*Flu*nomics Report

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



France

Developed in collaboration with
Dr Marco Del Riccio, MD
Assistant Professor in General and Applied Hygiene,
University of Florence, Italy
Specialist in Hygiene and Preventive Medicine

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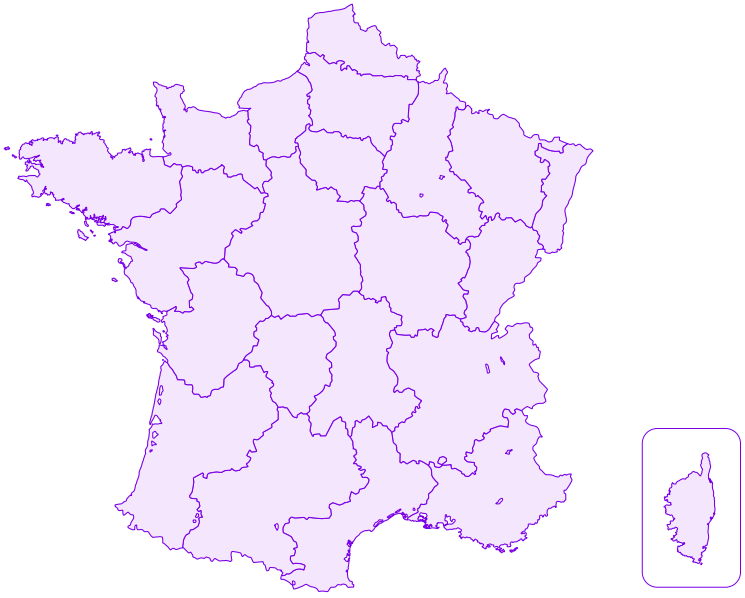
France has a recommendation framework and vaccination infrastructure to protect adults aged 65 and older against influenza, yet coverage remains well below the World Health Organization (WHO) target while severe influenza outcomes continue to be concentrated in adults aged 65+, reflecting several factors, including comorbidities, frailty, and age-related changes in immune function (immunosenescence).

The central challenge is strengthening implementation of national influenza prevention recommendations, including infection-prevention measures and access to vaccination, to support higher vaccination coverage rates (VCRs) in line with national recommendations.

France at a glance

Total population (2026): 69.1 million[1]

Adults aged 65+ years (2026): 15.2 million[1]



National influenza policy

Annual influenza vaccination is recommended for **adults aged 65+ years**, with preferential use of age-specific influenza vaccinations in this population; other influenza vaccine options may also be used in line with national recommendations and the current vaccination schedule.[2,3] Influenza vaccination is also recommended for people at increased risk of severe influenza, including those with **certain chronic conditions**, as well as other eligible groups such as pregnant women and healthcare professionals (HCPs). [2,3] For the complete and most up-to-date national vaccination recommendations, please refer to the French Ministry of Health website: https://sante.gouv.fr/prevention-en-sante/preserver-sa-sante/vaccination/calendrier-vaccinal.[3]

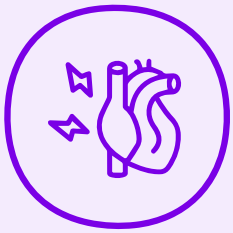
More than one in five people in France are aged 65+ years.[1] France has an **established influenza prevention infrastructure**, including national vaccination recommendations, vaccine delivery through primary care and pharmacies, and a longstanding national surveillance system capable of tracking influenza activity and severe outcomes.[2,4]

Though influenza affects people of all ages, the **risk of severe outcomes increases with age**, with influenza placing a substantial burden on adults aged 65+ years.

