Australian Respiratory Surveillance Report

Key messages

This report presents a national update on acute respiratory infections, including coronavirus disease 2019 (COVID-19), influenza and respiratory syncytial virus (RSV). It focuses on the current reporting period (23 February to 22 March 2026) and earlier severity reporting periods (up to 8 March 2026). These key messages do not provide detailed information on age distribution, jurisdictional patterns, or comparisons with previous years. This analysis and supporting data are available in the full report .

In the community: In the last month, self-reported influenza-like illness increased slightly among people who contacted the national health helpline and those who took part in community surveys. In the last month, COVID-19 cases increased 43.6%. Influenza cases continued to decrease in the last month and remain at low interseasonal levels. In the last month, RSV cases increased 62.5%, which is consistent with seasonal patterns.

In general practice: In the last month, general practice consultations for influenza-like illness increased at sentinel surveillance sites. Consultation rates are now relatively consistent with usual interseasonal levels.

In hospitals: Sentinel hospital admissions with severe acute respiratory infections decreased in the last severity reporting period, and most admissions were with RSV. Sentinel intensive care admissions with severe acute respiratory infections continued to decline in the last severity reporting period, and most admissions were with RSV. In the last month, the average daily intensive care bed occupancy for patients in droplet or airborne isolation decreased.

Deaths: COVID-19 has been the leading cause of acute respiratory infection mortality across the majority of 2023–2025; however, since August 2025 there have been more deaths involving influenza (both *due* to and *with*) each month than deaths involving COVID-19. The mortality burden of acute respiratory infections remains highest in older adults.

In laboratories: In the last month, test positivity for SARS-CoV-2 increased, test positivity for RSV remained stable, and test positivity for influenza decreased. The SARS-CoV-2 variant under monitoring, NB.1.8.1 has been the most commonly sequenced SARS-CoV-2 variant.

Vaccine coverage, effectiveness and match: In the last year, 9.7% of adults have received a COVID-19 vaccine. In 2025, influenza vaccine coverage reached 30.7%; however, 2026 data are not yet available. Most influenza isolates are a good match for the 2026 southern hemisphere vaccine components. The National RSV Mother and Infant Protection Program continues. To date, 221,223 Abrysvo doses have been administered, and nirsevimab uptake was 3.8% in the last six months.

Australian Respiratory Surveillance Report

This report was prepared by Lauren Welsh, Suzie Whitehead, Algreg Gomez and Jenna Hassall on behalf of the Australian Centre for Disease Control (CDC). We thank the staff and participants from the surveillance systems who contribute data for acute respiratory illness surveillance across Australia.

The report presents a national overview of acute respiratory infections in Australia, drawing information from several different surveillance systems. These surveillance systems help us to understand the distribution of acute respiratory illnesses in the community, the severity of infections including which populations might be at risk, and the impact of acute respiratory illnesses on the community and health system in Australia. Surveillance indicators presented in this report are based on the Australian National Surveillance Plan for COVID-19, Influenza, and RSV. A summary of data considerations for this report are provided below:

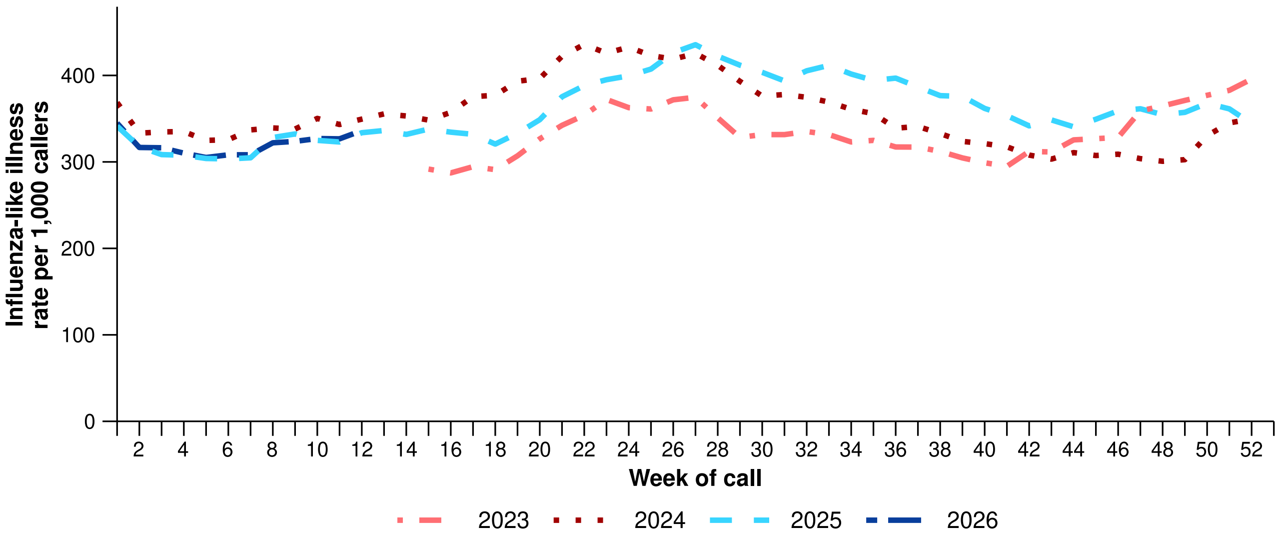
- Due to the dynamic nature of the surveillance systems used in this report, surveillance data are considered preliminary and subject to change as updates are received, with the most recent weeks considered particularly incomplete. Data in this report may vary from data reported in other national reports and reports by states and territories.
- Data in this report are presented by date of event (survey, diagnosis, admission or death) and by the International Organization for Standardization (ISO) week date system, with weeks defined as seven-day periods which begin on a Monday and end on a Sunday. The ISO week date system is used to support trends comparisons over time more effectively. The current reporting period includes 23 February to 22 March 2026 and where comparisons to the previous month are made, this includes 26 January to 22 February 2026.
- In Australia, states and territories (the Australian Capital Territory [ACT], New South Wales [NSW], the Northern Territory [NT], Queensland [Qld], South Australia [SA], Tasmania [Tas], Victoria [Vic] and Western Australia [WA]) report notified cases to the National Notifiable Diseases Surveillance System (NNDSS) based on the Australian national surveillance case definitions. NNDSS data are analysed and reported based on diagnosis date, which is the true onset date of a case if known, otherwise it is the earliest of the specimen date, the notification date or the notification received date. The NNDSS data for this report were extracted on 25 March 2026.
- Notification rates per 100,000 population presented in this report are for the given time period, with population data are based on the Australian Bureau of Statistics (ABS) Estimated Resident Population (ERP) for the reference period June 2024, released 12 December 2024 unless stated otherwise.
- To account for the lag in collection and provision of severity data from some surveillance systems, and for the time delay between illness onset and the development of severe disease outcomes, cases with an admission date or a diagnosis date in the last two weeks are excluded from severity analyses for hospitalisations and intensive care admissions. As such, the severity reporting periods are two weeks behind the end of the current reporting period. For this report, severity reporting includes data from 9 February to 8 March 2026 unless specified otherwise. Where comparisons to the previous severity month are made this includes 12 January to 8 February 2026.
- Death registrations from the ABS Provisional Mortality Statistics are now used as the primary data source for measuring acute respiratory infection associated deaths. The ABS mortality data is sourced from the Registry of Births, Deaths and Marriages and is separate from the NNDSS. Registration-based mortality data needs time to be received and processed, and so mortality statistics in this report may lag by at least two months.
- The responsibility for the interpretation and use of the material lies with the reader. The Australian CDC does not accept liability for any injury or loss or damage arising from the use of, or reliance upon, the content of the report. Analysis and reporting outputs were produced using R Statistical Software v4.3.1.
- For further information about this report, including data sources and considerations refer to the Technical Supplement or contact respiratory.surveillance@cdc.gov.au.

Community surveillance

Community surveillance monitors respiratory illnesses in the community, providing information on the number of people reporting respiratory symptoms, testing practices, and the impact of respiratory illnesses. Community surveillance includes notification data obtained from laboratory tests for infections. Infections that are diagnosed and notified are only a subset of the total number of infections occurring in the community.

- In the last month (23 February to 22 March 2026), there were more Healthdirect helpline callers with influenza-like illness (328 per 1,000 callers per month) than in the previous month (311 per 1,000 callers per month) (Figure 1).
- Rates of influenza-like illness among helpline callers have increased slightly since late February but remain similar to the same time in 2025 (Figure 1).

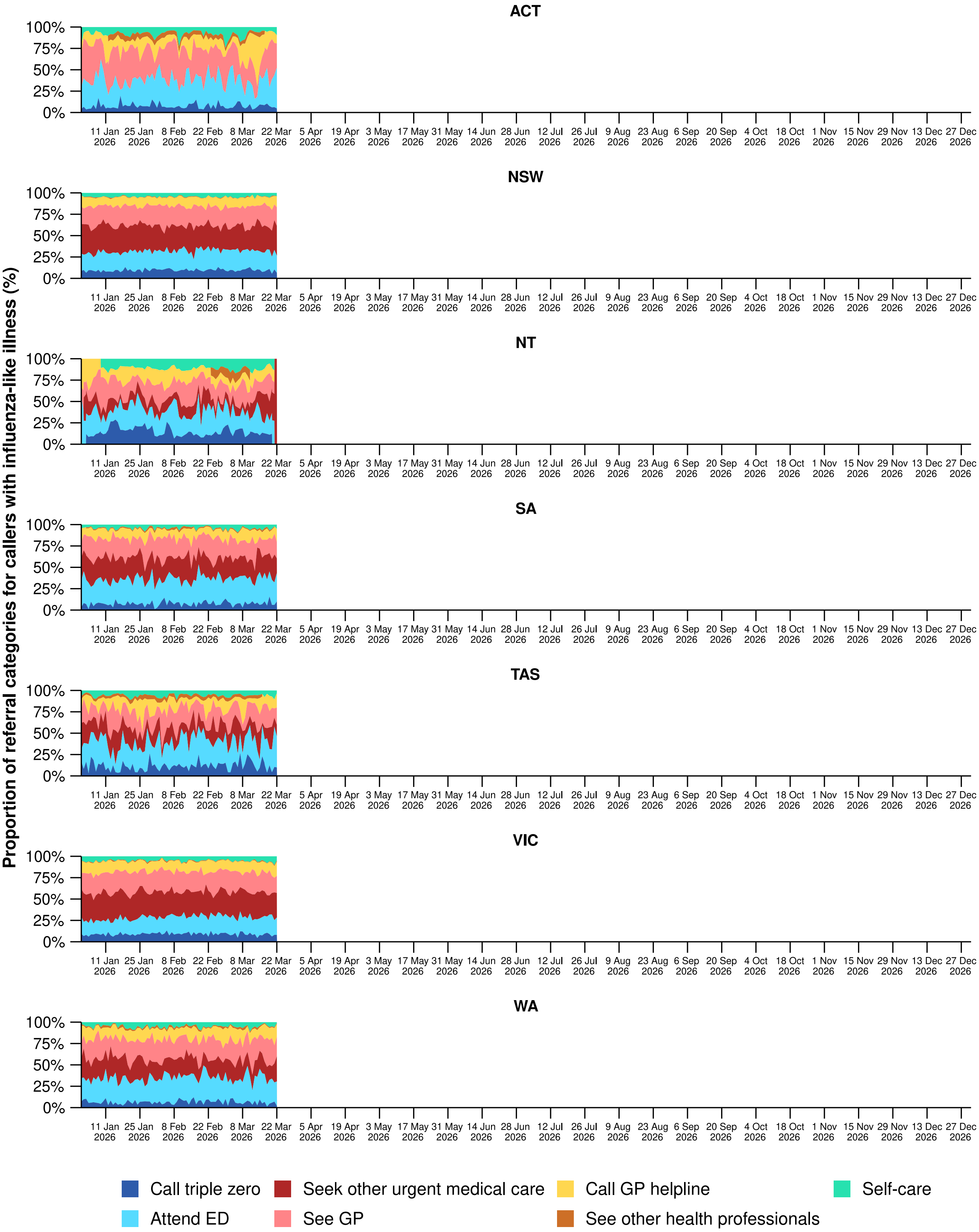
Figure 1: Rate of influenza-like illness per 1,000 helpline callers by year and week of call*, Australia†, 22 March 2023 to 22 March 2026



Source: Healthdirect Australia
* Healthdirect data prior to 22 March 2023 are unavailable as prior to this date a different data collection method was used.
† The Healthdirect helpline operates in all states and territories except Qld; therefore influenza-like illness trends will not be representative of Qld and may be underrepresented. See the Technical Supplement for more information.

- In the last month, there were slightly more Healthdirect helpline callers with influenza-like illness referred to seek urgent medical care (169 per 1,000 callers per month) than in the previous month (161 per 1,000 callers per month) (Figure 2).
  - Callers referred to seek urgent medical care include those referred to call triple zero, attend a hospital emergency department, contact a virtual emergency department, urgent care clinic or see a general practitioner within two hours.
- In the last month, referral pathways for influenza-like illness varied across Australia. NSW and Vic had the highest proportion of callers referred to see a general practitioner (GP) or seek other urgent medical care (Figure 2). By comparison, the ACT and Tas had a higher proportion of callers who were recommended to attend a hospital emergency department or call triple zero. The NT, SA and WA had similar proportions of callers referred to see a GP or seek other urgent medical care and recommended to attend a hospital emergency department or call triple zero (Figure 2).

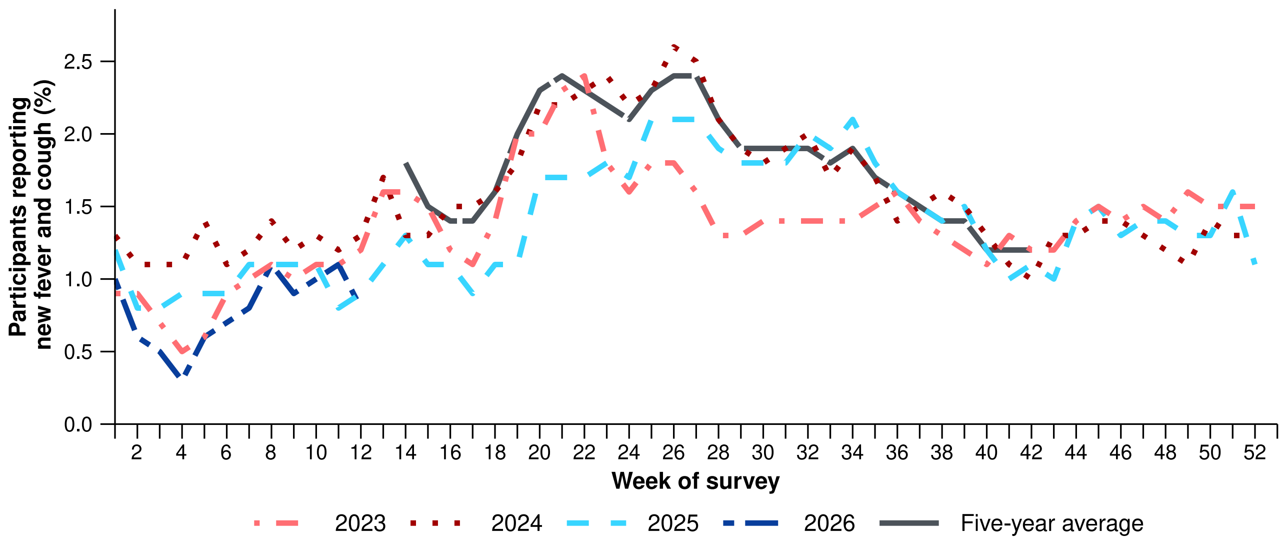
Figure 2: Proportion of referral categories* for helpline callers with influenza-like illness by jurisdiction† and call date, Australia, 1 January to 22 March 2026



Source: Healthdirect Australia
* See other health professionals category includes pharmacist, dentist, mental health provider, primary maternity care, poison information centre or other.
† The Healthdirect helpline operates in all states and territories except Qld; therefore influenza-like illness referral trends are not provided for Qld. See the Technical Supplement for more information.

