Protecting Infants Against RSV

A first year review of nirsevimab implementation in Québec and Ontario

Prepared by

RSV Awareness Consortium

In collaboration with the Society for Intelligence Management (SIM) Canada

March 2026

Support for this report was made possible through an educational grant from Sanofi Canada.

About the RSV Awareness Consortium

The RSV Awareness Consortium is a collaborative of health advocates, including non-governmental organizations, dedicated to spreading evidence-based knowledge. Our goal is to drive meaningful change across Canada by investing in both individual and societal health literacy, encouraging critical thinking and empowering people to make informed, independent decisions.

Our mission is to prevent RSV through proactive education, targeted outreach, and strong community support. We are committed to delivering accurate, unbiased information that helps individuals take charge of their health. To learn more about the consortium, visit https://rsvawareness.ca/.

About the Society for Intelligence Management

The Society for Intelligence Management (SIM) is an independent association that promotes evidenced-based knowledge translation, education and training, communication, and decision making. Its mandate is to ensure that the flow of information is accurate, reliable, and contributes to informed decision-making in a rapidly evolving world. To learn more about SIM, visit https://intelsociety.org/.

About this Report

This report synthesizes the current evidence on infant respiratory syncytial virus (RSV) immunization and summarizes Québec and Ontario experiences with implementing a universal program for infants. The objective of this report is to inform Canadian policymakers and health system managers who would benefit from a first year analysis to identify opportunities for evidence-informed public health strategies that support Canada's effort to control RSV in infants.

All stakeholders involved in RSV immunization should have access to new knowledge and innovative approaches that can strengthen prevention efforts.

Methodology

Advisory board meetings were held in 2025 in Montreal and Toronto with health professionals including neonatal nurse practitioners, family physicians, pediatricians, hospitalists, and community health representatives. The Montreal meeting was guided by five implementation domains: 1) **governance and leadership**; 2) **funding and reimbursement**; 3) **logistics, demand and distribution**; 4) **awareness and education**; and 5) **surveillance, impact and monitoring**. Analysis used an inductive approach; peer-reviewed manuscripts from the Toronto meeting provided additional information on Ontario program implementation.

Acknowledgements

Support for this report was made possible through an educational grant from **Sanofi Canada**.

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Infant RSV Program Policy Highlights

The inaugural 2024–25 nirsevimab programs in Québec, Ontario, Nunavut, Northwest Territories and Yukon represented a significant commitment to infant health, establishing a strong foundation for universal RSV prevention. Building on this initial success, there are opportunities to further refine these policies to minimize the impact of lower respiratory tract infections (LRTIs) and reduce hospital strain. By focusing on the following strategic pillars, the provinces can enhance the resilience and reach of their immunization framework:

- **Optimal Timing and Planning:** Aligning program start dates with the onset of the respiratory season ensures that infants receive timely protection while allowing for comprehensive clinical and educational planning.
- **Empowering Through Education:** Continuing to develop and disseminate consistent, high-impact educational resources across all healthcare settings, including prenatal programs and community clinics, will foster greater confidence and awareness among both families and clinicians.
- **Strengthening Community Access:** Optimizing distribution logistics to ensure birthing centers and community clinics have seamless, year-round access to doses, while expanding 'catch-up' opportunities in community care environments to reach all eligible infants.
- **Advancing Data-Informed Care:** Enhancing the integration of digital health records to better support newborn and newcomer populations. Investing in granular, real-time data will further enable the province to identify demographic gaps and drive evidence-based improvements.
- **Collaborative Innovation:** Facilitating ongoing dialogue and knowledge-sharing between regional health authorities and frontline providers to elevate best practices and build a more responsive provincial program.

Report

Introduction: The Threat of RSV

Respiratory syncytial virus (RSV) is a common and highly contagious respiratory virus that infects the lungs and breathing passages. Nearly all children will have been infected with RSV by the age of two (Daniels, 2024). While RSV can affect people of all ages, causing mild, cold-like symptoms in healthy adults and older children, it poses a significant health risk to healthy infants and young children and is the leading contributor to hospitalization among infants in North America (Li, 2022; NACI, 2024; Schanzer, et al., 2006).

RSV places a $66 million annual strain on the Canadian healthcare system, with infants under six months accounting for nearly half of those costs (Vadlamudi et al., 2025).

For infants, especially those under 8 months, premature babies, and those with underlying heart or lung conditions or weakened immune systems, RSV can lead to severe illness and potentially life-threatening

complications, including bronchiolitis,[1] pneumonia,[2] long-term lung issues such as recurrent asthma and wheezing later in childhood, dehydration and apnea that can lead to reduced fluid intake and pauses in breathing, particularly in very young infants (Abrams et al., 2024; Baraldi et al, 2022). Preterm infants in particular face a high burden or RSV-associated disease, accounting for 25% of hospitalizations (Wang et al., 2024). Preterm infants <28 weeks gestational age and infants with Down syndrome are at high risk of RSV infection throughout their first two years of life (Paramo et al., 2025).

