



Creating a Catalyst for Action Around Infant RSV Immunization



Alliance for Women's
Health & Prevention

Creating a Catalyst for Action Around Infant RSV Immunization

EXECUTIVE SUMMARY

Respiratory syncytial virus (RSV) remains the leading cause of hospitalization among infants in the United States, placing a substantial burden on children, families, clinicians, and the healthcare system. In recent years, major advances to help protect against RSV in infants have been brought to market, although significant gaps in awareness, access, reimbursement, and care coordination continue to limit uptake.

Highly effective prevention options are now available through maternal vaccination during pregnancy and infant immunization with long-acting monoclonal antibodies (mAbs), creating new opportunities to reduce severe illness, hospitalization, and healthcare strain associated with RSV disease. However, despite the availability of these prevention tools, uptake remains inconsistent across communities and healthcare settings.

Centers for Disease Control and Prevention (CDC) survey data indicate that infant RSV protection has improved over time, increasing from [57.0% during the 2024–25 RSV season](#) to [65.1% during the 2025–26 season](#) through maternal vaccination or receipt of a mAb. However, a substantial proportion of eligible infants remain unprotected. Among survey respondents whose infants had not yet received an RSV mAb and whose mothers had not received maternal RSV vaccination in the 2025–2026 survey, more than 10% reported that they “probably will not” or “definitely will not” have their infant receive an RSV mAb, suggesting that many eligible infants may continue to go unprotected against severe RSV disease.

CDC [data](#) also suggest a concerning drop-off in infant RSV mAb administration between January and March, as cumulative uptake begins to plateau even while RSV continues to circulate

widely in many parts of the country. Furthermore, families in rural and underserved communities may face [particular barriers](#) to uptake. As a result, many eligible infants remain unprotected during a critical window of vulnerability.

A range of educational, operational, financial, and policy barriers continue to contribute to these gaps in protection. Public awareness of RSV and available prevention options remains limited, while fragmented coordination between care settings can create missed opportunities for timely maternal and infant immunization. At the same time, reimbursement challenges, barriers within the Vaccines for Children (VFC) program, and limitations in healthcare infrastructure — particularly in rural communities — may further restrict access to RSV immunization for eligible infants.

Addressing these challenges will require sustained collaboration across the healthcare continuum. Policymakers, payers, clinicians, hospitals, public health leaders, and community organizations all have a role to play in improving education, strengthening reimbursement pathways, enhancing data tracking and care coordination, and integrating RSV immunization into maternal, newborn, and pediatric workflows. Together, these efforts can help ensure that more infants receive timely protection against severe RSV disease during their most vulnerable early months of life.

CONTENTS

- The Burden of RSV Disease Among Infants
- The Protection Landscape
- Barriers to Infant RSV Immunization
- Practical Strategies to Advance Uptake
- Call to Action: Increasing Uptake Requires All of Us

THE BURDEN OF RSV DISEASE AMONG INFANTS

Respiratory syncytial virus (RSV) is a **highly contagious** respiratory virus and the **leading cause of hospitalization** among infants in the United States. RSV spreads easily through respiratory droplets, direct physical contact, and contaminated surfaces, allowing it to move quickly through households, childcare settings, and communities during seasonal surges.

While RSV infections are extremely common, the **severity of illness is often unpredictable**. Some infants only experience mild cold-like symptoms such as congestion, coughing, decreased appetite, and fever, while others rapidly develop severe respiratory complications requiring emergency care or hospitalization. Infants younger than six months, premature infants, and children with chronic health conditions are at especially high risk. Additionally, **70% of the babies hospitalized** are born at full-term and are healthy, demonstrating that severe RSV disease can also occur in otherwise healthy infants with no known risk factors.

RSV typically follows a **seasonal pattern** in the United States, with cases increasing during the fall and peaking during the winter months. In most parts of the country, RSV season generally begins in **October or November and continues through March or April** (with some variance in Florida, parts of the Southeast, Hawaii, and other tropical or subtropical areas).

