



FEDERATION OF MEDICAL WOMEN OF CANADA

*Fédération des femmes médecins du Canada*

British Columbia and Alberta Infant RSV Protection Advocacy Group

POSITION STATEMENT · May 2026

# Why Universal Infant RSV Protection *is the* *Right Investment* for British Columbia and Alberta

*A call to align provincial policy with the April 2026 NACI recommendation for universal infant RSV immunization.*

PUBLISHED BY

**Federation of Medical Women of Canada**

*BC and AB Infant RSV Protection Advocacy Group*



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POSITION STATEMENT

# Why Universal Infant RSV Protection is the Right Investment for British Columbia (BC) and Alberta (AB)

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## POSITION STATEMENT

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## THE ISSUE AND THE ASK

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Respiratory syncytial virus (RSV) is the leading cause of severe respiratory infections in infants. In Canada, approximately 1 in 50 infants - about 2% - are hospitalized within their first year of life due to RSV.<sup>1</sup>

Importantly, up to 80% of these hospitalized infants were previously healthy with no pre-existing risk factors. This means that policies limited to “high-risk” groups fail to address the majority of severe cases and underestimates the true burden of disease. Beyond the immediate illness, RSV infection is also associated with longer-term complications, including asthma and reduced respiratory function.<sup>2,3</sup>

There is no curative treatment for RSV infection - only supportive care - making prevention the most effective strategy. Several preventive options are now available: short acting monoclonal antibody (palivizumab/SYNAGIS®), long-acting monoclonal antibodies (nirsevimab/BEYFORTUS® and clesrovimab/ENFLONZIA®), and a vaccination given during pregnancy (RSVpreF/ABRYSVO®).<sup>4</sup>

National surveillance data from the Surveillance Program for the Rapid Identification and Tracking of Infectious Diseases in Kids (SPRINT-KIDS), which monitors 14 pediatric hospitals across eight provinces, consistently identify RSV as the leading driver of winter acute care utilization.<sup>5</sup> Each year, approximately 5800 pediatric hospitalizations in Canada are attributable to RSV, at an estimated cost of \$66.2 million, with nearly half occurring in infants under 6 months of age.<sup>2</sup>

***Given this evidence and the availability of effective preventive tools, we urge BC and Alberta to adopt the April 10, 2026, recommendation from the National Advisory Committee on Immunizations (NACI) to implement a universal RSV immunization program for all infants. A high-risk-only approach is too narrow, inequitable, and misaligned with the true burden of disease.<sup>4</sup>***

## BACKGROUND

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RSV has long posed a significant clinical challenge for infants and a recurring seasonal strain on the health care system. Recent advances have transformed the prevention landscape. In 2023, Health Canada approved both a long-acting monoclonal antibody (nirsevimab/BEYFORTUS®) and a maternal vaccine (RSVpreF/ABRYSVO®), followed in 2026 by approval of a second long-acting monoclonal antibody (clesrovimab/ENFLONSIA®). Together, these innovations represent a major shift from reactive care to proactive prevention.

Despite the availability of effective preventive measures, implementation across Canada remains inconsistent. As early as 2024, provinces such as Ontario and Quebec have adopted universal programs with success - Ontario funding both the maternal vaccine and monoclonal antibody, and Quebec implementing a monoclonal antibody program. In their year of program launch, both provinces achieved high coverage rates 70% and 69% and substantial reductions in RSV-related hospitalizations.<sup>6-8</sup> BC and Alberta have yet to update and expand their RSV programs beyond high-risk populations. This approach is no longer evidence based policy and overlooks the fact that most severe RSV disease occurs in previously healthy infants.

While important groundwork like cost-effectiveness modelling has been done in BC and Alberta, critical gaps in policy analyses exist. Current policy decisions in both provinces are based on incomplete cost assessments. For example, BC's analysis<sup>9</sup> focuses primarily on direct acute care costs - such as emergency visits, hospitalizations, and intensive care admissions but does not account for broader system and societal impacts. These include the cost of transporting critically ill infants from rural and remote communities with limited local resources,<sup>10,11</sup> increased strain on the health of human resources (staff illness), lost productivity for parents, outpatient care costs, and recurrent respiratory illness in subsequent years. Equally important are the unquantifiable costs: the psychosocial burden on families, the trauma associated with acute care experiences,<sup>12</sup> and the distress experienced by the infant themselves.<sup>12</sup>

These gaps are equally relevant in Alberta, where northern, rural, and remote communities face significant barriers related to distance and access to prenatal and acute care.<sup>13</sup>

At the same time, awareness of RSV and its prevention remains limited among pregnant individuals. Many are not informed of the risks RSV poses to their infants or the preventive options available. A simplified universal program would enable clearer, more consistent conversations between health care providers and families, supporting informed decision-making. Ultimately, all infants deserve equitable protection from RSV.

