EHMA
European Health Management Association

TAKING INFANT RSV PROTECTION FROM ROLLOUT TO ROUTINE

A study on the initial implementation of RSV prophylaxis in France, Germany, Italy, and Spain

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TABLE OF CONTENTS

EXECUTIVE SUMMARY

The EHMA ReSolVe II study offers a compelling first investigation into how the recent availability of RSV prophylaxis for infants has changed the prevention landscape in European health systems. The study, leveraging surveys and interviews with over 100 experts in paediatric respiratory diseases, explores how the first nationwide rollouts of RSV long-acting monoclonal antibodies unfolded in four European countries: France, Germany, Italy, and Spain. The data uncovered offers valuable insights about what changed within hospitals and primary care, how staff and workflows were affected, and whether these national health systems appear ready to sustain and expand the programme in the coming seasons.

As the first in-depth cross-country analysis of the operational, workforce, and social readiness for this new preventive measure, this report and the comprehensive findings it presents should be carefully considered by all managers and policymakers working on public health, paediatric medicine, and health system sustainability.

Across all four countries studied, experts described a visible easing of the typical seasonal pressure on respiratory care settings over winter after long-acting monoclonal antibodies were made available as prophylaxis. Meaningfully, this was accompanied by a sense of collective achievement after years of heavy seasonal burden.

The clearest reported gains were in **health outcomes and patient flow**: hospitals faced fewer RSV-related admissions, paediatric and intensive-care beds were less strained, and emergency bottlenecks eased. **Operational efficiency** improved across the board, while financial effects were judged positive but uneven, reflecting different reimbursement and procurement models. **Staff well-being** was another notable benefit. Clinicians across multiple care settings reported that the lighter RSV caseload translated into calmer winter shifts and better psychological resilience. **Training demands** shifted away from acute case management towards the practicalities of administering and tracking prophylaxis, with most systems managing this transition without creating additional pressure on the workforce. Overall **staffing levels** remained stable, suggesting that the programme relieved rather thon intensified workload, even during its inaugural season where some initial structural challenges would be expected.

Promisingly, when respondents were asked for their perspective on the future, they judged **national infrastructures and regulatory mechanisms** largely fit to continue the programme. Logistics, storage capacity, and cold-chain reliability were not perceived as limiting factors. Financing mechanisms, while moderately strong, differed substantially between countries, with some regions still relying on *ad hoc* budgeting. The largest perceived obstacle to future success was sociocultural: **parental understanding and acceptance** of monoclonal antibody prophylaxis lagged far behind the clinical community's technical preparedness. Many health workers reported frequent parental hesitation, often rooted in confusion between monoclonal antibodies and vaccines, or attached to broader scepticism toward immunisation.

However, the extended expert interviews included in the study underscored additional opportunities for improvement that would build a stronger foundation for infant RSV prophylaxis moving forward. Notably, the **quality of training** on this prevention programme for health professionals appears to vary widely across the four countries. Spain was considered a reference case for consistent, pre-season training, whereas clinicians in Italy, Germany, and France reported uneven access to accredited courses or peer support. Training materials focused effectively on scientific content and logistics but rarely equipped professionals to handle nuanced conversations with parents.

Public communication campaigns were similarly uneven, with limited scope, regional fragmentation, and inconsistency in tone. As a result, health professionals found themselves as the primary source of information but were not equipped with the tools or time to build the necessary trust and understand among families.

Despite these gaps, ReSolVe II points an overall positive picture. The rollout of infant RSV prophylaxis in Europe had a technically robust, operationally successful first year that has already improved paediatric winter care. The challenge now is to consolidate that success by strengthening communication, harmonising procedures, and ensuring that every family, regardless of geography or background, receives accurate information and ready access to RSV long-acting monoclonal antibodies.

INTRODUCTION

Respiratory syncytial virus (RSV) is a principal viral cause of acute lower respiratory tract infection in infants and young children worldwide, accounting for an estimated 33 million episodes annually and more than 3 million hospital admissions in children under five years of age[1]. Among infants aged 0-6 months, the infection is associated with approximately 6.6 million acute lower respiratory infection episodes and 1.4 million hospital admissions globally[2], with bronchiolitis and viral pneumonia constituting the predominant clinical phenotypes driving RSV-related hospitalisations in temperate regions[1]. On top of that, severe infection during the first year of life has shown to increase the risk of later wheezing disorders and asthma, thereby extending the impact on families and health services through persistent airway morbidity[2].

From a system standpoint, the burden of RSV also appears to be substantial. Global direct medical spending on RSV-associated acute lower respiratory infection in 2017 was estimated at €4.82 billion, with inpatient care accounting for 55% of total expenditure. Inpatient management represents the largest cost component, and mean admission costs in high-income settings reach €3,452 per episode[3].

In recent years, long-acting monoclonal antibodies (mAbs) have introduced a novel prophylactic modality for RSV by providing passive neutralising immunity through a single intramuscular dose with an extended half-life of approximately 70 days[4]. Randomised trials demonstrate that nirsevimab reduces RSV-associated hospitalisation by 83.2% through the first season and maintains efficacy of 82.7% at 180 days, covering the full duration of typical RSV circulation[5]. Notably, early implementation reports from France, Spain and the United States confirm that population-wide infant prophylaxis is operationally feasible and associated with high programme uptake where supply remains sufficient[6].

The original ReSolVe project (2020-2022) examined the extent to which seasonal RSV epidemics disrupt European paediatric and emergency care pathways, with downstream impacts on workforce capacity, hospital logistics and service continuity. On this basis, ReSolVe II maps how the introduction of infant RSV prophylaxis is altering health-system demand patterns and preparedness requirements in Italy, Spain, Germany and France, where universal or near-universal immunisation programmes with nirsevimab were initiated between the 2023/24 and 2024/25 seasons.

