# RSV Protect

# Primary Care Implementation Brief

**by the FMWC Infant RSV Protection Collective**

**August 2026**

*FMWC has received financial support from Pfizer Canada for the development of this initiative.*
*The opinions expressed are solely those of the authors and not those of Pfizer Canada.*

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### All babies deserve protection from RSV

Most cases are in **healthy, full-term infants**
Risk of respiratory problems can **persist over the long term**
NACI recommends **universal, seasonal immunization** for all infants
RSV season is typically October to April

### RSV impacts families and the health care system

**5831 hospitalizations and $66 million in health care costs** annually
Key driver of seasonal surges in acute care use
On average, **infants stay in hospital for 6 days and parents miss 3.5 work days**

### Discussing RSV

Educate patients about the risk of respiratory disease, how to recognize respiratory distress, and when to seek emergency care
**Discuss immunizations early and often**
Recommend RSV immunization to all patients, regardless of risk status or insurance coverage
Provide educational resources and direct patients to evidence-based websites (e.g. RSVprotect.ca or vaccinesinpregnancycanada.ca)

### Two strategies for protection

**Maternal immunization** during pregnancy and **infant immunization** shortly after birth have proven efficacy in clinical trials and real-world studies
Immunization could prevent 75% of hospitalizations and 66% of ICU admissions

### The timing of immunization has changed

Immunize pregnant persons between 28 weeks' and 36 weeks + 6 days' gestation
**In pregnancy**, concurrent administration with other vaccines is **safe and effective**

# FMWC Infant RSV Protection Collective

## RSV Implementation Brief 2026

## Introduction

The respiratory syncytial virus (RSV) is a leading cause of lower respiratory infection (LRTI) among infants in Canada, with almost all children developing an infection by two years of age.[1] Easily spread between family members and in the community, RSV can cause severe disease, even impacting health later in life.[2,3] Since there is no cure, prevention is crucial. The FMWC is issuing this report to raise awareness and support Canadian primary care practitioners in implementing options for prevention.[1]

With new vaccines available and changes in clinical guidelines, health care professionals (HCPs), expecting parents, and policymakers should be made aware of the current best practices for RSV prevention. HCPs report a lack of resources for implementing, accessing, and tracking RSV vaccines.[4] To address these barriers, the FMWC has developed a brief summary of RSV prevention guidelines, implementation considerations, and suggestions for increasing uptake. Here, we present practical tips for implementing RSV prevention for primary care practitioners in Canada, based on current evidence, Canadian guidelines, and our clinical experience.

## Key considerations and practical tips for primary care practitioners

### 1. RSV may cause severe complications among infants and children

RSV causes a range of illnesses from upper respiratory tract infections through bronchiolitis and pneumonia. In the short term, complications may include respiratory distress, wheezing, and otitis media.[5,6] Healthy, full-term infants under the age of 6 months represent the majority of cases of severe RSV disease, RSV-related hospitalizations,[7] and intensive care unit (ICU) admissions.[8]

Symptoms may include cough, congestion, fever, wheezing, poor appetite, and difficulty breastfeeding and/or bottle feeding.[9] In very young babies, symptoms may include difficulty breathing, irritability, and reduced activity.[9] Infants who are hospitalized in their first year of life are at risk of additional respiratory events up to 5 years of age.[6] Those who contract RSV before the age of 2 years have an elevated risk of compromised respiratory function, asthma, pneumonia, and premature death from respiratory events that may persist into adolescence and adulthood.[2,3]

[1] *The Federation of Medical Women of Canada (FMWC), established in 1924, is a national organization committed to the advancement of women+ physicians and the promotion of the well-being of women+. The FMWC has been a leader in infant RSV protection advocacy since 2024, having convened two national task forces, a regional advocacy group, produced two previous white papers, a position statement and led national and regional advocacy work. This brief is grounded in the latest evidence and real-world outcomes demonstrating why universal infant RSV protection and informed shared decision making are essential for Canada to improve health outcomes for children, reduce stress and trauma for families, promote health equity, stabilize pediatric capacity, and reduce winter surges in acute care use.*

## 2. RSV infection impacts families, communities, and the health care system

RSV infection in infants affects parents and families through missed work, elevated stress, anxiety, and trauma, while imposing a high burden on the health care system.[10] In an Alberta study, the average length of stay in the hospital for an infant (a child up to 12 months of age) with RSV was 5.7 days; parents missed 3.5 work days on average.[10] RSV infections contribute to seasonal surges in pediatric hospitalizations and ICU admissions,[8,11] leading to approximately 5800 pediatric hospitalizations and $66 million in costs nationally.[12] Canadian national surveillance data consistently identify RSV as the leading driver of acute care utilization in the winter.[13]

