WFPHA World Federation of Public Health Associations

c/o Institute of Global Health · University of Geneva, Campus Biotech - G6 · Chemin des Mines 9, 1202 Geneva · Switzerland · www.wfpha.org

Protecting Every Child from Severe Respiratory Disease Through Immunization

Preventing death and disease from Respiratory Syncytial Virus (RSV) and Pneumococcal Disease in all our children

A Health Equity Imperative and a Call to Action

RSV and pneumococcal disease are longstanding threats to child health, but we are at a turning point: after decades of research, we now have safe and effective tools that can greatly reduce severe disease and hospitalization in young children. Therefore, with this Call to Action, The World Federation of Public Health Associations (WFPHA) and supporting leaders and organizations aim to catalyze urgent, equitable, and sustained investment in protecting every child against preventable respiratory disease. By doing so, we take a decisive first step in a broader, lifelong commitment: a life-course approach to immunization that safeguards health not just in the first months of life, but at every stage.

THE PROBLEM

Pneumonia is the leading infectious killer of children under five. It is not inevitable — it is preventable.

RSV is the single most important cause of severe pneumonia in infants globally. Pneumococcal disease is the second. Together they account for the majority of childhood pneumonia deaths. Both are preventable.

RSV also causes bronchiolitis and other RSV-attributable respiratory illnesses.

Yet the children who bear the greatest burden have the least access to prevention.

THE SOLUTION

We have the tools. We need the political will. We need to act urgently.

Two WHO Strategic Advisory Group of Experts on Immunization (SAGE)-endorsed approaches have the potential to greatly reduce childhood pneumonia, mortality and illness:

- **RSV prevention:** RSV long-acting monoclonal antibody interventions or RSV maternal vaccination. (1) — must be introduced and expanded.
- **Pneumococcal disease prevention:** Pneumococcal conjugate vaccine (PCV) — Already widely available — must be

Although this Call-to-Action addresses both RSV and pneumococcal prevention, it places particular emphasis on RSV since PCV is already incorporated into many national immunization programs, whereas the bigger advocacy gap sits with RSV.

The following conservative global estimates illustrate the need. Beyond mortality, RSV alone drives more than 3.6 million hospitalizations in children under five each year, placing recurring strain on pediatric wards and intensive-care unit (ICU) capacity, particularly during seasonal peaks. (3) To drive maximum public health protection, countries should make evidence-based immunization policy decisions based on local epidemiology, disease burden,

health system readiness, and national public health goals to ensure sustainable protection for both RSV and pneumococcal disease.

~700,000 children under 5 die of pneumonia each year (4, 5)	**>101,400** children die from RSV-attributable respiratory illness annually (6)	**97%** of RSV deaths occur in low- and middle-income countries (6)	**$20 – $52** returned per $1 invested in immunization programs overall (7)

Act today.
In one year: pediatric RSV hospitalizations fall up to 88%.
ICU admissions drop up to 90%. (8-10)
Results are visible, measurable — and politically rewarding.

We call upon **all stakeholders** – including government ministers, politicians and policymakers, health professionals, funders, industry, community leaders, and civil society - to act urgently and decisively to make RSV immunization a national priority in every country, for every child— while maintaining, simplifying and strengthening PCV immunization.

🏛️ Politicians & Policymakers	💰 Funders, Industry & Interest Groups	🫁 Healthcare Professionals (HCPs)	🤝 Civil Society, Community Leaders & Community Health Workers
▸ Prioritize RSV prevention alongside PCV in national immunization policies and programs ▸ Allocate funding — bridge vaccine/drug budget silos ▸ Set a national target: RSV coverage for every infant by next season ▸ Enhance surveillance systems to inform evidence-based decision making (e.g., RSV seasonality, burden of disease, and pneumococcal serotype distribution) and related implementation strategies ▸ Enhance real-world evidence capabilities to demonstrate public health impact and champion data: impact may be seen in the first year of implementation	▸ Fund country-level economic analyses and budget impact models to communicate Return on Investment (ROI) ▸ Invest in national/ regional production capacity when appropriate ▸ Finance integrated surveillance and real-world data needs ▸ Close implementation and accessibility gaps through e.g. tiered pricing, expanded LMIC regulatory filings, and manufacturing/supply commitments ▸ Ensure RSV + PCV financing fit into coherent investment strategies	▸ Integrate RSV and PCV immunization into antenatal, neonatal (RSV only) & pediatric pathways as appropriate ▸ Advocate for evidence-based reviews and timely NITAG recommendations/ Health Technology Assessment for funding ▸ Engage professional societies and trusted voices as champions for immunization ▸ Monitor and respond to hesitancy to long-acting monoclonal antibodies ▸ Invest in the ongoing training and professional development of HCPs ▸ Combine RSV + PCV advocacy in every vaccination engagement by HCPs	▸ Amplify demand for infant pneumonia prevention ▸ Counter misinformation with accessible and culturally appropriate narratives ▸ Advocate to elected representatives, through patients' associations ▸ Engage faith and community leaders as trust builders ▸ Champion equity: no child unprotected by geography, income or ethnicity

The data are strong. The tools exist.
Every day without action means preventable deaths.

