Review

Determinants of Maternal RSV Vaccination Uptake: A Narrative Review

Nikolaou I. Aikaterini , Soldatou Alexandra , Grantzi Georgia-Christiana , Giapros Vasileios , Ladomenou Fani *

Posted Date: 6 March 2026

doi: 10.20944/preprints202603.0501.v1

Keywords: respiratory syncytial virus; maternal vaccination; pregnancy; vaccine uptake; vaccine hesitancy; monoclonal antibodies; health services accessibility; health equity

 doi:10.20944/preprints202603.0501.v1

Review

Determinants of Maternal RSV Vaccination Uptake: A Narrative Review

Nikolaou I. Aikaterini [1,2], Soldatou Alexandra [3], Grantzi Georgia-Christiana [4], Giapros Vasileios [2] and Ladomenou Fani [1,*]

[1] Department of Pediatrics, School of Medicine, University of Ioannina, 45500 Ioannina, Greece
[2] Neonatal Intensive Care Unit, School of Medicine, University of Ioannina, 45500 Ioannina, Greece
[3] Department of Pediatrics, School of Medicine, National and Kapodistrian University of Athens, 15772 Athens, Greece
[4] Evangelismos General Hospital, 10676 Athens, Greece
* Correspondence: fladomenou@gmail.com

Abstract

Maternal vaccination against respiratory syncytial virus (RSV) represents a major advance in early-life infection prevention. Although clinical efficacy and early real-world effectiveness are well established, sustained population-level impact depends on equitable uptake. This review synthesizes determinants influencing maternal RSV vaccination within the evolving dual-strategy landscape that includes both maternal vaccination and infant monoclonal antibody prophylaxis. A structured narrative review was conducted following PRISMA principles. PubMed/MEDLINE and Google Scholar were searched for studies published between January 2022 and February 2026. Eligible studies examined behavioral, interpersonal, structural, economic, and policy determinants of maternal RSV vaccination uptake, as well as early implementation and modelling evidence. Findings were integrated within a multilevel analytical framework. Maternal uptake is shaped by interacting determinants across individual, healthcare provider, and health system domains. Key drivers include perceived infant disease severity, vaccine safety confidence, perceived effectiveness, and prior antenatal vaccination behavior. Healthcare provider recommendation consistently emerges as the strongest facilitator. Coverage variability reflects differences in reimbursement, antenatal care integration, and national policy endorsement. The coexistence of maternal vaccination and infant monoclonal antibody strategies introduces additional comparative decision-making complexity. Early implementation data indicate heterogeneous uptake and socioeconomic gradients, while modelling demonstrates sensitivity to coverage, timing, epidemiology, and cost. Translating biological efficacy into sustained public health benefit requires coordinated behavioral, structural, and policy strategies, strong provider engagement, and context-sensitive implementation frameworks to ensure equitable coverage.

Keywords: respiratory syncytial virus; maternal vaccination; pregnancy; vaccine uptake; vaccine hesitancy; monoclonal antibodies; health services accessibility; health equity

1. Introduction

Respiratory syncytial virus (RSV) remains a leading cause of acute lower respiratory tract infection (LRTI) in infants worldwide and a major contributor to pediatric morbidity and healthcare utilization [1]. The greatest burden occurs during the first six months of life, when immunological immaturity and limited therapeutic options increase vulnerability to severe disease [1]. RSV-associated hospitalization rates among otherwise healthy term infants remain substantial, with seasonal surges placing additional strain on healthcare systems [2,3] and generating considerable indirect societal costs, including parental work absenteeism [2]. In high-burden settings, RSV also contributes to infant mortality; modelling from South Africa suggests that maternal vaccination could

 doi:10.20944/preprints202603.0501.v1

avert substantial deaths under diverse epidemiological scenarios, with projected benefits outweighing potential risks [4].

Maternal vaccination is biologically supported by the transplacental transfer of immunoglobulin G, offering passive protection during the period when neonatal immune responses are still developing [5]. Empirical evidence confirms both the efficiency of this transfer and the persistence of RSV-specific antibodies in early infancy [6]. In the wake of post-pandemic disruptions to RSV transmission, resulting shifts in seasonal dynamics and population susceptibility further highlight the urgency of implementing scalable preventive strategies for this vulnerable age group [7].

Recent advances in structural vaccinology and monoclonal antibody development have reshaped RSV prevention [8,9]. Evidence from a pivotal phase 3 randomized controlled trial demonstrated that maternal RSVpreF vaccination significantly reduced medically attended RSV-associated LRTI and hospitalization in early infancy [10], while long-acting monoclonal antibody prophylaxis, including nirsevimab, achieved comparable efficacy among late-preterm and term infants [11]. These findings are reinforced by pooled evidence from systematic reviews, meta-analyses, Cochrane syntheses, and regulatory assessments, all of which confirm robust immunogenicity and favorable efficacy and safety profiles without increased perinatal risk [12–14]. Real-world obstetric data from routine immunization programs likewise show with no increased risk of preterm birth or adverse maternal or neonatal outcomes [15,16].

Early real-world effectiveness data corroborate trial findings. Test-negative and multicenter analyses from Argentina and the United Kingdom demonstrated substantial reductions in RSV-associated hospitalization among infants born to vaccinated mothers [17,18], while post-implementation surveillance from the United States and Italy suggests measurable declines in RSV-related hospitalization following deployment of maternal vaccination and/or monoclonal antibody programs [19,20]. Modelling and economic evaluations indicate that projected public health impact depends critically on coverage levels, timing, epidemiological context, and cost structures [21–24]. National guidance documents increasingly integrate these preventive strategies into RSV management frameworks [25,26], while recent syntheses situate RSV vaccination alongside influenza and Covid-19 immunization within routine RSV prevention strategies [27].

Nevertheless, biological efficacy does not automatically translate into population-level impact. Maternal vaccination programs historically demonstrate variable coverage across settings, shaped by interacting individual, interpersonal, structural, economic, and policy determinants. Emerging behavioral evidence from Europe, North America, and Asia indicates heterogeneous willingness to accept maternal RSV vaccination, influenced by perceived infant risk, safety concerns, prior vaccination behavior, healthcare provider recommendation, and comparative evaluation of infant monoclonal antibody alternatives [28–35]. The concurrent availability of maternal vaccination and infant monoclonal antibody prophylaxis further introduces a novel comparative dimension into antenatal decision-making [30,32].

To date, no comprehensive synthesis has systematically examined determinants of maternal RSV vaccination uptake across behavioral, structural, economic, and policy domains within the rapidly evolving dual-strategy RSV prevention landscape. Existing studies have largely addressed isolated components—such as intention, safety perceptions, or cost-effectiveness—without integrating these dimensions into a coherent implementation framework.

This narrative review synthesizes current evidence on determinants influencing maternal RSV vaccination uptake and uniquely situates them within a multilevel model that incorporates behavioral drivers, health system factors, economic context, and the comparative dynamics between maternal vaccination and infant monoclonal antibody strategies. By identifying cross-cutting themes, implementation gaps, and equity considerations, this review provides an integrated analytical foundation to inform clinical practice, program design, and global health policy.

 doi:10.20944/preprints202603.0501.v1

2. Methods

This narrative review was conducted using a structured literature search and reported in accordance with PRISMA principles. A narrative synthesis approach was selected because the objective was conceptual integration across heterogeneous evidence streams—including behavioral surveys, discrete choice experiments, qualitative studies, real-world implementation analyses, surveillance reports, and economic modelling—rather than quantitative effect estimation. Given the diversity of study designs, populations, and outcome measures, a systematic meta-analytic approach was not considered methodologically appropriate.

PubMed/MEDLINE and Google Scholar were searched for studies published between January 2022 and February 2026, reflecting the period during which maternal RSV vaccination and long-acting monoclonal antibodies became clinically and policy relevant. Search terms combined controlled vocabulary and free-text keywords related to RSV, maternal vaccination, pregnancy, uptake, acceptance, intention, vaccine hesitancy, determinants, implementation, nirsevimab, and monoclonal antibodies. Grey literature and policy documents were additionally identified through targeted searches of public health agency websites, including the World Health Organization.

Following duplicate removal, records were screened by title and abstract, and eligible articles underwent full-text review. Studies meeting predefined inclusion criteria were included in the final synthesis (Figure 1). Included studies addressed determinants of maternal RSV vaccine uptake, parental preferences between preventive strategies, real-world implementation data, economic or modelling analyses, or policy-relevant contextual factors. Randomized controlled trials evaluating vaccine efficacy were included selectively for contextual interpretation but were not the primary focus of behavioral synthesis. Studies unrelated to RSV prevention, preclinical or immunogenicity-only investigations without behavioral relevance, and commentaries without empirical data were excluded unless they provided substantive policy insight.

The diversity of study designs, populations, and outcome definitions precluded meaningful quantitative pooling of results; therefore, quantitative meta-analysis was not undertaken. Findings were synthesized narratively and organized thematically across behavioral, structural, economic, and policy-level determinants within a multilevel analytical framework. Given the narrative design and methodological heterogeneity, formal risk-of-bias tools were not applied. However, key quality features—including study design, sample size, clarity of outcome definitions, and potential sources of bias—were considered when interpreting the strength and consistency of the evidence. A summary of included empirical studies is provided in Table 1.

Table 1. Empirical Studies Examining Determinants and Uptake of Maternal RSV vaccination (2023–2026).