RSV is also the **leading cause of bronchiolitis and pneumonia** among children younger than 1 year of age in the United States. Bronchiolitis occurs when the small airways in the lungs become inflamed and filled with mucus, leading to wheezing, difficulty breathing, poor feeding, and dehydration. In more severe cases, RSV-related pneumonia can impair oxygen exchange and require supplemental oxygen, hospitalization, or intensive care support. Because there is **no specific antiviral treatment** routinely available for most RSV infections, care is generally supportive and may include hydration, fever management, oxygen therapy, and respiratory support for severe illness. Unfortunately, some children become critically ill, needing the support of a ventilator to breathe, which also requires a serious recovery process.



RSV places a substantial burden on infants, families, and the healthcare system. In the United States, RSV:

- Hospitalizes about **2 to 3 in every 100 babies under 3 months each year**
- Caused an estimated **58,000–80,000 hospitalizations** among children younger than 5 years old each year before immunization products became available
- Infects **almost all children by the time they are 2 years old**

Despite its prevalence, many parents and families are unaware of RSV disease, the available options for protection and their timing of administration, or the **safety and benefits** of maternal vaccination and infant immunization uptake.

Importantly, the burden of RSV is not experienced equally across populations. **Studies** have demonstrated **disparities in RSV hospitalization rates** based on demographic and socioeconomic factors, including race, ethnicity, insurance status, and geography. **Rural communities** may face



particular challenges related to RSV prevention and care, including limited access to maternal and pediatric clinicians, transportation barriers, hospital workforce shortages, and reduced access to preventive interventions during the birth hospitalization or early infancy period. These disparities highlight the importance of increasing awareness about the impact of RSV disease, ensuring equitable access to RSV prevention products, and strengthening the healthcare infrastructure to ensure every baby gets the care they need.

THE PROTECTION LANDSCAPE

Options for Prevention

In recent years, new, highly effective maternal and infant RSV prevention strategies have been developed and deployed — giving us more tools than ever before to protect infants against serious illness and hospitalization caused by RSV disease.

There are currently two primary approaches available to help protect infants against severe RSV disease: **maternal vaccination** during pregnancy and **infant immunization** with a long-acting monoclonal antibody (mAb) after birth.

The maternal RSV vaccine, Abrysvo (manufactured by Pfizer) was approved for use in pregnancy in August 2023 and recommended by the CDC in September 2023. It is recommended by both the [Centers for Disease Control and Prevention](#) (CDC) and the [American College of Obstetricians](#)

[and Gynecologists](#) (ACOG) for pregnant women at weeks 32 through 36 of gestation. In previous years, CDC has recommended maternal RSV vaccination from September through the end of January. On September 2, 2026, ACOG released [updated guidance](#) extending this typical vaccination period to March 1. For subsequent pregnancies, it is “currently not recommended that pregnant patients who received the maternal RSV vaccine during the previous RSV season receive an additional dose during a subsequent pregnancy,” according to [ACOG](#). “For patients vaccinated in a previous pregnancy, their infants should receive a monoclonal antibody during the current respiratory virus season.”

If the parent did not receive an appropriately-timed RSV vaccine while pregnant, or if the parent was vaccinated within 14 days of delivery, administration of a mAb is recommended by both the [CDC](#) and by the [American Academy of Pediatrics](#) (AAP) for infants under 8 months old entering their first RSV season. Typically, RSV mAb administration begins October 1 and continues through at least the end of March. The mAb provides immediate protection and should be administered either shortly before the RSV season (for babies born between April and September) or within 1 week after birth (for babies born October through March).

Ideally, the newborn dose is administered in the hospital prior to discharge. Additionally, babies who are ages 8-19 months and at risk for severe RSV disease (e.g., those with cystic fibrosis or immunodeficiency) are eligible to receive another mAb dose at the beginning of their second RSV season.



“Immunization” vs. “Vaccination”: Why We Use the Term “Immunization” for mAbs

Although monoclonal antibodies (mAbs) are often discussed alongside vaccines because they help protect against infectious disease, the term “immunization” is more accurate than “vaccination” when referring to RSV mAbs.