No one-size-fits-all — every country must select the approach best suited to its context, products, and system

Background evidence and implementation guidelines

This background brings together the economic case, the roles of HCPs and civil society, lessons from early-adopter countries, advocacy narratives, access considerations, health-system integration, and surveillance priorities. Section 1 shows why prevention pays off; Section 2 sets out what must happen politically to secure the best possible prevention strategy; Section 3 presents a transferable model backed by strong data for advocacy; Section 4 offers guidance for effective narrative and communication; Section 5 covers

accessibility and availability; Section 6 provides guidance on integrating immunization into the existing structures of the health system; Section 7 describes surveillance; and Section 8 is an implementation guide to adapt to different contexts. Where useful, specific notes are added to contextualize each section, and a take-home message closes every section to support advocacy and implementation. Selected references are provided at the end of the document.

Supporting information for decision-makers, funders, health professionals, and civil society

Worldwide, respiratory syncytial virus (RSV) is the leading cause of lower respiratory tract infection during infancy. Approximately 5% of hospitalized infants require pediatric intensive care unit (PICU) admission. (11)

RSV typically presents as a mild respiratory illness resembling a common cold. In infants, young children, older adults, and those with underlying health conditions or weakened immune systems it can rapidly progress to severe pneumonia or bronchiolitis, among other RSV-associated diseases with potentially fatal consequences. Every year, RSV conservatively causes approximately 100,000 deaths and more than 3.6 million hospitalizations in children under five years worldwide. Nearly half of those deaths occur in infants younger than six months. The burden falls overwhelmingly (97% of RSV deaths in children) on low- and middle-income countries, where access to even basic supportive care remains limited. (3)

WHO recommends two approaches for universal implementation: long-acting monoclonal antibody intervention or maternal vaccination, which are both effective, evidence-based strategies – the right choice depends on each country's health infrastructure and delivery capacity, with a small number of countries using both strategies concurrently to maximize coverage. (1) RSV seasonality varies substantially by region and climate. Countries should consider local RSV epidemiology, the timing and duration of peak seasons, and healthcare utilization patterns when determining implementation strategies and the timing of interventions.

When implemented alongside pneumococcal conjugate vaccination (PCV) which is already proven and widely deployed globally, RSV immunization completes a powerful, synergistic shield against the two leading infectious causes of severe childhood pneumonia, offering countries the most comprehensive protection currently available.

1. The Economic Case: Return on Investment

Preventing childhood respiratory diseases such as pneumonia and other RSV-attributable respiratory diseases is not an expenditure — **it is one of the most cost-effective investments a government can make.**

Immunization ROI	Country evidence – some examples
$20 per $1 invested Cost-of-illness approach, 94 LMICs (DoVE / Johns Hopkins / Health Affairs) **Up to $52 – $54 per $1** Value-of-statistical-life approach (UNICEF / DoVE) (7)	▸ **Chile:** Long-acting monoclonal antibody shown to be cost-saving vs. ~USD$21M annual RSV disease burden (12, 13) ▸ **Spain:** Universal long-acting monoclonal antibody use averted 215,878 RSV events; saved ~€48M direct costs (14, 15) ▸ **Canada:** ~47,609 RSV – health related events averted; ~CAD$45M healthcare savings (16) ▸ **LMICs:** Cost estimates varied widely (17)

Budget note: in many countries, vaccine and drug budgets sit in separate ministries — advocacy must target both simultaneously. Critically, long-acting monoclonal antibodies are in some countries not financed through traditional Expanded Program on Immunization (EPI) budgets. Countries must identify and activate alternative financing mechanisms — including hospital drug budgets, neonatal care funds, and innovative co-financing arrangements with Gavi or other strategic partners — to ensure these products are not blocked by budgetary silos before they reach the infant.

Key takeaway — Prevention is an investment, not a cost — immunization programs have been estimated to return $20–$52 for every $1 invested. The real barrier is not value for money but unlocking budget silos so immunization protects ALL infants.

