# *Flu*nomics Report

## From vaccination to protection – Understanding the influenza protection gap in older adults



Canada

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sanofi

# Canada

**Canada has a strong foundation for influenza prevention, but declining vaccination coverage and differences in provincial access mean protection does not consistently reflect the level of risk faced by older adults. With Canada's over-65s making up nearly one-fifth of the total population, strengthening both uptake and access to age-specific vaccination will become increasingly important.**

### Canada at a glance

**Total population (2026):**
**41.5 million**[1]

**Adults aged 65+:**
**8.1 million (approx. 19.5% of total population)**[2]



## Regional landscape

Canada comprises **10 provinces and three territories,** with publicly funded influenza vaccination programs delivered at the provincial and territorial level.[3,4] Each jurisdiction determines the requirements of its immunization program and how vaccines are made available locally, meaning **access to age-specific influenza vaccines can vary depending on where a person lives**.[4,5]

## National influenza policy

**National Advisory Committee on Immunization** (NACI) guidance recommends annual influenza vaccination for adults aged 65+ and supports preferential use of age-specific influenza vaccines for this population, where available, reflecting their increased risk of severe influenza outcome.[5]

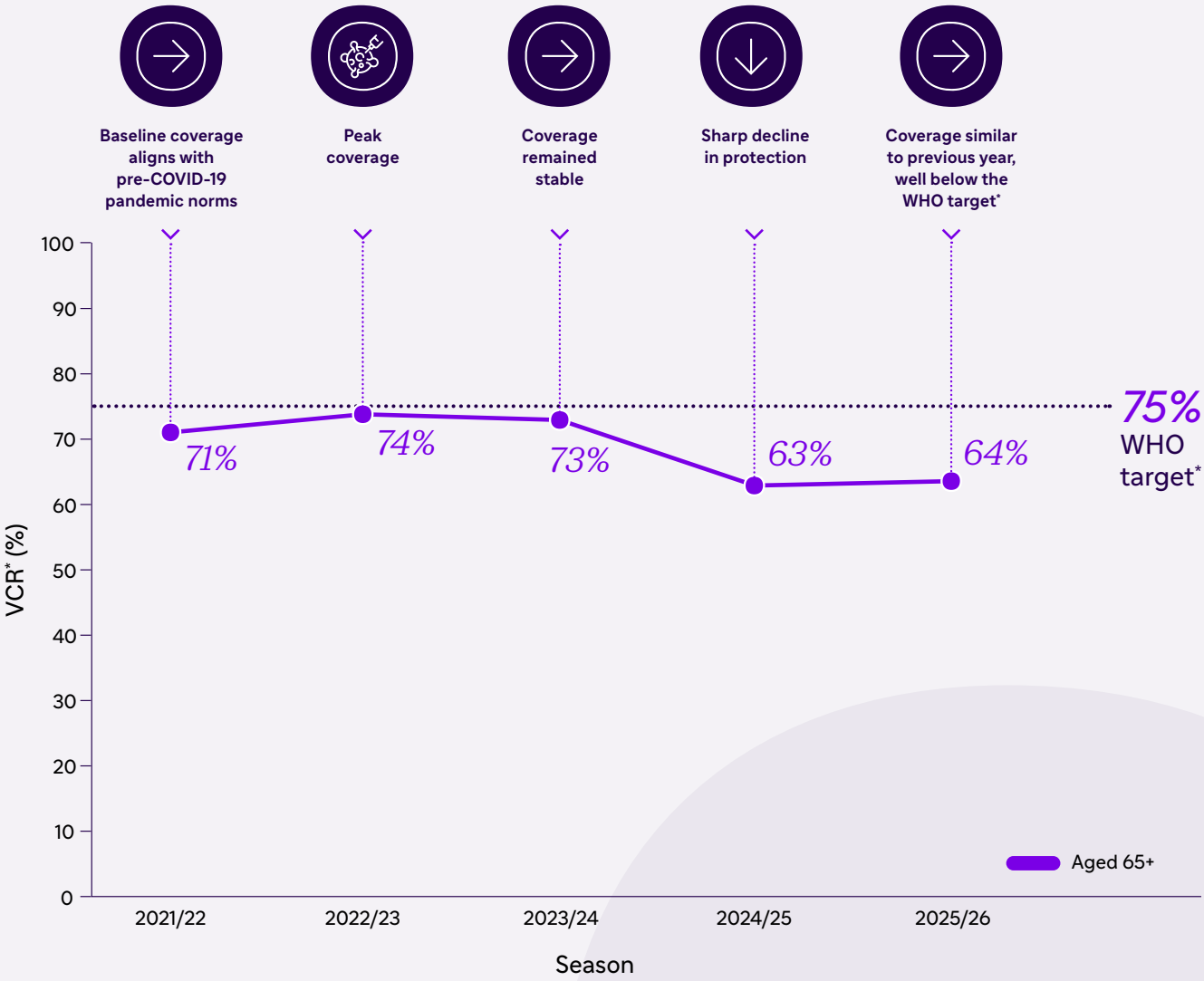
Canada has a **long-standing influenza prevention framework**, supported by publicly funded vaccination programs and national recommendations for older adults.[4,5] This is increasingly important as the population ages: adults aged 65+ accounted for around 13% of the population in 2006 to approximately 20% in 2025, an increase of 7 percentage points.[2,6] Vaccination coverage among adults aged 65+ remained above 70% between 2021/22 and 2023/24, reaching 74% in 2022/23 — **close to the World Health Organization (WHO) target of 75%**.[7-9]