Other risk factors for severe RSV disease in infants include chronic lung disease (e.g., bronchopulmonary dysplasia), cystic fibrosis with respiratory involvement, hemodynamically significant chronic cardiac disease, or compromised immune systems. However, 80% of hospitalized infants were previously healthy, underscoring that RSV is a threat to all term infants, not just those with high-risk conditions (Pisesky et al., 2016; Abrams et al., 2024; Vadlamudi et al., 2025).

In Canada, every winter, pediatric hospitals experience a wave of admissions linked to RSV, representing a major burden for the healthcare system due to the volume of hospitalizations, ICU admissions, and associated costs. Approximately 10%–20% of infants born in Canada seek medical care for RSV, often surpassing medically attended influenza cases (Abrams et al., 2024). Of all RSV-related hospitalizations in Canadian pediatric hospitals, almost a quarter will require admission to intensive care units (ICU) (Bourdeau et al., 2023). Of these ICU admissions, nearly half are infants under six months of age. Infants aged 0–5 months hospitalized with RSV have a higher likelihood of ICU admission or a hospital stay longer than 7 days (Abrams et al., 2024). Respiratory failure, in the most severe cases, necessitates advanced medical interventions such as intubation and mechanical ventilation (Peña-López, et al., 2024).

In Québec, annual RSV outbreaks are responsible for the majority (64%) of hospitalizations in children under 2 during the winter season (Papenburg et al., 2012). Common length of hospital stay is 4 days for infants 0–2 months and 3–5 months old, and 3 days for babies 6–11 months and 12–24 months old (NACI, 2024). RSV seasonality can vary between geographical regions[3] in the province and from year to year (see Tables 1 and 2 and Graph 1). Infants born in remote areas such as Nunavik often face difficult housing conditions, household crowding, and exposure to second-hand smoke, which are risk factors for severe RSV disease. Barriers to accessing timely medical care due to the vast geography of the province and the availability of transportation to children's hospitals are challenges that can delay treatment and lead to additional complications (INESSS, 2024). The cost of medical air transport is very expensive and involves medical risks for a young child. The potential for severe health outcomes makes preventative measures such as providing access to monoclonal antibody treatments such as nirsevimab a crucial strategy for protecting this vulnerable population during RSV season (Canadian Paediatric Society, 2024).

Similarly to Québec, the burden of RSV among infants born in Ontario has increased (Pisesky et al., 2016; Goyette et al., 2025). Historically, the provincial burden has been substantial, with 1% to 2% of all infants requiring hospital admission annually (Jorgensen et al., 2024). This risk is most acute among those under six months of age; furthermore, of all infants hospitalized with RSV, between 5% and 12% require escalation to ICU for respiratory support (Paes et al., 2024).

1 Bronchiolitis is an inflammation of the small airways in the lungs, which can cause congestion and make breathing difficult. It is a very common complication of RSV in infants and young children.
2 Pneumonia is an inflammatory condition of the lung. RSV can lead to an infection and inflammation of the lungs.
3 Seasonality of RSV in urban cities in Québec is from September to April whereas RSV seasons can last until June in northern and remote areas.

A New Tool with Proven Real-World Results

RSV prevention programs using passive immunization have been in use in Canada since 2002; most notably in Nunavik (KilliKelly et al., 2025; Robinson and Papenburg, 2025). These programs prioritized the protection of infants at highest risk of severe RSV disease. The approval of nirsevimab, a neutralizing long-acting monoclonal antibody that prevents RSV infection, by Health Canada in April 2023 provided an opportunity to expand protection to a broader birth cohort. In May 2024, the National Advisory Committee on Immunization (NACI)[4] recommended universal programs to provide vulnerable infants with equitable and preferential access to newer, longer-lasting protection against RSV.

Real-world evidence has since been definitive showing nirsevimab to be highly effective at preventing disease and associated acute respiratory illness (ARI) (Sun et al., 2023; Xu et al., 2025; Simões et al, 2023; Perramon-Malavez et al., 2025; Orsi et al., 2024; Lastrucci et al., 2025). Recent research has uncovered that infant hospitalizations due to RSV-related lower respiratory tract infections (LRTI) were 85.9% lower among infants immunized with nirsevimab in their first RSV season and 55.3% lower in their second season (Razzini et al., 2026). Analysis of Québec's inaugural RSV infant immunization program found RSV-associated hospitalization declined by 66% and effectiveness against RSV-associated emergency admission and intensive care admission was measured to be as high as 86% and 88% respectively (Carazo et al., 2025; Bemmo et al., 2025).