2. The Role of Healthcare Professionals and Civil Society

Governments should formally include RSV prevention alongside PCV in national immunization policies, fund it across the budget lines identified above, and set a national coverage target and timeline. Policy change requires political pressure from credible, trusted voices, through a unified narrative:

- ◊ Professional bodies (pediatric, obstetric, neonatology, primary care, etc.) should, in addition to current PCV approaches, formally endorse national RSV programs for all infants, advocate to NITAGs and policymakers, shape clinical practice guidelines, provide ongoing medical education, and publicly communicate their support for immunization.
- ◊ Civil society and community organizations should translate evidence into accessible language to build awareness and acceptability among parents and caregivers, serve as trusted local voices who build public confidence, and elevate prioritization among policymakers.
- ◊ Faith communities as powerful trusted intermediaries — especially where cultural or religious hesitancy exists - should advocate to save all our children.

Country examples - activities	Results
▸ **Murcia, Spain**: HCPs received continuous training and parents targeted education; eligible newborns were systematically offered RSV immunization before maternity discharge, with rapid catch-up for those not immunized at birth.	93.5% coverage; 92.4% immunized before maternity discharge; equity gap reduced from 5.7% to 2.3%. (18)
▸ **Stanford, USA**: A multidisciplinary team (infectious disease physicians, neonatology, pharmacy, and nursing) embedded eligibility checks and RSV immunization orders into discharge workflows across the newborn nursery, intermediate care nursery, and NICU, and provided education to staff and parents.	99% of eligible infants offered immunization before discharge; 71% received it. (19)
▸ **Zurich, Switzerland**: Obstetricians, neonatologists, and nurses provided consistent written/oral information and opportunities to discuss questions at multiple points from prenatal care through discharge; immunization was offered before hospital discharge.	78% of maternity newborns and 82% of neonatal-unit newborns immunized (long-acting monoclonal antibody or maternal vaccine) before discharge. (20)

Key takeaway — Policy change requires pressure from credible, trusted voices. A unified narrative across professional bodies, civil society, and faith communities amplifies the political impact.

3. The Domino Model: Lessons from Early Adopters

When one country acts and publishes results, neighboring governments face pressure to follow. Each success story lowers barriers and encourages action for the next jurisdictions. The domino effect is not passive — it must be actively managed.

Advocates and policymakers in early-adopter countries should share real-world evidence and impact of interventions, welcome delegations from neighboring governments, and actively encourage regional bodies to use first-mover evidence as the basis for fast-tracked policy adoption. In Latin America, this strategy has already driven adoption across more than 60% of the region. In Europe, France and Spain were among the earliest adopters; their early, well-documented results, described below, became reference points that other European countries used to justify their own introduction decisions. The same model should be replicated in Africa, Asia Pacific, the Middle East and Eastern Europe.

INFANT IMMUNIZATION EXAMPLES	
✔ **CHILE — Universal Program 2024** **First Southern Hemisphere nationwide program, followed successfully by neighboring countries** Long-acting monoclonal antibody integrated into the national newborn program (April 2024). • 98% coverage in-season. • 76% fewer RSV-LRTI hospitalizations. • 85% fewer ICU admissions. • No RSV-related deaths during study period vs. 13 the prior year. • Cost-saving at ~USD 225 per dose. • ~USD 23.5M net economic benefit in the first year. • Delivered through existing maternal-newborn infrastructure. (12, 13, 21-23)	✔ **FRANCE / LUXEMBOURG / SPAIN / IRELAND 2023–2025** **European early adopters — rapid results, regional domino effect** France 2023–24: 5,800 hospitalizations averted; 73–83% effectiveness. (24) France 2024–25: 84.9% hospitalizations averted in second season. (25) Luxembourg: 38% reduction in under-5 RSV hospitalizations. (9) Spain: 82–89% reduction in RSV hospitalization; severe disease and PICU admissions also markedly reduced. (26) Ireland: 437 hospitalisations, and 76 ICU admissions averted. The disease prevented fraction was 74.5%. (27) Early real-world evidence helped refine implementation and inform ongoing RSV immunization policy. (28)
MATERNAL IMMUNIZATION EXAMPLES	

ARGENTINA / US - Cross-regional confirmation — protection from birth, sustained across settings Argentina: 78.7% effectiveness against RSV hospitalization in infants under 6 months. (29) US: 49% effectiveness against RSV-associated emergency department encounters and 82% effectiveness against RSV-related hospitalization in infants during their first RSV season. (30)	**UK - National rollout of maternal vaccination, largest real-world evidence base to date** 81.3% effectiveness against RSV hospitalization when given ≥14 days before birth, rising to ~85% if ≥4 weeks before delivery. For preterm infants, hospitalization risk cut by 69.4% when mothers were vaccinated at least 14 days before birth. (31) Scotland: 72% effectiveness against hospitalization, results cited in UK Parliament and WHO global recommendations. (32)