The ReSolVe II study

The ReSolVe II study was conceived as a multinational mixed-methods observational investigation examining the implementation, operational impact, and longer-term sustainability of RSV prophylaxis programmes for infants across Italy, Spain, Germany, and France. It sought to determine how the introduction of long-acting monoclonal antibodies (mAbs) for RSV prophylaxis reconfigures health-system functioning and workforce dynamics, and whether the existing institutional and infrastructural arrangements are equipped to sustain such programmes beyond their first year of adoption.

The four participating countries were deliberately selected as early European adopters of nationwide, fully reimbursed RSV long-acting monoclonal antibody programmes for infants, with implementation initiated in Spain and France during the 2023-2024 RSV season and subsequently extended to Italy and Germany in the 2024-2025 season.

Conducted between 12 February and 16 October 2025, the study followed a two-phase compound design including quantitative and qualitative methodologies. **The first phase**, a cross-sectional online survey, captured structured evidence from clinical and administrative personnel operating in both inpatient and outpatient environments. The questionnaire investigated the perceived effects of the intervention along two axes: system-level implications, encompassing operational, financial, regulatory, infrastructural, logistical, and socio-cultural dimensions; and workforce-level implications, covering workload distribution, skill requirements, and coordination patterns across care settings. The concluding section assessed each country's readiness to sustain the programme in the medium term through ratings of organisational capacity, financing arrangements, and regulatory maturity.

Respondents were recruited through targeted dissemination via professional networks, national medical associations, and EHMA communication channels, with eligibility restricted to professionals directly involved in RSV prevention, diagnosis, care, or programme administration. Quantitative data were processed in R using descriptive statistics and stratified tabulations by country, care setting, and role, with prespecified exclusions applied to retain only responses pertinent to systems with an operational RSV prophylaxis programme.

The second phase consisted of semi-structured interviews designed to capture elements of RSV diagnosis, care and management not amenable to straightforward quantification. Issues pertinent to training provision, public awareness, equity of access and surveillance mechanisms, were regarded as too intricate to be reduced to questionnaire metrics, and therefore warranted qualitative examination. Discussions were framed against the 2023 EHMA Policy Recommendations, with the enquiry seeking not merely an appraisal of current practice but also the articulation of concrete directions for improvement.

Participants profiles

A total of 96 respondents constituted the overall survey cohort, with 44% from Spain, 24% from Germany, 23% from France and 9% from Italy. The sample demonstrated a clear dominance of clinical professionals, who constituted 83 out of 96 respondents, 86%, while the remaining 13 responders held administrative positions, either in exclusively managerial roles or in clinically affiliated administrative functions.

Likewise, approximately two thirds of the respondents were affiliated with inpatient care, while 19% were based in outpatient structures and 12% reported engagement across both settings, which illustrates a distribution that extends across the continuum of care. Importantly, the preponderance of professionals identifying as "primary vaccinators", 66%, serves as a clear indication that the questionnaire reached those most directly involved in prophylaxis delivery (Figure 1).

Figure 1

Respondent clinical roles and vaccinator status

Role Type	Primary Vaccinator	Not Primary Vaccinator	Total (n)	Primary Vaccinators (%)
Clinical	56	26	83	67%
Clinical Administrative	6	5	11	55%
Total	62	31	94	66%

* The total number of respondents differs from the overall survey cohort (n = 96) due to blank replies for this question.

The professional composition of the total cohort was heavily skewed towards paediatricians, who accounted for half of the sample, followed by neonatologists at 22% and nurses of all types at 13%. The remaining 13% comprised a diverse set of roles, including nursing assistants, pharmacologists, surgeons, anaesthesiologists, public health specialists, hygienists and preventive medicine professionals, biologists, obstetricians, and social workers, alongside isolated representations from internal medicine, midwifery, and non-medical health administration.

This concentration on paediatrics and nursing suggests that the data largely captures the views of those responsible for infant care and immunisation pathways, while broader system-level or ancillary perspectives are under-represented.

The interview series included 13 participants, with 39% coming from Spain, 31% from Italy, 15% from France and 8% from Germany. The group brought together clinicians involved in RSV prevention and care, as well as professionals holding managerial or coordination roles within regional health structures. Around two thirds worked primarily in outpatient or community-based settings, while the remainder were attached to hospital departments or operated across both. Institutional affiliations ranged from paediatric and neonatal wards to emergency units, vaccination centres, and regional health authorities. Several contributed insights from pharmacy and primary-care coordination, areas typically under-represented in observational research and surveillance data, yet central to understanding the logistical and prescribing dimensions of new prophylaxis programmes.

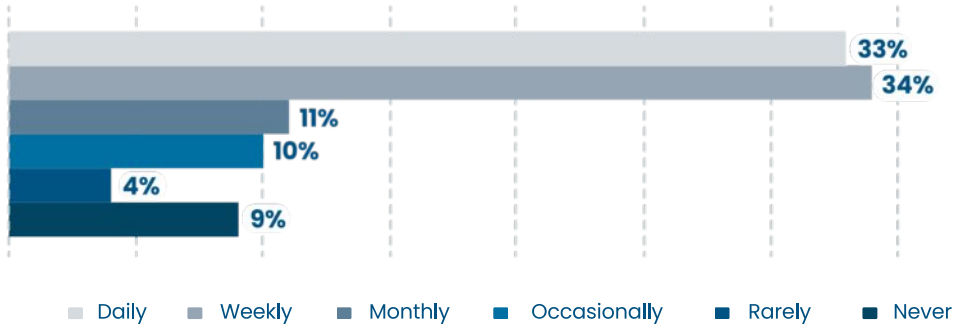
Awareness and familiarity

Participation was conditional on systems with active or planned prophylaxis; respondents expressing unawareness of national or regional implementation of long-acting monoclonal antibody use in infants were excluded from the analysis. Levels of familiarity with RSV characteristics among remaining respondents was consistently high. In the survey, 94% reported being "very familiar" with the virus and its paediatric impact, while only a marginal share declared partial familiarity (5%) or no familiarity at all (1%). The interview sample echoed this pattern, with ten of thirteen participants self-classified as "very familiar" with national or regional RSV prophylaxis use and three indicating only partial familiarity.

