

February 1 to February 7, 2015 (week 05)

Overall Summary

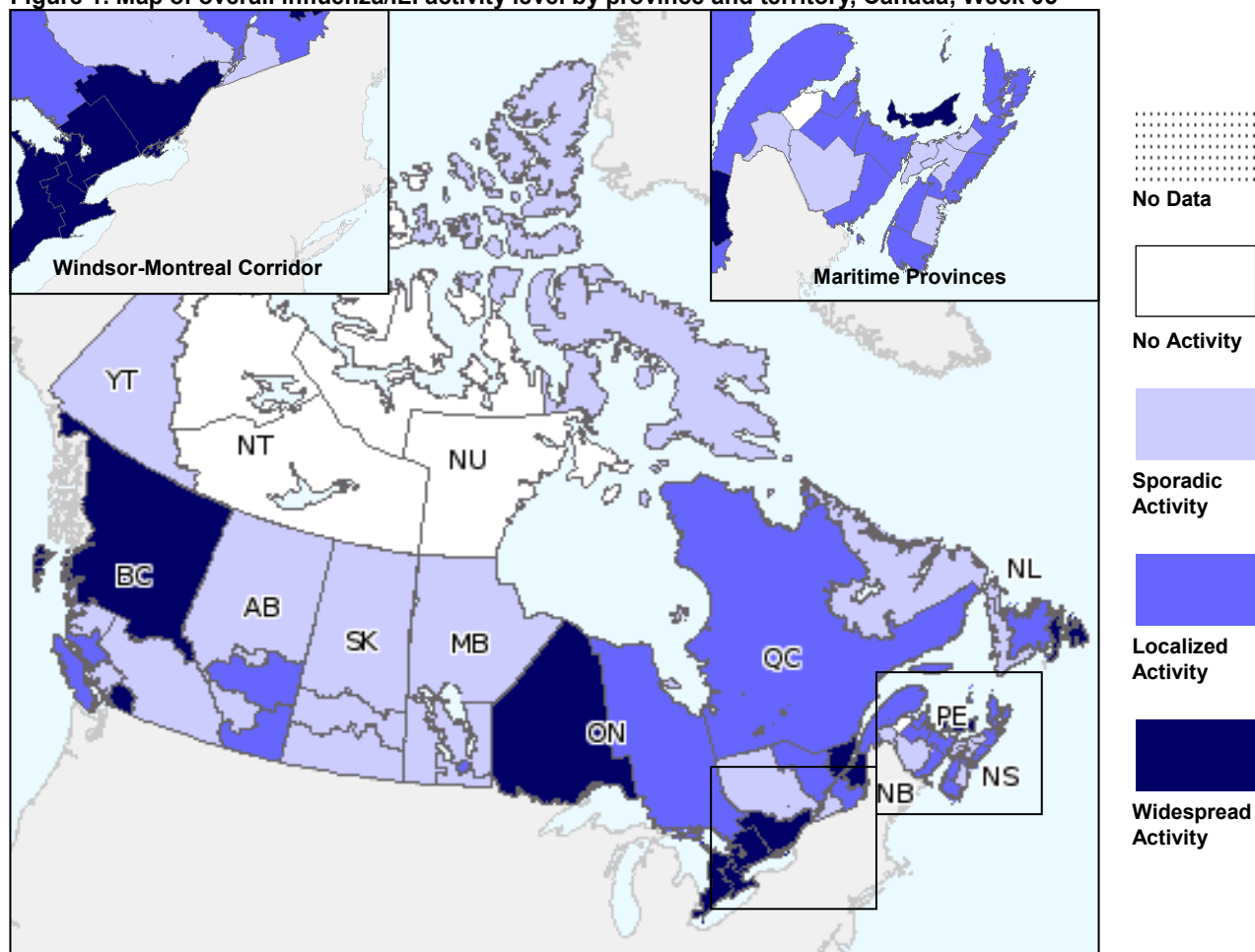
- In week 5, all influenza indicators with the exception of ILI and influenza activity continued to decline.
- There is ongoing influenza activity in the Western, Central and the Atlantic provinces, predominantly due to influenza A. Influenza B detections have been increasing steadily, particularly in the Prairies and in Quebec.
- A(H3N2) continues to be the most common type of influenza affecting Canadians. In both laboratory detections, hospitalizations and deaths and the majority of cases have been among seniors ≥ 65 years of age.
- Detections of respiratory syncytial virus (RSV) continue to be the second most frequently detected virus after influenza. In the Prairies and Quebec, the percent positive for RSV detections surpassed the percent positive for influenza detections in week 05.
- A record number of long term care facility (LTCF) outbreaks have been reported this season to date (n=910) and has surpassed the number of LTCF outbreaks reported in each of the past four seasons.
- Evidence from the National Microbiology Laboratory (NML) does indicate that this year's vaccine will continue to provide protection against the circulating A(H1N1) and B strains.

Are you a primary health care practitioner (General Practitioner, Nurse Practitioner or Registered Nurse) interested in becoming a FluWatch sentinel for the 2014-15 influenza season? Contact us at FluWatch@phac-aspc.gc.ca

Influenza/ILI Activity (geographic spread)

In week 05, 11 regions reported widespread activity: in BC(2), ON(6), QC, NF and PEI. Eighteen regions reported localized activity: in BC, AB(2), MB, ON, QC(3), NB(4), NS(5), and NL. Twenty-four regions reported sporadic activity: in YK, NU, BC(2), AB(3), SK(3), MB(4), QC(2), NB(2), NS(4), and NF(2). Compared to the previous week, the number of regions reporting widespread activity in week 05 increased. However the overall number of regions reporting elevated activity (widespread and localized) in week 05 declined from the previous week.

