First year of nirsevimab use in Argentina (2025): Report from a private vaccination center

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SUMMARY

Introduction. Since March 2025, nirsevimab, a monoclonal antibody for the prevention of respiratory syncytial virus infection (RSV), has been available in Argentina. The objective of this study was to describe the use of nirsevimab at a private vaccination center in the Buenos Aires Metropolitan Area, including the profile of infants vaccinated during its first year on the market.

Population and methods. A descriptive study was conducted using an online survey administered to caregivers of children who received nirsevimab.

The study analyzed sociodemographic variables, medical history, maternal RSV vaccination status, and the reason for the recommendation.

Results. A total of 232 caregivers responded; 93.5% were mothers, with a mean age of 37.1 years (SD 5.4); 92.7% had a college or university education; 99.6% had health insurance.

The mean age of the immunized children was 6.0 months (SD 3.9; range 0-21); 53.9% were male (N = 125); 19.8% attended daycare (N = 46); 10.8% (N = 25) had comorbidities, primarily heart disease (5.6%; N = 13) and chronic respiratory disease (4.7%; N = 11); 19.0% (N = 44) had ≥1 episode of bronchiolitis.

Reasons for recommendation: unvaccinated mother: 51.3% (N = 119); maternal vaccination in the previous year: 18.5% (N = 43); preterm infants <34 weeks: 14.7% (N = 34); risk factors: 6.5% (N = 15). The recommendation came from the pediatrician in 81.5% of cases (N = 189).

Conclusion. More than half of the administered doses were applied to infants who lacked protection from maternal immunity. Most were healthy infants during their first season and were recommended for immunization by their pediatrician.

Keywords: *respiratory syncytial virus infections; respiratory syncytial virus; infants; monoclonal antibodies; immunization programs.*

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INTRODUCTION

Respiratory syncytial virus (RSV) is the leading cause of acute lower respiratory tract infections (ALRTIs) in young children. In Argentina, the annual incidence of ARI is estimated at 47.5 per 1000 children, which equates to more than 175 000 cases per year.[1] According to the National Epidemiological Bulletin, 161,580 cases of bronchiolitis were reported in children under 2 years of age in 2025.[2]

Globally, it is estimated to be responsible for approximately one in every 50 deaths among children under 5 years of age, with the majority occurring in low- and middle-income countries.[1] Furthermore, it has been documented that a significant proportion of RSV-related deaths occur in the community setting.[3] In Argentina, community-acquired infant mortality attributable to RSV has been estimated at 0.27 per 1000 live births.[4]

RSV infection also has a significant economic impact on both healthcare systems and families. From a healthcare perspective, this is reflected in the high demand for hospital admissions due to lower respiratory tract infections in infants, which require hospital beds, diagnostic tests, and, in many cases, critical care, leading to increased costs. At the family level, this translates into financial burdens, including transportation costs, hospital care, and lost income from missed work. Taken together, these factors make RSV one of the leading causes of economic impact due to respiratory illness in early childhood.[5]

On the other hand, RSV infection during early childhood is associated with an increased risk of recurrent wheezing and asthma during childhood, contributing to long-term respiratory morbidity.[6]

For more than two decades, RSV immunoprophylaxis has relied on palivizumab, which is indicated for high-risk children and has been used in Argentina since 2007 as a public health policy for preterm infants and children under 2 years of age with risk factors.[7] Due to its relatively short half-life, this antibody requires monthly administration during the season when the virus is circulating. In Argentina, two new effective tools for RSV prevention have recently been introduced: maternal vaccination,[8] included in the National Immunization Schedule since March 2024,[9] and nirsevimab,[10,11] a long-acting monoclonal antibody, available in the private sector starting in March 2025.[12] Nirsevimab provides immediate passive immunity with a single dose and is recommended for infants during their first RSV season and for children under 2 years of age with risk factors.[13]

National scientific societies and the National Immunization Commission (CoNaIn, by its Spanish acronym) recommended its use as a complementary strategy for infants not protected by maternal vaccination (preterm infants, children of unvaccinated pregnant women or those with an inadequate immune response, and infants born outside the vaccination season), or with conditions that increase vulnerability to RSV. However, this strategy has not been implemented within the national public health system.[13-15]

The objective of this study was to describe the use of nirsevimab at a private vaccination center in the Buenos Aires Metropolitan Area (AMBA, by its Spanish acronym), including the profile of infants vaccinated during its first year on the market.

