Public Health Ontario | Santé publique Ontario

Ontario Respiratory Virus Tool



Technical Notes

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Public Health Ontario

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Introduction

The Ontario Respiratory Virus Tool is an interactive tool that provides weekly epidemiological information on respiratory virus activity in Ontario, including COVID-19, influenza, respiratory syncytial virus (RSV), and other respiratory viruses. The tool enables users to explore and download up-to-date data on case trends, outcomes, laboratory testing, outbreaks and projections. Through interactive visualizations, users can customize displays and data, examine trends over time and generate insights to support timely evidence informed decision making. The tool is updated Fridays throughout the year, with data up to the previous Saturday.

The purpose of this technical note document is to support interpretation of the data presented in the tool by describing the underlying data sources, methodologies, data definitions and important caveats and limitations. This document is intended for all users of the tool, including public health professionals, researchers, decision-makers, and members of the public seeking to better understand respiratory virus activity in Ontario, the data sources used in the tool and the methods of analysis.

Data Sources Overview

- **Laboratory testing (number of tests, percent positivity):** Data for all respiratory viruses are based on information received from the Ontario Laboratories Information System (OLIS). These data include respiratory virus tests conducted by participating labs from December 29, 2019 onwards and processed weekly at Public Health Ontario (PHO). Data prior to this date are of insufficient quality and are not included in this tool. Data prior to June 1, 2026 are fixed, whereas data from June 1, 2026 onwards are reprocessed weekly to capture updates to previous weeks. For more information, refer to the Laboratory Testing section.

- **Cases:** The methodology and data sources for counting cases have changed over time. For more information, refer to Table 1.

    - **OLIS-derived cases:** Data for COVID-19, influenza and RSV cases are derived from the same OLIS dataset used for laboratory testing (above). OLIS-derived case data are available from September 21, 2025 onwards for influenza, from June 2, 2024 onwards for COVID-19 and from December 29, 2019 for RSV. For more information, refer to the Cases: OLIS-Derived section.

    - **Public health unit (PHU) reported cases:** Data for confirmed influenza cases were previously obtained from the integrated Public Health Information System (iPHIS) or via direct aggregate reporting to PHO; these data are available up to September 20, 2025. Data for COVID-19 cases were obtained from the Public Health Case and Contact Management Solution (CCM) up to June 1, 2024. For more information, refer to the Cases: PHU Reported section.

- **Outbreaks:** Data for respiratory infection outbreaks for the current respiratory season are based on information extracted weekly from iPHIS by PHO. Data for previous respiratory seasons (2017–18 to 2025–26) will be extracted on September 30, 2026 and will remain fixed for the duration of the 2026–27 season. COVID-19 outbreaks created in CCM up to June 1, 2024 were extracted by PHO on June 27, 2024. For more information, refer to the Outbreaks section.

- **COVID-19 Deaths:** Data for COVID-19 cases with fatal outcomes are based on data extracted from iPHIS by PHO for records created after June 1, 2024. Data on fatal cases created up to June 1, 2024 were extracted from CCM on June 27, 2024. For more information, refer to the COVID-19 Deaths section.

- **Influenza antiviral susceptibility:** These data are received weekly from the Public Health Agency of Canada's (PHAC) National Microbiology Laboratory Branch (NMLB) and presented in the Key Findings. For more information, refer to the Influenza Antiviral Susceptibility section.

- **Whole genome sequencing:** Whole genome sequencing (WGS) data for SARS-CoV-2, influenza and RSV from PHO are published in reports on a periodic basis. Relevant WGS findings will be incorporated into the Key Findings section when available. Influenza strain characterization has been removed from this tool.

- **Hospital admissions:** These hospital admissions (I9) data are obtained from the Ministry of Health each week for COVID-19, influenza and RSV. For more information, refer to the Hospital Admissions section.
- **Hospital bed occupancy**: These bed census (I9) data are obtained from the Ministry of Health each week for COVID-19, influenza and RSV. For more information including details on when data components became available, refer to the Hospital bed occupancy section.
- **ICU bed occupancy**: These data are from the Critical Care Information System (CCIS), provided by CritiCall Ontario. For more information, refer to the Hospital ICU Bed Occupancy section.
- **Projections for SARS-CoV-2, influenza and RSV activity**: The data used for projections of respiratory virus percent positivity are obtained from OLIS. Additional data used for projections of hospitalization risk are obtained from the Ministry of Health's hospital admission (I9) data. Refer to the Projections section for more details.
- **Ontario population data**: Population estimates were received from Statistics Canada for the years 2016–2024,[1] and population projections were received from the Ontario Ministry of Finance for the years 2025–2026.[2]

Table 1: Data Sources and Available Dates for Case Indicators

Indicator	Data Source	Dates
COVID-19 Cases	CCM	Reported up to June 1, 2024 Last extracted June 27, 2024
COVID-19 Cases	OLIS	Reported from June 2, 2024 onwards
COVID-19 Deaths	CCM	Reported up to June 1, 2024 Last extracted June 27, 2024
COVID-19 Deaths	iPHIS	Reported from June 2, 2024 onwards
Influenza Cases	iPHIS/Aggregate reporting*	Reported up to September 20, 2025 Last extracted September 2, 2026 for cases reported up to September 20, 2025
Influenza Cases	OLIS	Reported from September 21, 2025 onwards
RSV Cases	OLIS	Reported from December 29, 2019 onwards

*Influenza cases were formerly reported exclusively via iPHIS with exception for two PHUs that reported counts in aggregate, starting in March 2020 and December 2023. From October 13, 2024 to September 20, 2025, additional PHUs reported influenza counts in aggregate directly to PHO.