Figure 1. Map of overall influenza/ILI activity level by province and territory, Canada, Week 05

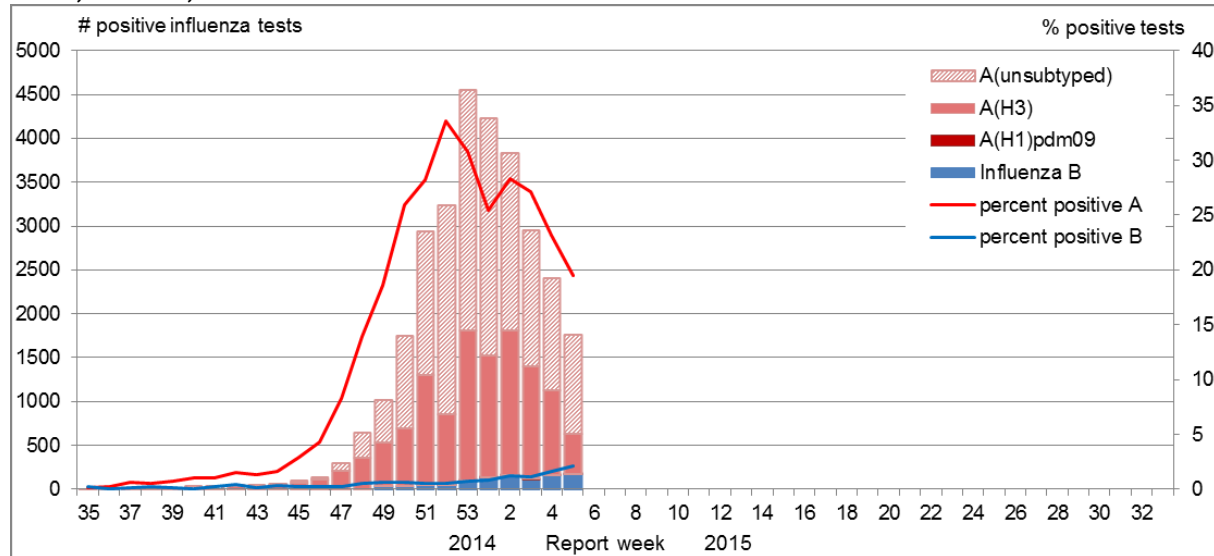


Note: Influenza/ILI activity levels, as represented on this map, are assigned and reported by Provincial and Territorial Ministries of Health, based on laboratory confirmations, sentinel ILI rates and reported outbreaks. Please refer to detailed definitions at the end of the report. Maps from previous weeks, including any retrospective updates, are available on the FluWatch website.

Influenza and Other Respiratory Virus Detections

The number of positive influenza tests decreased from 2,409 in week 04 to 1,729 in week 05. The percentage of positive influenza A tests decreased from 23.1% to 19.5%. The percentage of positive influenza B tests have been increasing for the past few weeks to 2.2% in week 05, the highest this season thus far (Figure 2). The proportion of influenza B detections were highest in the Prairies and Quebec in week 05 (influenza B accounted for 15%-36% of all influenza detections). To date, 96% of influenza detections have been influenza A, and 99.7% of those subtyped have been A(H3N2) (Table 1). To date this season, detailed information on age and type/subtype has been received for 27,061 cases. A significantly greater proportion of laboratory detections of influenza have been reported in adults ≥ 65 years of age (62%) this season (Table 2) compared to the 2013-14 season when only 15.6% of cases were in adults ≥ 65 years of age.

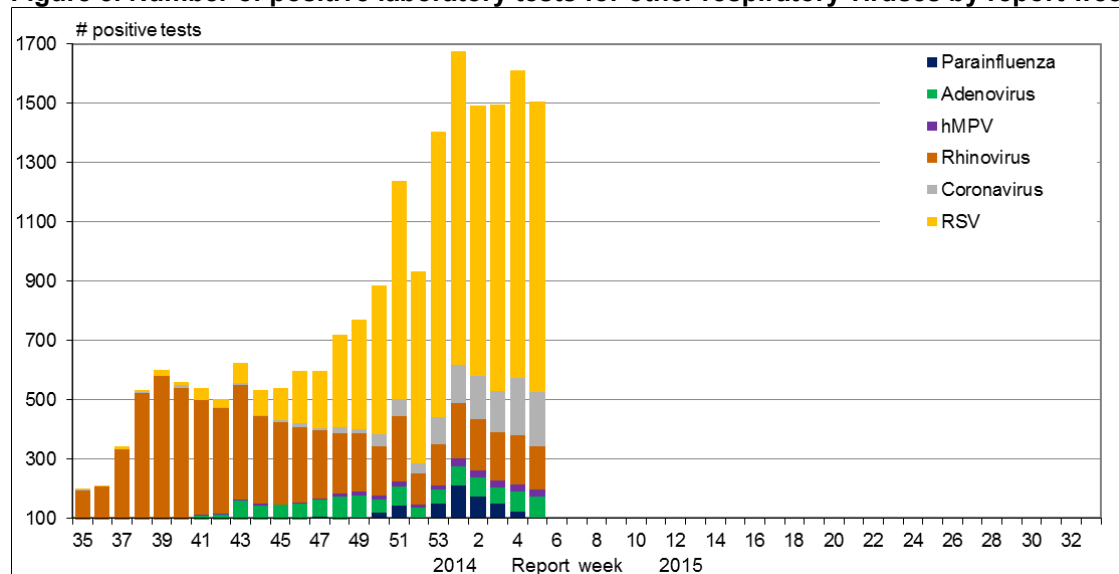
Figure 2. Number of positive influenza tests and percentage of tests positive, by type, subtype and report week, Canada, 2014-15



In week 05, the number of positive respiratory syncytial virus (RSV) tests decreased to 980 RSV detections and remains the second most frequently detected virus after influenza (Figure 3). In week 05, the percent positive for RSV detections in the Prairies and Quebec surpassed the percent positive for influenza detections in those regions. Detections of RSV since week 38 have been higher than in the previous season. Detections of all other respiratory viruses except adenovirus decreased in week 05. Detections of respiratory viruses (other than RSV) have generally been lower this season compared to the previous season.

For more details, see the weekly [Respiratory Virus Detections in Canada Report](#).

Figure 3. Number of positive laboratory tests for other respiratory viruses by report week, Canada, 2014-15



RSV: Respiratory syncytial virus; hMPV: Human metapneumovirus

Table 1. Weekly and cumulative numbers of positive influenza specimens by type, subtype and province, Canada, 2014-15

Reporting provinces ¹	Weekly (February 1 to February 7, 2015)					Cumulative (August 24, 2014 to February 7, 2015)				
	Influenza A				B	Influenza A				B
	A Total	A(H1)pdm09	A(H3)	A(UnS)	B Total	A Total	A(H1)pdm09	A(H3)	A(UnS)	B Total
BC	172	1	59	112	13	2872	9	2126	737	84
AB	52	1	38	13	29	3476	5	3325	146	299
SK	18	0	10	8	5	1238	0	763	475	20
MB	35	0	9	26	6	1046	0	366	680	30
ON	610	2	259	349	13	8429	12	3872	4545	106
QC	431	1	0	430	92	10151	4	422	9725	535
NB	150	0	36	114	7	576	0	102	474	24
NS	47	0	0	47	7	304	0	123	181	26
PE	20	0	20	0	0	80	1	77	2	1
NL	22	0	0	22	0	520	0	53	467	3
Canada	1,557	5	431	1,121	172	28692	31	11229	17432	1128
Percentage²	90.1%	0.3%	27.7%	72.0%	9.9%	96.2%	0.1%	39.1%	60.8%	3.8%