This declared knowledge base was reinforced by the frequency of clinical exposure. As shown in Figure 2, one third of survey participants, 33%, reported encountering infants with RSV or related complications on a daily basis, while a comparable proportion, 34%, did so weekly. A further 11% reported monthly encounters, while smaller proportions noted occasional or rare exposure. Only a small fraction, 9%, stated that they did not manage any such case over the last year, a finding largely explained by the presence of respondents whose professional remit does not centre on RSV itself but on adjacent aspects of maternal or childcare, such as public health, obstetrics, anaesthesiology, social work, and nursing functions oriented toward supportive or preventive care rather than clinical diagnosis.

Figure 2

Reported frequency of infant RSV encounters among survey respondents



In the aggregate, these distributions imply that the perspectives represented in the study derive predominantly from professionals with sustained and recurrent engagement with RSV in practice, with 92% across both questionnaire and interview samples expressing advanced familiarity with RSV.

PHASE I – SURVEY RESULTS

Healthcare systems

As shown in Figure 3, survey participants reported uniformly positive perceptions regarding the system-wide effects of introducing long-acting monoclonal antibodies for RSV prophylaxis. Mean values across the three assessed domains - operational efficiency, financial resources, and health outcomes - were all above the neutral midpoint of the scale (0), indicating a perceived net improvement following recent implementation.

The highest mean score was observed for **health outcomes (1.77 ± 0.57)**, revealing a broadly shared view that the intervention has led to measurable gains in clinical performance and patient trajectories, likely linked to reductions in RSV-related admissions and complications. **Operational efficiency (1.46 ± 0.84)** followed closely, suggesting that resource use, patient throughout, and procedural coordination benefitted substantially from decreased RSV caseloads. The narrower standard deviation for these two domains points to a relatively homogeneous perception across settings.

By contrast, **financial resources (0.86 ± 1.08)** received the lowest mean rating and displayed the widest dispersion. This indicates a more heterogeneous appraisal of economic effects, consistent with variations in national reimbursement structures and institutional budgetary arrangements.

While most respondents perceived the financial impact as favourable, some expressed reservations, possibly attributed to transitional budgetary pressures incurred during the first horizontal implementation cycle, including one-off procurement and set-up costs.

Figure 3

Perceived health system impact of long-acting RSV mAbs by domain

*Error bars represent ±1 standard deviation from the mean.

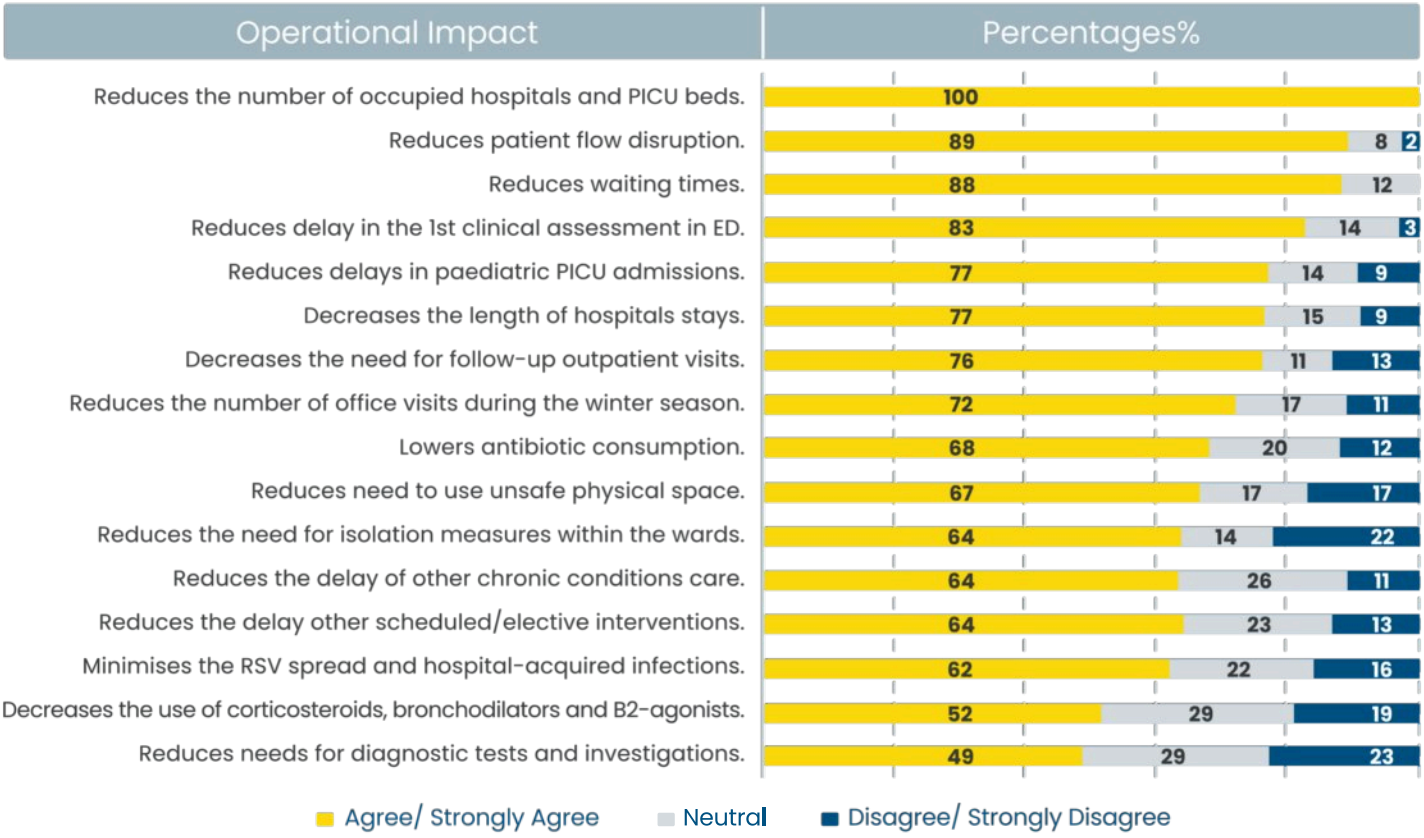
Moving forward, the study examined the operational dimension in greater depth, assessing how the perceived system improvements translated into specific service processes. As shown in Figure 4, the highest agreement rates were observed for indicators directly linked to acute care capacity and patient flow management, with nearly universal endorsement that the intervention **reduced the number of occupied hospital and PICU beds**, 100%, and **alleviated patient flow disruption**, 89%. Likewise, large majorities agreed that **waiting times and delays in emergency or paediatric assessments had declined**, confirming a perceived improvement in throughput across critical care nodes.