Advocacy note: *A key advocacy tool was counterfactual modelling — projecting what hospitalizations and deaths would have occurred without the intervention. Developed in partnership with data engineers and drawing on national health databases, these models gave Finance and Health Ministers a clear, verifiable picture of avoided costs and lives saved. This approach is replicable and should be developed in all countries introducing RSV prevention programs.*

Timing note: *Timing determines effectiveness for both products. For maternal vaccination, national programs generally recommend a window between 24 – 36 weeks of gestation, but regardless of when during pregnancy the dose is given, protection depends on the interval before delivery. Protection may be reduced when delivery occurs within 14 days of maternal vaccination. For long-acting monoclonal antibodies protection wanes over time after dosing. Therefore, timing depends on the infant's relationship to the RSV season: administered at birth if born during the season, or shortly before season onset if born earlier. (1, 33)*

Key takeaway — The domino effect must be actively managed: published results from early adopters should become the evidence neighboring governments use to justify their own decisions.

4. Narrative, Equity, and Countering Hesitancy

Science alone does not drive policy. Effective advocacy requires clear, emotionally resonant narratives connecting with parents, communities, and political leaders.

Core narrative principles:

- ◊ Every child, wherever born, deserves a first birthday free from a vaccine-preventable disease.
- ◊ RSV and PCV prevention together are a statement of equity. The burden falls hardest on families made vulnerable by structural disadvantage — including ancestry, economic status, and related social factors.
- ◊ Long-acting monoclonal antibodies are a new therapeutic class that might not be understood by parents and caregivers — this may prove a communication asset for some hesitant families.

Key messages for advocacy

For Policy Makers	For Healthcare Professionals	For Communities & Parents
"One immunization program. One year. Measurable results. Emptying pediatric wards of preventable RSV and pneumococcal admissions — a result visible within a single budget cycle. Your legacy for every child in your country, regardless of geography, income	*"Together, RSV and pneumococcal prevention can empty pediatric wards, as the first months of life are uniquely vulnerable. You have the tools, the evidence, and your patients need your voice."*	*"Either maternal vaccination during pregnancy or a single long-acting monoclonal antibody at birth for your baby. Both RSV immunization and pneumococcal vaccination are proven to prevent some of the most serious respiratory illnesses in the first months of life."*

Key takeaway — Data alone do not drive policy. Advocacy needs clear, equity-centered messages tailored to each audience — policymakers, professionals, and parents.

5. Access & Availability

Sustained access depends on a functioning market and predictable supply. The following conditions help ensure RSV prevention products reach every infant:

- ◊ Clear, upfront demand forecasting from countries allows manufacturers to plan supply appropriately.
- ◊ Healthy markets with multiple products drive competition and supply diversification and security.
- ◊ Pricing varies by country tier; Gavi eligibility and market-shaping must be actively pursued for LMICs, through UNICEF procurement pathways, pooled procurement, and tiered pricing arrangements.
- ◊ National or regional manufacturing capacity should be assessed and pursued where appropriate, to strengthen supply resilience.
- ◊ Both RSV prevention approaches — long-acting monoclonal antibodies and maternal vaccination — should be integrated into national programs and evaluated as new products gain regulatory approval, expanding supply options over time.
- ◊ Where resources are constrained, phased introduction should prioritize infants at greatest risk of severe RSV disease. (1)

Key takeaway — Whether products actually reach children depends on upfront demand forecasting, healthy vaccine markets with multiple products, functioning health systems and tier-based pricing pursued for LMICs.

6. Health Systems Integration — A Step-by-Step Approach

Implementation must be embedded in existing structures. Entry points include:

- ◊ Antenatal care: maternal RSV vaccination in the third trimester, building on existing antenatal infrastructure. Educate obstetricians and gynecologists, midwives, and other early-contact providers (OBGYNs) on all RSV prevention options, so they can guide families toward the most appropriate protection for the infant, including monoclonal antibodies when maternal vaccination is not given or is too close to delivery to provide adequate protection.
- ◊ Maternity wards / delivery services: RSV monoclonal antibody at birth — midwives, neonatologists as delivery agents. Ensure midwives, obstetric teams and neonatologists can identify infants who remain unprotected and provide a long-acting RSV monoclonal antibody at birth when indicated.
- ◊ Expanded Program on Immunization (EPI): Sustain and reinforce PCV programs through evidence-based decisions on vaccination schedules that reflect country-specific disease burden, epidemiology, and health system needs.
- ◊ Well-baby visits: catch-up dosing and surveillance
- ◊ Community health workers and primary care: rural and home-birth populations
- ◊ Faith-based organizations: trust-building and demand generation
- ◊ Real-world evidence generation: demonstrate effectiveness, impact, and value of the intervention to inform evidence-based decision-making