Vaccines work by stimulating the body’s immune system to produce its own long-term immune response, whereas mAbs provide

direct, season-long protection by delivering antibodies through a medication rather than being produced by the body’s own immune system. Because RSV mAbs do not activate the immune system in the same way traditional vaccines do, they are considered a form of passive immunization rather than vaccination.

There are two mAbs that have been approved for use by the U.S. Food & Drug Administration (FDA). The first mAb option, nirsevimab (brand name Beyfortus, manufactured by Sanofi and AstraZeneca), was approved in July 2023 and recommended by the CDC’s Advisory Committee on Immunization Practices (ACIP) shortly thereafter. In 2025, a second mAb, clesrovimab (brand name Enflonsia, manufactured by Merck), was approved by the FDA for infant RSV protection.¹

There is no preferential recommendation for use of maternal RSV vaccination or infant immunization with a mAb; the appropriate option depends on individual circumstances, including the timing of pregnancy.

While infants only need protection through one of these approaches (rather than both),² together, they create the opportunity to protect infants during their most vulnerable early months of life and help ensure that more babies receive some form of RSV protection, regardless of differences in prenatal care access, birth timing, geography, or healthcare utilization.

Because infant immunization with an RSV mAb presents distinct implementation, access, payment, and delivery considerations — particularly during the birth hospitalization and early infancy period — **this white paper focuses specifically on the role of infant RSV immunization through mAbs.**

	 Maternal RSV Vaccination	 Infant RSV Immunization with a mAb
How it works	A vaccine given during pregnancy stimulates the pregnant patient’s immune system to produce antibodies that pass to the infant prior to delivery to provide protection at birth.	A mAb is given directly to the infant and provides ready-made antibodies for immediate protection.
Timing	Given during pregnancy, between 32-36 weeks’ gestation during RSV season.	Given to eligible infants shortly before or during RSV season, ideally during the birth hospitalization if born during RSV season.
Recommendations	Recommended during pregnancy to prevent severe disease in young infants.	Recommended for the prevention of severe RSV disease in infants younger than 8 months entering or born during their first RSV season when maternal vaccination was not received, was received too close to (within 14 days of) delivery, or maternal vaccination status is unknown.
Insurance coverage	Generally covered without cost-sharing by most Affordable Care Act-regulated plans; also covered by Medicaid and the Vaccines for Children (VFC) program for eligible pregnant patients under 19 years of age.	Generally covered without cost-sharing by most Affordable Care Act-regulated plans; also covered by the Vaccines for Children (VFC) program for eligible infants.
Protective pathway	Protects the infant from birth through transferred maternal antibodies and typically eliminates the need for infant mAb.	Provides direct, immediate protection to infants whose parent did not receive an appropriately-timed vaccine during pregnancy.
Benefit	Hospitalization rates for RSV have fallen by <u>about half</u> since RSV prevention products became available.	

¹ Clesrovimab was approved by the FDA in June 2025 and recommended by the CDC shortly thereafter as an additional preventive option. The product remains FDA approved. Implementation through the Vaccines for Children (VFC) program and inclusion in the routine schedule may be affected by the court’s stay on ACIP actions taken after June 2025.

² The exception is for babies who were born within 14 days of maternal RSV vaccination. These infants are also recommended to receive a mAb.



BARRIERS TO INFANT RSV IMMUNIZATION

Addressing Seasonal Declines in RSV Immunization Uptake

By fall 2026, healthcare providers and families will enter the fourth RSV season with both maternal and infant immunization strategies available to help protect young children from severe disease. Both options are highly effective at preventing severe illness in young children. Unfortunately, even with these options available, RSV immunization rates remain suboptimal in communities across the country.

Centers for Disease Control and Prevention (CDC) survey data indicate that infant RSV protection has improved over time, increasing from [57.0% during the 2024–25 RSV season](#) to [65.1% during the 2025–26 season](#) through maternal vaccination (9.4%) or receipt of a mAb (55.7%). However, a substantial proportion of eligible infants remain unprotected. Among respondents whose infants had not yet received an RSV mAb and whose mothers had not received maternal RSV vaccination in the 2025-2026 survey, more than 10% reported that they “probably will not” or “definitely will not” have their infant receive an RSV mAb, suggesting that many eligible infants may continue to go unprotected against severe RSV disease.

