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FSS Sláinte Poiblí: Chosaint Sláinte

Respiratory Syncytial Virus (RSV) Immunisation Pathfinder 2.0 Programme 2025-2026

Evaluation – Technical Report

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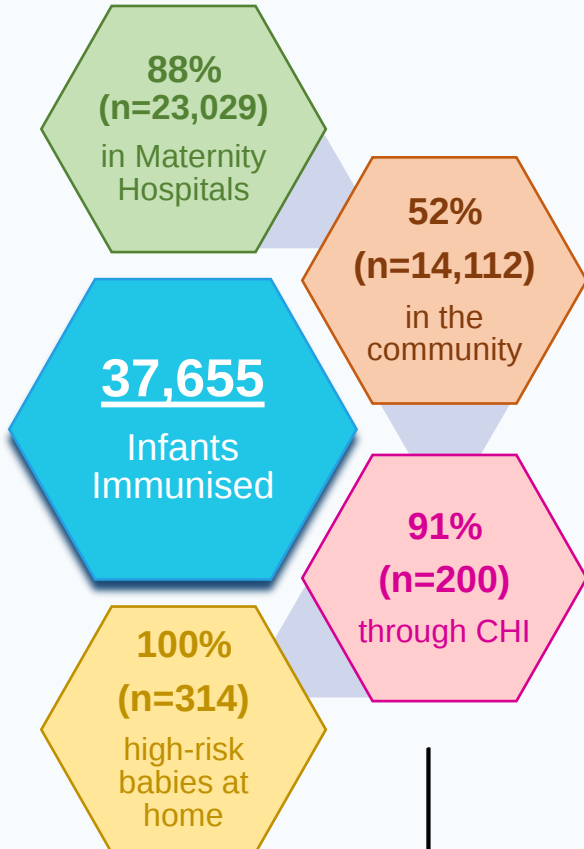
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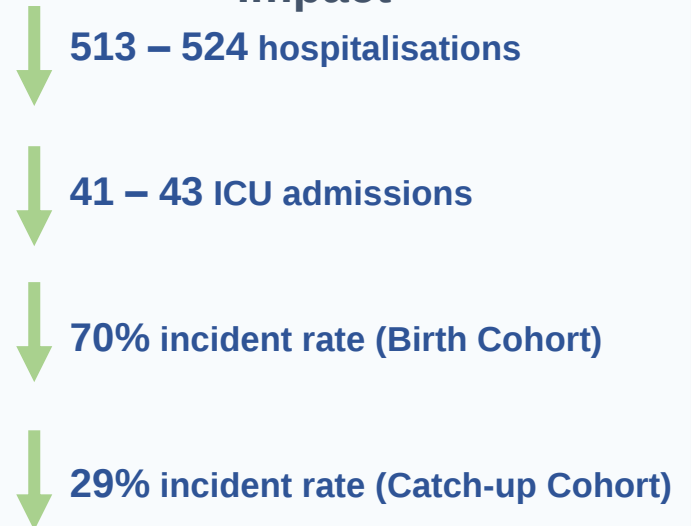
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Executive Summary

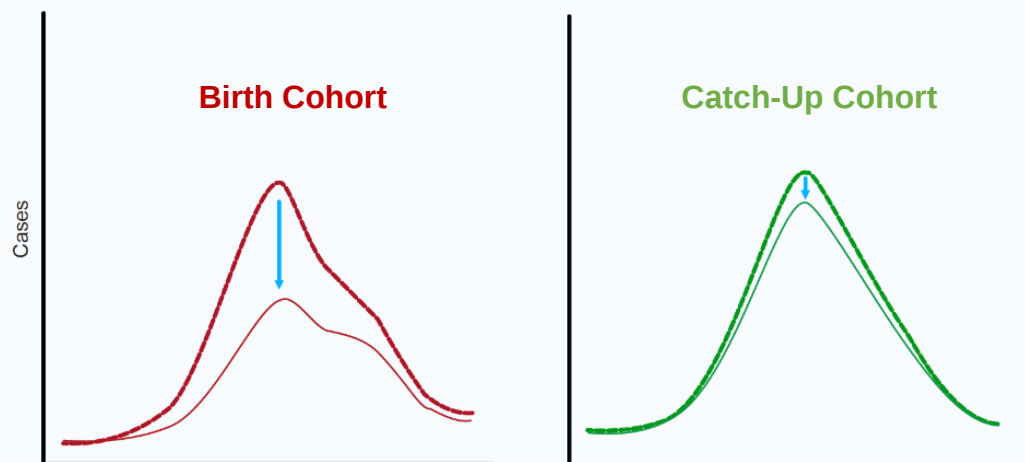
Immunisation Coverage



Impact



Reduction in Weekly Cases



Experience

“It was a pleasure to be involved”

Thank you!

“This winter, I can't recall seeing a young baby with RSV”

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Glossary of Abbreviations

CAR	Contract Approval Request
CCO	Chief Clinical Officer
CDC	Centers for Disease Control and Prevention
CIDR	Computerised Infectious Disease Reporting System
CLD	Chronic Lung Disease
DoH	Department of Health
EU	European Union
GDPR	General Data Protection Regulation
GP	General Practitioner
HIQA	Health Information and Quality Authority
HPSC	Health Protection Surveillance Centre
HSE	Health Service Executive
HERA	Health Emergency Preparedness and Response Authority
ICGP	Irish College of General Practitioners
IIS	Integrated Information Systems
IOM	Institute of Medicine
IPAS	International Protection Accommodation Service
ISO	International Organization for Standardization
IWG	Implementation Working Group
MN-CMS	Maternal and Newborn Clinical Management System
MVT	Mobile Vaccination Team
NHPO	National Health Protection Office
NIAC	National Immunisation Advisory Committee

NIIS	National Immunisation Information System
NIO	National Immunisation Office
PHN	Public Health Nurse
PICU	Paediatric Intensive Care Unit
REO	Regional Executive Officer
RREC	Research Ethics Committee
RSV	Respiratory Syncytial Virus
SOP	Standard Operating Procedure
TCP	Temperature Controlled Pharmaceuticals
T&T	Technology and Transformation
WHO	World Health Organization

1. Introduction



Respiratory Syncytial Virus

Respiratory syncytial virus (RSV) is a common, seasonal respiratory virus that typically circulates during the winter season (between weeks 40–20), with the highest burden of disease in infants and younger children (most are infected by 2 years of age) and older adults (≥ 65 years). Typically, RSV causes mild self-limiting upper respiratory symptoms and wheeze but in more severe cases the infection can progress to bronchiolitis, pneumonia, respiratory distress and can be fatal, particularly in vulnerable groups. Those most at risk from severe complications of RSV infection include infants < 6 months, premature infants, children < 2 years with congenital heart or lung disease and older adults (particularly those with comorbidities or who are immunocompromised).

During the 2023/2024 RSV season, the last season prior to the introduction of RSV immunisation, 1,431 children aged < 1 year were hospitalised with RSV in Ireland, equating to almost 2.5% of all children aged < 1 year in Ireland. Of those, 118 children aged < 1 year were admitted to Intensive Care Units (ICU) due to RSV. Children < 1 year accounted for 78% of all RSV-related ICU cases in the 2023/2024 RSV season. No children died from RSV in 2023/2024¹.

Nirsevimab (Beyfortus[®]) is a European Medicines Agency approved monoclonal antibody which provides passive immunity and immediate protection against RSV, lasting for approximately 150 days and can be given as a single dose for season-long protection². The efficacy and safety of nirsevimab was shown in the MELODY trial with a significant reduction in the incidence of RSV associated medically attended lower respiratory tract infections in infants born after 35 weeks reporting efficacy of 74.5%³. Real-world data from EU countries including Spain and France support the effectiveness of nirsevimab against RSV-associated hospitalisations and illness in infants^{4,5,6,7}.

RSV Immunisation Pathfinder 2.0 Programme

In Ireland in October 2023, the National Immunisation Advisory Committee (NIAC) recommended the passive immunisation of all infants against RSV during their first RSV season⁸, with further updates to the recommendations in March 2025⁹. In June 2024 the HSE established the RSV Immunisation Pathfinder 1.0 Programme – a pilot programme to offer nirsevimab to all infants born between 1st September 2024 and 28th February 2025 (the ‘birth cohort’), in addition to clinically high-risk infants aged 12 months or younger (including pre-term infants born < 30 weeks gestation, infants with congenital heart disease or chronic lung disease of prematurity, and immunocompromised infants). The pilot programme commenced

on 1st September 2024 and nirsevimab was offered to infants in all 19 maternity hospitals, in Children's Health Ireland (CHI) and to clinically high-risk infants at home by Temperature Controlled Pharmaceuticals (TCP) Homecare.

The RSV Pathfinder 1.0 Programme reported a national uptake of 83%, delivering a total of 22,444 infant immunisations between 1st September 2024 and 28th February 2025. Routine surveillance data of RSV among infants born in this period showed a significant reduction in the number of cases in this cohort in the 2024/2025 season (n=398) compared to previous post-COVID-19 seasons (2023/2024: n=1,142; 2022/2023: n=997; 2021/2022: 801). It is estimated that a total of 1,055 (95%CI:1,038–1,071) RSV notified cases, 459 (95%CI: 452–467) ED presentations, 437 (95%CI:430–443) hospitalisations, and 76 (95%CI:74–78) ICU admissions were averted in the 2024/2025 birth cohort¹⁰. Furthermore, an alternative impact methodology estimated that 532 (95% CI: 369-695) hospitalisations were averted in the cohort eligible for immunisation¹¹, which avows to the success of RSV Pathfinder 1.0 programme

An evaluation was undertaken following completion of the RSV Pathfinder 1.0 Pathfinder to capture lessons learned and inform future delivery¹². Building on the success of the first pilot, RSV Pathfinder 2.0 Pathfinder was launched in August 2025 to fully implement the recommendations of NIAC, offering RSV immunisation to all infants born from 1st March 2025 to 31st August 2025 (the 'catch-up cohort') in addition to the birth cohort (born 1st September 2025 to 28th February 2026) and high-risk infants as outlined above.

2. Aims and Objectives



Aims

The overall aim of the RSV Immunisation Pathfinder 2.0 Programme evaluation was to measure programme success and to understand the experience of parents availing of the programme and providers of the service. The evaluation also aimed to understand the opinions and experiences of parents whose infants were eligible for RSV immunisation but did not receive it.

The evaluation was guided by the following themes:

- effectiveness,
- efficiency,
- equity, and
- acceptability

with a view to generating recommendations that would inform programme planning for future RSV seasons.

The evaluation also aimed to assess the impact of Pathfinder 2.0 Programme on severe RSV illness in eligible cohorts.

Objectives

1. Describe the RSV Pathfinder 2.0 Programme

- a) Describe the RSV Pathfinder 2.0 Programme, with a specific focus on the Catch-up programme.

2. Measure Immunisation Uptake

- a) Analyse and report on the proportion of eligible infants receiving nirsevimab immunisation in the maternity unit based, Catch-up and high-risk infant programmes by week, nationally and by HSE region.
- b) Analyse and report on the RSV immunisation activity within the Catch-up programme including the number of clinics available each week nationally and by HSE region, booking activity, including the booking capacity and uptake of appointments at each clinic as well as non-attendance for booked appointments (DNAs).
- c) Analyse and report on those factors that appear to influence immunisation uptake in maternity hospitals that are using the Maternal & Newborn Clinical

Management System (MN-CMS), for example demographic features and ethnicity. A separate report will be generated on this objective.

3. Assess Immunisation Impact

- a) Assess the programme's epidemiological impact on RSV-related illness in the eligible cohorts i.e., Emergency Department presentations, hospitalisations, and paediatric intensive care unit (PICU) admissions during the RSV season 2025-26. A separate impact report is available and the findings are summarised in this report.

4. Qualitatively Evaluate Programme Implementation

- a) Evaluate the experiences of service users of the community-based Catch-up programme through the use of questionnaires/surveys and focus group interviews.
- b) Evaluate the experiences of service providers of the community-based Catch-up programme through the use of questionnaires/surveys and focus group interviews.
- c) Evaluate the experiences of service providers of the maternity hospital-based programme through the use of focus group interviews.
- d) Explore the opinions of parents of infants who were eligible for immunisation but were not immunised through the use of questionnaires/surveys and focus group interviews.
- e) Explore the preferences of service users, service providers and parents whose infants were not immunised in relation to future options for delivery site and channels for immunisation.
- f) Explore the opinions of key stakeholders involved in the delivery of the programme through semi-structured interviews
- g) Identify key facilitators and barriers to successful programme delivery.

3. Methods



Frameworks

This evaluation follows the U.S. Centers for Disease Control and Prevention (CDC) Framework for Programme Evaluation (**Figure 3.1**), as was the case for the RSV pathfinder programme 1.0 evaluation. This approach will ensure consistency and comparability between the two evaluations.

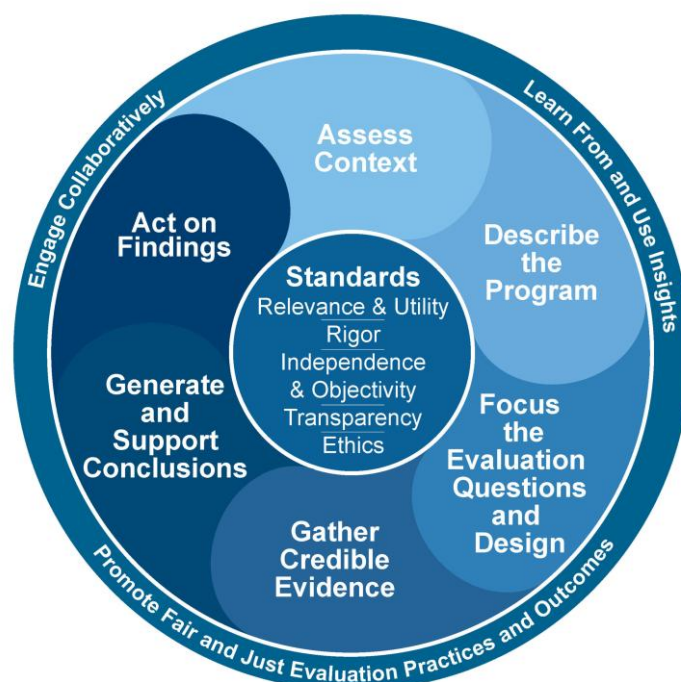


Figure 3.1. Centres for Disease Control and Prevention Framework for Programme Evaluation.

The evaluation is also guided by the quality assessment framework proposed by the Institute of Medicine (IOM)¹³ and the domains of healthcare quality adopted by the World Health Organization (WHO) and Health Information and Quality Authority (HIQA). These domains, as illustrated in the infographic below (source: Proctor *et al*, 2010¹⁴), can be divided into implementation, service, and client outcomes:

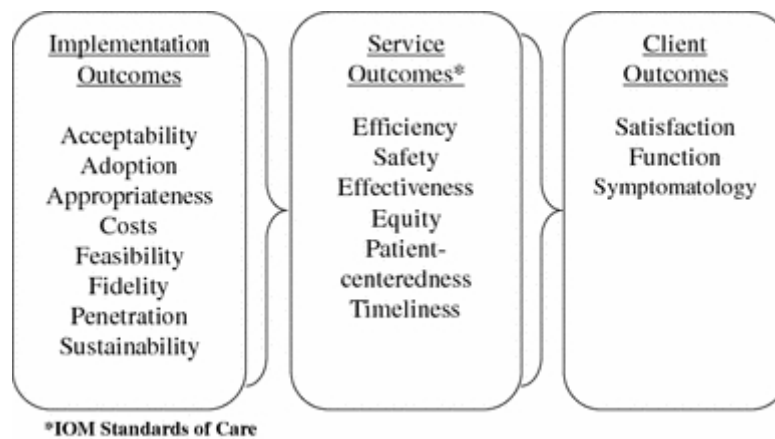


Figure 3.2. Domains of healthcare quality and standards of care, as described by the IOM⁵ and adopted by WHO and HIQA. Source: Proctor et al, 2010¹⁴.

Not all outcomes detailed are addressed in this evaluation, however the framework provides a useful guide and structure to ensure evaluation of key programme and service user parameters. This framework informs on the quantitative and qualitative data collection methods described in the following sections.

Describing the RSV Immunisation Pathfinder 2.0 Programme

The RSV Immunisation Pathfinder 2.0 Programme was described using a structured review of multiple data sources, including publicly available programme documentation and internal materials. These sources comprised training materials, standard operating procedures, frequently asked questions documents, and meeting minutes. This document review was supplemented by consultation with members of the steering committee and working groups responsible for the planning and implementation of the programme. The programme description focuses on the Catch-up Programme, as the maternity programme—having remained unchanged—is described in detail in the Pathfinder 1.0 technical report¹².

Uptake and Activity

Immunisation uptake was reported regularly, as part of programme operations. Details on immunisation uptake, including calculation processes are included in Chapter 4, Programme Description.

Impact

RSV Surveillance Data

Confirmed cases of RSV, emergency department (ED) presentations, hospitalisations, and intensive care unit (ICU) admissions of all ages notified between 1st September 2018 and 5th April 2026 were extracted from the Computerised Infectious Diseases Reporting System (CIDR). Descriptive analyses were performed in reference to the previous seven RSV seasons. Comparative analyses were performed using data from winter 2025/2026 (week 36-14) from the birth and catch-up cohort.

Estimated Number of Hospitalisations Averted

Effectiveness-based estimation (method 1)

All analyses were conducted separately for the birth and catch-up cohort using RSV case data from the 2025/2026 winter. All analyses were run separately for the outcomes: total cases, ED admissions (non-hospitalised), hospitalisations (non-ICU), ICU admissions, combined hospitalisations and ICU admissions, and combined ED presentations, hospitalisations and ICU admissions. Outcome-specific immunisation effectiveness estimates were used, see full impact report for details.

The number of cases, ED presentations, hospitalisations, and ICU admissions due to RSV that were averted by infant immunisation were calculated. For each outcome, this was estimated using the formula, adapted from Machado et al¹⁵.

$$NAE = n * \frac{IC * IE}{1 - (IC * IE)}$$

- NAE: the number of averted events/outcomes
- n: number of cases
- IE: the absolute immunisation effectiveness against the event/outcome
- IC: the cumulative population immunisation coverage

Hierarchical generalised additive models (method 2)

A hierarchical generalised additive model (GAM) was used to conduct a quasi-experimental analysis of RSV outcomes over time. This approach incorporates elements of an interrupted time series design and comparative group analysis, allowing estimation of the association between nirsevimab eligibility and RSV outcomes while accounting for seasonal trends, between-winter variability, and differences across immunisation/age groups.

Hierarchical GAMs were run for combined ED presentations, hospitalisations, and ICU admissions, combined hospitalisations and ICU admissions, and separately for just ED presentations and just hospitalisations. It was not possible to run separate GAMs for ICU admissions due to low numbers. Data for winters 2021/2022 until 2025/2026 (week 36-14) were included. Earlier winters were excluded due to differences in testing policy and practice in the pre-pandemic years. GAMs included an indicator for immunisation and age group, which had the categories birth cohort, catch-up cohort, <5 years, 5-64 years, and 65+ years old.

For each outcome, two GAMs were fitted with negative binomial errors and a log link function to model counts of weekly notified RSV cases over time, by winter and immunisation/age group. First a hierarchical GAM was fitted with fixed-effects for immunisation/age group and winter, a smooth (using thin plate splines with 20 knots throughout) for week, and additional smooths for week by immunisation/age group and by winter. This base model predicts winter- and immunisation/age group-specific RSV case counts across weeks, based on their additive effects (on the log scale) while borrowing strength from the marginal smooth for week estimated across all immunisation/age groups and winters.

To estimate any benefit of RSV immunisation in the eligible birth and catch-up cohorts, a fixed effect for a categorical indicator variable (hereafter referred to as the eligible cohorts model) was added to the base model. This indicator variable reflected whether a given week's count of RSV cases was observed in the immunisation/age group that was eligible to receive nirsevimab at birth (winters 2024/2025 and 2025/2026) or immunisation/age group that was eligible to receive nirsevimab in the catch-up campaign (winter 2025/2026). An estimate of averted RSV hospitalisations was based on summing the total number of model-predicted weekly cases by cohort (birth and catch-up) for this winter based on this effect estimate, and comparing it to the counterfactual; if the effect was equal to zero. Because the base model and the eligible cohorts model were nested, their respective fits to the data were evaluated using their Akaike information criteria (AIC) and a likelihood ratio test (LRT) of the two models.

Number of In-Patient Bed Days Avoided

The number of in-patient bed days that were averted by infant immunisation was calculated by multiplying the estimated number of hospitalisations and ICU admissions averted by the average length of hospital and ICU stay, respectively. The average length of hospital and ICU stay was taken from the health technology assessment of RSV immunisation by Health Information and Quality Authority Ireland¹⁶.

Number Needed to Immunise

The numbers needed to immunise (NNI) were calculated for the prevention of cases, ED cases, hospitalisations, and ICU admissions. The following formula, adapted from Machado et al.¹⁵, was used:

$$NNI = \frac{1}{(IE * (n + NAE)) / population}$$

- NNI: number needed to immunise
- IE: the absolute immunisation effectiveness against the event/outcome
- n: number of cases
- NAE: the number of averted events/outcomes

Qualitative Evaluation

Maternity Programme

Parental Feedback

Parental feedback from parents of newborns who were immunised in maternity hospitals was not formally sought for the purposes of the RSV Pathfinder 2.0 Programme evaluation. Parental feedback was collected as part of the pilot RSV Pathfinder Programme 1.0 and on considering the high success of the maternity programme last year, repeated feedback would be unlikely to provide additional insights. Parental feedback was sought from those parents whose child was eligible for RSV immunisation as part of the birth cohort but were not

immunised. This feedback was sought via invitation to complete an online survey developed for parents of eligible children within either the birth or catch-up cohorts, which included an invitation to attend a focus group interview, as is detailed further in the catch-up programme parental survey section below.

Provider Feedback

Evaluation of the maternity programme focused therefore on provider feedback, as it was thought that this feedback would provide more meaningful insights, should the maternity programme be permanently employed for RSV immunisation of newborns in the future. As with parental feedback from the maternity programme last year, it was anticipated that repeat survey administration to maternity hospital providers would provide limited additional findings. Directors of midwifery were therefore invited to participate in focus group interviews to discuss the maternity hospital programme experience. Focus group interview schedules are detailed in [Appendix A](#).

Catch-up Programme

Parental Feedback

Both, parents of eligible infants who attended the community clinics for immunisation, and parents whose infant was eligible for immunisation but did not attend, were invited to provide feedback on the programme. Two parental surveys were developed; one specifically for parents whose infant attended for immunisation and one for parents of infants who did not attend.

Surveys

Both parent surveys were accessible on line via a QR code, for completion on a mobile device.

Parents attending the community clinics were offered the survey QR code by clinic staff using posters and leaflets. All parents who attended the community clinics were eligible to complete the survey, which remained open throughout the RSV season. This survey contained multiple choice, Likert scale, and open-text questions and was available in English.

The QR code invitation to access the survey for those parents whose child was not immunised was issued via a variety of channels to increase the reach of the invitation and the uptake of the survey, including:

- HSE Child Health Public Health Social Media accounts (MyChild)
- HSE lactation consultant network
- HSE Community Family Networks
- HSE Public Health Nursing Clinics
- Private lactation consultants
- Cuidiu network
- National Social Inclusion Office – Traveller Health Network
- National Social Inclusion Office – Roma Health Network

All parents of infants who were eligible for immunisation but were not immunised were eligible to complete the survey, which remained open throughout the RSV season. This survey contained multiple choice, Likert scale, and open-text questions and was available in English. To promote inclusivity of all eligible parents to feedback the pathway to access the survey included an option for parents whose infant attended for immunisation as well as those who did not. It was acknowledged that this approach may result in duplicate returns from the parents of those infants who were immunised, as this survey was released after the survey targeting parents who had attended the clinics. It was also acknowledged that responses may be received from parents from the birth cohort, who had not been targeted for evaluation this year. Multiple avenues within the survey were developed to direct parents appropriately so that only response from those in the target group were collated. Parents accessing the survey whose children weren't within either the birth or catch-up cohorts were not requested for further details and were advised the purpose of the survey was to collect information from parents whose children were eligible for the programme.

Focus Group Interviews

Invitations to attend focus group interviews were included within both online surveys that were issued to parents. Parents expressed an interest in attending an interview by emailing the lead investigator of the evaluation and completed a consent form ([Appendix B](#)) prior to receiving an invitation to the meeting. Focus group interviews were held online using the Microsoft® Teams® platform. Participants were reminded of confidentiality and transcripts were recorded

using the in-built transcription software component. Focus group interviews were guided by the following themes.

For parents who attended for immunisation:

- Awareness of RSV as a public health concern.
- Awareness of the RSV Immunisation Catch-up Programme.
- Accessibility and acceptability of communications about the campaign.
- Accessibility of RSV immunisation
- The immunisation booking system, specifically it's user-friendliness and accessibility.
- Their experience of the catch-up campaign as a parental recipient of immunisation.
- Their views and opinions on the most appropriate future delivery of the RSV immunisation service.

For parents who did not attend for immunisation:

- Awareness of RSV as a public health concern.
- Awareness of the RSV Immunisation Catch-up Programme.
- Accessibility and acceptability of communications about the campaign.
- Accessibility of RSV immunisation including Booking system
- Barriers to RSV immunisation
- Their views and opinions on the most appropriate future delivery of the RSV immunisation service.

Additional informal interviews were carried out by community health workers in conjunction with mobile vaccination teams with members of underserved communities whose infants were eligible for immunisation, but who were not immunised, to further understand any challenges or barriers to receiving or attending for RSV immunisation.

Provider Feedback

Feedback was sought from service providers of the Pathfinder 2.0 programme, including from mobile vaccination team (MVT) staff and directors of midwifery (DsOM). More detailed feedback was sought from MVT providers of the Catch-up programme, as this was the first year of this part of the programme, whereas only high-level feedback was sought from the

maternity service, via the DsOM, as this part of the programme was evaluated in detail last year.

Survey

An invitation to participate in an online Qualtrics® survey was issued to MVT providers via a link and QR code, which was issued by email via the MVT leads in each HSE health region. All MVT members were eligible to participate in the survey, which remained open for a period of four weeks. The survey contained multiple choice, Likert scale, and open-text questions and was available in English.

Focus Group Interviews

MVT providers were invited to express interest in attending a focus group interview at the end of the online survey. Those providers expressing an interest were then asked to complete a consent form prior to receiving a link to an online meeting, which was hosted on the Microsoft® Teams® platform. Participants were reminded of confidentiality and transcripts were recorded using the in-built transcription software component. Focus group interviews were guided by the following themes:

- Information and communications about the programme,
- The booking system,
- Their experience of the catch-up programme,
- Their perceived experience of the parents attending the Catch-up programme,
- Their views on the most appropriate future delivery of the RSV immunisation service.

DsOM were invited to attend one of three focus groups according to the size of the maternity unit they were responsible for: small, medium, or large. Interviews were held online using Microsoft® Teams® and transcripts were recorded using the in-built transcription software.