66%	86%	88%
Decline in RSV-associated hospitalizations (Québec)	Effectiveness against emergency admission	Effectiveness against intensive care admission

Source: Carazo et al., 2025; Bemmo et al., 2025

Québec was among the first jurisdictions[5] to offer a universal RSV infant immunization program. Ontario was the second province to provide a comprehensive nirsevimab program and the first to offer prophylaxis maternal vaccination as a secondary option of prevention. Health Canada has since approved the use of clesrovimab in February 2026, further broadening RSV prevention options for Canadians.

RSV Infant Immunization Policy in Québec

The Québec health and social services network is organized into three main levels: 1) **central level**, which consists of the Ministère de la Santé de des Services Sociaux (MSSS), responsible for strategic functions such as allocating budgetary resources and evaluating health, social services, and public health; 2) **regional level**, which is composed of Santé Québec, the Centres intégrés de santé et de services sociaux (CISSS) and the Centres intégrés universitaires de santé et de services sociaux (CIUSSS). These regional entities are responsible for the management and delivery of health services within their territories. The public health services are typically managed at this level through a Direction de santé publique (Public Health Directorate) within each CISSS or CIUSSS; and 3) **local level**, which includes the various physical facilities (installations)

4 The National Advisory Committee on Immunization (NACI) is a national advisory committee of experts that provide guidance on the uses of vaccines approved by Health Canada.
5 The other province to offer nirsevimab through a universal program was Ontario. Since the fall of 2024, Nunavut, Northwest Territories and Yukon also provide universal immunization for infants against RSV.

such as hospitals, CLSCs (Local Community Services Centres), long-term care facilities, and other service points.

In addition to these three levels, there are other provincial organizations that fall under the responsibility of the MSSS, such as l'Institut national de santé publique du Québec (INSPQ), a public health expert body that provides scientific and technical support to the MSSS, the Institut national d'excellence en santé et services sociaux (INESSS)[6], la Régie de l'assurance maladie du Québec (RAMQ), which manages the Québec Health Insurance Plan, and Héma-Québec, the blood supplier for the province, and others.

Following the federal approval of nirsevimab, a technical review was completed by Québec's INESSS, which provided the MSSS with guidance on the use of nirsevimab in May 2024 (INESSS, 2024). In addition to INESSS's technical review, the Comité sur l'immunization du Québec (CIQ), Québec's expert group on immunization, recommended nirsevimab for infant RSV immunization also in May 2024 (CIQ, 2024). The MSSS announced a universal nirsevimab immunization program would be implemented for all infants born as of October 1, 2024.[7] Indication for nirsevimab administration also included infants under six (6) months of age at the start of the RSV season, and infants under eight (8) months of age at the start of the RSV season who had not already received it and who had a health condition or risk factors that increased their risk of infection (see Table 3 for list of health conditions and risk factors) (Gouvernement du Quebec, Programme immunisation, 2024).

A catch-up program was also available for vulnerable infants less than 19 months of age on October 1st and entering their second RSV season (see Table 4 for list of health conditions). For infants with vulnerable conditions, the administration of nirsevimab is required even if the mother received an RSV vaccine during pregnancy.[8] The authorized dose of nirsevimab at the beginning or during the first season is 50 mg for children weighing less than 5 kg and 100 mg for those weighing 5 kg or more (MSSS, Protocole immunisation Quebec, 2024). It is 200 mg for the second season, regardless of the child's body weight. Dosage and timing of immunization aligned with Health Canada product indication.

Several policy issues were considered in the decision to publicly fund nirsevimab in Québec. The burden of severe RSV disease in infants posed a substantial socio-economic strain on Québec families and health system (INESSS, 2024; Papenburg et al., 2020). The need to protect all infants from severe RSV disease was a growing concern among healthcare providers and parents who faced the possibility of re-hospitalizing premature infants who become ill. The emotional and psychological repercussions on parents and siblings was considered substantial, particularly for families in rural and remote communities (Alessandrini et al., 2025).

The potential additional benefits associated with reducing hospitalizations caused by RSV such as freeing up hospital and other medical resources such as staff that can be diverted to other patient populations, and providing more equitable healthcare to vulnerable infants in rural and remote communities were prioritized over the substantial initial costs associated with a universal nirsevimab program in the province (INESSS, 2024). Public knowledge and acceptance of nirsevimab was an important component for achieving high uptake with the nirsevimab program. Parental knowledge on RSV varies in Québec. Knowledge on RSV disease and the risks posed to infants appears to be common and there is general acceptance about the need to prevent illness in newborns through immunization (Bracht et al., 2023; Gagnon et al., 2025; McClymont et al., 2025). However, persistent knowledge gaps about RSV prevention appear to drive hesitancy (Baumgartner et al., 2025).

6 INESSS is a government agency that promotes the efficient use of resources in the health and social services sector. https://www.inesss.qc.ca/en/about-us/about-the-institut.html
7 The program ended April 1, 2025.
8 Maternal vaccination against RSV is available in Québec but not offered through the public program.