Consistent agreement was expressed for post-acute and outpatient parameters, such as **decreased length of stay**, 77%, **reduced need for follow-up visits**, 76%, and **fewer office visits during the winter period**, 72%. These findings suggest that the benefits extend beyond immediate hospital relief to continuity -of-care and ambulatory functions.

Consensus was weaker in relation to infection control and diagnostic or prescribing behaviour, with divergent views were most evident for statements concerning reduced diagnostic testing, 23%, decreased isolation measures, 22%, and lower corticosteroid or bronchodilator use, 19%. This distribution of opinions implies that downstream operational adjustments, requiring behavioural or procedural change, are less immediate and more dependent on institutional policies and clinical discretion than on the direct epidemiological effects of RSV prophylaxis itself.

Figure 4

Item-level perceptions of health system operational impact of long-acting RSV mAbs among clinical respondents



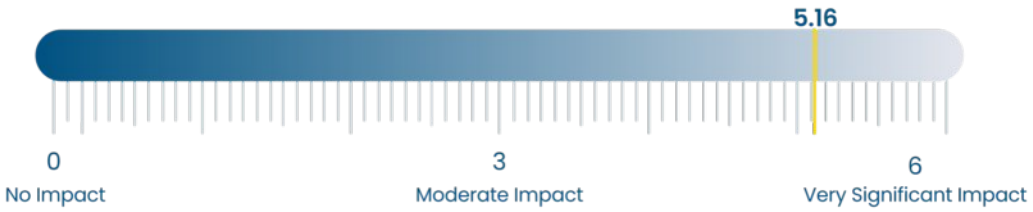
* Responses marked *"Not Applicable to my Role"* as well as incomplete responses were excluded from the denominator in percentage calculations.

Healthcare workforce

As a first step, the analysis examined the extent to which seasonal RSV epidemics were viewed to impact healthcare professionals in the absence of long-acting prophylaxis (Figure 5). Consistent with findings from the ReSolVe I, a mean score approaching the upper limit of "Very significant impact" underscores the recurrent and cross-sectoral nature of the seasonal stressor.

Figure 5

Perceived impact of the RSV epidemic on healthcare professionals, prior to long-acting prophylaxis



The analysis then turned to how the introduction of long-acting prophylaxis was perceived to influence workforce dynamics across distinct macro-domains. All domains, shown in Figure 6, yielded positive mean values, indicating a generally favourable assessment of the intervention's effect on professional practice and staff well-being.

The highest reported impact concerned **operational efficiency (1.36 ± 0.78)**, suggesting that the alleviation of RSV-related demand translated into more balanced workloads, smoother shift organisation, and fewer episodes of service saturation. **Psychological well-being (1.24 ± 0.75)** followed closely, attributed to a perceived reduction in stress, fatigue, and occupational strain during the winter period. The narrow dispersion for these two domains demonstrates a broadly homogeneous view among respondents, confirming that both operational and psychological relief were experienced consistently across settings.

Conversely, **education and training requirements (0.84 ± 0.80)** received a more moderate positive score, with slightly greater variability. This finding points to a context-dependent reconfiguration of training priorities rather than expansion, as competencies in acute RSV management were progressively substituted by instructions on prophylaxis administration and longitudinal follow-up procedures.

Figure 6

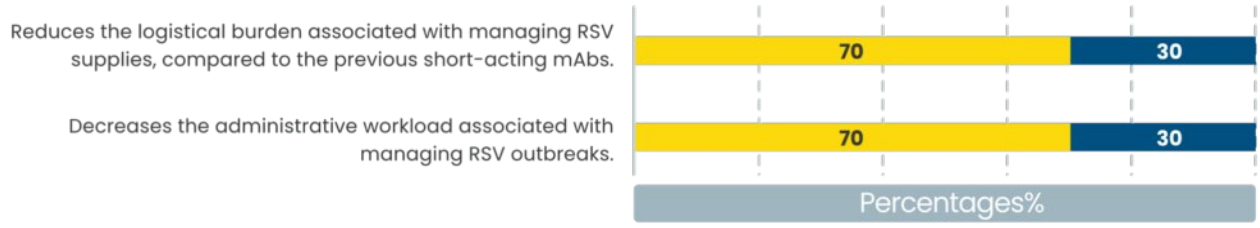
Perceived healthcare workforce impact of long-acting RSV mAbs by domain

*Error bars represent ±1 standard deviation from the mean.

Among respondents holding managerial roles specifically, a clear convergence of views emerged regarding procedural simplification. As shown in Figure 7, 70% of administrative staff observed that recently introduced RSV infant prophylaxis **lessened both the organisational burden of outbreak management and the logistical complexity of supply coordination.** This was observed in direct contrast to the prior use of Palivizumab, which was regarded as more demanding in terms of stock management and distribution logistics.

