

Seasonal Influenza



Public Health Branch

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Abbreviations

AMMI	Association of Medical Microbiology and Infectious Diseases
BMI	Body Mass Index
CD	Communicable disease
CPL	Cadham Provincial Laboratory
H	Hemagglutinin
IgG	Immunoglobulin G
ILI	Influenza-like illness
IP&C	Infection prevention and control
LTC	Long term care
MDA	Materials Distribution Agency
MHSU	Manitoba Health Surveillance Unit
MOH	Medical Officer of Health
N	Neuraminidase
PHIMS	Public Health Information Management System
RNA	Ribonucleic acid
SDO	Service delivery organization
SH	Shared Health
HCW	Healthcare worker

Summary of Updates

January 2026

The Seasonal Influenza Protocol has been revised to align with the standardized template for provincial communicable disease management protocols and to provide the most current information on seasonal influenza, resulting in significant changes from the previous version (2016). All sections have been reviewed and updated to align with current best practices and to reflect the goals and expectations for seasonal influenza management.

1. Etiology and Background

Influenza is a respiratory infection caused by the influenza virus. Various strains of the virus circulate seasonally throughout the world. There are four types of influenza viruses, types A, B, C and D. Influenza A and B viruses circulate and cause seasonal epidemics of disease (2).

- **Influenza A viruses** are further classified into subtypes according to two surface glycoproteins: hemagglutinin (H) and neuraminidase (N). There are numerous H and N subtypes. Mutations in the genes encoding the H and N glycoproteins during replication result in the constant emergence of new strains of influenza A viruses (3). Currently circulating in humans are subtype A(H1N1) and A(H3N2) influenza viruses.

Animals can also carry and be infected with influenza A viruses. Currently, avian influenza is circulating in birds and mammals globally and is caused by an influenza A H5 virus. Pigs are commonly infected with swine influenza viruses that are usually different from human influenza viruses. Variant influenza virus infections occur when a virus that normally spreads in swine is found in people (2).

- **Influenza B viruses** are not divided into subtypes but two antigenically and genetically distinct lineages of B viruses currently circulate among humans (3). Influenza type B viruses belong to either B/Yamagata or B/Victoria lineage. The influenza B/Yamagata lineage has not been detected anywhere in the world since March 2020 (6).
- **Influenza C virus** is detected less frequently and usually causes mild infections, thus does not present public health importance (2).
- **Influenza D viruses** primarily affect cattle and are not known to infect or cause illness in people (2).

Only influenza type A viruses are known to have caused pandemics. Influenza viruses constantly change. Slow changes are called antigenic drift, which consists of small genetic mutations. These changes to the influenza virus require the influenza vaccines to be updated each year.

Antigenic shift is an abrupt, major genetic change in an influenza A virus, resulting in a new (novel) virus that can infect humans. This can occur when the genetic material from two influenza viruses combine to form a virus with a new subtype (potentially including some from animals). A pandemic can

occur when a novel influenza A virus emerges that infects people, can spread efficiently, and to which people have little or no immunity.

2. Case Definition

Laboratory-Confirmed Case

Laboratory confirmation of infection:

- isolation of influenza virus from an appropriate clinical specimen

or

- demonstration of influenza virus antigen in an appropriate clinical specimen

or

- significant rise (e.g. fourfold or greater) in influenza IgG titre between acute and convalescent sera

or

- detection of influenza RNA (1).

Note: The [Provincial Respiratory Virus Surveillance Dashboard](#) reports laboratory-confirmed cases as outlined in this protocol. Case definitions of ILI and upper respiratory tract infections (URTI) used in LTC and acute care settings may include symptoms of clinical illness and would be different from the case definition in this protocol. Health care providers should refer to [Shared Health \(SH\) Outbreak Management Guidelines](#) for case definitions and follow the IP&C guidance provided by SH or their respective SDO.

3. Reporting and Other Requirements

3.1 Laboratory

All positive laboratory results for influenza are reportable to the MHSU by secure fax (204-948-3044) or electronic transfer. Clinical laboratories are required to submit isolate sub-cultures or primary specimens from individuals who tested positive for influenza virus to CPL within seven days of report, as per instructions from CPL. Influenza specimens from suspected or confirmed outbreaks should be submitted directly to CPL.

3.2 Health Care Provider

There are no specific reporting requirements for health care providers.