- In the last month, a slightly higher percentage of FluTracking participants reported new fever and cough symptoms (1.0%), than in the previous month (0.8%) (Figure 3).
- The weekly percentage of FluTracking participants reporting new fever and cough symptoms has been increasing from late January, though there were slight week on week decreases observed in March. This trend was similar to the same period in 2023 and 2025, but lower than the trend observed in the same period in 2024 (Figure 3).
- In the last month, a similar percentage of First Nations FluTracking participants reported new fever and cough symptoms (0.7%) compared with the previous month (0.8%). These findings could be impacted by smaller sample sizes and representativeness of the data. For more detailed trends, please refer to figure 2 in the FluTracking reports.

Figure 3: Age standardised percentage of survey participants reporting new fever and cough symptoms compared with the five-year average* by year and week of survey, Australia, 2023 to 22 March 2026



Source: FluTracking
* From 2020, FluTracking expanded their data capture period to year-round. Data before May and after October for any year before 2020 are not available for historical comparisons. The years 2020 and 2021 are excluded when comparing the current season to historical periods when influenza virus has circulated without public health restrictions. As such, the five-year average includes the years 2019 and 2022 to 2025.

- The average percentage of FluTracking participants reporting taking three or more days off work or normal duties, or seeking medical advice or care, due to fever and cough symptoms in 2026 is lower than the same period in previous years (Table 1).

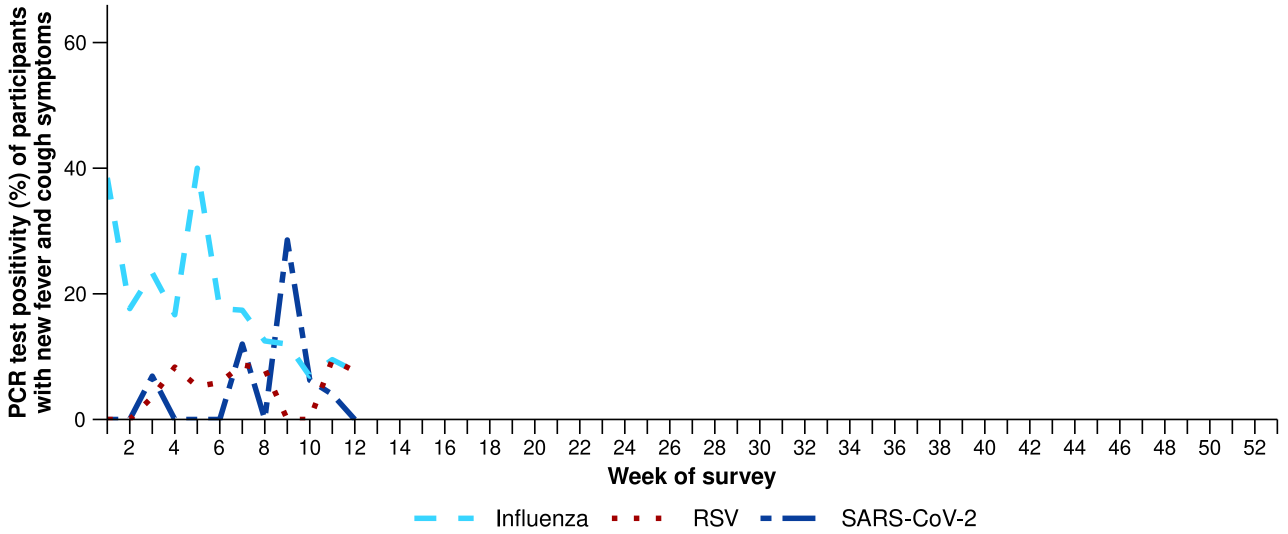
Table 1: Percentage of FluTracking participants reporting new fever and cough symptoms plus three or more days off work or normal duties or seeking medical advice or care*, Australia, up to 8 March† for 2023–2026

	2023	2024	2025	2026
Reported three or more days off work or normal duties	50.4%	52.2%	48.3%	44.7%
Reported seeking medical advice or care*	35.7%	32.0%	32.5%	31.1%

Source: FluTracking
* Includes those who sought medical advice from a general practitioner, Aboriginal and Torres Strait Islander health clinic, COVID-19 clinic, emergency department, or were admitted to hospital for fever and cough.
† While FluTracking data are collected in real time, data presented here are subject to a two week reporting delay to account for the time delay between illness onset and the development of severe disease outcomes.

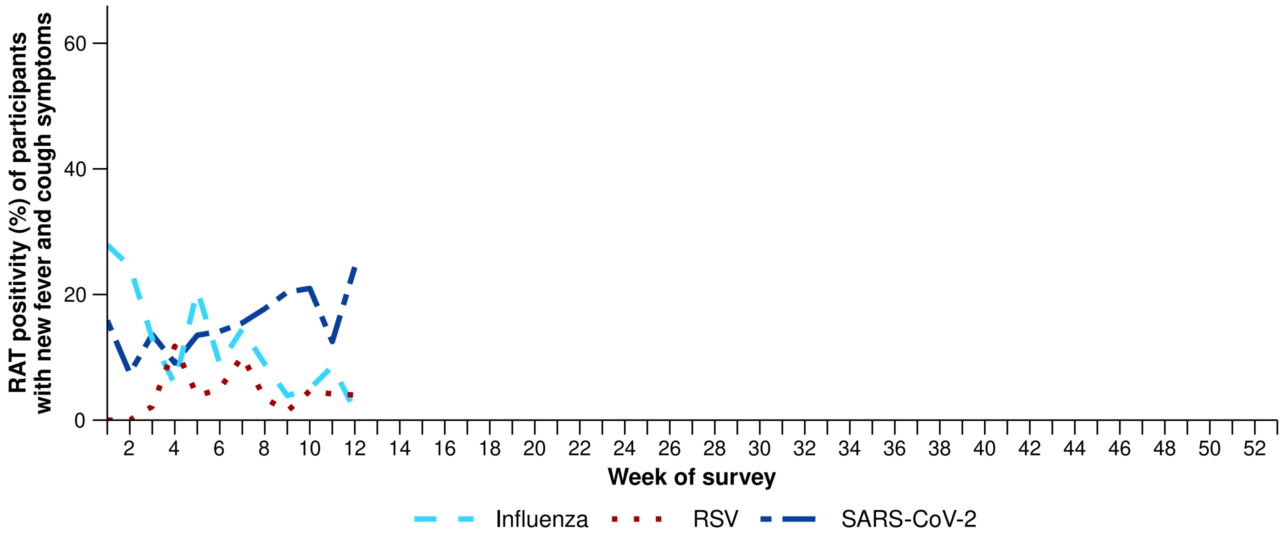
- In 2026, self-reported severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) positivity has varied, with polymerase chain reaction (PCR) positivity peaking in late February at 28.6%; while self-reported SARS-CoV-2 rapid antigen test (RAT) positivity increased steadily across January and February, decreased in mid-March and then increased to 24.4% positivity in late March (Figure 4a/b).
- Since January self-reported influenza PCR positivity declined, decreasing from 40.0% in late January to 7.7% in late March (Figure 4a). Self-reported influenza RAT positivity followed a similar decline, decreasing from 27.8% in early January to 1.6% in late March (Figure 4b).
- Self-reported RSV positivity has fluctuated in 2026, but RSV positivity has not exceeded 11.8% via either PCR or RAT (Figure 4a/b).
- For more detailed testing and self-reported positivity trends, please refer to the FluTracking reports.

Figure 4a: Self-reported PCR test positivity* among FluTracking participants with fever and cough symptoms by pathogen week of survey, Australia, 1 January to 22 March 2026



Source: FluTracking
* Denominator is based on participants who self-reported fever and cough symptoms and had a PCR test. Please refer to the Technical Supplement for more details.

Figure 4b: Self-reported RAT positivity* among FluTracking participants with fever and cough symptoms by pathogen and week of survey, Australia, 1 January to 22 March 2026



Source: FluTracking
* Denominator is based on participants who self-reported fever and cough symptoms and had a RAT. Please refer to the Technical Supplement for more details.

- In the last month (23 February to 22 March 2026), there was a 43.6% increase in COVID-19 cases, a 9.8% decrease in influenza cases, and a 62.6% increase in RSV cases.

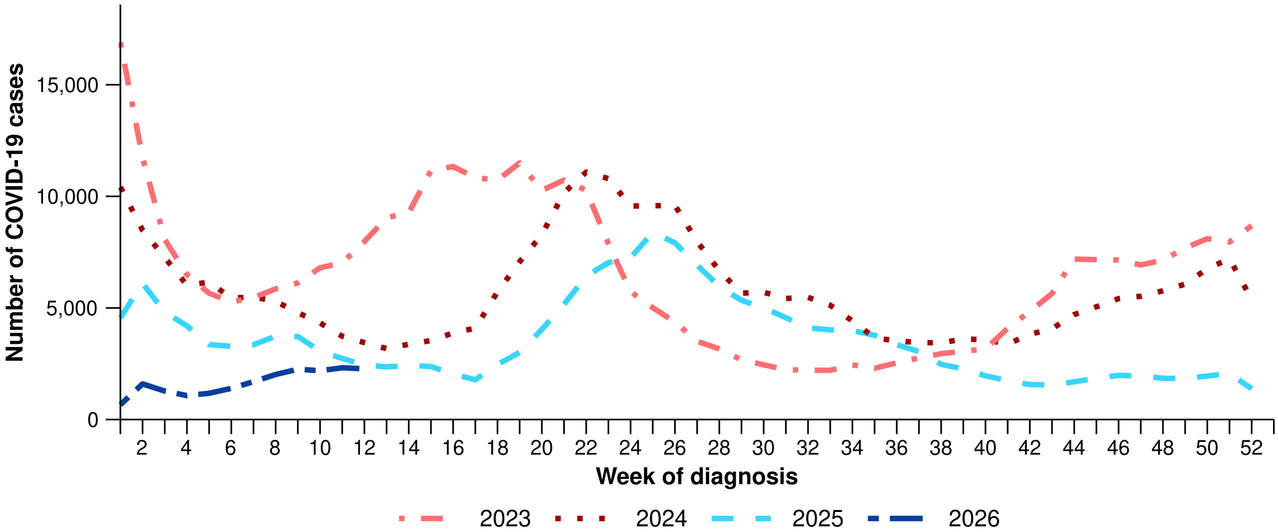
Table 2: Notified cases and notification rate per 100,000 population by disease, five-year age group, and jurisdiction*, Australia, 1 January to 22 March 2026

	COVID-19			Influenza			RSV		
	Reporting period (n)	Year to date (n)	Year to date (rate)	Reporting period (n)	Year to date (n)	Year to date (rate)	Reporting period (n)	Year to date (n)	Year to date (rate)
Age group (years)									
0–4	1,479	3,473	230	623	2,818	187	4,030	7,527	499
5–9	650	1,240	77	716	2,216	138	429	740	46
10–14	680	1,083	65	578	1,648	98	235	425	25
15–19	444	800	48	457	1,730	104	246	485	29
20–24	315	705	39	325	1,723	96	207	435	24
25–29	358	828	41	296	1,404	70	215	506	25
30–34	476	1,063	52	295	1,209	59	260	535	26
35–39	545	1,139	57	286	1,125	57	222	500	25
40–44	490	1,033	56	282	1,154	62	204	440	24
45–49	396	861	53	235	979	60	227	536	33
50–54	379	823	49	211	931	55	256	607	36
55–59	332	805	53	212	969	63	302	741	48
60–64	346	744	48	225	1,005	65	327	717	47
65–69	308	740	54	245	1,010	74	288	684	50
70–74	341	846	72	238	963	82	310	723	62
75+	1,492	3,737	172	620	2,789	129	977	2,268	105
Jurisdiction									
ACT	67	204	43	42	273	58	44	112	24
NSW	3,871	8,462	100	2,116	8,057	95	4,345	7,947	94
NT	35	119	47	48	478	187	133	508	199
Qld	2,624	5,388	96	2,384	7,317	131	2,792	5,793	104
SA	842	1,646	88	236	1,393	74	220	575	31
Tas	72	230	40	56	274	48	66	190	33
Vic	1,259	3,193	46	685	4,370	63	810	1,977	28
WA	264	687	23	288	1,523	51	325	767	26
Total	**9,034**	**19,929**	**73**	**5,855**	**23,685**	**87**	**8,735**	**17,869**	**66**

Source: National Notifiable Diseases Surveillance System (NNDSS)
* Total includes cases with missing age.

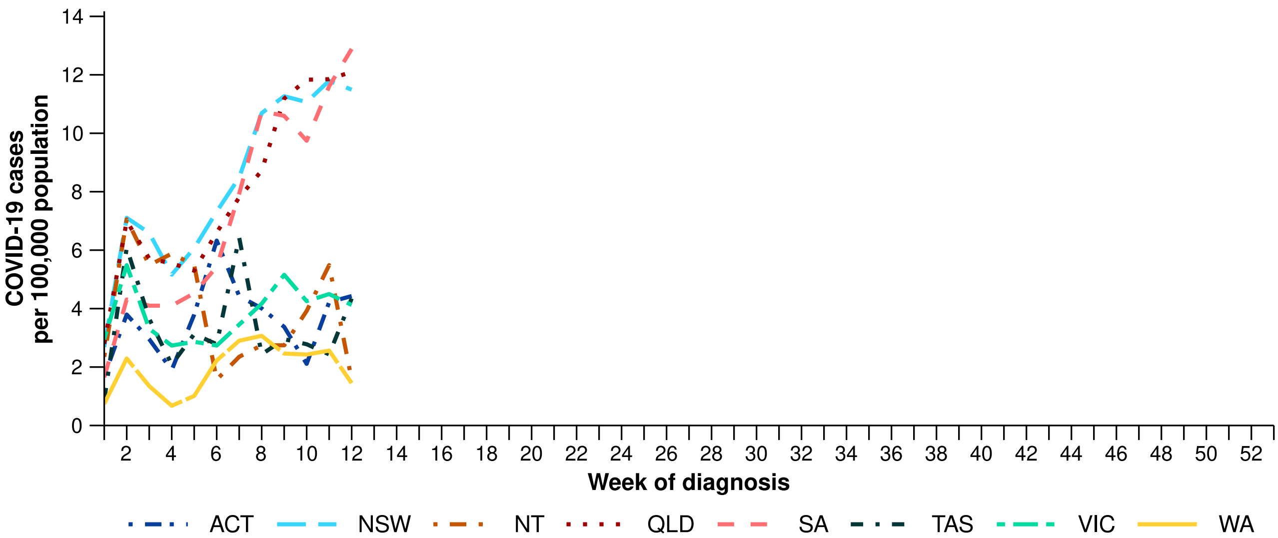
- In the last month, there were 9,034 COVID-19 cases, a 43.6% increase from 6,289 cases notified in the previous month (Table 2; Figure 5). This increase is likely due to waning immunity after the expected summer peak was not as pronounced in previous years.
- In the year to date, there have been 19,929 COVID-19 cases, 55.0% fewer than the 44,334 cases notified over the same period in 2025 (Table 2; Figure 5).
- In the last month, COVID-19 notification rates increased or remained relatively stable across most jurisdictions compared with the previous month, except in the ACT and Tas where notification rates decreased (Figure 6).