Furthermore, across the 14 state Immunization Information Systems (IIS) jurisdictions that

[reported](#) to the CDC in late April 2026 on RSV mAb administration and coverage estimates among infants less than 8 months old (excludes territories), mAb coverage ranged from 31.8% to 53.9% across jurisdictions, indicating strong variation across different geographies.

CDC [data](#) show that cumulative mAb uptake begins to plateau in January, suggesting a drop-off in administration even as RSV circulation remains high. This drop-off results in far too many babies going unprotected.

Several barriers to infant RSV immunization uptake persist.

1. EDUCATIONAL BARRIERS

One significant barrier to RSV immunization uptake is a **lack of awareness** among parents and the general population about RSV disease and the available prevention options. According to [one 2025 study](#), just 46% of parents were aware of RSV immunizations. RSV may also be less widely known compared to other, more familiar respiratory illnesses such as seasonal influenza (flu) and COVID-19. In the same study, only 35% of parents reported that they knew “a lot” about RSV, while 39% described themselves as somewhat knowledgeable and 20% reported that they knew what RSV was but not much else. Together, these findings suggest that many families may not fully understand the potential severity and unpredictability of RSV infection or the availability of preventive tools to protect infants during RSV season.

Public perceptions of RSV may also be shaped by its **association with COVID-19 and flu**, despite RSV carrying a different risk profile for infants. Hesitancy surrounding vaccines may therefore have downstream consequences for RSV immunization rates. In addition, individuals may conflate the timing of RSV prevention with that of COVID-19 and flu vaccination, which are typically recommended at the beginning of respiratory virus season in the early fall.

However, the challenge with RSV is not the timing of the season — which largely overlaps with flu — but the prevention approach. For flu, adult vaccine decision-makers are accustomed to guidance typically recommended early in the season to build immunity over time. In contrast, RSV prevention for infants follows a different model: protection is needed for infants born throughout the entire season. While the maternal RSV vaccine is administered earlier in the season to allow time for antibody transfer before birth, the option of an infant mAb provides immediate protection and is recommended for eligible infants of an unvaccinated parent born at any point during the season. Because of this difference, RSV prevention should be viewed as both an early-season and a season-long priority — yet some may perceive it as primarily an early-season intervention. This misunderstanding may contribute to lower immunization rates among infants born later in the season, despite their continued risk and the availability of effective, immediate protection.

Clinician perceptions may also influence RSV immunization rates. Some clinicians may experience a decrease in patients presenting with RSV disease because of prevention efforts and, therefore, believe RSV is less of a threat in the community. As a result, they may become less likely to proactively recommend immunization for all eligible infants, despite the important role prevention efforts play in reducing RSV-related hospitalization and severe disease.

2. ACCESS AND COST BARRIERS

Ideally, to reduce barriers and ensure timely protection against severe RSV disease, all eligible infants should receive an RSV mAb before discharge from their newborn hospital stay. However, major **payment and reimbursement barriers** have hindered this goal and contributed to suboptimal uptake. One major challenge involves the [Vaccines for Children \(VFC\) program](#), a federal entitlement program that provides recommended vaccines and vaccine-like products, including RSV mAbs, to children who are Medicaid-eligible, uninsured, underinsured, or American Indian or Alaska Native. [More than half](#)



of all children in the United States are eligible to receive vaccines through the VFC program.

Despite its importance, [only approximately one-third \(36%\) of birthing hospitals are enrolled in the VFC program](#). Historically, the only vaccine routinely administered during the newborn hospital stay was the [hepatitis B vaccine](#), which was universally recommended at birth in 1991. Due to the relatively low cost of hepatitis B vaccines, many hospitals chose to absorb the cost of providing the product to VFC-eligible newborns rather than navigate the VFC program's complex enrollment process. Unlike the hepatitis B vaccine, however, RSV mAbs are significantly more [expensive](#) (about \$25 a dose for a hepatitis B vaccine, in contrast to about \$500 a dose for an RSV mAb), and most hospitals are unable to absorb the cost of providing them to all VFC-eligible infants under their care. As a result, if a hospital is not enrolled in the VFC program, VFC-eligible infants in most states cannot receive RSV immunization during the birth hospitalization, creating a missed opportunity for protection during a highly vulnerable period of infancy.