However, **coverage fell sharply to 63% in 2024/25** and recovered by only one percentage point to 64% in 2025/26.[7] At the same time, vaccination policy is implemented provincially, with differences in funding and eligibility shaping access to age-specific influenza vaccines.[5]

**Together, these trends raise a broader question about whether Canada's strong prevention framework is consistently translating into protection that reflects older adults' age and risk.**

## Vaccination coverage has fallen from its recent peak

### Five-year influenza vaccination coverage rate (VCR)[7,8]




Vaccination coverage among adults aged 65+ fell by **10 percentage points between 2023/24 and 2024/25** and recovered by only one percentage point in 2025/26, remaining below the WHO target of 75%.[7-9] As Canada's older population grows, **sustained lower coverage leaves a greater proportion of older adults without vaccination against influenza**.[5,7,9]

Increasing vaccination coverage therefore remains a central priority, alongside equitable access to vaccines specific to age and risk. Provincial differences in **funding, eligibility and implementation can also shape access to age-specific influenza vaccines**, meaning that strengthening protection requires attention to both how many older adults are vaccinated and the vaccination they receive.[5]

** VCR: vaccination coverage rate; WHO: World Health Organization.*

# Healthcare professional (HCP) perspectives

## Patient confidence and perceived need remain important barriers to influenza vaccination among older adults*

Primary care HCPs highlighted a range of patient-driven barriers to influenza vaccination:

### Top patient-driven barriers encountered:

77%



**Misinformation about vaccines in general***

77%



**Previous negative experiences with influenza vaccination, including contracting influenza despite being vaccinated***

74%



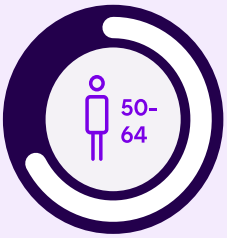
**Vaccine fatigue***

74%



**Lack of perceived need for influenza vaccination***

68%




**Perception of good health and low risk of influenza or complications***

**Key takeaway:** Improving vaccination coverage will require addressing confidence and perceived need alongside practical barriers to access and delivery.

### What HCPs said†



Primary Care Professional, Canada

> *"It can be logistically challenging for elderly [patients] with poor mobility to present to doctor's offices or pharmacies."*

***Source:*** *Ipsos online survey conducted on behalf of Sanofi among HCPs in Canada; fieldwork conducted 28 May-2 July 2026. Results reflect the views and practices of the surveyed sample.*

***Bases:*** *Primary care HCPs (n=82: 51 general practitioners (GPs)/family physicians (FPs) and 31 pharmacists).*

**** Question PC4:*** *Primary care HCPs were asked to consider patient-driven barriers to flu vaccination in their older adults (aged 65+) and select all the barriers you encounter in your practice; respondents could select multiple responses from a list of potential response options. The figures shown were not necessarily the most frequently selected answer options by surveyed HCPs.*

***† Question PA5:*** *Primary care HCPs were asked in their own words to summarize the main challenges to optimizing influenza protection among adults aged 65+ seen in their practice/pharmacy. Unprompted open-ended responses were collected with generative AI (genAI)-supported probing and analyzed using GenAI-assisted thematic analysis of verbatim free-text responses to identify key themes. Themes shown represent mentions from open-ended responses and should not be interpreted as majority consensus. Quote reproduced from an individual primary care professional response.*