### Comparisons with Ontario

**Ontario's** experience demonstrates that universal RSV prevention is both feasible and effective at scale. The province transitioned from a high-risk only program using palivizumab to a universal approach offering nirsevimab/BEYFORTUS® to all infants, as well as high-risk children under two years of age at the start of each RSV season.<sup>14</sup> In parallel, Ontario also funds maternal vaccination with RSVpreF/ABRYSVO® for pregnant individuals.

Early results from Ontario's first universal season highlight strong uptake and program success:

- 73% infants were protected against RSV through either nirsevimab or maternal vaccination.<sup>6</sup>
- 69% of newborns received nirsevimab prior to hospital discharge.<sup>6</sup>
- The primary challenge to reaching the target 90% coverage was not related to program delivery, supply, or health system capacity. Rather, it was driven by parental or caregiver decline (22%).<sup>6</sup>

### Comparisons with Quebec

**Quebec's** experience demonstrates that there was a substantial public health impact on infant RSV hospitalizations with the use of nirsevimab. Overall, the program was over 85% effective against ER admissions, ICU admissions and hospitalizations. This was seen as a 2/3 reduction of RSV associated hospitalizations. Furthermore, the authors suggest that there would be an increase in averted hospitalizations with higher uptake in the population and with an earlier start date.<sup>7</sup>

### International Comparisons

The effectiveness of universal RSV programs to protect infants has been corroborated by several international studies from the 2023-2024 season and 2024-2025 season.

- **Galicia, Spain**, a universal program with 94.4% coverage achieved an 85.9% reduction in RSV-related LRTI hospitalizations during the first season.<sup>15</sup> Remarkably, the program also showed sustained benefits into the second RSV season, with a 55.3% reduction in hospitalizations for the same cohort.<sup>15</sup>
- **United States (MMWR)**: Nirsevimab was 90% effective in preventing hospitalizations among infants immunized before 8 months of age.<sup>16</sup>
- **Catalonia, Spain**: Reductions of 87.6% and 90.1% were seen in hospital and ICU admissions, respectively, among eligible babies.<sup>17</sup>

- **France:** 2024-2025 was France's first season using a dual-strategy approach where the choice between nirsevimab and the RSVpreF vaccine was made by health care professionals and parents. Although both agents effectively reduce RSV-associated LRTI hospitalizations in infants, they differ in immunologic mechanisms, timing of administration, and the choice of strategy and its acceptance by the parents can be impacted by socioeconomic factors.<sup>18</sup>
  - Maternal RSVpreF vaccination offered better protection against RSV-associated LRTI hospitalization during the first 7 days of life, a period when the nirsevimab group exhibited a 194% higher risk of RSV-associated LRTI hospitalization.<sup>18</sup>
  - Yet with a median follow up of 84 days, the authors found infant nirsevimab immunization overall was associated with a 26% lower risk of RSV-related hospitalization and significantly reduced severe outcomes, including a 42% lower risk for PICU admission and a 43% lower risk of needing ventilator support compared to maternal immunization with RSVpreF.<sup>18</sup>
  - This comparison underscored the distinct roles of the agents, and how implementing both infant long-acting monoclonal antibodies and maternal vaccines allows healthcare systems to maximize population coverage, leverage the immediate, superior protection offered by the maternal vaccine in the first week, and maintain acute care capacity during the RSV season.
- **Argentina's** universal program with RSVPreF reported vaccine effectiveness against RSV-associated hospitalization of 81% at 3 months and 79% at 6 months.<sup>19</sup>
- The **United Kingdom** reported results with their RSVPreF program of 72% vaccine effectiveness against RSV-associated hospitalization.<sup>20</sup>

The evidence is clear: jurisdictions that commit to universal programs see a dramatic and immediate reduction in severe RSV burden. By remaining in a high-risk-only model, BC and Alberta are choosing to accept higher rates of infant hospitalization and PICU admission compared to their peers.