Substantial barriers to coverage also persist among commercial insurance plans. A major challenge stems from how hospitals are paid for inpatient newborn care. Many commercial insurance plans do not consistently provide appropriate payment to hospitals for purchasing and administering RSV mAbs during the birth hospitalization due to billing and payment challenges associated with inpatient newborn care. The hospital care of commercially insured newborns is typically covered through diagnosis-related group (DRG) payments, which provide hospitals with a bundled payment intended

to cover all services provided during the newborn stay. In most cases, these bundled payments do not account for the cost of purchasing and administering an RSV mAb as contracts between hospitals and payers must be re-negotiated to include these costs. Hospitals may attempt to bill commercial insurance plans for the product separately through line-item billing, but payment policies vary across payers and create uncertainty regarding whether the cost will be covered outside of the bundled DRG payment. As a result, while the patient is not charged for the product out of pocket, hospitals are forced to absorb its cost without payment until payer contracts are renegotiated or updated. This creates significant financial strain and administrative burden for hospitals and has led some hospitals to choose not to offer the RSV mAb to commercially insured infants at all. Overall, misaligned priorities and operational complexities result in a lack of clear, consistent pathways for hospitals to operationalize mAb administration at birth.

These payment issues may also have broader implications for equitable access to RSV protection. Some hospitals that are unable to sustainably provide RSV mAbs to commercially insured infants have chosen not to participate in the VFC program, citing concerns about offering the product only to certain patient populations. Consequently, barriers affecting both commercially insured and VFC-eligible newborns may ultimately result in hospitals not offering RSV immunization to any infants during the birth hospitalization — creating missed opportunities for timely protection during a critical period of vulnerability.

Additional barriers arise from **fragmented coordination** between birthing hospitals and outpatient clinicians for infants who do not receive the RSV mAb prior to discharge. Smaller medical practices may find stocking and administering the product financially prohibitive for commercially insured infants, particularly when payment is delayed. Separately, local health departments may face limited staffing, infrastructure, and VFC program capacity, reducing their ability to function as safety-net immunization providers for eligible infants. These challenges may be particularly acute in rural communities, where there are fewer points of care overall and persistent shortages of pediatricians and family medicine clinicians.

Federally qualified health centers (FQHCs) may help fill some of these gaps because they can participate in the VFC program and provide RSV immunization to eligible infants when hospital administration does not occur. However, FQHCs may also face operational barriers, including storage requirements, staffing limitations, difficulties scheduling newborn visits quickly enough after birth, and payment challenges for non-VFC patients.

Failure to administer an RSV mAb during the birth hospitalization has shifted the burden of access to outpatient settings, where additional logistical and coverage barriers often exist. In one [study](#), 73.8% of Medicaid infants had a first outpatient visit within 5 days, which is substantially lower than 84.7% among commercially insured infants. Some infants may also not return for care for several months thereafter, resulting in missed opportunities for RSV immunization and protection. Coordination challenges may also arise if it is unclear whether the infant's parent received an RSV vaccine at the appropriate point during pregnancy, leaving pediatric clinicians without sufficient information to determine whether the infant still requires an RSV mAb for protection. In the case that a parent's immunization status is unknown, [CDC](#) and [ACOG](#) recommend the administration of an infant mAb.



PRACTICAL STRATEGIES TO ADVANCE UPTAKE

Collaboration and Coordination

Improving RSV immunization uptake will require **stronger coordination and collaboration** across the healthcare system to ensure that all eligible infants are protected at multiple points of care. RSV immunization should be more effectively integrated into existing maternal, newborn, and pediatric workflows. In the case of infant immunization, an emphasis should be placed on ideally administering the mAb prior to newborn hospital discharge. Achieving this goal will require addressing both **public and private coverage barriers**. Payment to hospitals for the cost and administration of RSV mAb products must be ensured, while birthing hospitals should receive additional support in navigating the VFC program enrollment process. Both **commercial payment reform and expanded VFC program participation** are critical to improving access and ensuring equitable protection for infants across payer types.