## Older adults continue to experience substantial influenza burden

| | 2025/26[10] | 2024/25[11] | 2023/24[12] |
|---|---|---|---|
| Lab-confirmed influenza detections (total population) | 145,895 | 138,612 | 103,173 |
| Lab-confirmed influenza detections (65+ years)* | 49,123 (34.2%) | 45,080 (37.3%) | 22,948 (26.9%) |
| Hospitalizations (total population) | 24,960 | 25,278 | 4,516 |
| Hospitalizations (65+ years)† | 4,168 (56.2%) | 4,790 (59.1%) | 2,032 (45%) |
| ICU admissions (total population)‡ | 629 | 709 | 493 |
| ICU admissions (65+ years)‡‡ | NR‡ | NR‡ | 148 (30%) |
| Influenza-related deaths (total population) | 556 | 671 | 256 |
| Influenza-related deaths (65+ years)* | NR‡ | NR‡ | 182 (71%) |

National surveillance data indicate that **influenza activity increased from the 2023/24 to the 2024/25 season**, with higher numbers of laboratory-confirmed detections and reported severe outcomes.[11-13] In 2025/26, laboratory-confirmed influenza detections increased compared with 2024/25, while reported hospitalizations, intensive care unit (ICU) admissions and influenza-related deaths were lower. This mixed pattern reinforces the importance of considering multiple indicators when interpreting seasonal influenza burden.[10-12] However, it should be noted that changes in provincial and territorial reporting coverage mean that severe-outcome totals are not directly comparable across all three seasons.

** Percentages for adults aged 65+ years are calculated using laboratory-confirmed influenza detections with reported age as the denominator. Total detection figures include detections for which age was not reported.*

*† For 2025/26 and 2024/25, percentages for adults aged 65+ years are calculated using hospitalizations reported by participating jurisdictions providing age information as the denominator. All-age hospitalization totals include data from a broader set of reporting jurisdictions and therefore should not be used to calculate the age-specific shares.*

*‡ ICU = intensive care unit; NR = not reported.*

In 2025/26, **laboratory-confirmed influenza detections increased** compared with 2024/25, while reported hospitalizations, ICU admissions and influenza-related deaths were lower.[10-12] However, changes in reporting coverage **limit direct comparison of severe-outcome totals across seasons**. Among laboratory-confirmed detections with known age, adults aged 65+ accounted for 26.9% in 2023/2024, 37.3% in 2024/25 and 34.2% in 2025/26.[10-12] Among jurisdictions reporting age-specific hospitalization data, adults aged 65+ accounted for 59.1% of reported hospitalizations in 2024/25 and 56.2% in 2025/26.[10-12]



**6x**

**Higher risk of acute myocardial infarction during the first seven days following laboratory-confirmed influenza infection.[14]**

Canadian evidence found that the **risk of a heart attack** markedly increased during the first seven days following laboratory-confirmed influenza infection, reinforcing the **importance of influenza prevention within broader cardiovascular and healthy aging strategies**.[5,14]

However, **visibility of the most severe outcomes among older adults remains incomplete**. Age-stratified ICU admissions and influenza-related mortality were reported in the 2023/24 annual influenza report, but equivalent data for 2024/25 and 2025/26 are not yet publicly available, as consolidated annual reports for these seasons have not yet been published.[10-12]

**These data gaps limit visibility of the full burden of severe influenza among older adults and where opportunities may remain to strengthen protection.**

# HCP perspectives

## Cardiologists identify both respiratory and cardiovascular complications as drivers of influenza-related hospitalization in older adults

Cardiologists identified both **respiratory and cardiovascular complications** among the main causes of influenza-related hospitalization in adults aged 65+.

### Main causes of hospitalization reported by cardiologists:

*69%*



**Acute exacerbation of existing asthma or chronic obstructive pulmonary disease (COPD)***

*67%*



**Pneumonia***

*57%*



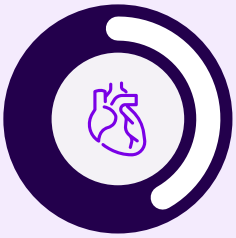
**Acute heart failure***

*43%*



**Cardiovascular problems leading to heart attack***

*39%*



**Cardiac arrhythmia or atrial fibrillation***



**Key takeaway:** HCP experience reinforces that the burden of influenza in older adults can extend beyond respiratory illness, including complications affecting cardiovascular health.