Table 2. Weekly and cumulative numbers of positive influenza specimens by type, subtype and age-group reported through case-based laboratory reporting³, Canada, 2014-15

Age groups (years)	Weekly (February 1 to February 7, 2015)					Cumulative (August 24, 2014 to February 7, 2015)						
	Influenza A				B	Influenza A				B	Influenza A and B	
	A Total	A(H1)pdm09	A(H3)	A (UnS)	Total	A Total	A(H1)pdm09	A(H3)	A (UnS)	Total	#	%
<5	72	0	6	66	12	1748	7	681	1060	99	1847	6.8%
5-19	36	0	6	30	26	1586	1	850	735	148	1734	6.4%
20-44	104	1	12	91	23	3002	9	1453	1540	171	3173	11.7%
45-64	105	1	16	88	33	3272	6	1403	1863	259	3531	13.0%
65+	502	0	87	415	44	16267	7	6329	9931	404	16671	61.6%
Unknown	10	0	8	2	0	103	0	87	16	2	105	0.4%
Total	829	2	135	692	138	25978	30	10803	15145	1083	27061	100.0%
Percentage²	85.7%	0.2%	16.3%	83.5%	14.3%	96.0%	0.1%	41.6%	58.3%	4.0%		

¹ Specimens from NT, YT, and NU are sent to reference laboratories in other provinces. Cumulative data includes updates to previous weeks.

² Percentage of tests positive for sub-types of influenza A are a percentage of all influenza A detections.

³ Table 2 includes specimens for which demographic information was reported. These represent a subset of all positive influenza cases reported. UnS: unsubtype: The specimen was typed as influenza A, but no result for subtyping was available.

Antiviral Resistance

During the 2014-2015 influenza season, the NML has tested 503 influenza viruses for resistance to oseltamivir and 502 influenza viruses for resistance to zanamivir and all were sensitive to both agents. A total of 783 (99.8%) influenza A viruses were resistant to amantadine (Table 3).

Table 3. Antiviral resistance by influenza virus type and subtype, Canada, 2014-15

Virus type and subtype	Oseltamivir		Zanamivir		Amantadine	
	# tested	# resistant (%)	# tested	# resistant (%)	# tested	# resistant (%)
A (H3N2)	428	0	428	0	782	781 (99.9%)
A (H1N1)	2	0	2	0	2	2 (100%)
B	73	0	72	0	NA ¹	NA ¹
TOTAL	503	0	502	0	784	783

¹NA: Not Applicable

Influenza Strain Characterizations

During the 2014-2015 influenza season, the National Microbiology Laboratory (NML) has characterized 172 influenza viruses [81 A(H3N2), 2 A(H1N1) and 89 influenza B].

Influenza A (H3N2): When tested by hemagglutination inhibition (HI) assay (n=81), one virus was antigenically similar to A/Texas/50/2012, five showed reduced titers to A/Texas/50/2012 and 75 were antigenically similar to A/Switzerland/9715293/2013, which is the influenza A(H3N2) component recommended for the 2015 Southern Hemisphere influenza vaccine. Additionally, 619 A(H3N2) viruses were unable to be tested by HI assay; however, sequence analysis showed that 617 belonged to a genetic group that typically shows reduced titers to A/Texas/50/2012. **Influenza A(H1N1):** Two A(H1N1) viruses characterized were antigenically similar to A/California/7/2009. **Influenza B:** Of the 89 influenza B viruses characterized, 82 viruses were antigenically similar to B/Massachusetts/2/2012, three viruses showed reduced titers against B/Massachusetts/2/2012, and four were B/Brisbane/60/2008-like (Figure 4).

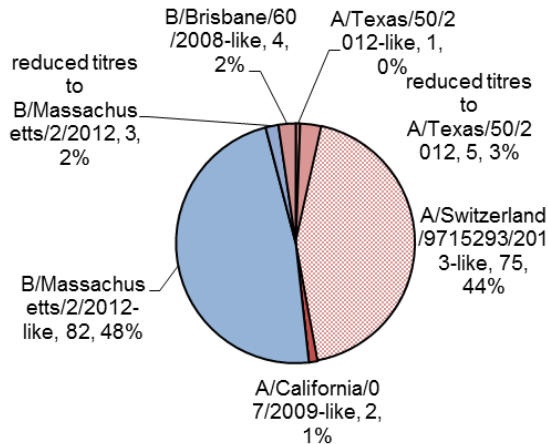


Figure 4. Influenza strain characterizations, Canada, 2014-15, N = 172

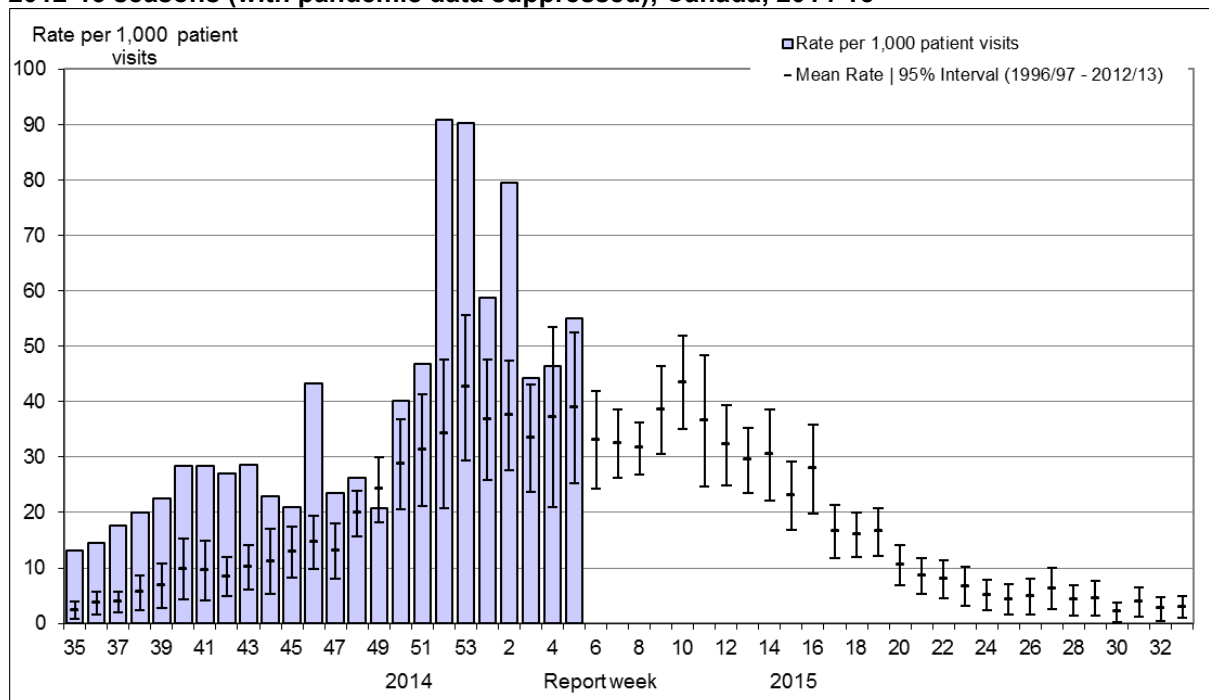
The NML receives a proportion of the number of influenza positive specimens from provincial laboratories for strain characterization and antiviral resistance testing. Characterization data reflect the results of haemagglutination inhibition (HAI) testing compared to the reference influenza strains recommended by [WHO](http://www.who.int).