3.3 Influenza Outbreaks in Acute Care and Long-Term Care Facilities

Institutional outbreaks are reportable to Public Health and will be documented in the PHIMS Outbreak module by regional CD Coordinators. PHIMS is used as the source of data for provincial outbreak reporting.

Regional/SDO IP&C are required to report all outbreaks in acute care, long-term care and any other setting to regional Public Health. Information regarding the outbreak(s) will be reported to the regional communicable disease coordinator(s) and/or MOH at the onset of an outbreak and when the outbreak has been declared over. Regional processes should be established regarding frequency of outbreak reporting/updates and additional notification requirements.

Refer to the Provincial Population and Public Health Standard Operating Procedure: [Documentation of Outbreaks in PHIMS](#).

For infection prevention and control outbreak definitions, and for guidelines for outbreak management of respiratory illness in Acute and Long Term Care settings, refer to: [IP&C outbreak management guidelines](#).

4. Epidemiology

4.1 Reservoir

Humans are the only known host for influenza types B and C viruses. Influenza A may infect both humans and animals (4). Influenza D viruses primarily affect cattle (2).

4.2 Transmission

The primary transmission route is person-to-person transmission through large respiratory droplets when infected persons cough or sneeze (3, 4). Transmission may also occur through direct or indirect contact with respiratory secretions (e.g., touching surfaces contaminated with influenza virus and then touching the eyes, nose or mouth). Aerosol transmission of small droplets may also transmit influenza, particularly during aerosol-generating medical procedures (AGMPs) (4). Individuals with asymptomatic infection can transmit virus to susceptible individuals (e.g., asymptomatic health care worker to patient/resident/client and vice versa) (9). Human influenza viruses may persist for hours on solid surfaces, particularly in lower temperatures and lower humidity (3).

4.3 Occurrence

There are around a billion cases of seasonal influenza globally annually, including 3–5 million cases of severe illness, and 290 000 to 650 000 respiratory deaths (2). For global influenza surveillance, refer to the following link: [Global Influenza Surveillance and Response System \(GISRS\)](#)(8).

For information on respiratory virus activity in the general population in Canada, refer to: [Flu \(influenza\): Monitoring through FluWatch - Canada.ca](#). The FluWatch program is a surveillance system consisting of virological surveillance, influenza and ILI activity level surveillance, syndromic surveillance, outbreak surveillance, severe outcome surveillance and vaccine monitoring. Data are provided by sentinel laboratories, provincial and territorial ministries of health, hospitals, primary care providers and volunteer Canadians (10). Refer to: [Overview of influenza monitoring in Canada - Canada.ca](#) for more information (11). Additionally, weekly viral respiratory infection data, based on

patients admitted among 70 participating acute care hospitals in ten provinces and one territory, is available at: [Viral respiratory infections: The Canadian Nosocomial Infection Surveillance Program \(CNISP\) — Canada.ca](#) (5).

For cases reported in Manitoba, refer to: [Respiratory Surveillance | Health | Province of Manitoba](#). The Provincial Respiratory Virus Surveillance Report provides current data and surveillance information on influenza and COVID-19 in Manitoba. The dashboard includes case counts and trends, severe outcomes, test volumes/test positivity, outbreaks, syndromic data, and vaccine monitoring. Refer to the [technical notes](#) for detailed definitions and data source information (12).

5. Clinical Presentation and Natural History

Influenza virus infection causes a wide spectrum of illness, from asymptomatic to severe. Most people recover within 7 to 10 days. However, severe illness can develop, which can result in hospitalization or death.

Clinical illness defined as influenza-like illness (ILI) is characterized by the acute onset of respiratory illness with fever and cough and with one or more of the following: sore throat, arthralgia (joint pain), myalgia (muscular pain), prostration (extreme exhaustion). In children under 5 years of age, gastrointestinal symptoms (e.g., nausea, vomiting, diarrhea) may also be present. In those under 5 years of age, or 65 years of age and older, fever may not be prominent (1).

Cough associated with influenza is often severe and can last two or more weeks (3). Some individuals may have lingering asthenia (lack of strength or energy) for several weeks (4).

Illness associated with novel influenza viruses may present with other symptoms (1).