Data Notes and Caveats

- Observed trends over time should be interpreted with caution for the most recent period due to reporting and/or data entry lags.
- All counts for COVID-19, influenza and RSV are subject to varying degrees of underreporting and may be an underestimate of the true number of individuals with the disease due to a variety of factors, such as disease awareness and medical care seeking behaviours, which may depend on severity of illness, clinical practice, changes in laboratory testing, access to testing and reporting behaviours. As such, data should be interpreted with caution.
- COVID-19 and influenza are diseases of public health significance in Ontario and are therefore reportable to the province per Ontario Regulation (O. Reg.) 135/18 (Designation of Diseases) and amendments under the Health Protection and Promotion Act (HPPA).[4,5] As of July 1, 2024, PHUs are only required to report COVID-19 cases with fatal outcomes in iPHIS. Other respiratory viruses, including RSV, are only reportable by PHUs in summary outbreak counts if they are the aetiologic agent responsible for respiratory infection outbreaks in institutions and public hospitals.
- iPHIS and OLIS are dynamic reporting systems which allow ongoing updates to data previously entered. As a result, data extracted from these information systems represent snapshots at the time of extraction and may differ from previous or subsequent reports.
- OLIS is a comprehensive data source which includes all testing conducted by laboratories in Ontario. Test methods and report formats are inconsistent across labs and change over time. To address this, the OLIS data are cleaned and processed using a modified version of the method developed by ICES (COVID19_processing.ipynb) which has been shared back with ICES.[3] This method uses highly variable result text to classify test results (i.e., which viruses were tested for and the result of the test) and it is therefore possible that a small proportion of results may be incorrectly assigned to viruses during PHO's weekly data processing.
- Data extracted from iPHIS including COVID-19 deaths as well as outbreaks of COVID-19 and respiratory infection outbreaks in institutions or public hospitals are updated weekly for the current respiratory season. Data for earlier seasons are updated annually.
- PHU reported case data represents individuals that got tested and/or were reported to PHUs and recorded in a provincial reporting system. The provincial reporting system(s) used as the data source for indicators have changed over time. Refer to Table 1 for the data source and dates relevant to case indicators.
- Due to differences in reporting timeframes, indicators in the ORVT may not align with similarly defined indicators presented on PHU websites. Where discrepancies exist, data presented on the PHU's website should be considered the most accurate.

- Effective January 1, 2025, the Ontario Ministry of Health approved the voluntary merger of nine local PHUs into four entities. We have incorporated the new names of these health entities in the ORVT as of October 3, 2025. Retroactive updates for PHU mergers are only made within the tool's graphs and associated data extracts. Refer to Table 2 for a summary of the changes.

- Respiratory seasons start from approximately September 1 of one year and end August 31 of the following year. In online tools and graphs depicting respiratory virus data by surveillance week, the surveillance week typically containing September 1 (week 35) is used as the first week of the respiratory season.

    - Surveillance weeks correspond to the FluWatch Public Health Agency of Canada (PHAC) influenza surveillance weeks.[6] For a list of the current respiratory season's surveillance weeks, refer to Appendix I.

    - The 2020–21 and 2025–26 respiratory seasons include a week 53, which occurs once every five to six years. In 2025–26, week 53 corresponded to the period from December 28, 2025 to January 3, 2026. In 2020–21, week 53 corresponded to the period from December 27, 2020 to January 2, 2021.

    - One notable exception to this respiratory season definition applies to projection estimates. For these analyses, respiratory seasons are defined as running from July 1 to June 30 of the following year to allow sufficient lead time to produce more accurate projection estimates.

- For indicators where cumulative rates are calculated, the start year for the respiratory season was used to determine the year for the population count used as the denominator. For example, for the 2025–26 respiratory season, the cumulative case rate is calculated using the 2025 population projections as the denominator.

- Records with unknown or missing ages were excluded from age-specific analyses.

- As of September 2026, age groups across several indicators presented in the ORVT were updated for alignment. These changes do not apply to hospitalization data (I9). However, the updated age groups can be aggregated to match the current age groups in the I9 data.

- Stratification by sex is not available in the ORVT, as it provides limited added value for understanding provincial trends in seasonal respiratory viruses.

- Data gaps may occur for various indicators. For a detailed list of current data gaps, refer to Appendix G.

Table 2: Merged Public Health Units and Data Availability in Maps

Current Public Health Unit	Former Public Health Units	Respiratory Season Data are Available From
Southwestern Health Unit	Elgin-St. Thomas Health Unit Oxford County Health Unit	2018–19
Huron Perth Public Health	Huron Public Health Perth Public Health	2020–21
Grand Erie Public Health	Brant County Health Unit Haldimand-Norfolk Health Unit	2025–26
Lakelands Public Health	Haliburton, Kawartha, Pine Ridge District Health Unit Peterborough Public Health	2025–26
Northeastern Public Health	Porcupine Health Unit Timiskaming Health Unit	2025–26
South East Health Unit	Hastings Prince Edward Public Health Kingston, Frontenac and Lennox & Addington Public Health Leeds, Grenville & Lanark District Health Unit	2025–26

Activity: COVID-19, Influenza and RSV

Percent Positivity Level and Weekly Indicator Change Data Sources

- Respiratory virus percent positivity level (e.g., low, high) is based on laboratory data.
- Weekly indicator change assessment was determined by considering a combination of indicators as detailed in Appendix A for COVID-19, Appendix B for influenza and Appendix C for RSV.
- Indicators and data sources for respiratory virus percent positivity level thresholds and weekly indicator changes have changed over time. For more information about OLIS data in this tool, refer to the Laboratory Testing section, as well as Appendix E.

Percent Positivity Levels

- Percent positivity is the percentage of tests that are positive for a given virus.
    - It is calculated by dividing the number of positive tests by the total number of tests performed for that virus in a given period.
    - Testing eligibility for COVID-19, influenza and RSV differ along with the number of tests performed. For the most up to date information on testing eligibility, refer to the current provincial guidance for Respiratory Viruses (including influenza).[7]
- Percent positivity at the provincial level should be interpreted with caution as it may not reflect the levels of activity across different sub-populations at a given time. Additionally, provincial percent positivity for a given virus can be impacted by changes in overall testing volume, particularly during periods of increased activity of another virus that is tested on the same panel. For example, increased influenza activity may lead to more respiratory virus testing overall, which could lower COVID-19 percent positivity even if the absolute number of COVID-19 detections remains similar.
- Percent positivity levels for COVID-19, influenza and RSV are developed by PHO and are used to monitor respiratory virus activity. For simplicity, percent positivity, as a single measure, was selected instead of a composite indicator using multiple measures, as this metric generally trends closely with case counts and outbreaks. These levels are reviewed every two years to adjust for changes in testing eligibility and algorithm that can affect testing volumes and thus percent positivity.
- For surveillance purposes, COVID-19, influenza and RSV are assigned to a percent positivity level of low, moderate, high, and very high to provide a snapshot of the extent to which these respiratory viruses are circulating. These levels may differ from those used nationally by PHAC and locally by public health units to describe percent positivity.
- Provincial COVID-19 percent positivity levels were last reviewed June 2026 and are defined as follows:
    - Low: <10.0% positivity
    - Moderate: 10.0%–16.9% positivity
    - High: 17.0%–24.9% positivity
    - Very high: ≥25.0% positivity
- Provincial influenza (i.e., influenza A & B combined) percent positivity levels were last reviewed June 2026 and are defined as follows:
    - Low: <10.0% positivity
    - Moderate: 10.0%–16.9% positivity
    - High: 17.0%–24.9% positivity
    - Very high: ≥25.0% positivity