Stakeholder Feedback

A series of further focus groups were undertaken to obtain feedback from key stakeholders, including: the RSV Steering Group, the Regional Directors of Public Health, the Catch-up programme clinical and operational leads, HSE communications, HSE Technology and

Transformation and booking portal vendors, and representatives of general practice (general practitioners and practice nurses). The focus groups were conducted virtually on the Microsoft® Teams® platform using a semi-structured interview format. The meetings were transcribed using the in-built transcription software.

The focus of the stakeholder interviews was lessons learned from the RSV 2.0 Pathfinder Programme (for those involved in delivery of nirsevimab to both the catch-up and maternity cohorts in the 2025/2026 season), and to explore ideas for future programme delivery and sustainability.

Data Analysis

Qualtrics was used as a survey platform for both parent and provider surveys from the Catch-up programme. Data collected from multiple choice questions was analysed descriptively; Likert scale responses were transformed and analysed numerically; open-ended questions, and responses from focus group interviews, were analysed thematically assisted by Microsoft® CoPilot®. Data analysis and graphical visualisations were performed in Microsoft® Excel® and R programme®.

Ethical Considerations

Ethical approval for this evaluation was granted from the Reference Research Ethics Committee (RREC) for HSE Dublin and Midlands (& HSE Centre) ([Appendix C](#)). Several ethical considerations were taken into account for this evaluation, including:

- **Stakeholder engagement**, to ensure the RSV programme meets the needs of the community and is delivered in a way that is sustainable and acceptable to providers.
- **Informed consent**: participants must be fully informed of the purposes of the programme evaluation, understand that participation is voluntary, and be informed of their right to withdraw at any time.
- **Data protection and confidentiality**: data collected as part of the programme evaluation would remain confidential and comply with General Data Protection Regulations (GDPR), including secure storage, handling, and processing.

4. Programme Description



Overview

The RSV Pathfinder 2.0 Programme was an expansion of the RSV Pathfinder 1.0 Programme, a pilot initiative launched in the 2024/2025 RSV season to reduce the burden of RSV infection in infants born between 1st September 2024 and 28th February 2025 and in risk infants most vulnerable to severe RSV related illness.

To fully implement NIAC recommendations for infants and high-risk children the 2025/2026 RSV season the RSV Pathfinder 2.0 extended delivery of infant immunisation with nirsevimab to all infants born between 1st March 2025 and 28th February 2026. In line with RSV Pathfinder 1.0 all infants born between 1st September 2025 and 28th February 2026 (the birth cohort) were offered immunisation postnatally in the maternity unit setting and high-risk infants were offered immunisation at home, delivered by TCP Homecare.

Infants born between 1st March and 31st August 2025 (the catch-up cohort) were offered immunisation in the community. Operational delivery of the catch-up programme was co-ordinated regionally with immunisations predominantly delivered through established HSE MVT infrastructure in community clinics by an existing workforce with expertise in vaccination delivery, governance, medicines management, cold chain management, clinic operations and public engagement.

Access to catch-up programme clinic appointments was via a Swiftqueue booking portal that went live on August 25th 2026. Immunisation appointments were initially available to eligible infants for a 6-week period from 1st September to 12th October 2025. In response to demand an additional four week 'mop-up' period of community immunisation clinics was provided from 17th November to 14th December 2025 to provide further opportunity for immunisation.

[Appendix D](#) lists the maternity hospitals and community sites that participated in RSV Pathfinder 2.0.

Expected Effects

The programme aimed to:

- Fully implement NIACs RSV immunisation recommendations 2025/2026 for infants and high-risk children
- Provide immediate protection against RSV for approximately 150 days after immunisation.

- Reduce RSV-related illness, particularly severe disease, hospitalisations and ICU admissions among eligible infants.

Activities

The programme involved:

- Administering a single dose of nirsevimab to all eligible infants in accordance with [NIAC recommendations](#).
- Procurement, storage and distribution of nirsevimab and other consumables.
- Educating parents about RSV and the benefits of immunisation through a national HSE communications campaign and healthcare professionals
- Design and delivery of an integrated HSE national communication plan.
- Supporting programme implementation to ensure streamlined delivery, through:
 - Development and approval of medicines protocols to support safe, effective and timely administration of nirsevimab by nurses, midwives, Emergency Medical Technicians, Paramedics and Advanced Paramedics.
 - Enactment of a statutory instrument, in collaboration with the Department of Health, to update the schedule of medicinal products which may be supplied and administered pursuant to Regulation 4F of the Medicinal Products (Prescription and Control of Supply) Regulations 2003. (See [SI 353 2025](#)).
 - Development of an updated [HSE National Standard Operating Procedure on Nirsevimab to reduce RSV and associated hospitalisations in Infants](#) to provide direction, information and support for staff working in Maternity Hospitals/ Units, Neonatal Units, Paediatric and community settings, including recommendations for standard practice. This includes detailed guidance on product storage and administration.

- Development of [relevant support resources](#) including consent forms and data collection forms; patient information leaflets; and frequently asked questions materials.
- Development of training and educational material for staff delivering the programme. (HSE training video on [YouTube](#))
- Provision of expert advice and guidance on clinical and medication stewardship issues and providing a point of escalation for queries and concerns by hospitals and community vaccination teams implementing the Pathfinder Programme via dedicated email rsvpathfinderprogramme@hpsc.ie.
- Implementation of information management and governance processes and pathways for documentation of immunisation records and provide direction on streamlining/integrating into existing processes where able.
- Monitoring and evaluating the Pathfinder 2.0 Programme

Monitoring

- Assessing RSV epidemiology and trends through surveillance/epidemiology reports produced by HPSC.
- Monitoring uptake of the RSV immunisation through weekly uptake reports developed by HPSC to provide strategic direction on course correction as needed.
- Assessing the epidemiological impact of the RSV nirsevimab programme; estimating averted hospitalisations and ICU admissions.

Governance

The programme was governed by a programme steering group (membership listed in [Appendix E](#)) which oversaw the activities of the following subgroups:

- Programme Implementation Working Group
- Operations Management Subgroups

- Evaluation and Reporting Subgroup

The programme steering group was accountable to the HSE Immunisation Oversight Committee, Operational governance, oversight and accountability for implementation of the programme at maternity sites and community clinics rested with each Regional Executive Officer (REO)

Eligibility

The eligibility criteria for nirsevimab administration to infants in the RSV Pathfinder 2.0 Programme were determined by the NIAC 'Updated Recommendations for the Passive Immunisation of Infants against RSV during the 2025/2026 Season'⁹, as follows:

1. All infants who are born during the RSV season from 1 September 2025 to 28 February 2026 (i.e., the birth cohort). These infants should receive nirsevimab ideally prior to discharge home from a maternity hospital.
2. All infants who are aged ≤6 months at the start of the RSV season, i.e., born between 1st March 2025 and 31st August 2025 (the catch-up cohort). These infants should receive nirsevimab prior to the start of the RSV season.
3. All high-risk infants¹ aged ≤12 months at the start of their first RSV season. These infants should receive nirsevimab prior to the start of the RSV season.
4. All ex-preterm infants under 24 months of age with chronic lung disease (CLD)² in their second RSV season. These infants should receive nirsevimab prior to the start of the RSV season.
5. Infants who will be severely immunocompromised during the RSV season may also be considered for nirsevimab in consultation with their treating specialist. These infants should receive nirsevimab prior to the start of the RSV season.
6. Neonates with prolonged hospitalisation from birth due to prematurity or other reasons should receive nirsevimab shortly before discharge from hospital if they are being discharged during or shortly before the RSV season³.

¹ Infants currently eligible for palivizumab as outlined in Chapter 18a of NIAC Immunisation Guidelines of Ireland.

² Children with CLD (defined as those who required at least 28 days of supplemental oxygen after birth) and who continue to require medical intervention (supplemental oxygen, chronic corticosteroid, or diuretic therapy) for 6 months preceding the RSV season

³ Earlier inpatient administration may be considered if infant is considered at risk of RSV exposure in hospital. Dosing in infants with a body weight from 1.0 kg to <1.6 kg is based on extrapolation; no clinical data are available. Exposure in infants <1 kg is anticipated to yield higher exposures than in those weighing more. The benefits and risks of nirsevimab use in infants <1 kg should be carefully considered.

Data Collection Methods

Community Clinics

Paper based data collection forms were completed by the MVT staff providing nirsevimab to the catch-up cohort in the community setting and were stored in accordance with local HSE data management guidance. A mechanism to collate the data from these data collection forms at a national level has not been established. Data was also collected on the Swiftqueue system.

Maternity Sites

Paper-based data collection forms

A significant number of maternity sites used [paper data collection forms](#) to record information relevant to nirsevimab acceptance, refusal and administration (if relevant). This was a duplicate record with one copy kept in the patient chart and another kept aside for eventual upload to a national data repository. However, a mechanism to collate the data from these data collection forms at a national level has not been established.

Maternal & Newborn Clinical Management System and data management

The National Maternity Hospital Dublin, the Rotunda Hospital, the Coombe Hospital, Cork University Maternity Hospital, University Maternity Hospital Limerick and University Hospital Kerry (UHK) use the Maternal & Newborn Clinical Management System (MN-CMS) electronic record system, that facilitates the electronic recording of nirsevimab immunisation data. Informatics pharmacist posts were granted for the Rotunda and National Maternity Hospitals to provide them with the analytic capacity to report in detail on the determinants of nirsevimab uptake in hospitals using the MN-CMS system.

Electronic data from maternity hospital Maternal and Newborn Clinical Management System (MN-CMS) sites were collected and analysed at the end of the RSV immunisation maternity programme. The previous evaluation included detailed analytics from two MN-CMS sites with informatics pharmacy support. With MN-CMS now live across a total of six maternity hospitals, covering 62% of births, this evaluation aimed to include data from all six sites to enable comprehensive and standardised analysis across regions. Characteristics analysed included:

- Infant characteristics

- Sex
- Gestational age
- Birthweight
- Day/time of birth
- Admission to a neonatal unit (yes/no)
- Feeding status
- Maternal characteristics
 - Age
 - Parity
 - Type of care
 - Delivery type
 - Ethnicity
 - Socioeconomic group

Analysis of MN-CMS data was performed by informatics and pharmacy colleagues and a detailed report of the findings will be available in a separate report. Briefly, logistic regression, including both univariable and multivariable analyses, were used to examine characteristics associated with immunisation uptake within maternity sites.

Data Collection for Uptake Reporting

Community Clinics

Appointment record data was manually downloaded on a weekly basis from the Swiftqueue portal by the Vaccine-preventable Disease (VPD) team at HPSC. This included appointment records for all regional clinics.

Maternity Sites

Aggregate data was collected on a weekly basis from each maternity site (both paper and electronic based sites) by the VPD team using a Qualtrics survey reporting tool in line with the 2024/2025 RSV Pathfinder 1.0 Programme.

CHI and TCP Homecare

Weekly aggregate data was also reported by CHI and TCP Homecare to the VPD team at HPSC using a Qualtrics survey reporting tool.

Weekly Uptake Reporting

Throughout the programme, the HPSC produced and circulated a progress report on nirsevimab uptake on a weekly basis. This report included uptake in maternity hospitals, CHI and TCP Homecare clients, as well as national and regional catch-up programme uptake. The weekly uptake reports were circulated to Regional Executive Officers (REOs), Regional Directors of Public Health (RDPHs) and hospital management teams in addition to members of the Steering Group, senior HSE leaders and the Chief Medical Officer and officials at the Department of Health.

Birth Cohort

Maternity Hospital Programme

Crude Uptake

Weekly and cumulative RSV immunisation uptake rates were calculated by HPSC nationally, regionally, and for each site ([Appendix D](#)), using the formulae below:

$$\text{Week X uptake} = \frac{\text{Number of eligible infants immunised during week X}}{\text{Number of eligible infants born during week X}}$$

$$\text{Cumulative uptake} = \frac{\text{Number of eligible infants immunised up to week X}}{\text{Total number of eligible infants}}$$

CHI Programme

Infants who were admitted postnatally to CHI following delivery were offered nirsevimab immunisation at discharge. Weekly and cumulative RSV immunisation uptake rates were calculated by HPSC using the below formula:

$$\text{Week X uptake} = \frac{\text{Number of eligible admitted infants immunised in week X}}{\text{Total number of eligible infants admitted during week X}}$$

$$\text{Cumulative uptake} = \frac{\text{Number of eligible admitted infants immunised up to week X}}{\text{Total number of eligible infants admitted up to week X}}$$

Home Care Programme for High-risk Infants

High-risk infants eligible for nirsevimab immunisation were identified by clinical teams and referred for immunisation to be delivered at home by the TCP homecare team. Uptake in this cohort was calculated as follows:

$$\text{Week X uptake} = \frac{\text{Number of high-risk infants immunised in week X}}{\text{Total number of eligible infants referred to TCP in week X}}$$

$$\text{Cumulative uptake} = \frac{\text{Number of high-risk infants immunised up to week X}}{\text{Total number of high-risk infants referred to TCP up to week X}}$$

Catch-up Cohort

Crude Uptake⁴

RSV immunisation uptake reports were generated weekly by HPSC. Data was extracted from the Swiftqueue system on a weekly basis for analysis. Weekly uptake reports included national and regional uptake data and the number of immunisations provided to infants at both a national and regional level. Uptake was calculated both weekly and as a cumulative percentage using the formulae below:

$$\text{Week X uptake} = \frac{\text{Number of eligible infants immunised in week X}}{\text{Total number of eligible infants}^5}$$

$$\text{Cumulative uptake} = \frac{\text{Number of eligible infants immunised up to week X}}{\text{Total number of eligible infants}}$$

⁴ Uptake in this section only refers to clinic attendees and does not include a small number of children from the 'catch-up cohort' who were immunised in hospital as inpatients.

Clinic Activity – Data collection and activity reporting

Parents booked catch-up programme clinic appointments through a Swiftqueue booking portal available on the HSE website. Data available from the Swiftqueue booking platform included:

- HSE region
- Clinic location
- Date of appointment
- Time of appointment
- Name
- Email
- Date of birth
- Gender
- Phone
- Address
- IHI number
- PPS number
- Whether or not the person attended the appointment
- Outcome (e.g., “Immunised”)
- Record creation time

The RSV Immunisation Pathfinder 2.0 Implementation group generated activity reports to describe the number of immunisations administered as a proportion of the overall capacity of the catch-up programme, to indicate areas of supply/demand mismatch and allow for real-time restructuring of the service, as well as to indicate geographical regions where heightened targeted media campaigns might be necessary. This approach enabled dynamic impact assessment regarding requirements to initiate additional media or messaging campaigns and to capture any subsequent changes in programme delivery and uptake. Within regional data, raw numbers of immunisations by individual clinic site were available to help guide real-time service planning.

Communications

On 21st August 2025, a Department of Health [press release](#) announced that an expanded Respiratory Syncytial Virus (RSV) Immunisation Programme would run during the 2025-2026 RSV season.

Summary of HSE Communication Campaign

The national HSE Communications Team, in collaboration with Public Health, HPSC and regional teams, delivered a national communications programme to support uptake of RSV immunisation for eligible infants. The core objectives were to improve public understanding of RSV immunisation, provide clear and accessible information on safety and benefits, and encourage timely uptake through maternity services or community clinics for the Catch-up cohort.

The plan included: a range of paid and non-paid, proactive and responsive communications, public relations activities involving clinical experts, digital and social media campaigns, and the development of multilingual information materials to support awareness and informed decision-making.

Communications emphasised that RSV immunisation is the most effective way to protect infants from serious illness and hospitalisation, is safe and effective, and is available free of charge for babies born between 1 March 2025 and 28 February 2026. Messaging also highlighted the importance of timely uptake, particularly for infants born between March and August, due to time-limited availability.

The campaign prioritised parents-to-be and parents of infants aged 0–6 months, with a focus on relevance rather than broad reach to maximise engagement in order to deliver the strongest possible outcomes against the campaign objectives. Social media campaigns ran from August 2025 to January 2026 across Meta® (Facebook® and Instagram®), TikTok® and Pinterest®. The social media strategy was structured around three pillars: awareness and education, action and access, and trust and reassurance. Additional communications were also actioned to highlight the mop-up clinics, which followed the end of the Catch-up programme, encouraging parents to make an appointment. Tailored messaging also ensured inclusion of underserved communities.

A wide range of materials supported the campaign, including multilingual patient information leaflets and posters, national and regional press releases, social media campaigns, and internal staff communications. Paid search advertisements also directed people to HSE.ie for trusted advice on RSV immunisation, as well as symptoms of RSV. Press activity occurred at key points (programme launch (August 25th 2025), reminder phase (September 16th 2025), and Mop-up clinic promotion (November 11th 2025)), achieving strong national media coverage; a number of press releases were issued nationally and regionally, with clinical experts interviewed on national media, as well as personal stories shared. Media coverage

included Ireland AM on Virgin Media, Morning Ireland on RTÉ Radio 1 and Newstalk news syndications (**Figure 4.2**).



The leaflet features the HSE logo at the top left. The title 'Zadbaj o ochronę dziecka przed RSV' is centered in a large, teal font. Below the title, on a dark teal background, is a photograph of a woman holding a sleeping baby. To the left of the photo, white text provides information about RSV, including its prevalence and the availability of the vaccine, nirsevimab.

HSE

Zadbaj o ochronę dziecka przed RSV

Obecnie dostępna jest możliwość ochrony dziecka przed syncyotialnym wirusem oddechowym (RSV).

Czym jest RSV i dlaczego warto chronić dziecko przed tym wirusem?

RSV to powszechny wirus wywołujący infekcje dróg oddechowych u małych dzieci. Niemowlęta poniżej trzeciego miesiąca życia chorują na RSV częściej niż starsze dzieci.

W okresie zimowym jedno na dwoje noworodków w Irlandii zakazi się wirusem RSV, a wiele z nich będzie wymagało opieki medycznej ze strony lekarza rodzinnego lub oddziału ratunkowego szpitala dziecięcego. Cztery noworodki na sto poddaje się hospitalizacji z powodu RSV, a niektóre z nich wymagają specjalnego leczenia na oddziałach intensywnej terapii.

Najlepszym sposobem na ochronę dziecka przed wirusem RSV jest nirsevimab.

Figure 4.1. Infant RSV Immunisation Information Leaflet made available in Polish.

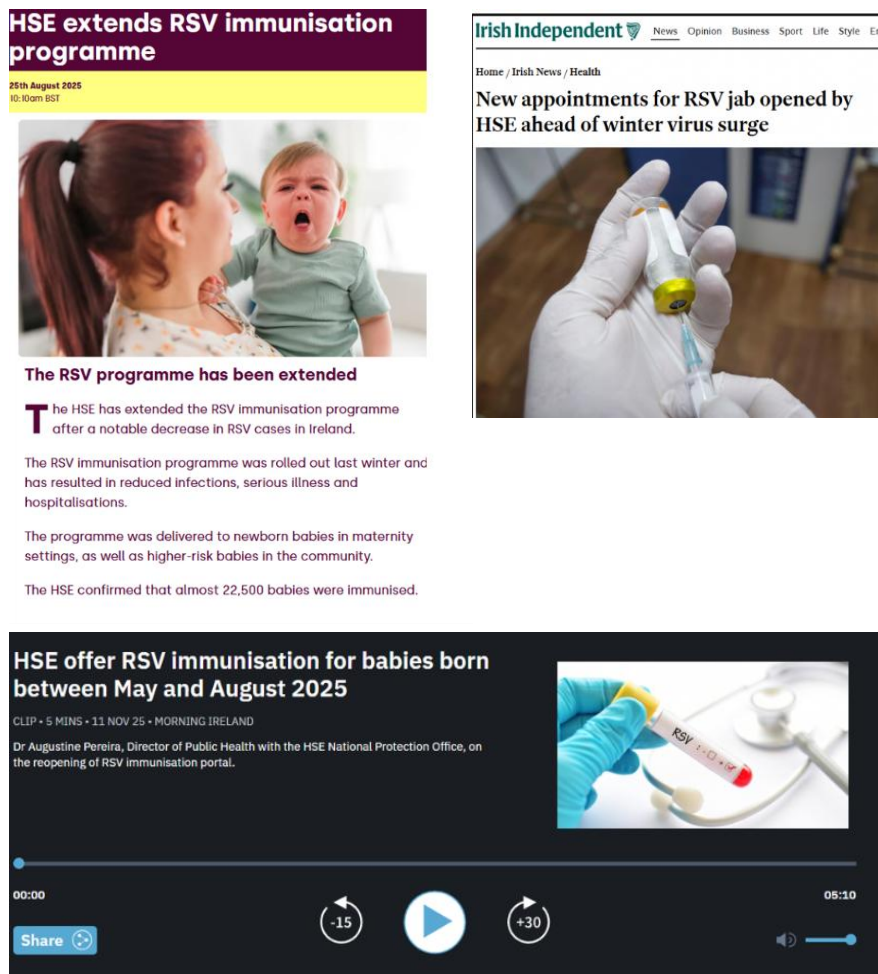


Figure 4.2. Press Articles and Radio Interviews on the RSV Immunisation Programme.

Campaign Performance

Social media campaigns achieved 15.1 million impressions and reached 2.4 million users, with a strong click-through rate of 3.2%, exceeding public health benchmarks (**Figure 4.3**). Targeted “mop-up” campaigns further drove action, demonstrating the effectiveness of urgency-based messaging.



Figure 4.3. Social Media Advertisement Performance across Meta®, TikTok® and Pinterest®, August 25th 2025 – January 31st 2026. CTR, click-through rate.

Website engagement was also substantial, with over 68,000 visits to RSV immunisation pages during the campaign period, peaking at launch and when mop-up clinics were announced. Paid search advertising complemented social media, generating 6,400 clicks with a high 15% click-through rate, particularly driven by searches related to symptoms and vaccines

5. Uptake and Activity



Uptake

Between September 1st 2025 and February 28th 2026, a total of **37,655 infants** were immunised across birth, catch-up and high-risk cohorts. Uptake data were reported to key stakeholders on a weekly basis.

Birth Cohort

Maternity Hospitals and Children's Health Ireland (CHI)

The overall cumulative uptake from September 1st 2025 to February 28th 2026 in maternity hospitals (n=19) and CHI was **88.0%, n= 23,229 (Figure 5.1)**. This was an increase in uptake compared with the 2024/2025 programme when 82.6% of eligible infants were immunised.

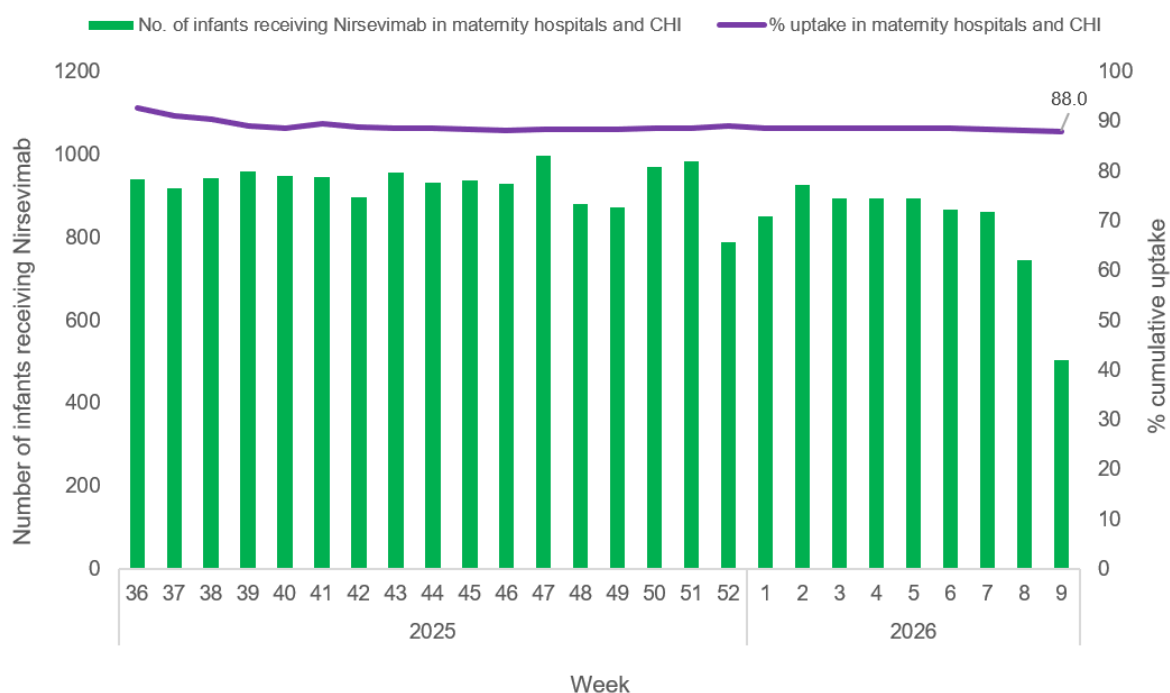
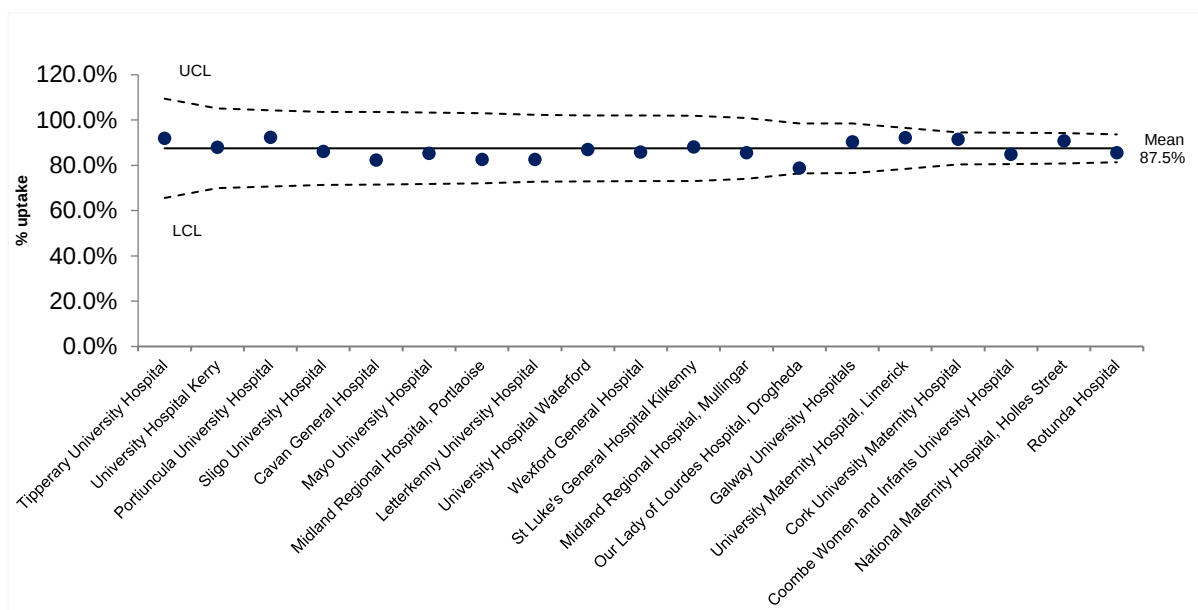


Figure 5.1. Number of infants immunised per week and cumulative percentage uptake in maternity hospitals and CHI during the RSV immunisation programme (01/09/2025 – 01/03/2026).