Beyond acute respiratory illness, influenza is associated with:



~8-fold increased risk of stroke in the first 3 days following laboratory-confirmed influenza infection, with elevated risk persisting for up to 28 days[5,6]



A **10-fold increased risk of myocardial infarction** (heart attack) within the first 3 days following laboratory-confirmed influenza infection[5,6]

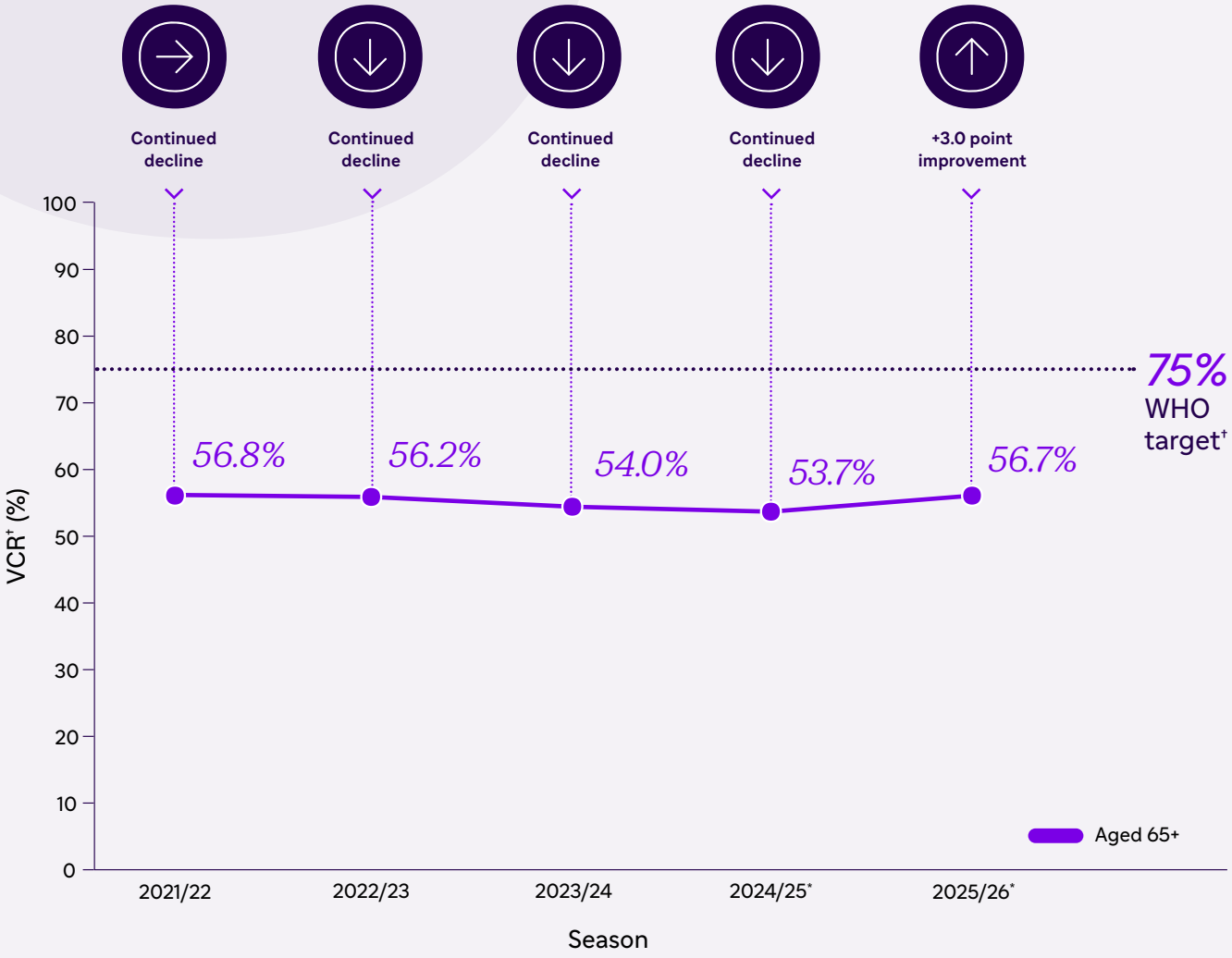


Functional decline following hospitalization in **23%** of adults aged 65+ years[7]

These consequences are particularly important in France given the scale of its older population. Approximately 15 million people aged 65+ live in France, representing approximately 15% of the EU's total population aged 65+.[1,8] This population is projected to reach approximately 19.4 million by 2050, representing 28% of the population.[9]

Looking at how VCRs have evolved over time provides an important starting point for understanding why this burden persists.

Five-year influenza VCR[10-12]



Following several consecutive seasons of declining influenza vaccination coverage, France recorded improvement among adults aged 65 and older in 2025/26, **the first increase since the COVID-19 pandemic**.[10-12] However, the data show that this population continues to experience the majority of severe influenza outcomes.