### What HCPs said†



**Cardiologist, Canada**

*“Advancing age and chronic conditions like heart failure or COPD.”*

***Source:*** *Ipsos online survey conducted on behalf of Sanofi among HCPs in Canada; fieldwork conducted 28 May-2 July 2026. Results reflect the views and practices of the surveyed sample.*

***Bases:*** *Cardiologists (n=51).*

****Question SA3:*** *Cardiologists were asked which complications of flu were the main causes of hospitalization; respondents could select multiple complications. The figures shown were not necessarily the most frequently selected answer options by surveyed HCPs.*

***†Question SA2b:*** *Cardiologists were asked in their own words and based on their clinical experience what key factors lead to hospitalization for patients with influenza. Unprompted open-ended responses were analyzed using GenAI-assisted thematic analysis of verbatim free-text responses to identify key themes. Themes shown represent mentions from open-ended responses and should not be interpreted as majority consensus. Quote reproduced from an individual cardiologist response.*

# The impact of severe influenza extends beyond hospitalization

For older adults, the consequences of severe influenza can persist **beyond the acute infection**. Canadian evidence among adults hospitalized with laboratory-confirmed influenza found substantial healthcare resource use alongside longer-term consequences including **functional decline**, **disability and mortality following hospitalization**.[15,16]

**The consequences can continue after hospitalization**[15,16]
*(Canadian adults hospitalized with laboratory-confirmed influenza, 2010/11–2012/13)*

**2011/12**[15]

**23.0%**
**Persistent functional decline***

**12.5%**
**Catastrophic disability***

**12.1%**
**Died within 30 days post-discharge***

**2010/11–2012/13**[16]

**10.8-day**
**Average hospital stay**

**CAD $14,031**
**Average inpatient hospitalization cost (2015 prices)**

**14.4%**
**Required ICU admission**

**90%**
**Had at least one comorbidity**

**While these data predate the COVID-19 pandemic, they illustrate how the consequences of severe influenza can extend beyond discharge, affecting healthcare resources, functional health and independence.[15,16] As Canada's population ages, preventing severe influenza is therefore relevant not only to reducing hospital burden, but also to supporting healthy aging.[3]**

**Functional decline and catastrophic disability percentages are among influenza survivors at 30 days post-discharge (n=304); mortality is among the full influenza cohort (n=346).*

# HCP perspectives

## HCPs report that influenza season places pressure across primary and secondary care services

**Primary care HCPs** reported widespread system strain during influenza season, with **increased patient demand and longer wait times**, **and workforce pressures** among the most commonly experienced challenges.

*70%*
**Increased patient demand in their clinical setting***

*63%*
**Staff shortages within the wider system***

*63%*
**Longer wait times for patients to be seen***

*57%*
**Staff shortages within their practice/team***

*56%*
**Reduced clinical time due to increased time dedicated to influenza vaccine administration***

*54%*
**Increased hospitalizations/ hospital bed shortages***

**Key takeaway:** Frontline experience shows that influenza burden is reflected across healthcare delivery, from increased primary care demand to pressure on hospital admissions, emergency services, and resources.

### What HCPs said†

Cardiologists described **similar pressures in secondary care**.

**Cardiologist, Canada**

*"Flu in older adults adds real pressure in winter, mainly through more ED [emergency department] visits, admissions, bed shortages and longer stays. The biggest issue is when flu worsens heart failure, COPD, or other chronic conditions, because these patients often need more monitoring and take longer to discharge."*

***Source:*** *Ipsos online survey conducted on behalf of Sanofi among HCPs in Canada; fieldwork conducted 28 May-2 July 2026. Results reflect the views and practices of the surveyed sample.*