- Provincial RSV percent positivity levels were last reviewed June 2026 and are defined as follows:
    - Low: <5.0% positivity
    - Moderate: 5.0%–9.9% positivity
    - High: 10.0%–14.9% positivity
    - Very high: ≥15.0% positivity
- The threshold for the start of seasonal influenza activity is a provincial percent positivity level ≥5%. The threshold for inter-seasonal activity is when the provincial percent positivity level is <5%. This aligns with national seasonal thresholds.[8]
- Percent positivity levels for influenza were updated for the 2024–25 respiratory season because the review of the 2023–24 levels identified strong rationale for aligning with levels for COVID-19 for 2024–25 (e.g., changes in testing). Levels were reviewed ahead of the 2026–27 respiratory season and no updates were required.
- RSV percent positivity levels were developed for the first time for the 2024–25 respiratory season using RSV percent positivity values reported in the previous five seasons (2019–20 to 2023–24). RSV-specific percent positivity levels were deemed necessary as weekly percent positivity for RSV is generally lower than those for COVID-19 and influenza, particularly in post-pandemic seasons. Levels were reviewed ahead of the 2026–27 respiratory season and no updates were required.
- COVID-19 percent positivity levels were developed using the following approach:
    - COVID-19 percent positivity levels were developed initially for the 2022–23 respiratory season. COVID-19 percent positivity values reported in 2022 were evaluated against the PHO-developed percent positivity levels for pre-pandemic influenza and other respiratory viruses. It was determined that COVID-19-specific percent positivity levels should be developed because percent positivity for COVID-19 was lower than the percent positivity values that had been used for setting the levels for influenza.
    - The percent positivity levels have been adjusted and narrowed based on observed COVID-19 percent positivity levels throughout the pandemic. For example, during the Omicron surge (wave 5), the Ontario health system experienced an overwhelming number of cases and higher than usual hospital occupancy; the weekly percent positivity at this time reached an all-time high of over 29.4%, which provided the additional context for setting the very high range as ≥25%. After reviewing the minimum, maximum and median percent positivity values, percent positivity levels were selected and these were reviewed by the Ministry of Health and local PHU partners prior to being finalized.
    - COVID-19 percent positivity levels were reviewed ahead of the 2026–27 respiratory season and no updates were required.

- Percent positivity levels were developed for surveillance and situational awareness purposes. Decisions regarding public health action and/or infection prevention and control should not solely rely on percent positivity level thresholds as context specific indicators should be considered (e.g., the group at risk, current trajectory of trends, immunization coverage, transmissibility, severity, risk tolerance, as well as local factors such as health care capacity and access to care, current measures in place, etc.).

- Percent positivity estimates for respiratory viruses calculated from OLIS data prior to the COVID-19 pandemic are of insufficient quality and completeness and are not included in the ORVT.

Weekly Indicator Change

- Timely entry of outbreak data by PHUs, including the 'Date Outbreak Declared Over', is critical for correct activity level assessments for influenza as well as COVID-19 and RSV.

- Respiratory infection outbreaks without a Date Outbreak Declared Over are considered to still be ongoing.

- Outbreaks with no recorded 'Date Outbreak Declared Over' and no recorded 'Onset Date/Time for Last Case' are automatically set to be 'over' when the outbreak reported date is over 90 days prior to the reporting week.

PHU Activity Levels: Influenza

- Public health unit-level influenza activity levels, including the Influenza Activity Map and the Public Health Unit Activity Levels indicator, have been removed from the tool following the discontinuation of this assessment approach by the Public Health Agency of Canada.

Influenza Antiviral Susceptibility

- Antiviral susceptibility testing is completed for influenza positive isolates received by the National Microbiology Laboratory (NML) from laboratories across Canada, with data available in the tool for Ontario and nationally. Oseltamivir and Zanamivir are the two antiviral drugs monitored, with susceptibility categorized as either resistant or susceptible.

Laboratory Testing Data: All Respiratory Viruses

- Due to phased onboarding of laboratories reporting SARS-CoV-2 tests into OLIS, data may be incomplete for the early months of the COVID-19 pandemic.

- Data for the most recent weeks may be incomplete as not all testing is finalized in the week that the specimen is collected.

- Testing eligibility and laboratory testing algorithms may vary over time, which may affect trends in testing volumes, and the ability to compare trends over time respiratory seasons.

    - For the most up to date information on testing eligibility, refer to the current provincial testing guidance for Respiratory Viruses (including influenza).[7]

- Surveillance week is assigned based on the sample collection date, if available; otherwise, it is based on the sample received or test date.

- A person may have tests on different days. As a result, the number of tests performed may not reflect the number of persons tested and the percentage of tests that were positive may not translate to the number of specimens or persons testing positive. Only one test result per person per day is retained based on a hierarchy developed by PHO.

- Each test is assigned to a PHU based on postal code using the following hierarchy: postal code of the tested individual > practitioner postal code > reporting lab postal code. This approach could lead to test results being assigned to a different PHU from where an individual resides.

Cases: COVID-19, Influenza and RSV

OLIS-Derived

- Data for COVID-19, influenza and RSV cases are currently derived from the same OLIS dataset used for laboratory testing (above). For more information about OLIS and laboratory testing, refer to the Laboratory Testing section.

- For COVID-19, a positive PCR/NAAT result is counted as a case if separated in time by at least 90 days from a previous positive result. These data are available from June 2, 2024 onwards.

- For influenza A and influenza B, a positive PCR/NAAT result is counted as a case if separated in time by at least 30 days from a previous result. Positive influenza A results within 30 days of each other are considered separate cases only if the influenza subtype is available from both tests and is different. These data are available from September 21, 2025 onwards.

    - Influenza A cases are categorized by subtype (H1N1 and H3N2). Not all laboratory-confirmed influenza A cases are subtyped. Influenza A case subtype details are available in the Cases tab of the tool.

- For RSV, a positive PCR/NAAT result is counted as a case if separated in time by at least 30 days from a previous positive result. These data are available from December 29, 2019 onwards.

- The PHU assigned to each case is based on the earliest positive test result for the case.

- OLIS-Derived COVID-19, influenza and RSV cases are not the same as PHU Reported cases and are calculated using laboratory testing data obtained from OLIS, as opposed to cases reported by PHUs (COVID-19 and influenza only), following notification, application of the provincial case definitions and entered by the PHU in a disease reporting system.