Maternity Hospitals (n=19)

The overall cumulative uptake from September 1st 2025 to February 28th 2026 in maternity hospitals was **87.3% (n=23,029)**, ranging from 78.9% to 92.5% (**Figure 5.2**). This is compared to an uptake of 81.8% in the 2024/2025 season.



*CHI and TCP data are not included in the analysis as processes and calculation of uptake differ for these 2 elements

Figure 5.2. Funnel plot (P chart) of RSV immunisation of eligible infants in 19 maternity hospitals* from September 1st 2025 to February 28th 2026. .

While the difference in uptake between the lowest and highest uptake rates across all 19 maternity units was 13.5% (78.9% – 92.4%), the uptake in all maternity units fell between the lower and upper limits of the funnel plot, indicating that there was no statistically significant difference in uptake across all units.

Children's Health Ireland (CHI)

The overall cumulative uptake from September 1st 2025 to February 28th 2026 in the eligible cohort at CHI was 91.3% with 200 eligible infants immunised. This compared with 225 infants immunised in the 2024/2025 season, an uptake of 95.7%.

High-risk Cohort

The overall cumulative uptake from September 1st 2025 to February 28th 2026 in high-risk babies was 100% with all 314 babies referred to TCP Homecare immunised.

Catch-up Cohort

The overall cumulative uptake in the catch-up cohort was **52.0%**, ***n* = 14,112** (Figure 5.3). The total uptake for the catch-up cohort varied by region, with the highest uptake of 61.9% in HSE Midwest (Figure 5.4).

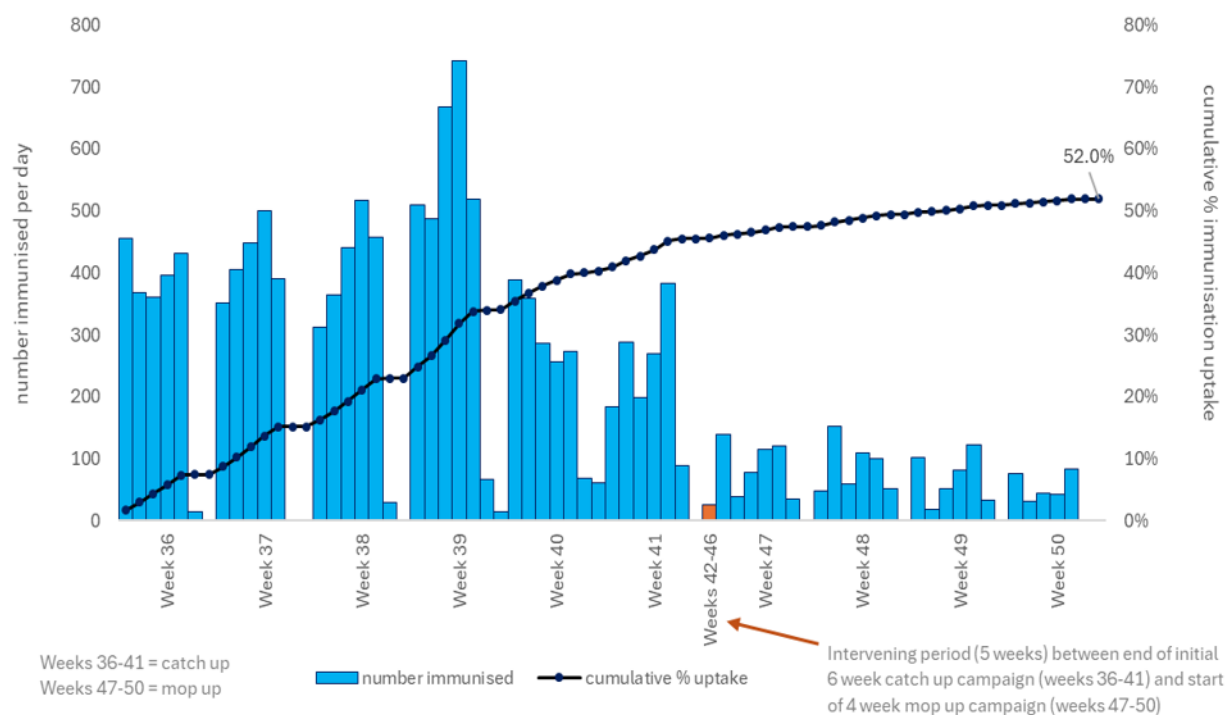


Figure 5.3. Daily and Cumulative Immunisation Uptake in the Catch-up Programme, 01/09/2025-14/12/2025.

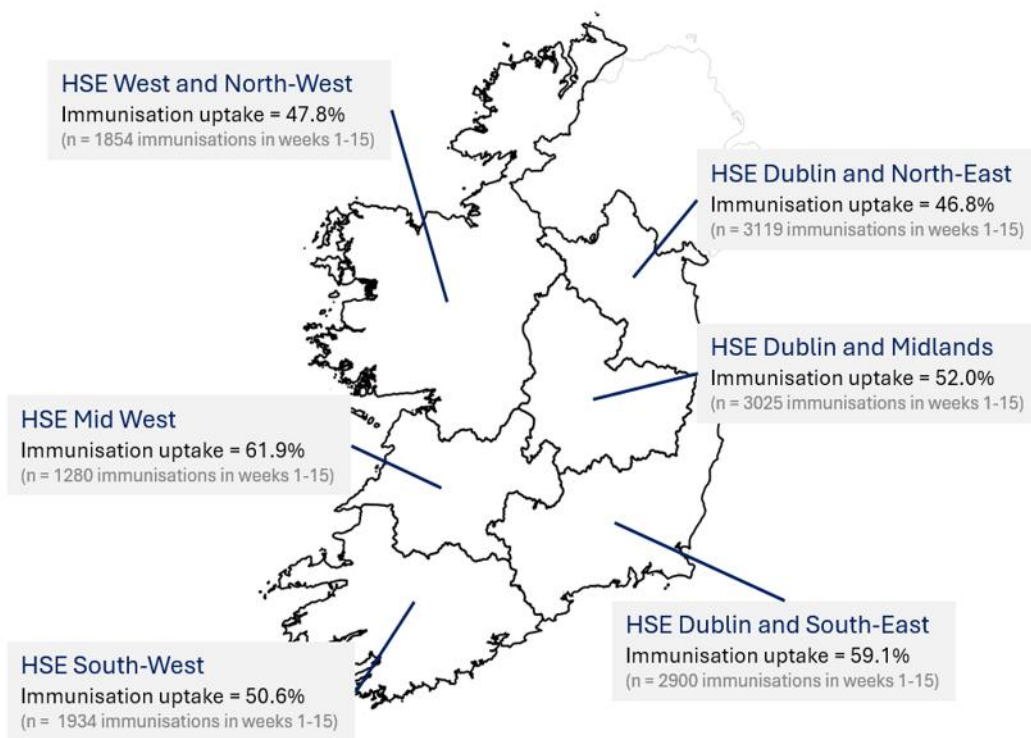


Figure 5.4. Catch-up cohort immunisation uptake by HSE Region, 01/09/2025 – 14/12/2025.

Activity

Utilisation activity was recorded by measuring clinic capacity and bookings to understand clinic utilisation and enable a dynamic response to demand during the programme, (**Table 5.1** and **Table 5.2**).

Table 5.1. Clinic Capacity, Booking Activity, and Utilisation by HSE Region during the six-week Catch-up Programme.

	Capacity Grand Total	Bookings Grand Total	Utilisation% Grand Total	Eligible Population	% Population covered by Capacity	% Population covered by bookings	No. Clinics Held	No. locations
Row Labels								
RSV HSE Dublin and Midlands	4,430	2,778	63%	5,819	76%	48%	126	29
RSV HSE Dublin and North East	4,324	2,998	69%	6,658	65%	45%	88	21
RSV HSE Dublin and South East	4,386	2,643	60%	4,911	89%	54%	139	32
RSV HSE Mid West	2,320	1,091	47%	2,068	112%	53%	70	23
RSV HSE South West	3,672	1,766	48%	3,825	96%	46%	86	26
RSV HSE West and North West	3,250	1,644	51%	3,882	84%	42%	117	38
National	22,385	12,920	58%	27,163	82%	48%	626	169

Table 5.2. Clinic Capacity, Booking Activity, and Utilisation by HSE Region during the four-week Mop-up Programme.

	Capacity				Bookings				Utilisation %			
Row Labels	Week 1 MU	Week 2 MU	Week 3 MU	Week 4 MU	Week 1 MU	Week 2 MU	Week 3 MU	Week 4 MU	Week 1 MU	Week 2 MU	Week 3 MU	Week 4 MU
RSV HSE Dublin and Midlands	697	659	777	567	167	119	91	109	23.96	18.06	11.71	19.22
RSV HSE Dublin and North East	502	569	437	354	101	114	68	46	20.12	20.04	15.56	12.99
RSV HSE Dublin and South East	217	250	248	220	124	117	106	103	57.14	46.80	42.74	46.82
RSV HSE Mid West	93	100	122	66	41	44	105	47	44.09	44.00	86.07	71.21
RSV HSE South West	108	162	63	69	48	87	48	50	44.44	53.70	76.19	72.46
RSV HSE West and North West	294	196	143	80	96	94	55	55	32.65	47.96	38.46	68.75
National	1911	1936	1790	1356	577	575	473	410	30.19	29.70	26.42	30.24

6. Impact



RSV Epidemiology

The 2025/2026 RSV season in Ireland (characterised by the overall number of notified RSV cases) was broadly similar to the 2023/2024 and 2024/2025 seasons. However, the timing of the epidemic curve has shifted, with the peak and decline of RSV cases occurring later than recent seasons (**Figure 6.1**). This overall trend masks important differences by age group. The epidemiology of RSV in infants aged less than one year was notably altered, reflecting the impact of the national RSV Immunisation Pathfinder Programme 2.0.

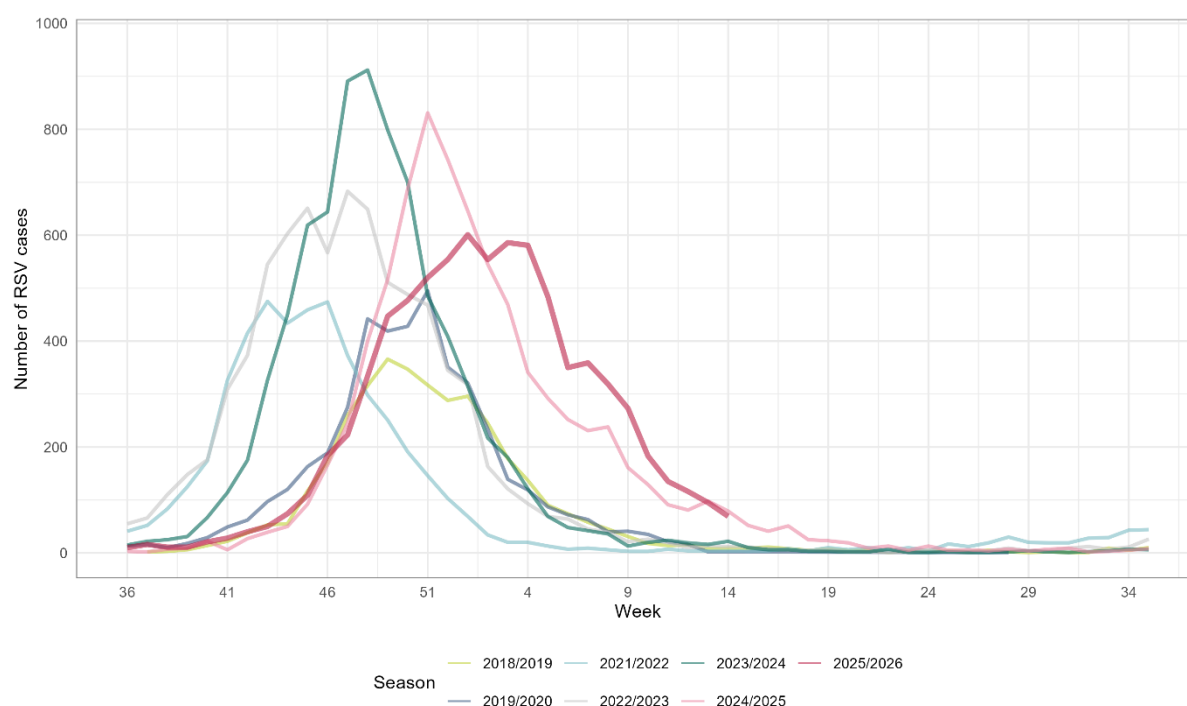


Figure 6.1. Number of RSV cases in total population, by week and season, 2018/2019 – 2025/2026 (weeks 36-35).

Table 6.1 summarises RSV cases notified among infants born between 1st September and 28th February (birth cohort), compared across RSV winters from 2021/2022 to 2025/2026. In winter 2025/2026, there were 403 cases among the birth cohort, which was less than in winter 2023/2024 (65% reduction). ED presentations (non-hospitalised) decreased by 54%, hospitalisations (non-ICU) by 74%, and ICU admissions by 80%. This indicates a continued reduction in severe RSV cases following the introduction of the nirsevimab immunisation programme for newborns.

Table 6.1. Number of RSV cases among those born between 1st September and 28th February (birth cohort), by outcome and winter, 2021/2022 – 2025/2026.

Winter*	ED [†] (%)	Hospitalised (non-ICU) (%)	ICU [‡] (%)	Total cases
2021/2022	341 (42%)	400 (50%)		803
2022/2023	472 (47%)	492 (49%)		1,007
2023/2024	399 (35%)	595 (52%)	89 (8%)	1,154
2024/2025	183 (47%)	117 (30%)	31 (8%)	389
2025/2026	184 (46%)	152 (38%)	18 (4%)	403

* Week 36 until week 14

[†] ED presentations, excluding hospitalised cases

[‡] ICU surveillance for RSV began in October 2023

Similarly, **Table 6.2** summarises RSV cases notified among infants born between 1st March and 31st August (catch-up cohort), compared across RSV winters from 2021/2022 to 2025/2026. In winter 2025/2026, there were 695 cases among the catch-up cohort, which was less than in winter 2023/2024 (49% reduction). ED presentations (non-hospitalised) decreased by 47%, hospitalisations (non-ICU) by 60%, and ICU admissions by 52%. This indicates a reduction in severe RSV cases following the start of the nirsevimab immunisation programme for older infants.

Table 6.2. Number of RSV cases among those born between 1st March and 31st August (Catch-up cohort), by outcome and winter, 2021/2022 – 2025/2026.

Winter*	ED [†] (%)	Hospitalised (non-ICU) (%)	ICU [‡] (%)	Total cases
2021/2022	387 (42%)	433 (47%)		923
2022/2023	460 (46%)	479 (47%)		1,009
2023/2024	655 (48%)	566 (42%)	23 (2%)	1,352
2024/2025	507 (49%)	316 (31%)	18 (2%)	1,027
2025/2026	346 (50%)	229 (33%)	11 (2%)	695

* Week 36 until week 14

[†] ED presentations, excluding hospitalised cases

[‡] ICU surveillance for RSV began in October 2023

Figure 6.2 illustrates the number of RSV cases presenting to hospitals, by week, in birth and catch-up cohorts across the 2018/2019 to 2025/2026 seasons.

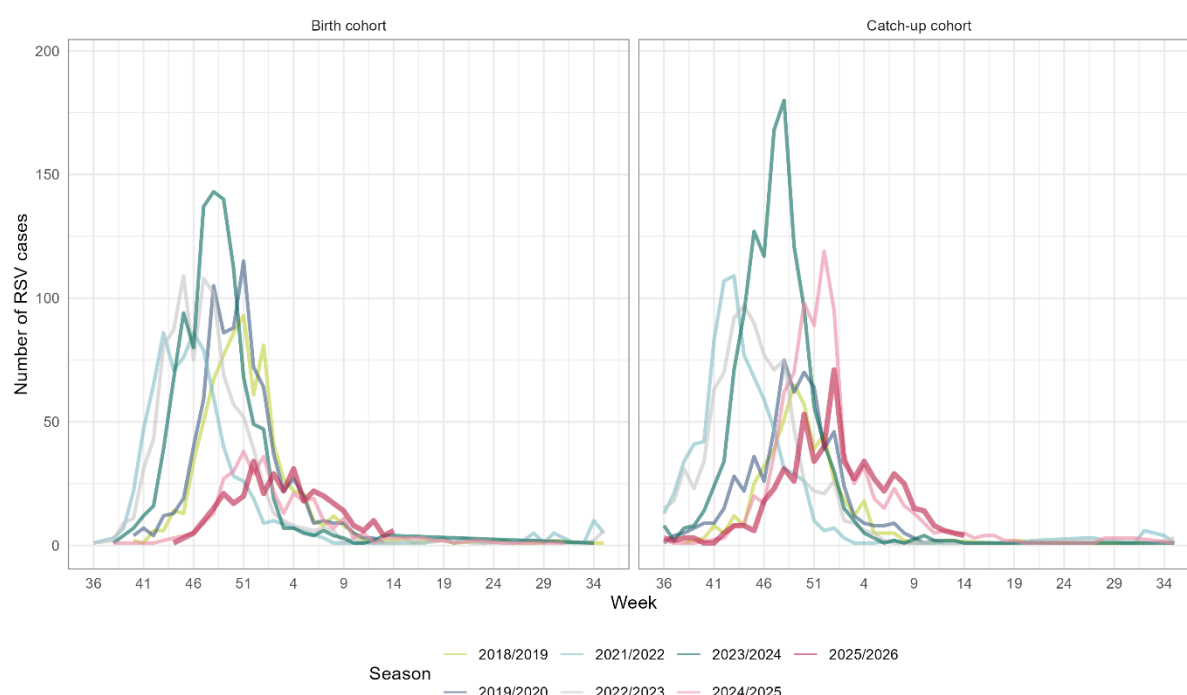


Figure 6.2. Number of RSV cases (ED, hospitalised and ICU) among birth and catch-up cohort, by week and season, 2018/2019 – 2025/2026 (weeks 36-35).

Averted cases

Method 1

Based on observed events and the reported effectiveness of nirsevimab, it was estimated that the nirsevimab immunisation programme in the 2025/2026 season averted 442 ED presentations (non-hospitalised, 71% of expected), 364 hospitalisations (non-ICU, 71% of expected), and 35 ICU admissions (66% of expected) among the birth cohort (**Table 6.3, Figure 6.3**). It was estimated that 1,227 hospital bed days and 287 ICU bed days were averted in this group. The number needed to immunise was 54 (95% CI: 50-58) to prevent one ED presentation (non-hospitalised), 65 (95% CI: 60-71) to prevent one hospitalisation, and 675 (95% CI: 494-857) to prevent one ICU admission.

Table 6.3. Observed, expected, and averted RSV cases among those born between 1st September and 28th February (birth cohort), by outcome, 2025/2026.

Outcome	Observed	Expected (95% CI)	Averted (95% CI)
ED presentation*	184	626 (370-881)	442 (436-447)
Hospitalisation (non-ICU)	152	516 (305-727)	364 (360-368)
ICU admission	18	53 (31-75)	35 (34-36)

*ED presentations do not include hospitalised cases

For the catch-up cohort, it was estimated that the programme averted 240 ED presentations (non-hospitalised, 41% of expected), 155 hospitalisations (non-ICU, 40% of expected), and 7 ICU admissions (38% of expected) (**Table 6.4, Figure 6.3**). It was estimated that 521 hospital bed days and 56 ICU bed days were averted in this group. The number needed to immunise was 58 (95% CI: 53-63) to prevent one ED presentation, 88 (95% CI: 80-97) to prevent one hospitalisation, and 2,026 (95% CI: 1,086-2,966) to prevent one ICU admission.

Table 6.4. Observed, expected, and averted RSV cases among those born between 1st March and 31st August (Catch-up cohort), by outcome, 2025/2026.

Outcome	Observed	Expected (95% CI)	Averted (95% CI)
ED presentation*	346	586 (380-793)	240 (237-243)
Hospitalisation (non-ICU)	229	384 (249-519)	155 (153-156)
ICU admission	11	18 (12-24)	7 (7-7)

*ED presentations do not include hospitalised cases

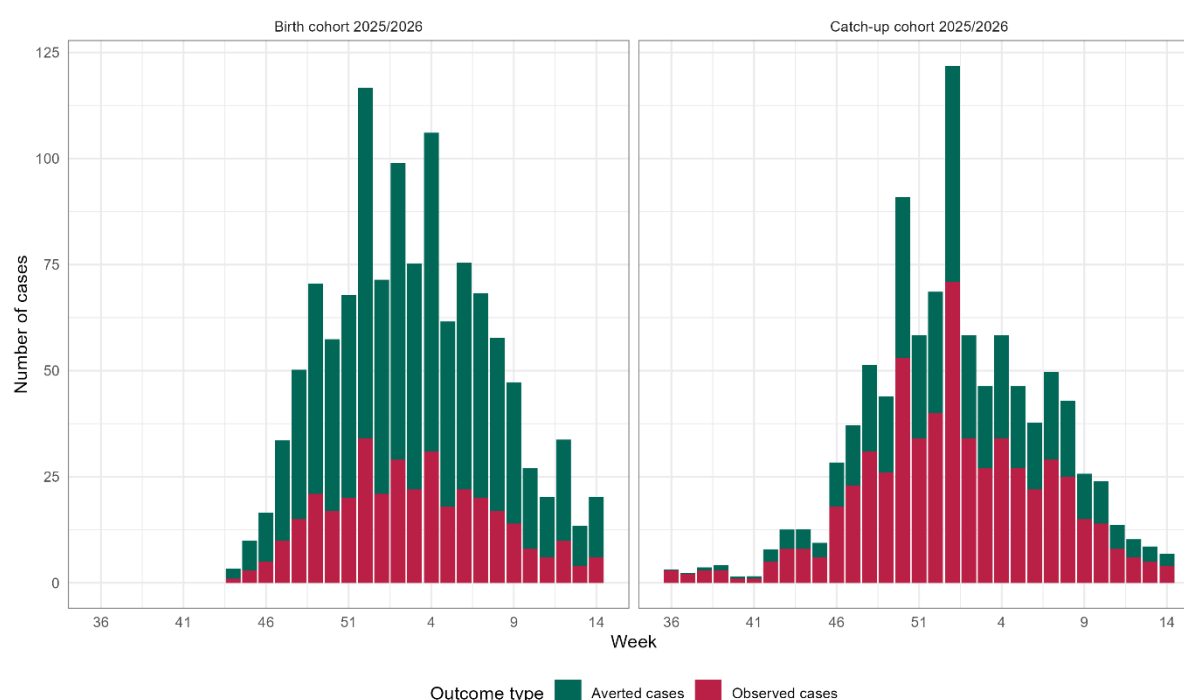


Figure 6.3. Number of observed and averted RSV cases (ED presentations, hospitalisations and ICU admissions), by cohort and week, 2025/2026.

Method 2

Based on observed events of RSV seasons 2021/2022–2025/2026 in the two cohorts and the other age groups, it was estimated that the nirsevimab immunisation programme averted 418 (95% CI: 317-520) ED presentations (non-hospitalised) and 395 (95% CI: 316-474) hospitalisations among the birth cohort. Among the catch-up cohort, it was estimated that the programme averted 149 (95% CI: 64-235) ED presentations and 99 (95% CI: 43-154) hospitalisations (non-ICU). It was not possible to estimate averted ICU admissions due to low numbers.

In **Figure 6.4**, the difference between the curves visualises the effect of nirsevimab on the number of ED presentations, hospitalisations and ICU admissions. We estimated a 70% reduction in the incidence rate for the birth cohort and a 29% reduction for the catch-up cohort, for combined ED presentations, hospitalisations and ICU admissions.

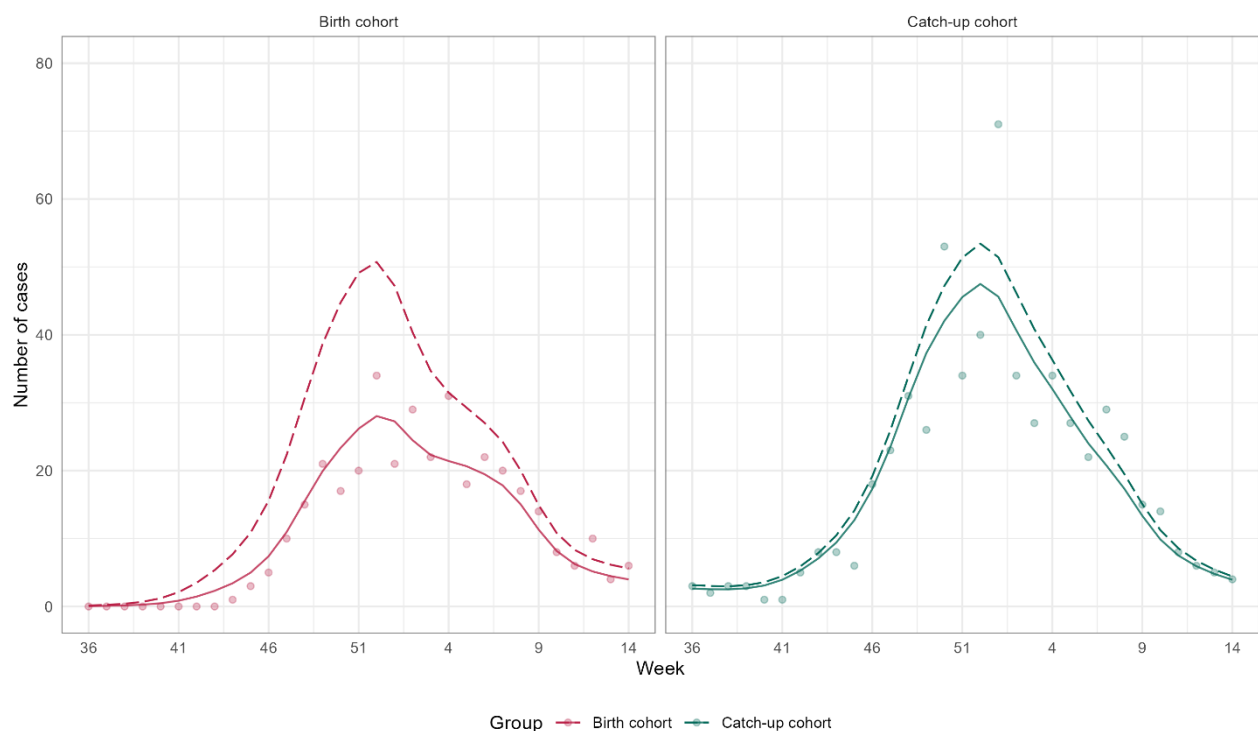


Figure 6.4. Observed weekly RSV cases (ED presentations, hospitalisations and ICU admissions) and model predicted values for the birth and Catch-up cohort for the 2025/2026 winter. The points reflect the observed counts; the dashed line reflects the predicted values if there had been no RSV immunisation programme; the solid line reflects the predicted values for the immunised cohorts.