Figure 5: Notified COVID-19 cases by year and week of diagnosis, Australia, 2023 to 22 March 2026



Source: National Notifiable Diseases Surveillance System (NNDSS)

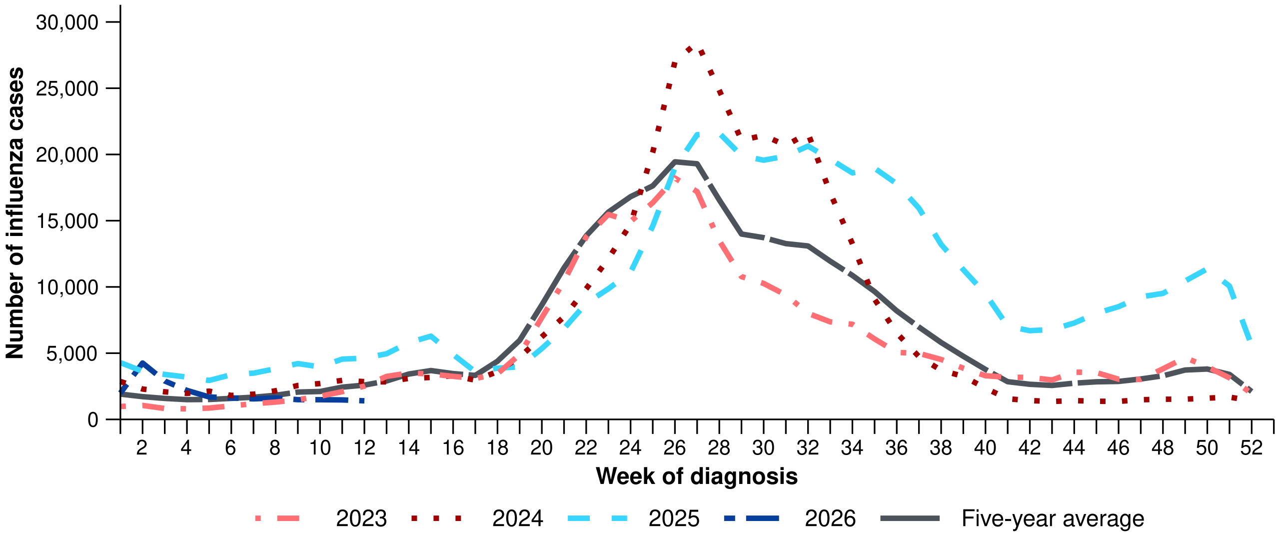
Figure 6: Notification rates per 100,000 population for COVID-19 cases by state or territory and week of diagnosis, Australia, 1 January to 22 March 2026



Source: National Notifiable Diseases Surveillance System (NNDSS)

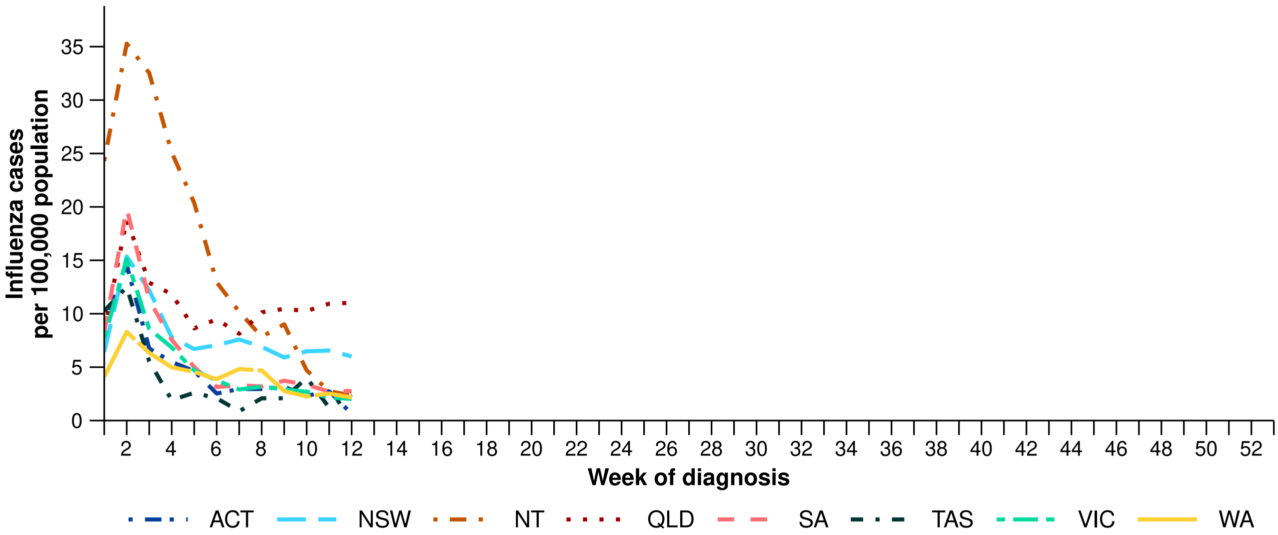
- In the last month, there were 5,855 influenza cases, a 9.8% decrease from 6,489 cases notified in the previous month (Table 2; Figure 7).
- In the year to date, there have been 23,685 influenza cases, 44.0% fewer than the 42,331 cases notified over the same period in 2025 when elevated early interseasonal activity occurred (Table 2; Figure 7).
- In the last month, influenza notification rates decreased or remained relatively stable across most jurisdictions compared with the previous month, except in Qld and Tas where notification rates increased slightly (Figure 8).

Figure 7: Notified influenza cases and five-year average* by year and week of diagnosis, Australia, 2023 to 22 March 2026



Source: National Notifiable Diseases Surveillance System (NNDSS)
* The years 2020 and 2021 are excluded when comparing the current season to historical periods when influenza virus has circulated without public health restrictions. As such, the five-year average includes the years 2019 and 2022 to 2025. Please refer to the Technical Supplement for interpretation of the five-year average.

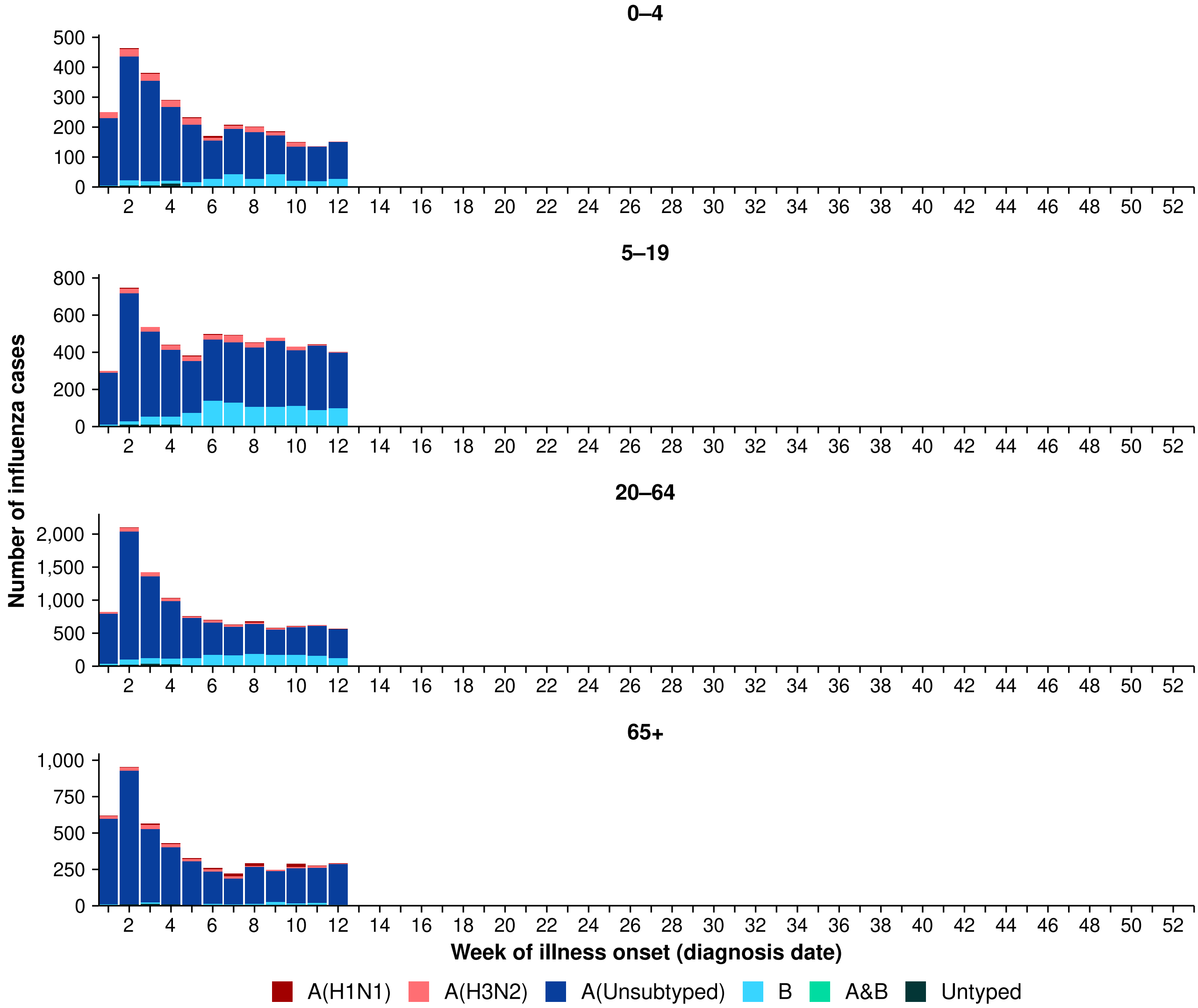
Figure 8: Notification rates per 100,000 population for influenza cases by state or territory and week of diagnosis, Australia, 1 January to 22 March 2026



Source: National Notifiable Diseases Surveillance System (NNDSS)

- In the last month, there were 4,675 influenza A cases, a 11.4% decrease from 5,275 influenza A cases notified in the previous month, and there were 1,121 influenza B cases, a 5.2% decrease from 1,183 influenza B cases notified in the previous month.
  - In the last month, there were 54 influenza A(H1N1) cases, a 56.1% decrease from 123 cases notified in the previous month.
  - In the last month, there were 158 influenza A(H3N2) cases, a 52.1% decrease from 330 cases notified in the previous month.
- In the year to date, influenza A(Unsubtyped) has accounted for most cases across all age groups, but since early February there has been an increasing number of influenza B notifications (Figure 9). Trends in influenza subtypes are influenced by differences in the number and selection of influenza samples that undergo typing across age groups and healthcare settings.

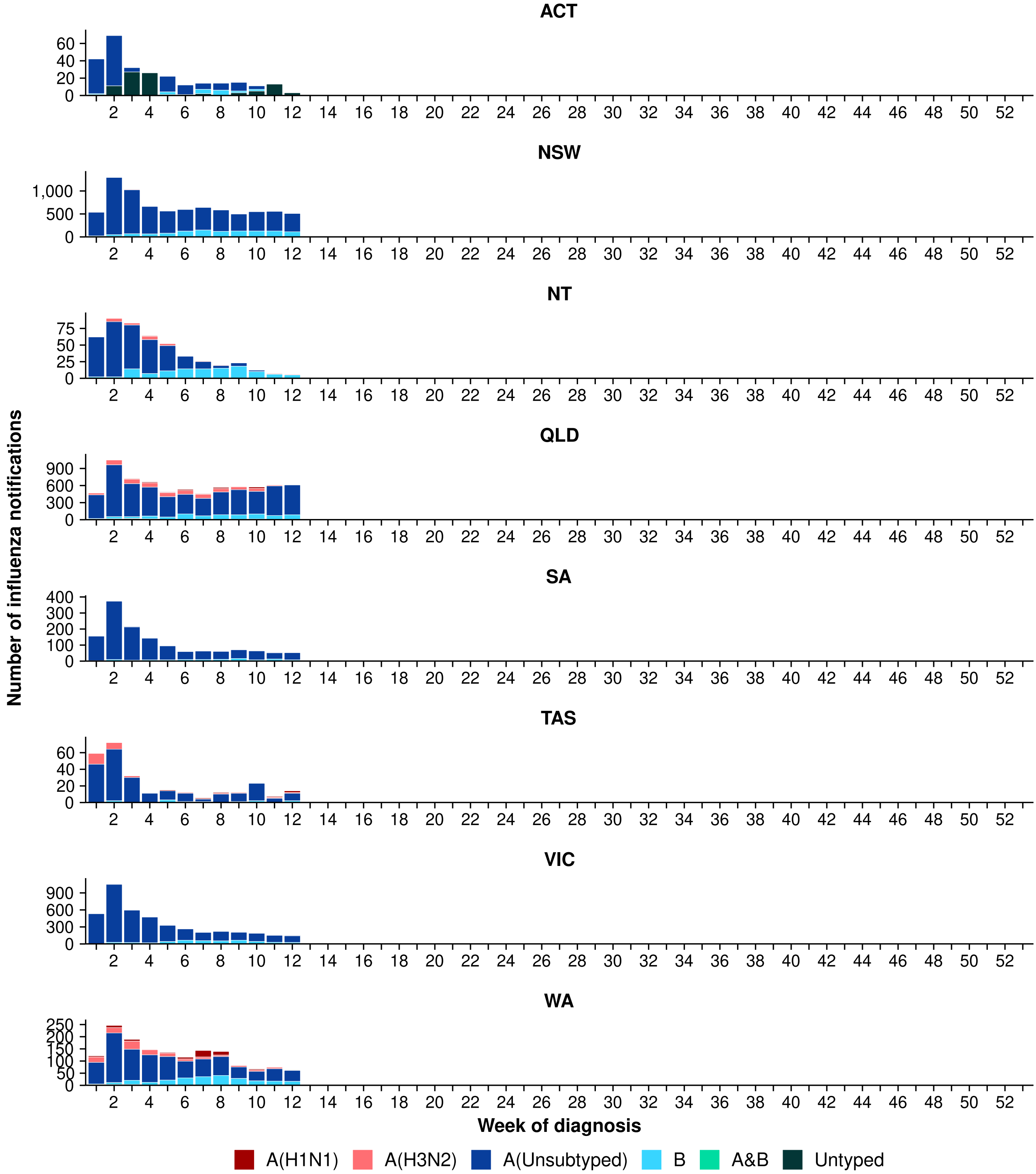
Figure 9: Notified influenza cases by influenza subtype, age group*, and week of diagnosis, Australia, 1 January to 22 March 2026



Source: National Notifiable Diseases Surveillance System (NNDSS)
* Axis varies between age groups.

- In the year to date, influenza A(Unsubtyped) has accounted for most influenza cases across all jurisdictions; however, an increasing number of influenza B notifications has been observed in most jurisdictions since early February, most notably in the NT. A small number of influenza A(H3N2) notifications have been observed in the NT, Qld, Tas, and WA (Figure 10).
- Trends in influenza subtypes are influenced by jurisdictional differences in the number and selection of influenza samples that undergo typing.

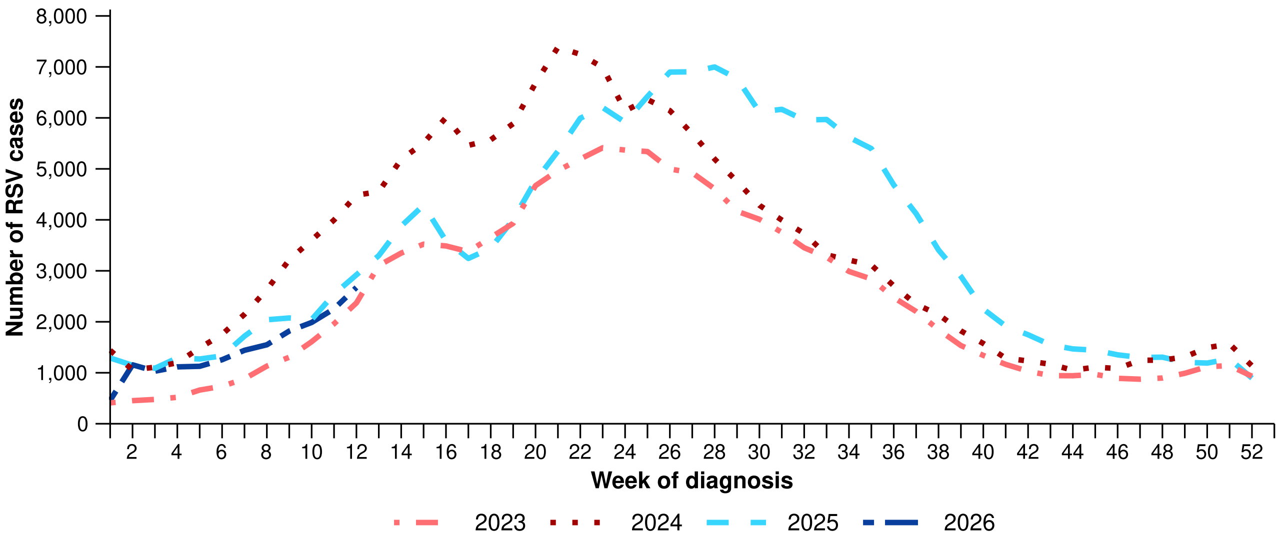
Figure 10: Notified influenza cases by influenza subtype, jurisdiction*, and week of diagnosis, Australia, 1 January to 22 March 2026



Source: National Notifiable Diseases Surveillance System (NNDSS)
* Axis varies between jurisdictions.