Country	Study	Design	Population	Strategy	Outcome	Key Facilitators	Key Barriers	Phase
Greece	Damatopoulou 2024 [28]	Cross-sectional	Pregnant women	Maternal vaccine	Intention	High perceived infant risk; prior antenatal vaccination	Safety uncertainty; limited RSV awareness	Pre-implementation
UK	Broad 2025 [29]	National survey	Pregnant / postpartum	Maternal vaccine	Intention	Provider recommendation; perceived disease severity	Safety concerns in pregnancy; low RSV knowledge	Pre-implementation
Canada	McClymont 2025 [32]	National survey	Pregnant / postpartum	Maternal vs mAb	Preference	Trust in healthcare providers; perceived infant benefit	Preference shift with safety concerns	Early implementation
USA	Nuzhath 2025 [58]	Cross-sectional	Pregnant women	Maternal vs mAb	Preference	Direct infant protection framing	Differences in safety perception	Early implementation

 doi:10.20944/preprints202603.0501.v1

Japan	Okubo 2026 [64]	Nationwide survey	Pregnant women	Maternal vaccine	Uptake	Provider engagement; system access	Limited awareness; reimbursement uncertainty	Implementation
USA	Blauvelt 2025 [67]	Multisite cohort	Pregnant women / infants	Maternal + mAb	Uptake	Health-system coordination	Coverage disparities	Implementation
France	Bonnel 2025 [70]	Prospective cohort	Infants (maternal/mAb context)	mAb (nirsevimab)	Uptake	Structured campaign rollout	Socioeconomic variability	Implementation
UK	Razai 2025 [71]	Cross-sectional	Pregnant women	Maternal vaccine	Uptake	National recommendation; service integration	Socioeconomic gradients	Implementation

Abbreviations: RSV, respiratory syncytial virus; mAb, monoclonal antibody; UK, United Kingdom; USA, United States.

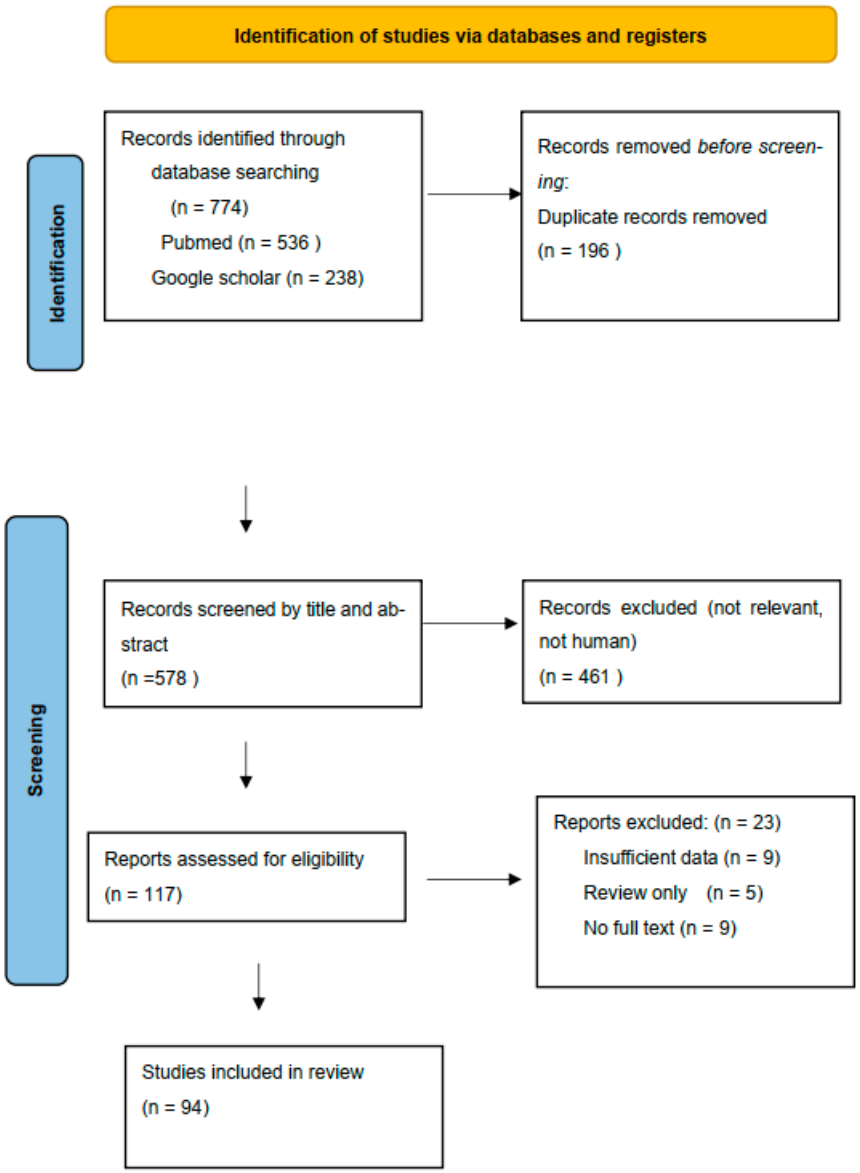

Figure 1. PRISMA flow diagram of search procedure.

 doi:10.20944/preprints202603.0501.v1

3. Epidemiological and Clinical Context

RSV remains a leading cause of hospitalization among infants globally, particularly during the first six months of life [1]. Surveillance data from diverse regions—including Europe—consistently demonstrate substantial early-life morbidity and healthcare utilization [2], while seasonal peaks continue to exert pressure on pediatric services [3].

Post-pandemic disruptions in viral transmission altered traditional RSV seasonality, producing atypical resurgences and increased susceptibility among previously unexposed cohorts [7]. These shifts have reinforced the need for preventive strategies capable of protecting infants during the period of highest vulnerability to severe LRTI.

The biological rationale for maternal RSV vaccination is grounded in maternal–fetal immune mechanisms. Transplacental transfer of maternal immunoglobulin G provides passive neonatal protection during early infancy, when endogenous immune responses are immature [5]. Empirical evidence confirms efficient antibody transfer and early-life persistence of RSV-specific antibodies [6], although physiological antibody decline limits the duration of passive protection and highlights the need for optimally timed antenatal vaccination [36]. In addition to pathogen-specific benefits, maternal vaccination may also reduce neonatal infections and subsequent antibiotic exposure, aligning with broader antimicrobial stewardship goals [37].

Consistent with accumulated clinical and post-licensure evidence, randomized trials, pooled analyses, and real-world effectiveness studies demonstrate substantial protection against RSV-associated lower respiratory tract infection and hospitalization in early infancy following maternal RSVpreF vaccination and long-acting monoclonal antibody administration, including nirsevimab [10–12,17,18,39–43]. Additional post-licensure pharmacovigilance and obstetric data have not identified significant safety concerns [12,15,16,38,44], and early programmatic implementation has been associated with measurable reductions in RSV-related hospitalizations in several settings [19,20].

Despite strong clinical and effectiveness evidence, translation into sustained public health impact depends on implementation performance and equitable maternal uptake. Durable reductions in RSV morbidity depend on timely administration and adequate, equitable uptake of maternal vaccination during pregnancy. Understanding determinants of acceptance, access, and coverage is therefore essential to bridging the gap between clinical efficacy and real-world public health benefit.

4. Determinants of Maternal RSV Vaccination Uptake

Maternal uptake of RSV vaccination is shaped by interacting determinants across individual, interpersonal, structural, and policy domains [28–34,45,46], summarized in Table 2. While robust clinical efficacy and post-licensure safety data provide the foundation for program implementation [10,17,18,43,44], maternal decision-making remains inherently multidimensional, shaped by risk perception, trust, access, and contextual influences. The multilevel framework adopted in this review aligns with established implementation models such as CFIR and the Theoretical Domains Framework [47–49], strengthening conceptual coherence and facilitating the translation of identified determinants into targeted implementation strategies.

Table 2. Multilevel Determinant Framework for Maternal RSV Vaccination Uptake.

Determinant Level	Determinant Construct	Theoretical Mapping	Empirical Evidence	Direction of Association
Individual	Perceived infant susceptibility/severity	Health Belief Model (Perceived risk)	Damatopoulou 2024 [28]; Callaghan 2025 [30]	↑ intention
Individual	Vaccine safety confidence	5C – Confidence	Broad 2025 [29]; McClymont 2025 [32]	↓ acceptance when low
Individual	Comparative decision framing (maternal vs mAb)	Risk–benefit appraisal; decisional balance	Callaghan 2025 [30]; McClymont 2025 [32]; Nuzhath 2025 [58]	Preference shift when maternal safety concerns present

 doi:10.20944/preprints202603.0501.v1

Interpersonal	Provider recommendation	Social norms; cue to action (HBM)	Broad 2025 [29]; McClymont 2025 [32]	↑ uptake
Structural	Reimbursement and delivery integration	5C – Constraints	Trusinska 2025 [45]; Okubo 2026 [64]	↑ coverage when funded and integrated
Structural	Equity and access constraints	Access theory; health equity frameworks	Blauvelt 2025 [67]; Bonnel 2025 [70]	↓ uptake in socioeconomically disadvantaged groups
Policy	National endorsement and guideline alignment	Institutional trust; policy diffusion	Montesinos 2026 [25]; Navér 2026 [26]	↑ system integration and provider confidence

Abbreviations: RSV, respiratory syncytial virus; HBM, Health Belief Model; 5C, confidence, complacency, constraints, calculation, collective responsibility.

4.1. Distinguishing Intention from Observed Uptake

Intention and preference studies rely on hypothetical scenarios and may not directly translate into real-world behavior. In contrast, observed uptake reflects the influence of additional structural, financial, and service-delivery factors. For this reason, intention and preference findings are interpreted separately from observed coverage data throughout this review.

4.2. Individual-Level Determinants

4.2.1. Perceived Infant Risk and Disease Severity

Perceived susceptibility to and severity of RSV infection in early infancy consistently predict maternal intention to vaccinate [28,30,33]. In a Greek cohort, heightened perception of disease severity and infant vulnerability was associated with greater acceptance of maternal vaccination [28]. Similar associations were observed in Italy and North America, where recognizing RSV as a significant cause of infant hospitalization increased willingness to vaccinate [30,33].

Baseline awareness and perceived risk of RSV vary across populations [29,31]. Higher perceived likelihood of infant RSV illness and positive vaccine attitudes have been consistently associated with greater willingness to accept maternal vaccination and infant monoclonal antibodies [31], underscoring the importance of risk communication within implementation strategies. Qualitative data from Australia show that mothers seek clear, consistent, provider-endorsed information, and that informational gaps may delay decision-making [50].