7. Qualitative Evaluation



Online Surveys

Survey responses were collated and analysed following programme delivery. A total of 3,189 valid survey responses were returned across the three surveys; parents whose children were immunised returned 3,076 survey responses; parents whose children were not immunised returned 14 responses*; service providers returned 99 responses. Blank responses were excluded from the analysis and therefore the total number of responses presented in each figure may vary slightly. Surveys were analysed independently and findings were then collated together according to the following themes:

- Respondent Demographics
- Knowledge and Awareness
- Information and Communications
- Programme Service Delivery
- Experience of the Programme
- Challenges to RSV Immunisation

Focus Group Interviews

A total of 10 expressions of interest to participate in a focus group interview were received from parents whose infants were immunised; 4 expressions were received from service providers; no expressions of interest to participate in focus groups were received from parents of children who were not immunised. Four parents responded to the formal focus group invitation and three attended the focus group interview. Three providers responded to the formal invitation and three attended for interview.

One HSE region, as part of extensive efforts to receive feedback from the parents whose children were not immunised, undertook additional informal feedback with small groups of parents within the Roma community. This informal feedback is presented within the “Challenges to RSV Immunisation” section, where these results were felt to be most relevant. Verbatim quotes, where relevant, are presented to support other sections.

Stakeholder Feedback

Stakeholder feedback was sought from various groups who were involved in the pathfinder programme, as described in the methods sections above. Informal semi-structured interviews were held with the following groups:

- Directors of Midwifery
- Regional Directors of Public Health
- General Practitioners and Practice Nurses
- Communications Team
- Programme Operations Directors
- HSE Technology and Transformation and Swiftqueue Teams
- RSV Pathfinder Steering Committee
- Maternity Hospital Pharmacists

Specific quotes have been highlighted and are presented, at times, across various results sections where that quote was deemed to provide additional impact to the data presented. In these instances, additional text is provided to describe the source of the statement.

Interpretation of Results

Survey and focus group responses are presented together by the following themes:

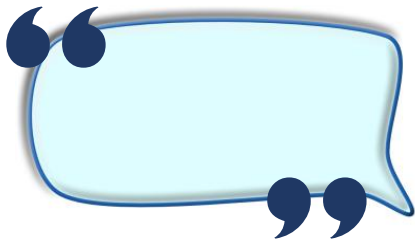
1. Knowledge and Awareness
2. Information and Communication
3. Programme Experience
4. Challenges and Barriers

Survey responses are presented graphically. Where it was considered appropriate to group several 5-level Likert responses by theme, these are presented as diverging stacked bar charts with the “neutral” response collapsed to allow for positive/negative divergence. This was considered appropriate as the neutral response was less likely to influence or inform future decision-making and explains why total visual percentages may not always add to 100%. The response options to individual questions in many cases were different (as appropriate to the specific question being asked), however the theme of “very positive” to “very negative” was consistent across all questions. The below key (**Figure 7.1**) indicates how to interpret responses across all of these graphs.

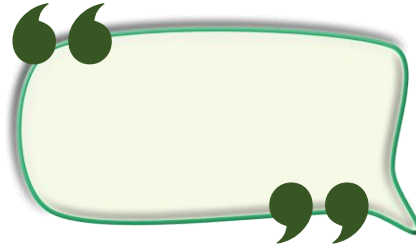


Figure 7.1. Survey Response Interpretation Key. Responses to surveys are presented as diverging stacked bar charts with the neutral response collapsed to allow for positive/negative divergence. Responses vary across questions, however, all responses in red indicate the most negative response to the question and those in dark blue indicate the most positive response.

High level focus group findings are presented thematically alongside survey results, including testimonies that have been selected as supportive of the findings presented. For further reference, in-depth focus group interview analyses are detailed in [Appendix F](#) and [Appendix G](#). For interpretation of the focus group interview statements and testimonials, **Figure 7.3** illustrates the key to determine their source:



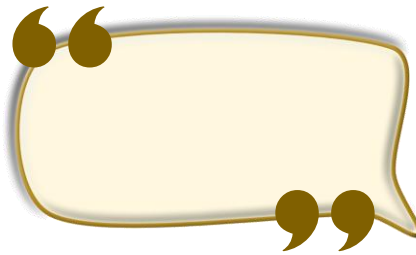
Parents who attended community clinics



Service providers of community clinics



**Parents whose children were eligible for
nirsevimab but did not attend community
clinics**



Programme stakeholders

Figure 7.2. Focus Group Statement and Testimonial Key. Supportive testimonies were selected and are presented alongside thematic statements within the text. The source of the statement can be identified by using the colour scheme.

Respondent Demographics



Respondent demographics across the two parental surveys are presented in **Table 7.1**, below, to include age group, whether the (un)immunised child was the parent's first baby, respondents' first language, ethnicity, and resident county. First language is presented condensed into "English", "Irish", "other European", and "non-European".

Table 7.1. Demographic Characteristics of Parents who Provided Survey Responses.

Parents of Children who were Immunised			Parents of Children who were not Immunised			
<i>Catch-up Cohort (n = 3,076)</i>			<i>Catch-up Cohort (n = 7)</i>		<i>Maternity Hospital Cohort (n = 7)</i>	
Characteristic	Number ¹	% ²	Number ¹	% ²	Number ¹	% ²
Age Group						
17 – 29	337	12.1	2	29	1	14.3
30 – 39	2112	75.7	5	71	3	42.9
40 +	341	12.2	0	0	2	29
First Baby						
Yes	1366	49.2	2	29	3	42.9
No	1440	51.8	5	71	3	42.9
First Language						
English	2382	84.9	3	42.9	5	71
Irish	64	2.3	0	0	0	0
Other European ³	213	7.6	1	14.3	0	0
Non-European ⁴	146	5.2	0	0	0	0
Unknown	0	0	3	42.9	2	29
Ethnicity						
White						
White Irish	2223	80	5	71	3	42.9
White Irish Traveller	2	< 0.1	0	0	0	0
White Roma	7	0.3	2	29	0	0
Any other white background	204	7.3	0	0	2	29
Black						
Black Irish	7	0.3	0	0	0	0
Black African	26	0.9	0	0	0	0
Any other black background	4	0.1	0	0	0	0
Asian						
Asian Irish	18	0.6	0	0	0	0
Asian Indian	136	4.9	0	0	0	0
Chinese	11	0.4	0	0	0	0
Any other Asian background	0	0	0	0	0	0
Other, including mixed background						
Arab	13	0.5	0	0	0	0
Mixed group/background	39	1.4	0	0	0	0

Other group/background	68	2.4	0	0	0	0
Prefer not to say	24	0.9	0	0	1	14.3

¹ total values are based only on valid responses;

² where total percentage does not add to 100%, unknown or missing values are either not shown or have been excluded in the calculation

³ in descending frequency: Portuguese, Spanish, French, Italian, German, Croatian, Polish, Ukrainian, Romanian, Dutch, Lithuanian, Danish, Hungarian, Bulgarian, Czech, Finnish, Irish Sign Language, Latvian, Luxembourgish, Swedish, Welsh. Language may not be representative of county of origin, particularly for Portuguese, Spanish, French (see **Figure 7.3**);

⁴ in descending frequency: Indian, Filipino, Urdu, Arabic, Chinese, Brazilian, Russian, Bengali, Persian, Vietnamese, Afrikaans, Bangla, Hebrew, Igbo, Indonesia, Korean, Kurdish, Mende, Mongolian, Ndebele, Nepalese, Pashto, Somali, Tanzanian, Tigrinya, Turkish.

English was the most commonly reported first language among parents whose children were immunised. **Figure 7.3** shows those languages reported as first language other than English. Some language returns have been condensed to facilitate reasonable interpretation, for example, various dialects of the Indian and Chinese languages are reported as “Indian” and “Chinese”, respectively, as this was thought to be more informative at a high level.



Figure 7.3. Reported first language among parents attending immunisation clinics whose first language was not English.

Parents of Unimmunised Children

Parents of those children who were eligible to receive the RSV immunisation, but who were not immunised, had a low response rate to the surveys and none returned an expression of interest for focus group interview. It was therefore challenging to infer findings from the data that were collected.

Service Providers

All HSE regions were represented among service provider respondents, with 98% identifying as members of the MVTs (**Table 7.2**).

Table 7.2. Demographic Characteristics of Service Providers who Returned Survey Responses.

Service Providers (<i>n</i> = 99)		
Characteristic	Number	%
HSE Region		
HSE Dublin and North East	18	18.2
HSE Dublin and Midlands	5	5.1
HSE Dublin and South East	21	21.2
HSE South West	23	23.2
HSE Mid West	18	18.2
HSE West and North West	13	13.1
National Level	1	1
Professional Role		
Mobile Vaccinator	97	98
Administration	1	1
Paediatric Hospital Staff	1	1

Service Provider Capacity

Service provider capacity to deliver the catch-up, including mop-up, programme was generally sustained across the 10 weeks of service delivery (**Figure 7.4**), however, there was a small but noticeable drop off in the number of service providers available for the final weeks of the mop-up period.

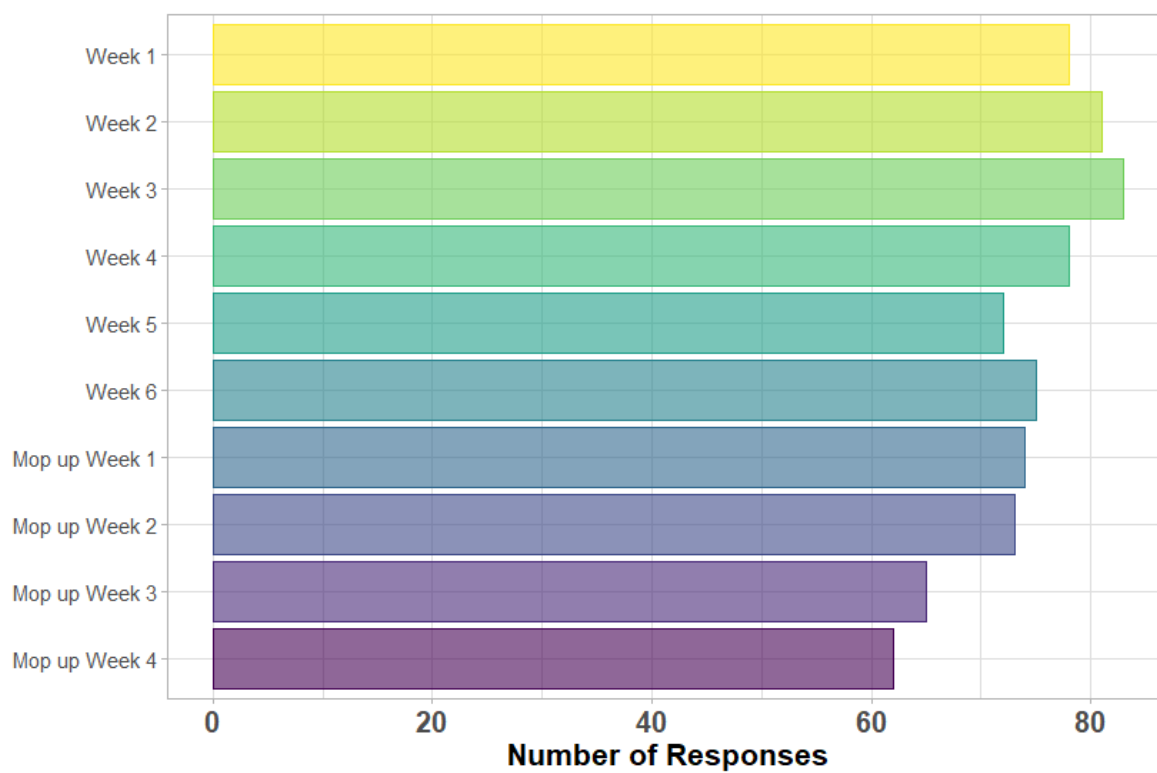


Figure 7.4. Number of Service Providers by Week of Catch-up Programme.

Knowledge and Awareness



Parents who attended the community clinics for RSV immunisation reported, overall, a high level of awareness of RSV as a childhood illness and perceived the disease to be either “Very” or “Extremely” serious (**Figure 7.5**). Respondents also indicated that information received prior to, and on the day of, immunisation was adequate, rated information clarity highly, and perceived themselves to be well informed with respect to making a decision on whether to proceed with immunisation for their child.

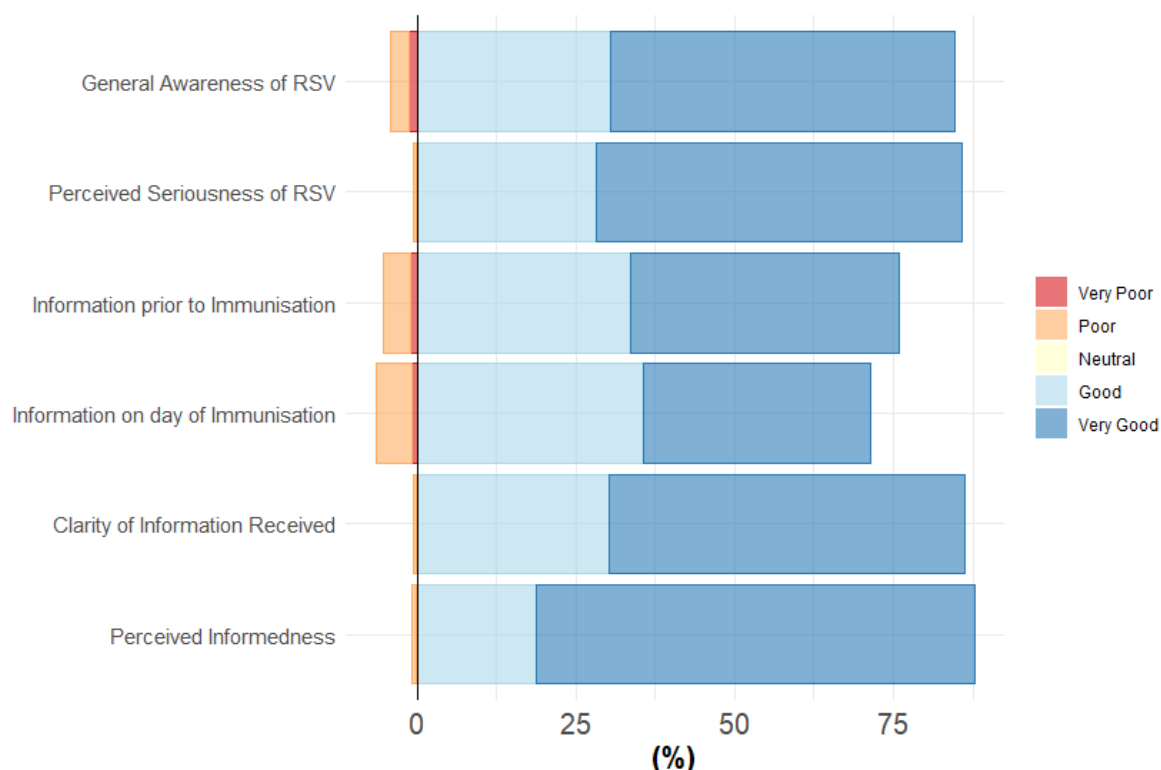


Figure 7.5. Self-assessed Knowledge and Awareness of RSV among Parents whose Children were Immunised.

Parents who did not attend for immunisation also reported a high level of awareness of RSV as a childhood illness and generally perceived the seriousness of the disease to be high (**Figure 7.6**). Awareness, however, of the immunisation programme was lower with 43% and 29% indicating that they were aware of the Catch-up and Maternity immunisation programmes, respectively. This cohort of parents also reported not receiving enough information on RSV immunisation, not having enough time, and overall, not being well enough informed to make a decision on whether to attend for the immunisation.

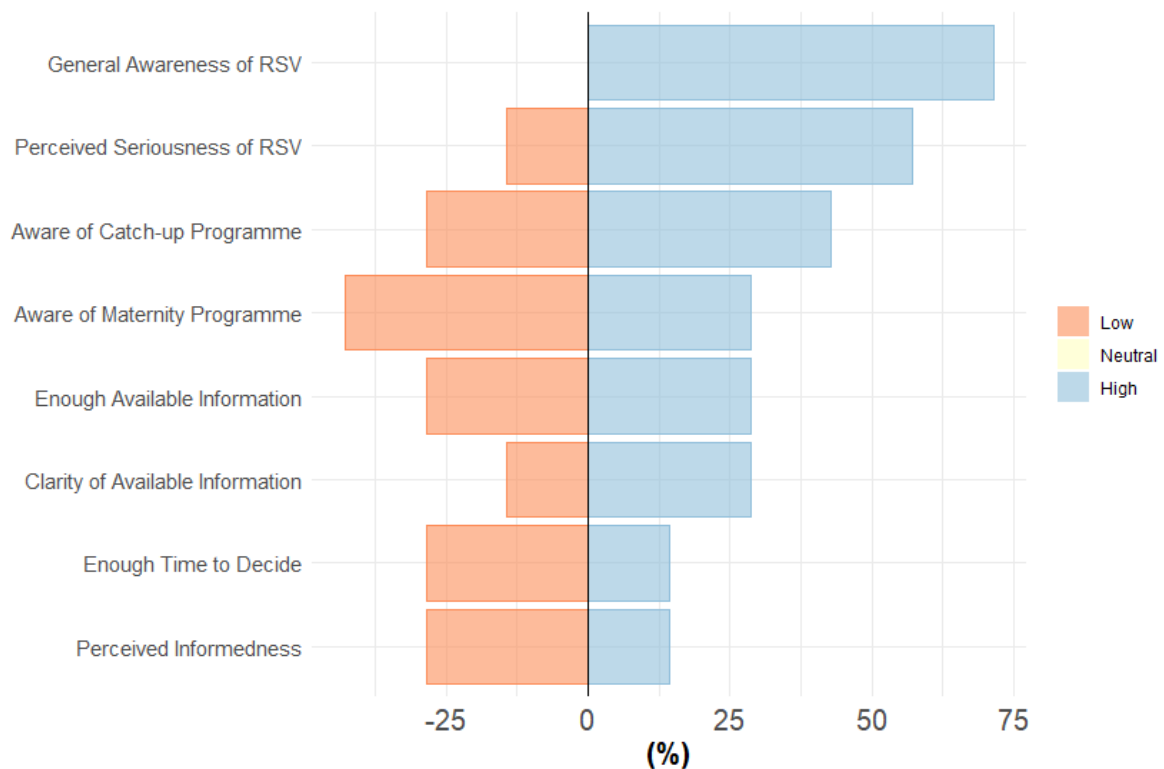


Figure 7.6. Self-assessed Knowledge and Awareness of RSV among parents whose children were not Immunised but were eligible for Immunisation in the Catch-up Programme.

The majority of parents who attended the clinics indicated that they were motivated to attend either on the advice of a healthcare worker (who, in some cases, were family friends or relatives) or because of perceived seriousness of RSV disease for their child (**Figure 7.7**). 10% of respondents indicated that they had an older child who had had RSV previously and some commented that a friend had had that experience.



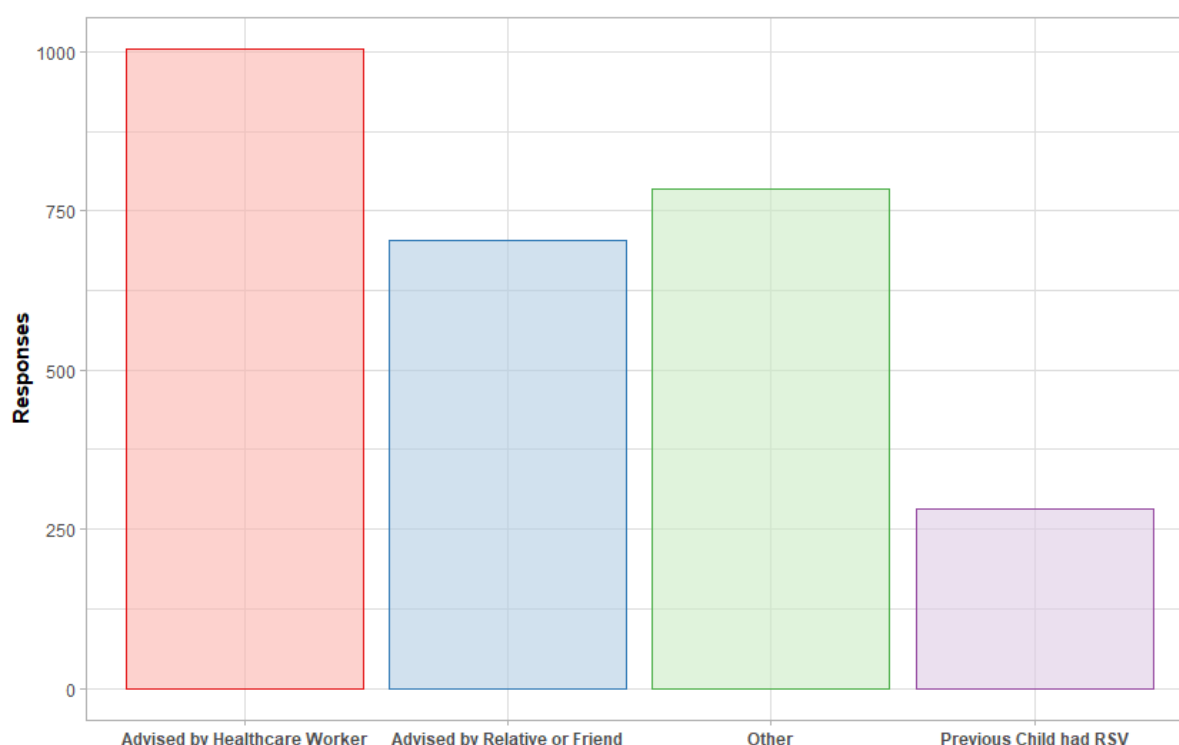


Figure 7.7. Parental motivation to attend for Immunisation.

Other motivations reported in surveys and expressed during focus group interviews included knowing someone who's child had RSV previously, the respondent themselves being employed as a healthcare worker, and awareness of the dangers of RSV infection.

Social media and 'Friends/Family' were reported as the main sources of awareness on the Catch-up programme for parents who attended the clinics (**Figure 7.8**). It was not clear whether social media sources were part of the targeted HSE communications social media campaign or from other social media sources or influencers, or indeed a combination of these. Several anecdotal reports from parents and service providers suggested that medical doctors with a significant social media presence were important in positively influencing parents to attend for RSV immunisation. Other healthcare resources, such as General Practitioners (GPs), Public Health Nurses (PHNs), and HSE website materials ranked were also popular sources of information for parents.

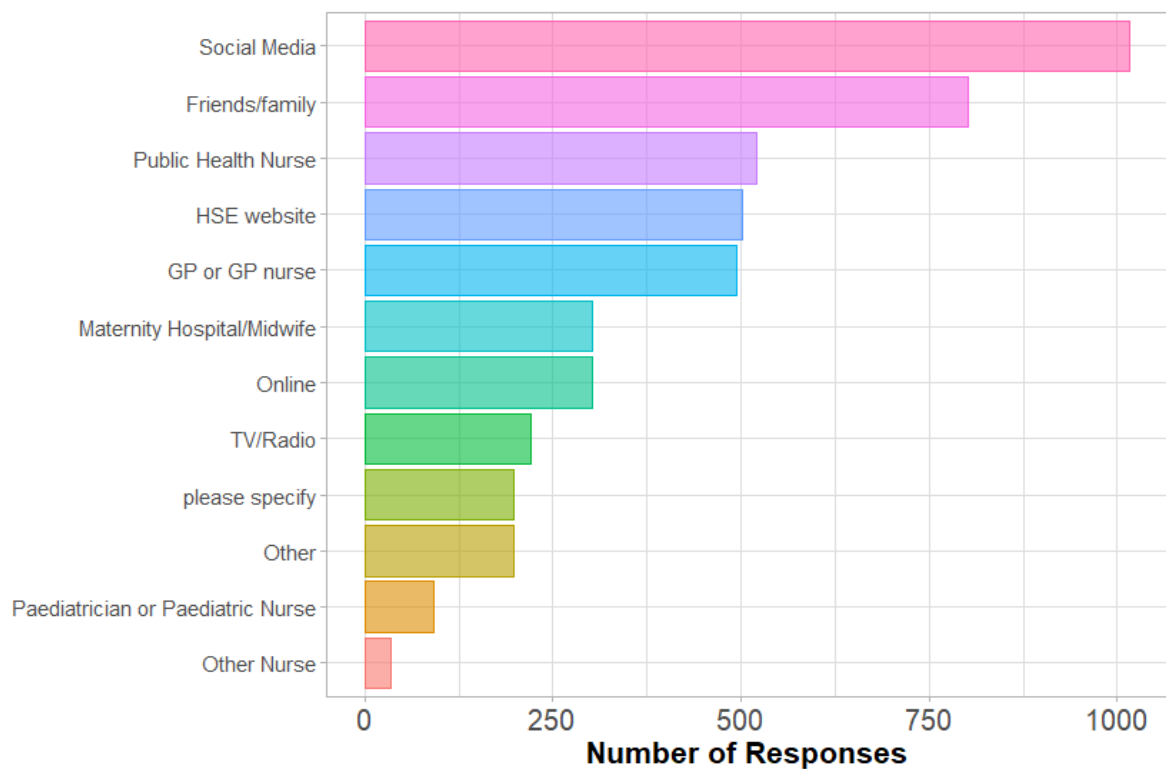


Figure 7.8. Major source(s) of awareness about the RSV Immunisation Catch-up Programme among parents whose children were immunised.

I didn't notice any HSE campaign about it. For me, it was non-HSE sources that I would have seen it on Instagram, two doctors in particular...

It was hard to find out information about when it was going to be run out initially... there was no further information... I rang my GP and they knew nothing about it and it was really unclear as to where you were going to access it in the community

Parents who did not attend the clinics, but who were aware of the Catch-up programme, reported social media, HSE leaflet, and GP/GP nurse as top sources of information (**Figure 7.9**), although, as previously described, it was challenging (as with all results from this group) to infer findings or inform recommendations, given the low response rate.

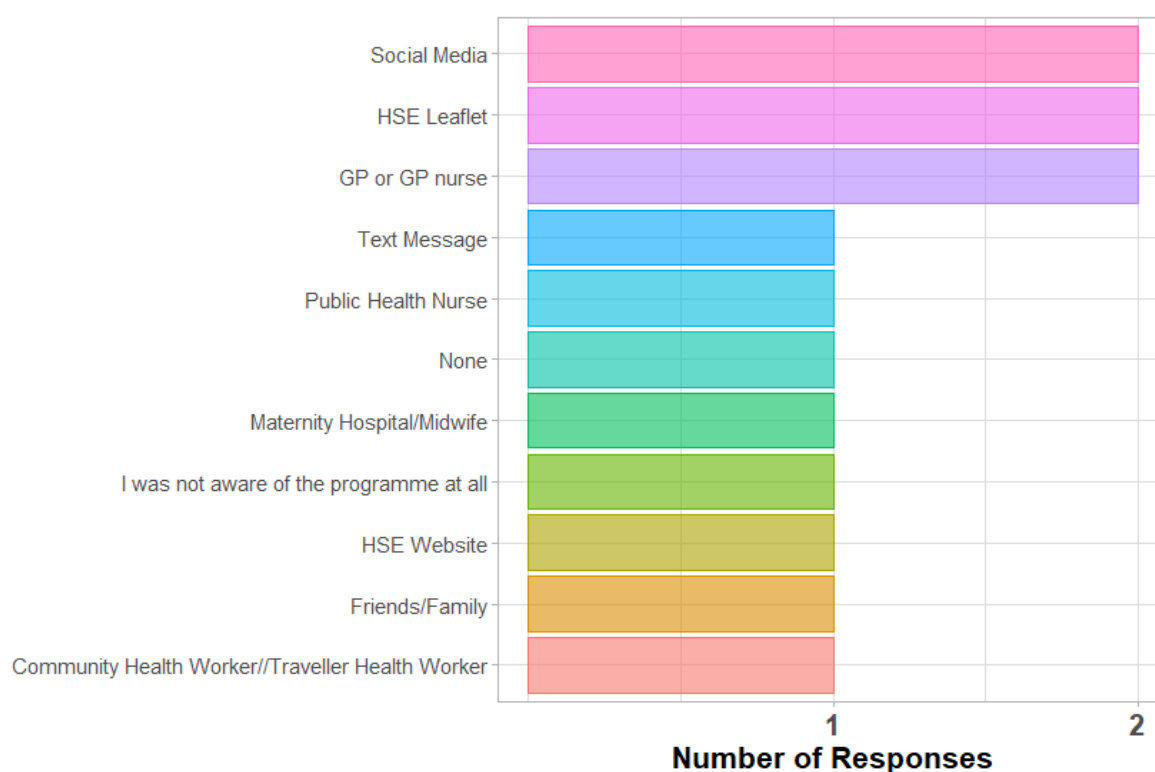


Figure 7.9. Source(s) of information about the RSV Immunisation Catch-up Programme among parents whose children were not immunised.