The recommended components for the 2014-2015 northern hemisphere trivalent influenza vaccine include: an A/California/7/2009(H1N1)pdm09-like virus, an A/Texas/50/2012 (H3N2)-like virus, and a B/Massachusetts/2/2012-like virus (Yamagata lineage). For quadrivalent vaccines, the addition of a B/Brisbane/60/2008-like virus is recommended.

Influenza-like Illness Consultation Rate

The national influenza-like-illness (ILI) consultation rate increased to 55.0 consultations per 1,000, which is slightly above expected levels for week 05 (Figure 5). The rate were highest among the 5 to 19 years of age group (64.9 consultations per 1,000) and lowest among the adults ≥65 years of age (33.9 consultations per 1,000)

Figure 5. Influenza-like-illness (ILI) consultation rates by report week, compared to the 1996-97 through to 2012-13 seasons (with pandemic data suppressed), Canada, 2014-15

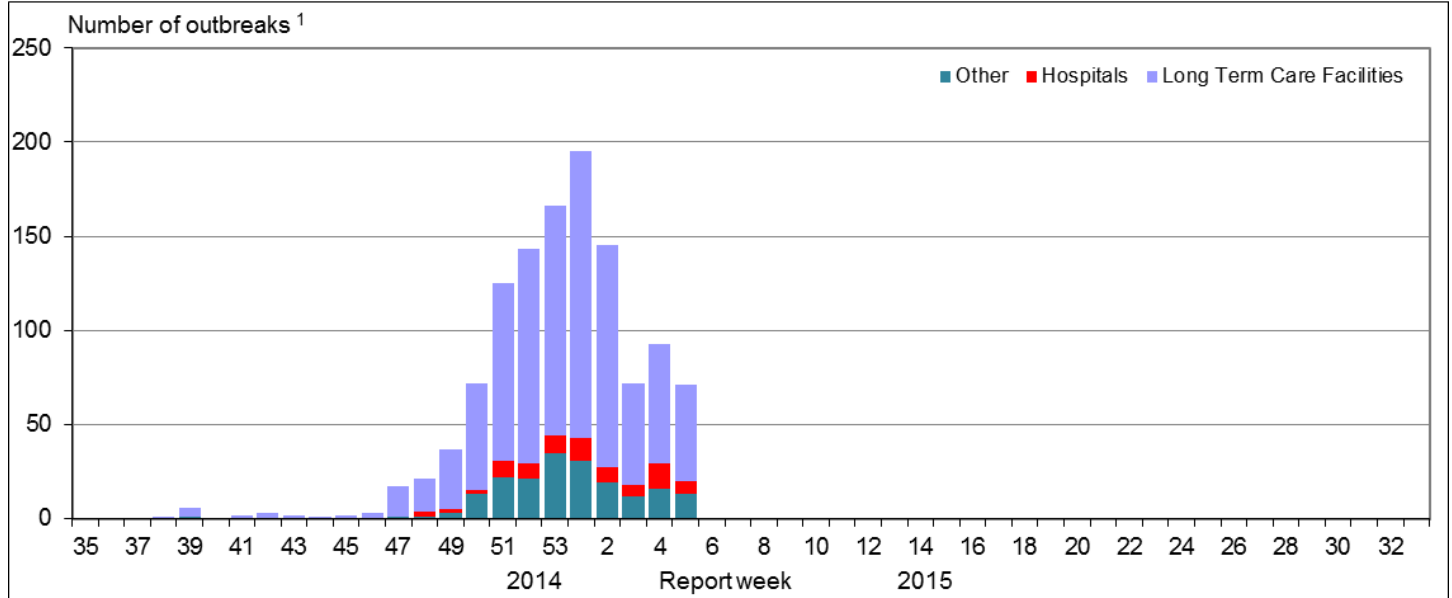


No data available for mean rate for weeks 19 to 39 for the 1996-1997 through 2002-2003 seasons. Delays in the reporting of data may cause data to change retrospectively. The calculation of the average ILI consultation rate over 17 seasons was aligned with influenza activity in each season. In BC, AB, and SK, data is compiled by a provincial sentinel surveillance program for reporting to FluWatch. Not all sentinel physicians report every week.

Influenza Outbreak Surveillance

In week 05, 71 new outbreaks of influenza were reported, which is lower than the number of outbreaks reported in the previous week. Fifty-one outbreaks were reported in long-term care facilities (LTCF), 7 in hospitals and 13 in institutional or community settings (Figure 6). An additional 8 outbreaks of ILI were reported in schools. Among the outbreaks in which the influenza subtype was known, five LTCF outbreaks were associated with A(H3N2). To date this season, 910 outbreaks in LTCFs have been reported and the majority of those with known subtypes were attributable to A(H3N2). There has been a higher number of reported influenza outbreaks to date this season compared to the same period in previous seasons.