More common complications of influenza include secondary bacterial pneumonia (e.g., *Streptococcus pneumoniae* or *Staphylococcus aureus*), exacerbations of underlying respiratory conditions, otitis media, laryngotracheobronchitis, and bronchitis. Other complications may include primary pneumonia, encephalitis, aseptic meningitis, transverse myelitis, myocarditis, pericarditis, Guillain-Barré syndrome, and Reye Syndrome. Reye syndrome is a complication that occurs almost exclusively in children taking aspirin, primarily in association with influenza B virus (or varicella zoster virus), and presents with severe vomiting and confusion, which may progress to coma due to swelling of the brain. Most deaths due to influenza typically occur among persons age 65 years and older (4).

The people at high risk of influenza-related complications or hospitalization include:

- adults 65 years of age and older
- children younger than 5 years of age
- pregnant people
- adults and children with the following chronic health conditions:
 - cardiac or pulmonary disorders
 - diabetes mellitus and other metabolic diseases
 - cancer and other immunocompromising conditions due to underlying disease or therapy

- renal disease
- anemia or hemoglobinopathy
- neurologic or neurodevelopmental conditions
- class 3 obesity (defined as BMI of 40 kg/m² and over)
- children up to 18 years of age undergoing treatment for long periods with acetylsalicylic acid
- people of any age who are residents of personal care homes and other long-term care facilities.
- Indigenous Peoples (6).

5.1 Incubation Period

The incubation period is usually two days but ranges from one to four days (3,4).

5.2 Period of Communicability

Adults may be able to spread influenza to others from the day before symptoms start to approximately 5 days after symptoms start. Children and people who are immunocompromised may be infectious for longer (6).

5.3 Susceptibility

5.3.1 Host susceptibility

Susceptibility depends upon several factors, including natural or vaccine-induced levels of protective immunity in the population, the age and health condition of the population, and the properties of the influenza viruses, including antigenicity and pathogenicity, as well as transmissibility (3).

5.3.2 Vaccine efficacy and effectiveness

Influenza vaccine has been shown in randomized controlled clinical trials to be efficacious in providing protection against influenza infection and illness. However, the effectiveness of the vaccine can vary from season to season and by influenza vaccine strain type and subtype. Influenza vaccine effectiveness depends on how well the vaccine strains match with circulating influenza viruses, the type and subtype of the circulating virus, as well as the health and age of the individual receiving the vaccine (13).

Antibody response after vaccination depends on several factors, including the age of the recipient, prior and subsequent exposure to antigens, and the presence of immune compromising conditions. Protective levels of humoral antibodies, which correlate with protection against influenza infection, are generally achieved by 2 weeks after vaccination; however, there may be some protection afforded before that time (13).

During seasonal epidemics, much of the population has partial protection because of earlier infections from related viruses and/or vaccine. Vaccine-induced protection may result from the boosting of

previously acquired antibodies or elicitation of new antibodies that effectively neutralize circulating viruses (3).

6. Testing and Diagnosis

Influenza may be clinically indistinguishable from disease caused by other respiratory viruses, such as rhinovirus, respiratory syncytial virus, parainfluenza, adenovirus, severe acute respiratory syndrome coronavirus 2, and other pathogens (3). During influenza season, viral testing should be considered for individuals with ILI only if the results might influence clinical management or were specifically requested as part of active formal surveillance systems.

If an unusual or highly virulent form of influenza is suspected, the lab and ultimately CPL should be notified prior to sample submission and the suspicious circumstances indicated on the CPL requisition (e.g. poultry worker with ill birds). CPL can determine whether a detected influenza virus is type A or B. Hemagglutinin antigen determination is also available, but may not be routinely performed (e.g., H1 or H3). Variant typing is currently conducted on a subset of positives in cooperation with the National Microbiology Lab in Winnipeg. Antiviral drug resistance testing is available after consultation with CPL.

Laboratory confirmation of influenza virus infection can be done by several methods. Currently the most sensitive and specific test for the rapid detection of influenza viruses is the reverse transcription polymerase chain reaction (RT-PCR) assay for the detection of virus-specific ribonucleic acid (RNA) sequences from nasopharyngeal secretions from a flocked swab or aspiration; tracheal aspirate or bronchoalveolar lavage fluid (3). Refer to the SH [Respiratory Virus Specimen Collection](#) document.

Ideally, respiratory specimens should be collected as early in the illness as possible. Virus shedding generally starts to wane by the third day after onset of symptoms. In most cases, virus is not detected after 5 days in adults, depending upon the testing method, although virus shedding can occur for longer in children and immunocompromised individuals (3).