Information and Communication



National and regional programme communications to service providers were reported to be either “Good” or “Very Good” by the majority of respondents. Service provider perspectives on programme communications to parents whose children were eligible for RSV immunisation was, however, deemed to “Poor” by the majority of respondents (**Figure 7.10**). Quality of communications to parents was deemed by 42% of providers to be “Good” or “Excellent” However, service providers deemed the majority of elements of the communication strategy to parents to be “Poor” or “Very Poor”, including the quantity, frequency, accessibility, reach, visibility, and methods of communication employed. This was also fed back in the provider focus group where it was suggested that targeting a wider audience might have improved uptake, considering the perceived importance of family members on parents’ decision-making processes (and who themselves might not have been in the target demographic for the communications campaign). It must be acknowledged that service users were not the target audience for the programme communications campaign and therefore may not have had visibility of the campaign. Nonetheless, service provider opinions on the communications campaign were collected in an effort to gather “on the ground” intel from valuable interactions with service users. (**Figure 7.11**).

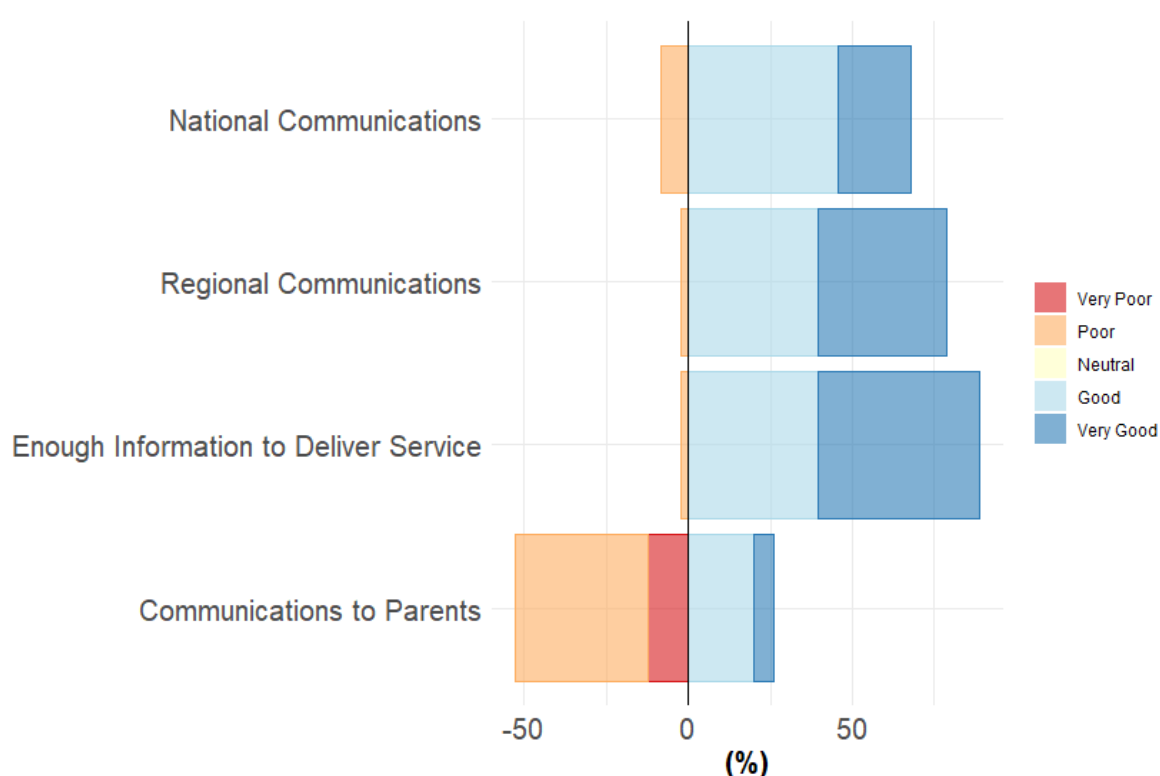


Figure 7.10. Service provider review of overall communications to providers and to parents of eligible children.

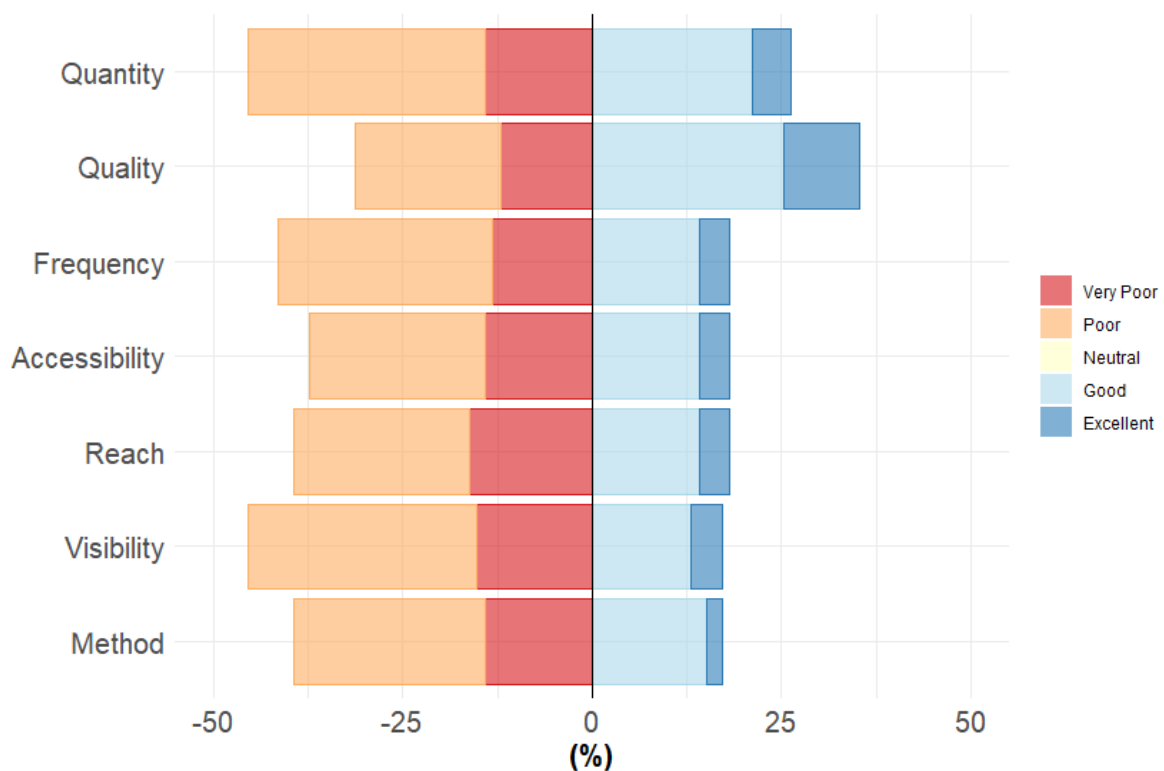


Figure 7.11 Service provider review of specific elements of communications to parents of eligible children.

Service providers also noted the absence of a dedicated helpline to assist with parents who were trying to arrange catch-up clinic appointments, which they felt should be considered in future programmes. Overall, the group emphasized the importance of effective communication channels, such as those described below and illustrated in **Figure 7.12**.



SMS text messages were reported to be the most effective method of communication to parents, with 63% of providers reporting these to be “Moderately Effective” or “Highly Effective”. Parents also reported the value of text messages and appreciated receiving these. Challenges, however, included incomplete contact information databases making it difficult for

providers to know which parents had already attended the clinics and therefore would not require a text message reminder.

Medical social media influencers, non-HSE social media, and health professional communication were also deemed to be a highly effective methods of communication to parents by service providers. In particular, medical social media influencers were raised as an important motivating factor for parents who decided to attend for immunisation. Service providers deemed national and regional radio and press releases to be the most ineffective methods of communication to parents (**Figure 7.12**).

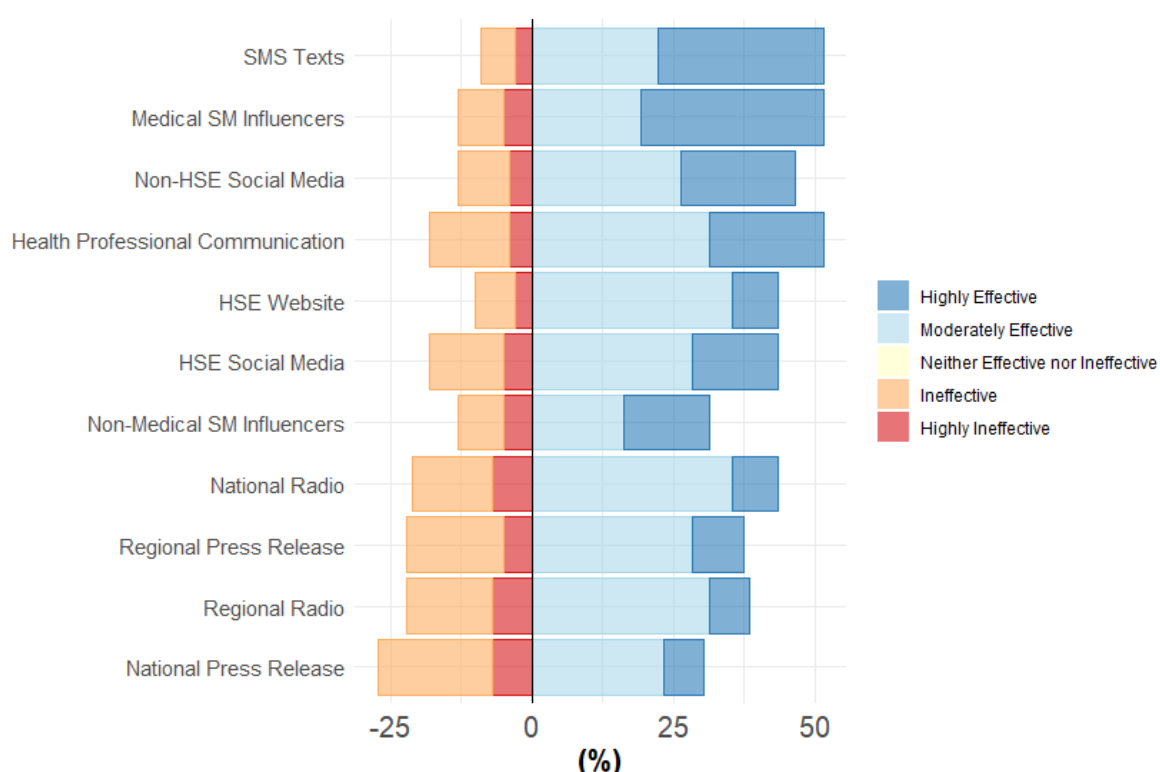
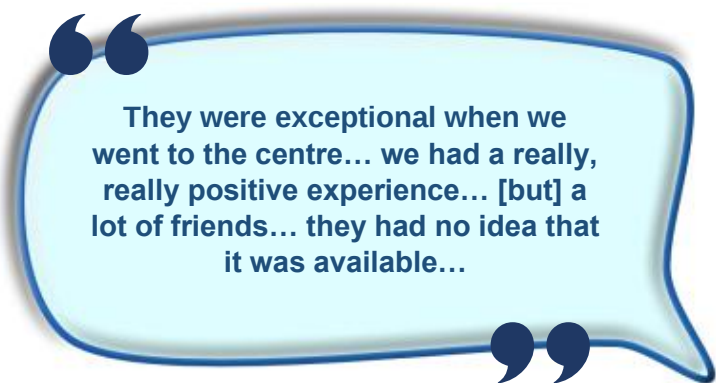


Figure 7.12. Service provider reported effectiveness of communications methods employed throughout the Catch-up Programme.

Parents and providers who attended focus group interviews suggested that earlier and repeated communication would be important for future programmes, targeting women during the antenatal time when it may be easier to digest the information and give people time to consider. Nearly all groups interviewed as part of the evaluation highlighted issues with delayed or fragmented communication, including delayed communication from national structures to the regional and local teams responsible for implementation of the catch-up programme for the first time. Maternity sites also reported delayed communications and patient information resources, resulting in insufficient early information for parents.

Some parents reported receiving text message reminders from their GP, which they considered highly valuable as information from a trusted source. GPs were highlighted multiple times by parents who attended for immunisation as their source of health information. They noted that their GPs appeared to be largely uninformed of the programme this year. Parents expressed a desire that GPs would be better informed or more involved in the future as they trust their GP and interviewees believed this would increase uptake among parents who did not attend for immunisation. Insufficient advance engagement with GPs, practice nurses and public health nurses as trusted healthcare providers during the antenatal and postnatal period, was also highlighted particularly by operational groups who implemented the catch-up programme, including the Regional Directors of Public Health, the Operational Leads, and HSE Communications. Primary care participants in the evaluation (general practitioners and practice nurses) who were not involved in delivery of the 2025/2026 programme had mixed views on the level of engagement from the HSE. Some reported the communications and level of engagement was sufficient as GPs were not responsible for implementation. However, others reported minimal awareness of the HSE communications in advance of the programme and as a result the opportunity to promote the immunisation to patients was missed.



They were exceptional when we went to the centre... we had a really, really positive experience... [but] a lot of friends... they had no idea that it was available...

Programme Experience



MVT Preparedness to Deliver Service

Service providers of the catch-up programme reported a high level of preparedness to deliver the programme with all respondents indicating that they were either “Quite prepared” or “Very prepared”. 16.2% of respondents indicated that they had “Not enough” or “Far too little” time to deliver the service (**Figure 7.13**).

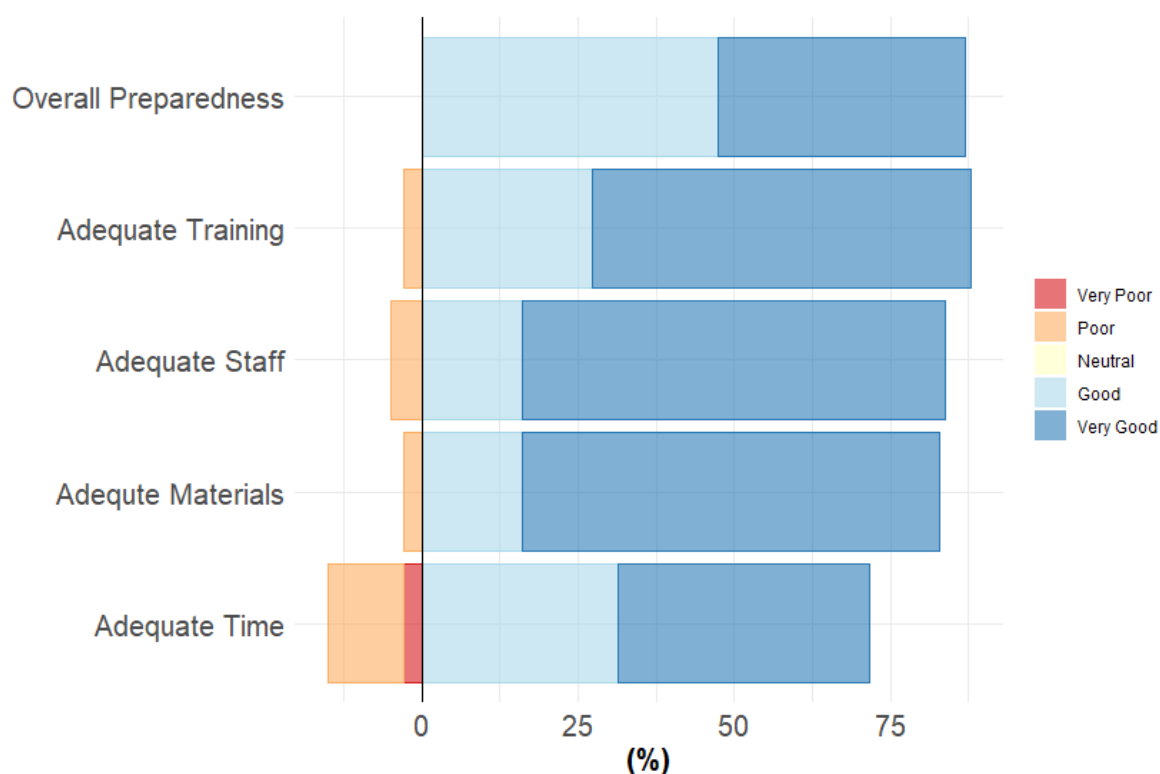


Figure 7.13. Mobile Vaccination Team preparedness to deliver the programme.

Parental Experience of the Catch-up Programme

Parents who attended the catch-up programme clinics reported an overwhelmingly positive experience with 96% of respondents indicating their experience was “Very Good” and only 0.1% of respondents reporting a negative experience. The majority of community vaccination clinic parameters and logistics were also scored positively with 98% of respondents reporting that they were either attended to “immediately” or seen in “less than 15 minutes. The booking system was also generally rated highly with 96% of parents describing the booking system as either “Easy” or “Very Easy” to use for arranging an appointment. Overall, 94% of parents said they would “Definitely” recommend the RSV immunisation programme to other parents (**Figure 7.14**).

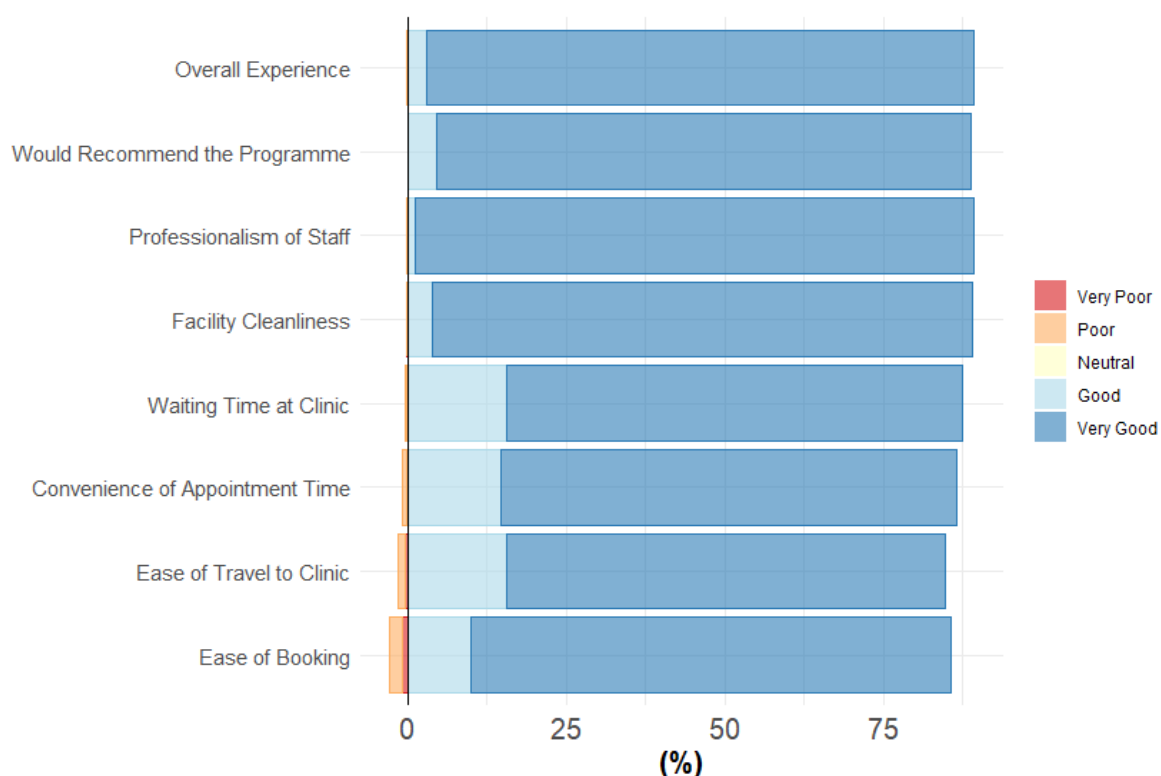
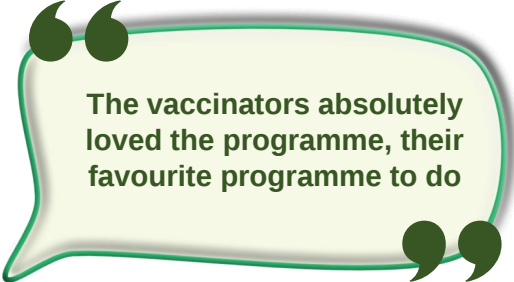


Figure 7.14. Parental experience of Catch-up Programme clinics.

Parents attending focus group interviews expressed overall positive feedback about the catch-up programme, in particular praising the efficiency and kindness of the MVT staff. However, despite the overwhelmingly positive feedback on the booking system, some parents attending the focus groups described confusion when trying to arrange an appointment and having to travel a significant distance to an available community clinic, as it was unclear at the time of booking whether their local clinic was offering appointments or not.

Stakeholders expressed overall positive reflections on the programme with some commending the 52% uptake within the catch-up cohort given the community programme was in its first year of operation. GPs who were interviewed expressed unanimously that the programme was beneficial to patients and would support the provision of RSV immunisation in general practice in the future.



The vaccinators absolutely loved the programme, their favourite programme to do



This winter, I can't recall seeing a young baby with RSV

GP, 30th April 2026

Future Service Delivery

Programme Sustainability

Resource, staffing, and funding constraints

Many stakeholder groups described the programme as relying on existing staff, goodwill, or reallocated budgets, which raised concerns about sustainability. This was particularly prominent in feedback from Regional Directors, DsOM, Operational Leads, and HSE Technology and Transformation. There was repeated emphasis on the need for dedicated funding, funded year-round roles rather than seasonal roles, and clearer budget planning.

Sustaining staff engagement and demonstrating impact

A number of groups, particularly Operational Leads and DsOM, highlighted the importance of maintaining staff engagement by sharing clinical impact, success stories, and visible benefits of the programme. This was seen as important for morale, sustainability, and ongoing buy-in.

Need to embed RSV into broader routine immunisation and prevention messaging

A recurring suggestion across the stakeholder groups was that RSV should not be treated as a one-off or separate initiative, but rather integrated into wider antenatal, infant immunisation, and winter vaccination messaging. Stakeholders viewed this as an important approach for both programme sustainability and public understanding.

Future Service Delivery Location Preference

When asked about where parents would like to see this service delivered in the future:

- 56% advised they would like to continue with the current model of delivery via community clinics,
- 26% stated a preference for delivery in GP practices, and
- 14% indicated they would like to receive the immunisation from the public health nurse.

Very few respondents (3.9%) indicated a preference for hospital-based delivery (**Figure 7.15**).

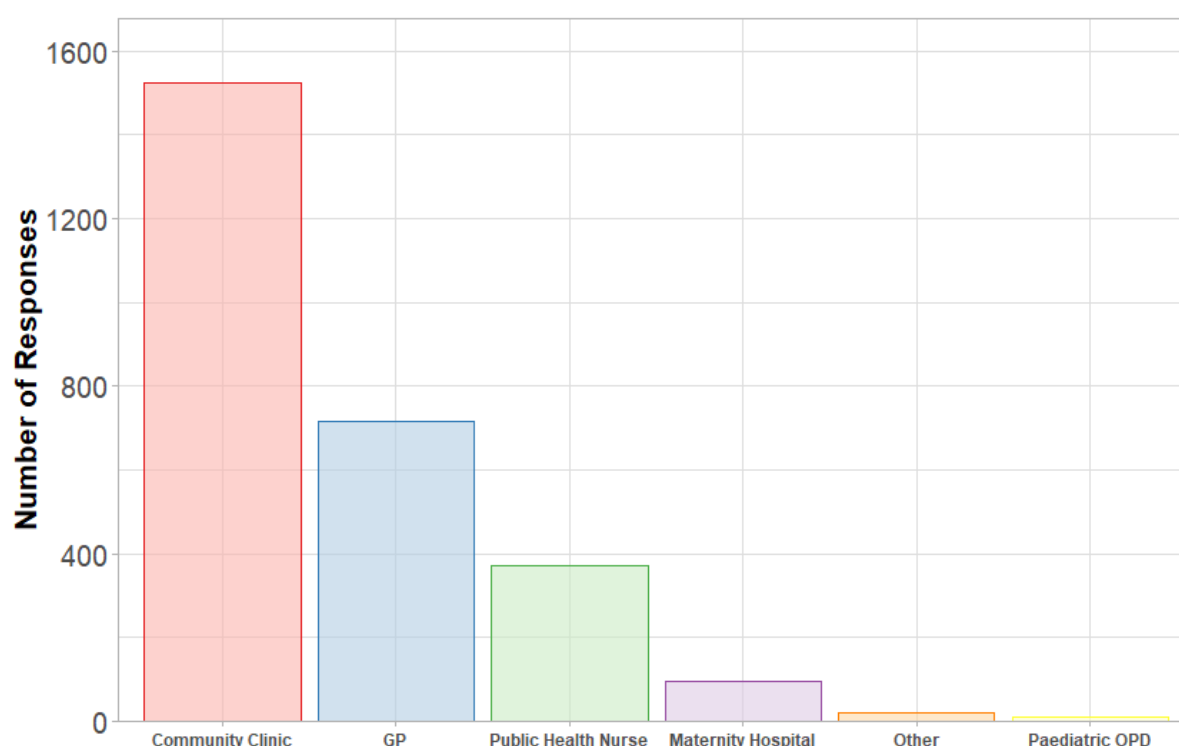


Figure 7.15 Preferred future delivery location reported by parents attending immunisation clinics.

Parents attending the focus group interviews indicated that GP practices would likely be the optimum delivery model, leveraging the opportunity for concurrent delivery of childhood winter vaccines and immunisations alongside the primary childhood immunisation programme that is currently delivered by GPs, potentially increasing the uptake of the RSV immunisation. Some parents suggested that packaging the RSV immunisation alongside other vaccines and health advice as part of a protective kit for “baby’s first winter” might be a way of engaging with parents to understand the importance of the immunisation over the winter months.