Evidence from Asia aligns with these findings. In Taiwan, greater RSV knowledge and higher perceived risk were associated with increased willingness to accept infant RSV vaccination [35]; in Japan, knowledge of disease and vaccine characteristics correlated with favorable attitudes [51]; and in Turkey, greater awareness was linked to more positive views toward immunization [52]. Collectively, these studies underscore that informational deficits and perceived disease risk represent consistent—and modifiable—determinants of maternal decision-making.

4.2.2. Perceived Vaccine Effectiveness

Perceived effectiveness is closely tied to risk appraisal. Survey data show that higher perceived likelihood of infant RSV illness and positive vaccine attitudes are associated with greater willingness to accept maternal RSV vaccination and infant monoclonal antibodies [31]. Real-world evidence from Argentina and the UK reinforces these perceptions, demonstrating substantial reductions in RSV-related hospitalization among vaccinated cohorts [17,18]. While the behavioral impact of communicating such evidence has not been quantified, the association between perceived benefit and intention indicates that real-world outcomes may play a meaningful role in shaping maternal decisions [30,31].

 doi:10.20944/preprints202603.0501.v1

4.2.3. Safety Concerns During Pregnancy

Safety concerns remain the most consistently reported barrier to maternal RSV vaccine acceptance [29,32]. In England, uncertainty regarding vaccine safety was the principal driver of hesitancy [29], while Canadian respondents with safety reservations were more likely to prefer infant monoclonal antibody strategies [32].

Accumulating evidence does not indicate major safety signals: meta-analyses and obstetric cohort studies demonstrate robust immunogenicity without increased perinatal risk [12,13,15,53]. Nonetheless, hesitancy persists, highlighting divergence between objective safety evidence and subjective risk perception. Broader analyses situate vaccine decisions within dynamics of institutional trust and communication [54]. Transparent, dialogue-based counselling remains central. Digital discourse analyses further reveal recurring safety narratives and trust-related concerns influencing maternal appraisal [55].

4.2.4. Prior Maternal Vaccination Behavior

Previous acceptance of pertussis or influenza vaccination predicts willingness to receive the RSV vaccine [28,30,31,34]. These decisions are embedded within broader antenatal immunization culture; variations by provider recommendation and hospital practice have been noted in Czech maternity hospitals [56].

4.2.5. Comparative Evaluation of Preventive Strategies

A distinctive feature of RSV prevention is the simultaneous availability of maternal vaccination and infant monoclonal antibody prophylaxis, creating a comparative decision environment [30]. Canadian data from the COVERED Study demonstrate broad acceptance of both modalities, although preference shifted toward infant monoclonal antibodies when concerns regarding vaccination during pregnancy were present [32]. Preferences were shaped by perceived maternal safety, directness of infant protection, trust in healthcare providers, and prior antenatal vaccination experience. Comparable patterns were observed in the United Kingdom, where safety perceptions and trusted healthcare advice emerged as principal determinants of preference [57].

Additional survey data confirm that perceptions of maternal safety, direct infant protection, and institutional trust influence acceptance and comparative considerations [58,59]. Perspectives from immigrant communities highlight further cultural and communication dimensions [60]. Economic modeling highlights that intervention cost and duration of protection substantially influence comparative cost-effectiveness of maternal vaccination and monoclonal antibody strategies [61], while cross-national analyses identify perceived trade-offs between maternal and infant options [62]. Maternal uptake thus reflects multidimensional evaluation across parallel preventive pathways rather than a single-option acceptance process. The structural and behavioral distinctions between maternal vaccination and infant monoclonal antibody prophylaxis illustrate the complexity of this dual-prevention environment and are summarized in Table 3.

Table 3. Comparative Characteristics of Maternal Vaccination and Infant Monoclonal Antibody Strategies.

Dimension	Maternal Vaccination	Infant mAb (e.g., nirsevimab)
Timing of administration	During late pregnancy (antenatal period)	At birth or early infancy
Mechanism of protection	Transplacental transfer of vaccine-induced maternal IgG antibodies	Direct passive administration of monoclonal antibodies to the infant
Biological dependency	Requires adequate maternal immune response and placental transfer	Independent of maternal immune status
Maternal exposure	Yes (maternal systemic immune activation)	No maternal exposure
Onset of infant protection	Immediately at birth (if administered within recommended gestational window)	After infant administration

 doi:10.20944/preprints202603.0501.v1

Duration of protection	Limited to early infancy; dependent on antibody waning kinetics	Defined duration based on monoclonal antibody half-life
Primary behavioural driver	Maternal risk–benefit evaluation during pregnancy	Preference for direct infant-targeted protection
Key safety perception focus	Vaccine safety during pregnancy	Infant safety and novelty of biologic agent
Structural integration pathway	Integrated into routine antenatal care services	Delivered through neonatal or paediatric services
Policy implementation considerations	Requires antenatal coverage and provider recommendation	Requires procurement, cold-chain logistics, and infant follow-up systems

Abbreviations: RSV, respiratory syncytial virus; mAb, monoclonal antibody; IgG, immunoglobulin G.

4.3. Interpersonal Determinants: Healthcare Provider Influence

Healthcare provider recommendation is one of the most consistently identified facilitators of maternal RSV vaccine acceptance [28,29,32,34]. In the England-wide survey, willingness to receive antenatal RSV vaccination increased substantially when recommended by a trusted healthcare professional [29]. Comparable findings were observed in Greece and Canada, where endorsement from obstetricians or midwives significantly influenced intention [28,32].

Mixed-methods evidence suggests that the strength, clarity, and timing of provider recommendation are critical factors [34]. Provider communication serves as a bridge between scientific evidence and maternal decision-making, mediating interpretation of safety and effectiveness data.

These findings are consistent with established patterns observed in other antenatal vaccination programs, reinforcing the central role of obstetric care providers in promoting uptake.

4.4. Sociodemographic and Contextual Variation

Associations between sociodemographic characteristics and maternal RSV vaccine acceptance appear context-dependent. Education level has been associated with increased willingness in some studies, potentially reflecting differences in health literacy and access to information [28,33]. However, effect sizes and consistency vary across populations.

Cross-national differences in intention and preference further suggest the influence of contextual factors, including institutional trust, prior experience with antenatal vaccination campaigns, and broader cultural attitudes toward vaccination [28,29,32,33].

Although preliminary analyses suggest potential disparities, comprehensive population-level equity analyses of observed RSV maternal vaccine uptake remain limited. Early variability in coverage across implementation settings indicates that structural and socioeconomic factors may influence access and acceptance [45].

4.5. Health System and Structural Determinants

Real-world data demonstrate variability in maternal RSV vaccination uptake across healthcare systems [45]. Differences in national policy endorsement, reimbursement mechanisms, integration into antenatal care pathways, and logistical accessibility appear to shape program performance. Implementation contexts characterized by clear recommendations and coordinated delivery structures tend to exhibit more consistent uptake, whereas fragmented systems may experience slower or uneven adoption.

Professional society endorsement constitutes an additional structural determinant influencing program implementation. A recent position statement from the Mexican Association of Pediatrics outlining recommendations for immunoprevention of RSV during pregnancy and infancy reflects growing institutional support for maternal vaccination strategies within Latin America [25]. Such national-level guidance may shape provider recommendation behavior, facilitate policy alignment, and promote integration of maternal RSV vaccination into routine antenatal care services.

 doi:10.20944/preprints202603.0501.v1

Programmatic infrastructure and financing mechanisms can also directly influence access to RSV preventive products. In the United States, expansion of birthing hospital enrollment in the Vaccines for Children program was implemented to facilitate infant immunization against RSV and reduce structural barriers at the point of care [63]. This example illustrates how policy instruments and funding frameworks can enhance equitable access, particularly for socioeconomically vulnerable populations, and demonstrates the role of system-level interventions in translating recommendations into practice.

Discrete choice experiment findings from the Netherlands indicate that cost, convenience, and delivery setting significantly influence parental preferences for RSV prevention strategies [46]. These results suggest that structural accessibility—including financial coverage, integration into routine antenatal visits, and minimization of additional appointments—plays a critical role in translating intention into actual uptake.

Nationwide survey data from Japan further illustrate how structural and policy contexts shape coverage [64]. In that setting, maternal RSV vaccine uptake was influenced not only by individual-level attitudes but also by healthcare system factors such as access pathways and provider engagement. This underscores that behavioral determinants operate within broader organizational frameworks that can either facilitate or constrain vaccination. Complementary qualitative evidence highlights additional barriers unique to the Japanese context, including limited public awareness of maternal RSV vaccination, insufficient provider recommendation, and uncertainty regarding reimbursement mechanisms [65]. These findings emphasize that even in health systems with established antenatal care infrastructure, information gaps and policy ambiguity can hinder program uptake. Broader regional commentaries further contextualize these structural challenges. In Southern Europe, strengthening routine antenatal care and integrating maternal vaccination within established obstetric services have been identified as key strategies to close the maternal vaccination gap and ensure equitable implementation of new RSV prevention programs [66].

When maternal RSV vaccination is embedded within established antenatal vaccination programs, operational barriers may be reduced and provider recommendation more consistently implemented. Conversely, unclear reimbursement policies, supply instability, or limited integration into routine antenatal pathways may constrain program performance despite generally favorable maternal attitudes. These structural conditions therefore influence the degree to which individual intention can translate into sustained and equitable program delivery. The multilevel framework presented here reflects an integrative conceptual synthesis derived from convergent behavioral and implementation evidence rather than a single predefined theoretical model.

5. Real-World Uptake and Early Implementation Signals

Despite established clinical efficacy and early real-world effectiveness [10,17,18], observed program coverage remains heterogeneous [45]. A recent systematic review and meta-analysis identified marked cross-national variability in uptake, reflecting differences in policy endorsement, reimbursement mechanisms, and delivery structures [45]. National data from Japan demonstrated measurable but variable maternal vaccine coverage shaped by perceived infant risk, provider recommendation, and safety confidence [64]. Similar patterns emerged in the United States, where a multicentre cohort reported concurrent RSVpreF and nirsevimab uptake with modest overall coverage, gradual seasonal increases, and persistent sociodemographic disparities [67]. Provider preparedness further influenced implementation: surveys of Turkish pediatricians revealed variability in familiarity with RSV prevention strategies [68], while US physicians' perceptions of disease burden and preventive preferences affected counselling practices [69].