Stronger partnerships between hospitals, outpatient clinicians, public health departments, community health centers, FQHCs, and mobile health units may also help bridge gaps in care for infants who do not receive RSV immunization during the birth hospitalization. These partnerships may be particularly important in rural communities, where clinician shortages, transportation barriers, and limited healthcare infrastructure can make timely follow-up care more difficult. More broadly, **continued cross-sector collaboration** among clinicians, hospitals, public health leaders, payers, pharmacies, and policymakers will be necessary to address the operational, financial, and educational barriers that continue to limit uptake. Establishing a **multidisciplinary working group** that includes voices from across the healthcare continuum could help identify practical, coordinated solutions that work for all stakeholders involved in infant RSV prevention.



Data Tracking

There is a significant opportunity to improve RSV immunization **data tracking and coordination** across care settings. Currently, RSV immunization is monitored through a fragmented patchwork of systems, including state and local health department-operated IIS, electronic health records (EHRs), VFC program inventory systems, pharmacy and medical claims data, and hospital reporting systems. This lack of interoperability can make it difficult for clinicians and public health officials to accurately determine whether an infant has received protection through maternal vaccination or infant mAb immunization, identify gaps in coverage, and monitor uptake trends across populations and regions.

Additional data collection and analysis are particularly needed at the **state level** to better understand the decline in RSV mAb administration that often occurs between January and March of each RSV season. In general, RSV immunization data should be collected and analyzed in a more **disaggregated manner** in order to identify disparities and reveal where gaps in immunization rates persist across geographic regions, racial and ethnic groups, insurance types, and other demographic factors.

Improving the use of electronic medical records may also help support more consistent uptake. Specifically, for pregnant individuals receiving prenatal care, **reminders about RSV prevention options within EHR systems should continue throughout the end of RSV season** — which may vary depending on national and local epidemiology — to ensure that eligible infants born later in the season are not overlooked for protection.

System Transformation

Ensuring equitable access to RSV immunization for infants is not only a policy challenge, but also a **care delivery and system alignment issue**, where current hospital workflows and payment structures are not designed to adequately support newer preventive interventions administered at birth. A sustainable payment pathway must be established that recognizes the unique and critical role mAbs play in preventing severe RSV illness among newborns and young infants.

Creating a more **reliable and standardized payment framework across Medicaid and commercial insurance markets** would help alleviate these challenges and reduce financial uncertainty for hospitals and clinicians. Federal and state policymakers, payers, and healthcare stakeholders should consider policies that support separate reimbursement for RSV immunization products administered during the newborn stay, streamline billing processes, and clarify coverage expectations for clinicians. Additional support for birthing hospital participation in programs such as the VFC program may also help expand access for underserved populations. Improving payment is not solely a financial issue — it is a public health imperative.

Education

Education will remain a critical component of improving RSV immunization uptake among both clinicians and families. Clinician educational efforts should include **clear, consistent recommendations** regarding RSV prevention, while parent education should emphasize the

potential severity and unpredictability of RSV disease and bronchiolitis in infants. Clinicians must be made aware that RSV season extends well into the spring months and that every infant born to a pregnant individual who did not receive an appropriately timed RSV vaccine during pregnancy should receive an RSV mAb when born at any point during RSV season. Reinforcing these recommendations consistently across obstetric, newborn, and pediatric care settings may help reduce confusion and improve timely protection for eligible infants. In particular, required discharge counseling can provide an important opportunity to deliver clear, consistent information before families leave the hospital.