7. Control

7.1 Management of Cases

Public health follow-up is not required for individual cases. General advice for individuals in the community with respiratory symptoms is to remain at home until they are well enough to resume normal activities and have been afebrile for at least 24 hours without the use of fever-reducing medication. Individuals at high risk of severe illness (refer to [section 5](#)) should consult their health care provider to determine whether testing and antiviral treatment are recommended. Additional precautions to prevent transmission (refer to [section 7.6.2](#)) to those at higher risk of severe illness are recommended to continue until all symptoms have resolved.

7.2 Management of Cases in Health Care Settings

[Routine Practices](#) are the foundation for preventing the transmission of microorganisms during care and are always required in all health care settings with all patients/residents/clients. In addition, droplet and contact precautions are required for the management of patients/residents/clients with seasonal influenza in acute and long-term care settings. Refer to the SH [respiratory virus season IP&C planning and response](#) document for further guidance (15).

Note: Airborne precautions in addition to droplet and contact precautions are indicated for the management of avian influenza (refer to: [Notice: Interim recommendations for infection prevention and control of avian influenza in healthcare settings - Canada.ca](#)) and pandemic influenza in all health care settings (refer to 6.2 of [Annex F: Prevention and Control of Influenza during a Pandemic for All Healthcare Settings](#)).

Health Care Workers: Health care settings may have specific requirements for workers. Further information is available here: [Occupational Health Services - Shared Health](#).

7.3 Treatment of Cases

Antiviral medications to reduce influenza morbidity and mortality are recommended for people with influenza symptoms in high-risk groups or who are severely ill. Detailed antiviral recommendations for specific populations (e.g., children and youths, adults with renal impairment) are available from the Association of Medical Microbiology and Infectious Diseases Canada (AMMI) at <https://ammi.ca/en/resources/> and from the Canadian Paediatric Society at: [The use of antiviral drugs for influenza: Guidance for practitioners | Canadian Paediatric Society](#) (18). Consultation with Pediatric Infectious Diseases is recommended for antiviral treatment or prophylaxis of children less than 1 year of age. Salicylates should not be given to children and adolescents because it may increase the risk for developing Reye's syndrome (4).

Decisions to initiate antiviral treatment for individuals with suspected influenza should not be delayed pending laboratory confirmation. If indicated, empiric antiviral treatment should be started as soon as possible, ideally within 48 hours of symptom onset. However, treatment may still be considered beyond 48 hours, particularly if symptoms worsen or if the individual requires hospital admission.

At present, only two neuraminidase inhibitors are available for use in Manitoba through MDA for the purpose of outbreak management in high-risk settings: oseltamivir (Tamiflu®), which is available in capsule form, and zanamivir (Relenza®), which is available only as an inhaled powder for oral inhalation. These two drugs are licensed and commonly used for the treatment and prevention of seasonal influenza. Additional antiviral drugs may become available in the future through MDA. Although amantadine remains licensed in Canada, it is no longer recommended due to high rates of resistance observed among circulating influenza A viruses (16).

7.4 Management of Contacts

Routine antiviral chemoprophylaxis for asymptomatic contacts in community settings is not recommended (17). Use of antiviral chemoprophylaxis may be considered in outbreak management within facility settings (refer to [section 7.5](#)).

Refer to Appendix D of AMMI guidelines for guidance on when to provide chemoprophylaxis or early treatment ([Use of antiviral drugs for seasonal influenza: Foundation document for practitioners](#)).

7.5 Outbreak Management in High-Risk Settings

LTC residents are vulnerable to infection with influenza due to communal living, behavioral factors, shared spaces, and transit between other healthcare facilities. Older adults and those with pre-existing medical conditions are also at risk of more severe disease and have higher mortality when infected with influenza.

For influenza outbreaks in Acute and LTC settings refer to the [IP&C outbreak management guidelines](#), including the outbreak management quick reference: [outbreak-management-qrg.pdf](#). The decision on whether an institutional outbreak definition has been met may be reached by IP&C in consultation with Infectious Diseases physicians, MOH or Epidemiologists as needed (14). Situations which do not meet the outbreak definition can be discussed with regional MOH or IP&C physician/designate to determine if oseltamivir is indicated.