RSV Infant Immunization Policy in Ontario

In 2024–2025, Ontario pivoted from a targeted approach to a universal strategy, prioritizing nirsevimab for all infants born on or after April 1, 2025, as well as for high-risk children up to 24 months of age[9] (Ontario Ministry of Health, 2025). While the National Advisory Committee on Immunization (NACI) and Ontario provincial guidelines preferentially recommend infant immunization with nirsevimab, Ontario also publicly funded maternal vaccination as an alternative. Prophylaxis maternal vaccination is available to individuals between 32 and 36 weeks of gestation who will deliver during the RSV season, providing passive immunity to the newborn (Ontario Ministry of Health, 2025).

Québec RSV Infant Immunization Program

Infant RSV Program Implementation

The RSV infant immunization program was planned and coordinated by the MSSS and according to INESSS reimbursement criteria for defining the program's start and end dates using public health indicators, as well as establishing the scope and eligibility criteria for the nirsevimab program. Nirsevimab was integrated into the Protocole d'Immunisation du Québec (PIQ)[10] and its immunization calendar, ensuring awareness among healthcare providers through guidance documents and webinars. A single point of contact was established at the Ministry to handle inquiries about the program.

At the regional level, Santé Québec coordinated two main streams for program administration: 1) hospitals and birthing centers where a single dose of nirsevimab was administered before hospital discharge; and 2) CLSCs and local points of service for catch-up immunization of infants born between April and October 2024. Appointments for community immunization at local points of service are managed via the Clic Santé portal. The Centre intégré de santé et de services sociaux (CISSS) and Centre intégré universitaire de santé et de services sociaux (CIUSSS), such as pharmacists or vaccination program managers, acted as liaisons between hospitals, public health units, CLSCs (Local Community Service Centers), and the MSSS. These regional bodies also developed their own guidelines for consistent implementation. Hospitals and CLSCs adhered to the PIQ guidelines, with CLSCs not requiring a prescription for eligible individuals. The CISSS/CIUSSS were responsible for managing and allocating the necessary funding and resources within their respective regions to support the program's implementation in hospitals and CLSCs.

Infant RSV Program Logistics and Distribution

The MSSS managed the allocation of doses to public health regions. It also organized information sessions for CISSS/CIUSSS implementation committees to facilitate dose ordering and approval through a system called SI-PMI (Système d'information de périnatalité et de la petite enfance)[11] for vaccine management, supply tracking and requisitions within the CISSS network. The SI-PMI is an integrated module in the Québec vaccine registry. Local healthcare provider staff training was offered through the ENA (l'Environnement numérique d'apprentissage provincial). The CISSS/CIUSSS managed their local supply and allocated the product to healthcare institutions based on forecasted doses. Hospitals, CLSCs, and birthing centers were responsible for forecasting their own dose needs and communicating them upwards.

9 Ontario expanded eligibility in 2024 to include infants born on or after January 1.
10 The Protocole d'Immunisation du Québec (PIQ) is the tool for all health professionals in Québec involved in vaccination and takes precedence over any other document about vaccination.
11 Information about the SI-PMI is available at: https://www.msss.gouv.qc.ca/professionnels/vaccination/registre-vaccination/deploiement/

Program Awareness and Education

The MSSS developed comprehensive guidance and webinars for healthcare professionals and educational materials for public awareness of the program. The CISSS/CIUSSS played a crucial role in disseminating information through their web pages, linking to MSSS documents. Healthcare leaders were also instrumental in promoting the program to colleagues and families. Professional organizations and associations also developed webinars to create awareness within their networks.

Program Surveillance, Impact, and Monitoring

It is mandatory for all immunized infants in Québec to be registered with the provincial vaccine registry, which is crucial for studies on uptake and other public health criteria such as adverse events following immunization. There are several initiatives in Québec to monitor and assess the impact of the nirsevimab program and population coverage. At present, the MSSS is generating real-world effectiveness data to assess the program's impact on RSV disease and hospitalizations in the province.

Ontario RSV Infant Immunization Program

Infant RSV Program Implementation

Beginning in late 2024, Ontario transitioned from a targeted to a universal RSV prevention program that prioritized nirsevimab for all infants. The implementation was executed through a multi-setting delivery model (Provincial RSV Advisory Group, 2025). Infants born during the RSV season (November–April) were primarily immunized in hospital birthing units prior to discharge, while those born outside RSV season (January–October) receive catch-up doses through primary care providers or local public health clinics. To ensure comprehensive coverage, the province also provided maternal vaccination as a secondary option for pregnant individuals between 32 and 36 weeks of gestation. This rollout was supported by the BORN Ontario information system[12], which mandates real-time data entry from hospital birthing units to monitor provincial uptake and identify regional gaps in access to ensure equitable protection across the province. Additional RSV outcomes data such as RSV hospitalizations and viral surveillance is collected through Public Health Ontario's Respiratory Virus Tool.