Socioeconomic gradients also modulate coverage. In France, adherence to the nirsevimab campaign was associated with sociodemographic and healthcare access variables [70], and early UK data showed comparable disparities without excess adverse obstetric outcomes [71]. US surveillance during the 2023–2024 season documented expanding but incomplete infant protection through

 doi:10.20944/preprints202603.0501.v1

maternal vaccination and/or nirsevimab [72], with additional state-level and Vaccine Safety Datalink analyses confirming site-level and demographic variability in uptake [73–75].

In Europe, Austrian real-world data linked uptake of RSVpreF vaccination and nirsevimab with reductions in RSV disease burden [76], and surveillance in the United States and Italy similarly documented post-implementation declines in RSV-associated hospitalizations [19,20,77]. Although bronchiolitis admissions are not exclusively RSV-related, these convergent findings suggest that coordinated deployment can reduce seasonal pediatric respiratory morbidity. Accurate estimation of maternal vaccine coverage depends on surveillance quality; Australian data highlighting discrepancies between registry-based and administrative reporting underscore the importance of robust data linkage and completeness [78].

Overall, structured and coordinated implementation can translate demonstrated biological efficacy into measurable population-level benefit. However, much of the behavioral literature continues to assess stated intention rather than verified vaccination behavior [28,29,32], underscoring the need to integrate behavioral insights with implementation data to clarify how determinants operate under routine program conditions.

6. Cross-Cutting Themes and Research Gaps

Several cross-cutting themes emerge from the current evidence base. First, the behavioral–implementation interface remains insufficiently characterized. Although moderate to high stated willingness has been reported across settings—particularly when accompanied by strong healthcare provider recommendation [28,29,32]—real-world coverage remains heterogeneous [45]. The extent to which stated intention translates into observed uptake under routine program conditions therefore remains unclear. Most behavioral studies rely on cross-sectional designs assessing intention rather than longitudinal vaccination behavior, limiting causal inference regarding determinants of actual uptake. Broader maternal vaccination research similarly identifies persistent knowledge gaps in understanding behavioral and implementation determinants during pregnancy [79]. Addressing these gaps requires prospective, registry-linked, population-based cohort studies capable of examining interactions between behavioral drivers and structural or policy-level facilitators. Large-scale record-linkage platforms can further strengthen burden estimation, coverage measurement, and outcome evaluation [80].

Second, comparative decision-making now defines the RSV prevention landscape. The coexistence of maternal vaccination and infant monoclonal antibody prophylaxis creates a dual-strategy framework distinct from traditional antenatal programs, with maternal vaccination providing transplacental protection and monoclonal antibodies offering direct infant protection [30,32,81]. Policy developments—such as ACIP recommendations for clesrovimab in the United States [82] and European endorsement of maternal RSV vaccination [83]—reflect institutional integration of both approaches. Preferences are shaped by safety perceptions, perceived control, and timing of protection at the individual level, while modelling shows that population impact depends on coverage, timing, and implementation efficiency [21].

Economic evaluations consistently demonstrate strong context sensitivity. Maternal RSV vaccination has been shown to be cost-effective under defined assumptions in Hong Kong [22]. Analyses from Nepal and British Columbia similarly support context-specific value, although results vary according to program design and epidemiological assumptions [23,24]. Additional evaluations from Chile, Norway, and the Netherlands indicate that optimal strategies differ according to local epidemiology, pricing structures, health system capacity, financing arrangements, and achievable coverage levels [61,84,85]. Comparative modelling from Canada assessed both nirsevimab and maternal RSVpreF vaccination, demonstrating that relative cost-effectiveness depends on product pricing, seasonal burden, and program uptake [86]. US modelling further demonstrates marked sensitivity to vaccine price, baseline disease burden, and coverage assumptions [87,88]. A systematic review confirmed substantial heterogeneity in modelling approaches and outcome metrics, underscoring the importance of transparent parameterization and cross-study comparability [89].

 doi:10.20944/preprints202603.0501.v1

Beyond economic considerations, epidemiological modelling emphasizes temporal alignment. Regional variability in RSV seasonality directly influences optimal intervention timing [90]. US modelling demonstrates that alignment with local transmission dynamics significantly affects projected effectiveness and cost-efficiency of both maternal and monoclonal antibody strategies [91]. Dynamic transmission models further reveal variability driven by assumptions regarding coverage, duration of protection, baseline epidemiology, and seasonal dynamics [92]. Effective optimization therefore requires integrated consideration of epidemiology, timing, economic sustainability, coverage feasibility, and health system capacity.

Third, the translation of safety and effectiveness evidence into behavioral change remains incompletely understood. Although post-marketing surveillance, pooled analyses, obstetric cohort studies, and living meta-analyses have not identified unexpected safety signals [12,15,43,44], safety concerns persist in behavioral research [29,32]. Empirical evidence examining how communication of evolving safety and real-world effectiveness data influences actual uptake remains limited. Experimental studies assessing message framing, counselling approaches, and implementation strategies are largely absent. Consequently, the mechanisms through which updated evidence reshapes risk perception and vaccination behavior remain underexplored.

Digital information ecosystems may further shape maternal risk appraisal. Social media analyses from Italy identified recurring safety narratives, institutional trust dynamics, and comparative framing of preventive options during early rollout [55]. These findings suggest that public discourse may influence maternal decision-making alongside clinical counselling.

Fourth, generalizability remains constrained by the geographic concentration of behavioral evidence in high-income countries. Modelling and economic evaluations from Asia, Europe, and the Americas demonstrate expanding geographic representation [22–24]. Additional transmission and optimization models further highlight sensitivity to timing and epidemiology [46,84,85,88,90,92]. Given the substantial global RSV burden [1], context-specific behavioral, modelling, and implementation research is essential to ensure equitable and evidence-based global deployment.

7. Equity and Ethical Considerations

Equitable implementation of maternal RSV vaccination requires addressing both structural access barriers and the conditions that support informed, autonomous decision-making. Although higher education has been associated with increased intention to vaccinate [28,33], systematic analyses of inequities in observed coverage remain limited. Available evidence indicates that reimbursement mechanisms, policy endorsement, and integration into routine antenatal care shape differential access across settings [45]. Equity concerns are particularly salient given the disproportionate RSV burden in low- and middle-income countries [1]. The vast majority of global RSV-related deaths occur in LMICs, making equitable access to maternal RSV vaccination a public health and ethical imperative. Most behavioral and implementation evidence derives from high-income contexts, where studies from Europe and North America consistently document the influence of safety perceptions, prior vaccination behavior, and provider recommendation on intention, preference, and uptake [28–31]. Canadian and Italian investigations reinforce these patterns [32–34]. In contrast, emerging LMIC data remain comparatively sparse. A feasibility study from The Gambia reported generally favorable attitudes toward maternal RSV vaccination but also highlighted concerns related to healthcare access, information provision, and trust in antenatal services [93]. Modelling from South Africa projected substantial mortality reductions, with benefits outweighing potential risks across diverse epidemiological scenarios [4]. Together, these findings suggest that maternal RSV vaccination could meaningfully contribute to child survival strategies in high-burden settings, provided structural and financial barriers are addressed.

Global analyses underscore that equitable deployment requires coordinated policy action. Key barriers include financing constraints, supply limitations, regulatory heterogeneity, cold-chain requirements, and uneven integration into maternal and child health systems [94]. Without pooled procurement strategies, tiered pricing, and strengthened antenatal platforms, new RSV preventive

 doi:10.20944/preprints202603.0501.v1

technologies risk widening existing disparities. Early implementation data from high-income countries demonstrate reductions in RSV-associated hospitalizations following maternal vaccination and/or monoclonal antibody rollout [19,20], but achieving similar impact in lower-resource settings will depend on affordability, supply chain reliability, antenatal care coverage, and timely access. Documented cross-national variation in uptake further illustrates the risk of inequitable deployment [45].

Ethically, maternal RSV vaccination requires balancing clear communication of infant benefit with respect for maternal autonomy. Safety concerns during pregnancy remain influential [29,32], making transparent communication of post-marketing surveillance [44], pooled safety analyses [12], and real-world effectiveness evidence [17,18] essential to maintaining trust. In dual-strategy contexts, clear explanation of comparative mechanisms, timing, and duration of protection supports informed decision-making [30,32,46]. Achieving equity therefore requires more than biological efficacy: it demands coordinated financing, strengthened antenatal systems, robust monitoring, and ethically grounded communication strategies that support autonomous maternal choice.

8. Implications for Clinical Practice and Policy

Effective implementation of maternal RSV vaccination requires coordinated action across behavioral, structural, economic, and health-system domains. Healthcare provider engagement remains foundational: strong recommendation from obstetricians or midwives consistently increases maternal willingness to vaccinate [28,29,32,34]. Provider training should prioritize clear, consistent communication of safety and effectiveness evidence, including real-world protection data [17,18], pooled safety analyses [12], and population-level obstetric outcomes [15,16], ensuring that counselling is both evidence-based and responsive to maternal concerns.

Embedding RSV vaccination within routine antenatal immunization pathways can reduce logistical barriers and enhance uptake [45]. National recommendations and professional society endorsement—including recent Latin American guidance [25]—strengthen policy coherence and provider confidence. Structural reforms, such as expanding birthing-hospital participation in the Vaccines for Children program in the United States, demonstrate how financing and delivery mechanisms can promote equitable access [63]. Updated Swedish guidelines further illustrate alignment between prevention strategies and clinical management pathways [26], underscoring the importance of integrating RSV vaccination into established maternal–child health infrastructures.