***Bases:*** *Primary care HCPs (n=82: 51 GPs/FPs and 31 pharmacists), cardiologists (n=51).*

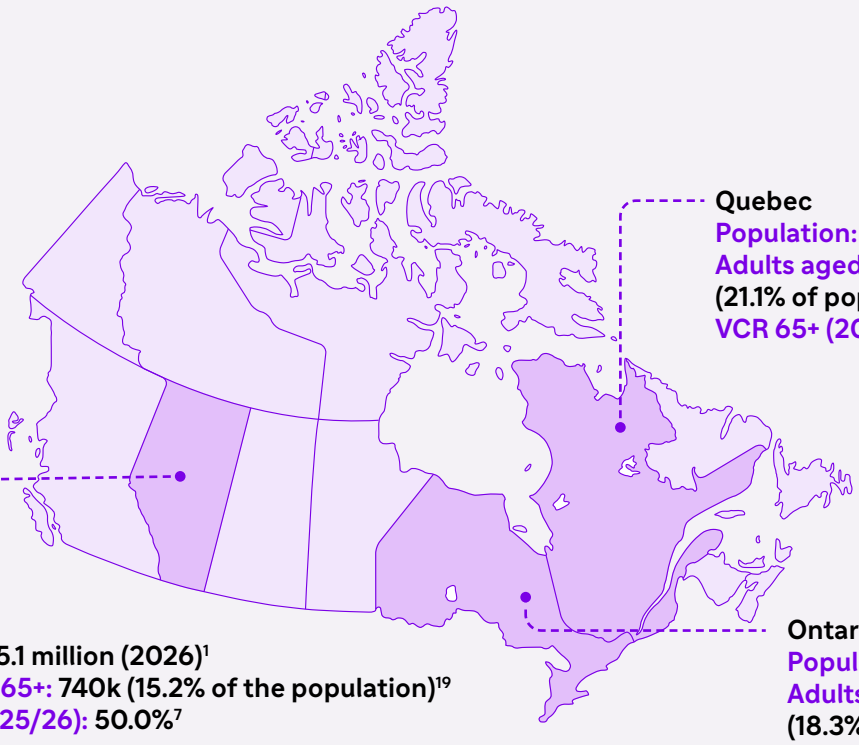
***Question PC2:** Primary care HCPs were asked which signs of system strain they typically experience in their practice during influenza season; respondents could select multiple responses from a list of potential response options. The figures shown were not necessarily the most frequently selected answer options by surveyed HCPs.*

***† Question SB4:** Cardiologists were asked in their own words to summarize the main impact influenza and its complications among adults aged 65+ have on the secondary-care health system, considering firstly overall system-level impact and secondly the impact on their day-to-day practice. Unprompted open-ended responses were analyzed using GenAI-assisted thematic analysis of verbatim free-text responses to identify key themes. Themes shown represent mentions from open-ended responses and should not be interpreted as majority consensus. Quote reproduced from an individual cardiologist response.*

# Provincial policy shapes the protection older adults receive

**National recommendations provide a framework for influenza prevention, but funding, eligibility and delivery are determined provincially. As a result, where an older adult lives can influence the vaccination options available to them. Ontario, Quebec and Alberta illustrate how provincial decisions can shape influenza protection in practice.[5,17,18]**

## Three provinces, three approaches to influenza protection



**Quebec**
**Population:** 9.0 million (2026)[1]
**Adults aged 65+:** 1.91 million (21.1% of population)[19]
**VCR 65+ (2025/26):** 61.8%[7]

**Alberta**
**Population:** 5.1 million (2026)[1]
**Adults aged 65+:** 740k (15.2% of the population)[19]
**VCR 65+ (2025/26):** 50.0%[7]

**Ontario**
**Population:** 16.1 million (2026)[1]
**Adults aged 65+:** 2.9 million (18.3% of population)[19]
**VCR 65+ (2025/26):** 66.7%[7]

### Ontario

- **Number of influenza cases:** 39,691[17]
- **Number of influenza cases in 60+:** 17,003[17]
- **Influenza-related hospitalizations:** 8,759[17]
- **Adults aged 65+ with 2+ chronic conditions:** 68.6%[19]

**Recommendation:** Ontario recommends **annual influenza vaccination for adults aged 65+**, including the **use of age-specific vaccines** designed to address the specific needs of the older adults at higher risk of severe influenza outcomes and help align protection more closely with age-related risk and declining immune function.[20,21]

**Approach:** Ontario has taken a **comparatively proactive approach** to influenza prevention in older adults, although fragmented immunization records continue to limit visibility of vaccination status and under-protected populations across the province.[19-21]

## Quebec

- **Number of influenza cases:** ~43.4k[22]
- **Number of influenza cases in 65+:** NR
- **Influenza-related hospitalizations in 65+:** NR
- **Adults aged 65+ with 2+ chronic conditions:** 60.1%[19]

**Recommendation:** Quebec recommends **annual influenza vaccination for older adults and other populations** at increased risk of complications.[23] For the **2025/26 season**, age-specific influenza vaccination is preferentially offered to adults aged 65+ living in long-term care facilities or designated intermediate resources, and to adults aged 75+ with chronic conditions.[23,24]

**Approach:** Quebec therefore takes a **more targeted approach** to publicly funded age-specific vaccination than the national recommendation for adults aged 65+, with access prioritized according to age, underlying risk and care setting.[5,24] At the same time, gaps in routinely available age-specific surveillance data make it more difficult to fully assess the influenza burden among older adults in the province.