Infant RSV Program Logistics and Distribution

The implementation of Ontario's universal infant RSV program relied on a centralized, logistics model coordinated by the Ministry of Health and local Public Health Units (PHUs). The provincial supply chain utilized the Ontario Government Pharmaceutical and Medical Supply Service (OGPMSS) to distribute nirsevimab directly to birthing hospitals and regional depots. Maternal vaccines were distributed to public health units and to community healthcare providers. This approach ensured high uptake and reduced system strain. Emphasis was placed on the administration of nirsevimab in-hospital prior to newborn discharge. Community-based delivery for infants born outside the RSV season was managed by primary care providers who ordered nirsevimab from their local PHU.

Program Awareness and Education

Ontario's RSV infant immunization program outreach utilized an integrated public health framework that embeds RSV awareness into the broader seasonal respiratory virus campaign. By leveraging the trusted

12 The BORN Ontario information system captures RSV data from births at time of delivery. It also captures self-reported maternal vaccination. It does not capture RSV immunization administered by community health services.

provider model, the province focused outreach efforts on high-impact clinical touchpoints, such as prenatal consultations and hospital discharge processes, to ensure parents receive information at the point of decision-making. These efforts were supplemented by a robust suite of multilingual and culturally tailored resources developed by the Provincial Council for Maternal and Child Health (PCMCH)[13]. Furthermore, the province employed digital tools like Health811 and the Ontario.ca/RSV hub to provide the public RSV immunization information (Paes et al., 2024).

Analysis and Discussion

The RSV program in Québec and Ontario have shown promising initial uptake and effectiveness. Significant opportunities exist for improvement, particularly in enhancing communication and education for both healthcare professionals and the public, as well as leveraging data for more targeted interventions and better real-world impact. Success is underpinned by the public funding of nirsevimab and its integration into public health immunization programs and hospital protocols, making it widely accessible.

70%	69%	41
Initial uptake among infants <6 months (Québec)	Nirsevimab coverage (Ontario, excl. community)	Immunizations needed to avert one hospitalization

Sources: Bemmo et al., 2025; BORN, 2026; Carazo et al., 2025

Initial uptake in Québec was 70% among infants <6 months of age (Bemmo et al., 2025). Reduction in RSV-associated hospitalization was observed as 66% and effectiveness among emergency admission and intensive care admission were observed at 86% and 88% respectively (Carazo et al., 2025). Acute bronchiolitis emergency department visits decreased by 35% and between 323 and 746 hospitalizations were estimated to have been prevented during the first year of the program (Bemmo et al., 2025). During Ontario's first year of program implementation, coverage with nirsevimab was 69% excluding infants immunized in community, reflecting a positive start for the program (BORN, 2026). Additionally, Quebec's first year of universal nirsevimab immunization program has shown the number needed to immunize (NNI) to avoid one RSV-related hospitalization is low compared to other routine immunization programs. It is estimated that 41 infant immunizations and 58 infant catch-up immunizations are needed to avert one RSV-associated hospitalization in Quebec, making the RSV universal monoclonal program cost-efficient to the healthcare system and beneficial to all infants (Carazo et al., 2025).

The clear roles of the MSSS in defining program parameters and regional health authorities (CISSS/CIUSSS) in local implementation provided a structured framework. The establishment of a single point of contact at the Ministry was also a positive aspect. The CISSS/CIUSSS were able to develop their own localized guidelines and manage their supply, indicating a degree of flexibility and adaptability in implementation and administration of nirsevimab after the birth for those born during or just before RSV season, which appears to have been an efficient strategy for promoting uptake. Private sector involvement in healthcare provider education initiatives and the support from professional organizations through webinars contributed positively to program awareness

13 Provincial Council for Maternal and Child Health. 2026 Respiratory Viruses. https://pcmch.on.ca/respiratory-viruses-and-immunizations/

and acceptance among healthcare professionals. These initiatives added to the MSSS support made available to healthcare professionals throughout the province.

Initial adoption of the nirsevimab program brought to light several key opportunities for improvement in its implementation. In hospital settings, the process of registering immunizations was found to be resource intensive, as access to the registry was not open to all involved in the program roll out in Québec. A related challenge was that many new parents did not yet have their provincial health cards, which made reporting immunization data difficult. Within community care, there were opportunities to improve communication about the program. Information on when the program started was limited in Québec, and clear instructions on how to handle catch-up immunizations were not widely available. Additionally, ensuring consistent availability of doses based on a child's weight was noted as an area for further clarity and support. Healthcare providers had few opportunities to share insights and communicate experiences with troubleshooting. Channels for collaborative problem-solving could have help streamline implementation efforts. An RSV program evaluation by Public Health Ontario revealed similar barriers to the implementation of nirsevimab in 2024-2025 (PHO, 2025).