Where infrastructure is weak: begin with highest-risk infants and expand progressively. Do not delay while waiting for a perfect system. Specialists to engage include obstetricians, midwives, sage-femmes, neonatologists, pediatricians, GPs, community nurses, pharmacists and faith health liaisons.

Key takeaway — Integrate into existing structures rather than building new ones; where infrastructure is weak, start with the highest-risk infants and expand — do not wait for a perfect system.

7. Real-World Evidence: Measure What You Protect

Measure the burden. Measure the impact. Make success visible.

Surveillance is not universally in place — building robust RSV and pneumococcal disease surveillance is an immediate implementation priority to monitor disease burden, alongside any program launch. Improved data collection can provide a more complete picture of disease trends. Standardized reporting is essential to better identify remaining burden, detect shifts in serotype distribution, and inform evidence-based immunization policies.
While this section focuses mainly on RSV data generation, strengthening PCV surveillance is also critical and requires more consistent, high-quality data collection across settings, including improved case detection, laboratory confirmation, and serotype monitoring. Timely, standardized reporting is essential to better identify remaining burden, detect shifts in serotype distribution, and inform evidence-based immunization policies.

Developing or strengthening data generation capacity for infant RSV immunization requires:

- ◊ Establishing baseline pre-introduction burden-of-disease estimates and continuing post-introduction monitoring to track changes in RSV hospitalization rates, PICU/ICU admissions and length of stay.
- ◊ Collecting first-season real-world impact data rapidly (hospitalization rates, ICU use, length of stay), which are essential for program continuation, buy-in from civil society and HCPs, and political and economic sustainability. Multi-year data are needed to demonstrate sustained impact.
- ◊ Activating pharmacovigilance systems for both monoclonal antibody and maternal vaccination products.
- ◊ Feeding national data into global LMIC evidence — every national program contributes to the shared knowledge base, and active data sharing on surveillance, effectiveness, and impact between countries is essential to build and sustain advocacy momentum.
- ◊ Communicating results publicly to HCPs and civil society, and feeding them rapidly back to programs, is also a political asset: it demonstrates ROI to parliaments and finance ministries.
- ◊ Advocating for RSV to be added to national notifiable disease lists — a prerequisite for generating the local burden data that policymakers require and for demonstrating program impact from day one.
- ◊ Guaranteeing virological surveillance (mutations).

Key takeaway — Measure from the outset and in a standardized way: surveillance is what makes impact visible, credible, and sustainable over time.

8. Implementation Guide

There is no universal solution. Each country must choose the approach that best fits its context. The following steps provide a practical starting framework:

- ◊ **Know your burden** — Gather or strengthen RSV surveillance data to quantify local disease and mortality, as well as timing of RSV seasonality.
- ◊ **Assess your system** — Evaluate antenatal care coverage, birth registration, and newborn care infrastructure.
- ◊ **Check product access** — Identify which WHO-recommended products are licensed, supplied, and priced appropriately for your country tier.
- ◊ **Run the numbers** — Conduct a budget impact and cost-effectiveness analysis across available vaccine and drug financing mechanisms.
- ◊ **Gauge community readiness** — Assess vaccine confidence and identify whether there is hesitancy towards monoclonal antibodies.
- ◊ **Engage your NITAG** — Bring evidence to your National Immunization Technical Advisory Group for a formal policy recommendation.
- ◊ **Integrate and launch** — Embed the chosen approach within existing maternal, newborn, and immunization platforms — and generate real-world evidence immediately.
- ◊ **Measure and adapt** — Track impact of the intervention in the first season, publish results, and use data to expand and sustain the program.

Key takeaway — Eight steps, from “know your burden” to “measure and adapt” — a practical framework each country adapts to its own context.

This is a rare, urgent and timely opportunity to protect countless children from severe respiratory disease. The WFPHA and those who recognize the importance of this opportunity call on all organizations, professionals and citizens who seek fairer, healthier and more equitable societies to join with us by signing this document and committing to drive the changes outlined in the Call to Action.

9. References

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10. Acknowledgements

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