Figure 7

Item-level perceptions of healthcare workforce impact of long-acting RSV mAbs among administrative respondents

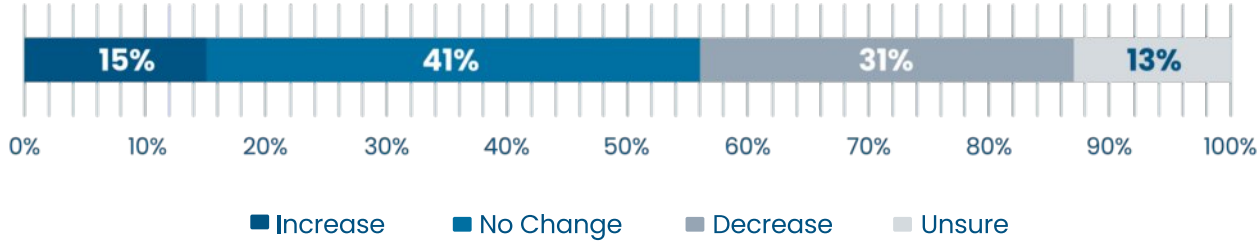


Moving on, the study explored the intricate question of whether the national rollout of RSV prophylaxis influenced healthcare staffing requirements during the RSV season, a subject often viewed as contentious due to the balance between reduced clinical burden and emerging procedural responsibilities. As presented in Figure 8, responses exhibited **marked variability**, with 40% reporting no variation, 30% having perceived a reduction, 15% an increase, and 13% expressing uncertainty.

The prevalence of responses reporting no change is compatible with the interpretation that, in the first year of nationwide implementation, **most facilities maintained their existing staffing** patterns. However, the observed dispersion highlights the absence of a consolidated trend and implies that staffing dynamics are mediated by baseline workforce capacity and care delivery models.

Figure 8

Distribution of reported changes in healthcare staffing needs during RSV season



Readiness for implementation

The concluding component of the questionnaire assessed the capacity of healthcare systems in the four participating countries to consolidate long-acting RSV mAb prophylaxis within their routine national immunisation programme over the coming years.

Across the survey cohort, the highest readiness levels were expressed in **infrastructural and operational domains**, both exceeding mean scores of five on a six-point scale. These results convey that the physical and procedural conditions for prophylaxis deployment were already in place, with adequate storage capacity, reliable distribution mechanisms, and a clinically competent workforce to deliver the intervention. Yet, within the infrastructure domain, readiness was considerably lower for supporting functions related to digital tracking (4.1), population outreach to remote or underserved areas (4.0), and invitation or recall systems (3.6). This pattern aligns with a common dependence on digital system maturity and cross-system data integration, which tend to be less uniformly developed than facility-based infrastructure.

Regulatory and policy structures ranked immediately after, with mean values around 5.3, signifying near-complete integration of RSV prophylaxis into NIPs (National Immunisation Programmes).

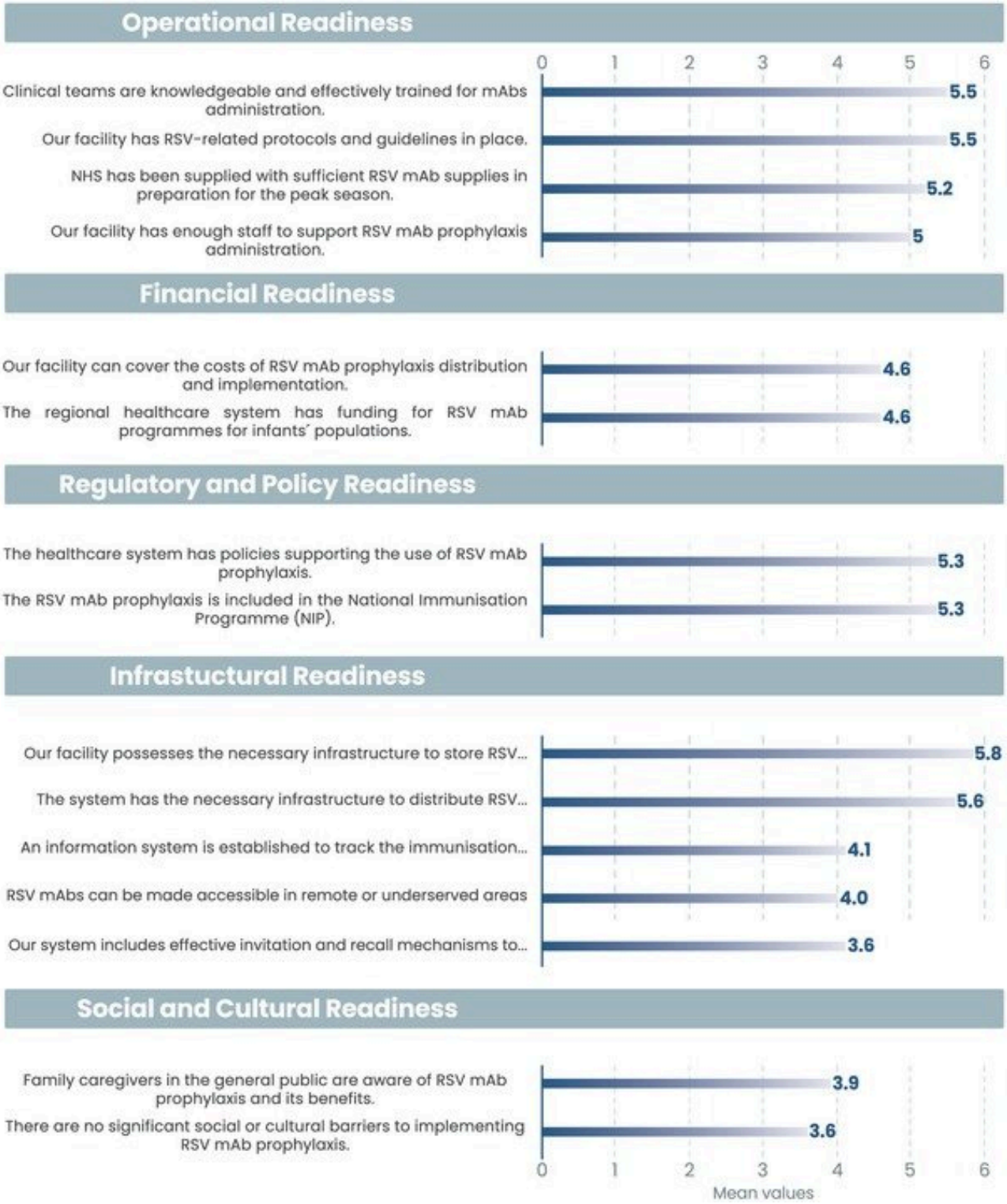
In terms of **financial readiness**, reported levels were moderately positive (=4.6), interpreted as evidence that while resource allocations were generally secured at a macro level, disparities persisted across regions and service delivery points.