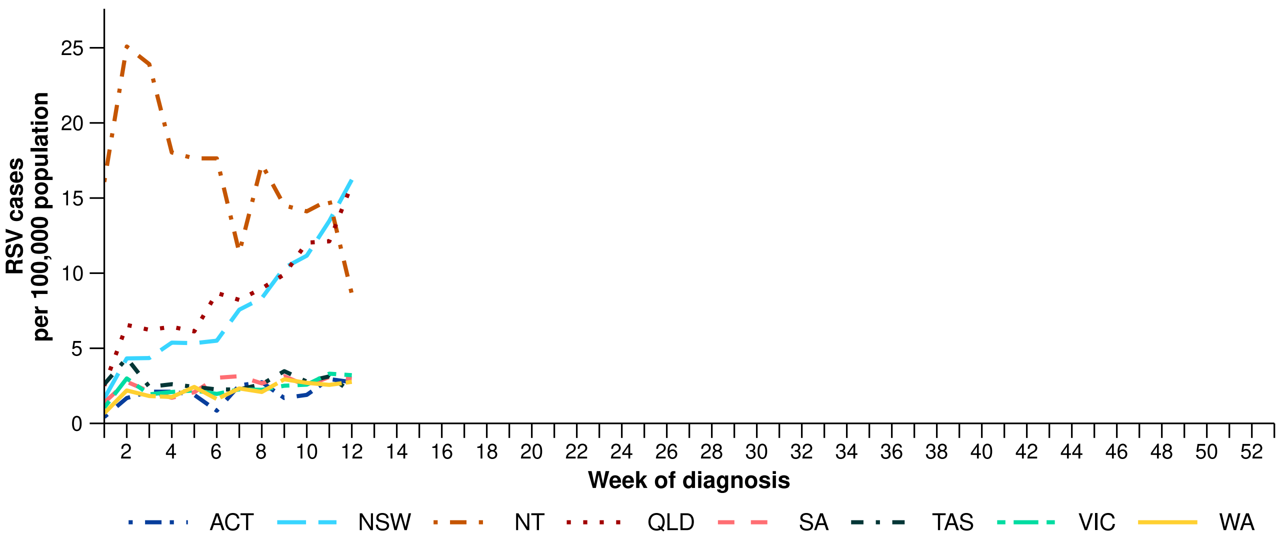
- In the last month, there were 8,735 RSV cases, a 62.6% increase from 5,373 cases notified in the previous month (Table 2; Figure 11).
- In the year to date, there have been 17,869 RSV cases, 10.9% fewer than the 20,061 cases notified over the same period in 2025 (Table 2; Figure 11).
- In the last month, RSV notification rates increased or remained relatively stable across most jurisdictions compared with the previous month with notable increases in NSW and Qld. Notification rates continued to decrease in the NT after reaching a peak of 25 cases per 100,000 population per week in early January 2026 (Figure 12).

Figure 11: Notified RSV cases by year and week of diagnosis, Australia, 2023 to 22 March 2026



Source: National Notifiable Diseases Surveillance System (NNDSS)

Figure 12: Notification rates per 100,000 population for RSV cases by state or territory and week of diagnosis, Australia, 1 January to 22 March 2026



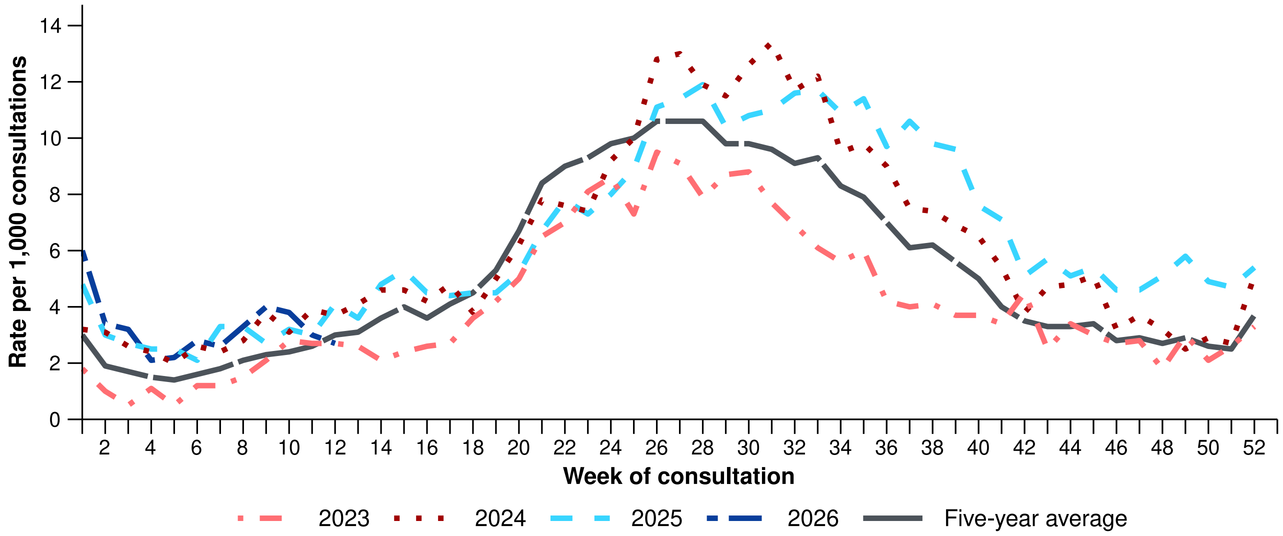
Source: National Notifiable Diseases Surveillance System (NNDSS)

Primary care surveillance

Primary care surveillance monitors the number and characteristics of people who have presented to a general practice with influenza-like illness and provides insight on the different respiratory pathogens that are causing illness in the community.

- In the last month (23 February to 22 March 2026), there were more general practice consultations for influenza-like illness (3.4 notifications per 1,000 consultations per month) compared to month (2.7 notifications per 1,000 consultations per month) (Figure 13).
- From late January, influenza-like illness consultation rates have gradually increased, with a slight decrease observed in mid-March, following a similar trend to that in the same period in 2024 and 2025 (Figure 13).

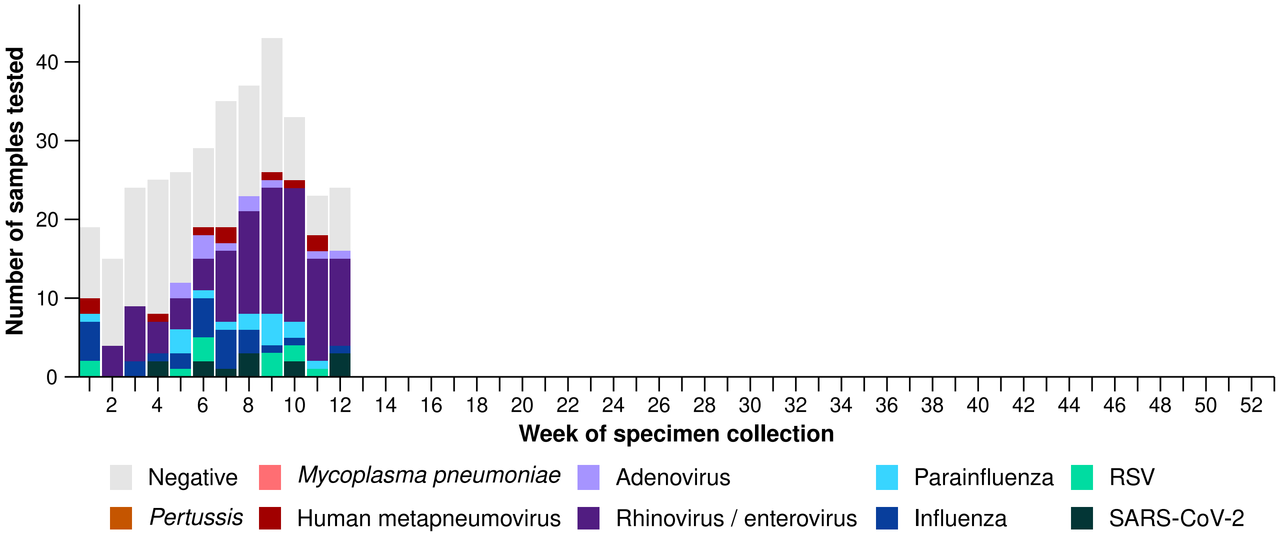
Figure 13: Rate of influenza-like illness notifications per 1,000 consultations per week in sentinel general practice sites compared with the five-year average by year and week of consultation*†, Australia, 2023 to 22 March 2026



Source: Australian Sentinel Practices Research Network (ASPREN)
* The years 2020 and 2021 are excluded when comparing the current season to historical periods when influenza virus has circulated without public health restrictions. As such, the five-year average includes the years 2019 and 2022 to 2025. Please refer to the Technical Supplement for interpretation of the five-year average.
† Please refer to the Technical Supplement for notes on impact of COVID-19 on ASPREN data.

- In the last month, 69.1% (85/123) of people attending general practice with influenza-like illness who were tested have then tested positive for a respiratory pathogen.
- In the last month, rhinovirus (67.1%; 57/85) was the most commonly detected pathogen, followed by RSV (7.1%; 6/85) and SARS-CoV-2 (5.9%; 5/85) (Figure 14).
- In the year to date, 56.8% (189/333) of people attending general practice with influenza-like illness who were tested have then tested positive for a respiratory pathogen.
- In the year to date, rhinovirus (54.0%; 102/189) has been the most commonly detected pathogen, followed by influenza (13.8%; 26/189), SARS-CoV-2 (6.9%; 13/189), RSV (6.3%; 12/189), and adenovirus (5.8%; 11/189) (Figure 14).

Figure 14: Number of samples tested for respiratory pathogens among people with influenza-like illness attending sentinel general practice sites by respiratory pathogen and week of specimen collection, Australia, 1 January to 22 March 2026



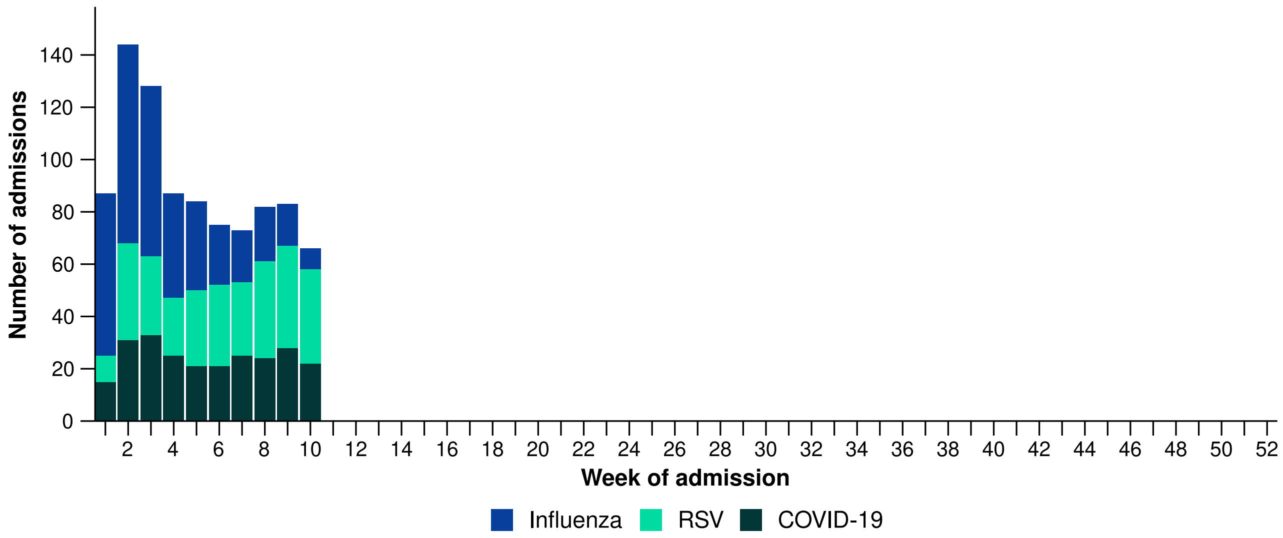
Source: Australian Sentinel Practices Research Network (ASPREN)
Note: All ASPREN swab samples are transported to the SA Pathology laboratory in Adelaide to be tested for viral and bacterial respiratory pathogens via a multiplex real-time reverse transcription polymerase chain reaction (RT-PCR) assay using in-house primers.

Hospital-based surveillance

Hospital-based surveillance monitors persons with more severe illness who have been admitted to hospital for their respiratory illness (severe acute respiratory infections). Hospital-based surveillance also measures the ability of the health system to cope with the number of severe acute respiratory infection admissions to ensure delivery of safe, timely and quality health care.

- In the last severity reporting period (9 February to 8 March 2026), fewer patients were admitted to a sentinel hospital with a severe acute respiratory infection (n=304), than in the previous severity reporting period (n=374).
  - In the last severity reporting period, at sentinel hospitals there was 1.0% fewer admissions with COVID-19 (from 100 to 99), 59.9% fewer admissions with influenza (from 162 to 65), and 25.0% more admissions with RSV (from 112 to 140), compared to the previous severity reporting period.
- In the year to date for severity reporting (1 January to 8 March 2026), there have been 909 admissions with severe acute respiratory infections at sentinel hospitals. Most patients with a severe acute respiratory infection have been admitted with influenza (n=365) followed by RSV (n=299) (Figure 15).