In rural and remote communities, RSV has additional impacts because children may need to be transported to distant hospitals, leading to additional individual and systemic costs, missed work, and other disruptions for families.[14] Children in remote areas have a 60% greater risk of hospitalization due to RSV infection, compared with those in metropolitan areas.[15]

## 3. All babies deserve protection from RSV – not only those at high risk

Preterm infants, those with Down syndrome, and those with multisystem chronic conditions have the highest rates of hospitalization due to RSV.[16] However, the greatest number of RSV cases, in total, occur in healthy infants with no risk factors.[7,17,18] Québec researchers predict that infant RSV vaccination could avert up to 75% of hospitalizations and up to 66% of ICU admissions.[11] This would also reduce the need for additional physician visits among babies and children and improve health outcomes throughout life. All infants born in Canada deserve the chance to be protected from RSV.

## 4. Parents have a choice of two effective immunization strategies – maternal immunization during pregnancy and infant immunization shortly after birth

Two strategies are available, namely active immunization of the pregnant woman or pregnant person, and passive immunization of the infant shortly after birth using preformed monoclonal antibodies (mAbs) (Table 1). Clinicians are encouraged to use the algorithm shown in Figure 1 to assist in shared decision-making regarding immunization choices. Both strategies are effective against severe disease, hospitalization, and ICU admission.

In Québec in 2024-25, nirsevimab was >85% effective in preventing infant hospitalizations and ICU admissions.[11] These data are consistent with studies in Europe and the USA which found nirsevimab to be over 80% effective.[19]

In the Québec study, the number needed to immunize (NNI) to prevent one hospitalization was 41 for infants born during the RSV season and 76 for infants aged <6 months at the start of the season; nirsevimab could prevent about two-thirds of hospitalizations and 60% of ICU admissions.[11] Effectiveness would increase further with higher uptake and with an earlier start to the program (e.g., Oct 1 instead of Nov 1, and completion of catch-up immunization by October).

Maternal RSVpreF has also demonstrated robust effectiveness in population-based studies. In Scotland, 82.2% effectiveness against RSV-related hospitalization of infants was reported,[20] and Argentina's national program reported 78.5% effectiveness against hospitalization for severe RSV disease through 6 months of age.[21] Results from Australia's national program included 89% effectiveness against RSV-related LRTI hospitalizations.[22]

**Table 1. RSV immunization options.**

| Agent | RSVpreF[23] | Clesrovimab[24] | Nirsevimab[25] |
|---|---|---|---|
| Brand name | **ABRYSVO®** | **ENFLONSIA®** | **BEYFORTUS®** |
| Type of agent | Subunit vaccine with no adjuvant | Monoclonal antibody (mAb) | Monoclonal antibody (mAb) |
| Mechanism of action | RSV F protein, pre-fusion; antibodies formed are transferred from pregnant person to infant | MAbs directed against site IV of RSV F protein both pre- and post-fusion; extended half-life | MAbs directed against site θ of RSV F protein, pre-fusion; extended half-life |
| Indication(s) | Pregnant individuals at 32-36 weeks' gestation<br><br>**NACI recommendation: administer at $28^{+0/7}$ to $36^{+6/7}$ weeks' gestation[1,*]** | Infants in first RSV season | Infants entering first RSV season<br>Infants entering second RSV season who remain at high risk of severe RSV disease |
| Dose (all agents are given as intramuscular injections) | 120 µg in 0.5 mL | 105 mg in 0.7 mL | For infants entering first RSV season:<br>Infants < 5 kg: 50 mg (0.5 mL)<br>Infants ≥5 kg: 100 mg (1 mL)<br><br>For infants entering second RSV season: 200 mg<br>(2 injections of 1 mL) |
| Other considerations | May be given concomitantly with other vaccines recommended in pregnancy, such as Tdap and Rho(D) immune globulin | May be given concomitantly with childhood vaccines<br><br>Dose is not weight-banded | May be given concomitantly with childhood vaccines |

[*] This off-label recommendation is meant to encourage HCPs to immunize at every opportunity rather than being limited to a narrower window.

