www.healthvermont.gov/immunizations-infectious-disease/influenza/flu-activity-and-surveillance) Virginia (http://www.vdh.virginia.gov/epidemiology/influ in-virginia/influenza-surveillance/)

Wyoming (https://health.wyo.gov/publichealth/infectious-disease-epidemiology-unit/disease/influenza/) New York City (http://www1.nyc.gov/site/doh/providers topics/flu-alerts.page)

World Health Organization:
Additional influenza surveillance information from participating WHO member nations is available through FluNet ⬈ (https://www.who.int/tools/flunet) and the Global Epidemiology Reports. ⬈ (https://www.who.int/teams/global-influenza-programme/surveillance-and-monitoring/influenza-surveillance-outputs)

WHO Collaborating Centers for Influenza:
Australia ⬈ (http://www.influenzacentre.org/Surveillance_Samples_Received.html), China ⬈ (http://www.chinaivdc.cn/cnic/), Japan ⬈ (http://idsc.nih.go.jp/index.html), the United Kingdom ⬈ (https://www.crick.ac.uk/research/worldwide-influenza-centre), and the United States (http://www.cdc.gov/flu/) (CDC in Atlanta, Georgia)

Europe:
The most up-to-date influenza information from Europe is available from WHO/Europe and the European Centre for Disease Prevention and Control ⬈ (http://www.flunewseurope.org/).

Public Health Agency of Canada:
The most up-to-date influenza information from Canada is available in Canada's weekly FluWatch report ⬈ (http://www.phac-aspc.gc.ca/fluwatch/).

Public Health England:
The most up-to-date influenza information from the United Kingdom is available from Public Health England ⬈ (http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/SeasonalInfluenza/).

A description of the CDC influenza surveillance system, including methodology and detailed descriptions of each data component is available on the surveillance methods (http://www.cdc.gov/flu/weekly/overview.htm) page.