The lowest scores were observed in **social and cultural readiness** (3.6-3.9), a range that still denotes moderate favourability but comparatively lags behind the higher-performing domains.

This discrepancy corresponds to a broader pattern in which behavioural and communicative dimensions of long-acting RSV prophylaxis, notably uneven confidence among caregivers, are yet in a formative stage.

Figure 9

Reported levels of readiness for long-acting RSV mAbs prophylaxis implementation by domain

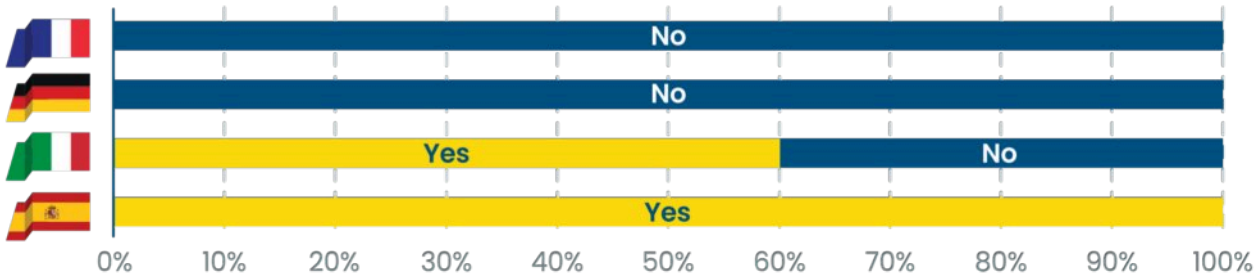


PHASE II - INTERVIEW INSIGHTS

As a first point, focus was placed on **capacity building and training programmes**. Not all interviewed participants reported prior participation in nationally or regionally coordinated training on RSV and the administration of monoclonal antibodies across recent years. Figure 10 shows that interviewed healthcare professionals in France and Germany had not received any relevant instruction, while participation was universal in Spain and partial in Italy, 60%. This pattern serves as a reminder of the uneven dissemination of operational knowledge among European countries.

Figure 10

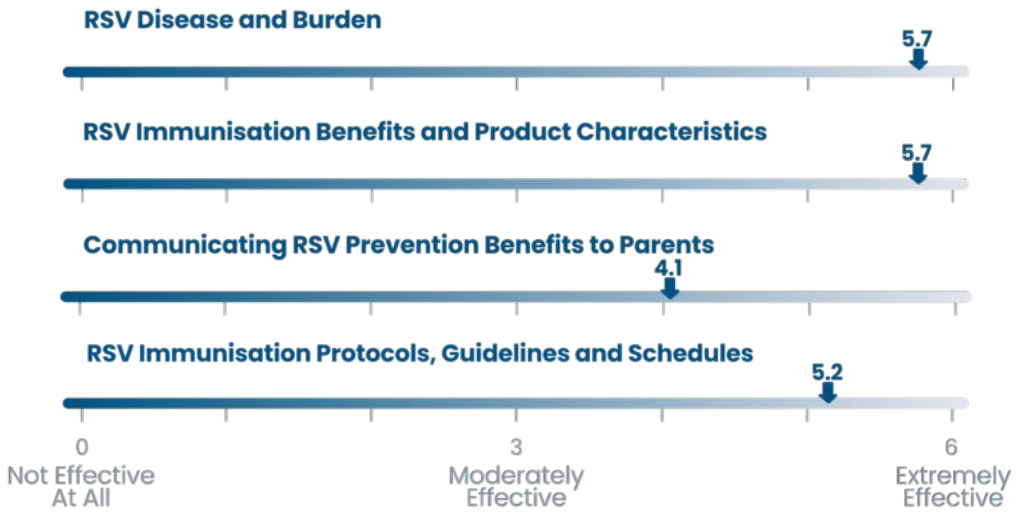
Participation in RSV-related training per country (interviewed cohort)



Among those who had attended educative sessions, activities were not necessarily contemporaneous with the study period, as they were commonly concentrated during the immunisation season. When invited to evaluate the quality and effectiveness of courses across different dimensions, participants conveyed a strong sense of preparedness in technical domains, alongside more reserved views on communication-related skills, as illustrated in Figure 11.

Figure 11

Perceived effectiveness of training on RSV-related domains



Interviews then turned to **public awareness and acceptance**, previously identified in the quantitative survey as the least consolidated component of readiness. The discussion revealed uneven progress across settings: awareness initiatives were reported in Germany, Italy, and Spain, while in France and parts of Italy such campaigns were either absent or insufficiently visible. Given that the study was conducted during the summer period, several participants among those acknowledging the presence of such initiatives clarified that these referred primarily to seasonal campaigns implemented during the RSV peak months.