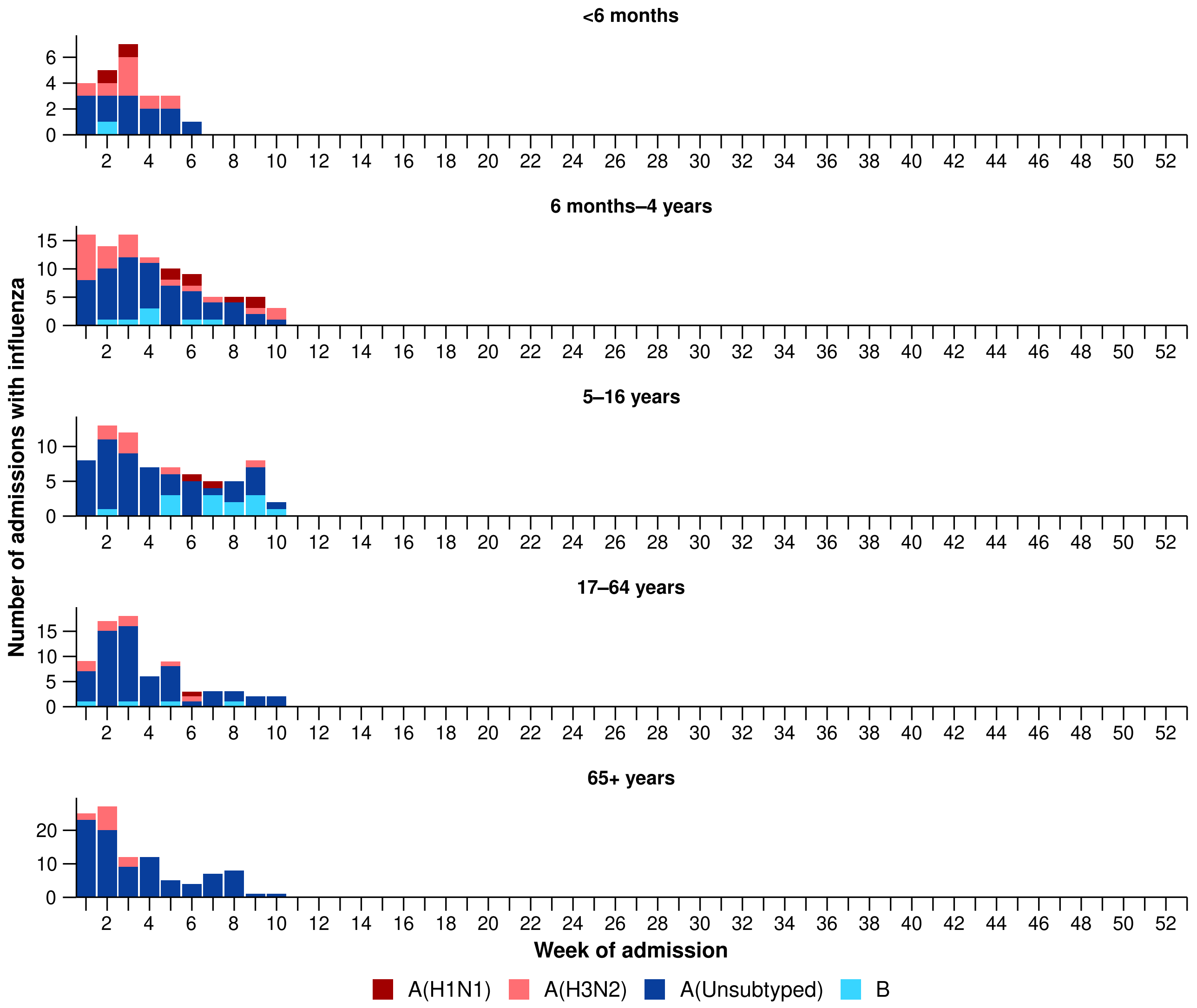
Figure 15: Total number of patients (children and adults) admitted with a severe acute respiratory infection to sentinel hospitals by disease and week of admission, Australia, 1 January to 8 March 2026



Source: Influenza Complications Alert Network (FluCAN)

- Patients admitted to sentinel hospitals with influenza have mostly been admitted with influenza A (93.2%; 340/365), while 6.8% (25/365) were admitted with influenza B.
  - Most hospital admissions with influenza A have been with influenza A(Unsubtyped) (79.7%; 271/340), followed by influenza A(H3N2) (16.8%; 57/340) and then influenza A(H1N1) (3.5%; 12/340).
- In the year to date for severity reporting, influenza A (Unsubtyped) was the most commonly detected influenza type in all age groups; however, an increasing number of school aged children (5 to 16 years) have been admitted to hospital with influenza B since mid-February (Figure 16).

Figure 16: Number of patients admitted with influenza to sentinel hospitals by influenza subtype, age group*, and week of admission, Australia, 1 January to 8 March 2026



Source: Influenza Complications Alert Network (FluCAN)
* Axis varies between age groups. The age distribution of admissions with influenza may not reflect the age distribution of all patients.

- There were no children under 6 months admitted with influenza to sentinel hospitals from mid-February to mid-March (Figure 16).
- More children (those aged 16 years and younger) have been admitted with RSV to sentinel hospitals than with COVID-19 or influenza (Table 3a).
- Children admitted to sentinel hospitals with influenza tended to be older than children admitted with COVID-19 or RSV (Table 3a).
- Children admitted to sentinel hospitals with RSV had a slightly longer length of hospital stay compared to children with influenza or COVID-19; however, the difference in the length of stay was minor (Table 3a).
- Sadly, a small number of children admitted to sentinel hospitals with influenza or RSV have died (Table 3a).

Table 3a: Demographic characteristics and outcomes for children admitted with a severe acute respiratory infection to a sentinel hospital by disease*†‡, Australia, 1 January to 8 March 2026

	COVID-19 Year to date for severity reporting (n=130)	Influenza Year to date for severity reporting (n=191)	RSV Year to date for severity reporting (n=232)
Age (years)			
Median [IQR]	1 [0-3]	3 [1-7]	1 [0-2]
Age group (years)			
< 6 months	35 (26.9%)	23 (12.0%)	50 (21.6%)
6 months – 4 years	65 (50.0%)	95 (49.7%)	168 (72.4%)
5–16 years	30 (23.1%)	73 (38.2%)	14 (6.0%)
Indigenous status			
Aboriginal and Torres Strait Islander	9 (6.9%)	22 (11.5%)	40 (17.2%)
Length of hospital stay (days)†			
Median [IQR]	1 [1-2]	1 [1-2]	2 [1-3]
Patient admission location‡			
Admitted to hospital ward	128 (98.5%)	182 (95.3%)	221 (95.3%)
Admitted to intensive care directly	2 (1.5%)	9 (4.7%)	11 (4.7%)
Discharge status†			
Alive	95 (73.1%)	171 (89.5%)	191 (82.3%)
Died	-	1 (0.5%)	1 (0.4%)
Incomplete/missing	35 (26.9%)	19 (9.9%)	40 (17.2%)

Source: Influenza Complications Alert Network (FluCAN)
* Does not include patients with missing age; therefore, the sum of age-specific totals above may not equal the total number of patients.
† For patients who are still in hospital data may not be complete; therefore, these data are not included in the length of stay or discharge status. In addition, length of stay data excludes patients that acquired their infection in hospital.
‡ Admission location reflects the initial admission ward. Some patients may be initially admitted to general ward then later admitted to an intensive care and this is not reflected here. Does not include patients with missing admission location; therefore, the sum of admission location specific totals above may not equal the total number of patients.

The Paediatric Active Enhanced Disease Surveillance (PAEDS) network carries out enhanced sentinel hospital surveillance for some acute respiratory infections or conditions in children. PAEDS data for acute respiratory infections in children are presented in the Australian Respiratory Surveillance Reports in the sentinel hospital data from FluCAN. For additional information on COVID-19 in children, Paediatric Inflammatory Multisystem Syndrome (PIMS-TS) following COVID-19, influenza in children, or RSV in children please visit the PAEDS webpages and dashboards.

- More adults (those aged 17 years and over) have been admitted with influenza to sentinel hospitals than with COVID-19 or RSV (Table 3b).
- A greater proportion of adults aged 65 years and over have been admitted to sentinel hospitals with COVID-19, influenza and RSV compared to adults aged 17–64 years (Table 3b).
- Adults admitted to sentinel hospitals with COVID-19 had a longer length of hospital stay compared to adults admitted with influenza or RSV (Table 3b).
- Sadly, a small number of adults admitted to sentinel hospitals with COVID-19, influenza or RSV have died (Table 3b).

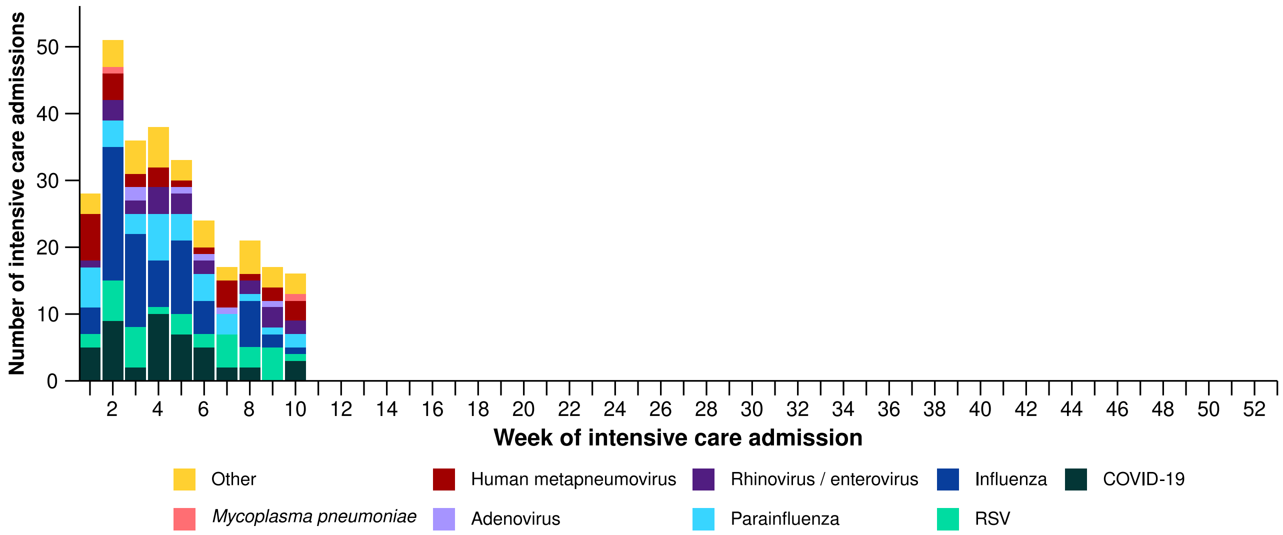
Table 3b: Demographic characteristics and outcomes for adults admitted with a severe acute respiratory infection to a sentinel hospital by disease*†‡, Australia, 1 January to 8 March 2026

	COVID-19 Year to date for severity reporting (n=115)	Influenza Year to date for severity reporting (n=174)	RSV Year to date for severity reporting (n=67)
Age (years)			
Median [IQR]	74 [61-83]	70 [48-80]	70 [59-82]
Age group (years)			
17–64 years	36 (31.3%)	72 (41.4%)	21 (31.3%)
65 years and over	79 (68.7%)	102 (58.6%)	46 (68.7%)
Indigenous status			
Aboriginal and Torres Strait Islander	14 (12.2%)	15 (8.6%)	8 (11.9%)
Length of hospital stay (days)†			
Median [IQR]	6 [2-9]	3 [1-6]	4 [2-8]
Patient admission location‡			
Admitted to hospital ward	110 (95.7%)	160 (92.0%)	63 (94.0%)
Admitted to intensive care directly	5 (4.3%)	14 (8.0%)	4 (6.0%)
Discharge status†			
Alive	69 (60.0%)	143 (82.2%)	51 (76.1%)
Died	5 (4.3%)	3 (1.7%)	4 (6.0%)
Incomplete/missing	41 (35.7%)	28 (16.1%)	12 (17.9%)

Source: Influenza Complications Alert Network (FluCAN)
* Does not include patients with missing age; therefore, the sum of age-specific totals above may not equal the total number of patients.
† For patients who are still in hospital data may not be complete; therefore, these data are not included in the length of stay or discharge status. In addition, length of stay data excludes patients that acquired their infection in hospital.
‡ Admission location reflects the initial admission ward. Some patients may be initially admitted to general ward then later admitted to an intensive care and this is not reflected here. Does not include patients with missing admission location; therefore, the sum of admission location specific totals above may not equal the total number of patients.

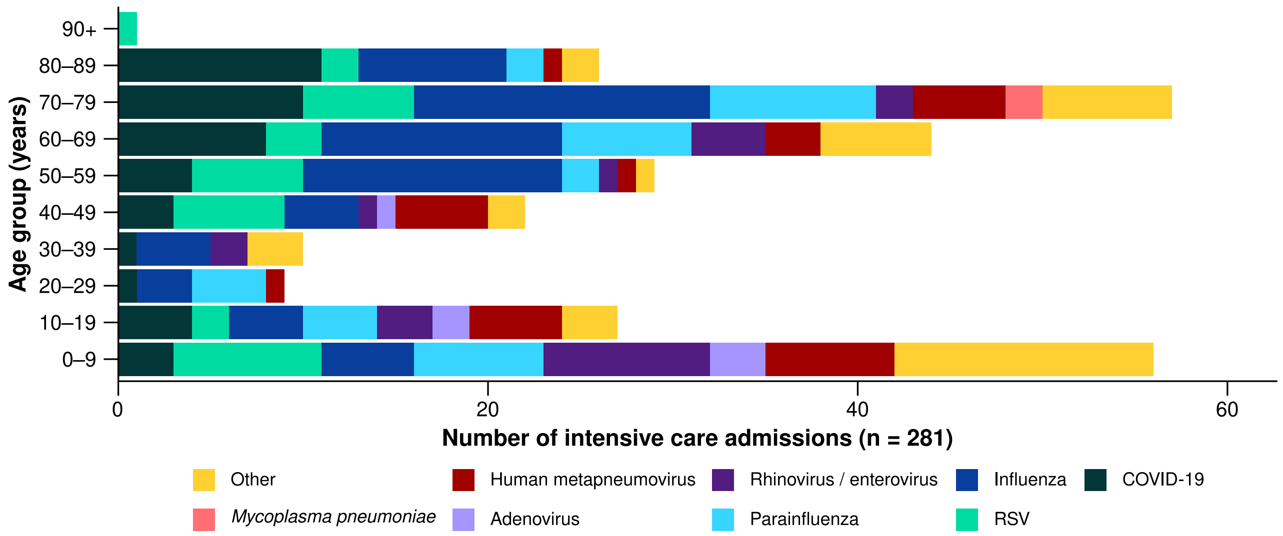
- In the last severity reporting period for sentinel intensive care (9 February to 8 March 2026), fewer patients have been admitted to a sentinel intensive care with a severe acute respiratory infection (n=63), than in the previous severity reporting period (n=114) (Figure 17).
- In the year to date for severity reporting (1 January to 8 March 2026), most patients were admitted to sentinel intensive care with influenza, followed by COVID-19 (Figure 17; Table 4).

Figure 17: Number of patients admitted with severe acute respiratory infections to a sentinel intensive care by disease and week of admission, Australia, 1 January to 8 March 2026



Source: Short Period Incidence Study of Severe Acute Respiratory Infection (SPRINT-SARI) Australia
Note: A range of diagnostic testing procedures are utilised across hospitals in Australia. SPRINT-SARI does not specify which diagnostic testing method should be utilised as this is the domain of the hospital and treating clinicians.

Figure 18: Number of patients admitted with severe acute respiratory infections to a sentinel intensive care by disease and age group*, Australia, 1 January to 8 March 2026



Source: Short Period Incidence Study of Severe Acute Respiratory Infection (SPRINT-SARI) Australia
Note: 14.9% (37/248) of patients had co-infections of respiratory pathogens; therefore, the sum of pathogen-specific totals above may not equal the total number of severe acute respiratory infection patients.
* The age distribution of severe acute respiratory infection intensive care admissions may not reflect the age distribution of all patients.

- In the year to date for severity reporting, most admissions have been among children aged 0–9 years or among adults aged 50 years and over (Figure 18; Table 4).
- A higher proportion of admissions with parainfluenza required invasive mechanical ventilation; however, length of invasive mechanical ventilation was longest among those with hMPV. The length of intensive care stay was longest among those with parainfluenza (Table 4).
- Sadly, a number of patients have died in hospital (Table 4).