Figure 6. Overall number of new laboratory-confirmed influenza outbreaks by report week, Canada, 2014-2015

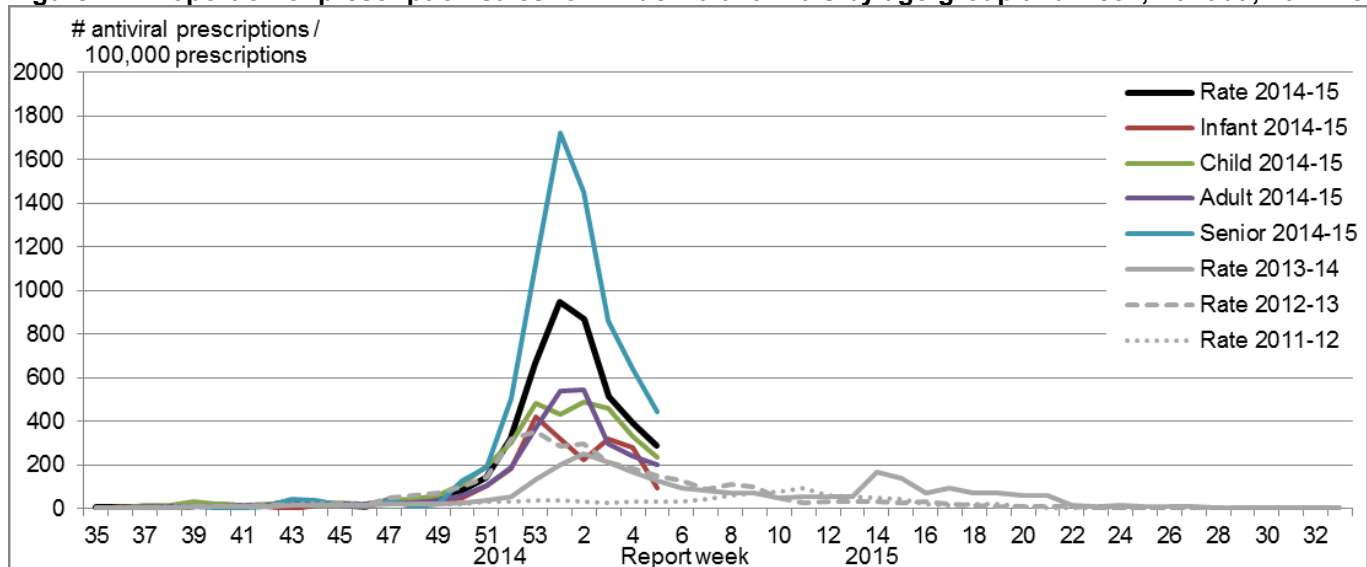


¹All provinces and territories except NU report influenza outbreaks in long-term care facilities. All provinces and territories with the exception of NU and QC report outbreaks in hospitals. Outbreaks of influenza or influenza-like-illness in other facilities are reported to FluWatch but reporting varies between jurisdictions. Outbreak definitions are included at the end of the report.

Pharmacy Surveillance

During week 05, the proportion of prescriptions for antivirals decreased to 290.2 antiviral prescriptions per 100,000 total prescriptions (down from 391.1 per 100,000). The rate for antivirals since week 48 has been higher than the previous three seasons (Figure 7). The rate in all age groups decreased in week 05. The rate was highest amongst seniors at 650.0 per 100,000 total prescriptions and lowest among infants at 91.9 per 100,000 total prescriptions.

Figure 7 – Proportion of prescription sales for influenza antivirals by age-group and week, Canada, 2014-15



Note: Pharmacy sales data are provided to the Public Health Agency of Canada by Rx Canada Inc. and sourced from major retail drug chains representing over 2,500 stores nationwide (excluding Nunavut) in 85% of Health Regions. Data provided include the number of new antiviral prescriptions (for Tamiflu and Relenza) and the total number of new prescriptions dispensed by Province/Territory and age group. Age-groups: Infant: 0-2y, Child: 2-18y; Adult: 19-64y, Senior: ≥65y

Sentinel Hospital Influenza Surveillance

Paediatric Influenza Hospitalizations and Deaths (IMPACT)

In week 05, 16 laboratory-confirmed influenza-associated paediatric (≤ 16 years of age) hospitalizations were reported by the Immunization Monitoring Program Active (IMPACT) network: 12 cases of influenza A and four cases of influenza B (Figure 8a). Among the reported cases, 6 (38%) were < 2 years of age, 9 (56%) were 2 to 9 years of age and one (6%) was 10-16 years of age. One case was admitted to the ICU. To date this season, 489 hospitalizations have been reported by the IMPACT network, 458 (94%) of which were cases of influenza A. Among cases for which the influenza A subtype was reported, 99% (142/144) were A(H3N2) (Table 4). To date, 56 cases were admitted to the ICU, of which 34 (61%) were 2 to 9 years of age (Figure 9a). Three deaths have been reported.

Note: The number of hospitalizations reported through IMPACT represents a subset of all influenza-associated paediatric hospitalizations in Canada. Delays in the reporting of data may cause data to change retrospectively.

Adult Influenza Hospitalizations and Deaths (PCIRN)

In week 05, 89 laboratory-confirmed influenza-associated adult (≥ 16 years of age) hospitalizations were reported by the PHAC/CIHR Influenza Research Network (PCIRN) Serious Outcomes Surveillance (SOS) network. Among the cases in week 05, 71 cases (80%) were in adults over the age of 65 and 84 cases (94%) had influenza A (Figure 8b). To date this season, 1,532 cases have been reported; 1,505 (98%) with influenza A. The majority of cases (83%) were among adults ≥ 65 years of age (Table 5). One hundred and five ICU admissions have been reported and 78 cases were adults ≥ 65 years of age. A total of 81 ICU cases reported to have at least one underlying condition or comorbidity. Of the 72 ICU cases with known immunization status, 24 (33%) reported not having been vaccinated this season. Sixty-six deaths have been reported, 59 (89%) of the deaths were adults > 65 years of age (Figure 9b).

Note: The number of hospitalizations reported through PCIRN represents a subset of all influenza-associated adult hospitalizations in Canada. Delays in the reporting of data may cause data to change retrospectively.