Given the availability of alternative preventive options, counselling must clearly articulate mechanisms, timing, duration of protection, and the complementary roles of maternal vaccination and monoclonal antibodies [30,32,46]. Modelling indicates that population-level impact depends on coverage, timing, and implementation efficiency [21], while cost-effectiveness varies according to pricing structures and resource constraints across settings [22–24]. Regional variation in RSV seasonality further necessitates alignment of immunization schedules with local transmission dynamics [90], reinforcing the need for context-specific implementation strategies.

Beyond RSV-specific outcomes, maternal vaccination may contribute to broader neonatal infection prevention and antimicrobial stewardship efforts [37]. Positioning RSV vaccination within comprehensive maternal–child health strategies can facilitate long-term integration and sustainability.

Robust surveillance systems are essential to monitor coverage, safety, equity indicators, and seasonality alignment during rollout [45]. Strengthened data linkage and real-time monitoring enable early identification of disparities, guide corrective action, and ensure that demonstrated biological efficacy translates into consistent, equitable program delivery. Ultimately, successful implementation will depend not only on the biological performance of the vaccine but on the capacity of health systems to deliver it reliably, equitably, and in ways that support informed maternal choice.

 doi:10.20944/preprints202603.0501.v1

9. Limitations

This narrative review has several limitations. First, the synthesis reflects substantial heterogeneity in the available evidence base, spanning cross-sectional surveys, qualitative studies, discrete choice experiments, modelling analyses, and observational effectiveness data. Variation in study design, populations, measurement tools, and outcome definitions—particularly regarding intention, preference, and documented uptake—limits direct comparability across studies and precludes quantitative aggregation [45]. Conceptual constructs such as risk perception, trust, and safety concerns are operationalized inconsistently, and few studies employ validated behavioral measures, reducing construct validity and limiting the transferability of findings.

Second, most behavioral and implementation evidence originates from high-income countries, constraining generalizability to low- and middle-income settings where antenatal care coverage, health-system capacity, financing mechanisms, and cultural norms differ substantially [93,94]. Although modelling studies broaden geographic representation [4], empirical data on program integration, verified coverage, and real-world implementation in high-burden regions remain limited. Structural and cultural determinants—such as medicalization of antenatal care, provider-driven decision-making, and norms surrounding medical interventions during pregnancy—are insufficiently examined across settings.

Third, many behavioral investigations assess stated intention rather than documented vaccination behavior, limiting the ability to estimate real-world coverage dynamics and to determine how behavioral determinants translate into actual program participation under routine conditions [28,29,32]. Early implementation data are emerging but remain temporally constrained and subject to reporting variability, registry completeness, and differential access to antenatal services [78].

Fourth, comparative evidence on maternal vaccination and infant monoclonal antibodies remains incomplete. Few studies evaluate real-world preferences, sequencing strategies, or the behavioral and operational implications of dual-strategy availability. As a result, the impact of comparative framing, perceived control, and timing of protection on actual uptake remains insufficiently characterized.

Fifth, economic and transmission models rely on assumptions regarding seasonality, duration of protection, baseline disease burden, pricing structures, and achievable coverage levels. These parameters vary across settings and over time, and updates as programs mature may meaningfully alter projected impact and cost-effectiveness estimates [21,89,91]. Incorporating empirically derived uptake parameters, health-system constraints, and context-specific delivery pathways would enhance policy realism.

Finally, few studies apply formal implementation science frameworks such as CFIR, TDF, or RE-AIM. The absence of structured implementation constructs limits the ability to identify modifiable determinants, specify mechanisms of action, and design scalable, context-adapted implementation strategies. Post-marketing surveillance and real-world effectiveness data remain limited given the recency of program introduction, underscoring the need for robust pharmacovigilance, data linkage, and equity-focused monitoring systems.

Despite these limitations, the convergence of biological, clinical, behavioral, economic, and implementation evidence provides a coherent foundation for understanding determinants of maternal RSV vaccination uptake and for informing future research and policy deliberation.

10. Future Perspectives

Several priority directions emerge for advancing evidence and policy on maternal RSV vaccination. First, prospective longitudinal and registry-linked cohort studies are needed to characterize determinants of documented maternal vaccination behavior under routine program conditions [45,80]. Linkage between antenatal immunization registries, birth records, and infant outcome datasets would enable accurate assessment of program participation, safety surveillance, and effectiveness across diverse implementation settings [78].

 doi:10.20944/preprints202603.0501.v1

Second, comparative effectiveness and optimization research should continue to evaluate maternal vaccination and monoclonal antibody strategies within dynamic, context-specific frameworks. Modelling consistently shows that projected public health impact and cost-effectiveness are highly sensitive to achievable coverage and seasonal timing [21,90], while additional transmission and optimization models highlight the influence of pricing structures, baseline epidemiology, and program uptake parameters [86,89,92]. Incorporating empirically derived uptake patterns and health-system constraints into economic and transmission models would substantially enhance policy realism.

Third, research on communication, risk perception, and decision-making is needed to clarify how evolving safety and real-world effectiveness evidence shapes maternal choices [29,32]. Experimental and implementation-oriented studies evaluating message framing, provider counselling strategies, and digital information environments are particularly warranted, given evidence that public discourse influences vaccine attitudes during early rollout phases [55].

Fourth, expanding implementation research in low- and middle-income countries is essential. While modelling suggests substantial mortality and morbidity benefits in high-burden settings [4], and feasibility studies indicate general acceptability in African contexts [93], empirical data on health-system integration, financing mechanisms, and verified coverage remain limited. Achieving equitable global impact will require coordinated procurement strategies, context-adapted delivery models, and strengthened antenatal care infrastructure [94].

Finally, sustained pharmacovigilance and real-world effectiveness evaluation will be critical as programs mature. Transparent reporting frameworks, including post-marketing surveillance [12,43,44], are necessary to maintain public confidence and support adaptive policy refinement.

11. Conclusion

Maternal RSV vaccination represents a major advance in early-life infectious disease prevention, supported by strong biological rationale, robust clinical efficacy, and emerging real-world effectiveness. Within the current dual-strategy landscape, maternal vaccination—together with long-acting monoclonal antibodies—offers a realistic opportunity to substantially reduce RSV-associated hospitalization and infant respiratory morbidity and to reshape the RSV epidemiological landscape. Yet biological performance alone cannot secure population-level benefit. Sustained and equitable impact depends on high coverage, seamless integration into antenatal care systems, context-sensitive policy implementation, and transparent communication addressing safety, effectiveness, and the comparative roles of available preventive options. By synthesizing behavioral, structural, economic, and policy determinants within a unified analytical framework, this review clarifies the drivers of maternal RSV vaccination uptake and provides a strategic foundation for implementation research, policy translation, and equitable global deployment.

Author Contributions: Conceptualization, A.N. and F.L..; methodology, A.N. and F.L..; validation, A.N. and F.L..; formal analysis, A.N. and F.L..; investigation, A.N.; writing—original draft preparation, A.N.; writing—review and editing, A.N., A.S., G.-C.G., V.G. and F.L.; supervision, A.S., V.G. and F.L. All authors have read and agreed to the published version of the manuscript.

Funding: This research received no external funding.

Institutional Review Board Statement: Ethics approval was not required for this review study.

Informed Consent Statement: Not applicable.

Data Availability Statement: No new data were created or analyzed in this study. Data sharing is not applicable to this article.

Conflicts of Interest: The authors declare no conflicts of interest.