POPULATION AND METHODS

A descriptive study was conducted between March and September 2025. The study included families of children under 2 years of age who received nirsevimab during the study period at the 18 vaccination centers of the Vacunar S.A. network and through the "Vacunar en casa" (Vaccinating at home) program in the AMBA.

Data collection was conducted retrospectively using a self-administered, semi-structured survey on Google Forms, which was sent via WhatsApp to the caregivers of the immunized children.

A pilot study was first conducted with 10 participants. After completing the survey, participants were asked to provide feedback on the comprehensibility, clarity, and relevance of each item, as well as on the instrument's length. The feedback received enabled adjustments to the wording and structure. The survey is detailed in the supplementary material.

The study collected sociodemographic data on the family group, medical history, source of the prescription, reason for prescribing the antibody, and co-administration with vaccines.

Quantitative variables were reported as the mean and standard deviation, or the median and interquartile range, and categorical variables were reported as frequencies and percentages. Data processing and analysis were performed using Stata v14.

The study was approved by the Clinical Research Ethics Committee (CEIC) Stamboulian (PRIISA.BA registration 15551).

RESULTS

Between March 12 and September 30, 2025, a total of 772 children received nirsevimab. A total of 232 families responded to the survey, for a response rate of 30.1%.

The sociodemographic characteristics of the caregivers are described in *Table 1*. The immunized population ranged in age from 0 to 21 months; 90% were under 12 months of age. The sociodemographic and clinical characteristics of the infants are described in *Table 2.*

The patient's pediatrician was the primary prescriber of the monoclonal antibody (N = 189; 81.5%), followed by the neonatologist (N = 27; 11.6%). To a lesser extent, the referral came from the pulmonologist (N = 5; 2.2%), obstetrician-

Table 1. Sociodemographic characteristics of caregivers

Variable	N (%)	
Age (years) (N = 197)	Mean (SD)	37.1 (5.4)
	Median (IQR)	37 (34-40)
Nationality (N = 230)	Argentine	225 (97.8)
	Bolivian	3 (1.3)
	Paraguayan	1 (0.4)
	Peruvian	1 (0.4)
Place of residence (N = 232)	Greater Buenos Aires*	119 (51.3)
	Autonomous City of Buenos Aires	103 (44.4)
	Other	10 (4.3)
Relationship (N = 232)	Mother	217 (93.5)
	Father	15 (6.5)
Mother's education level (N = 232)	College/tertiary education	215 (92.7)
	High school graduate	14 (6.0)
	High school dropout	2 (0.9)
	"I'd rather not answer."	1 (0.4)

Comprising the following municipalities in the province of Buenos Aires: Almirante Brown, Avellaneda, Berazategui, Berisso, Brandsen, Campana, Cañuelas, Ensenada, Escobar, Esteban Echeverría, Exaltación, Ezeiza, Florencio Varela, General Las Heras, General Rodríguez, General San Martín, Hurlingham, Ituzaingó, José C. Paz, La Matanza, La Plata, Lanús, Lomas de Zamora, Luján, Malvinas Argentinas, Marcos Paz, Merlo, Moreno, Morón, Quilmes, Pilar, Presidente Perón, San Fernando, San Isidro, San Miguel, San Vicente, Tigre, Tres de Febrero, Vicente López, Zárate.

SD: standard deviation, IQR: interquartile range.

Table 2. Sociodemographic and clinical characteristics of infants

Variable		N (%)
Age (months)	Mean (SD); range	6.0 (3.9); 0-21
	Median (IQR)	5 (3-7)
Age <12 months		210 (90.5)
Sex (N = 23	Male	125 (53.9)
	Female	107 (46.1)
Health insurance (social security and private health insurance (N = 231)	Yes	230 (99.6)
	No	1 (0.4)
Attendance at daycare (N = 232)	Yes	46 (19.8)
	No	186 (80.2)
Chronic illness (N = 232)	Yes	25 (10.8) *
	No	207 (89.2)
History of chronic obstructive pulmonary disease (N = 232)	Yes	44 (19.0) **
	No	188 (81.0)
Siblings under 5 years of age (N = 232)	Yes	56 (24.1)
	No	176 (75.9)*

Heart disease (N = 12), chronic lung disease (N = 10), heart disease and chronic lung disease (N = 1), neurological disease (N = 1), genetic syndrome (N = 1).

*** 20/44 required hospitalization.*

SD: standard deviation, IQR: interquartile range.

gynecologist (N = 2; 0.9%), and cardiologist (N = 2; 0.9%); some caregivers reported more than one referring professional. 7.8% of families (N = 18) reported that the referral was requested by the caregiver themselves from the pediatrician, while 1.3% (N = 3) indicated that the initial recommendation came from a family member or acquaintance. In all cases, administration was performed with a medical prescription.