While this represents an encouraging signal, **coverage remains well below the WHO target of 75%**, leaving more than 40% of adults aged 65+ years unvaccinated and vulnerable to severe influenza outcomes.[11-13]

However, vaccination coverage alone does not indicate which types of influenza vaccines are administered. In France, annual seasonal influenza vaccination is recommended for adults aged 65 and older, alongside recommended infection-prevention measures.[2,3] National recommendations preferentially recommend age-specific influenza vaccines for this population, while also permitting the use of standard-dose vaccines.[2,3] During the 2025/26 season, 28.9% of vaccinated adults aged 65 and older received an influenza vaccine preferentially recommended for their age group.[3,11]

** VCR estimates are reported as of February 28, 2025 for the 2024/25 season and February 28, 2026 for the 2025/26 season.[11,12]*

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

Protection in practice

During the 2025/26 influenza season, France's national health insurance system introduced **targeted short message service (SMS) reminders** encouraging eligible and at-risk individuals to get vaccinated as influenza activity intensified across the country.[14]

Why it matters

Proactive reminder systems can help **reduce missed opportunities** for prevention including vaccination by prompting eligible people to act at the point of highest perceived risk. As part of a broader prevention strategy, these approaches **may support more timely uptake** among adults aged 65+ years and help translate national recommendations into real-world protection.

Influenza vaccination coverage increased during the 2025/26 season, and adults aged 65+ accounted for most severe outcomes

	2024/25[12]	2025/26[11]
Influenza VCR (65+)†	53.7%	56.7%
Hospitalizations following emergency department attendance for influenza/influenza-like illnesses (ILIs) (all ages)	29,100	24,000
Share of hospitalizations among people aged 65+	60%	66%
Electronically certified deaths mentioning influenza (all ages)*	4,925	4,389
Share of electronically certified deaths among people aged 65+*	92%	95%

2025/26: Severe outcomes remained concentrated in 65+[11]

66% of hospital admissions

57% of intensive care unit (ICU) admissions

95% of electronically certified influenza deaths

Estimated overall mortality impact **~12,700** all-cause excess deaths

** Mortality figures represent electronically certified deaths mentioning influenza as directly causing or contributing to death. Electronic death certification covered approximately 50% of national mortality at the end of 2024 and varied by region and place of death.*

† VCR: vaccination coverage rate.

The figures above demonstrate that adults aged 65+ years bear the **overwhelming burden of severe influenza in France**.[11,12] As the older population continues to grow, gaps in vaccination coverage leave large numbers of people potentially vulnerable to severe outcomes. While vaccination coverage increased in 2025/26, it remains below the WHO target of 75%.[10-13]

Yet this only tells part of the story. Influenza is often viewed as a seasonal respiratory infection, but its impact extends far beyond acute symptoms. Adults aged 65+ years are particularly vulnerable to complications that can affect both their immediate and their long-term health and independence. In France, we've seen that the burden of influenza extends beyond respiratory illness and can have **important cardiovascular and functional consequences**.

Cardiovascular complications reported during influenza hospitalization[15]

A nationwide retrospective cohort study using the Programme de médicalisation des systèmes d'information (PMSI) database identified 45,819 patients of all ages hospitalized with seasonal influenza in France between December 1, 2018 and February 28, 2019.[15]

Of the 45,819 patients hospitalized with seasonal influenza during the 2018/19 season, the following cardiovascular diagnoses were observed among hospitalized patients with influenza.[15]

Atrial fibrillation	Stroke	Myocardial infarction
15.8%	1.2%	1.1%

These findings describe complications occurring during influenza hospitalization rather than the excess cardiovascular risk attributable to influenza, reinforcing that severe influenza can affect multiple organ systems, not just the respiratory tract.[15]

This **broader impact** may be particularly important for adults aged 65+ years, as demonstrated by the AEQUI study.[16] It found that adults in this age group who were hospitalized with severe infectious diseases had greater severe frailty (14.1% vs 9.7% in non-infectious hospitalizations).[16] Although the study was not specific to France or influenza alone, it included French centers and suggested that severe infections, including respiratory infections, can contribute to **loss of independence and frailty** in adults aged 65+ years.