 doi:10.20944/preprints202603.0501.v1

References

1. World Health Organization. Respiratory syncytial virus (RSV). Available online: https://www.who.int/teams/immunization-vaccines-and-biologicals/diseases/respiratory-syncytial-virus-(rsv) (accessed on 23 October 2025).
2. Gourzoulidis, G.; Solakidi, A.; Markatis, E.; Detsis, M.; Siahanidou, T.; Dimitriou, G.; et al. Burden of respiratory syncytial virus disease in infants and the potential value of maternal immunization in Greece. *Front. Public Health* 2025, 13, 1611483. https://doi.org/10.3389/fpubh.2025.1611483.
3. Foley, D.A.; Phuong, L.K. RSV: An update on prevention and management. *Aust. Prescr.* 2025, 48, 34–39. https://doi.org/10.18773/austprescr.2025.018.
4. Monoi, A.; Endo, A.; Procter, S.R.; Leuba, S.I.; Flasche, S.; Jit, M.; et al. The benefits and risks of maternal RSV vaccination on mortality in South Africa: A modeling study. *PLoS Med.* 2026, 23, e1004625. https://doi.org/10.1371/journal.pmed.1004625.
5. Parish, M.A.; Klein, S.L. Maternal–fetal impact of respiratory viral infections: Immune mechanisms and clinical outcomes. *Immunol. Rev.* 2026, 337, e70099. https://doi.org/10.1111/imr.70099.
6. Kosaka, Y.; Ito, T.; Hattori, K.; Saito, A.; Okuda, Y.; Ochiai, D.; et al. Transplacental transfer of antibodies against pertussis and respiratory syncytial virus and follow-up after birth. *J. Infect. Chemother.* 2026, 32, 102877. https://doi.org/10.1016/j.jiac.2025.102877.
7. Koloi, A.; Dimopoulou, D.; Papakonstantinou, D.; Damianos, G.; Korentzelou, V.; Kotzamani, M.T.; et al. Impact of COVID-19 pandemic on bronchiolitis epidemiology in Greece. *Medicina* 2025, 61, 1746. https://doi.org/10.3390/medicina61101746.
8. Murray, A.; Chu, H.Y. A promise fulfilled: Updates on respiratory syncytial virus vaccines and monoclonal antibodies. *J. Allergy Clin. Immunol.* 2026, 157, 38–44. https://doi.org/10.1016/j.jaci.2025.10.023.
9. Vain, N.E.; Manzoni, P.; Yeo, K.T. Respiratory syncytial virus: What's new in prevention? *Semin. Fetal Neonatal Med.* 2025, 30, 101667. https://doi.org/10.1016/j.siny.2025.101667.
10. Kampmann, B.; Madhi, S.A.; Munjal, I.; et al. Bivalent prefusion F vaccine in pregnancy to prevent RSV illness in infants. *N. Engl. J. Med.* 2023, 388, 1451–1464.
11. Hammitt, L.L.; Dagan, R.; Yuan, Y.; et al. Nirsevimab for prevention of RSV in healthy late-preterm and term infants. *N. Engl. J. Med.* 2022, 386, 837–846.
12. Saad, K.; Alomari, O.; Dizdaroguları, G.E.; Mokresh, M.E.; Hussein, W.M.; Eyvazova, H.; et al. Maternal RSV vaccine: A systematic review and meta-analysis of immunogenicity and perinatal safety. *Immunol. Res.* 2025, 73, 177. https://doi.org/10.1007/s12026-025-09732-4.
13. Saif-Ur-Rahman, K.M.; King, C.; Whelan, S.O.; Blair, M.; Donohue, S.; Madden, C.; et al. Efficacy and safety of respiratory syncytial virus vaccines. *Cochrane Database Syst. Rev.* 2025, 9, CD016131. https://doi.org/10.1002/14651858.CD016131.
14. Alandijany, T.A.; Qashqari, F.S. Evaluating the efficacy, safety, and immunogenicity of FDA-approved RSV vaccines: A systematic review of Arexvy, Abrysvo, and mResvia. *Front. Immunol.* 2025, 16, 1624007. https://doi.org/10.3389/fimmu.2025.1624007.
15. Solsman, A.M.; Metz, T.D.; Benton, J.; Godfred-Cato, S. Maternal respiratory syncytial virus vaccination and preterm birth: A Utah statewide retrospective cohort study. *Obstet. Gynecol.* 2026, 147, 127–130. https://doi.org/10.1097/AOG.0000000000006130.
16. Gabet, A.; Bertrand, M.; Jabagi, M.J.; Kolla, E.; Olié, V.; Zureik, M. Maternal and neonatal outcomes after respiratory syncytial virus prefusion F protein vaccination during pregnancy: Analysis from the 2024–2025 immunization campaign in France. *Obstet. Gynecol.* 2026, 147, 118–126. https://doi.org/10.1097/AOG.0000000000006121.
17. Pérez Marc, G.; Vizzotti, C.; Fell, D.B.; Di Nunzio, L.; Olszevicki, S.; Wolf Mankiewicz, S.; et al. Real-world effectiveness of RSVpreF vaccination during pregnancy. *Lancet Infect. Dis.* 2025, 25, 1044–1054. https://doi.org/10.1016/S1473-3099(25)00156-2.
18. Williams, T.C.; Marlow, R.; Cunningham, S.; Drysdale, S.B.; Groves, H.E.; Hunt, S.; et al. Bivalent prefusion F vaccination in pregnancy and RSV hospitalisation in infants in the UK. *Lancet Child Adolesc. Health* 2025, 9, 655–662. https://doi.org/10.1016/S2352-4642(25)00155-5.

 doi:10.20944/preprints202603.0501.v1

19. Patton, M.E.; Moline, H.L.; Whitaker, M.; Tannis, A.; Pham, H.; Toepfer, A.P.; et al. Interim evaluation of RSV hospitalization rates. *MMWR Morb. Mortal. Wkly. Rep.* 2025, 74, 273–281. https://doi.org/10.15585/mmwr.mm7416a1.
20. Menegale, F.; Vezzosi, L.; Tirani, M.; Scarioni, S.; Odelli, S.; Morani, F.; et al. Impact of routine prophylaxis with monoclonal antibodies and maternal immunization. *Euro Surveill.* 2025, 30, 2400637. https://doi.org/10.2807/1560-7917.ES.2025.30.14.2400637.
21. Kieffer, A.; Ghemmouri, M.; Soudani, S.; Shin, T.; Hodges, E.; Greenberg, M.; et al. Comparison of the public health impact of RSV disease prevention options for infants: A static decision model of the US birth cohort. *Expert Rev. Vaccines* 2025, 24, 1086–1098. https://doi.org/10.1080/14760584.2025.2591816.
22. Wang, Y.; Rui, M.; Wei, Q.; Leung, T.F.; Leung, T.Y.; You, J.H.S. Cost-effectiveness of maternal vaccination against respiratory syncytial virus in Hong Kong: A decision-analytical analysis. *Expert Rev. Vaccines* 2025, 24, 1015–1023. https://doi.org/10.1080/14760584.2025.2589208.
23. Rave, N.; Sharma, A.K.; Chapagain, R.H.; Nguyen, A.; Pecenka, C.; Shaaban, F.L.; et al. Cost-effectiveness of introducing a maternal vaccine or long-acting monoclonal antibody to prevent infant respiratory syncytial virus disease in Nepal. *J. Glob. Health* 2025, 15, 04292. https://doi.org/10.7189/jogh.15.04292.
24. Taleshi, J.; Viñeta Paramo, M.; Watts, A.; Chilvers, M.; Wong, J.M.H.; Piszczek, J.; et al. Cost-effectiveness of infant and maternal RSV immunization strategies in British Columbia, Canada. *Vaccine* 2025, 68, 127936. https://doi.org/10.1016/j.vaccine.2025.127936.
25. Montesinos Ramírez, C.; Saltigeral Simental, P.; Ortiz Ibarra, F.J.; Avilés Robles, M.J.; Martínez Longoria, C.A.; Jiménez-Juárez, R.N.; et al. Position statement of the Mexican Association of Pediatrics on the immunoprevention of respiratory syncytial virus infection during pregnancy and infancy. *World J. Pediatr.* 2026, 22, 78–93. https://doi.org/10.1007/s12519-025-00997-1.
26. Navér, L.; Andersson, E.; Blomgren, F.; Ljungberg, H.; Luthander, J.; Nordlander, A.; et al. Updated Swedish guidelines for the management and treatment of RSV infection. *Infect. Dis.* 2026, 58, 150–163. https://doi.org/10.1080/23744235.2025.2580945.
27. Scott, J.; Abers, M.S.; Marwah, H.K.; McCann, N.C.; Meyerowitz, E.A.; Richterman, A.; et al. Updated evidence for COVID-19, RSV, and influenza vaccines for 2025–2026. *N. Engl. J. Med.* 2025, 393, 2221–2242. https://doi.org/10.1056/NEJMsa2514268.
28. Damatopoulou, A.; Matalliotakis, M.; Diamanta, Y.; Pikrides, I.; Ierapetritis, E.; Kakouri, P.; et al. Prospective attitudes towards respiratory syncytial virus (RSV) vaccine in pregnant women in Greece. *Behav. Med.* 2024. https://doi.org/10.1080/08964289.2024.2424171.
29. Broad, J.; Letley, L.; Adair, G.; Walker, J.; Benzaken, T.; Saliba, V.; et al. An England-wide survey on attitudes towards antenatal and infant immunisation against respiratory syncytial virus amongst pregnant and post-partum women. *Vaccine* 2025, 62, 127482. https://doi.org/10.1016/j.vaccine.2025.127482.
30. Callaghan, T.; Wise, L.A.; Regan, A.K. Intention to use RSVpreF vaccine or nirsevimab to prevent infant RSV among pregnant individuals. *Pediatr. Infect. Dis. J.* 2025. https://doi.org/10.1097/INF.0000000000004889.
31. Gidengil, C.; Jones, J.M.; Fleming-Dutra, K.E.; et al. Willingness to receive maternal RSV vaccine and infant monoclonal RSV antibody. *Open Forum Infect. Dis.* 2023, 10 (Suppl. 2), 1633.
32. McClymont, E.; Wong, J.M.H.; Forward, L.; Blitz, S.; Barrett, J.; Bogler, T.; et al.; COVERED Team. Acceptance and preference between respiratory syncytial virus vaccination during pregnancy and infant monoclonal antibody among pregnant and postpartum persons in Canada. *Vaccine* 2025, 50, 126818. https://doi.org/10.1016/j.vaccine.2025.126818.
33. Miraglia Del Giudice, G.; Sansone, V.; Airoma, F.; et al. Respiratory syncytial virus: Willingness towards a future vaccine among pregnant women in Italy. *Vaccines* 2023, 11, 1691.
34. Gagnon, D.; Gubany, C.; Ouakki, M.; Malo, B.; Paquette, M.; Brousseau, N.; et al. Factors influencing acceptance of RSV immunization for newborns among pregnant individuals: A mixed-methods study. *Vaccine* 2025, 55, 127062.
35. Huang, O.; Tan, B.F.; Lu, C.Y. Taiwanese parental perspectives on RSV: Knowledge, risks, and acceptance toward immunization. *Vaccine* 2026, 70, 128005. https://doi.org/10.1016/j.vaccine.2025.128005