7.5.1 Antiviral Treatment During Institutional Outbreaks

All symptomatic patients/residents/clients with laboratory-confirmed virus infection should be treated with an appropriate influenza antiviral medication. After one case of laboratory-confirmed influenza has been detected, all other symptomatic cases should be considered for treatment where appropriate (21). Recovered patients/residents/clients with prior, laboratory-confirmed influenza A or B during the outbreak in question do not require treatment.

When an outbreak has been declared in an institution, oseltamivir treatment is supplied to patients/residents/clients through the provincial vaccine warehouse (refer to [section 7.5.3](#)).

7.5.2 Antiviral Chemoprophylaxis during Institutional Outbreaks

When an outbreak is declared, unless contraindicated, antiviral chemoprophylaxis:

- Is recommended for all potentially exposed patients/residents/clients who have not had ILI, regardless of influenza vaccination history (21, 22). Facility-specific factors such as physical layout and resident interactions should also be considered. Recovered patients/residents/clients with prior, laboratory-confirmed influenza A or B during the outbreak in question do not require prophylaxis.
- May be considered for all unimmunized and recently immunized (within 14 days) HCWs who provide care to people at high risk of complications (21, 22).

- May be considered for HCWs, regardless of vaccination status during outbreaks with strains for which the current vaccine is not well matched (23).

The responsibility for the prescribing and provision of chemoprophylaxis to HCWs resides with the institution and/or individual regional health authority.

Asymptomatic adult patients/residents/clients with creatinine clearance greater than 60 mL/min should receive oseltamivir 75 mg once daily for 10 days or until the outbreak is determined to be over, whichever occurs first. For detailed dosing guidance, including adjustments for renal impairment refer to *Table 2: Oseltamivir and zanamivir treatment of influenza* and *Table 3: Recommended oseltamivir regimens for prevention and treatment of patients with renal impairment* of the AMMI guidance- [Use of antiviral drugs for seasonal influenza: Foundation document for practitioners](#).

If the outbreak is not over after 10 days, the regional MOH or IP&C physician/designate should be consulted to see if prophylaxis should continue.

Patients/residents/clients or HCWs receiving chemoprophylaxis who develop ILI should be assessed and tested to determine the cause of their illness, which may be due to the current virus, another viral agent or an oseltamivir-resistant influenza virus. Expert consultation is suggested to address the cause, organize testing for neuraminidase inhibitor resistance, and to assess the possible need to switch to another neuraminidase inhibitor (24). To limit the potential transmission of antiviral drug-resistant influenza virus, measures should be taken to reduce the contact between ill persons taking antiviral drugs for treatment and other persons, including those receiving antiviral chemoprophylaxis (25).

When an outbreak has been declared in an institution, oseltamivir prophylaxis is supplied to patients/residents/clients through the provincial vaccine warehouse (refer to [section 7.5.3](#)).

7.5.3 Ordering Antiviral medications

In pre-outbreak settings, oseltamivir may be obtained through regular drug procurement channels.

Once an outbreak has been declared, oseltamivir can be ordered by the facility Medical Director, Infectious Diseases Specialist, the regional MOH or IP&C physician/designate through the provincial vaccine warehouse.

Facilities located **within Winnipeg** must order oseltamivir directly from the provincial vaccine warehouse. Facilities located **outside of Winnipeg** need to be aware of where pre-positioned oseltamivir is located within their region and use that supply BEFORE ordering from the provincial vaccine warehouse, especially for after hours requests. Facilities located outside of Winnipeg are responsible for arranging procurement from the site with pre-positioned oseltamivir. Refer to Table 1 below for guidance on ordering oseltamivir from the provincial vaccine warehouse, based on facility location.

Table 1: Ordering oseltamivir in outbreak settings

Scenario	Contact Method	Information Required	Follow-up
Winnipeg - Regular Hours (8am-4pm)	Email: vacmda@gov.mb.ca Subject: URGENT Antiviral Order-[Facility Name]	<ul style="list-style-type: none"> Facility name Holding point code Quantity (boxes of 10 capsules) Destination address 	Confirm by phone: 204-948-1333 or 1-855-683-3306
Winnipeg - After Hours	Call: 204-805-4096 (leave voicemail if unanswered)	<ul style="list-style-type: none"> Caller's name and phone Facility name Holding point code Indicate outbreak response Quantity Destination address Approval from ordering provider 	N/A
Outside Winnipeg-Urgent	Use pre-positioned stock first. If critical shortage: follow Winnipeg-After Hours process	Same as above	N/A
Outside Winnipeg-Stock Replenishment	Email: vacmda@gov.mb.ca Subject: ANTIVIRAL ORDER- Stock Replenishment	<ul style="list-style-type: none"> Facility name Holding point code Quantity Destination address 	Confirm by phone: 204-948-1333 or 1-855-683-3306

Note: Product supplied in boxes of 10 capsules (75 mg or 30 mg). Indicate number of boxes required.