**Figure 1. Decision-making algorithm for RSV prevention (adapted from Páramo et al.[26]). A, decision-making for maternal immunization with RSVpreF (ABRYSVO®). B, decision-making for immunization of the infant with monoclonal antibodies (mAbs; nirsevimab (Beyfortus®) or clesrovimab (ENFLONSIA®)). Due to a lack of data, NACI currently has no recommendations for repeated immunization in subsequent pregnancies. NACI suggests administering a mAb to the infant after birth for infants born in subsequent pregnancies of women who previously received the maternal vaccine. Several countries outside of Canada with national RSVpreF maternal immunization programs do recommend immunization in each pregnancy.[1]**

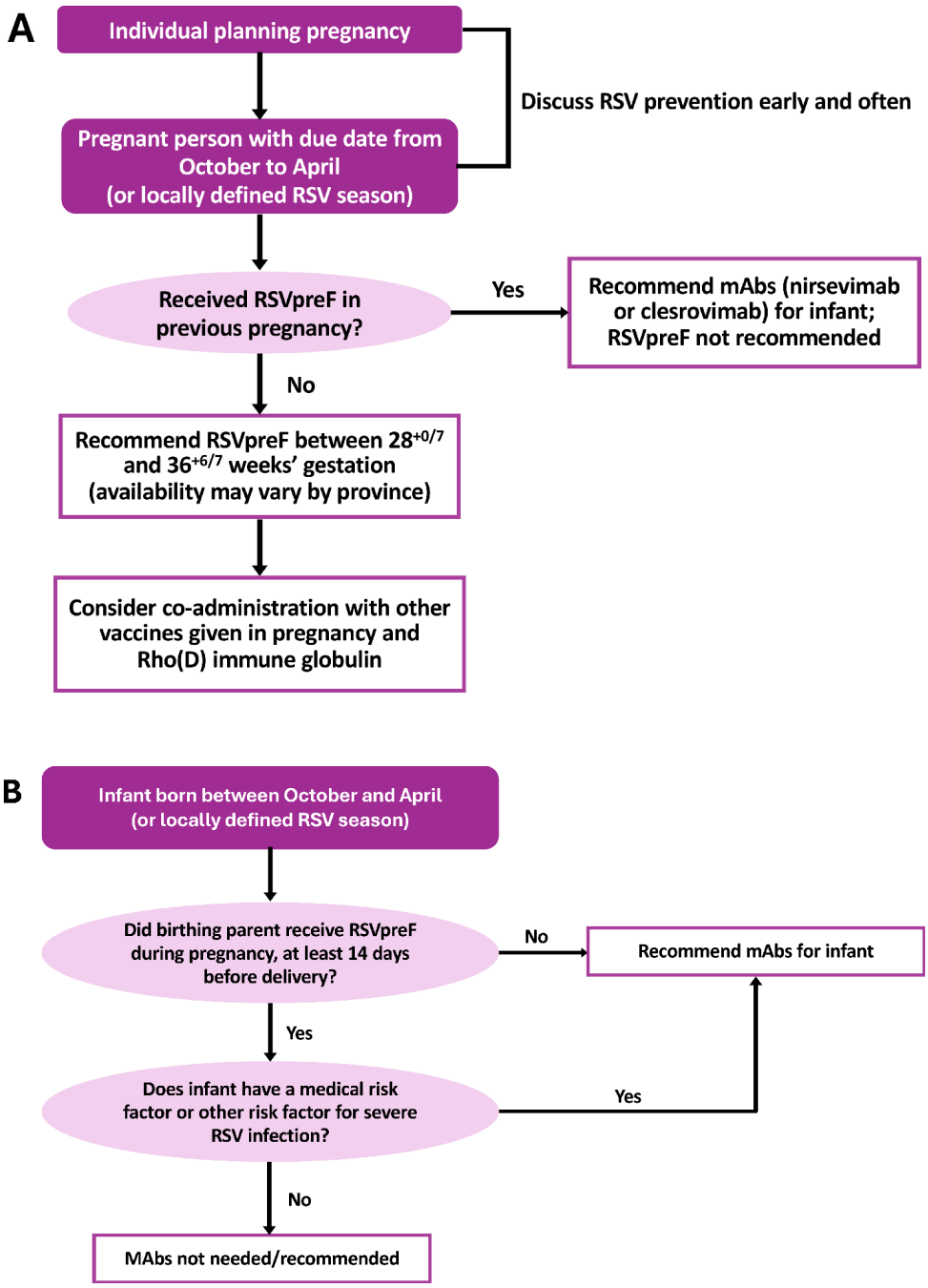

**Table 2. Risk factors for severe RSV disease in infants.**[1]

| Medical risk factors | Other risk factors |
|---|---|
| Chronic lung disease | Born <2 weeks after pregnant woman/pregnant person received RSVpreF |
| Cystic fibrosis with respiratory involvement and/or growth delay | Transportation for treatment of severe RSV disease would be complex |
| Hemodynamically significant chronic cardiac disease | Risk of severe RSV disease intersects with established social and structural health determinants |
| Severe immunodeficiency | |
| Severe congenital airway anomalies impairing clearing of respiratory secretions | |
| Neuromuscular disease impairing clearing of respiratory secretions | |
| Down syndrome | |
| Premature birth (less than 32 weeks' gestation) | |

## 5. Many pregnant women and pregnant people prefer maternal immunization during pregnancy over infant immunization after birth

In Canadian and Australian studies, most individuals indicated that they would prefer RSV immunization during pregnancy over immunization of their infants after birth;[27] reasons for the preferences included sparing the infant injections and providing immunity starting before birth with no delay.[28]

## 6. The timing of maternal RSV immunization has changed. Immunize pregnant individuals between 28 weeks' and 36 weeks + 6 days' gestation

In a study of over 40 000 infants in France, nirsevimab had greater effectiveness than maternal RSVpreF except in the first week of life, when RSVpreF provided greater protection.[29] New data show that the effectiveness of maternal RSVpreF increases, becoming equivalent to nirsevimab, if given at least 8 weeks before delivery.[30] Although early studies raised concerns of a risk of preterm birth with RSVpreF given before 32 weeks' gestation, current data show no such risk.[31-34] Therefore, both NACI[1] and the World Health Organization[31] recommend giving RSVpreF in pregnancy beginning at 28 weeks' gestation.[1] In accordance with the SOGC recommendations[35] and current best practices, we recommend administering RSVpreF in pregnancy between $28^{+0/7}$ weeks and $36^{+6/7}$ weeks (36 weeks + 6 days).

Regarding seasonality, gestational timing and the start of the RSV season should be considered, allowing at least two weeks for the pregnant person's humoral immune response to build and for passive antibody transfer to the developing fetus. NACI recommends that RSVpreF could be administered starting in September to protect infants expected to be born in November.[1]