PHU Reported

- COVID-19 case data from CCM are no longer being updated. However, data up to June 1, 2024 are available in the tool and the data considerations below apply.
    - Only cases meeting the confirmed case classification as listed in the MOH Case Definition – Coronavirus Disease 2019 (COVID-19) document at the time of report are included.[10]
    - Cases of confirmed reinfection, as defined in the provincial case definitions, are counted as unique cases.
    - Reported Date is the date the COVID-19 case was reported to public health.
    - COVID-19 cases from CCM for which the Classification and/or Disposition was reported as ENTERED IN ERROR, DOES NOT MEET DEFINITION, IGNORE, DUPLICATE, or any variation on these values have been excluded. The provincial case count for COVID-19 may include some duplicate records, if these records were not identified and resolved.
    - Orientation of case counts by geography is based on the Permanent Health Unit (also referred to as Diagnosing Health Unit or DHU). DHU refers to the case's public health unit of residence at the time of illness onset and not necessarily the location of exposure. Cases for which the DHU was reported as MOH-PHO (to signify a case is not a resident of Ontario) have been excluded from the analysis.
- Influenza case data from iPHIS are no longer being updated. However, data up to September 20, 2025 will remain available in the tool and the data considerations below apply.
    - Dates used for laboratory-confirmed influenza cases are based on the date the case was reported to the PHU as recorded in iPHIS or directly to PHO in aggregate format by some PHUs.
    - Cases of influenza A&B are included in the influenza A counts. In the respiratory seasons before the COVID-19 pandemic, cases of influenza A&B made up less than 0.4% of all influenza cases.
    - Influenza A cases may be further categorized into a subtype (H3 and H1). Not all laboratory-confirmed influenza A cases are subtyped.
    - Age group is set to unknown for all influenza cases reported in aggregate by PHUs to PHO.

Severity Indicators: COVID-19, Influenza and RSV

Hospital Admissions

- Hospital admissions data present the total number of new confirmed test positive patients admitted in the facility in the 24 hours preceding 12 midnight.

- Hospital admissions data by PHU is determined based on the location of the hospital, not the patient's home address or health unit of residence.
- Hospital admissions data are available by age group for COVID-19 but are not currently available by age group for influenza or RSV. The age groups presented for these indicators differ from those elsewhere in the tool such as cases by age group.

Hospital Bed Occupancy

- Hospital bed occupancy data presents the average daily occupancy count per week of people in hospital (including intensive care unit (ICU)) with active COVID-19/influenza/RSV (i.e., tested positive). People may be counted in bed occupancy data for multiple days if length of stay is greater than one day.
    - The 'Hospital Bed Occupancy (total)' indicator accounts for hospital bed occupancy among people in hospital with active COVID-19/influenza (regardless of whether the reason for admission was COVID-19/influenza or a non-COVID-19/non-influenza related illness with a subsequent positive test for COVID-19).
    - The 'Hospital Bed Occupancy (due to infection)' indicator accounts for hospital bed occupancy among people in hospital for active COVID-19/influenza (i.e., admitted, COVID-19/influenza positive and primarily being treated for COVID-19/influenza).
- The 'Combined hospital bed occupancy' indicator is a PHO-calculated indicator that presents the combined average daily occupancy count per week of people in hospital (including ICU) with COVID-19/influenza/RSV (i.e., tested positive for at least one). People may be counted in bed occupancy data for multiple days if length of stay is greater than one day.
- Hospital bed occupancy data by PHU is determined based on the location of the hospital, not the patient's home address or health unit of residence.
- Hospital bed occupancy data are available by age group, however the age groups presented for these indicators differ from those elsewhere in the tool such as cases by age group. The age groups presented have changed as of September 2025 to better reflect high-risk groups.
- Start dates for bed occupancy indicators vary. Refer to Appendix D: Table D1 for details.

Hospital ICU Bed Occupancy

- COVID-19 hospital ICU bed occupancy (total) represents the average total daily occupancy count per week of people in ICU with laboratory confirmation of SARS-CoV-2 (i.e., tested positive).
    - The data source for this indicator was updated as of October 25, 2024 and includes 'total' people in ICU testing positive for COVID-19. Previously, this indicator accounted for people in ICU 'because' of COVID-19 which included people who are currently negative for COVID-19, but admitted or re-admitted to the ICU as a result of their prior COVID-19 illness.

- Influenza hospital ICU bed occupancy represents the total number of patients with lab-confirmed influenza A or B admitted to ICU.
- RSV hospital ICU bed occupancy represents the total number of patients in ICU testing positive for RSV.
- Laboratory confirmation of COVID-19, influenza or RSV may be from any date during the patient's current ICU admission until ICU discharge or death occurs.
- Start dates for bed occupancy indicators vary. Refer to Appendix D: Table D1 for details.

Deaths: COVID-19

- Data on deaths from CCM (up to June 1, 2024) and iPHIS (after June 1, 2024) are likely under-reported as this event may occur after the completion of public health follow up of cases. Cases that died after follow-up was completed may not be captured in CCM or iPHIS.
- For surveillance purposes, a COVID-19 death is defined as a death resulting from a clinically compatible illness in a confirmed COVID-19 case, unless there is a clear alternative cause of death that cannot be related to COVID-19 (e.g., trauma). There should be no period of complete recovery between the illness and the reported death.
- Deaths are determined by using the Outcome and Type of Death fields in CCM or iPHIS. COVID-19 deaths are counted where the Outcome value is 'Fatal' and the Type of Death value is not 'DOPHS was unrelated to cause of death', 'Reportable disease was unrelated to cause of death' or 'Under PHU Review'.
- COVID-19 deaths are placed in time using the 'Date of Death' field in CCM or the 'Outcome Date' field in iPHIS.
    - If the date of death is missing in CCM, the outcome date field in CCM is used as a proxy. When there is no outcome date in either CCM or iPHIS, then the case reported date is used.
- COVID-19 deaths in cases 0 to 17 years of age are not stratified by PHU due to concerns regarding small counts of this sub-population, particularly in smaller health units.
- Historical COVID-19 outcome data between January 15, 2020 to March 31, 2023 were updated as part of a provincial data quality initiative. As a result, changes to historical COVID-19 cases and deaths were included in this tool as of December 1, 2023.
- Deaths due to influenza and RSV are excluded, because these data are incomplete or not available in a suitable timeframe for routine provincial surveillance. iPHIS data on fatal outcomes for influenza and RSV are incomplete.

Outbreaks: Respiratory Infections Outbreaks

- Outbreak reported week is based on the outbreak reported date (e.g., the date the outbreak was reported to the PHU), and if unavailable, the date the PHU created the outbreak in the provincial reporting system.
- Outbreaks are declared by the local Medical Officer of Health or their designate in accordance with the Health Protection and Promotion Act and criteria outlined in Ministry guidance documents.[5]
- Outbreaks with co-circulation of respiratory viruses other than SARS-CoV-2 and influenza are reported as having been caused by 'more than one pathogen'.
- Confirmed outbreaks in institutions (as defined in the HPPA) and public hospitals are reported in four groupings in this tool: Long-Term Care Homes (LTCH), Retirement Homes (RH), Hospitals and Other.[5]
- Outbreaks with no exposure setting information and in settings other than LTCHs, RHs and hospitals (e.g., community settings, daycares, schools and childcare facilities) are excluded from the outbreak severity analyses.
- PHUs indicate the outbreak setting using the exposure setting field in iPHIS and the location fields in CCM for COVID-19 outbreaks reported up to June 1, 2024. When there is no setting information, the outbreak is reported as having an unknown/missing setting regardless of the information captured in the text field for the outbreak name.
- Further data caveats and methods relating to outbreak-associated cases and outbreak severity are outlined in the Outbreak Severity Measures section.