7.5.4 Management of Simultaneous COVID-19 and Influenza Outbreaks

In facility outbreaks, more than one respiratory pathogen may be detected. Consider the following guidance to assist with management of symptomatic individuals when both COVID-19 and influenza are identified during an outbreak:

- Send a swab for PCR testing for both COVID-19 and influenza.
- While results are pending, provide influenza antiviral therapy.
 - If positive for influenza and negative for COVID-19, continue influenza antiviral therapy as indicated.
 - If negative for influenza and positive for COVID-19, discontinue influenza antiviral therapy and consider COVID-19 antiviral therapy as indicated.

- If positive for both influenza and COVID-19, consider COVID-19 antiviral therapy and provide influenza antiviral therapy as indicated (note that whether significant drug-drug interactions occur with co-administration is presently uncertain).
- If negative for both influenza and COVID-19 but respiratory disease is continuing or progressing, further diagnostic testing and clinical consultation may be considered before influenza antiviral therapy is discontinued (19).

7.6 Preventive Measures

7.6.1 Immunization

The influenza vaccine has been shown to reduce doctor visits, hospitalizations, and deaths due to influenza, especially for those at higher risk of severe influenza illness. Influenza immunizations are encouraged and available annually for all people in Manitoba 6 months of age and older (20). For further information on recommendations and eligibility requirements refer to: [Seasonal Influenza \(Flu\) Vaccines and Eligibility | Health | Province of Manitoba](#).

Additionally, individuals whose occupational or recreational activities place them at increased risk of exposure to avian influenza A(H5N1) viruses are advised to receive the seasonal influenza vaccine annually. This may help reduce the risk of co-infection with both seasonal influenza and avian influenza A(H5N1) viruses, which could otherwise lead to a viral reassortment and the emergence of a human-transmissible strain with pandemic potential (13).

7.6.2 Additional Preventive Measures

There are general preventive measures that can be taken to limit the spread of seasonal influenza:

- Staying home when ill. When ill, individuals should avoid close contact with others, especially people at higher risk of severe illness or complications from a respiratory infection and avoid non-essential visits to high-risk settings (e.g. healthcare facilities, personal care homes).
- Practicing good hand hygiene by washing hands with soap and water (minimum of 15 seconds) or using an alcohol-based hand sanitizer.
- Practicing respiratory etiquette by covering coughs and sneezes and considering masks as an added layer of protection (posters for public display are available here: [Province of Manitoba | Vaccine-Preventable Respiratory Illnesses](#)).
- Cleaning and disinfecting surfaces and objects that are frequently touched by many people.
- Improving air ventilation in indoor spaces.

8 Key Investigation Components for Public Health Response

Influenza does not typically require routine public health intervention. In low-risk community settings, individual case management, contact tracing, and outbreak response are not required. Management of settings with high numbers of respiratory illness/high absenteeism should follow general advice on

community measures to decrease transmission. Settings such as schools and daycares may connect with public health for guidance when absenteeism rates are higher than expected. Note that absenteeism rates have been influenced by the additional impact of COVID-19 on top of the typical pre-pandemic circulating respiratory viruses, along with recommendations to stay home when sick. As a result, there is not a specific threshold for concern about absenteeism, but rather a change in what has been observed.

9. Documentation Guidelines and Resources

Individual case and contact documentation are not required.

For surveillance purposes, MHSU will enter influenza lab-confirmed reports and assign to service delivery organizations.

Upon declaration of an outbreak (i.e., in high-risk community settings such as in acute care and long-term care facilities) regional Public Health (i.e. CD Coordinator) is responsible for documenting the influenza outbreak in the PHIMS Outbreak module (7). For the process of outbreak documentation and the required data elements, refer to the Provincial Population and Public Health Standard Operating Procedure: [Documentation of Outbreaks in PHIMS](#).

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