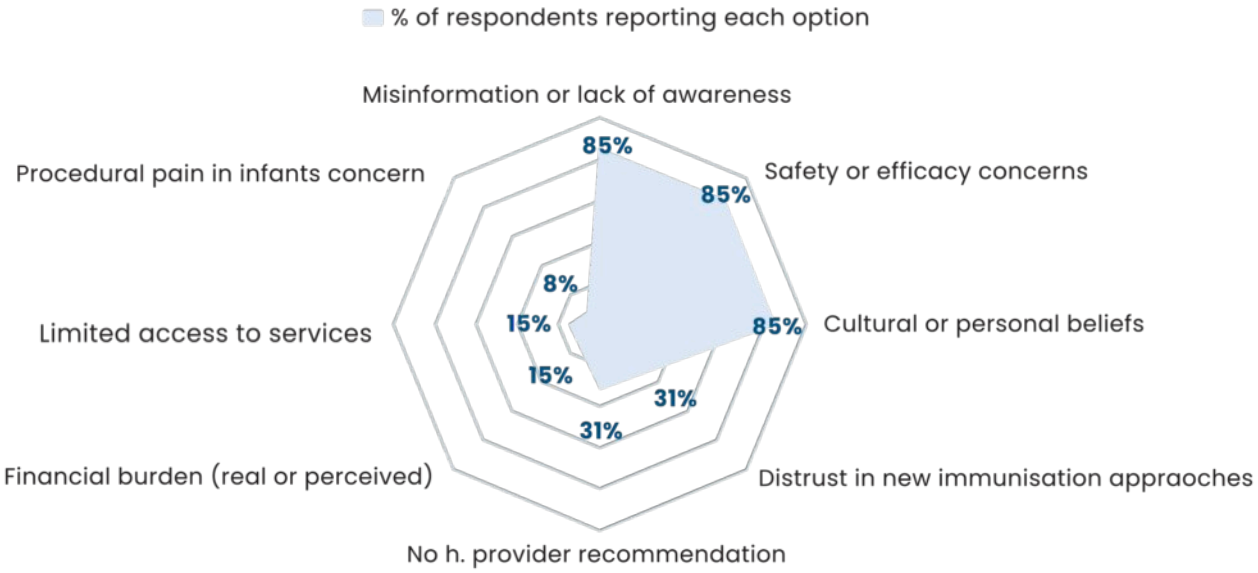
However, the perceived effectiveness of these initiatives in conveying central messages to parents and caregivers was more variable. Ratings ranged from 3 to 6 on a six-point scale, yielding a mean score of 4.8, which positions effectiveness within a moderate range.

Interviewees were asked to identify the main barriers to parental acceptance and uptake of long-acting RSV mAbs, which are summarised in Figure 12.

Three interrelated domains - information asymmetry about mAbs preventive role, concerns regarding potential side effects, and cultural framing of immunisation - were consistently cited as the dominant determinants, each reported by 85% of participants (n=II). Secondary factors included distrust in new immunisation technologies and absence of explicit healthcare-provider endorsement (n=4; 31% each), while a smaller proportion cited structural impediments such as financial or access constraints (n=2; 15%). A single participant referred to concerns regarding procedural discomfort in infants, a reminder that perceptions of the intervention's acceptability can be also influenced by emotive cues.

Figure 12

Reported frequency of parental barriers to uptake of RSV mAbs (interviewed cohort)



TAKEAWAYS AND RECOMMENDATIONS

Quantitative evidence from Phase I and Phase II indicates that the introduction of long-acting monoclonal antibodies for infant RSV prophylaxis has generated system-wide effects that are directionally consistent across countries and professional roles, with impacts concentrated on service pressure, workforce functioning, and delivery readiness.

The intervention performed **most effectively in relieving acute-care pressure**. Respondents reported marked reductions in winter congestion across paediatric wards, intensive-care units, and emergency departments, accompanied by improved patient flow and fewer service bottlenecks. These effects were observed at scale and with high convergence, indicating that the programme delivered immediate operational gains during peak RSV periods.

Service delivery benefits were strongest where RSV burden had been most concentrated. Hospital occupancy, emergency throughput, and continuity of care showed the clearest improvements, while areas less directly linked to RSV incidence demonstrated weaker and more variable effects. This pattern suggests that the prophylaxis programme achieved its primary objective of mitigating seasonal demand surges, with secondary effects on clinical practice evolving more gradually.

From a workforce standpoint, the programme **was effective in moderating seasonal workload intensity** without destabilising staffing structures. Respondents reported improved shift organisation and reduced service saturation, together with gains in professional well-being. No systematic evidence of staffing disruption or increased personnel requirements during the rollout phase was noted.

In terms of implementation readiness, **the programme benefitted from pre-existing foundational conditions**. Clinical protocols, and regulatory alignment were widely assessed as adequate, which enabled timely integration into routine service delivery. **Infrastructural readiness was more variable**, with supporting digital infrastructure elements at a less advanced stage of development.

Surprisingly, societal-facing dimensions **lagged behind technical delivery**. Quantitative interview ratings indicate that, while professional preparedness was high, communication capacity and public awareness were less consolidated. Remaining barriers to uptake were predominantly informational and perceptual rather than organisational, financial, or clinical.

Overall, the quantitative evidence indicates that **the programme functioned effectively where health-system control was greatest** – namely acute care, service organisation, and workforce management. As a result, consolidation of benefits now depends less on further structural investment and more on improving alignment between established delivery capacity and caregiver understanding.

In aggregate, the empirical results point to a clear asymmetry between areas governed primarily by institutional levers and areas in which performance hinges on behavioural alignment outside formal care settings. On this basis, the policy guidance is structured into **two interlinked sets**, corresponding to these distinct mechanisms of influence.