COVID-19

- Confirmed outbreaks of COVID-19 are defined in Ministry of Health's Appendix 1: Case Definitions and Disease Specific Information for COVID-19.[10] Guidance for specific settings includes: Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings.[11]
    - Outbreak definitions changed over the course of the pandemic and outbreaks were declared based on the definitions in place at the time of their occurrence.
    - Note: Prior to May 5, 2021, a confirmed COVID-19 outbreak in a long-term care home or retirement home setting was defined as a single, laboratory-confirmed case of COVID-19 in a resident or staff member.
- Data on outbreak settings are based on information entered in CCM up to June 1, 2024 and in iPHIS from June 2, 2024 onwards. Outbreaks with missing setting information and in settings other than long-term care homes (LTCH), retirement homes (RH), and hospitals are excluded from the outbreak severity analyses.

- All data relating to COVID-19 outbreak-associated cases, hospitalizations and deaths in LTCH, RH or public hospitals are based on summary counts reported in CCM up to June 1, 2024 and in iPHIS from June 2, 2024 onwards. The summary counts include cases that are symptomatic or test positive by rapid antigen test (RAT) or by PCR/nucleic acid amplification test. Previously reported counts of COVID-19 cases, hospitalizations and deaths in LTCHs and RHs were based on individual reports of PCR-confirmed cases, which were identified in CCM through linkage to a risk factor and/or outbreak associated with a LTCH, RH or hospital. Due to this difference in ascertainment of outbreak status, summary outbreak counts in this tool should not be compared directly to outbreak indicators in other reports that are based on individually reported laboratory confirmed cases.

- Summary case counts for COVID-19 outbreaks for the 2022–23 respiratory season may be less complete compared to subsequent time periods. Even though PHUs were required to enter summary outbreak case counts, more emphasis was placed on individual case data entry until April 1, 2023 when the reporting requirement was changed to allow PHUs to focus on entry of summary case counts for outbreaks in LTCH, RH, and hospital instead of individual linking of cases to outbreaks in these facilities.

- COVID-19 outbreaks are reported separately and outbreak summary count of cases are all attributed to SARS-CoV-2 when multiple viruses are listed in the outbreak record in iPHIS.

- All outbreaks reported as confirmed are counted even if no summary case counts have been entered in the summary section in iPHIS, with the exception of the Outbreaks > Severity tab where only outbreaks with summary case counts entered are included in the analyses.

Influenza, RSV and Other Respiratory Viruses

- Outbreaks that do not meet the provincial outbreak definition are excluded from analyses. Refer to Appendix 1: Respiratory Infection Outbreaks in Institutions and Public Hospitals document for current outbreak definitions. [12]

- Outbreaks where influenza is identified are counted under the appropriate influenza category ("Influenza A" or "Influenza B") even if other viruses (other than SARS-CoV-2) are also identified in the outbreak. Outbreaks of "influenza A&B" are included in the counts for outbreaks of influenza A.

- For outbreak severity analyses, all influenza types are grouped under the single category "Influenza (all types)".

Outbreak Severity Measures: All Respiratory Viruses

- All data relating to outbreak-associated cases, hospitalizations and deaths are based on summary case counts reported in the outbreak summary section of iPHIS or CCM (for COVID-19 up to June 1, 2024).

- Outbreak-associated cases are individuals that were line listed for the outbreak (i.e., related to the outbreak) and may include cases that are symptomatic with or without an epidemiologic link, and/or test positive by rapid antigen test (COVID-19 only) or an approved laboratory method (e.g., PCR/nucleic acid amplification test). As summary counts are ascertained differently from individually reported laboratory confirmed cases, direct comparisons are more likely to be inaccurate.

- Hospitalized outbreak-associated cases are individuals who were line listed and met the outbreak case definition and subsequently admitted to hospital because of their infection.

- Deaths are counted as outbreak-related deaths (i.e., excluding deaths where the disease was unrelated to the cause of death) that occurred in individuals who were line listed and met the outbreak case definition.

- Attack rates are calculated as:

$$\frac{\text{(Cases in residents/staff)}}{\text{(Number of residents/staff in the affected area)}}$$

    - If the number of cases or the number of residents/staff in the affected area was not available, then the attack rate for that outbreak was not calculated and not included in the summary of attack rates.

    - Attack rates calculated to be over 100% were set to 100% for the purposes of this tool.

- Case hospitalization rates are calculated as:

$$\frac{\text{Hospitalizations among resident/staff cases occurring as a result of their infection}}{\text{Number of Cases in residents/staff}}$$

    - If the number of hospitalizations is missing, then the hospitalization rate was not calculated and not included in the summary of hospitalization rates.

    - Hospitalization rates calculated to be over 100% were set to 100% for the purposes of this tool.

- Case fatality rates are calculated as:

$$\frac{\text{Deaths among resident/staff cases occurring as a result of their infection}}{\text{Number of Cases in residents/staff}}$$

    - If the number of deaths was missing, then the case fatality rate was not calculated and not included in the summary of case fatality rates.

    - Case fatality rates calculated to be over 100% were set to 100% for the purposes of this tool.

- Outbreak duration is measured in days and is calculated as '*Date of onset of illness in last case - Date onset of illness in first case'*. It is not calculated for outbreaks missing either of these dates. If an outbreak had a calculated duration less than 0 days, then the outbreak was excluded from calculations of summary duration measures. Duration is not calculated for ongoing outbreaks.

- The interquartile range (IQR) used for attack, hospitalization and fatality rates as well as outbreak duration is between the 25th and 75th percentiles of the data.

Projections: COVID-19, Influenza and RSV

- Projections shown in the ORVT are intended to provide situational awareness of potential near-term changes in respiratory virus percent positivity and hospitalization risk for the entire province of Ontario; they do not reflect individual-level risk nor provide estimates of the expected number of cases or hospitalizations due to SARS-CoV-2, influenza, or RSV. These projections should be considered alongside context-specific indicators (e.g., the group at risk, current trajectory of trends, immunization coverage), local factors (e.g., health care capacity and access to care), and other measures for assessing respiratory virus activity (e.g., wastewater concentration for SARS-CoV-2, hospital admissions).

    - Of note, hospital admissions may underestimate the true level of severe viral respiratory disease in the population as some individuals with severe disease may not seek hospital care and so may not be captured in the I9 data.