Table 4 – Cumulative numbers of paediatric hospitalizations with influenza reported by the IMPACT network, Canada, 2014-15

Age groups	Cumulative (24 Aug. 2014 to 07 Feb. 2015)					
	Influenza A				B	Influenza A and B
	A Total	A(H1) pdm09	A(H3)	A (UnS) ²	Total	# (%)
0-5m	72	0	14	58	3	75 (15.3%)
6-23m	98	1	31	66	13	111 (22.7%)
2-4y	112	1	37	74	4	116 (23.7%)
5-9y	117	0	39	78	7	124 (25.4%)
10-16y	59	0	21	38	4	63 (12.9%)
Total	458	2	142	314	31	489
%¹	93.7%	0.4%	31.0%	68.6%	6.3%	100.0%

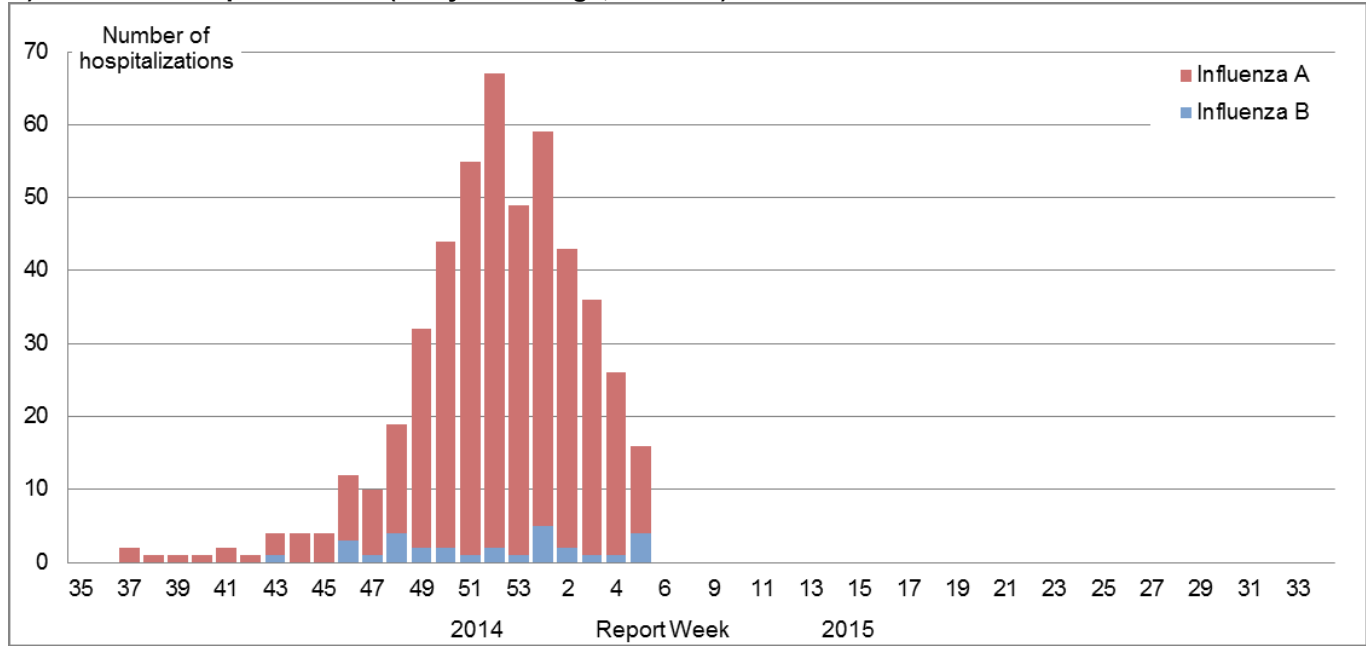
Table 5 – Cumulative numbers of adult hospitalizations with influenza reported by the PCIRN-SOS network, Canada, 2014-15

Age groups (years)	Cumulative (15 Nov. 2014 to 07 Feb. 2015)					
	Influenza A				B	Influenza A and B
	A Total	A(H1) pdm09	A(H3)	A (UnS)	Total	# (%)
16-20	4	0	1	3	0	4 (%)
20-44	82	1	34	47	2	84 (5%)
45-64	167	0	68	99	3	170 (11%)
65+	1252	3	476	773	22	1274 (83%)
Total	1505	4	579	922	27	1532
%	98%	0%	38%	61%	2%	100%

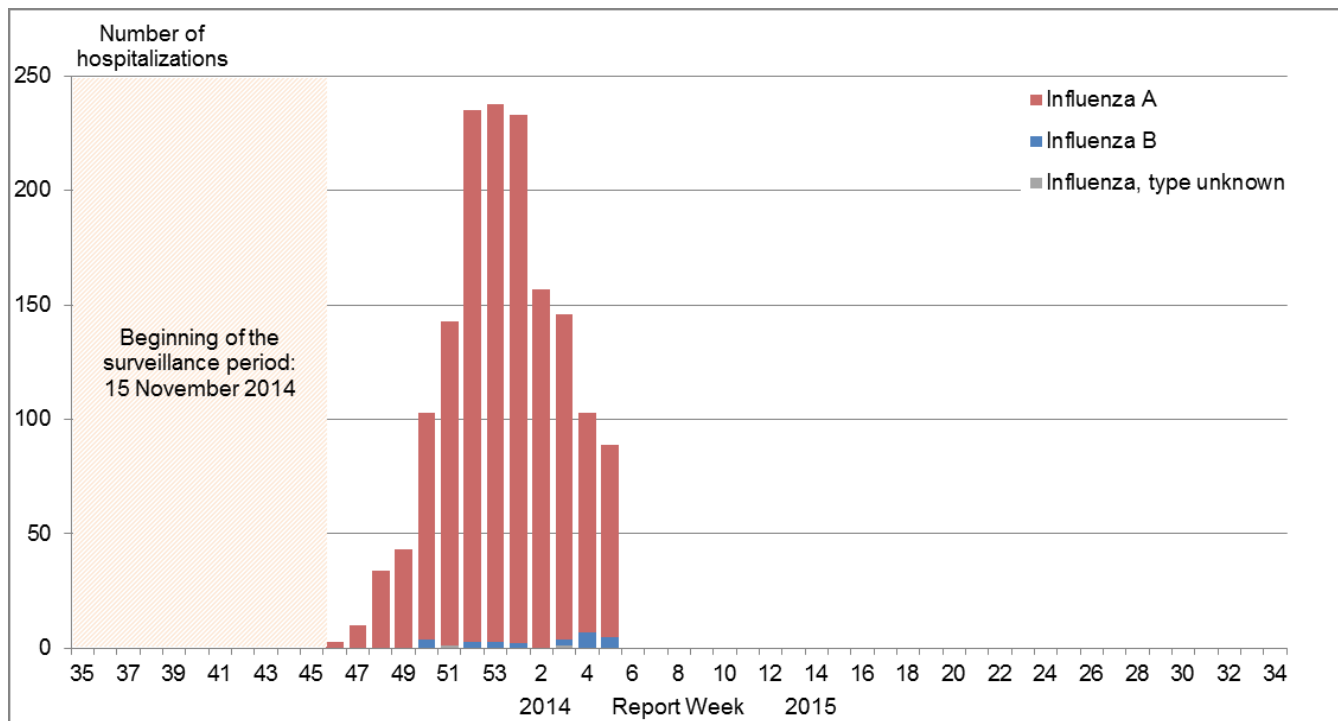
¹ Percentage of tests positive for sub-types of influenza A are a percentage of all influenza A detections. UnS: unsubtype: The specimen was typed as influenza A, but no result for subtyping was available.