Service providers indicated a strong preference for future delivery in community clinics, with some indicating a preference for a combination of options including community clinics, GP practices, and pharmacies (**Figure 7.16**).

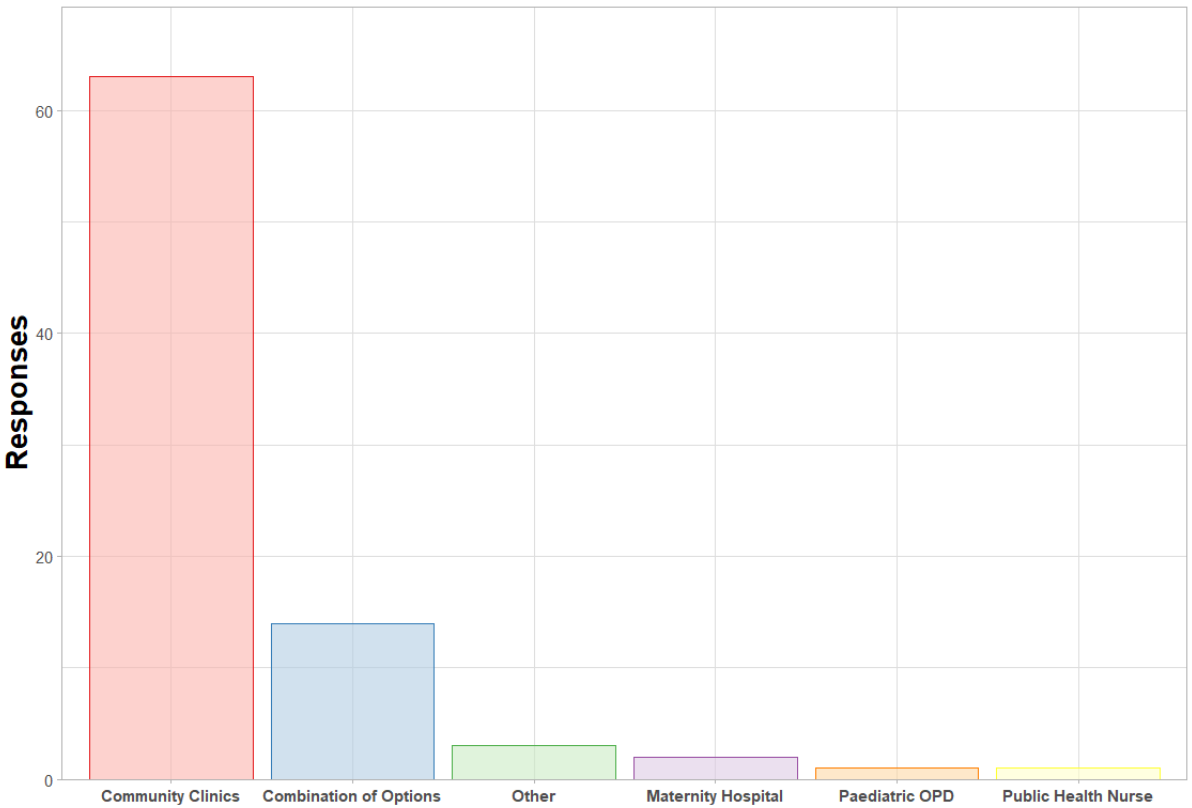


Figure 7.16. Preferred future delivery location reported by service providers of the Catch-up Programme.

Providers attending focus group interviews expressed a high level of satisfaction with their involvement in the catch-up programme and were enthusiastic about participation going forward. Providers generally acknowledged the advantages of shifting the programme's delivery to GP practices. However, they also indicated that MVTs might have a useful future role in the RSV immunisation programme, particularly to deliver a targeted service to underserved populations who might not have equitable GP access. It was noted that MVTs have experience and established relationships with many community groups.

Various stakeholder groups also indicated a preference that RSV immunisation delivery would be provided in primary care and maternity services, as trusted and familiar patient-facing services, rather than as a standalone or separate campaign, thus improving parental confidence and normalising the programme to support increased uptake. Many stakeholders supported a hybrid delivery model, whereby delivery to the catch-up cohort would be primarily through GPs with targeted support from MVTs for specific groups, particularly those with GP access challenges. Stakeholders valued flexibility, particularly for reaching underserved populations and maintaining programme efficiency.

Challenges to RSV Immunisation



Challenges for parents who attended for immunisation

82% of parents who attended for RSV immunisation reported no barriers to attending the community clinics. Of those who did report challenges, the majority of respondents reported “Arranging Childcare”, “Getting time off work”, and “Transport” as the most significant barriers to attending clinics (**Figure 7.17**).

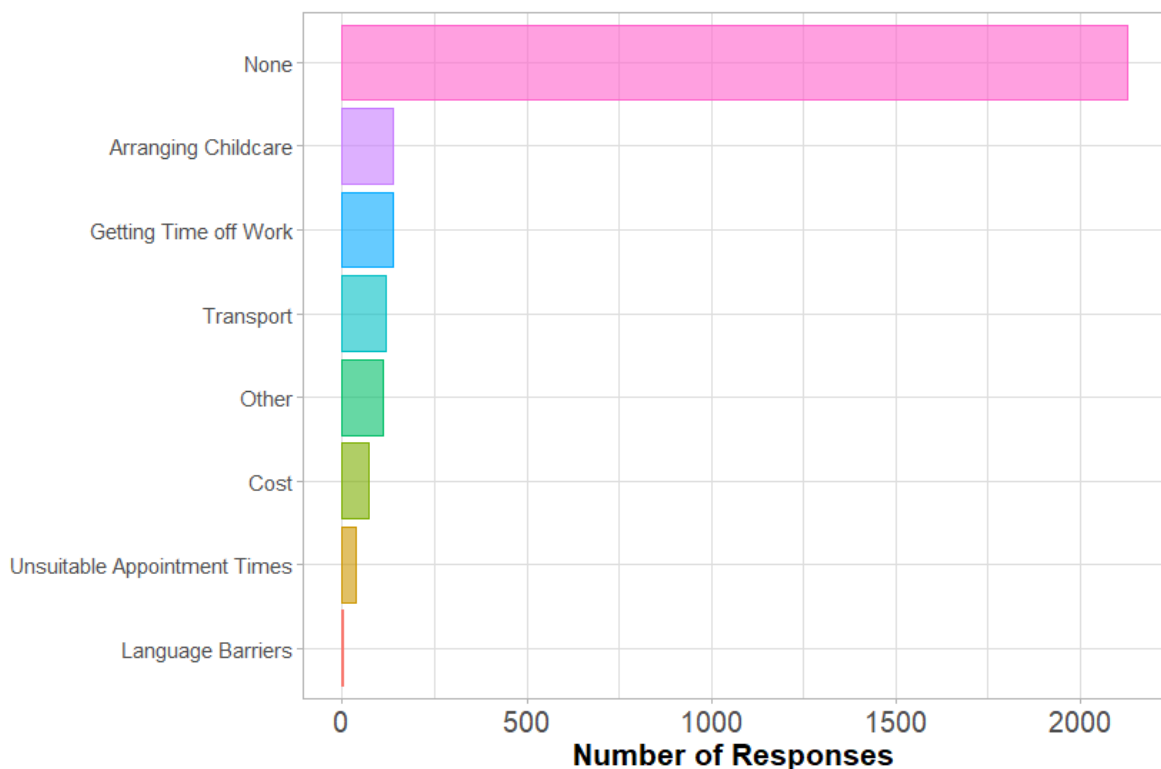


Figure 7.17. Challenges to attending for RSV Immunisation reported by parents who attended catch-up clinics.

Challenges raised by parents who attended the focus group interviews included a lack of clarity and available information on when and where to access RSV immunisation, as mentioned earlier.

Given the low survey response rate from parents whose baby was not immunised, it was harder to ascertain the barriers that may have been experienced by this group. Of those who did respond, most indicated a lack of communication or knowledge of the programme (**Figure 7.18, red**) or expressed a personal view that babies receive too many immunisations or had a safety concern regarding the RSV immunisation in particular (**Figure 7.18, purple**).

Challenges for parents who did not attend for immunisation

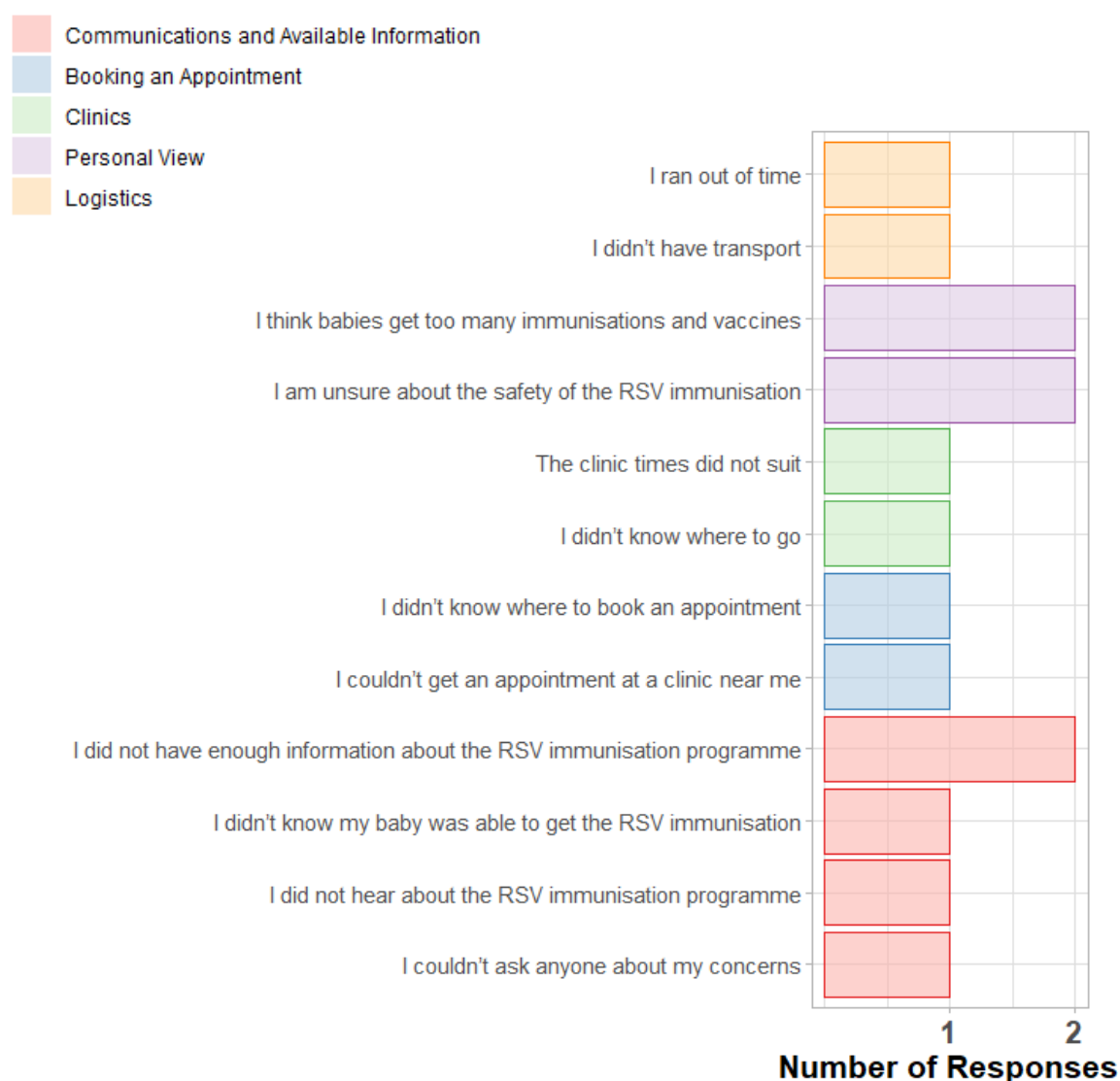


Figure 7.18. Challenges to Attending for RSV Immunisation Reported by those Parents who did not attend Catch-up Clinics.

Informal feedback from one HSE region following discussion with mothers from the Roma community suggested that some mothers (~50%) within this community had attended for immunisation and others had not. Those who attended generally did so on the advice of a family member, often a more senior family member. Those who did not attend quoted information they had seen online in their own language that had suggested the immunisation was not safe. This influenced their decision not to attend. Some mothers who had not attended for immunisation and whose child had subsequently acquired RSV infection, expressed regret at their decision not to avail of the immunisation. Some of these mothers reported that they themselves had then advised other family members to get the immunisation because of their

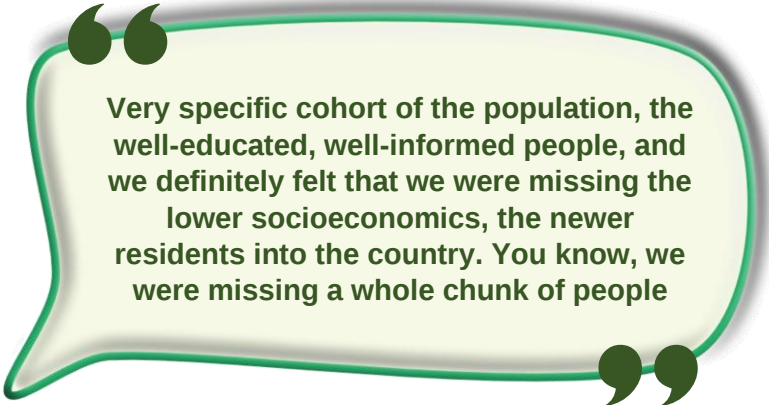
own lived experience of RSV infection. Within one local community, all women expressed a desire to be informed of options for receiving RSV immunisation. Full details of this informal feedback are available in [Appendix H](#).



RSV immunisation uptake within this group is shaped less by opposition to healthcare and more by information gaps, misinformation, and reliance on trusted family sources

Roma Health Worker, 9th April 2026

Interviewees across a number of stakeholder groups noted that uptake was initially higher among well-informed families and healthcare workers, while underserved or “harder-to-reach” groups were less likely to access the programme. Stakeholders repeatedly called for targeted strategies for underserved populations, flexible delivery models, and outreach approaches that would improve equitable access.



Very specific cohort of the population, the well-educated, well-informed people, and we definitely felt that we were missing the lower socioeconomics, the newer residents into the country. You know, we were missing a whole chunk of people

Operational Challenges

Regional Directors of Public Health, Operational Leads, HSE Communications, HSE Technology and Transformation/Dedalus (Swiftqueue providers), the HPSC reporting team,

and the Steering Committee reported in stakeholder interviews that the catch-up programme was implemented with insufficient lead-in time. This was also highlighted by the DsOM in relation to the maternity programme. Maternity units had developed knowledge and experience through delivery of the initial RSV Pathfinder 1.0 Programme, and had anticipated its continuation, but they emphasised the importance of timely notification to ensure that expectant mothers of all eligible infants could be informed during the antenatal period and made aware in advance of both the maternity and catch-up programmes.

In relation to delivery of the catch-up programme, operational leads and HSE Technology and Transformation and Dedalus all highlighted challenges with administrative burden, fragmented systems, data management, booking systems, and lack of integration. There was strong support for more streamlined digital systems, integrated records, and clearer reporting and data governance arrangements. This point was reiterated by maternity programme stakeholders, particularly by DsOM in the medium-sized and smaller maternity units that are still paper-based.

Additional detailed feedback from the focus groups conducted with other stakeholders, including Regional Directors of Public Health, Operational Leads, HSE Communications, HSE Technology and Transformation/Dedalus (Swiftqueue providers), the HPSC reporting team, and the Steering Committee is available in [Appendix G](#).

8. Discussion



The RSV Immunisation Pathfinder 2.0 Programme built on the success of the Pathfinder 1.0 Programme delivered during the 2024/2025 RSV season. This programme evaluation demonstrates that the programme was effective, acceptable, and operationally feasible, achieving substantial uptake and delivering high-quality service experiences. The expansion from Pathfinder 1.0 to include a catch-up cohort enabled broader population coverage and provided valuable insights into the health system's ability to deliver a nation-wide immunisation programme when given a very short lead-in time. However, while the programme achieved its core objectives within a compressed timeframe, important system-level challenges were identified across implementation, communication, equity, and sustainability domains. These findings are critical in informing Pathfinder 3.0 and the transition from a pathfinder model to a sustainable national RSV immunisation programme.

RSV Pathfinder 2.0 was a highly effective and impactful programme as indicated by the impact on RSV disease outcomes in the affected population. By achieving immunisation uptake of 88% and 52% across birth and catch-up cohorts respectively, significant reductions in ED presentations, hospitalisations and ICU admissions were seen in both cohorts. During winter 2025/2026, estimated reductions in RSV-related ED presentations, hospitalisations, and ICU admissions ranged from 70% to 71% for the birth cohort and from 29% to 40% for the catch-up cohort, across modelling approaches. It was estimated that infant immunisation in both groups averted over 1,000 ED, hospitalised and ICU cases, therefore significantly reducing RSV-related infant morbidity in Ireland.

High parental satisfaction, reflected in willingness to recommend the programme and positive feedback on clinic experiences, supports the acceptability and perceived value of RSV immunisation. Parental survey response patterns suggest that early adopters were predominantly well-informed populations, including healthcare workers and those with higher health literacy. Later uptake was driven by increased awareness and the use of individual text messages to parents, suggesting that initial programme reach did not extend equally across all population groups. The community-based MVT clinics contributed significantly to the positive parental experience reported throughout the evaluation, providing accessible locations, with adequate parking reduced barriers for parents attending with young infants.

A consistent finding across surveys, focus groups, and stakeholder feedback was the presence of inequities in programme reach. Engagement with the programme appeared to be higher among more informed, socioeconomically advantaged populations, while service providers reported lower participation among certain cohorts of the population, including migrant populations, non-English speakers, and those with lower health system engagement. Some barriers highlighted by parents whose infants were not immunised included limited

awareness of the programme and insufficient information and time to make an informed decision. These findings emphasise that equity must be central to future programme design, with targeted strategies to address the needs of a variety of populations.

The evaluation identified a high level of awareness of RSV disease and the immunisation programme among parents who attended clinics. Anecdotal evidence from the small number of responses from non-attenders indicated a similar awareness of RSV disease but a lower awareness of the immunisation programme.

The national communications campaign achieved strong reach through digital platforms, including substantial social media engagement, however, the programme communications were limited by the short lead-in time to programme launch. While a 52% immunisation uptake among the catch-up cohort is commendable, it was less than what was hoped. Some stakeholders, including parents suggested that trusted healthcare providers such as GPs and public health nurses were underutilised in promoting the programme, while some of the target population reported limited public visibility of official messaging. Contrary to recognised communications best practice, parents and healthcare providers indicated a preference to receive early communication regarding the RSV Immunisation Programme, even if programme-specifics could not be provided. Consideration should be given to this in future programmes as an alert to the target population of the upcoming programme.

Service providers perceived that the communications to parents was inadequate. However as mentioned previously, it is important to note that service providers were not the target audience for the parental communications campaign, therefore their visibility of the campaign was limited. In contrast to service providers' feedback, parents that attended immunisation clinics reported to be largely well informed, and the communications campaign performance metrics indicated substantial website engagement.

Direct communication with the target population via text messages was found to be highly effective and should be included in any future programmes. Consideration should also be given to the continued use of targeted social media campaigns and expand the use of personal stories. Furthermore, more engagement with other family members should be considered given the high frequency of respondents who indicated that family members were either an important source of awareness of the immunisation programme or were important in their decision to attend for immunisation. These findings suggest that combining digital platform communications, personalised messaging and integrating with primary healthcare providers would be of benefit for future programmes. Additionally, there was broad support from all stakeholder groups for earlier, year-round, multi-channel communication from the HSE to the general public, to ensure awareness amongst parents at the beginning in the antenatal period.

The rapid implementation of Pathfinder 2.0, including the design and delivery of the catch-up programme, represents a significant operational achievement and demonstrated the value of maintaining a skilled regional vaccination workforce capable of responding rapidly to emerging public health priorities. However, this evaluation highlights that catch-up programme delivery occurred under sub-optimal planning conditions, with short lead-in times identified as a major constraint across all stakeholder groups. Whilst some groups were informed of the intention to deliver an RSV Pathfinder Programme for the 2025/2026 season as early as April 2025, the decision to proceed was not finalised until July 2025, when most stakeholders were informed of the need to implement the programme, including incorporating the new catch-up cohort, with a go-live date in late August 2025. This affected operational planning, staffing, communication, training, booking setup, and stakeholder engagement. In addition, the RSV campaign coincided with other priority HSE winter vaccination programmes, including influenza and COVID-19, which utilised the same MVT workforce, resulting in challenges in delivering multiple programmes in parallel. Findings from MVT service providers indicated a small but noticeable drop off in the number of staff available for the final weeks of the Mop-up programme, which may reflect the competing service requirements for delivery of these other winter vaccination programmes. All stakeholders emphasised the need for much earlier programme confirmation with longer lead-in time for future seasons to facilitate optimal delivery.

The timing and duration of the programme also encountered some challenges. The catch-up clinic activity monitoring indicated that clinic demand peaked late in the initial 6-week delivery window. This, along with parental feedback at the time, suggested a mop-up period was warranted. However, interest appeared to wane quickly before the mop-up phase commenced, resulting in reduced engagement during the mop-up phase. This suggests that the timing and structure of the programme were not fully aligned with parental behaviour or seasonal demand. This should be considered in programme planning for future seasons.

For the birth cohort, the current model of delivery through maternity services delivered high immunisation uptake (88%). Feedback from DsOM indicated that the delivery of the programme at maternity unit level was in general reported to be integrated into routine maternity care. Consequently, delivery of RSV immunisation to the birth cohort in maternity units was considered the optimal model of delivery and should continue in future programmes.

In Pathfinder 2.0 the delivery of the catch-up programme at community clinics staffed by existing experienced MVTs was well received by parents, popular with service providers and enabled rapid programme rollout. The MVT model also provided flexibility to support equity-focused delivery, including engagement with social inclusion services and outreach to

underserved populations during the programme. However, there was strong consensus among stakeholders that this approach was not optimal as a stand-alone long-term model. Primary care, particularly general practice, was identified as the preferred setting for future programme delivery to the catch-up cohort. Benefits of this approach include: the established relationships between GPs, practice nurses and parents, convenience and accessibility, and integration with other routine child health services including the primary childhood immunisation programme. MVTs, however, were recognised as a flexible and scalable public health resource with a critical role to play in future programmes, specifically in reaching populations less engaged with primary care, and thus supporting a hybrid delivery model.

While MVT staff expressed high levels of satisfaction in delivering Pathfinder 2.0, any involvement of this workforce in future programmes requires further workforce planning. These teams are excessively reliant on temporary and agency staff and the continued utilisation of this workforce in the RSV Immunisation Programme and other immunisation programmes requires a regularisation of existing posts into a stable, funded workforce to ensure ongoing staff engagement and goodwill.

The time-limited nature of the catch-up programme emerged as a key limitation to Pathfinder 2.0. The catch-up campaign delivery model did not fully align with parental decision-making timelines and the seasonal patterns of RSV transmission. While parents should be advised and encouraged to immunise their babies in the pre-RSV season period, similar to winter vaccines, RSV immunisation should be available throughout the winter to offer further opportunities for immunisation.

Going forward, from 2026/2027, RSV immunisations will be recorded in the National Immunisations Information System (NIIS). This will facilitate more detailed uptake reporting and identification of population cohorts and geographical areas with sub-optimal uptake.

Strengths and limitations

This evaluation has several strengths. A mixed-methods approach was used, combining routinely collected programme and surveillance data with surveys, focus group interviews and stakeholder feedback. This enabled assessment of programme implementation, uptake, impact, acceptability and equity from multiple perspectives. The use of established evaluation frameworks supported a structured approach and allows comparison with the RSV Pathfinder 1.0 evaluation. The evaluation also benefited from national programme data, weekly uptake

reporting, and triangulation of findings across parents, service providers, operational teams, maternity services, primary care representatives and other key stakeholders.

There are also important limitations. Parental survey findings are subject to response and selection bias, with a high number of responses from parents who attended for immunisation and very limited feedback from parents whose infants were eligible but not immunised. No focus group interviews were completed with parents of unimmunised infants, limiting interpretation of barriers among this key group. Survey responses were self-reported and may not be representative of all eligible families. Some qualitative findings were based on small numbers of participants or informal feedback, limiting generalisability.

The impact analysis had several limitations including potential RSV case misclassification, incomplete case ascertainment, and the inability to directly link RSV surveillance and immunisation data. In addition, the impact estimates rely on modelling assumptions and cannot establish causality or fully capture indirect effects (e.g. potential herd immunity or reduced transmission), furthermore the analysis did not account for possible confounding factors (including sex, region, socio-economic status, premature birth, health seeking behaviour, and changes in testing policy or practice).

Finally, programme data systems were not integrated across settings, and variation in data collection methods between maternity sites, community clinics and other providers limited the ability to conduct more detailed analyses of equity, determinants of uptake and longer-term programme effectiveness.

9. Recommendations



General Recommendations

1. Timely stakeholder engagement:

Implement an early, formal engagement plan for maternity services, general practitioners, practice nurses, public health nurses, regional directors of public health, and community mobile vaccination teams and other relevant programme partners. Include clear expectations about delivery model, training and education for immunisation providers and printed informational material to raise awareness in parents of infants that will be eligible for the 2026/2027 pathfinder programme.

Owner: RSV Pathfinder 3.0 Steering and Implementation Working Groups

2. Communication strategy:

Ensure the communication strategy delivers well-resourced, national and regional multi-channel communications that are accessible and timely reach key groups including;

- parents,
- their family and social networks (e.g., grandparents),
- healthcare professionals

and include targeted communications to improve uptake in underserved populations.

Recommended communications include:

2.1 The early communication of generic information to parents and healthcare providers confirming that RSV Pathfinder 3.0 will start in September 2026, clearly indicating that further details will be available closer to the go-live date of the programme.

2.2 Consider consultation with parents of eligible children to inform communications campaign for RSV Immunisation Pathfinder 3.0

2.3 Implementation of a standardised SMS reminder system to parents supported by contact data cleansing and standard operating procedures to ensure prompt invitation to participants at the start of the programme and further reminders later in the season for targeted and mop-up clinics.

2.4 The use of immunisation champions/user stories, to improve reach, to deliver a wider educational piece on RSV and focus awareness on the availability of the immunisation.

2.5 Communication from the Pathfinder 2.0 Steering Group to all service providers from maternity and community programmes providing direct feedback on the impact and success of the programme due to their efforts.

Owners: HSE National Communications, NIO Communications, HSE Regional Communications, Pathfinder 2.0 Steering Group

3. Governance and lead-in time:

Establish a governance structure for the RSV immunisation programme aligned to and integrated within the existing NIO governance of the Primary Childhood Immunisation programme to prevent nirsevimab being viewed as 'separate' to routine infant immunisations by parents/guardians and reinforce public trust in the immunisation. This structure should provide timely information, education and escalation routes to providers to ensure an appropriate lead-in time for delivery of the RSV immunisation programme in the 2026/2027 season.