HCP perspectives

Surveyed cardiologists and pulmonologists report influenza-season pressure across multiple areas of care

When considering influenza and its potential complications among adults aged 65+, cardiologists and pulmonologists reported a **high or very high impact** on several areas of care during the influenza season:

93%



of cardiologists and pulmonologists report a high or very high impact of influenza and influenza complications on demand for emergency care services*

87%



of cardiologists and pulmonologists report a high or very high impact of influenza and influenza complications on demand for intensive and critical care services*

83%



of cardiologists and pulmonologists report a high or very high impact of influenza and influenza complications on hospital resources, including beds and equipment, etc.*

83%



of cardiologists and pulmonologists report a high or very high impact of influenza and influenza complications on number of hospital admissions*



Key takeaway: HCP perspectives illustrate how influenza-season pressure among older adults can be experienced across multiple parts of secondary care, extending beyond admissions alone.

What HCPs said†

Secondary-care HCPs described how influenza-season pressure can extend **beyond patients with influenza**, affecting bed capacity, workload and the care of patients with other conditions.



Cardiologist, France

"No available beds, enormous challenges finding a bed for other heart patients."

Source: *Ipsos online survey conducted on behalf of Sanofi among HCPs in France; fieldwork conducted 5 June–2 July, 2026. Results reflect the views and practices of the surveyed sample.*

Base: *Secondary-care HCPs (n=100; 50 cardiologists and 50 pulmonologists).*

****Question SB5:*** *Cardiologists and pulmonologists were asked to what extent different aspects of secondary care are impacted by influenza season and the potential for influenza complications in older adults; figures shown represent respondents selecting "very high" or "high impact" (other answer options were: "no impact", "very low impact", "low impact", "moderate impact", and "I don't know).*

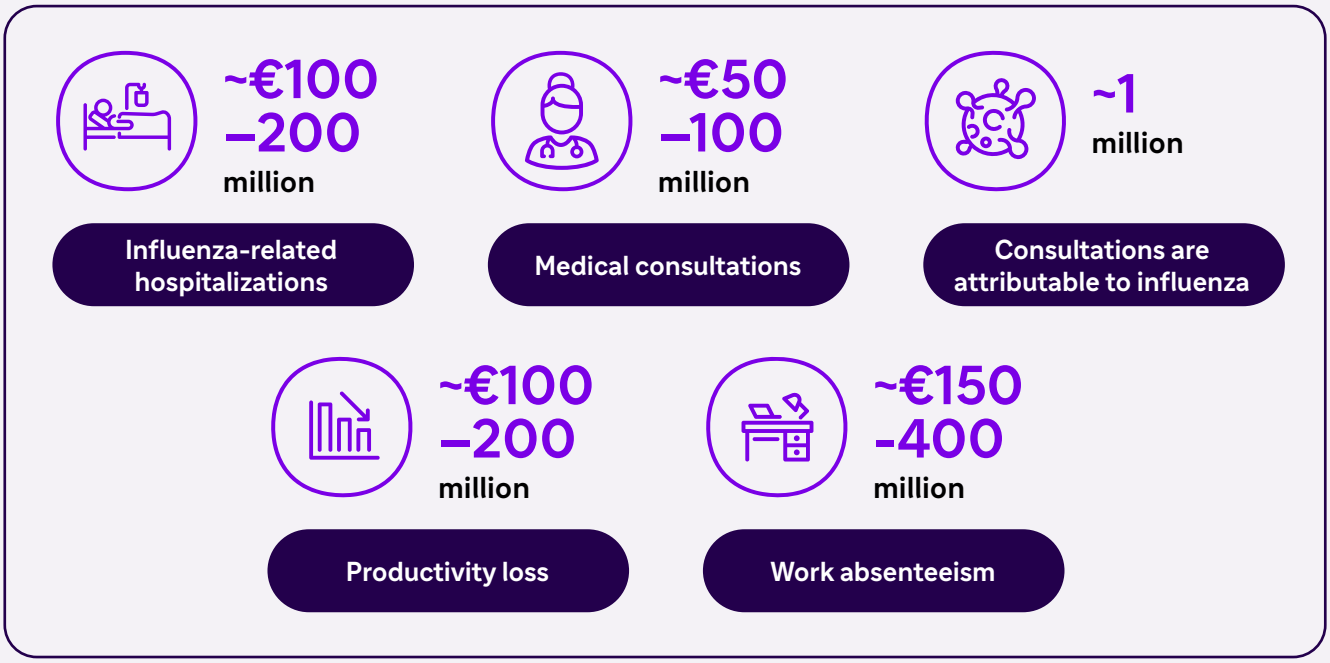
†Question SB4: *Cardiologists and pulmonologists were asked in their own words to summarize the main impact influenza and its complications among adults aged 65+ have on the secondary-care health system, considering firstly overall system-level impact and secondly the impact on their day-to-day practice. 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.*