Figure 8 – Number of cases of influenza reported by sentinel hospital networks, by week, Canada, 2014-15

A) Paediatric hospitalizations (≤16 years of age, IMPACT)



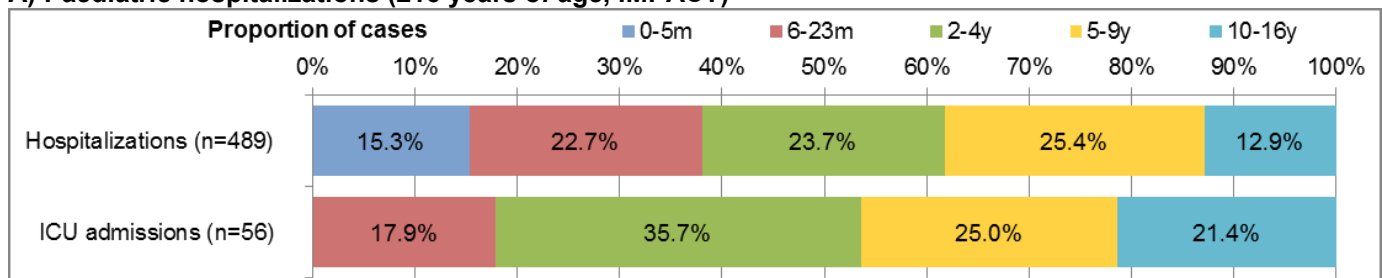
B) Adult hospitalizations (≥16 year of age, PCIRN-SOS)



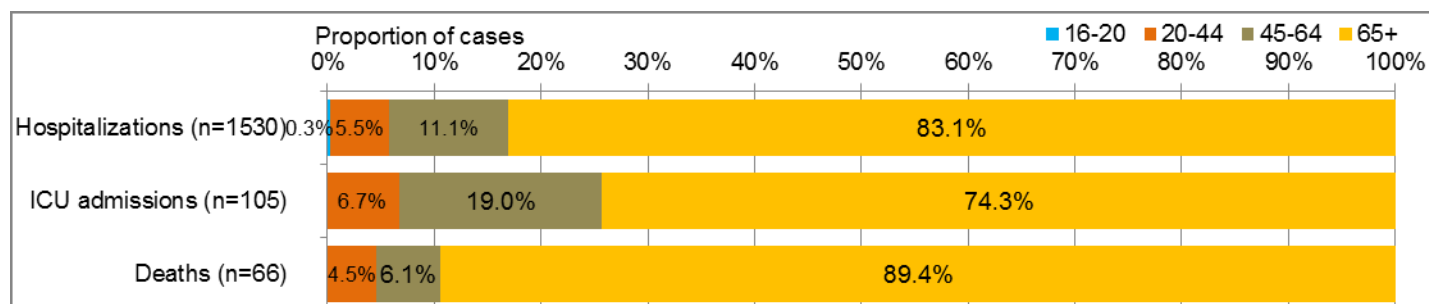
Note: Data for week 46 is based on data collected for 1 day only and do not represent the number of hospitalizations for the entire week.

Figure 9 – Percentage of hospitalizations, ICU admissions and deaths with influenza reported by age-group, Canada, 2014-15

A) Paediatric hospitalizations (≤16 years of age, IMPACT)



B) Adult hospitalizations (≥16 year of age, PCIRN-SOS)



Provincial/Territorial Influenza Hospitalizations and Deaths

In week 05, 292 laboratory-confirmed influenza-associated hospitalizations were reported from participating provinces and territories* which is less than the number reported in week 04 (n=345). Of the 292 hospitalizations, all but four were influenza A, and 73% were in patients ≥65 years of age. Since the start of the 2014-15 season, 4,458 hospitalizations have been reported; 4,368 (98%) with influenza A. Among cases for which the subtype of influenza A was reported, 99.7% (2110/2117) were A(H3N2). The majority of cases (71%) were ≥65 years of age (Table 6). A total of 189 ICU admissions have been reported to date, all with influenza A: 65% (122) were in adults ≥65 years of age and 35% (67) were in adults 20-64 years. A total of 307 deaths have been reported since the start of the season: four children <5 years of age, two children 5-19 years, 21 adults 20-64 years, and 280 adults ≥65 years of age. Adults 65 years of age or older represent 91% of all deaths reported this season. Detailed clinical information (e.g. underlying medical conditions) is not known for these cases.

* Note: Influenza-associated hospitalizations are not reported to PHAC by the following Provinces and Territory: BC, NU, and QC. Only hospitalizations that require intensive medical care are reported by Saskatchewan. ICU admissions are not distinguished among hospital admissions reported from Ontario. Data may also include cases reported by the IMPACT and PCIRN networks. The number of new influenza-associated hospitalizations and deaths reported for the current week may include cases from Ontario that occurred in previous weeks, as a result of retrospective updates to the cumulative total. It is important to note that the hospitalization or death does not have to be attributable to influenza, a positive laboratory test is sufficient for reporting.

Table 6 – Cumulative number of hospitalizations with influenza reported by the participating provinces and territories, Canada, 2014-15

Age groups (years)	Cumulative (24 Aug. 2014 to 07 Feb. 2015)					
	Influenza A				B	Influenza A and B
	A Total	A(H1 pdm09)	A(H3)	A (UnS)	Total	# (%)
0-4	313	2	121	190	4	317 (7%)
5-19	197	0	100	97	7	204 (5%)
20-44	218	1	117	100	10	228 (5%)
45-64	461	2	231	228	15	476 (11%)
65+	3125	1	1490	1634	49	3174 (71%)
Unknown	54	1	51	2	6	60 (1%)
Total	4368	7	2110	2251	91	4459
Percentage¹	98.0%	0.2%	48.3%	51.5%	2.0%	100.0%

¹ Percentage of tests positive for sub-types of influenza A are a percentage of all influenza A detections. UnS: unsubtype: The specimen was typed as influenza A, but no result for subtyping was available.