To better inform and improve the program, awareness of nirsevimab among both the public and healthcare professionals needs to be expanded (Paes et al., 2025). Initial outreach and dissemination of educational materials fell short in reaching intended audiences. Healthcare providers have expressed a need for a range of tools to help support implementation at the local level. Furthermore, precision in language by standardizing terminology (e.g., 'monoclonal injection or immunization' or 'preventive antibody medication' rather than 'vaccine') across all healthcare providers will improve consistent messaging and avoid confusion when discussing the program with patients was stressed as critical.

Additional opportunities for parental education include collaborating with midwives at birthing centers. Many educational opportunities were not leveraged amply through birthing centers or community care. Ontario midwives also encountered an initial barrier to accessing doses as they did not have the scope of practice to administer and order nirsevimab until November 2025. Prior to this change to their scope of practice, midwives required a hospital level medical directive to access nirsevimab. This suggests potential issues in the distribution and accessibility channels for certain care settings. Distribution issues could have been identified early in the implementation process if access to more granular data, such as inventory data, coverage among vulnerable populations, and hospital admissions in acute care was available for monitoring and analysis purposes. Current data availability doesn't fully support comprehensive, real-time program monitoring and targeted interventions in Québec but Ontario was able to capture some administrative data through BORN's birthing registry. Dashboards at the center level and MSSS levels could have tracked uptake and identify areas needing more support. Both provinces struggled with nirsevimab inventory and faced shortages of the 50mg dose for smaller babies.

Conclusion and Recommendations

Provinces should move toward integrated and supportive RSV immunization frameworks to sustain current programs in Québec and Ontario and to streamline adoption in other jurisdictions.

This approach begins with establishing a consistent, early start date for the immunization season, which would allow for more thorough parental education and coordinated planning across all care settings, including hospitals, family practices, and community clinics. By providing healthcare professionals with standardized, approachable communication tools and resources, the provinces can foster a more uniform message that addresses parental questions with clarity and empathy. Logistically, enhancing the distribution network to community care environments and refining institutional forecasting will ensure that protection is both timely and equitable, particularly for newcomers and vulnerable populations. Furthermore, investing in granular, real-time data dashboards and facilitating peer-to-peer learning platforms will empower regional health partners to share best practices and continuously refine their outreach. Ultimately, shifting toward a collaborative, data-informed strategy will strengthen public confidence and safeguard the health of Québec and Ontario's youngest residents.

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Tables and Graphs

Table 1: Number and percentage of positive cases for influenza A and B viruses, respiratory syncytial virus, and SARS-CoV-2 by region of residence in Québec for 2024-2025

RSS	Influenza A	Influenza B	VRS	SARS-CoV-2
Bas-Saint-Laurent (01)	0 / 128 (0,00 %)	0 / 128 (0,00 %)	0 / 34 (0,00 %)	3 / 162 (1,85 %)
Saguenay - Lac-Saint-Jean (02)	0 / 144 (0,00 %)	0 / 144 (0,00 %)	0 / 140 (0,00 %)	7 / 170 (4,12 %)
Capitale-Nationale (03)	2 / 479 (0,42 %)	0 / 479 (0,00 %)	0 / 479 (0,00 %)	56 / 625 (8,96 %)
Mauricie et Centre-du-Québec (04)	0 / 195 (0,00 %)	0 / 195 (0,00 %)	1 / 185 (0,54 %)	23 / 378 (6,08 %)
Estrie (05)	1 / 259 (0,39 %)	0 / 259 (0,00 %)	0 / 132 (0,00 %)	18 / 283 (6,36 %)
Montréal (06)	3 / 745 (0,40 %)	1 / 745 (0,13 %)	0 / 599 (0,00 %)	75 / 1040 (7,21 %)
Outaouais (07)	0 / 108 (0,00 %)	1 / 108 (0,93 %)	1 / 107 (0,93 %)	9 / 120 (7,50 %)
Abitibi-Témiscamingue (08)	0 / 41 (0,00 %)	0 / 41 (0,00 %)	0 / 41 (0,00 %)	0 / 41 (0,00 %)
Côte-Nord (09)	0 / 72 (0,00 %)	0 / 72 (0,00 %)	0 / 72 (0,00 %)	0 / 76 (0,00 %)
Nord-du-Québec (10)	0 / 21 (0,00 %)	0 / 21 (0,00 %)	0 / 20 (0,00 %)	1 / 25 (4,00 %)
Gaspésie - Îles-de-la-Madeleine (11)	0 / 33 (0,00 %)	0 / 33 (0,00 %)	0 / 11 (0,00 %)	7 / 88 (7,95 %)
Chaudière-Appalaches (12)	1 / 216 (0,46 %)	0 / 216 (0,00 %)	0 / 215 (0,00 %)	11 / 340 (3,24 %)
Laval (13)	0 / 261 (0,00 %)	1 / 261 (0,38 %)	2 / 194 (1,03 %)	34 / 312 (10,90 %)
Lanaudière (14)	1 / 83 (1,20 %)	0 / 83 (0,00 %)	0 / 78 (0,00 %)	19 / 234 (8,12 %)
Laurentides (15)	1 / 322 (0,31 %)	0 / 322 (0,00 %)	0 / 317 (0,00 %)	25 / 436 (5,73 %)
Montérégie (16)	1 / 747 (0,13 %)	0 / 747 (0,00 %)	0 / 727 (0,00 %)	38 / 896 (4,24 %)
Nunavik (17)	0 / 23 (0,00 %)	0 / 23 (0,00 %)	0 / 23 (0,00 %)	0 / 23 (0,00 %)
Terres-Cries-de-la-Baie-James (18)	0 / 6 (0,00 %)	0 / 6 (0,00 %)	0 / 6 (0,00 %)	1 / 23 (4,35 %)
Inconnu	0 / 0	0 / 0	0 / 0	0 / 29 (0,00 %)
Hors-Québec	0 / 71 (0,00 %)	0 / 71 (0,00 %)	0 / 35 (0,00 %)	1 / 17 (5,88 %)
Total	**10 / 3954 (0,25 %)**	**3 / 3954 (0,08 %)**	**4 / 3415 (0,12 %)**	**328 / 5318 (6,17 %)**