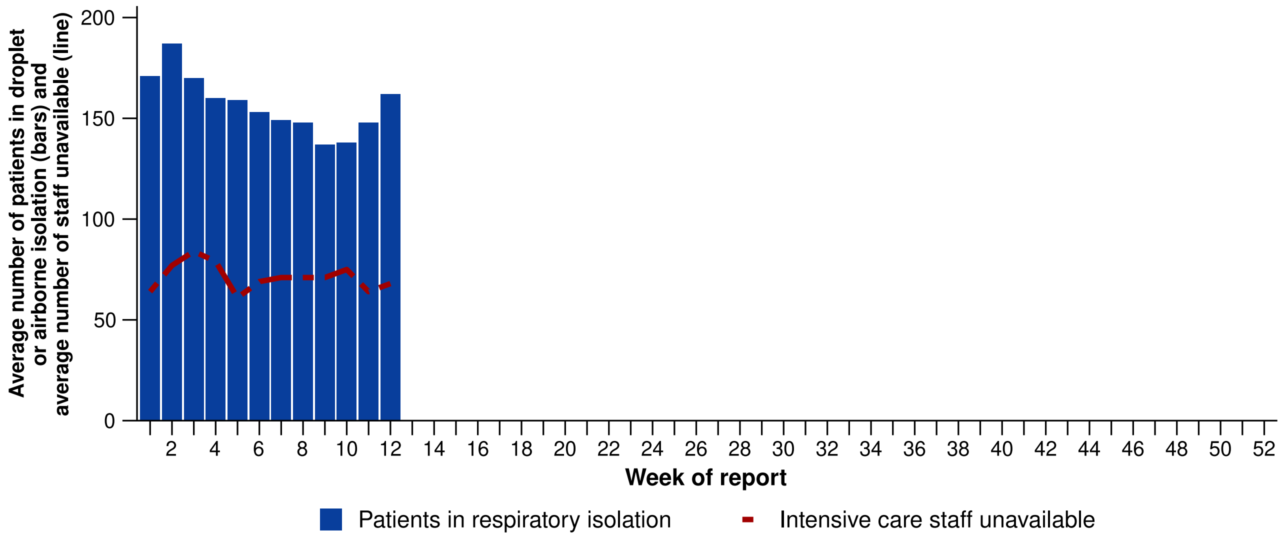
Table 4: Demographic characteristics and outcomes of patients admitted with a severe acute respiratory infection to a sentinel intensive care by disease*†, Australia, 1 January to 8 March 2026

	COVID-19	hMPV	Influenza	Mycoplasma pneumoniae	Parainfluenza	RSV
	Year to date for severity reporting (n=45)	Year to date for severity reporting (n=28)	Year to date for severity reporting (n=71)	Year to date for severity reporting (np)	Year to date for severity reporting (n=35)	Year to date for severity reporting (n=34)
Age (years)						
Median [IQR]	68 [48–79]	42 [10–64]	60 [43–74]	np	60 [14–74]	53 [12–69]
Indigenous status						
Aboriginal and Torres Strait Islander	2 (4.4%)	2 (7.1%)	11 (15.5%)	np	2 (5.7%)	8 (23.5%)
Non-Indigenous	43 (95.6%)	26 (92.9%)	60 (84.5%)	np	33 (94.3%)	26 (76.5%)
Received invasive mechanical ventilation						
Number (%)	14 (31.1%)	6 (21.4%)	20 (28.2%)	np	14 (40.0%)	8 (23.5%)
Length of invasive mechanical ventilation (days)*						
Median [IQR]	4 [1–8]	7 [4–9]	3 [1–11]	np	2 [1–4]	3 [1–4]
Length of intensive care stay (days)*						
Median [IQR]	3 [2–7]	2 [1–5]	2 [1–6]	np	4 [2–7]	3 [2–3]
Length of hospital stay (days)*						
Median [IQR]	9 [3–15]	6 [4–9]	7 [4–12]	np	8 [4–13]	8 [4–13]
Patient outcome†						
Ongoing care in intensive care	1 (2.2%)	–	1 (1.4%)	np	2 (5.7%)	2 (5.9%)
Ongoing care in hospital ward	4 (8.9%)	1 (3.6%)	4 (5.6%)	np	–	–
Transfer to other hospital / facility	4 (8.9%)	5 (17.9%)	11 (15.5%)	np	3 (8.6%)	3 (8.8%)
Discharged home	27 (60.0%)	20 (71.4%)	47 (66.2%)	np	23 (65.7%)	26 (76.5%)
Died in hospital	9 (20.0%)	2 (7.1%)	7 (9.9%)	np	7 (20.0%)	3 (8.8%)

Source: Short Period Incidence Study of Severe Acute Respiratory Infection (SPRINT-SARI) Australia
Note: 14.9% (37/248) of patients had co-infections of respiratory pathogens; therefore, the sum of pathogen-specific totals above may not equal the total number of severe acute respiratory infection patients.
* For patients receiving ongoing care in intensive care data may not be complete; therefore, data are not included in the length of ventilation or stay.
† Patients who have been admitted with no discharge information for less than 90 days have been assumed to have ongoing care in the hospital. Patients who have no outcome entered or have been admitted for more than 90 days with no discharge information have been treated as missing. np = not published.

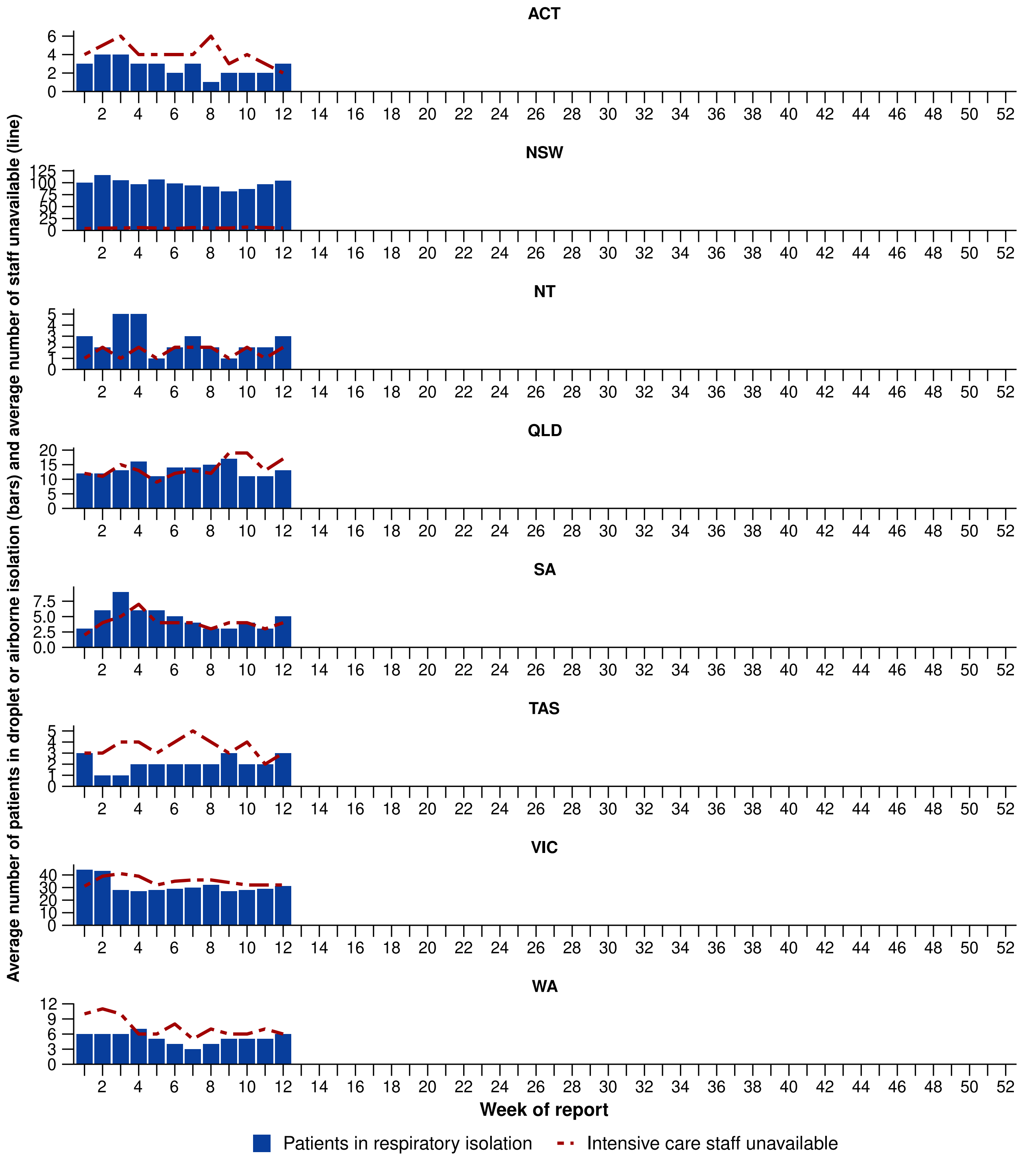
- In the last month (23 February to 22 March 2026), there were an average of 146 intensive care patients in droplet or airborne isolation for any suspected or confirmed respiratory pathogen each day, a 3.9% decrease from an average of 152 patients in isolation each day reported in the previous month (Figure 19).
    - Suspected or confirmed respiratory pathogens may include nationally notifiable conditions such as COVID-19, influenza, RSV or pertussis (Whooping cough) but also other non-notifiable respiratory pathogens like adenovirus, hMPV, parainfluenza, rhinovirus or bacterial infections causing atypical pneumonias.
- In the last month (23 February to 22 March 2026), there were an average of 69 intensive care staff unavailable to work due to illness each day, a 1.5% increase from an average of 68 staff unavailable each day reported in the previous month (Figure 19).
- In the last month, the average number of intensive care patients in droplet or airborne isolation for any suspected or confirmed respiratory pathogen each day varied across jurisdictions compared with the previous month, with the average number of patients in isolation each day decreasing in NSW, SA and Vic but increasing in Tas and WA (Figure 20).
- In the last month, the average number of intensive care staff unavailable to work due to illness each day varied across jurisdictions compared with the previous month, with the average number of staff unavailable each day decreasing in the ACT and Vic but increasing in NSW and Qld (Figure 20).

Figure 19: Weekly average daily occupancy of intensive care patients in droplet or airborne isolation for any suspected or confirmed respiratory pathogen and the weekly average daily number of intensive care staff unavailable to work due to illness by week of report*, Australia, 1 January to 22 March 2026



Source: Critical Health Resource Information System (CHRIS)
* Intensive care staff include both medical and nursing staff. Staff unavailability will be underestimated in NSW as most public hospitals in NSW do not report staff unavailability.

Figure 20: Weekly average daily occupancy of intensive care patients in droplet or airborne isolation for any suspected or confirmed respiratory pathogen and the weekly average daily number of intensive care staff unavailable to work due to illness by jurisdiction and week of report*†‡, Australia, 1 January to 22 March 2026



Source: Critical Health Resource Information System (CHRIS)
* Axis varies between jurisdictions.
† NSW isolation data from public hospitals includes all patients occupying intensive care beds in isolation precautions, including those in contact isolation precautions, rather than just droplet or airborne isolation precautions, which will overestimate the average number of patients occupying intensive care beds in droplet or airborne isolation in NSW. For this reason, NSW data may not be comparable to data from other jurisdictions.
‡ Intensive care staff include both medical and nursing staff. Staff unavailability will be underestimated in NSW as most public hospitals in NSW do not report staff unavailability. For this reason, NSW data may not be comparable to data from other jurisdictions.

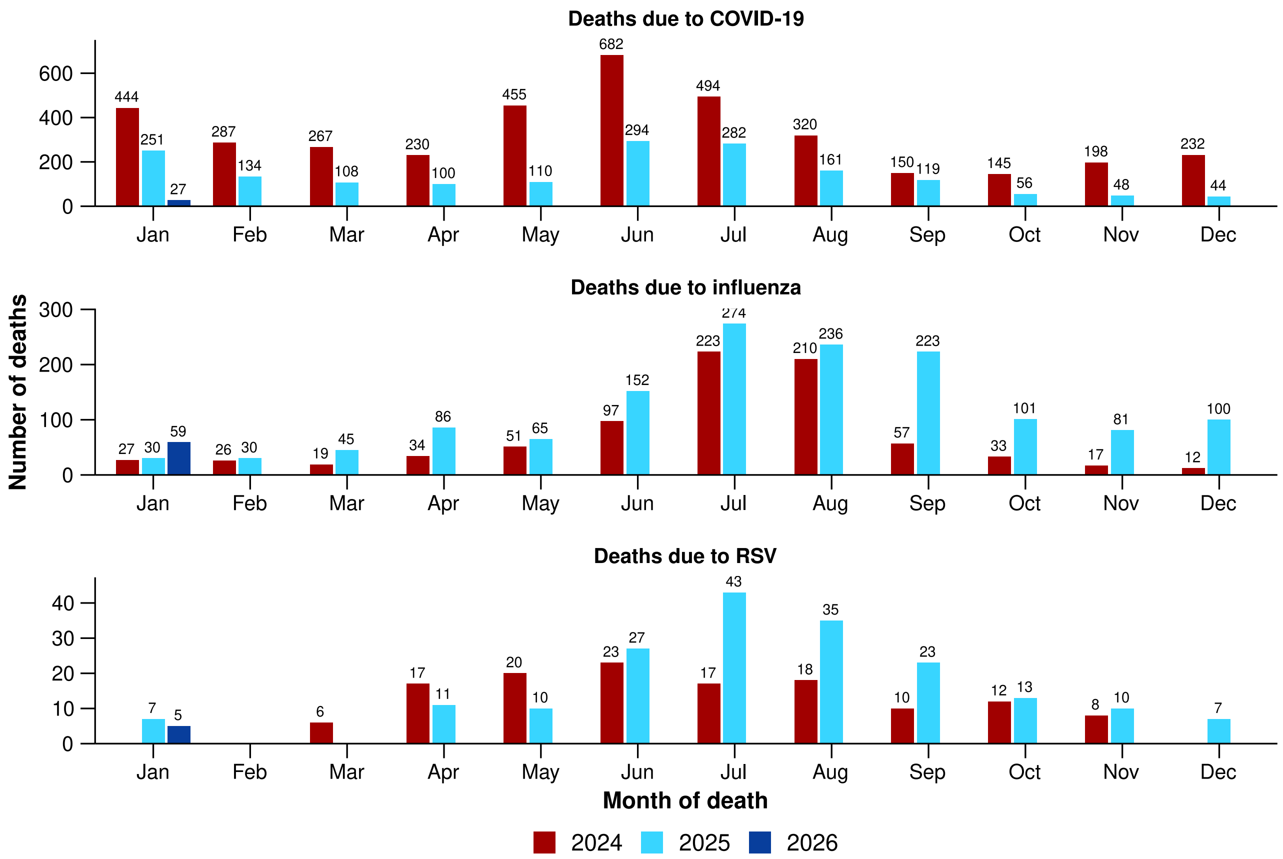
Mortality surveillance

Death registrations can provide information on the scale and severity of disease associated with acute respiratory infections. An acute respiratory associated death is one where the death was *due to* the disease (the illness has caused terminal complications such as pneumonia) or the person has died *with* the disease (a person has died from another cause but the illness still contributed significantly to death). For more information on death registrations including completeness, timeliness, and detailed definitions of deaths *due to* and *with* acute respiratory infections, refer to the Technical Supplement.

Please note, there has not been an update to the Provisional Mortality Statistics, as such the mortality surveillance data presented here have not been updated since the previous report.

- COVID-19 has been the leading cause of acute respiratory infection related mortality across the majority of 2023–2025; however, since August 2025, the number of deaths involving influenza (both *due* to and *with*) each month exceeded the number of deaths involving COVID-19.
- In 2025, the mortality rate for deaths involving influenza (both *due* to and *with*) was higher for Aboriginal and Torres Strait Islander people than non-Indigenous people; however, the rate for deaths involving COVID-19 was lower for Aboriginal and Torres Strait Islander people than non-Indigenous people.
- All three of these acute respiratory infections are more likely to cause death in older age groups than younger age groups.