- "Nowcast" estimation methodology[13] is used to create projection indicators.

- Data are available in the following age groups and categorized as follows: <18 years are assigned as pediatric, 18–64 years as adult, and 65+ years as older adult.

    - All analyses exclude those with a missing age group.

    - For the older adult age group, interpretation of projections should additionally account for differences in hospital admission patterns and the higher likelihood of residency in congregate care facilities (e.g., long-term care homes) compared to the adult (18–64) age group.

- Projections are not available by PHU.

- COVID-19, influenza and RSV percent positivity projections should be assessed independently due to differences in provincial testing strategies and populations eligible for testing.

- Trends over time should be interpreted with caution as the most recent period of data may be subject to reporting and/or data entry lags, which may impact the accuracy of projections. Changes in testing eligibility over time and in testing and reporting practices across different laboratories may also impact the accuracy of projections.

- PHO regularly assesses the accuracy of these models to ensure accurate and timely projections of respiratory virus activity in Ontario. Thus, model refinement and recalibration activities may occur throughout the respiratory virus season with updates reflected in future publications. Models may be updated due to changes in testing eligibility, evolving data availability, emerging variants, and emerging seasonal patterns and trends as the respiratory virus season progresses.

- Interpret prediction estimates with caution when percent positivity is low, as small changes in test results can produce large fluctuations in percent positivity estimates and result in wider prediction intervals.

- Model validations have demonstrated a likelihood of overestimating activity as respiratory viruses approach their seasonal peaks. This pattern suggests that projected values for the weeks leading up to the seasonal peaks may exceed subsequently observed activity.

Change Assessment Calculations

- Appendix F outlines how the week over week changes are assessed and reported on in the Overview section of the Projections tab. Changes are determined by comparing the percent change between the observed values of the fitted line for the most recent date with observed data, to the predicted values for the latest prediction date (i.e., the most recent date with observed data plus 14 days).

Percent Positivity Projections

- For each pathogen and age group, generalized additive models (GAMs) are fitted to observed daily percent positivity data from OLIS for the past two-year period to generate 14-day projections of pathogen-specific percent positivity, along with 95% prediction intervals.

- The GAMs are fitted using restricted cubic splines applied to the date of testing, with knots located 28 days apart throughout the summer (i.e., June 1 through August 31, inclusive) and 14 days apart throughout the rest of the respiratory season. The most recent knot is located 14 days from the most recent date of observed data included in the model, meaning that the positivity projection is based on a linear interpolation of percent positivity.

- Projected estimates for each age group are combined to estimate an overall projection for each virus.

- For the influenza model, influenza A and B percent positivity are modelled separately, as well as combined into an overall influenza projection.

Hospitalization Risk Projections

- Generalized linear models (GLMs) are developed using daily, pathogen-specific percent positivity, date, and annual and biannual Fourier seasonality terms (to adjust for underlying viral respiratory disease trends) as independent variables. The total, age-specific number of hospitalizations reported for COVID-19, influenza and RSV are the outcomes of interest (dependent variable).

    - Influenza A and B percent positivity are included as separate age-specific covariates.

    - The calibration model is based on percent positivity and hospitalization data for the most recent two-year period from the data extraction date. This model is subsequently applied to the projected virus-specific percent positivity data (described above, refer to “Methods: Percent Positivity Projections”) to obtain weekly estimates of the projected risk of hospitalization in the upcoming 14-day period, along with 95% prediction intervals.
        - To ensure continued accuracy of calibration weights, ongoing calibration activities and assessments of predictive performance occur throughout the respiratory virus season, with changes documented in future reports.
    - Several model specifications were considered, including different methods to account for seasonality (e.g., number of Fourier terms), approaches for implementing smoothing splines (e.g., cubic regression), and model functional forms (e.g., GLM, GAM). The best fitting model was defined as having the smallest prediction error when compared against a testing data set which was not included when training the model.
- The relative risk of hospitalization is calculated relative to a period with historically low hospitalization risk. For our calculation of risk, the average estimated weekly risks between May 1, 2025 through June 30, 2026 for each age group were used. For reference, the average total number of new observed hospitalizations for COVID-19, influenza and RSV (i.e., combined) during this period was:
    - 10.8 per week among the pediatric age group,
    - 23.3 per week among the adult age group, and
    - 47.2 per week among the older adult age group.
- Threshold values used for assessing risk of hospitalization and representing low, medium, high, and very high risk of hospitalization are determined using a combination of subject matter expertise and empirical analyses of quantiles for each age group.
    - These threshold values are: 2.0, 3.0, and 5.0, respectively.

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Appendix A: COVID-19 Indicators

Cases

- Any move from 0 → **Higher**
- Any move to 0 → **Lower**
- If cases in the previous week were under 50:
    - an increase of 5 or more cases → **Higher**
    - a change less than 5 cases → **Similar**
    - a decrease of 5 or more cases → **Lower**
- If cases in the previous week were over 50:
    - an increase of 10% or more cases → **Higher**
    - a change less than 10% of cases → **Similar**
    - a decrease of 10% or more cases → **Lower**

Percent Positivity

- Any move from 0 → **Higher**
- Any move to 0 → **Lower**
- If percent positivity in the previous week was under 10%:
    - an increase of 0.5 percentage point or more → **Higher**
    - a change less than 0.5 percentage point → **Similar**
    - a decrease of 0.5 percentage point or more → **Lower**
- If percent positivity in the previous week was 10% or over:
    - an increase of 5% or more → **Higher**
    - a change less than 5% → **Similar**
    - a decrease of 5% or more → **Lower**

Outbreaks

- Any move from 0 → **Higher**
- Any move to 0 → **Lower**
- If the number of new outbreaks in the previous week was under 50:
    - an increase of 5 or more outbreaks → **Higher**
    - a change less than 5 outbreaks → **Similar**
    - a decrease of 5 or more outbreaks → **Lower**
- If the number of new outbreaks in the previous week was over 50:
    - an increase of 10% or more → **Higher**
    - a change less than 10% → **Similar**
    - a decrease of 10% or more → **Lower**

Overall Weekly Indicator Change

The interpretation of the weekly indicator change is compared against the current epidemiologic context, which considers the number of cases, outbreaks and percent positivity. When a percent positivity level is crossed (e.g., from low to moderate) this may be considered as well. If there is discordance between the individual indicator assessments, the magnitude of the change in each indicator is considered.