Source: Institut national de santé publique du Québec (INSPQ). Surveillance de l'influenza et des infections respiratoires virales par TAAN: semaine 25-32 se terminant le 9 août 2025.
https://www.inspq.qc.ca/sites/default/files/documents/influenza/20242025/2025-32.pdf?rapport=32

Table 2: Number and percentage of positive cases for influenza A and B viruses, respiratory syncytial virus, and SARS-CoV-2 by age group for 2024-2025 in Québec

Âge	Influenza A	Influenza B	VRS	SARS-CoV-2
< 1 an	0 / 205 (0,00 %)	0 / 205 (0,00 %)	2 / 204 (0,98 %)	11 / 181 (6,08 %)
1 - 4 ans	0 / 137 (0,00 %)	0 / 137 (0,00 %)	0 / 132 (0,00 %)	2 / 148 (1,35 %)
5 - 9 ans	1 / 60 (1,67 %)	0 / 60 (0,00 %)	0 / 59 (0,00 %)	3 / 66 (4,55 %)
10 - 14 ans	1 / 47 (2,13 %)	0 / 47 (0,00 %)	0 / 46 (0,00 %)	2 / 47 (4,26 %)
15 - 19 ans	0 / 57 (0,00 %)	0 / 57 (0,00 %)	0 / 53 (0,00 %)	5 / 70 (7,14 %)
20 - 29 ans	0 / 181 (0,00 %)	1 / 181 (0,55 %)	1 / 156 (0,64 %)	31 / 273 (11,36 %)
30 - 39 ans	0 / 223 (0,00 %)	0 / 223 (0,00 %)	0 / 199 (0,00 %)	35 / 332 (10,54 %)
40 - 49 ans	1 / 233 (0,43 %)	0 / 233 (0,00 %)	0 / 200 (0,00 %)	29 / 325 (8,92 %)
50 - 59 ans	1 / 307 (0,33 %)	0 / 307 (0,00 %)	0 / 264 (0,00 %)	31 / 460 (6,74 %)
60 - 69 ans	3 / 625 (0,48 %)	0 / 625 (0,00 %)	0 / 535 (0,00 %)	35 / 808 (4,33 %)
70 - 79 ans	2 / 838 (0,24 %)	0 / 838 (0,00 %)	1 / 698 (0,14 %)	57 / 1136 (5,02 %)
80 - 89 ans	0 / 730 (0,00 %)	2 / 730 (0,27 %)	0 / 614 (0,00 %)	60 / 1006 (5,96 %)
>= 90 ans	1 / 311 (0,32 %)	0 / 311 (0,00 %)	0 / 255 (0,00 %)	27 / 463 (5,83 %)
Inconnu	0 / 0	0 / 0	0 / 0	0 / 3 (0,00 %)
Total	**10 / 3954 (0,25 %)**	**3 / 3954 (0,08 %)**	**4 / 3415 (0,12 %)**	**328 / 5318 (6,17 %)**

Source: Institut national de santé publique du Québec (INSPQ). Surveillance de l'influenza et des infections respiratoires virales par TAAN: semaine 25-32 se terminant le 9 août 2025.
https://www.inspq.qc.ca/sites/default/files/documents/influenza/20242025/2025-32.pdf?rapport=32