The annual economic burden of influenza in France is substantial

The consequences of influenza are felt not only by patients and healthcare systems, but also across the **wider economy**.

Historical estimates of the annual economic burden of influenza in France[17,18]

Compilation of historical annual cost estimates reported in a 2025 briefing



A 2025 briefing compiling historical estimates reports that influenza could result in 1.5–2 million lost workdays annually, while employees who continue working when ill may experience productivity reductions of 20–50%.[18] These estimates help to illustrate the substantial societal impact of influenza beyond healthcare alone.

If the burden of influenza is so well established, and if adults aged 65+ years consistently experience the greatest share of severe outcomes, *why do substantial protection gaps remain?*

From policy to practice: why protection gaps remain

Since May 2025, HAS has preferentially recommended age-specific influenza vaccines for adults aged 65+, while standard-dose vaccines remain an option in line with national recommendations, as part of a broader approach to influenza prevention that also includes recommended infection-prevention measures.[2,3] During the 2025/26 season, 28.9% of vaccinated adults aged 65+ years received a preferentially recommended vaccine.[11] This provides an **early indication** of how the preferential recommendation is reflected in vaccination practice. However, vaccine choice is only one aspect of implementation: translating national guidance into protection also depends on how **consistently influenza prevention is integrated** across healthcare settings.

This means making influenza prevention a more systematic part of the patient journey, **from primary care and pharmacy through to specialist and hospital care**. Adults aged 65+ years may interact with multiple HCPs over the course of a season, creating opportunities to check vaccination status, discuss influenza risk and recommend prevention in line with national guidance.

Effective implementation therefore depends on more than awareness of recommendations. Clear coordination between care settings, visibility of vaccination status and consistent opportunities to act on national guidance are all important to reducing the gap between policy and protection in practice.

HCP perspectives

National influenza guidance is widely recognized, but implementation gaps remain

Surveyed HCPs reported **high familiarity with national influenza vaccination guidelines specifically in relation to adults aged 65+**, while secondary-care findings point to opportunities to strengthen coordination across the care pathway.

87%



of surveyed HCPs report being very or somewhat familiar with national influenza vaccination guidelines for older adults*

91%



of primary care HCPs report being very or somewhat familiar with national guidelines*

82%



of cardiologists and pulmonologists report being very or somewhat familiar with national guidelines*

80%



of cardiologists and pulmonologists tend to or strongly agree that inter-specialty coordination for influenza prevention needs to be improved in their area to ensure better outcomes†

52%



of cardiologists and pulmonologists tend to or strongly agree that influenza prevention policy is well integrated between primary and secondary care in their area†

Key takeaway: The findings suggest that awareness of national guidance is relatively high among surveyed HCPs, but familiarity alone does not ensure consistent implementation across care settings; coordination between primary and secondary care remains an important consideration.