 doi:10.20944/preprints202603.0501.v1

36. Liu, J.; Wei, M.; Shen, R.; Qi, S.; Wang, B.; Shi, X.; et al. Seroepidemiology of respiratory syncytial virus and influenza in infants: A prospective cohort study in China, 2023–2024. *Int. J. Infect. Dis.* 2025, 160, 108070. https://doi.org/10.1016/j.ijid.2025.108070.
37. Galiza, E.P.; Nakebembe, E.; Mboizi, R.; Okek, E.; Le Doare, K. Maternal vaccination to prevent neonatal infections and combat antimicrobial resistance. *Semin. Fetal Neonatal Med.* 2025, 30, 101680. https://doi.org/10.1016/j.siny.2025.101680.
38. Fly, J.H.; Stultz, J.S.; Eiland, L.S. Maternal RSVpreF vaccine: A novel agent for respiratory syncytial virus prevention in infants. *Ann. Pharmacother.* 2025, 59, 758–766. https://doi.org/10.1177/10600280241302775.
39. Gentile, A.; Juárez, M.D.V.; Lucion, M.F.; Gregorio, G.; López, O.; Fernández, T.; et al. Maternal immunization with RSVpreF vaccine: Effectiveness in preventing RSV-associated hospitalizations in infants under 6 months in Argentina. *Pediatr. Infect. Dis. J.* 2025, 44, 988–994. https://doi.org/10.1097/INF.0000000000004878.
40. Scruzzi, G.F.; Franchini, C.G.; Giorgetti, A.C.; Fonseca Ingüe, L.; Sarmiento, D.D.; Belfiore, S.M.; et al. Evaluation of the effectiveness of the respiratory syncytial virus vaccine in children under 6 months of age in Córdoba, Argentina. *Arch. Argent. Pediatr.* 2025, 123, e202510741. https://doi.org/10.5546/aap.2025-10741.eng.
41. Hsiao, A.; Hansen, J.; Fireman, B.; Timbol, J.; Zerbo, O.; Mari, K.; et al. Effectiveness of nirsevimab against RSV and RSV-related events in infants. *Pediatrics* 2025, 156, e2024069510. https://doi.org/10.1542/peds.2024-069510.
42. Wadia, U.; Moore, H.C.; Richmond, P.C.; Levy, A.; Bell, L.; Pienaar, C.; et al. Effectiveness of nirsevimab in preventing RSV-hospitalisation among young children in Western Australia 2024. *J. Infect.* 2025, 90, 106466. https://doi.org/10.1016/j.jinf.2025.106466.
43. Lee, B.; Trusinska, D.; Ferdous, S.; Pei, R.; Kwok, H.H.Y.; Schwarze, J.; et al. Real-world effectiveness and safety of nirsevimab, RSV maternal vaccine and RSV vaccines for older adults: A living systematic review and meta-analysis. *Thorax* 2025, 80, 838–848. https://doi.org/10.1136/thorax-2025-223376.
44. Palmero, M.; Martin, R.A.; Olson, B.; Millares, L.; Melinek, M.; Waggoner, D.; et al. Side effects associated with respiratory syncytial virus prefusion F (RSVpreF) maternal vaccination: A scoping review. *Cureus* 2025, 17, e88162. https://doi.org/10.7759/cureus.88162.
45. Trusinska, D.; Lee, B.; Ferdous, S.; Kwok, H.H.Y.; Gordon, B.; Gao, J.; et al. Real-world uptake of nirsevimab, RSV maternal vaccine, and RSV vaccines for older adults: A systematic review and meta-analysis. *eClinicalMedicine* 2025, 84, 103281. https://doi.org/10.1016/j.eclinm.2025.103281.
46. Langedijk, A.C.; van den Dungen, F.; Harteveld, L.; van Leeuwen, L.; Smit, L.; van den Boer, J.; et al. Preferences of Dutch parents and expectant parents for respiratory syncytial virus prevention strategies: A discrete choice experiment. *Infect. Dis. Ther.* 2025. https://doi.org/10.1007/s40121-025-01214-2.
47. Damschroder, L.J.; Aron, D.C.; Keith, R.E.; Kirsh, S.R.; Alexander, J.A.; Lowery, J.C. Fostering implementation of health services research findings into practice: A consolidated framework for advancing implementation science. *Implement. Sci.* 2009, 4, 50. https://doi.org/10.1186/1748-5908-4-50.
48. Damschroder, L.J.; Reardon, C.M.; Opra Widerquist, M.A.; Lowery, J. The updated Consolidated Framework for Implementation Research based on user feedback. *Implement. Sci.* 2022, 17, 75. https://doi.org/10.1186/s13012-022-01245-0.
49. Cane, J.; O'Connor, D.; Michie, S. Validation of the theoretical domains framework for use in behaviour change and implementation research. *Implement. Sci.* 2012, 7, 37. https://doi.org/10.1186/1748-5908-7-37.
50. Carew, C.; Rak, A.; Tuckerman, J.; Pidd, D.; Vasiliadis, S.; Danchin, M.; et al. A qualitative exploration of Australian women's vaccination experiences and information needs for routine, COVID-19 and respiratory syncytial virus vaccines in pregnancy. *Midwifery* 2025, 146, 104402. https://doi.org/10.1016/j.midw.2025.104402.
51. Machida, M.; Inoue, S.; Furuse, Y.; Oka, E.; Ueda, Y.; Fukushima, S.; et al. Exploring the knowledge and attitude toward respiratory syncytial virus vaccine and associated factors among pregnant women in Japan during the early post-marketing phase. *Vaccine* 2025, 61, 127434. https://doi.org/10.1016/j.vaccine.2025.127434.

 doi:10.20944/preprints202603.0501.v1

52. Demirci, B.; Özkaya-Parlakay, A.; Yılmaz, M.; Ekici, H.; Erçel, M.M.; Türker Ergün, G.; et al. Evaluation of pregnant women's knowledge about RSV and immunization attitudes before infant immunization with monoclonal antibodies in Turkey. *J. Trop. Pediatr.* 2025, 71, fmaf024. https://doi.org/10.1093/tropej/fmaf024.
53. Alami, A.; Pérez-Lloret, S.; Mattison, D.R. Safety surveillance of respiratory syncytial virus (RSV) vaccine among pregnant individuals: A real-world pharmacovigilance study using the Vaccine Adverse Event Reporting System. *BMJ Open* 2025, 15, e087850. https://doi.org/10.1136/bmjopen-2024-087850.
54. Baumgartner, M.K.; Hanslik, G.; Schneider, M.; Franitza, M.; Schneider, M.; von Andrian, H.C.; et al. Navigating parental hesitancy in public health: The case for RSV immunization in newborns. *J. Perinatol.* 2025, 45, 981–985. https://doi.org/10.1038/s41372-025-02282-5.
55. Gesualdo, F.; Casigliani, V.; Arzilli, G.; De Vita, E.; Porretta, A.D.; Croci, I.; et al. Social media insights on the introduction of RSV immunoprophylaxis in Italy. *Hum. Vaccin. Immunother.* 2025, 21, 2569734. https://doi.org/10.1080/21645515.2025.2569734
56. Pazdiora, P.; Jelínková, H.; Kozerovský, M.; Hubáček, P. Vaccination in pregnancy – A study in maternity hospitals of the Pilsen Region, Czech Republic. *Epidemiol. Mikrobiol. Imunol.* 2025, 74, 158–165. https://doi.org/10.61568/emi/11-6568/20250808/141315.
57. Paulson, S.; Munro, A.P.S.; Cathie, K.; Bedford, H.; Jones, C.E. Protecting against respiratory syncytial virus: An online questionnaire study exploring UK parents' acceptability of vaccination in pregnancy or monoclonal antibody administration for infants. *Pediatr. Infect. Dis. J.* 2025, 44 (Suppl. 2), S158–S161. https://doi.org/10.1097/INF.0000000000004632.
58. Nuzhath, T.; Khobragade, N.; Regan, A.K.; Pinkney, J.A.; Wise, L.; Callaghan, T. Pregnant women's perceptions of RSVpreF vaccine and nirsevimab for infant RSV prevention. *Vaccine* 2025, 62, 127590. https://doi.org/10.1016/j.vaccine.2025.127590.
59. Kuntz, J.L.; Babu, T.M.; Feldstein, L.R.; Englund, J.A.; Frivold, C.J.; Groom, H.C.; et al. Knowledge about respiratory syncytial virus and acceptance of infant monoclonal antibody for RSV and RSV vaccination during pregnancy. *Pediatr. Infect. Dis. J.* 2025, 44 (Suppl. 2), S162–S166. https://doi.org/10.1097/INF.0000000000004566.
60. Felek Boyvat, S.; Hinderstein, S.; Aragona, E.; Loyal, J. Perspectives of Spanish-speaking families on RSV immunoprophylaxis for healthy newborns. *J. Immigr. Minor. Health* 2025, 27, 1009–1017. https://doi.org/10.1007/s10903-025-01742-6.
61. Langedijk, A.C.L.; van den Dungen, F.; Harteveld, L.; van den Boer, J.; Smit, L.; Averin, A.; et al. Cost-effectiveness of immunization strategies to protect infants against respiratory syncytial virus in the Netherlands. *Hum. Vaccin. Immunother.* 2025, 21, 2521912. https://doi.org/10.1080/21645515.2025.2521912.
62. Wang, B.; Andraweera, P.; Chen, G.; Ong, J.J.; Lassi, Z.; Marshall, H. Respiratory syncytial virus (RSV) vaccine choices during pregnancy. *Public Health* 2026, 251, 106114. https://doi.org/10.1016/j.puhe.2025.106114.
63. Olmsted, K.E.; Ramsey-Omonua, T.; Thomas, E.S.; Lee, J.T.; Owens, L.; Graitcer, S.; et al. Expanding birthing hospital enrollment in the Vaccines for Children program to increase infant immunization against respiratory syncytial virus — United States, October 2023–March 2025. *MMWR Morb. Mortal. Wkly. Rep.* 2025, 74, 589–591. https://doi.org/10.15585/mmwr.mm7437a2.
64. Okubo, Y.; Honjo, R.; Tsuzuki, S. Coverage and determinants of maternal RSV vaccination in Japan: A nationwide survey. *J. Infect. Chemother.* 2026, 32, 102892. https://doi.org/10.1016/j.jiac.2025.102892.
65. Oka, E.; Ueda, Y.; Yagi, A.; Machida, M.; Furuse, Y.; Tabuchi, T. Challenges to promoting maternal respiratory syncytial virus vaccination in Japan. *Vaccine* 2025, 48, 126767. https://doi.org/10.1016/j.vaccine.2025.126767.
66. Ladomenou, F.; Matalliotakis, M. Closing the maternal immunization gap: Strengthening antenatal care in Southern Europe. *Vaccine* 2026, 77, 128374. https://doi.org/10.1016/j.vaccine.2026.128374.
67. Blauvelt, C.A.; Zeme, M.; Natarajan, A.; Epstein, A.; Roh, M.E.; Morales, A.; et al. Respiratory syncytial virus vaccine and nirsevimab uptake among pregnant people and their neonates. *JAMA Netw. Open* 2025, 8, e2460735. https://doi.org/10.1001/jamanetworkopen.2024.60735.