Owners: RSV Pathfinder 3.0 Steering Group, NIO

4. Catch-up cohort delivery model optimisation:

For delivery of programme to the catch-up cohort the adoption of a mixed delivery model should be considered, with delivery primarily in general practice, ensuring convenient access to immunisation by known and trusted healthcare providers in the usual place of care in the

community. Additional complementary community capacity of targeted clinics and outreach delivered by HSE MVTs should be considered, leveraging the expertise of an existing skilled and flexible public health workforce. This should be informed by regional health intelligence to develop targeted approaches for underserved groups (e.g., tailored communications - regionally, flexible clinics partnerships, opportunistic delivery) and real-time monitoring of uptake to identify gaps to improve equitable access to the programme.

Owners: RSV Pathfinder 3.0 Steering and Implementation Working Groups, Regional Executive Officers, Regional Directors of Public Health, NIO, ICGP, NSIO

5. Ensure sustainability of programme delivery by maternity services:

Building on the successes of delivery of the RSV Immunisation Pathfinders Programmes to newborns in maternity sites in the 2024/2025 and 2025/2026 seasons the continued delivery of immunisation to the birth cohort using this model is recommended. This requires appropriate funding for sustained provision of the programme at all sites, including staff and supporting resources.

Further recommendations:

5.1 Consideration of the creation and funding of a midwifery role that would incorporate health promotion activities (health education, vaccines in pregnancy, vitamin K, folic acid etc) within the hospital's maternity unit rather than a seasonal RSV specific role. This role would ensure year-round promotion of pregnancy-related public health initiatives likely improving uptake and engagement by expectant mother, and would overcome the challenge that many sites have reported in filling short-term temporary part-time posts for the 6 months of the RSV season.

5.2 In line with HSE policy of 'making every contact count' all healthcare workers should be encouraged to promote the RSV immunisation programme and provide education and information to parents as required.

Owners: RSV Pathfinder 3.0 Steering Group, Regional Executive Officers, Directors of Midwifery at participating maternity sites

6. Data Management and Governance:

Ensure appropriate guidelines and standard operating procedures are in place to ensure appropriate data management and governance of patient data at providers sites, including MVT offices, maternity sites not currently using the Maternal & Newborn Clinical Management System (MN-CMS), and data held in the Swiftqueue booking portal.

Continue with model of utilising reporting functionality of MN-CMS to gather uptake data and generate analysis on maternal and neonate characteristics and other factors associated with uptake in MN-CMS sites. Roll out of the MN-CMS to all maternity units will be of benefit to the programme.

Further recommendations:

6.1 Should a mixed model of delivery be adopted for the catch-up cohort it will be crucial that all immunisations are recorded in a timely manner by GPs/GP nurses and MVTs on the National Immunisation Information System (NIIS) to avoid immunisation administration errors.

6.2 Recording on NIIS is not currently feasible for the birth cohort immunised in the maternity setting. Therefore, in the event of primary care-based delivery of a component of RSV Pathfinder 3.0, it is crucial that RSV immunisation status is clearly documented on discharge letters to GPs for all infants discharged from maternity sites to avoid immunisation administration errors.

6.3 Inclusion of RSV immunisation data on NIIS with improvements to data linkage between NIIS and Public Health's new outbreak case and incident and surveillance system (OCIMS) to ensure complete record-keeping and to facilitate future impact and effectiveness studies, including for vulnerable populations.

Owners: RSV Pathfinder 3.0 Steering Group, Maternity Units

Additional Recommendations

7. Data quality and uptake measurement:

Reporting requirements, including a measurement plan outlining the variables to be collected, should be considered in the programme design phase of Pathfinder 3.0 with early involvement of the HPSC VPD team to permit resource planning during the winter season when there are competing priorities.

Improve denominator and eligibility datasets for the catch-up cohort through the use of birth notification data available from local child health departments.

Consider a revised approach to reporting uptake in high-risk infants administered nirsevimab in the home to include all high-risk infants identified as eligible for immunisation in the denominator.

Owners: HPSC, RSV Pathfinder 3.0 Steering and Implementation Working Groups

8. Funding and approvals:

8.1 Agree and communicate ring-fenced funding for Pathfinder 3.0 to key partners including maternity, community, primary care, HSE T&T/external vendors.

8.2 For HSE incurred costs with third party vendors all financial approvals must be in place before any changes in scope or additional work is commissioned.

Owners: RSV Pathfinder 3.0 Steering Group, DOH

9. Booking portal and user experience:

9.1 Should a booking portal be required for RSV Pathfinder 3.0 and future programmes consider redesign of the booking portal to allow visibility of programme-wide clinic options and availability, instead of the staggered release of appointments implemented in Pathfinder 2.0.

- 9.2 Provide clear and accessible information on local clinics. It was suggested that the button/link to book an appointment on HSE website should be more prominently placed on the webpage.

Owners: RSV Pathfinder 3.0 Implementation Working group, NIO, HSE Technology & Transformation

10. Scheduling to reduce opportunity costs:

Should a mixed model of GP/MVT delivered care be decided on for RSV Immunisation Pathfinder 3.0, the delivery of the RSV Immunisation Pathfinder 3.0 Programme should be co-ordinated with the delivery of other winter immunisation programmes. For example, consider planning delivery of the catch-up programme ahead of peak periods of winter virus vaccination activity (e.g., early autumn) to protect capacity and coverage elsewhere whilst permitting flexibility in the system to permit regional teams to provide mop-up clinics or multiple vaccine clinics to meet demand. An early and sufficient lead-in time would facilitate the planning required to implement this approach effectively.

Owners: MVTs, RDPH, ICGP, NIO

10. Conclusion



The RSV Immunisation Pathfinder 2.0 Programme was successfully implemented and achieved strong uptake, particularly within maternity services and among high-risk infants. Substantial uptake was also achieved in the first-year of a catch-up programme delivered by MVTs in community clinics. Feedback from parents, service providers and key stakeholders was broadly positive, indicating that the programme was acceptable, valued and operationally feasible. The principal challenge identified was the short lead-in time, which limited opportunities for comprehensive planning, stakeholder engagement, communications, workforce mobilisation and operational readiness.

Future programme delivery should continue through maternity units for the birth cohort, with catch-up immunisation delivered primarily through general practice, supplemented by MVTs delivering immunisation to high-risk infants and populations experiencing barriers to accessing general practice. Future programmes would benefit from earlier confirmation and a longer implementation lead-in time to support timely communications, workforce planning, system readiness and equitable access.

11. Appendices

A spiral-bound notebook with a silver metal spiral binding on the right side. The notebook is open to a blank, lined page. A silver stapler is placed on the left side of the page. A silver pen is placed on the right side of the page, near the bottom. The word "Appendix" is written in the center of the page in a black, serif font.

Appendix

Appendix A: Schedule of Focus Groups

#	Stakeholder Group (n)	Date
1	Regional Directors of Public Health (n=6)	20/03/2026
2	Parents of infants immunised in community clinics (n=3)	23/03/2026
3	Providers – mobile vaccination team members (n=3)	24/03/2026
4	Operational leads	27/04/2026
5	Directors of Midwifery: (3 groups) 1. large sites with MC-NMS (n=3), 2. medium sites (n=4) using paper-based records 3. smaller sites (n=2) using paper-based records	01/04/2026, 08/04/2026, 02/04/2026
6	Pharmacists (maternity sites)	17/04/2026
7	General Practitioners (n=4) and Practices Nurses (n=1)	21/04/2026, 30/04/2026
8	HSE Communications	20/04/2026
9	RSV Pathfinder 2.0 Steering Committee	21/04/2026
10	HSE T&T/Swiftqueue	28/04/2026
11	HPSC VPD Team responsible for reporting uptake (n=3)	04/06/2026



RSV Immunisation Pathfinder 2.0 Programme 2025 – 2026

Focus Group Interview Consent Form

Thank you for your expression of interest in attending a focus group interview on your experience of the RSV Immunisation Pathfinder 2.0 Programme.

We very much value your opinion.

Please see some information below about the focus group interviews and indicate whether you are happy to attend.

These focus groups are:

- **Voluntary and confidential:** means you don't have to take part, and your identity and answers will be kept confidential. If you do decide to take part, you can change your mind and withdraw at any time without needing to give a reason.
- **Used only for service improvement:** the information you provide will only be used to improve our service.
- **Conducted online:** we use Microsoft Teams to meet with you. We meet with small groups of 5 to 10 people at one time. You will be asked to have your camera on. All participants will be advised of their duty to confidentiality before the interview starts.

Data Protection Statement

A record of what is said on the focus group will be recorded by Microsoft Teams. This recording is only in text, you will not be video-recorded. This text is used by the HSE RSV Immunisation Evaluation team to analyse the findings. The recorded text is stored on a secure HSE-HPSC server and will not be shared with anyone outside of the RSV Immunisation Evaluation team. The recorded text is then deleted after it has been analysed. Data security will be maintained at all times at HSE-HPSC,

which is accredited for Information Security Management ISO 27001. HPSC is compliant with the requirements of data protection legislation, specifically the General Data Protection Regulation (GDPR) and the Data Protection Act 2018.

If you have any questions, please contact: Dr Kevin Brown (HSE):
kevin.brown1@hse.ie.

Please sign **one of the options** below to indicate whether you **do** or **do not** consent to take part in a focus group interview.

1. I **do** consent to taking part in a focus group interview with the RSV Immunisation Evaluation team, as described above:

Signature: _____

Print name: _____

Date: _____

2. I **do not** consent to taking part in a focus group interview with the RSV Immunisation Evaluation team, as described above:

Signature: _____

Print name: _____

Date: _____

Appendix C: Letter of Ethical Approval



Reference Research Ethics Committee Dublin & Midlands (&
HSE Centre)
C/o Department of Public Health, Dublin and Midlands
Health Region
Offaly
Ireland, R35 TY28

22 Jan 2026

Dr Brown
Department of Public Health, HSE Dublin and South East
Mill Lane, Palmerstown
Dublin,
Ireland

RE: Research Ethics Committee notification of Ethical Approval (Favourable Opinion)

Dear Dr Brown,

Study Title:	RSV Immunisation Pathfinder 2.0 Evaluation
HSE REC NERMS Reference No: (please quote this number of all correspondence)	20251692-RDMLRREC
Chief Investigator:	Dr Kevin Brown
Research Ethics Committee:	Reference Research Ethics Committee Dublin & Midlands (& HSE Centre)
Date of decision:	05 Dec 2025
Outcome of review:	Ethical Approval

Thank you for your application. We are pleased to confirm ethical approval (favourable opinion) for the above study on the basis of the information provided in the application form, protocol and supporting documentation. Your study is now approved and may commence subject to the standard conditions specified below.

Ethical review of research sites

The ethical favourable opinion applies to any Research sites outlined in the application which are under the jurisdiction of this Research Ethics Committee (see REC website for details). This is, subject to management and local governance permissions, authorisations and approvals prior to the start of the

Page 1 of 5

Appendix D: Programme Delivery Sites

Catch-up Programme

HSE Dublin & North East
Ashbourne Old Health Centre
Balbriggan Primary Care Centre
Ballymun Healthcare Facility
Barrack Street Primary Care Centre
Boyne Health Centre
Carrickmacross Primary Care
Claremont Stadium
Coolock Primary Care Centre
Corduff Primary Care Centre
Drumalee Primary Care
Dunshaughlin Health Care Unit
Grangegorman Primary Care Centre
Kells Primary Care Centre
Louth Meath Vaccination Centre
Market Street Health Centre
Monaghan Community Vaccination Clinic
Summerhill Primary Care Centre
Swords Health Centre
Trim Primary Care Centre
Virginia Primary Care
HSE Dublin & Midlands
Athy PCC
Ballyboden Primary Care Centre
Ballyfermot and Palmerstown Primary Care Centre
Baltinglass PCC
Blessington PCC
Camlin Assessment Hub - Ballyminion Primary Care Centre
Castledermot Community Centre

Celbridge PCC
Clane PCC
Clonbrusk Primary Care Centre
Clondalkin Primary Care Centre
Derrinturn PCC
Elinor Lyons Building (The Meath Campus)
Inchicore Primary Care Centre
Kilcock PCC
Kilnamanagh - Tymon Primary Care Centre
Laois Offaly Vaccination Base
Mullingar Primary Care Centre
Newbridge Health Centre
Newbridge Primary Care Centre
Old County Road Health Centre
Portarlinton Primary Care Centre
Rathangan PCC
Rathmines Health Centre
Rialto Primary Care Centre
Springfield - Tallaght PCC (The Russell Building)
St Joseph's Health Centre
St Marys PCC
Tullamore Primary Care Centre
HSE Dublin & South East
Arklow Primary Care Centre
Ballinteer Primary Care Centre
Bray Primary Care Centre
Cahir Primary Care Centre
Carlow Vaccination Centre
Carnew Primary Care
Carrick on Suir Primary Care Centre
Clonskeagh Conference Centre

Community Care Kilkenny
Dungarvan Primary Care Centre
Ferrybank Primary Care Centre
Gorey Health Centre
Kiladreenan Vaccination Centre
Kilcreene Orthopaedic Hospital
Leopardstown Primary Care Centre
Loughlinstown Health Centre
Mounttown Community Centre
New Ross Health Centre
Newpark Primary Care Centre
Rathdrum Primary Care Centre
Ringsend Primary Care Centre
Shankill Primary Care Centre
South Tipperary Vaccination Centre
St Brocs - Clonskeagh Hospital
Thomastown Primary Care Centre
Tipperary Primary Care Centre
Waterford Vaccination Centre
Wexford Primary Care Centre
Wexford Vaccination Centre
Wicklow Primary Care Centre
HSE South West
Bandon Primary Care Centre
Bantry Newtown Vaccination Centre
Blackrock Hall Primary Care Centre
Borg Warner
Caherciveen Day Hospital
Carrigaline Primary Care Centre
Carrigtwohill Primary Care Centre
Charleville Primary Care Centre

Clonakilty Primary Care Centre
Cobh Primary Care Centre
Dingle Primary Care Centre
Duhallow Primary Care Centre
Fermoy Primary Care Centre
Kenmare Primary Care Centre
Killarney South DOC
Kinsale Primary Care Centre
Listowel Primary Care Centre
Macroom Primary Care Centre
Mallow Primary Care Health Centre
Midleton Health Centre
Quality Hotel, Redbarn
Skibbereen Dental Building
St. Mary's Primary Care Centre
Teach Mhuire Day Centre, Mayfield
Westfield Integrated Care Centre, Ballincollig
Youghal - St. Raphael's, 'Chestnut Unit'
HSE Mid West
Ballynanty Health Centre
Cappamore Health Centre
Castletroy Primary Care Centre
ClareCastle Health Centre
Croom Primary Care Centre
Dooradoyle Health Centre
Ennis Primary Care
Ennistymon Health Centre
Hospital Health Centre
Kilmallock Primary Care Centre
Kilrush Health Centre
Kings Island Primary Care Centre

Newcastle West Primary Care Centre
Newport Health Centre
Rathkeale Health Centre
Roscrea Primary Care Centre
Roxtown Health Centre
Scariff Health Centre
Shannon Health Centre
Southill Health Centre
St. Brendan's Health Centre
The Derg Centre
Thurles Primary Care Centre
Tyone Health Centre
HSE West and North West
Athenry Primary Care Centre
Ballina RSV Catch Up Clinic
Ballinamore Community Vaccination Clinic
Ballinasloe Primary Care Centre
Ballinrobe RSV Catch Up Clinic
Ballymote Community Vaccination Clinic
Boyle RSV Catch Up Clinic
Buncrana Primary Care Centre
Carraroe Health Centre
Carrigart Health Centre
Castlebar RSV Catch Up Clinic
Castlerea Health Centre RSV Catch Up Clinic
Claremorris RSV Catch Up Clinic
Clifden Health Centre
Donegal Town Primary Care Centre
Dunfanaghy Primary Care Centre
Dungloe Community Hospital
Enniscronne Community Vaccination Clinic

Galway City East Primary Care Centre
Glenties Primary Care Centre
Gort Health Centre (Dental Clinic)
IPAS/BOTP Residents RSV Catch Up Clinic
Leitrim Community Vaccination Base
Loughrea Primary Care Centre
Monksland PCC RSV Catch Up Clinic
Moycullen Primary Care Centre
MRVB RSV Swinford Catch Up Programme
Newtowncunningham Primary Care Centre
Roscommon RSV Catch Up Clinic
Shantalla Health Centre
Sligo Community Vaccination Base
South Donegal Community Vaccination Clinic
St Francis' Primary Care Centre
St Mary's Parish Centre
Strokestown RSV Catch Up Clinic
The Vestry
Tuam Health Centre
Westport PCC RSV Catch Up Clinic

Maternity Programme

Hospitals
HSE Dublin & North East
Rotunda Hospital
Our Lady of Lourdes Hospital, Drogheda
Cavan General Hospital
HSE Dublin & Midlands
Coombe Women and Infants University Hospital
Midland Regional Hospital, Portlaoise
Midland Regional Hospital, Mullingar
HSE Dublin & South East

Tipperary University Hospital
Wexford General Hospital
University Hospital Waterford
National Maternity Hospital, Holles Street
St Luke's General Hospital Kilkenny
HSE South West
University Hospital Kerry
Cork University Maternity Hospital
HSE Mid West
University Maternity Hospital, Limerick
HSE West and North West
Letterkenny University Hospital
Sligo University Hospital
Mayo University Hospital
Portiuncula University Hospital
Galway University Hospital
Other
Children's Health Ireland (Crumlin and Temple Street)
Temperature Controlled Pharmaceuticals (TCP) Homecare

Appendix E: Membership of RSV Pathfinder 2.0 Programme Steering Group and Subgroups

Steering Group Membership

Name	Role
Dr Éamonn O'Moore (Co-Chair)	Director National Health Protection
Ciaran Browne (Co-Chair)	Acute Operations/HSE Access and Integration
Dr Anne Sheahan	Regional Director Public Health, Department of Public Health
Dr John Cuddihy	National Director of Public Health
Dr John Murphy	National Neonatal Lead, NWHIP
Dr Ciara Martin	National Clinical Advisor and Group Lead for Children and Young People
Angela Dunne	NWIHP National Lead Midwife
Dr Abigail Collins	Clinical Lead Child Health Public Health, HSE Public Health
Dr Augustine Pereira	Director of Public Health Medicine, HSE National Health Protection Office (NHPO)
Dr Lisa Domegan	Principal Epidemiologist HPSC
Dr Lucy Jessop	National Lead for Immunisation, NIO
Dr Brian Cleary	Pharmacist Executive Manager Rotunda
David Fitzgerald	Pharmacist Executive Manager NMH
Kathryn Shaw	Senior Pharmacist, Antimicrobial Stewardship, CHI at Crumlin
Marnie McDermott	Procurement manager, HSE Procurement
Maurice Kelly	Client Director, HSE Communications
Ciara NiRuairc	Head of Communications Strategy, Planning and Delivery, HSE Communications
Margaret Tobin	Head of Finance Business Partnering, National Finance Division, HSE
Dr Jane Finucane	Senior Medical Officer, HPSC
Dr Lois O'Connor	Consultant in Public Health Medicine, HSE NHPO
Dr Victor Aiyedun	National Clinical Lead for Surveillance, HSE HPSC and NHPO
Ellen Perry	HPSC Administrative Assistant

Implementation Working Group Membership

Name	Role
Dr Augustine Pereira (Chair)	Director of Public Health, National Health Protection Office
Dr John Murphy (Vice Chair)	National Neonatal Lead, NWHIP
Dr Ciara Martin (Vice Chair)	National Clinical Advisor and Group Lead for Children and Young People
Dr Jane Finucane	Senior Medical Officer, HPSC
Dr Jane Salmon	Senior Medical Officer, HPSC
Dr Mark Campbell	Senior Medical Officer, HPSC
Ellen Perry	Administrative Assistant, HPSC
Dr Ciaran Browne	Acute Operations/HSE Access and Integration
Dr Cliona Murphy	Clinical Director NWIHP
Angela Dunne	NWIHP National Lead Midwife
David Fitzgerald	Pharmacist Executive Manager NMH
Kathryn Shaw	Antimicrobial Stewardship Pharmacist, CHI at Crumlin
Prof. Brian Cleary	Pharmacist Executive Manager Rotunda
Dr Abigail Collins	National Lead Clinical, Child Health Public Health NHCP
Dr Lucy Jessop	National Lead for Immunisation, NIO
Dr Sarah Geoghegan	Clinical Lead National Immunisation Advisory Committee
Noreen Curtin	National Vaccination Programme, Access and Integration
Sabrina Byrne	General Manager, National Vaccination Programmes, Access and Integration
Maurice Kelly	HSE Communications
Dr Lisa Domegan	Principal Epidemiologist HPSC
Dr Lois O'Connor	Consultant in Public Health Medicine (CPHM) HSE National Health Protection Office (NHPO)
Dr Aileen Kitching	CPHM National Social Inclusion Office
Dr Anne Sheahan	RDPH Public Health HSE South West
Corrina Broderick	Clinical Lead, HSE Immunisation Service
Dr Deirdre Mulholland	Regional Director of Public Health, HSE Dublin and North East
Dr Paul Mullane	Consultant in Public Health Medicine, HSE Dublin and North East
Fiona Hanrahan	Director of Midwifery, Rotunda Hospital
Dr Fionnuala Cooney	RDPH Public Health HSE Dublin and Midlands
Tommy Flatley	General Manager for Vaccination, HSE Dublin and Midlands
Patricia Dever	Clinical and Operation Lead, Immunisation Service, HSE West and North West
Siobhan Canny	Group Director of Midwifery Saolta
Kate Cassidy	Immunisation Lead and General Manager, HSE Dublin and South East
Celine Conroy	Director of Nursing, HSE Dublin and South East
Dr Mai Mannix	RDPH, HSE Midwest
Carmel O'Connor	Director of Nursing, Immunisation Team, Health and Wellbeing, HSE Midwest
Deirdre Hegarty	DON, HSE Mid West, Director of Nursing, Immunisation Team, Health and Wellbeing, HSE Midwest

Maura Hickey	DON, Vaccination Services, A/General Manager, HSE West and North West (retired)
Deirdre Slevin	DON, HSE West and North West
Shona Gallagher	Operational Manager, HSE Community Care, Cavan, Donegal, Leitrim, Monaghan, Sligo

Implementation Working Deputies and Subgroup Members

Name	Role
Mary Rowland	ADOM NWIHP
Clare Kennedy	ADOM NWIHP
Dr Fergal O Shaughnessy	Irish Medicines in Pregnancy Service
Dr Joan Devin	Irish Medicines in Pregnancy Service/Rotunda Hospital
Grace O Connor	Irish Medicines in Pregnancy Service
Cormac Mcadam	NWIHP Communication Officer
Fiona Gaffney	Rotunda
Dr Patrick Gavin	Paediatric Consultant in Infectious Diseases, CHI
Dr Michael Boyle	Obstetric Consultant Rotunda
Aoife Morrissey	HSE Communications
Emmanuel Bello	National Social Inclusion Office
Dr Treasa Kelleher	CPHM Public Health HSE South West
Dr Mary O'Meara	CPHM, HSE Dublin and North East
Dr Suzanne Cotter	CPHM, HSE Dublin and North East

Evaluation and Reporting Subgroup Membership

Name	Role
Dr Lois O'Connor (Co-chair)	CPHM National Health Protection Office
Dr Kevin Brown	Specialist Registrar Public Health Medicine, Department of Public Health HSE Dublin and South East
Dr Michael Carton (Co-chair)	Principal Epidemiologist, VPD, HPSC
Dr Lisa Domegan	Principal Epidemiologist, RVU, HPSC
Dr Piaras O'Lorcain	Senior Epidemiologist, VPD, HPSC
Dr Eimear Keane	Epidemiologist, VPD, HPSC
Eva Rushe	Surveillance Assistant, VPD, HPSC
Dr Jane Finucane	Senior Medical Officer, HPSC
Laura Kayert	EPIET Fellow, HPSC
Dr Victor Aiyedun	National Clinical Lead for Surveillance, HPSC
Dr Augustine Pereira	Director of Public Health, National Health Protection Office
Noreen Curtin	National Vaccination Programme, Access and Integration
Fiona Hanrahan	Director of Midwifery, Rotunda Hospital
Patricia Dever	Clinical and Operation Lead, Immunisation Service, HSE West and North West
Sabrina Byrne	General Manager, HSE National Vaccinations Programme – Access and Integration
Sue Jameson	Patient Partner, Cuidiú
Mandy Daly	Patient Partner, Irish Neonatal Health Alliance
Kate Cassidy	Immunisation Lead and General Manager, HSE Dublin and South East
Leon O'Hagan	Senior Informatics Pharmacist, Rotunda Hospital
Avril Dempsey	Pharmacist, National Maternity Hospital
Ciara Ní Ruairc	Head of Communications Strategy, Planning and Delivery, HSE
Aoibheann Ní Shuilleabháin	Senior Communications Manager, HSE
Celine Conroy	Director of Nursing, HSE Dublin and South East
Dr Scott Walkin	Antimicrobial Resistance & Infection Control Clinical Lead, Irish College of General Practitioners
Dr Toney Thomas	National Director of Nursing, Health Protection, NHPO
Dr Geraldine McDarby	HSE
Dr Brian Keating	Specialist Registrar in Public Health Medicine, Department of Public Health HSE Dublin and South East

Appendix F: Detailed Focus Group Findings:

- Parents of babies who were immunised
- Catch-up programme service providers

Parents of babies who were immunised

Parents generally expressed positive feedback about the RSV immunisation programme, particularly praising the efficiency and kindness of the staff at community clinics. Many attendees were motivated to participate due to concerns about RSV risks, especially with older siblings attending childcare settings. However, there were challenges noted regarding the clarity and availability of information on where and when to access the vaccine, leading some parents to travel significant distances to obtain it.

Parents reported that the availability of information about the programme was inconsistent at times, highlighting that GPs and public health nurses often had limited knowledge about the programme when contacted.

Social media was a major source of information, with parents following trusted clinicians on platforms like Instagram who actively promoted the vaccine. However, they reported limited awareness of the official HSE social media campaign. Text message reminders from GPs/HSE were highly valued by participants as a direct and trusted communication channel encouraging vaccine uptake.

Parental feedback advised that the booking portal was easy to use, though some experienced confusion regarding clinic availability due to a staggered release of appointments. This resulted in some uncertainty as to whether slots were full or not yet available.

Suggestions for improving communication included earlier and repeated communication, especially antenatally, using accessible formats such as simple videos explaining RSV and its risks, and clearer booking instructions linked directly in messages.

Parents whose babies were immunised were strongly supportive of the continuation of the RSV immunisation programme with the following additional suggestions:

- Delivery of the immunisation through GP practices, integrated into routine GP visits for other primary childhood immunisations, to leverage familiarity, convenience, and existing relationships, thus potentially increasing uptake.
- Combine the RSV vaccine with other routine immunisations or health checks was suggested to reduce the number of separate appointments.

- Implement reminder systems, including texts or letters, were recommended to encourage timely vaccination, especially for those who might forget or delay.
- Framing the vaccine as protection for “baby’s first winter” was proposed to make the messaging more relatable and reduce perceived burden.