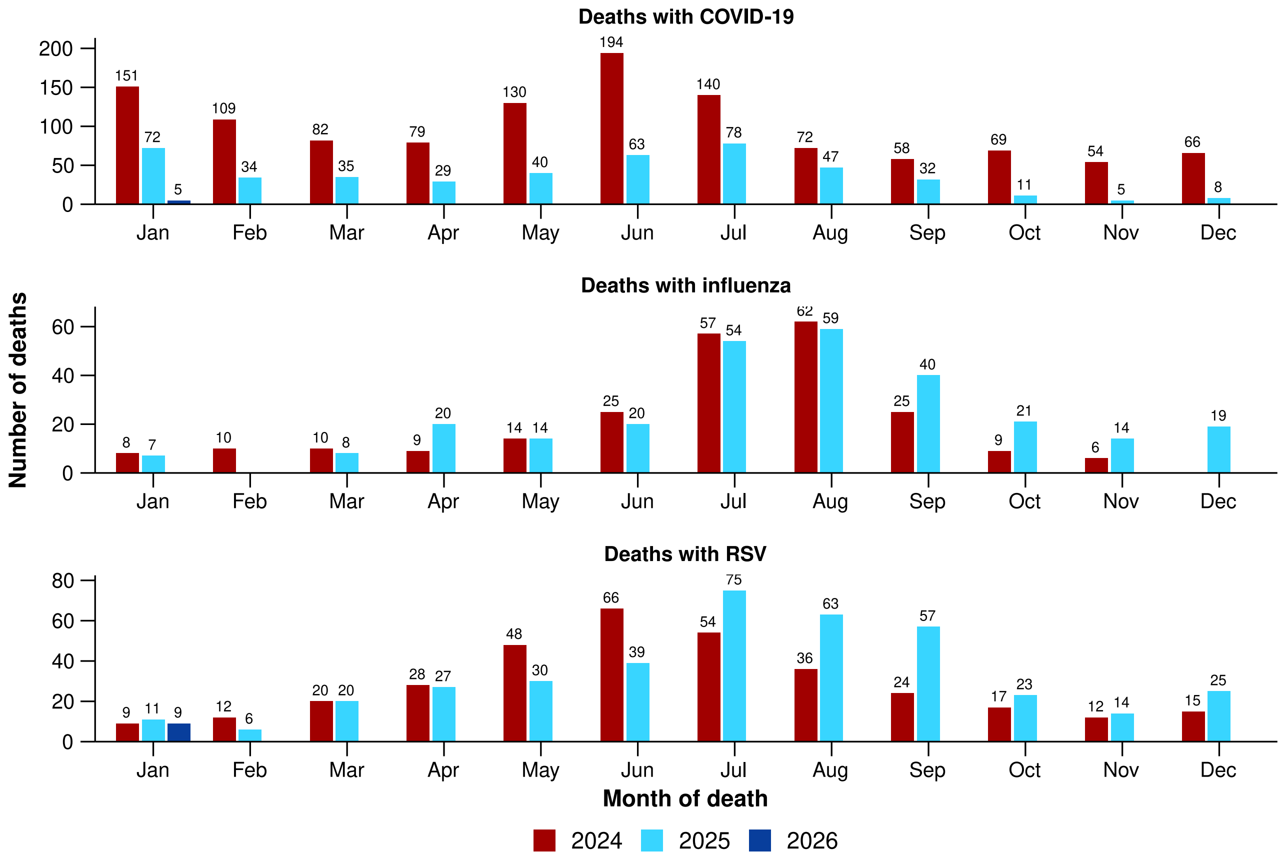
Figure 21a: Provisional numbers of deaths *due to* an acute respiratory infection*† by month, year, and disease, Australia, 1 January 2023 to 31 January 2026



Source: Australian Bureau of Statistics, Deaths due to acute respiratory infections in Australia, released 24 February 2026.
* Axis varies between acute respiratory infections.
† Data is provisional and subject to change. It can take several weeks for death registrations to be reported, processed, coded, validated, and tabulated. Therefore, the data shown here may be incomplete. Data for some months were not published by the ABS due to small counts, and therefore not reported here. Data includes all deaths (both doctor and coroner certified) that occurred and were registered by 31 January 2026.

- Deaths *due to* COVID-19 fell in October 2025 to the lowest levels since July 2021. The 1,707 deaths *due to* COVID-19 in 2025 are well below both 2024 (3,904 deaths) and 2023 (4,610) (Figure 21a).
- Deaths *due to* influenza fell in November 2025 before increasing again in December and remain high for the time of year. There were 1,423 deaths *due to* influenza in 2025, above the 1,276 deaths recorded in 2017 and the 1,072 deaths recorded in 2019, which were recent high-mortality years for influenza (Figure 21a).
  - Although the number of deaths due to influenza in 2025 were high, this is expected when there are higher case numbers, and other surveillance systems have not indicated that illness has been more severe in 2025 compared to previous years.
- Deaths *due to* RSV decreased in November and December 2025 and are comparable to the number of deaths in October 2023 and 2024 (Figure 21a).
- Deaths *with* COVID-19 have fallen in November 2025 and increased slightly in December but remain at extremely low levels (Figure 21b).
- Deaths *with* influenza also decreased in November 2025 and increased slightly in December. Deaths *with* influenza have been higher than the number of deaths *with* influenza in the comparable month in 2024 or 2023 for several months (Figure 21b).
- Deaths *with* RSV decreased in November 2025 and increased in December. Levels have generally been higher than in 2023 and 2024 since July 2025. The number of deaths *with* RSV was higher in 2025 (390 deaths) than in 2024 (341 deaths) and in 2023 (279 deaths) (Figure 21b).

Figure 21b: Provisional numbers of deaths *with* an acute respiratory infection*† by month, year, and disease, Australia, 1 January 2023 to 31 January 2026



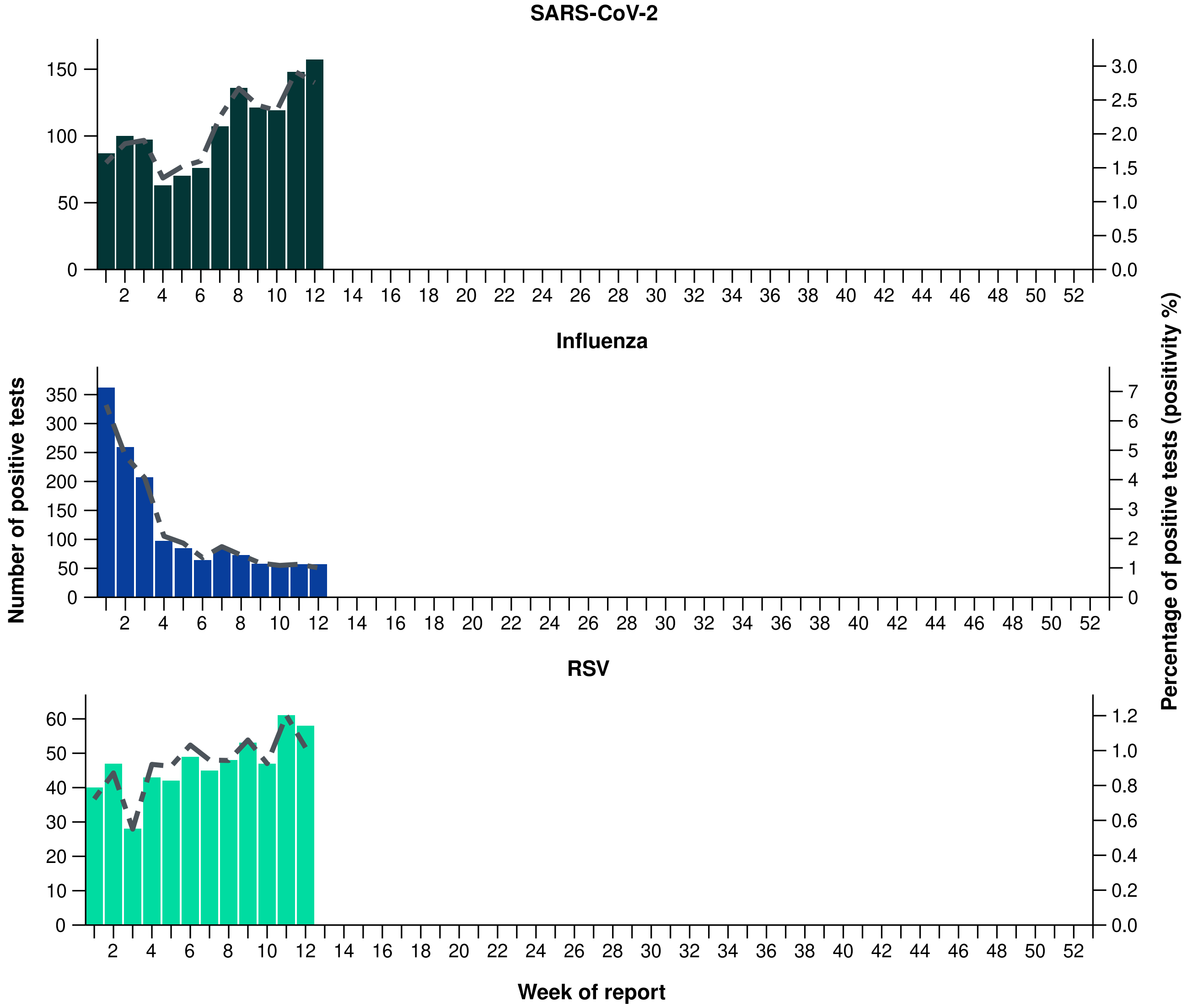
Source: Australian Bureau of Statistics, Deaths due to acute respiratory infections in Australia, released 24 February 2026.
* Axis varies between acute respiratory infections.
† Data is provisional and subject to change. It can take several weeks for death registrations to be reported, processed, coded, validated, and tabulated. Therefore, the data shown here may be incomplete. Data for some months were not published by the ABS due to small counts, and therefore not reported here. Data includes all deaths (both doctor and coroner certified) that occurred and were registered by 31 January 2026.

Laboratory surveillance

Sentinel laboratory surveillance monitors the percentage of tests with the notifiable condition detected (i.e. test positivity). It also provides information on what pathogens are circulating, potential changes in the pathogens that might affect their infectiousness, severity, ability to evade vaccine and/or infection-acquired immunity, or resistance to antivirals.

- In the last month (23 February to 22 March 2026), the percentage of SARS-CoV-2 tests that were positive increased (from 2.7% to 2.9%), the percentage of influenza tests that were positive decreased (from 1.3% to 1.1%) and the percentage of RSV tests that were positive remained stable (from 0.9% to 0.9%) (Figure 22).

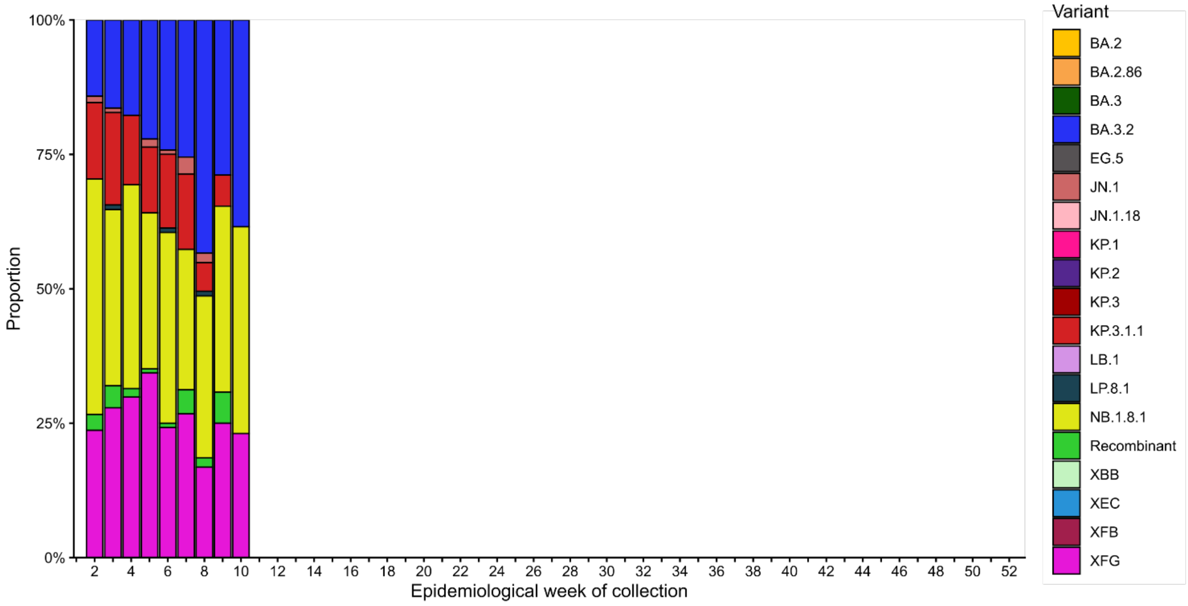
Figure 22: Number of tests positive (bars) and percentage of tests positive (line) for SARS-CoV-2, influenza or RSV of those specimens tested by sentinel laboratories by week of report*†, Australia, 1 January to 22 March 2026



Source: Sentinel laboratories, including National Influenza Centres
* Number of specimens tested excludes data from WA as testing denominator data are different for the three pathogens in Western Australia.
† A small minority of total samples from Victoria are tested only by respiratory panel (influenza, parainfluenza, adenovirus, human metapneumovirus, seasonal coronaviruses, RSV, and some picornaviruses) but not for SARS-CoV-2. These minority samples include only forensic materials; all other samples are tested by respiratory panel and SARS-CoV-2 assay.

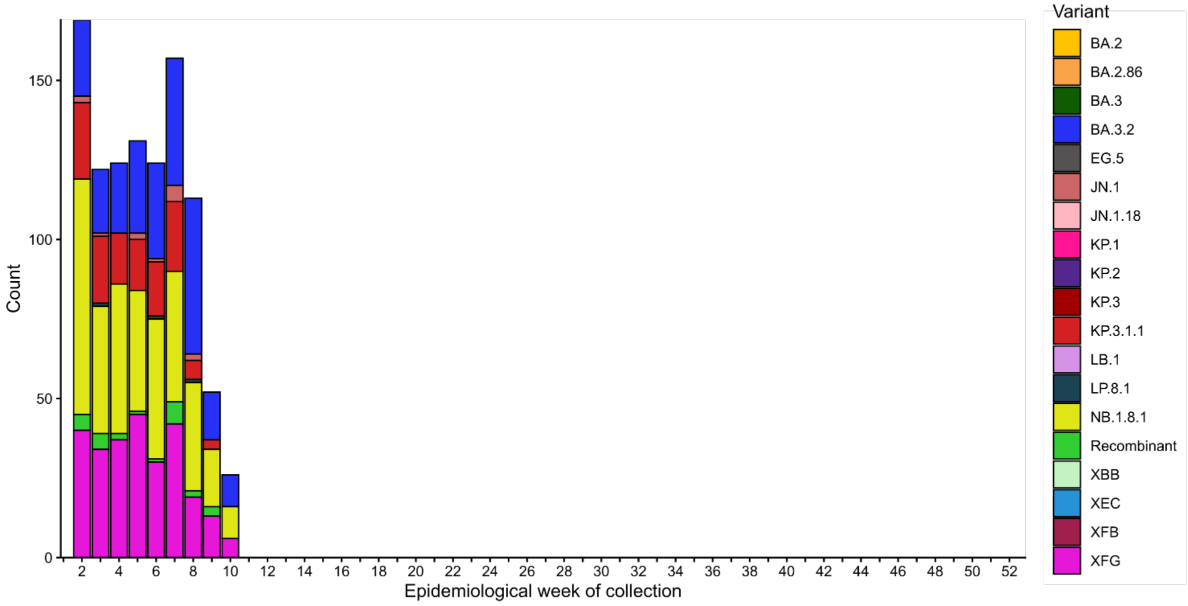
- There were 78 SARS-CoV-2 sequences uploaded to AusTrakka with dates of collection in the last 28 days (23 February to 22 March 2026). These sequences were from NSW, Qld, SA and Tas with the most recent date of collection from 8 March 2026. Due to the limited number of sequences in the last 28 days the following trends may not be representative.
- Most sequences were assigned to the BA.2.86 sub-lineage within B.1.1.529 (Omicron) or recombinants consisting of one or more Omicron sub-lineages (Figure 23a/b). In the last 28 days:
  - 3.8% (3/78) of sequences were from the sub-sub-lineages JN.1 (BA.2.86.1.1), specifically KP.3.1.1.
  - 64.1% (50/78) of sequences were recombinant or recombinant sub-lineages, the most common including NB.1.8.1 (n=28) and XFG (n=19).
  - 32.1% (25/78) of sequences were identified as BA.3.
  - There were no BA.1, BA.4, BA.5 or other BA.2 sub-sub-lineage sequences.
- NB.1.8.1 was the most common sub-lineage in the last 28 days, accounting for 35.9% (28/78) of sequences (Figure 23a).
- The World Health Organization (WHO) have identified certain sub-sub-lineages and recombinants as variants under monitoring (VUM) because of their epidemiological, pathological, or immunological features of concern. A select number are highlighted below due to their relevance in the Australian context. There are:
  - 385 BA.3.2 (most recently designated VUM) sequences in AusTrakka, including 25 collected in the last 28 days
  - 1,062 XFG sequences in AusTrakka, including 19 collected in the last 28 days
  - 3,316 NB.1.8.1 sequences in AusTrakka, with 28 collected in the last 28 days
  - 4,434 KP.3.1.1 sequences in AusTrakka, with 3 sequences identified in the last 28 days.