Table 3 details the reasons for vaccination; the most common reason was the mother's lack of vaccination, followed by mothers who had been vaccinated in the previous year, which included the period of the official vaccination campaign or the last few months of the year, based on individual recommendations, since vaccination remained available throughout the year in the private sector.

43.1% (N = 100) received other vaccines during the same visit.

77.9% (N = 180) reported not receiving a discount through their health insurance.

DISCUSSION

The study included a population of caregivers, mainly Argentine mothers residing in the AMBA, who had completed university or college-level education. The immunized children were mostly under one year of age, with no comorbidities or history of lower respiratory tract infections. This profile of use is consistent with the evidence, which shows that RSV causes the majority of severe cases in healthy, full-term infants,[16] and aligns with the indication for nirsevimab, which is intended for all infants, unlike palivizumab.[13,15] It is worth noting that the protection provided by nirsevimab has been shown to last for at least 150 days, covering a full season of viral circulation,[17] and new evidence suggests that its effectiveness could last up to a year,[18] which reinforces its programmatic utility in healthy infants.

The patient's pediatrician was the primary prescriber of nirsevimab, followed by the neonatologist, underscoring the central role of these specialties in implementing this new preventive strategy.[15]

Regarding the reasons for referral, more than half involved children whose mothers had not been vaccinated against RSV, consistent with the maternal vaccination coverage recorded in 2024.[19,20] This highlights the need to strengthen counseling on maternal vaccination and on passive immunization of infants during pregnancy, as noted by various scientific societies.[15,21]

A notable finding was the use of nirsevimab in a group of infants whose mothers had received the RSV vaccine in the previous season or the prior year, representing a use outside current recommendations. However, at the international level, while no country recommends using both strategies in the same individual as a matter of public health policy, there is also no formal safety contraindication.[13-15] In this context, documents such as those from the Spanish Association of Pediatrics and the U.S. Centers for Disease Control and Prevention (CDC) acknowledge that the decision could be individualized, allowing the healthcare professional or parents to choose to use both preventive interventions.[19,22]

This study has some limitations. First, the surveyed population consisted exclusively of families who visited Vacunar centers in the AMBA, which could introduce selection bias and limit the generalizability of the results. Although socioeconomic status was not assessed using a specific instrument, certain observed characteristics, such as health coverage and reported educational level, are consistent with

Table 3. Reason for prescribing by response rate (N = 232)

Reason for prescribing nirsevimab	N (%)
Mother not vaccinated against RSV	119 (51.3)
Mother vaccinated against RSV in the previous season or the previous year	43 (18.5)*
Premature infant (gestational age <34 weeks)	34 (14.7)
Infant or child with a risk factor	15 (6.5)
Mother vaccinated against RSV, with delivery within 14 days	10 (4.3)
Others	11 (4.7)

In this population, the average age of those immunized was 8 months.

RSV: respiratory syncytial virus.

a population of medium-to-high socioeconomic status; therefore, the findings may not reflect the experience of other sectors, which may have faced access issues due to the cost of the monoclonal antibody. Furthermore, the reasons for the lack of maternal RSV vaccination were not investigated, so this aspect cannot be examined in greater depth. Finally, this is a descriptive study, which limits the ability to explore associations between variables.

This study provides initial data on the use of nirsevimab in Argentina, at a time when the antibody was not yet available in the public sector. A strength of the study is that it collects direct information from families during the first season of implementation, enabling an early characterization of prescribing and real-world use of the intervention. Taken together, these data are valuable for understanding the local context and guiding implementation strategies in future seasons.

The inclusion of nirsevimab in the National Immunization Schedule as a complementary strategy could help improve equity in access and promote universal coverage in the future.[3,11,20] In this context, studies will be needed to assess the population-level impact of nirsevimab implementation and its potential scope within public access strategies.

CONCLUSION

During the first season of nirsevimab administration at a private vaccination center in the AMBA, more than half of prescriptions were for infants not protected by maternal RSV vaccination. The immunized population consisted mainly of healthy infants experiencing their first season of exposure, and the prescriptions were primarily issued by pediatricians. ■

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The supplementary material provided with this article is presented as submitted by the authors. It is available at: https://www.sap.org.ar/docs/publicaciones/archivosarg/2026/11018_AO_Castellano_Anexo.pdf

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