Source: *Ipsos online survey conducted on behalf of Sanofi among HCPs in France; fieldwork conducted 5 June–2 July, 2026. Results reflect the views and practices of the surveyed sample.*

Base: *All HCPs (n=251; 101 general practitioners (GPs)/family practitioners (FPs), 50 pharmacists, 50 cardiologists and 50 pulmonologists).*

**** Question PB1/SC1:*** *HCPs were asked how familiar they were with national influenza vaccination guidelines when it comes to flu prevention specifically in relation to adults aged 65+. Figures shown represent respondents selecting "I am very familiar" and "I am somewhat familiar" (other answer options were: "I am not very familiar", "I am not at all familiar" and "I don't know").*

† Question SA5: *Secondary-care HCPs only (n=100; 50 cardiologists and 50 pulmonologists) were asked to what extent they agreed or disagreed with statements concerning influenza prevention and vaccination among adults aged 65+ and how this is managed in their area; figures shown represent respondents selecting "strongly agree" or "tend to agree" (other answer options were: "strongly disagree", "tend to disagree", "neither agree nor disagree" and "I don't know").*

What HCPs said

HCPs described several aspects of guideline implementation that work well in practice, including **health-insurance reminders and pharmacy-based vaccination**. They also identified opportunities to improve vaccination-status visibility and coordination across healthcare settings.*



Pulmonologist, France

"Vaccination uptake is still not enough. Non-routine checking of vaccine status at the hospital or impossible to know. Room for improvement with coordination between private practice-hospital."

Source: *Ipsos online survey conducted on behalf of Sanofi among HCPs in France; fieldwork conducted 5 June–2 July, 2026. Results reflect the views and practices of the surveyed sample.*

Base: *All HCPs (n=251; 101 GPs/FPs, 50 pharmacists, 50 cardiologists and 50 pulmonologists).*

**** Questions: PB3/SC3:*** *PCPs (n=101), pharmacists (n=50), cardiologists (n=50) and pulmonologists (n=50) 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 pulmonologist response.*

Closing the gap between risk and protection

Closing the gap between influenza risk and prevention including vaccination will require **action across three areas**: increasing vaccination uptake among adults aged 65+, strengthening implementation of national vaccine recommendations, and integrating influenza prevention more consistently across the care pathway.

1 Strengthen influenza prevention through infection-prevention measures and support implementation of national vaccination recommen-dations for adults aged 65+



Challenge

Vaccination coverage among adults aged 65+ years remains **below the WHO target of 75%**, with available data showing that only 28.9% of vaccinated adults aged 65+ received a preferentially recommended age-specific vaccine during the 2025/26 season.[11,13]

Opportunity

Increase influenza vaccination coverage among adults aged 65+, while supporting implementation of national recommendations that preferentially recommend age-specific influenza vaccines for this population, while also permitting the use of standard-dose vaccines.

How this could be achieved

- **Expand proactive reminder and recall initiatives**, building on successful approaches such as targeted outreach to eligible populations.
- **Provide HCPs with evidence-based resources** to help them explain the risk of severe influenza and support informed vaccination decisions in line with national recommendations.
- **Reinforce the importance of infection-prevention measures**.

2 Integrate influenza prevention across the care pathway



Challenge

Adults aged 65+ years at **greatest risk frequently interact with healthcare services**, yet influenza prevention is not always consistently integrated across primary care, specialist care and hospital settings.

Opportunity

Make every appropriate healthcare interaction an **opportunity to protect** adults aged 65+ years from severe influenza outcomes.

How this could be achieved

- **Integrate influenza prevention** into routine chronic disease management and specialist care pathways, including cardiovascular care where appropriate.
- **Expand opportunities to assess and offer influenza vaccination** in hospital and secondary care settings, including at transitions of care.

3 Strengthen the systems that support consistent implementation



Challenge

Awareness of national influenza guidance is high among surveyed HCPs, but **gaps remain in coordination between care settings** and in the **visibility of patients' vaccination status**, which can make consistent implementation more difficult.

Opportunity

Strengthen the practical systems and coordination needed to translate national recommendations into consistent protection across healthcare settings.

How this could be achieved

- **Improve visibility and sharing of influenza vaccination status** across primary care, specialist and hospital settings to support more consistent identification and follow-up.
- **Monitor VCRs and the use of different vaccine types** among adults aged 65+ to assess how consistently national recommendations are implemented in practice.

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:

1. **Epidemiological impact**
2. **Vaccination coverage**
3. **Economic impact**
4. **Policy & system impact**
5. **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) • 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) • No weighting or calibration applied to dataset
Eligibility and screening criteria:	• Must have spent between 3-40 years working within current role • Must spend 70% of professional time in clinical setting (seeing patients/customers) • 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 • 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 • 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.

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