## 7. Administer RSV vaccines concurrently with other vaccines recommended in pregnancy

The change in timing now allows RSV vaccines to be given with other vaccines such as Tdap (typically given at 27-32 weeks[36]) and Rho(D) immune globulin (typically given at 28 weeks, if required), increasing convenience and accessibility for pregnant individuals. Concurrent administration of RSVpreF with influenza and Tdap vaccines is safe[37] and is recommended by the SOGC[35] and WHO.[31] Concurrent administration with other non-live vaccines, including COVID-19, is also considered to be safe for pregnant women and pregnant people according to basic vaccine principles.[37-39]

Due to a lack of data, NACI currently has no recommendations for repeated immunization in subsequent pregnancies. NACI suggests administering a mAb to the infant after birth for infants born in subsequent pregnancies of women who previously received the maternal vaccine. Several countries outside of Canada with national RSVpreF maternal immunization programs recommend immunization in each pregnancy.[40-44]

## 8. To maximize the effectiveness of a monoclonal antibody, administer nirsevimab or clesrovimab to infants shortly after birth during the RSV season (October through April or according to local epidemiology)

In Canada, the RSV season was historically from November to April, but off-season infections are increasing,[45] and an earlier start (e.g., October 1) is predicted to increase effectiveness.[11] NACI encourages each jurisdiction to define the RSV season based on local epidemiology.[1]

MAbs should be offered to all infants in their first RSV season (unless born to an immunized woman or person) and to infants who are at continued higher risk during their second RSV season (Table 2).[1] For most infants who are not at increased risk of severe RSV disease, mAbs are not expected to offer additional protection if the infant is born to an immunized woman or person, provided that birth occurred more than 2 weeks after immunization and that there is no reason to believe transplacental antibody transfer was disrupted.[1]

Nirsevimab or clesrovimab should be administered from birth for infants born during the RSV season, and prior to the RSV season for those born outside it.[24,25] Eligible infants who are admitted to the hospital immediately after birth during the RSV season should receive a mAb before discharge; clinical judgment should be applied regarding this timing.[1]

Currently, nirsevimab is authorized for newborn babies and infants during their first RSV season and for children up to 24 months of age with an elevated risk of severe RSV disease, such as those with cystic fibrosis or Down syndrome.[25] Clesrovimab is authorized for newborn babies and infants during their first RSV season only.[24]

## 9. Commit to universal infant RSV protection

Provincial policy should formally adopt universal RSV prevention for all infants. A high-risk-only strategy is clinically insufficient, as it fails to protect the majority of infants who require acute care. Every infant - regardless of medical history or geographic location - should have access to seasonal RSV protection. Aligning with the latest guidance from NACI,[1] provinces should ensure that universal programs that include all infants, not only those deemed to be high-risk, are in place.