## KEY CONSIDERATIONS FOR ACTION

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### Policy Recommendations for British Columbia and Alberta

Based on the strength of current evidence and the realities of pediatric care in Western Canada, four priority actions are recommended:

## 1. 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.<sup>4</sup> Every infant - regardless of medical history or geographic location - should have access to seasonal RSV protection.

*Aligning with the latest guidance from the National Advisory Committee on Immunization, provinces should move toward programs that include all infants, not just those deemed high-risk.*

## 2. Broaden the Decision-Making Framework

Government evaluations must move beyond narrow short-term payer costs. The framework must include:

- **Family Burden:** Work loss, travel, and financial strain.<sup>21</sup>
- **Psychosocial Stress:** The impact on parental mental health and sibling care.<sup>12</sup>
- **Systemic Costs:** The expense of pediatric inter-facility transport and air evacuations<sup>22</sup> and related safety issues.
- **Long-term Morbidity:** Potential reductions in subsequent respiratory issues like asthma and recurrent infections and decreased lung capacity with early death.<sup>3</sup>

*Failure to do so reaches a conclusion that is focused on limited data and prevents the development of a universal program that protects all infants.*

## 3. Treat RSV Prevention as a System-Capacity Strategy

Universal prevention should be recognized as a critical tool for maintaining health system capacity during peak winter months. Reducing infant RSV-related admissions alleviates pressure on emergency departments, paediatric wards, and ICUs, helping ensure timely care for all children - not only those at high risk for respiratory illness.<sup>5</sup>

*Without this approach, seasonal surges will continue to strain capacity and compromise access to care.*

## 4. Advance Equity Across All Communities

Equity must be central to program design. Infants in rural, remote, and Indigenous communities face additional barriers, including limited local care and the need for transport to higher level facilities. Access to RSV prevention should not depend on postal code. Universal programs help

ensure that all infants in BC and Alberta have equitable protection, comparable to other provinces/territories in Canada and to children living in major urban centers.<sup>10,13</sup>

***Failure to do so raises equity and ethical questions as to why we are not protecting all infants from a disease that has no curative treatment and relies on prevention.***

## CONCLUSION

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Expanding RSV protection to all infants is not simply an immunization policy decision - it is fundamental to child health, rural health equity, and overall health-system sustainability. The current high-risk-only approach in British Columbia and Alberta is misaligned with both the true burden of disease and the demonstrated success of universal programs in other jurisdictions.<sup>8</sup>

Evidence from the SPRINT-KIDS network and international surveillance consistently demonstrates that RSV hospitalizations are common, often severe, and disproportionately affect previously healthy infants.<sup>5,7,15-18</sup> At the same time, the broader economic burden - particularly on families - remains underrecognized in traditional cost models.<sup>21</sup>

With the availability of effective preventive tools, including long-acting monoclonal antibodies such as nirsevimab and clesrovimab, as well as maternal vaccination with RSVPreF, provinces now have the capacity to substantially reduce - the annual pediatric winter surge driven by RSV.<sup>4,5</sup>

Failing to adopt a universal approach risks leaving families vulnerable and perpetuates avoidable strain on already stretched healthcare systems. In contrast, a universal program offers a practical, evidence-based path forward that aligns with both clinical need, system priorities and NACI guidelines.

Policymakers now face a clear choice. By acting with both pragmatism and ambition, BC and Alberta can ensure that all families are supported in making informed decisions and that every infant - regardless of geography or risk status - has equitable protection from RSV.

## ABOUT THE FEDERATION OF MEDICAL WOMEN OF CANADA

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The Federation of Medical Women of Canada (FMWC) was established in 1924 and is a national organization committed to the professional, social and personal advancement of women physicians and trainees and to the promotion of the well-being of women+ both in the medical profession and in society at large.

*The vision of the Federation is that Canadian medical women are upheld/empowered professionally and personally and viewed as the preeminent advocates for women's evolving health and well-being.*

## BC and AB Infant RSV Protection Advocacy Group by FMWC

The FMWC has been a leader in infant RSV protection advocacy in Canada since 2024, having convened two national task forces, produced two previous white papers and led national advocacy work. Given that BC and Alberta are among the last provinces to implement a universal program, we convened the BC and Alberta Infant RSV Protection Advocacy Group to develop an urgent, actionable position statement. This statement is grounded in the latest evidence and real-world outcomes, demonstrating why universal infant RSV protection is essential for BC and Alberta to stabilize pediatric capacity, reduce winter surges, and improve health equity.

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