## Alberta

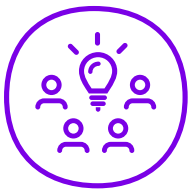
- **Influenza cases:** 20,128[25]
- **Number of influenza cases in 60+:** 5,323 (26.4%)[25]
- **Influenza-related hospitalizations in 60+:** 2,685 (61.8%)[25]
- **Influenza-related ICU admissions in 60+:** 149 (45.5%)[25]
- **Influenza-related deaths in 60+:** 245 (86.9%)[25]
- **Adults aged 65+ with 2+ chronic conditions:** 66.8%[19]

**Recommendation:** Alberta recommends **annual influenza vaccination for adults aged 65+ and other high-risk populations**, including the use of age-specific vaccines, designed to address the specific needs of the older adults at higher risk of severe influenza outcomes and help align protection more closely with age-related risk and declining immune function.[18,26]

**Approach:** Alberta provides **publicly funded access** to age-specific influenza vaccination for adults aged 65+, aligning the provincial age threshold with national recommendations for older adults.[5,18]

**Multimorbidity remains an important consideration** for healthy aging and chronic disease management, with more than 60% adults aged 65+ living with two or more chronic conditions in the regions assessed.[8,19] Risk associated with underlying conditions is also evident before the age of 65. In **population-based surveillance** from the Toronto and Peel regions, adults aged 50–64 years with at least one underlying chronic condition had an average annual influenza-associated hospitalization rate of 41.0 per 100,000, approaching the 45.9 per 100,000 observed across adults aged 65–74 years.[27] This reinforces the **importance of considering both age and underlying health** when identifying adults at increased risk of severe influenza.

Despite **provincial variation**, Canada maintains a **comparatively strong influenza prevention infrastructure** including:[4,5]



**Universal public programs**



**Broad pharmacy participation**



**Growing domestic vaccine manufacturing capacity**

However, vaccination coverage among adults aged 65+ has fallen sharply in recent seasons and remains well below the WHO target of 75%.[7,9]

**Access to age-specific vaccines** for older adults **remains inconsistent** across Canada. While national recommendations support the use of age-specific influenza vaccine approaches for older adults, differences in provincial funding, eligibility criteria, and implementation mean that access to vaccines vary considerably between provinces and age groups.[5] **Visibility of these protection gaps** also remains limited, as national vaccination coverage estimates are largely survey-based rather than registry-based, reducing the ability to accurately identify under-protected populations and monitor protection consistently across provinces.[5]

# HCP perspectives

## Provincial guidance plays an important role in how primary-care HCPs implement influenza prevention

Primary care HCPs report that **provincial guidance plays a substantial role alongside national recommendations** when managing influenza prevention for older adults.

*37%*



**Follow national guidelines to some extent, but are mostly guided by regional guidelines***

*22%*



**Mostly follow national guidelines to manage influenza prevention, but regional guidelines can play a role***

*22%*



**Follow both national and regional guidelines***

*15%*



**Closely follow national guidelines to manage influenza prevention***



**Key takeaway:** National recommendations provide a common framework, while provincial guidance plays an important role in how influenza prevention is translated into practice.

### What HCPs said†



**Cardiologist, Canada**

*"If we could give the flu shot in our clinic, it would be offered, discussed, and given all in one place. Right now, we can discuss the flu shot, but we still have to hope the patient will make a trip to their pharmacy and have it administered at another time."*

***Source:*** *Ipsos online survey conducted on behalf of Sanofi among HCPs in Canada; fieldwork conducted 28 May-2 July 2026. Results reflect the views and practices of the surveyed sample.*

***Bases:*** *Primary care HCPs (n=82: 51 GPs/FPs and 31 pharmacists), cardiologists (n=51).*

**** Question PB2a:*** *Primary care HCPs were asked how closely they follow national immunization guidelines for influenza vaccination among adults aged 65+ in their practice; figures represent percentage of respondents selecting each option.*

***† Questions: SC3:*** *Cardiologists were asked about the practical implementation of influenza prevention guidelines for older adults, whether national, local or regional, including what works well in practice and what does not. Unprompted open-ended responses were analyzed using GenAI-assisted thematic analysis of verbatim free-text responses to identify key themes. Themes shown represent mentions from open-ended responses and should not be interpreted as majority consensus. Quote reproduced from an individual cardiologist response.*