Infants deemed to be at higher risk should receive mAbs even if the mother or parent was immunized during pregnancy.[1] This includes infants who are born less than two weeks after maternal RSV immunization, those with certain medical conditions, those living in remote areas, and those whose risk intersects with social and structural determinants of health, as in Indigenous communities (Table 2).

Guidelines issued in 2026 strongly recommend universal, seasonal RSV immunization for all infants in Canada.[1] NACI now recommends earlier immunization of pregnant individuals, at $28^{+0/7}$-$36^{+6/7}$ weeks of gestational age, which also aligns with the WHO recommendation.[31] Aligning with the latest guidance from NACI, provinces should ensure that universal programs to protect infants from RSV are in place for the 2026-2027 season.

## 10. Promote health equity by offering RSV immunization to all pregnant persons and all infants and advocating for Canada-wide public funding

No parent should have to watch their baby struggle to breathe. In the 2024-2025 RSV season, the introduction of new vaccines led to reductions in RSV-related hospitalizations and ICU admissions, even in provinces without public funding for maternal or infant immunization.[11] Immunized infants would generally have been from families with the ability to pay out of pocket. Public funding across Canada would enable equitable protection by allowing all families, regardless of income, geographic location, or primary care access, to protect their children against RSV.

Clinicians are encouraged to prescribe and administer RSV immunizations (maternal RSVpreF and/or mAbs for the infant) for all parent/infant pairs, regardless of RSV risk status or insurance coverage.

## Recommendations for raising awareness about RSV prevention among Canadian families, HCPs, and policymakers

Many parents, pregnant women, and pregnant people are not familiar with the effects of RSV infection and the options for protecting their children. In addition, HCPs may not be aware of the latest updates to clinical guidelines for prevention. To protect Canadian infants and children, it is important to raise awareness of RSV disease.

## 11. Discuss the importance of protection against RSV and other infectious diseases early and often – starting even before pregnancy

Expecting parents may lack awareness about RSV infection, its effects and strategies for prevention.[46] Provider recommendation is a primary factor influencing intent to vaccinate. Clinicians should discuss the importance of protecting infants against RSV and other infectious diseases early on, starting at the stage of pre-pregnancy counseling. Clinicians should continue the discussion throughout pregnancy, i.e., at the points below, and consider adding reminders to their EMR macros:

- Confirmation of pregnancy appointment
- First prenatal appointment
- 28-week appointment
- Final reminder at 36 weeks

Clinicians should emphasize that concurrent administration of RSVpreF with other vaccines, and with Rho(D) immune globulin, is safe.

Individuals may need time to review educational resources, consider the options for protecting their infant, and ask questions. Provide handouts and direct patients to evidence-based websites such as http://www.rsvprotect.ca/, a website authored by the FMWC, or http://www.vaccinesinpregnancycanada.ca/. These websites are kept up to date with evidence-based information.

## 12. Explore barriers to RSV protection with each individual

In the 2024-25 RSV season in Ontario, 22% of parents declined nirsevimab.[4] Reasons for declining immunizations may include a lack of information, unanswered questions, general concerns about medical interventions for an infant, cost, and/or a lack of awareness of the effects of RSV infection.[46] Clinicians are encouraged not to assume vaccine hesitancy and to explore the barriers faced by each individual.

## 13. Promote RSV awareness and evidence-based resources through social media, AI, and community events

We recommend an awareness campaign using multiple avenues such as social media and community events. Online environments such as Facebook, Instagram, TikTok, and Reddit are broadly accessible and allow the rapid sharing of health information nationally and internationally.[47] These channels promote discussion and interaction, allowing people to ask questions, share experiences, and access evidence-based information regardless of location, socioeconomic status, language, and culture. This is especially important for individuals with barriers to accessing medical care, such as those living in rural and remote communities (almost one-third of the Canadian population[48]) and those who do not have a primary care provider (about 19% of the population[48]). As more people turn to AI tools for health answers, the campaign should also ensure that evidence-based information is available on websites that are optimized for extraction by AI engines.