The first set of recommendations is informed by domains in which quantitative and qualitative evidence demonstrated strong consistency and a high degree of operational consolidation. The action points below concern the **reinforcement of delivery arrangements within the health system**, where institutional authority, professional capacity, and organisational preparedness are adequately in place. Priority is given to protocol harmonisation, workforce preparedness, clinical oversight, and the codification of knowledge. The objective is to codify current practice, reduce unwarranted variation across regions and professional groups, and secure the incorporation of RSV prophylaxis into standard service delivery arrangements.

1

Establish uniform annual immunisation protocols

A joint timetable for RSV prophylaxis should be issued and communicated uniformly across all relevant professional groups. The protocol should specify timings, eligibility criteria and task distribution, with explicit mention to the role of midwives with the delivery pathway.

2

Involve frontline personnel in programme design

The planning of immunisation programmes should formally include practising clinicians, nurses and midwives, so as to guarantee operational feasibility and a balanced distribution of tasks across professional groups.

3

Incorporate communication competencies into curricula

Training frameworks should incorporate modules on motivational and risk-benefit communication to strengthen professionals' capacity to counsel caregivers and address parental hesitancy.

4

Institutionalise accredited counselling courses

Accredited pre-season courses featuring simulated consultations should be developed for paediatric and other frontline staff. The objective is to embed counselling as a measurable skill rather than a theoretical construct.

5

Clarify product classification and clinical guidance

Clear guidance is required to differentiate vaccines from monoclonal antibodies, hence removing ambiguity at the point of care and preventing the transfer of clinical decisions to uninformed carers.

6

Reinforce peer-to-peer and practice-based learning

Interactive workshops and collegial exchange should supersede static lecture formats. Direct engagement between practitioners promotes the contextual transfer of expertise and procedural coherence.

7

Develop a centralised scientific resource repository

A single central digital platform is necessary to host validated efficacy data, real-world evidence, technical protocols, and reference materials. System-wide access would support evidence-based practice and standardise communication.

The second set of recommendations targets domains in which performance remains limited despite sufficient technical capacity. Collected evidence indicates that constraints now arise primarily from caregiver knowledge, risk perception, and navigation of access pathways rather than from delivery capability.

Proposed measures pertain to the interfaces beyond the clinical setting, including public communication, incentive design, early-life counselling, recall and follow-up arrangements, and outreach models. The aim is to align existing delivery capacity with caregiver engagement, thereby converting system readiness into sustained and equitable uptake.

1

Integrate RSV prophylaxis into standard immunisation reimbursement channels

Standardise RSV prophylaxis financing within national immunisation schemes so that reimbursement procedures match existing vaccine frameworks and hospitals retain zero-cost access to procurement.

2

Avoid conflation of RSV prophylaxis with vaccination

Frame RSV prophylaxis communication using modality-specific terminology that distinguishes mAbs prophylaxis from vaccination, to avoid false equivalence at the point of care and prevent spill-over of generalised vaccine hesitancy.

3

Utilise testimonial and digital media campaigns

Leverage patient narratives, visual storytelling, and mainstream digital platforms to reinforce awareness of RSV risks and resonance with target audiences.

4

Introduce incentive mechanisms for health professionals

Adopt performance-linked reimbursement and bonus schemes that reward clinicians for achieving defined RSV immunisation coverage targets, hence reducing inter-regional variability in delivery rates.

5

Embed midwives and obstetricians in early-stage parental counselling

Formalise the role of midwives and obstetric providers in antenatal education to deliver sequential guidance from pregnancy through early infancy.

6

Promote post-delivery follow-up

Introduce automated postnatal follow-up procedures within electronic health record systems, including invitation and recall mechanisms, to support adherence to immunisation schedules, with a focus on off-season deliveries.

7

Produce multilingual and culturally mediated communication channels

Disseminate multilingual, culturally neutral materials and engage mediators or trusted community figures to guide access to health services and counter misinformation on mAbs-based prophylaxis.

8

Deploy non-traditional vaccination units

Extend RSV prophylaxis administration to mobile health teams and authorised pharmacies, particularly in underserved or transient communities.

REFERENCES

1. Bianchini S, Silvestri E, Argentiero A, Fainardi V, Pisi G, Esposito S. Role of respiratory syncytial virus in pediatric pneumonia. Microorganisms. 2020;8(12):2048. doi:10.3390/microorganisms8122048.

2. Cedrone F, Montagna V, Del Duca L, Camplone L, Mazzocca R, Carfagnini F, et al. Epidemiology of bronchiolitis and respiratory syncytial virus and analysis of length of stay from 2015 to 2022: retrospective observational study of hospital discharge records from an Italian southern province before and during the COVID-19 pandemic. Diseases. 2024;12(1):17. doi:10.3390/diseases12010017.

3. Zhang S, Akmar LZ, Bailey F, Rath BA, Alchikh M, Schweiger B, et al. Cost of respiratory syncytial virus-associated acute lower respiratory infection management in young children at the regional and global level: a systematic review and meta-analysis. J Infect Dis. 2020;222(Suppl_7):S680-S687. doi:10.1093/infdis/jiz683.

4. Drysdale SB, Cathie K, Flamein F, Knuf M, Collins AM, Hill HC, et al. Nirsevimab for prevention of hospitalizations due to RSV in infants. N Engl J Med. 2023;389(26):2425-35. doi:10.1056/NEJMoa2309189.

5. Munro APS, Drysdale SB, Cathie K, Flamein F, Knuf M, Collins AM, et al. 180-day efficacy of nirsevimab against hospitalisation for respiratory syncytial virus lower respiratory tract infections in infants (HARMONIE): a randomised, controlled, phase 3b trial. Lancet Child Adolesc Health. 2025;9(6):404-12. doi:10.1016/S2352-4642(25)00102-6.

6. Morris T, Acevedo K, Alvarez Aldeán J, Fiscus M, Hackell J, Pérez Martín J, et al. Lessons from implementing a long-acting monoclonal antibody (nirsevimab) for RSV in France, Spain and the US. Discov Health Syst. 2025;4:21. doi:10.1007/s44250-025-00198-7.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