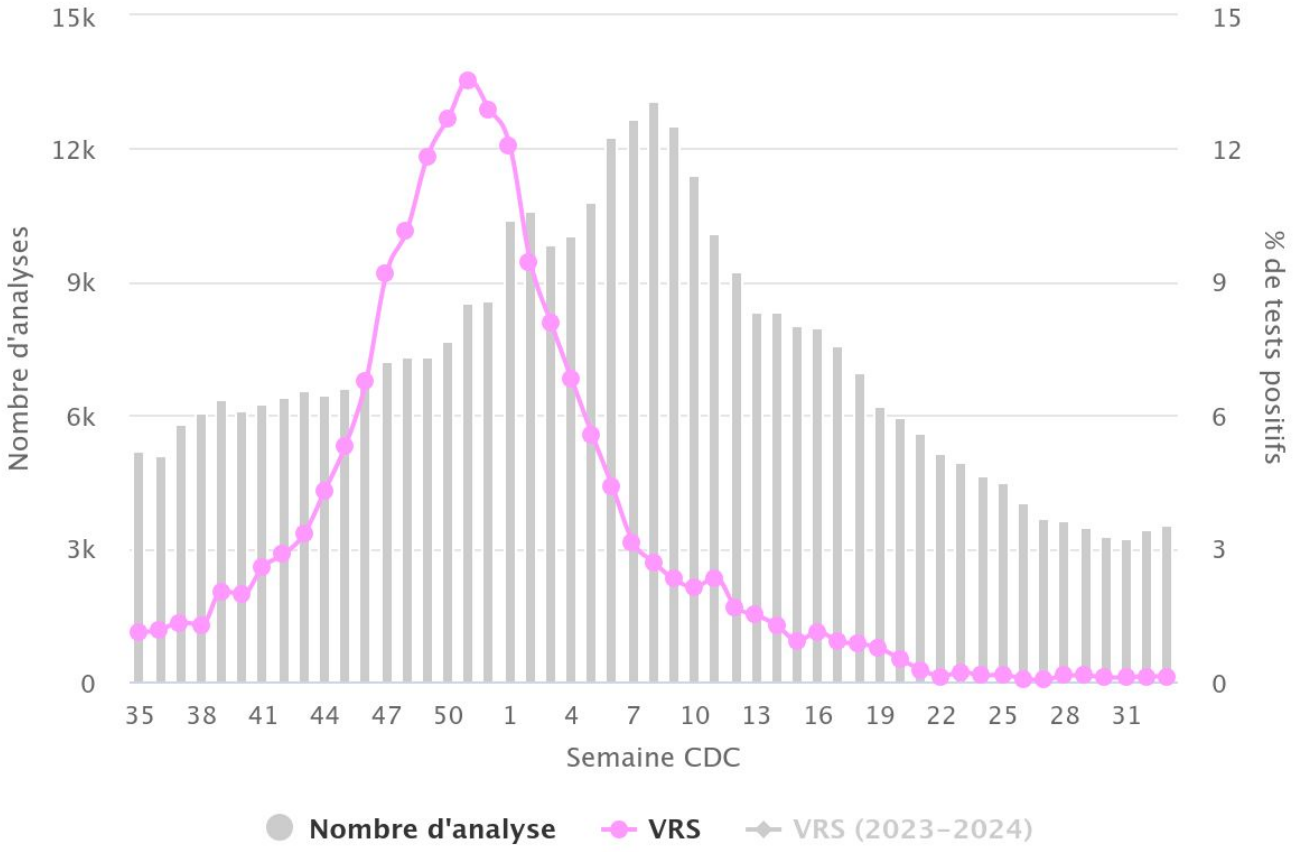
Table 3: Québec RSV Risk Factors and Health Conditions of Infants Less than 6 Months of Age

Risk Factors	Health Conditions
• Infants born prematurely at less than 37 weeks of pregnancy • Infants residing in remote and isolated communities, with priority given to those at high risk of complications	Infants with: • Bronchopulmonary dysplasia • Chronic lung disease • Hemodynamically significant congenital heart disease or cardiomyopathy • Moderate or severe pulmonary hypertension • Down syndrome • Cystic fibrosis • Significant airway secretion clearance impairment (neuromuscular disorder or congenital upper airway anomaly) • Bone marrow, stem cell, or solid organ transplant

Table 4: Québec Health Conditions of Infants Less than 19 Months of Age Eligible for Nirsevimab

Health Conditions
Infants with: • Bronchopulmonary dysplasia • Chronic lung disease • Hemodynamically significant congenital heart disease or cardiomyopathy • Moderate or severe pulmonary hypertension • Down syndrome • Cystic fibrosis • Significant airway secretion clearance impairment due to a neuromuscular disorder or a congenital upper airway anomaly • Bone marrow, stem cell, or solid organ transplant

Graph 1: Respiratory syncytial virus tests reported and percentage of positive tests in clinical laboratories, by reporting week, Québec, 2024-2025



Source: Institut national de santé publique du Québec (INSPQ). Vigie des virus respiratoires par les laboratoires cliniques. Données provisoires en date du 16 août 2025. https://www.inspq.qc.ca/influenza