Parent education efforts should begin early in pregnancy — well before the gestation time frame of 32–36 weeks when maternal vaccination is recommended — and clearly explain the timing and differences between maternal RSV vaccination and infant mAb immunization. Educational materials and counseling should be culturally relevant and help families understand that multiple opportunities exist to protect infants against RSV. Messaging should remain simple, direct, and action-oriented, with a particular focus on the urgency and potential severity of RSV-related bronchiolitis in young infants. In addition, storytelling efforts featuring clinicians or parents with lived experiences caring for infants with severe RSV disease may help personalize the risks associated with RSV and improve awareness, trust, and acceptance of prevention strategies.



CALL TO ACTION: INCREASING UPTAKE REQUIRES ALL OF US

Increasing uptake of RSV immunization among infants will require sustained collaboration and shared accountability across the healthcare system. Policymakers, payers, clinicians, hospitals, public health leaders, and community organizations each play an essential role in ensuring that all eligible infants have timely access to protection against severe RSV disease. Continued efforts to strengthen education, improve payment pathways, reduce operational barriers, and expand coordination across care settings is critical to preventing infants from falling through gaps in the healthcare system.



POLICYMAKERS must remain committed to improving access to RSV prevention and passing legislation that recommends education efforts. This includes supporting policies that ensure parents receive clear information about RSV prevention options early in pregnancy and prior to hospital discharge, as well as strengthening programs that support equitable access to immunization across communities.



PAYERS must immediately establish a payment pathway for hospital administration of mAb products. They must also provide clear, consistent, and ongoing communication regarding coverage policies for RSV mAbs, including commitments to coverage extensions that align with changing RSV seasonality and existing ACIP and medical society recommendations. Reducing uncertainty around payment and coverage is essential to supporting provider participation and hospital administration of RSV immunization.



CLINICIANS play a particularly important role in improving awareness and trust among families. Obstetric, newborn, and pediatric clinicians should understand what their RSV immunization rates look like, begin conversations about RSV prevention early in pregnancy, and continue discussing protection options throughout the perinatal and newborn period. Clear, proactive communication can help families better understand the severity of RSV disease, the timing of prevention options, and the importance of protecting infants throughout the RSV season. At the same time, health systems and hospitals must continue integrating RSV mAb administration into maternal and newborn workflows to ensure that eligible infants are identified and protected before discharge whenever possible. Strengthening coordination across inpatient and outpatient settings will be essential to ensuring that no infant falls through the cracks in receiving timely RSV protection.



HOSPITALS should work with their state immunization programs to enroll in the Vaccines for Children program, which provides mAb products at no cost to the hospital and its patients. Hospitals should prioritize negotiations with commercial payers to ensure that payment is not a barrier to every baby receiving a mAb product prior to hospital discharge.



PARENTS AND CAREGIVERS must take an active role by asking their prenatal care team about RSV prevention early in pregnancy and discussing whether maternal vaccination is appropriate before the recommended vaccination window. Before delivery, families should understand whether their baby is expected to need an RSV mAb after birth. During the birth hospitalization, parents should confirm whether their infant needs and has received recommended protection, and follow up promptly with their pediatric provider if immunization does not occur before discharge. Parents and caregivers should also ask about coverage or available assistance if cost or access presents a barrier.

CONTRIBUTORS

This white paper includes the perspectives of the following individuals:

Michelle Fiscus, MD, Chief Medical Officer, Association of Immunization Managers

Millicent Gorham, PhD (Hon), MBA, CEO, Alliance for Women's Health and Prevention

Natasha Hansen, MPH, Government Affairs Lead, Vaccinate Your Family

Sabrina Ho, MPH, Grassroots and Communications Coordinator, National Rural Health Association

Kristen Santiago, MS, Executive Director, National Coalition for Infant Health

Margot Savoy, MD, MPH, Chief Medical Officer, American Academy of Family Physicians

Sofia Teferi, MD, Spokesperson, American Academy of Pediatrics; Pediatric Hospitalist; Principal Investigator, Velocity Clinical Research

Michael Warren, MD, MPH, Chief Medical and Health Officer, March of Dimes

Amy Wofford, CRNP, Spokesperson, National Association of Pediatric Nurse Practitioners; Pediatric Hospitalist





Alliance for Women's
Health & Prevention

womenshealthandprevention.org

September 2026