Figure 23a: SARS-CoV-2 Omicron sub-lineage* sequences by sample collection date, showing (A) proportions and (B) count per week†‡, Australia, 1 January to 22 March 2026



Source: AusTrakka
* Some sub-sublineages are shown alongside their parent lineage, but not included in the parent lineage totals. For instance, KP.2 and KP.3 are sub-sub lineages of JN.1, so the total of JN.1 sequences will be higher than shown in the corresponding colour alone, and should include the KP.2 and KP.3 totals.
† Sequences in AusTrakka aggregated by week and reported based on date of sample collection, not date of sequencing.
‡ Proportions in Figure 24a may not be representative when sequence numbers are small; refer to Figure 24b. Data for earlier weeks may change between reporting periods as sequences with older collection dates are uploaded. These numbers are not equivalent to number of cases, as there are many cases which may not be sequenced. Non-VOI and non-VUM Omicron sub-lineages have been collapsed into parent lineages BA.1, BA.2, BA.3, BA.4 and BA.5.

Figure 24: SARS-CoV-2 Omicron sub-lineage* sequences by sample collection date, showing the count of sequences per week†‡, Australia, 1 January 2022 to 22 March 2026



Source: AusTrakka
* Some sub-sublineages are shown alongside their parent lineage, but not included in the parent lineage totals. For instance, KP.2 and KP.3 are sub-sub lineages of JN.1, so the total of JN.1 sequences will be higher than shown in the corresponding colour alone, and should include the KP.2 and KP.3 totals.
† Sequences in AusTrakka aggregated by week and reported based on date of sample collection, not date of sequencing.
‡ Data for earlier weeks may change between reporting periods as sequences with older collection dates are uploaded. These numbers are not equivalent to number of cases, as there are many cases which may not be sequenced. Non-VOI and non-VUM Omicron sub-lineages have been collapsed into parent lineages BA.1, BA.2, BA.3, BA.4 and BA.5.

- In the year to date, the WHO Collaborating Centre for Reference and Research on Influenza has antigenically characterised 209 influenza viruses from Australia (Table 5), of which:
  - 97.6% (204/209) have been influenza A(H3N2)
  - 2.4% (5/209) have been influenza B/Victoria.
- In the year to date, there have been no influenza A(H1N1) or influenza B/Yamagata viruses characterised (Table 5). The last influenza B/Yamagata virus characterised in Australia was in a sample from 2020.
- None of the samples tested by the WHO Collaborating Centre for Reference and Research demonstrated highly reduced inhibition to oseltamivir or zanamivir.

Table 5: Australian influenza viruses typed by haemagglutination inhibition assay and jurisdiction*†, 1 January to 22 March 2026

Strain	ACT	NSW	NT	Qld	SA	Tas	Vic	WA	Total
A(H1N1)	0	0	0	0	0	0	0	0	0
A(H3N2)	19	24	62	8	4	6	78	3	204
B/Victoria lineage	0	0	4	0	0	0	1	0	5
B/Yamagata lineage	0	0	0	0	0	0	0	0	0
Total	**19**	**24**	**66**	**8**	**4**	**6**	**79**	**3**	**209**

Source: World Health Organization (WHO) Collaborating Centre for Reference and Research on Influenza
*Viruses tested by the WHO Collaborating Centre for Reference and Research on Influenza are not necessarily a random sample of all those in the community and early-year data may be based on limited samples received. There may be up to a month delay on reporting of samples.
† Jurisdiction indicates the residential location for the individual tested, not the submitting laboratory.

Vaccine coverage, effectiveness and match

Vaccine coverage, effectiveness and match for acute respiratory infections are monitored from several data sources in Australia. Refer to the Technical Supplement for more information.

Vaccine coverage

- Nationally, 2.2% of adults (aged 18 years and over) have received a COVID-19 vaccine in the last six months (Table 6).
- Nationally, fewer adults have received a COVID-19 vaccine in the last 12 months (9.7%; Table 6), compared to the 12 months prior (9.8% from 18 March 2024 to 16 March 2025).
- In the last 12 months, vaccine coverage varied in all age groups, with the largest variation seen in 75 years and over age group (from 35.4% in the 12 months prior to 37.3% in the last 12 months).
- There has been substantial variation in COVID-19 vaccine coverage across age groups, ranging from 4% in adults aged 18–64 years to 37.3% in adults aged 75 years and over. Vaccine coverage increases with increasing age (Table 6).
- There has been some variation in vaccine coverage across jurisdictions, ranging from 3.9% in the NT to 16.6% in Tas (Table 6).

Table 6: COVID-19 vaccine coverage*†‡ by age group and jurisdiction, Australia, 17 March 2025 to 22 March 2026

Age group	ACT	NSW	NT	Qld	SA	Tas	Vic	WA	Total
Last 12 months (17 March 2025 to 22 March 2026)									
18–64 years	9.1	3.4	1.9	3.8	4.0	7.3	4.3	4.0	4.0
65–74 years	42.5	21.5	13.9	22.0	24.3	34.1	23.7	23.4	23.2
≥ 75 years	60.1	35.5	24.2	35.9	38.1	50.1	36.6	38.2	37.3
All ages (18 years and over)	16.4	8.9	3.9	9.2	10.8	16.6	9.7	9.4	9.7
Last 6 months (22 September 2025 to 22 March 2026)									
18–64 years	1.5	0.6	0.5	0.7	0.7	1.0	0.7	0.4	0.7
65–74 years	10.4	4.2	3.3	4.3	5.2	6.1	4.5	3.4	4.4
≥ 75 years	24.0	11.3	6.7	11.2	13.4	15.5	11.7	9.6	11.8
All ages (18 years and over)	4.2	2.2	1.0	2.1	2.8	3.5	2.2	1.6	2.2

Source: Australian Immunisation Register (AIR) as at 23 March 2026
* COVID-19 vaccine coverage among the general population uses the most recently available Australian Bureau of Statistics Estimated Resident Population (ERP) as denominator for population data. Age in years is calculated as at the reporting week.
† COVID-19 vaccine coverage is influenced by changes in COVID-19 vaccine recommendations and eligibility criteria. For this reason, coverage rates in the current 12 month period and previous 12 month periods may not be directly comparable. Coverage data in these tables may differ slightly from coverage estimates in other reports due to differences in calculation methodologies and/or different data download dates.
‡ Jurisdiction is based on the state or territory in which a vaccine was administered and may differ from a person's residential address. Population denominator data used to calculate COVID-19 vaccine coverage are based on an individual's residential address. Total rows will include individuals where jurisdiction was missing.

- Nationally, 0.8% of Aboriginal and Torres Strait Islander adults (aged 18 years or over) have received a COVID-19 vaccine in the last six months (Table 7).
- Nationally, slightly fewer Aboriginal and Torres Strait Islander adults have received a COVID-19 vaccine in the last 12 months (4.1%; Table 7), compared to the 12 months prior (4.5% from 18 March 2024 to 16 March 2025).
- In the last 12 months, vaccine coverage decreased in all age groups of Aboriginal and Torres Strait Islander people, with the largest decrease seen in 65–74 years age group (from 16.5% in the 12 months prior to 15.4% in the last 12 months).
- Among Aboriginal and Torres Strait Islander people there has been substantial variation in COVID-19 vaccine coverage across age groups, ranging from 2.3% in adults aged 18–64 years to 24.3% in adults aged 75 years and over. Vaccine coverage increases with increasing age (Table 7).
- Among Aboriginal and Torres Strait Islander people, there has been slight variation in vaccine coverage across jurisdictions, ranging from 2.5% in the NT to 8.4% in Tas (Table 7).

Table 7: COVID-19 vaccine coverage*†‡ among Aboriginal and Torres Strait Islander populations by age group and jurisdiction, Australia, 17 March 2025 to 22 March 2026

Age group	ACT	NSW	NT	Qld	SA	Tas	Vic	WA	Total
Last 12 months (17 March 2025 to 22 March 2026)									
18–64 years	5.5	2.3	1.8	2.2	2.4	4.7	3.3	2.0	2.3
65–74 years	29.0	16.2	8.9	14.8	15.5	27.9	17.7	14.1	15.4
≥ 75 years	42.6	25.9	13.9	22.4	26.0	37.3	29.3	24.5	24.3
All ages (18 years and over)	8.1	4.5	2.5	3.7	4.3	8.4	5.7	3.4	4.1
Last 6 months (22 September 2025 to 22 March 2026)									
18–64 years	0.8	0.4	0.5	0.3	0.5	0.7	0.6	0.3	0.4
65–74 years	7.6	3.1	2.6	2.5	2.8	5.3	3.9	2.4	3.0
≥ 75 years	10.5	8.1	4.5	6.5	7.8	9.4	8.7	5.7	7.2
All ages (18 years and over)	1.5	0.9	0.8	0.7	0.9	1.5	1.3	0.6	0.8

Source: Australian Immunisation Register (AIR) as at 23 March 2026
* COVID-19 vaccine coverage among Aboriginal and Torres Strait Islander populations is based on the AIR population as known at the reporting week. Age in years is calculated as at the reporting week.
† COVID-19 vaccine coverage in the most recent 12 month period may not be directly comparable to previous 12 month periods due to changes in COVID-19 vaccine eligibility criteria. Coverage data in these tables may differ slightly from coverage estimates in other reports due to differences in calculation methodologies and/or different data download dates.
‡ Jurisdiction is based on the state or territory in which a vaccine was administered and may differ from a person's residential address. Population denominator data used to calculate COVID-19 vaccine coverage are based on an individual's residential address. Total rows will include individuals where jurisdiction was missing.

- *Influenza vaccine coverage data are not yet available for the 2026 seasonal influenza campaign in. Influenza vaccine coverage data are expected to be reported from May 2026.*

- Since the commencement of the National RSV Mother and Infant Protection Program on 3 February 2025, 221,223 Abrysvo doses have been administered to pregnant people (Table 8).
- While high maternal vaccine uptake is a positive indicator of maternal program success, it may result in lower nirsevimab uptake rates in infants. This is because maternal antibodies passed to the infant can provide protection against RSV, potentially reducing the need for infant immunisation.

Table 8: Number of doses of Abrysvo administered to pregnant people by jurisdiction*, Australia, 3 February to 22 March 2026

Age group	ACT	NSW	NT	Qld	SA	Tas	Vic	WA	Total
15–24 years	292	5,551	491	5,251	1,200	605	3,273	2,102	18,767
25–39 years	5,074	58,907	1,938	35,637	13,219	4,149	52,552	19,155	190,632
40–54 years	341	3,884	95	1,857	740	180	3,615	1,112	11,824
Total (15–54 years)	5,707	68,342	2,524	42,745	15,159	4,934	59,440	22,369	221,223

Source: Australian Immunisation Register (AIR) as at 23 March 2026
* Jurisdiction is based on the state or territory in which a vaccine was administered and may differ from a person's residential address. Total rows will include individuals where jurisdiction was missing.

- In the last six months, 3.8% of infants (aged < 8 months) have received nirsevimab (Table 9).
- There has been slight variation in nirsevimab uptake in infants across jurisdictions, ranging from 0.6% in SA to 10.4% in the NT (Table 9).
- The current trend is likely due to variation in the seasonality and eligibility criteria between state and territory programs, as well as the presence of previous nirsevimab programs. Some state and territory programs are seasonal (from 1 April to 30 September), whereas others are year-round. In states with seasonal programs (SA, Tas, Vic, and parts of WA), uptake may appear disproportionately lower at this time of the year.

Table 9: Nirsevimab (Beyfortus) uptake in the last six months*†‡ by age group and jurisdiction, Australia, 22 September 2025 to 22 March 2026

Age group	ACT	NSW	NT	Qld	SA	Tas	Vic	WA	Total
Infants (aged < 8 months)	1.3	4.2	10.4	9	0.6	1.8	1.0	1.5	3.8
Young children (aged ≥ 8 to 24 months)	0.1	0.1	0.2	0	0.0	0.1	0.1	0.1	0.1

Source: Australian Immunisation Register (AIR) as at 23 March 2026
* Reporting of RSV monoclonal antibodies to the AIR is not compulsory; therefore, uptake is likely to be underestimated. Uptake data in these tables may differ slightly from estimates in other reports due to differences in calculation methodologies and/or different data download dates.
† For infants and young children vaccinated, age in months is calculate as months between the immunisation encounter and date of birth rounded down as at the reporting date. For the infant and young children population, age in months is calculated as months between the AIR data extract date and date of birth rounded down as at the reporting date.
‡ Jurisdiction is based on the state or territory in which a vaccine was administered and may differ from a person's residential address. Total rows will include individuals where jurisdiction was missing. Population denominator data used to calculate nirsevimab uptake are based on an individual's residential address as recorded on Medicare.

Vaccine effectiveness

- Vaccine effectiveness (VE) is the reduction in risk of influenza and its complications in those vaccinated, compared to those not vaccinated.
- Interim Australian data as part of the Global Influenza Vaccine Effectiveness (GIVE) Collaboration indicate that in 2025, people who received the influenza vaccine were about 53% less likely to visit general practice or be hospitalised with influenza compared to those who were unvaccinated.
  - These interim estimates were based on incomplete data. Final 2025 VE estimates – expected to be released in the 2025 Annual Australian Respiratory Surveillance Report later in 2026 – may change.
- It is too early to assess VE for the 2026 influenza season.

Vaccine match

- In the year to date, 93.1% (190/204) of influenza A(H3N2) isolates and 100% (5/5) of influenza B/Victoria lineage isolates characterised have been antigenically similar to the corresponding 2026 southern hemisphere vaccine components.

2026 southern hemisphere vaccine composition

The composition of influenza vaccines for Australia in 2026 differs from the 2025 southern hemisphere and 2025/26 northern hemisphere composition. The 2026 southern hemisphere vaccine contains two new strains for the influenza A(H1N1)pdm09 and A(H3N2) subtype virus components.

The following influenza viruses are used for the 2026 southern hemisphere trivalent influenza vaccines in Australia:

Egg-based influenza vaccines:

- an A/Missouri/11/2025 (H1N1)pdm09-like virus
- an A/Singapore/GP20238/2024 (H3N2)-like virus
- a B/Austria/1359417/2021 (B/Victoria lineage)-like virus.

Cell-based influenza vaccines:

- an A/Missouri/11/2025 (H1N1)pdm09-like virus
- an A/Sydney/1359/2024 (H3N2)-like virus
- a B/Austria/1359417/2021 (B/Victoria lineage)-like virus.

The continued absence of confirmed detection of naturally occurring B/Yamagata lineage viruses after March 2020 is indicative of a very low risk of infection by B/Yamagata lineage viruses. Since September 2023, the WHO has recommended that the inclusion of a B/Yamagata lineage antigen in seasonal influenza vaccines is no longer warranted.