See additional data on [Reported Influenza Hospitalizations and Deaths in Canada: 2009-10 to 2014-15](#) on the Public Health Agency of Canada website.

Emerging Respiratory Pathogens

Human Avian Influenza

Influenza A(H7N9):

Since the last FluWatch report, 83 new laboratory-confirmed cases of human infection with avian influenza A(H7N9) virus were reported by the World Health Organization. Globally to February 12, 2015, the WHO reported a total of 571 laboratory-confirmed human cases with avian influenza A(H7N9) virus, including 204 deaths.

Documents related to the public health risk of influenza A(H7N9), as well as guidance for health professionals and advice for the public is updated regularly on the following websites:

[PHAC – Avian influenza A\(H7N9\)](#)

[WHO – Avian Influenza A\(H7N9\)](#)

Influenza A(H5N6): Since the last FluWatch report, one new case of human infection with avian influenza A (H5N6) virus from China has been reported by the World Health Organization. Globally to February 12, 2015, the WHO has been informed of a total of three cases of avian influenza A (H5N6) virus, including two deaths.

Middle East Respiratory Syndrome Coronavirus (MERS-CoV)

Since the last FluWatch report, 12 new laboratory-confirmed cases of MERS-CoV have been reported by the World Health Organization. Globally, from September 2012 to February 12, 2015, the WHO has been informed of a total of 977 laboratory-confirmed cases of infection with MERS-CoV, including 359 deaths. All cases have either occurred in the Middle East or have had direct links to a primary case infected in the Middle East. The public health risk posed by MERS-CoV in Canada remains low (see the [PHAC Assessment of Public Health Risk](#)) and for the latest global risk assessment posted by the WHO on February 5, 2015: [WHO MERS-CoV](#)

Documents related to the public health risk of MERS-CoV, as well as guidance for health professionals and advice for the public is updated regularly on the following websites:

[PHAC – Middle East respiratory syndrome coronavirus \(MERS-CoV\)](#)

[WHO – Coronavirus infections](#)

Avian Influenza A(H5)

The Canadian Food Inspection Agency (CFIA) is continuing its investigation into an outbreak of highly pathogenic avian influenza H5N2 virus in British Columbia's Fraser Valley. To date, there have been 11 commercial infected premises and one non-commercial infected premise with H5N2.

On February 7, 2015 an additional non-commercial farm in the Fraser Valley was confirmed to be infected with highly pathogenic avian influenza H5N1. This is the first time the H5N1 strain of the virus has been detected during the current avian influenza outbreak. The CFIA applies the same disease control measures following detections of H5N1 and H5N2. The infected premise is under quarantine, depopulation of the affected birds has been completed and disposal measures are underway. Avian influenza viruses do not pose risks to food safety when poultry and poultry products are properly handled and cooked. Further information on the outbreak is provided on the following CFIA website.

[CFIA - Notifiable Avian Influenza](#)

For the latest Travel Health Notice on Avian Influenza (H5N1) visit the following webpage: [PHAC – Travel Health Notice](#)

International Influenza Reports

[World Health Organization influenza update](#)

[World Health Organization FluNet](#)

[WHO Influenza at the human-animal interface](#)

[Centers for Disease Control and Prevention seasonal influenza report](#)

[European Centre for Disease Prevention and Control - epidemiological data](#)

[South Africa Influenza surveillance report](#)

[New Zealand Public Health Surveillance](#)

[Australia Influenza Report](#)

[Pan-American Health Organization Influenza Situation Report](#)

FluWatch Definitions for the 2014-2015 Season

Abbreviations: Newfoundland/Labrador (NL), Prince Edward Island (PE), New Brunswick (NB), Nova Scotia (NS), Quebec (QC), Ontario (ON), Manitoba (MB), Saskatchewan (SK), Alberta (AB), British Columbia (BC), Yukon (YT), Northwest Territories (NT), Nunavut (NU).

Influenza-like-illness (ILI): Acute onset of respiratory illness with fever and cough and with one or more of the following - sore throat, arthralgia, myalgia, or prostration which is likely due to influenza. In children under 5, gastrointestinal symptoms may also be present. In patients under 5 or 65 and older, fever may not be prominent.

ILI/Influenza outbreaks

Schools: Greater than 10% absenteeism (or absenteeism that is higher (e.g. >5-10%) than expected level as determined by school or public health authority) which is likely due to ILI. Note: it is recommended that ILI school outbreaks be laboratory confirmed at the beginning of influenza season as it may be the first indication of community transmission in an area.

Hospitals and residential institutions: two or more cases of ILI within a seven-day period, including at least one laboratory confirmed case. Institutional outbreaks should be reported within 24 hours of identification. Residential institutions include but not limited to long-term care facilities (LTCF) and prisons.

Workplace: Greater than 10% absenteeism on any day which is most likely due to ILI.

Other settings: two or more cases of ILI within a seven-day period, including at least one laboratory confirmed case; i.e. closed communities.

Note that reporting of outbreaks of influenza/ILI from different types of facilities differs between jurisdictions.

Influenza/ILI Activity Levels

1 = No activity: no laboratory-confirmed influenza detections in the reporting week, however, sporadically occurring ILI may be reported

2 = Sporadic: sporadically occurring ILI and lab confirmed influenza detection(s) with **no outbreaks** detected within the influenza surveillance region†

3 = Localized: (1) evidence of increased ILI* ;
(2) lab confirmed influenza detection(s);
(3) **outbreaks** in schools, hospitals, residential institutions and/or other types of facilities occurring in **less than 50% of the influenza surveillance region†**

4 = Widespread: (1) evidence of increased ILI*;
(2) lab confirmed influenza detection(s);
(3) **outbreaks** in schools, hospitals, residential institutions and/or other types of facilities occurring **in greater than or equal to 50% of the influenza surveillance region†**

Note: ILI data may be reported through sentinel physicians, emergency room visits or health line telephone calls.

** More than just sporadic as determined by the provincial/territorial epidemiologist.*

† Influenza surveillance regions within the province or territory as defined by the provincial/territorial epidemiologist.

We would like to thank all the Fluwatch surveillance partners who are participating in this year's influenza surveillance program.

This report is available on the Public Health Agency website at the following address: <http://www.phac-aspc.gc.ca/fluwatch/index.html>.

Ce rapport est disponible dans les deux langues officielles.