# Closing the gap between risk and protection

Sustaining strong influenza protection in older adults will become increasingly important to reducing avoidable hospitalizations, preserving healthy aging, and limiting pressure on health systems. **Three priority areas** could help strengthen protection for older adults and reduce the burden of influenza across Canada:

## 1 Improve vaccination uptake and integrate influenza prevention into healthy aging and chronic disease care



### Challenge

Influenza vaccination coverage among adults aged 65+ declined sharply in 2024/25 and remained well below the WHO target in 2025/26.[7,9] At the same time, **many older adults live with chronic conditions that increase their vulnerability to severe influenza outcomes**, while influenza itself can exacerbate chronic disease, contribute to cardiovascular complications and affect independence.[2,14]

### Opportunity

Increase vaccination uptake by **making influenza prevention a more consistent** part of healthy aging, chronic disease and cardiovascular care, helping HCPs to identify, engage and vaccinate older adults at increased risk.[5,9]

### How this could be achieved

- **Embed influenza vaccination discussions**, proactive identification and reminders into routine primary care, pharmacy, chronic disease and cardiovascular care.
- **Strengthen targeted education and outreach** to address misinformation, vaccine fatigue and low perceived risk, while reinforcing the broader consequences of influenza for adults aged 65+.

## 2 Improve equity in access to age-specific influenza vaccination



### Challenge

National recommendations support **preferential use of age-specific influenza vaccines** for adults aged 65+, but the specific age-specific vaccination options available through publicly funded programs can **vary between provinces and territories**.[5] Quebec also takes a more targeted approach to age-specific vaccination, with access prioritized according to age, underlying risk, and care setting. The NACI itself notes that availability of different influenza vaccines may vary by region and from year to year.[4,5]

### Opportunity

**Improve equity** by ensuring older adults have **more consistent access to age-specific influenza vaccination options across Canada**, while expanding access in jurisdictions where current provincial eligibility is narrower than the national recommendation for adults aged 65+.

### How this could be achieved

- **Reduce provincial and territorial differences** in access to age-specific influenza vaccination options, supporting greater choice and more equitable implementation of national recommendations.
- **Expand access to age-specific vaccination** for adults aged 65+ where provincial programs currently apply more targeted eligibility criteria, including in Quebec.

3

## Strengthen immunization registries, data, and age-specific influenza surveillance



### Challenge

Fragmented immunization records and continued reliance on survey-based vaccination estimates **limit the ability to identify under-protected adults** and assess **how consistently vaccination recommendations are being implemented**. Gaps in timely age-specific reporting of severe influenza outcomes can further limit visibility of burden among older adults.

### Opportunity

**Strengthen adult immunization records** and **age-specific surveillance** to provide **a more complete and timely picture** of who has been vaccinated, where protection gaps remain, and how influenza affects older adults.

### How this could be achieved

- **Improve linked immunization records** so vaccination history can be captured and accessed across adulthood and across healthcare settings.
- **Improve standardized, timely age-specific reporting** of influenza vaccination coverage and severe outcomes, including hospitalizations, ICU admissions and mortality.

# Methodology

Flunomics brings together **publicly available epidemiological**, **vaccination**, **economic and policy evidence** to examine **how influenza affects older adults** across **nine countries**:




Together, these data provide a broader understanding of how influenza burden, protection, and health system performance interact in aging populations.

The report incorporates **the most recent evidence available for each country at the time of analysis**, including data from the **2025/26 influenza season where published**. Where newer surveillance data were not yet available, the latest validated national datasets and longer-term trends were used to provide context. As reporting schedules differ between countries, the reference period varies by market.

## The evidence framework

Flunomics examines five interconnected dimensions of protection:

| Dimension | Focus |
|---|---|
| **Epidemiological impact** | Influenza burden, including cases, hospitalizations, ICU admissions and mortality, with a focus on older adults. |
| **Vaccination coverage** | Influenza vaccination coverage trends among older adults, including the most recent publicly available national estimates. |
| **Economic impact** | Published evidence describing the direct and indirect costs of influenza to individuals, health systems and society. |
| **Policy & system impact** | How vaccination recommendations are implemented in practice, including delivery, access, surveillance and system performance. |
| **Opportunity** | Evidence-informed opportunities to strengthen protection for older adults based on observed burden and implementation gaps. |

## Country approach

Each country chapter follows a consistent analytical framework comprising five sections:




**Epidemiological impact**




**Vaccination coverage**




**Economic impact**




**Policy & system impact**




**What needs to change**

Recognizing that **health systems are organized differently across countries**, policy and system analyses are undertaken either at national level or through selected regional case studies, depending on how influenza vaccination programs are delivered. This approach allows the report to assess how policy translates into real-world protection while respecting **differences in governance**, **implementation and data availability**.