Appendix B: Influenza Indicators

Cases

- Any move from 0 → **Higher**
- Any move to 0 → **Lower**
- If cases in the previous week were under 50:
    - an increase of 5 or more cases → **Higher**
    - a change less than 5 cases → **Similar**
    - a decrease of 5 or more cases → **Lower**
- If cases in the previous week were over 50:
    - an increase of 10% or more cases → **Higher**
    - a change less than 10% of cases → **Similar**
    - a decrease of 10% or more cases → **Lower**

Percent Positivity

- Any move from 0 → **Higher**
- Any move to 0 → **Lower**
- If percent positivity in the previous week was under 10%:
    - an increase of 0.5 percentage point or more → **Higher**
    - a change less than 0.5 percentage point → **Similar**
    - a decrease of 0.5 percentage point or more → **Lower**
- If percent positivity in the previous week was 10% or over:
    - an increase of 5% or more → **Higher**
    - a change less than 5% → **Similar**
    - a decrease of 5% or more → **Lower**

Influenza Outbreaks

- Any move from 0 → **Higher**
- Any move to 0 → **Lower**
- If the number of new outbreaks in the previous week was under 50:
    - an increase of 5 or more outbreaks → **Higher**
    - a change less than 5 outbreaks → **Similar**
    - a decrease of 5 or more outbreaks → **Lower**
- If the number of new outbreaks in the previous week was over 50:
    - an increase of 10% or more → **Higher**
    - a change less than 10% → **Similar**
    - a decrease of 10% or more → **Lower**

Overall Weekly Indicator Change

The interpretation of the weekly indicator change is compared against the current epidemiologic context. When a percent positivity level is crossed (e.g., from low to moderate) this may be considered as well. If there is discordance between the indicator assessments, the magnitude of the change in each indicator is considered.

Appendix C: RSV Indicators

Cases

- Any move from 0 → **Higher**
- Any move to 0 → **Lower**
- If cases in the previous week were under 50:
    - an increase of 5 or more cases → **Higher**
    - a change less than 5 cases → **Similar**
    - a decrease of 5 or more cases → **Lower**
- If cases in the previous week were over 50:
    - an increase of 10% or more cases → **Higher**
    - a change less than 10% of cases → **Similar**
    - a decrease of 10% or more cases → **Lower**

Percent Positivity

- Any move from 0 → **Higher**
- Any move to 0 → **Lower**
- If percent positivity in the previous week was under 10%:
    - an increase of 0.5 percentage point or more → **Higher**
    - a change less than 0.5 percentage point → **Similar**
    - a decrease of 0.5 percentage point or more → **Lower**
- If percent positivity in the previous week was 10% or over:
    - an increase of 5% or more → **Higher**
    - a change less than 5% → **Similar**
    - a decrease of 5% or more → **Lower**

Outbreaks

- Any move from 0 → **Higher**
- Any move to 0 → **Lower**
- If the number of new outbreaks in the previous week was under 50:
    - an increase of 5 or more outbreaks → **Higher**
    - a change less than 5 outbreaks → **Similar**
    - a decrease of 5 or more outbreaks → **Lower**
- If the number of new outbreaks in the previous week was over 50:
    - an increase of 10% or more → **Higher**
    - a change less than 10% → **Similar**
    - a decrease of 10% or more → **Lower**

Overall Weekly Indicator Change

The interpretation of the weekly indicator change is compared against the current epidemiologic context. When a percent positivity level is crossed (e.g., from low to moderate) this may be considered as well. If there is discordance between the indicator assessments, the magnitude of the change in each indicator is considered.

Appendix D: Hospital and ICU Outcome Data and Start Dates

Table D1: Start Dates for Bed Occupancy Indicators

Disease	Indicator	Population	Start date
COVID-19	Hospital bed occupancy (total)	Overall	April 1, 2020
COVID-19	Hospital bed occupancy (total)	By age group*	October 11, 2021
COVID-19	Hospital bed occupancy (due to infection)	Overall	January 9, 2022
COVID-19	Hospital ICU bed occupancy	Overall	April 1, 2020
COVID-19	Hospital Admissions	Overall	April 1, 2020
COVID-19	Hospital Admissions	By age group*	October 11, 2021
Influenza	Hospital bed occupancy (total)	Overall and by age group**	November 27, 2022
Influenza	Hospital bed occupancy (due to infection)	Overall	November 27, 2022
Influenza	Hospital ICU bed occupancy	Overall	August 8, 2023
Influenza	Hospital Admissions	Overall	November 27, 2022
RSV	Hospital bed occupancy	Overall and by age group†	November 27, 2022
RSV	Hospital ICU bed occupancy	Overall	October 15, 2024 (pediatric) October 20, 2024 (all)
RSV	Hospital admissions	Overall	November 27, 2022

*As of September 2, 2025, COVID-19 bed occupancy and hospital admissions age groups have changed and are presented as 0 to 4, 5 to 17, 18 to 49, 50 to 64, 65 to 74, 75+. Data by age group will not be updated retroactively to reflect the new categories.

** Influenza bed occupancy for people aged 0 to 17 years are presented from November 27, 2022 to October 31, 2023 as a single stratum and as of November 1, 2023 as three mutually exclusive age groups (0 to 4, 5 to 11, 12 to 17). As of September 2, 2025, influenza bed occupancy age groups have changed and are presented as 0 to 4, 5 to 17, 18 to 49, 50 to 64, 65 to 74, 75+. Data by age group will not be updated retroactively to reflect the new categories.

†As of September 2, 2025, RSV bed occupancy age groups have changed and are presented as < 1, 1, 2 to 4, 5 to 17, 18 to 49, 50 to 64, 65 to 74, 75+. Data by age group will not be updated retroactively to reflect the new categories.

Appendix E: Percent Positivity Levels and Weekly Indicator Change Assessment Data Sources

Table E1: Data Source and Dates for Indicators Used in Weekly Indicator Change Assessments by Disease

Disease	Indicator	Data Source and Dates
COVID-19	Cases*	CCM (up to June 1, 2024) OLIS-derived (as of June 2, 2024)
COVID-19	Percent Positivity	PD-NOC (up to June 1, 2024)** OLIS (as of June 2, 2024)
COVID-19	Outbreaks	CCM (up to June 1, 2024) iPHIS (as of June 2, 2024)
Influenza	Cases	iPHIS for all PHUs except Toronto Public Health and Ottawa Public Health (up to October 12, 2024) iPHIS or reported in aggregate directly to PHO (October 12, 2024 to September 20, 2025) OLIS-derived (as of September 21, 2025)
Influenza	Percent Positivity	PHAC CERIPP respiratory virus detection tables (up to October 12, 2024)** OLIS (after October 12, 2024)
Influenza	Outbreaks	iPHIS
RSV†	Cases	OLIS-derived (as of August 30, 2026)
RSV†	Percent Positivity	OLIS
RSV†	Outbreaks	iPHIS

*COVID-19 case indicator was not used in the weekly indicator change assessment from June 1, 2024 to September 21, 2025.