 doi:10.20944/preprints202603.0501.v1

68. Yıldız, İ.; Gönüllü, E.; Yılmaz, S.; Zengin, E.; Yeşilbaş, O.; Soysal, A. Turkish pediatricians' knowledge, attitudes, and awareness of respiratory syncytial virus (RSV) infection and immunization strategies: A cross-sectional study. *Turk. J. Pediatr.* 2025, 67, 153–161. https://doi.org/10.24953/turkjpediatr.2025.5528.
69. Choi, Y.; Berjonneau, E.; Vincent, B.; Dwyer, B.; Chun, B.; Petigara, T.; et al. Assessment of physicians' perception of pediatric respiratory syncytial virus disease and preferences for immunization strategies in the United States. *Hum. Vaccin. Immunother.* 2025, 21, 2498264. https://doi.org/10.1080/21645515.2025.2498264.
70. Bonnel, M.; Perrella, B.; Vaux, S.; Brunet, M.L.; Jarreau, P.H.; Parat, S.; et al. Adherence to the nirsevimab immunization campaign: Analysis of sociodemographic and medico-economic influences. *Eur. J. Pediatr.* 2025, 184, 736. https://doi.org/10.1007/s00431-025-06581-z.
71. Razai, M.S.; Kalafat, E.; Prasad, S.; Lee-Wo, C.; Heath, P.T.; Khalil, A. Perinatal outcomes and uptake of RSV vaccine during pregnancy in South London: A cross-sectional study. *BMJ Open* 2025, 15, e101592. https://doi.org/10.1136/bmjopen-2025-101592.
72. Boundy, E.O.; Fast, H.; Jatlaoui, T.C.; Razzaghi, H.; Harris, L.; Nguyen, K.; et al. Respiratory syncytial virus immunization coverage among infants through receipt of nirsevimab monoclonal antibody or maternal vaccination — United States, October 2023–March 2024. *MMWR Morb. Mortal. Wkly. Rep.* 2025, 74, 484–489. https://doi.org/10.15585/mmwr.mm7431a3.
73. Kemp, M.; Capriola, A.; Schauer, S. RSV immunization uptake among infants and pregnant persons—Wisconsin, October 1, 2023–March 31, 2024. *Vaccine* 2025, 47, 126674. https://doi.org/10.1016/j.vaccine.2024.126674.
74. Irving, S.A.; Crane, B.; Weintraub, E.S.; Patel, S.A.; Razzaghi, H.; Daley, M.F.; et al. Infant respiratory syncytial virus immunization coverage in the Vaccine Safety Datalink: 2023–2024. *Pediatrics* 2025, 155, e2024070240. https://doi.org/10.1542/peds.2024-070240.
75. Homo, R.L.; Smith, S.; Donahue, M.L.; Groberg, A.; Wooten, A.; Ponnapakkam, A. Demographic characteristics associated with uptake of neonatal respiratory syncytial virus prophylaxis. *Mil. Med.* 2026, 191, e57–e61. https://doi.org/10.1093/milmed/usaf269.
76. Höck, M.; Borena, W.; Brunner, J.; Wechselberger, K.; Scheiring, J.; Ralser, E.; et al. Acceptance and impact of nirsevimab and the RSVpreF vaccine following implementation in Austria. *Front. Public Health* 2025, 13, 1686581. https://doi.org/10.3389/fpubh.2025.1686581.
77. Ghirardo, S.; Madini, B.; Ullmann, N.; Zago, A.; Ghezzi, M.; D'Auria, E.; et al. The impact of nirsevimab on bronchiolitis-related hospitalizations: A multicenter Italian retrospective comparative study. *Pediatr. Pulmonol.* 2026, 61, e71500. https://doi.org/10.1002/ppul.71500.
78. Sonneveld, N.; Wilson, E.; Ennis, S.; McRae, J.; Macartney, K.; Liu, B. Reporting of pregnancy vaccinations across two data sources, New South Wales, Australia, 2017–2022. *Public Health Res. Pract.* 2026, 36, PU25021. https://doi.org/10.1071/PU25021.
79. Hunter, O.F.; McClymont, E.; Lau, O.; Bettinger, J.A.; Castillo, E.; Crowcroft, N.S.; et al. Knowledge gaps and research priorities regarding vaccination in pregnancy: A Canadian perspective from the prevention of infections in the maternal-infant dyad (PRIMED) consortium. *Vaccine* 2025, 62, 127594. https://doi.org/10.1016/j.vaccine.2025.127594.
80. Sarna, M.; Taye, B.; Le, H.; Giannini, F.; Glass, K.; Blyth, C.C.; et al. Cohort profile: A population-based record linkage platform to address critical epidemiological evidence gaps in respiratory syncytial virus and other respiratory infections. *Int. J. Popul. Data Sci.* 2024, 9, 2376. https://doi.org/10.23889/ijpds.v9i2.2376.
81. Ali, A.; Shamim, L.; Ibrahim, A.; Humayun, M.A.; Khan, M.H.; Akbar, A.; et al. Maternal respiratory syncytial virus (RSV) vaccination: Current status and comparison to monoclonal antibodies (mAbs) for RSV prevention in infants and children. *J. Mother Child* 2025, 29, 93–100. https://doi.org/10.34763/jmotherandchild.20252901.d-25-00012.
82. Moulia, D.L.; Link-Gelles, R.; Chu, H.Y.; Jamieson, D.; Brooks, O.; Meyer, S.; et al. Use of clesrovimab for prevention of severe respiratory syncytial virus-associated lower respiratory tract infections in infants: Recommendations of the Advisory Committee on Immunization Practices—United States, 2025. *MMWR Morb. Mortal. Wkly. Rep.* 2025, 74, 508–514. https://doi.org/10.15585/mmwr.mm7432a3.

 doi:10.20944/preprints202603.0501.v1

83. Ramasauskaite, D.; Savona-Ventura, C.; Minkauskiene, M.; Mahmood, T. Respiratory syncytial virus vaccination in pregnancy—Position statement by the European Board and College of Obstetrics and Gynaecology (EBCOG). *Eur. J. Obstet. Gynecol. Reprod. Biol.* 2025, 310, 113978. https://doi.org/10.1016/j.ejogrb.2025.113978.
84. Bolanos, R.; Araos, R.; Gonzalez, C.; Sepulveda, D.; Falconi, J.F.; Averin, A.; et al. Cost-effectiveness of strategies using preventive interventions to protect infants in Chile from respiratory syncytial virus. *Expert Rev. Vaccines* 2025, 24, 904–913. https://doi.org/10.1080/14760584.2025.2562201.
85. Værnø, S.G.; Oteiza, F.; Gillebo, M.; Havdal, L.B.; Mwaura, D.N.; Husby, Ø.; et al. Cost-effectiveness analysis of a maternal vaccination program against respiratory syncytial virus in Norway. *Influenza Other Respir. Viruses* 2025, 19, e70161. https://doi.org/10.1111/irv.70161.
86. Bugden, S.; Mital, S.; Nguyen, H.V. Cost-effectiveness of nirsevimab and maternal RSVpreF for preventing respiratory syncytial virus disease in infants across Canada. *BMC Med.* 2025, 23, 102. https://doi.org/10.1186/s12916-025-03928-z.
87. Averin, A.; Quinn, E.; Atwood, M.; Weycker, D.; Shea, K.M.; Law, A.W. Cost-effectiveness of bivalent respiratory syncytial virus prefusion F (RSVpreF) maternal vaccine among infants in the United States. *Vaccine* 2025, 58, 127191. https://doi.org/10.1016/j.vaccine.2025.127191.
88. Averin, A.; Law, A.W.; Weycker, D.; Atwood, M.; Quinn, E.; Atwell, J.E.; et al. Potential public health and economic impact of maternal vaccination with bivalent respiratory syncytial virus prefusion F (RSVpreF) vaccine for the prevention of acute respiratory infection among infants in the United States. *Expert Rev. Vaccines* 2025, 24, 403–411. https://doi.org/10.1080/14760584.2025.2503966.
89. Zhu, B.; Lu, Y.; Zhou, Y.; Li, W.; Wu, Y.; Bao, Y.; et al. Economic evaluations of RSV preventive strategies: A systematic review of cost-effectiveness and modeling approaches. *Front. Public Health* 2025, 13, 1672683. https://doi.org/10.3389/fpubh.2025.1672683.
90. Couto, P.; Campbell, H.; Li, Y.; Rondy, M.; Leite, J.; Rodriguez, A.; et al. Implications of respiratory syncytial virus seasonality for the timing of passive immunisation scenarios in Latin America and the Caribbean: A cross-sectional modelling study. *Vaccine* 2025, 68, 127934. https://doi.org/10.1016/j.vaccine.2025.127934.
91. Nguyen, D.; Lee, H.; Pavia, A.T.; Nelson, R.E.; Samore, M.; Chaiyakunapruk, N. Optimizing timing for respiratory syncytial virus prevention interventions for infants. *JAMA Netw. Open* 2025, 8, e2522779. https://doi.org/10.1001/jamanetworkopen.2025.22779.
92. Bicego, A.; Wood, J.G.; Newall, A.T.; Hogan, A.B. Effectiveness of maternal vaccines and long-acting monoclonal antibodies against respiratory syncytial virus disease burden in early life: A scoping review of dynamic modelling studies. *Vaccine* 2025, 68, 127868. https://doi.org/10.1016/j.vaccine.2025.127868.
93. Jasseh, I.; Manka, M.; Mendy, S.; Bajinka, O.; Makalo, L. Feasibility and acceptability of respiratory syncytial virus vaccination in mothers for infant protection at Edward Francis Small Teaching Hospital, The Gambia. *J. Epidemiol. Glob. Health* 2025, 15, 118. https://doi.org/10.1007/s44197-025-00467-x.
94. Shaaban, F.L.; Groenendijk, R.W.; Baral, R.; Caballero, M.T.; Crowe, J.E., Jr.; Englund, J.A.; et al. The path to equitable respiratory syncytial virus prevention for infants: Challenges and opportunities for global implementation. *Lancet Glob. Health* 2025, 13, e2165–e2174. https://doi.org/10.1016/S2214-109X(25)00379-1.