Physical educational resources for patients (e.g., posters, handouts) should be distributed to HCP offices and at community events attended by parents and families.

Awareness messages should include the following:

- RSV can cause severe disease in infants, and there is no specific curative treatment
- There are two options for protection
- Protecting babies against RSV keeps them out of the hospital and reduces their risk of lung disease in the future
- Protecting babies against RSV saves medical costs and reduces the burden on our health care system

## 14. Educate patients about RSV prevention, how to recognize respiratory distress, and when to seek emergency care

Expecting parents should have access to evidence-based information about RSV and RSV prevention in order to make informed decisions for their children. Parents may not be familiar with the signs of respiratory distress. They should be given educational resources and counseled on how and when to seek emergency care. Parents should also receive information about risk factors for RSV infection in infants, such as prematurity, small for gestational age, multiple birth, multiple siblings, exposure to daycare, and

comorbidities or chronic conditions such as Down syndrome, cystic fibrosis, and cardiovascular or pulmonary disease.[49]

## 15. Provide HCPs with tools, evidence-based resources, and information about access pathways

Access pathways for RSV prevention are inconsistent across Canada. Funding, product availability, prescribing authority, and locations of administration vary considerably between jurisdictions. Providing practical implementation guidance would better equip healthcare providers to navigate these differences and ensure timely access to RSV protection for eligible pregnant individuals and infants. Immunization recommendations are much more likely to result in follow-through when providers clearly understand where and how patients can receive immunization.

HCPs must be able to inform their patients about whether the vaccine is publicly funded in their province, where they should go to receive it, and the eligibility criteria for both RSVpreF and mAbs. If community pharmacies form part of the access pathway, it is important to ensure that pharmacists and electronic prescribing systems have been updated to reflect NACI's new recommendation to immunize pregnant persons beginning at 28 weeks' gestation. Many EMRs and prescribing systems still display outdated recommendations (e.g., 32–36 weeks or even ≥34 weeks), which could unintentionally delay immunization and reduce infant protection. Keeping all members of the perinatal care team aligned with current guidance is critical. Guidelines and options for RSV immunizations should be accessible in clinical decision-support software and resources should be available for all HCPs, including midwives, who attend a large proportion of births. RSV immunization discussion prompts should be integrated into perinatal records.

There is also an opportunity to highlight co-administration workflows. For practices already administering the publicly funded Tdap vaccine, maternal RSV immunization could be incorporated into the same visit at approximately 28 weeks to improve access and uptake. Similarly, guidance would be helpful for situations where the opportunity for maternal vaccination is missed. HCPs would benefit from practical information on infant monoclonal antibody access, including current eligibility criteria (e.g., universal versus high-risk programs), funding, timing of administration, and whether products are available before hospital discharge or through outpatient/community services.

## 16. Advocate to provincial governments and public health agencies for universal public funding for infant RSV protection

Although progress has been made toward publicly funded RSV prevention programs in Canada, not all provinces offer the same coverage, and some provinces do not provide a choice between maternal and infant immunizations. Without public funding, only parents who can afford to pay out of pocket are likely to opt for RSV prevention. This leads to inequitable care in which infants from families with lower incomes will not be protected. All infants in Canada deserve protection from RSV disease. Aligning with the latest guidance from NACI, provinces should ensure that a universal program to protect infants from RSV is in place for the 2026-2027 season.

## Recommendations for future research about RSV prevention

The research demonstrating that RSV vaccines are safe and effective, comprising both randomized clinical trials and real-world studies, is clear. Nevertheless, gaps in our scientific understanding of RSV prevention still exist. To better protect Canadians, the FMWC Infant RSV Protection Collective recommends more support for research on the health of women, pregnant persons, and children, and continuing research into specific questions such as:

- The safety and effectiveness of repeating maternal immunization for individuals who received RSVpreF in previous pregnancies
- The duration of protection from maternal and infant vaccination
- The persistence of anti-RSV antibodies in human milk
- A national immunization registry to facilitate better tracking of immunizations and research on local uptake, safety and effectiveness by province and region remains an ongoing need

## Conclusion

With two effective and safe strategies now available to prevent RSV disease in infants, the FMWC Infant RSV Protection Collective recommends we act now to raise awareness, educate, and communicate knowledge of the risks of RSV and the options for prevention.

Visit RSVProtect.ca for more information.

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# Appendix: FMWC Infant RSV Protection Collective Members

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