**PD-NOC and PHAC data sources have been removed from the tool and replaced with OLIS.

† RSV percent positivity levels and weekly indicator change assessments began the week of October 13, 2024. Cases were included as an indicator in the RSV weekly indicator change assessment starting the week of August 30, 2026.

Appendix F: Projections Indicators

Percent Positivity Projections

- Any move from 0 → **Increase**
- Any move to 0 → **Decrease**
- If percent positivity in the previous week was under 10%:
    - An increase of 0.5 percentage point or more → **Increase**
    - A change less than 0.5 percentage point → **Remain stable**
    - A decrease of 0.5 percentage point or more → **Decrease**
- If percent positivity in the previous week was 10% or over:
    - An increase of 5% or more → **Higher**
    - A change less than 5% → **Similar**
    - A decrease of 5% or more → **Lower**

Hospitalization Risk Projections

- An increase of 5% or more → **Increase**
- A change less than 5% → **Remain stable**
- A decrease of 5% or more → **Decrease**

Appendix G: Data Gaps

Table G1: List of Indicators and Current Data Gaps

Indicator	Data Gap
Hospital ICU bed occupancy	Missing ICU data for COVID-19, influenza and RSV due to a system outage impacting data from September 9, 2023 to October 20, 2023
Hospital Admissions	Missing hospitalization data from August 22, 2025 to September 1, 2025
Hospital Bed Occupancy	Missing hospitalization data from August 22, 2025 to September 1, 2025
Laboratory Testing Data	A test description change in OLIS nomenclature was implemented by Ontario Health on April 30, 2026. As laboratories adopted the change gradually, some test rejections and missing respiratory testing records occurred starting on the week of April 26, 2026. Data were corrected prospectively, while historical records were not updated. Several laboratories had OLIS respiratory test mapping issues that caused missing testing or inaccurate submission. These were resolved prospectively; however, some historical data remain missing or were excluded due to these issues. Missing/excluded data include: • Niagara Health System from November 9, 2024, to October 1, 2025 • Northwestern Health Unit Laboratories (Dr. Peter D. Pan, Sioux Lookout Meno Ya Win Health Centre, Dryden Regional Health Centre, Riverside Health Centre Facilities Inc.) from January 1, 2020, to January 22, 2026 • Humber River Hospital from January 1, 2020, to March 17, 2026

Appendix H: Goal and Objectives of the Ontario Respiratory Virus Surveillance Program

Goal: To promote early detection and provide timely, comprehensive information regarding viral respiratory infections in Ontario, including influenza, COVID-19 and respiratory syncytial virus (RSV), in order to guide prevention and control efforts.

Objectives:

1. To raise awareness of respiratory virus activity and support the implementation of appropriate prevention and control measures, accurate and timely information is collected that will:
    - Allow the determination of the onset, duration, conclusion, geographic patterns, severity and progression of seasonal respiratory virus activity
    - Detect unusual events (e.g., new respiratory pathogens, unusual outcomes or syndromes, unusual severity or distribution, and new influenza strains including epizootic strains, antigenic drift/shift)
    - Identify dominant circulating respiratory viruses
    - Identify influenza types and subtypes to enable comparisons between circulating influenza strains and strains included in and/or recommended for the current season's influenza vaccine
    - Estimate viral respiratory illness indicators such as attack rates, emergency department visits, hospitalization rates, and case fatality rates
    - Identify high-risk groups for viral respiratory illness and complications
    - Allow comparisons with national and international respiratory virus activity
2. To share accurate and timely surveillance information with public health partners at the local, provincial, national and international levels in order to:
    - Anticipate and guide prevention, response, and control efforts
    - Evaluate treatment, prophylaxis and control measures in the management and termination of outbreaks
    - Guide and inform timely research

Appendix I: Surveillance Weeks

Table I1: Surveillance Weeks for the 2026–27 Respiratory Infection Season

Surveillance week	Start date (Sunday)	End date (Saturday)
Week 35	30-Aug-26	05-Sep-26
Week 36	06-Sep-26	12-Sep-26
Week 37	13-Sep-26	19-Sep-26
Week 38	20-Sep-26	26-Sep-26
Week 39	27-Sep-26	03-Oct-26
Week 40	04-Oct-26	10-Oct-26
Week 41	11-Oct-26	17-Oct-26
Week 42	18-Oct-26	24-Oct-26
Week 43	25-Oct-26	31-Oct-26
Week 44	01-Nov-26	07-Nov-26
Week 45	08-Nov-26	14-Nov-26
Week 46	15-Nov-26	21-Nov-26
Week 47	22-Nov-26	28-Nov-26
Week 48	29-Nov-26	05-Dec-26
Week 49	06-Dec-26	12-Dec-26
Week 50	13-Dec-26	19-Dec-26
Week 51	20-Dec-26	26-Dec-26
Week 52	27-Dec-26	02-Jan-27
Week 1	03-Jan-27	09-Jan-27
Week 2	10-Jan-27	16-Jan-27

Surveillance week	Start date (Sunday)	End date (Saturday)
Week 3	17-Jan-27	23-Jan-27
Week 4	24-Jan-27	30-Jan-27
Week 5	31-Jan-27	06-Feb-27
Week 6	07-Feb-27	13-Feb-27
Week 7	14-Feb-27	20-Feb-27
Week 8	21-Feb-27	27-Feb-27
Week 9	28-Feb-27	06-Mar-27
Week 10	07-Mar-27	13-Mar-27
Week 11	14-Mar-27	20-Mar-27
Week 12	21-Mar-27	27-Mar-27
Week 13	28-Mar-27	03-Apr-27
Week 14	04-Apr-27	10-Apr-27
Week 15	11-Apr-27	17-Apr-27
Week 16	18-Apr-27	24-Apr-27
Week 17	25-Apr-27	01-May-27
Week 18	02-May-27	08-May-27
Week 19	09-May-27	15-May-27
Week 20	16-May-27	22-May-27
Week 21	23-May-27	29-May-27
Week 22	30-May-27	05-Jun-27
Week 23	06-Jun-27	12-Jun-27
Week 24	13-Jun-27	19-Jun-27
Week 25	20-Jun-27	26-Jun-27

Surveillance week	Start date (Sunday)	End date (Saturday)
Week 26	27-Jun-27	03-Jul-27
Week 27	04-Jul-27	10-Jul-27
Week 28	11-Jul-27	17-Jul-27
Week 29	18-Jul-27	24-Jul-27
Week 30	25-Jul-27	31-Jul-27
Week 31	01-Aug-27	07-Aug-27
Week 32	08-Aug-27	14-Aug-27
Week 33	15-Aug-27	21-Aug-27
Week 34	22-Aug-27	28-Aug-27
Week 35 (2027–28)	29-Aug-27	04-Sep-27

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