## Interpreting the findings

Flunomics is intended to **support informed discussion rather than direct comparison between countries**. Surveillance systems, case definitions, reporting practices, age thresholds and data availability differ substantially across markets. As a result, vaccination coverage is the only indicator presented comparatively across all countries; all other findings are interpreted within their national context.

Where evidence gaps exist – particularly in age-specific hospitalization, mortality or economic data – they are explicitly identified throughout the report. These **gaps are treated as important findings**, highlighting **opportunities to strengthen surveillance**, **improve visibility of influenza burden and better inform future policy and implementation**.

**Dr Marco Del Riccio** contributed the foreword and provided scientific advice on the identification, interpretation, and presentation of evidence included in this report.

## Survey research element

To support the findings of this report and further explore the burden of influenza in each of the countries covered by this report, **Sanofi sponsored an independent survey of frontline HCPs** to understand real-world perspectives on optimizing influenza protection among older adults, the extent and challenges of annual flu burden, and how well existing guidelines translate into successful implementation.

**Ipsos**, a market research agency based in the UK, conducted the research on behalf of Sanofi. The following table summarizes the key aspects of survey design.

| Survey parameters | |
|---|---|
| **Data collection:** | Computer-Assisted Web Interviewing (CAWI). A semi-structured questionnaire designed to collect both quantitative metrics (closed list, option select, rating scale, numeric responses) and qualitative feedback (open-ended free-text response), rendered for online self-completion by respondent. All respondents were self-selecting, all data shown is therefore based on those healthcare professionals who chose to take part in the survey |
| **Sample type:** | Non-probability, unstratified, therefore not designed to be statistically representative of the respective HCP universes in each country. Instead, specific minimum numerical targets for subgroups (region, years in practice, practice type) were applied to ensure a good level of sample diversity and geographical coverage |
| **Sample source:** | Online panels of relevant HCPs who have opted-in to receive invitations to participate in market research surveys |
| **Sample size:** | n=1353 across 8 countries and 5 HCP classifications (countries/HCP types per table below) |
| **Sample quotas:** | Applied to country and HCP type within country (see quota table below) |
| **Data analysis:** | • Responses aggregated into simple descriptive statistics (e.g. percentage of sample selecting response option/range of response or mean score for numeric responses)<br>• Open-ended/free-text questions were analyzed by generative AI and organized into response themes (percentage of sample where all or part of response attributed to derived theme)<br>• No weighting or calibration applied to dataset |
| **Eligibility and screening criteria:** | • Must have spent between 3-40 years working within current role<br>• Must spend 70% of professional time in clinical setting (seeing patients/customers)<br>• GPs/FPs/Nurses working in clinic/office-based practices; Pharmacists working in retail pharmacies (single location or with multiple branches under same ownership); Specialists working in clinic/medical centers or in hospital settings; Cardiologists must not be working in specialized fields only<br>• Minimum 150 (primary care HCPs) and 100 patients (secondary care HCPs) seen in a typical month and at least 20% within defined older age category<br>• No pharmaceutical company work as consultant or researcher |
| **Fieldwork dates:** | 28th May to 13th July 2026 inclusive |

| Survey sample size by country and HCP type | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| HCP type* | England | France | Germany | Italy | Spain | Portugal | Canada | USA | Total |
| **Primary care** | | | | | | | | | |
| GP/FP* | 100 | 101 | 100 | 101 | 54 | 50 | 51 | 155† | **712** |
| Retail Pharmacist | - | 50 | 51 | - | - | - | 31 | 54 | **186** |
| Nurse | - | - | - | - | 51 | - | - | - | **51** |
| **Secondary care** | | | | | | | | | |
| Pulmonologist | 50 | 50 | - | - | - | - | - | - | **100** |
| Cardiologist | - | 50 | 50 | - | 53 | 50 | 51 | 50 | **304** |
| **Total** | **150** | **251** | **201** | **101** | **158** | **100** | **133** | **259** | **1353** |

** HCP = healthcare professional; GP = general practitioner; FP = family practitioner.*

*† 50 working in health systems/large clinics and included internal medicine working in primary care.*

# References

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