Catch up programme service providers

Program Planning and Execution

It was noted that the catch-up programme was planned and implemented rapidly due a short lead-time. The timely development of medicine protocols and training materials by the programme’s Implementation Working Group was commended. However, due to the short lead-in time communication to healthcare providers and parents was widely regarded as delayed, leading to missed opportunities to inform expectant and new parents about the program in a timely manner. Service providers felt early communication to maternity hospitals and public health nurses was lacking, which affected awareness among parents of babies born in the months leading up to the program launch.

Participants noted that the initial uptake was strong among healthcare workers and well-informed families, but there was a significant gap in reaching lower socioeconomic groups, newer residents, and international communities. Efforts such as leaflet drops to public health nurses and GP practices, as well as text messaging campaigns, helped increase awareness but were implemented relatively late in the programme timeline.

Communication Challenges and Strategies

The group emphasized the importance of effective communication channels, reporting the absence of a dedicated RSV help line or booking telephone number caused confusion amongst some parents. Social media and local champions, such as well-known healthcare influencers (including consultant paediatrician), played a crucial role in spreading awareness.

Text messaging was highlighted as a valuable tool, with positive feedback from parents who appreciated timely reminders. However, challenges included incomplete contact information (e.g., missing mobile numbers) and difficulties filtering out those already vaccinated to avoid redundant messages.

Early and targeted communication, ideally starting at hospital discharge and continuing through public health nurse visits and GP appointments, was recommended to improve uptake.

Programme Duration and Delivery Model

Participants suggested that the programme's initial six-week catch-up period was too short and that extending it through the winter months, similar to the influenza campaign would better align with parents' demand and seasonal timing. "Pop-up" clinic, short, well-advertised session, were proposed as an effective model to increase accessibility and uptake, especially when combined with strong communication efforts.

Data Management and Operational Feedback

Challenges included slow responses to some initial clinical queries, difficulties in managing appointment availability and visibility of same, and the burden of paperwork. The upcoming inclusion of RSV immunisation data in NIS is expected to streamline consent, eligibility verification, and data recording for MVTs, reducing administrative workload.

Equity and Accessibility Concerns

A major theme was the difficulty in reaching marginalised groups, including lower socioeconomic families, single parents, and non-English-speaking migrants. Despite efforts to engage these populations through targeted clinics in IPAS settings in some areas and liaison with migrant support settings, many were missed, likely due to communication barriers and lack of awareness about RSV. The participants underscored the need for culturally sensitive and linguistically appropriate communication and outreach to improve equity in immunisation coverage.

Parental Perspectives and Barriers to Uptake

Providers recounted conversations with parents revealing common barriers such as concerns about infant size or health status at the time of vaccination, misunderstandings about RSV versus other illnesses, and confusion about whether RSV immunisation was part of the routine schedule. Positive motivators for attendance included personal or community experiences with severe RSV illness, trusted recommendations from healthcare providers, and the protective nature of the immunisation.

Future Delivery Model

Participants favoured maintaining the community-based immunisation teams rather than shifting entirely to GP practices, noting the ability of community teams to reach populations less engaged with primary care, including vaccine-hesitant groups. The distinction between vaccination and immunisation was noted as significant for some parents, particularly those

reluctant about traditional vaccines, who were more receptive to the RSV immunisation delivered through community clinics.

Appendix G: Detailed Focus Group Feedback - Other Stakeholders

Regional Directors of Public Health

A meeting was held with the Regional Directors of Public Health or their alternate (n=6), as key stakeholders in delivering the catch-up programme, to get feedback and insights into their experience of this process, and to specifically explore the following topics from a regional operational perspective:

- Planning and operations;
- Communications;
- Equitable access; and
- Future model of programme delivery to the catch-up cohort and suggested improvements

Planning and operations

It was widely agreed that the lead time for regional implementation of a new programme was insufficient, particularly given the different governance structure of this standalone immunisation programme compared to all other immunisation programmes that fall under the governance of the National Immunisation Office (NIO). As a result, regional planning for programme delivery was viewed as very rushed and sub-optimal highlighting the short lead in time and late provision of information to MVTs for the initial campaign.

Minimal lead time (~2 weeks) for the mop-up clinics which coincided with the seasonal respiratory virus vaccination programme for nursing homes (influenza and COVID-19) was reported by participants. It was stated that mop-up clinics diverted MVT resources away from influenza and COVID 19 vaccination programmes and as a result some MVTs did not reach certain nursing homes until mid-December 2025 (mid-way through an early influenza season). This represented a significant opportunity cost.

Participants reported that navigating the new delivery pathway of the RSV programme at a regional level with support from NHPO, including a new process for clinical queries, was challenging at times, particularly when responses to clinical queries were delayed. The established pathway NIO-led programmes was preferred for future delivery of the programme.

The need for early clarification regarding funding for provision of the immunisation, both in maternity units and in community settings, was cited as important. A number of regions used existing budget to deliver the catch-up programme this season and no additional funding has been factored into the 2026 budget for ongoing delivery. This approach appears punitive to

the departments that did not request extra funding in 2025, highlighting the need for public health input into regional budget planning and allocation. In terms of the planning for the delivery in maternity sites participant noted that no additional resources were provided to deliver the programme, nonetheless maternity services ran with the programme this year very effectively.

Communications

The need for earlier internal communications, i.e., national leads to the regional leads, to allow sufficient lead in time to operationalise the programme was highlighted. Nevertheless, it was widely felt that good uptake (>50%) was achieved given this was a new programme that was rolled out in very short time. It was reported that messaging from a national level was to continually increase numbers which was viewed as criticism even though the issue on the ground was not lack of supply of clinics rather the lack of demand from parents.

In terms of external communications, i.e., HSE national and regional communications to parents, the lack of high profile public national campaign was raised with participants suggesting the need for a broader campaign beyond targeting the parent age demographic (i.e. wider family members including grandparents) as many parents unaware of the programme. Future communications should include clear messaging to the maternity cohort in the antenatal period (starting at the booking appointment) to ensure parents are aware and well informed of the immunisation in advance of the birth.

Participants suggested parent information for the next pathfinder programme should be issued from as early as March 2026, particularly to raise parental awareness of the Catch-up campaign. They also suggested further engagement by HSE Communication with parents/GPs/midwives on how to improve the reach of messaging (for example focus groups) and incorporating RSV immunisation into routine communications for childhood vaccines (i.e. the Primary Childhood Immunisation Programme) as soon as possible, so it is not seen as a separate or distinct campaign by parents.

A lack of funding for regional communications was reported and the opportunity to arrange local communications in parallel with national HSE communications would be welcomed by the group.

Equity

All regional leads agreed that healthcare workers and their families were the first to attend the community clinics, along with middle class and well-informed parents. Whilst some regions opportunistically provided targeted clinics for beneficiaries of temporary protection (BOTP), the need for campaigns targeting vulnerable and underserved populations was highlighted and a future opportunity in the future to use MVTs to targeted these populations (particularly if the programme moves to general practice).

Future model of programme delivery to the catch-up cohort and suggested improvements

Whilst the MVTs very successfully delivered the catch-up programme in the initial 2025/2026 season participants viewed primary care as the best model of delivery in the long term given the need for a convenient and trusted model with parents already engaged with their GPs and practice nurses. However, the ongoing involvement of MVTs and greater regional autonomy for future strategies to engage vulnerable and underserved groups was proposed by participants. This approach would also promote integrated working across the health system as in some regions paediatric nurses involved in delivery of the programme.

Written and text communications with parents were effective at increasing uptake and participants recommended that these should be issued early with reminders during the season to improve uptake in the catch-up cohort.

In terms of birth cohort programme delivery by the maternity hospitals in the second season the participants highly commended the implementation building on prior experience but did outline the need for timely communication and dedicated funding to sustain the success of the first two seasons.

Operational Leads

A focus group including six operational leads (n=6), from HSE Access and Integration and HSE Health and Wellbeing, was conducted to gain insights into the operational successes and challenges in delivering RSV immunisation to the catch-up cohort in the community setting.

Short Lead-In Time and Programme Setup Challenges:

The impact of the short lead-in time for the RSV catch-up programme in the following areas highlighted the need for earlier planning and communication in future campaigns.

- It was challenging to establish the new catch-up programme in a short timeframe, as many considerations were new and required rapid decision-making and adaptation by the regional teams.
- The programme's start date was postponed by a week, which overlapped with other busy periods for the teams resulting in operational pressures in terms of resource management and increased workload for staff.
- Earlier decisions and communication from the national level would help alleviate these pressures and ensure earlier regional engagement and timely planning to avoid unforeseen last-minute challenges in future years.

Stakeholder and Parent Engagement Gaps:

The group identified missed opportunities for early engagement with parents and key stakeholders such as GPs and public health nurses, noting that delayed communications contributed to lower uptake and limited awareness of the catch-up campaign.

The short lead-in time prevented early engagement with parents, especially new parents, which likely contributed to lower uptake rates and missed opportunities to foster programme champions. The group also reported that GPs, public health nurses, and practice nurses were not formally informed about the programme in advance, thus limiting their ability to inform parents and support the campaign effectively.

In terms of the impact on underserved populations the group observed that initial uptake was higher among well-informed parents or those with connections to healthcare workers, while harder to reach groups were underrepresented highlighting the need for targeted engagement strategies.

Communication and Public Awareness Campaign:

The effectiveness of the communication strategy discussed, with the group expressing concern that real world impact of the social media-focused campaign might not have been as strong as the reach of the communications engagement metrics suggested. A wider and more sustained strategy to disseminate information using multi-channel approaches, with additional measurement of the communications campaign reach, was suggested.

Booking System and Data Management:

Challenges with the Swiftqueue booking portal, including limited appointment visibility, labour-intensive data cleansing to set up text messaging reminder service, and the need for real-time, integrated immunisation recording systems to reduce clinical risk and improve efficiency particularly if a mixed model of community-based delivery to the catch-up cohort is planned for future seasons.

Appointments were released on a staggered basis, allowing only two weeks of visibility at a time, which some parents found confusing and a barrier to booking. However, there was an operational rationale for this staggered release, namely to encourage early booking and manage demand but the group acknowledged this may have had unintended consequences for accessibility which should be considered in future years.

The process of cleansing data for text-message alerts was widely reported as a labour-intensive process and emphasized the need for integrated, real-time record systems to avoid duplication and clinical risk, especially if multiple delivery modes are used in future years.

Systems integration for future campaigns was discussed with efforts ongoing by the HSE Access and Integration team to integrate the booking and data systems with GP practice management software, but there are challenges in creating records for newborns that require further solutions.

Programme Logistics, Mop-Up Clinics, and Uptake Patterns:

In terms of the timing of the main and subsequent mop-up clinics, uptake peaked in week 6, the final week, of the initial immunisation phase, likely due to growing awareness and word-of-mouth, but declined sharply during the mop-up phase. It was suggested that momentum was lost due to the pause in the programme with parents shifting focus to other seasonal winter illnesses such as influenza,

In balancing access and programme efficiency the trade-off between providing geographically widespread access to clinics and ensuring efficient use of resources was highlighted. The

group reported the challenges of running clinics in smaller towns with low attendance compared to offering clinics in urban areas with higher uptake and the need to weigh equity of access against resource efficiency.

Models where clinics serve multiple purposes, such as combining healthcare worker and RSV clinics, to improve efficiency and make better use of available resources (already in practice with MVTs in some regions)

Future delivery Models and Hybrid Approaches:

Different delivery models for the RSV programme considered, including GP-led, mobile vaccination teams, and hybrid approaches, emphasizing the need for flexibility, resource allocation, and targeted outreach to underserved groups.

The group suggested that GP delivery of the programme would enable a longer, more flexible campaign, whereas mobile vaccination teams are restricted to more structured, time-limited clinics due to resource constraints and competing winter priorities.

A hybrid model where GPs provide the majority of immunizations and mobile teams focus on special groups, such as underserved populations or the high-risk cohort currently covered by TCP home providers was also viewed positively.

In addition there was support for the idea of flexible clinics, including weekend or evening sessions, to maximize uptake during peak interest periods and ensure coverage for hard-to-reach groups.

Data Accuracy and Measurement for Programme Evaluation:

To improve denominator accuracy in future programme evaluations and uptake reporting the group suggested using birth notifications from child health departments for more accurate uptake calculations rather than national birth rates used to date.

Programme sustainability and staff engagement:

The group discussed the need to consider the long-term sustainability of the RSV programme and to communicate its positive impact through real-life stories and experiences, in addition to data on clinical outcomes. Concerns about maintaining enthusiasm and resources for the RSV programme over time were noted with the group emphasizing the importance of integrating the immunisation into routine preventive care. Communicating the impact to those delivering the programme in both community and maternity settings was seen as crucial to ongoing staff engagement, this could include sharing stories and feedback from clinicians and

families to illustrate the programme's benefits to promote continued support among staff and stakeholders.

Directors of Midwifery

The Directors of Midwifery of all maternity units involved in the delivery of the RSV Pathfinder 2.0 to the birth cohort, in total 19 units, were invited to participate in a focus group to provide feedback on implementation of the programme during the second season. The maternity sites were allocated to one of three groups, based on unit size, with group 1 including the 5 large maternity units (3,900-8,600 annual live births) that all use the MC-MNS electronic patient record system, group 2 including 7 medium sized units (~1,400-2,700 annual live births) that all use paper-based patient records, and group 3 which included 7 smaller sized units (~700-1,400 annual live births) with all bar one site also using paper-based patient records. Semi structured interviews were conducted with each of the groups separately, group 1 n=3, group 2 n=4 and group 3 n=3, with the following key themes emerged across the groups:

- Programme implementation and operational experience
- Staffing, resources and sustainability
- Communications with expectant mothers and the general public
- Future delivery

Programme implementation and operational experience

Across all groups, the implementation of the second RSV pathfinder programme was significantly smoother compared to the first year, reflecting learning, improved workflows, and clearer role allocation. However, delayed confirmation and notification of the programme in the second year remained a major challenge, limiting the lead time for preparation, training, and timely antenatal engagement.

Operational models varied by unit size and available infrastructure with the larger units that have electronic patient record systems benefiting from the efficiency of streamlined consent, monitoring, and follow-up processes. Smaller units that relied on paper-based systems, reported increased administrative burden and the need for manual identification of unimmunised infant in the postnatal period to ensure appropriate follow up to minimise the risk of missed immunisations. Practical solutions implemented in these units included dedicated RSV “rounds” by an assigned member of staff, joint labour and postnatal ward responsibilities, and enhanced handover documentation to confirm immunisation. The expansion of electronic maternity and immunisation systems was strongly supported across all groups.

Staffing, resources and sustainability

Staffing constraints were consistently identified across all groups as the most significant risk to programme sustainability. The key issues highlighted included: lack of approved or

funded WTE posts reported by some sites; reliance on agency staff, retired staff, and the goodwill of existing staff to deliver the programme; and the use of short-term or seasonal contracts that does not align with the need for year-round communication and education of RSV risk and the availability of nirsevimab during infants' first RSV season.

Units with dedicated coordinators or named leads reported high uptake, enhanced co-ordination, organisation and staff engagement. There was strong consensus across all groups on the need for 12-month funded immunisation roles and the integration of RSV into the wider health promotion of antenatal and postnatal vaccinations (e.g. influenza, pertussis and BCG).

Participants reported that staff engagement improved markedly when clinical impact data from co-located paediatric units were shared, when success stories were visible, and when clear leadership and coordination was present. All groups emphasised the staff pride in contributing to measurable reductions in RSV-related admissions and illness. However, some units reported that the comparative league tables of uptake in maternity units that were circulated during the RSV season created added pressure and stress for staff, sometimes undermining morale and failing to recognise maternal choice and the right to decline the immunisation.

Communications with expectant mothers and the general public

Communication was widely regarded as delayed and insufficiently sustained between delivery of the first and second pathfinder programmes. Many women first encountered RSV information at delivery, postnatally or shortly before vaccination, limiting informed decision-making.

Effective strategies to improve education and information-sharing amongst the women identified included; antenatal discussions and face-to-face education, digital messaging (e.g. text platforms, WhatsApp voice notes) and peer influence on postnatal wards. There was strong agreement that year-round national communication, rather than seasonal messaging, is essential.

Future delivery

The RSV programme is effective and valued, with clear clinical benefit but longer-term sustained success depends on early confirmation of programme continuation, sustained funding, dedicated coordination roles at each maternity unit to ensure year-round communication and planning. Without these, there is a real risk of staff fatigue, declining uptake, and loss of momentum.

HSE Communications

Four members of the HSE National Communications and Public Affairs teams participated in a meeting to provide feedback on the planning and impact of the national communications strategy for the RSV Pathfinder 2.0 Programme. The Communications team also shared the findings of a 'RSV immunisation Communications evaluation 2025-2026' conducted internally upon completion of the programme, further details available in Appendix J.

The HSE National Communications and Public Affairs plan included a range of paid and non-paid, proactive and responsive communications; PR activity encouraging immunisation including interviews with clinical experts; social media and digital campaigns signposting to HSE.ie; and the development of information materials to support awareness and informed decision making in partnership with Public Health. The communication assets used in the campaign included patient information materials, national and regional press releases as part of the public relations strategy, a social media strategy specifically targeting the parents of babies born between March 2025 and February 2026, and HSE staff communications.

The targeted HSE social media campaign prioritised reaching the most relevant audience rather than maximising broad population reach, in order to deliver the strongest possible outcomes against the campaign objectives. Focused targeting support improved platform optimisation (channels such as Meta® perform best when campaigns are built around clearly defined audience signals) and higher relevance and engagement rates (particularly important for health information and behaviour-change communications). The communications team explained that whilst broader targeting would increase overall reach, it would also significantly increase the proportion of impressions served to people outside the priority audience. This can dilute campaign effectiveness and reduce the likelihood of the ads reaching the intended cohort at an optimal frequency.

Further feedback from the participants included:

- Time pressure and short lead time was highlighted with communications press release on 25th August just 1 week in advance of programme go-live.
- The group re-iterated the need for finalised logistics for programme delivery to be in place before national communications can issue. They highlighted the need for a clear messaging of the action required of parents (i.e., click through to HSE website and to book a clinic appointment via the live booking portal) rather than general communication signposting the upcoming campaign.

- HSE Communications launched social media campaign to target the demographic of parents of newborn infants, using the social media platforms Meta (Facebook/Instagram), TikTok & Pinterest with interest-based targeting (i.e., parenting content) to reach the intended audience of parents with young infants. The initial phase of the campaign aimed at raising awareness with broader reach on social media and then retargeted users with click-through to the HSE website and booking portal.
- The success of the social campaign was evidenced by the following metrics:
 - 15.1 million impressions
 - 2.4 million users reached
 - 3.2% click-through rate
- Additional press releases, interviews and print/online news content included coverage on national newspapers, radio and television stations.
- Messages received by HSE social media and HSELive from parents were generally in relation to difficulties booking clinic appointments.

Participants made the following suggestions in relation to future RSV immunisation campaigns:

- Communications manage multiple vaccination campaigns for pregnant women (influenza, COVID-19, pertussis) and recommend incorporating RSV into the overall winter messaging for expectant mothers.
- Information and advice from trusted clinical touchpoints is important to optimise engagement with behaviour-change communications, therefore, it is crucial to inform general practitioner, practice nurses and public health nurses as early as possible in future campaigns.
- Recommend the inclusion of testimonials and patient stories in future social media campaigns (as these usually perform well).
- Cautioned the use of paid influencers to promote the programme – this can be viewed negatively by public and the risk that messaging of external influencers may not align with HSE policies and best practice.

HSE Technology and Transformation and Dedalus (Swiftqueue Provider)

A joint focus group was held with staff from HSE Technology and Transformation (n=2) and Dedalus Healthcare Ireland (n=4), the contracted providers of the Swiftqueue online booking portal, to get feedback on the implementation of the booking system for the community-based RSV immunisation clinics for the catch-up cohort.

Timeline Challenges:

The group agreed the rapid rollout of the RSV immunisation programme for the catch-up cohort was challenging, highlighting the short lead time and resource constraint as the main issues. The urgent requirement for an online booking system for the catch-up cohort was communicated in July 2025 with only a month to deliver the product, though it was initially flagged in April 2025. This coincided with a busy period when teams were already engaged with other priority projects, leading to significant pressure on limited resources within both organisations. The group emphasised the importance of receiving as much advance notice as possible for future programs to allow for better resource allocation and reduce last-minute pressure on teams.

Enabling Factors:

The weekly stand-up calls with all stakeholders, including clinical teams, Swiftqueue, and IT, were welcomed by both organisations and effectively enabled the project to progress in a timely manner and resolved issues quickly. The programme also benefited from the use of previous programme specifications (i.e. the MMR catch up campaign specifications) as a starting point to develop the system avoiding a de novo development.

Financial Management and Approval Processes:

Challenges related to funding clarity, unexpected additional costs, and the necessity for upfront financial approvals and transparent communication between clinical, IT, and vendor teams was highlighted. HSE T&T reported that the project was primarily funded from their budget, despite funding requests centrally, and urged that in future funding needs to be agreed upfront. In addition, it was stressed that specifications must be agreed and approved in advance and any additional work and associated costs requires advanced approval by all relevant parties to avoid unplanned expenditures and ensure proper budget management. Additional costs were incurred due to requests from clinical team (made directly to Dedalus without informing HSE T&T) which were billed at the end of the project. Dedalus reported that the urgency and evolving scope of the project often led them to proceed without

full financial approvals to meet deadlines but acknowledged the need for clearer scope and approval processes to avoid such situations.

Reporting and Data Governance Issues:

The group reported a lack of clear reporting requirements and a clear data governance plan at the outset of the project, highlighting the need for early agreement on data handling and reporting for future programs. HSE T&T outlined the involvement of the Integrated Information Systems (IIS) team throughout the project, but there was lack of clarity on what reporting was needed or how it would be provided, resulting in inefficient use of resources. The lack of agreement on data ownership, long-term storage, and transfer of data collected during the programme was also highlighted with the risk of potential operational costs if data remains in Swiftqueue.

Providers System Capacity and Technical Scalability:

The technical capacity of the Swiftqueue system was discussed with the assurance of its ability to handle high volumes and proposing automation and template-driven processes to improve efficiency for future rollouts. Currently clinic setup processes are manual due to variability, but Dedalus is exploring ways to automate these steps if information is provided in a standardized template, which would reduce deployment time and errors.

The group also reflected on the challenges of translating clinical requirements into technical specifications and the importance of early, structured engagement between clinical, operational, and IT teams. It was acknowledged that clinical teams often lack clarity on technical requirements and equally technical teams benefit from understanding the clinical workflows to propose optimal solutions, mutual understanding of workflows should be promoted in future programmes. Dedalus proposed developing a playbook or spreadsheet template to guide clinical teams in providing the necessary information in a format that facilitates rapid and accurate system setup.

Steering Committee

Feedback was provided by eleven steering committee members including a presentation on insights from an evaluation of the administration of the RSV query log during the Pathfinder 2.0 Programme. This evaluation highlighted the ongoing need for support with queries in Pathfinder 3.0 with the highest number of queries from GPs. The NIO will be responsible for delivering the programme in the coming 2026/2027 season and it was noted that their remit is to respond to clinical queries only. However, in line with the current NIO programmes delivered by GPs/pharmacists/schools immunisation teams/MVTs it is anticipated that queries from members of the public will be redirected to NIO via those clinical teams. HSE Communications suggested that HSELive could provide an additional channel to support for queries from public.

Higher uptake in the first catch-up cohort immunisation period noted when compared to the mop-up period for the same cohort. There was underutilised capacity in clinics raising questions about cost effectiveness but also the delivery was planned around the existing seasonal winter vaccine campaigns (influenza/COVID-19) resulting in early administration of nirsevimab in September 2026 and the need to pivot back to mop-up clinics in November. Moving away from a 'windowed opportunity' to available of the RSV immunisation and making it available during the RSV season was suggested, particularly as parents more likely to seek it later in the year when winter viruses are circulating.

It was noted that the RSV programme could be perceived as 'different' as delivery in community clinics breaks the link with primary care delivery which could impact the trust and confidence in the programme as delivered outside the normal setting for infant immunisations. Primary care delivery would help 'culturally normalise' the programme rather than delivering it as a standalone programme.

Ongoing need for provision of RSV immunisation to the cohort of high risk infants (the 'TCP cohort' in 2025/2026) was raised. All infants referred to TCP for nirsevimab received the immunisation (~300) but data on the cohort of eligible children not available. It was noted that TCP had largely completed this cohort by December 2025 but with a significant amount of unused product. A tendering process is required for home delivery to the high-risk cohort but it was suggested that nirsevimab could be administered to this cohort in either the primary care setting or at home by MVTs in the future (depending on agreed model of delivery) thus negating the requirement for an external third party service provider.

In the absence of a final decision on the model of delivery for the catch-up cohort in the 2026/2027 season, and whilst higher uptake would be expected if nirsevimab is offered in primary care, consideration needs to be given to how uptake could be increased if delivered in community clinics again. It was widely accepted that a decision on model of delivery for the catch-up cohort is required as soon as possible to allow sufficient lead time for implementation (staff training, communications etc).

General Practitioners

Focus groups were held with GPs (n=4) and practice nurses (n=1) to explore primary care perspectives and experience of the RSV immunisation programme in the 2025/2026 season, particularly in relation to the catch-up cohort delivery in the community.

Communications and Engagement:

Feedback on communications and engagement with primary care, in advance and during the programme, was mixed. Some GPs reported hearing about the programme on national radio news programmes rather than directly from the HSE, with others reporting being informed by ICGP and HSE communications via e-mail and webinars. Those informed by ICGP and HSE communications felt the level of communication and engagement with GPs was sufficient and appropriate given general practice was not responsible for the delivery of the pathfinder. GPs with young infants who had availed of the immunisation in the 2024/2025 and 2025/2026 had a greater awareness and were better informed of the programme compared to other colleagues (GPs and practice nurses).

Future Delivery in Primary Care:

Feedback on the possible future delivery of the RSV immunisation in primary care was very positive. Participants reflected that where GP practices are involved in delivering the service staff will be far more engaged and literate in the promotion of the immunisation. In addition, they highlighted GPs are uniquely placed to case find eligible infants and schedule RSV immunisation clinics early in the RSV season and offer it opportunistically as the season progresses. As numbers of eligible infants in each practice will be relatively low ordering of appropriate levels of product is anticipated thus minimising waste.

GPs and practice nurses maintained that awareness of the programme and RSV infection amongst patients likely to grow with each season programme delivered – at present first time parents less aware of RSV than those with two or more children. They noted that RSV awareness amongst parents was heightened during seasons of high RSV infection e.g. post-COVID-19 season recently

Pharmacy and Bioinformatics

The RSV Immunisation Pathfinder Programme represents the first national immunisation programme in Ireland to utilise maternity electronic healthcare record data (MN-CMS) across multiple maternity units to evaluate determinants of uptake and programme performance. This work was enabled through collaboration between pharmacy informatics, clinical teams, public health and national programme leads. The expansion of MN-CMS across maternity hospitals has enabled standardised data collection and analysis, providing timely insights into programme uptake, equity, and operational performance. Continued investment in this capability will be essential to support the transition from a successful pathfinder programme to a sustainable national service.

A key priority is the establishment of dedicated, sustainable funding for pharmacy informatics and clinical analytics roles. Pharmacy informatics teams designed and implemented the analytical framework used to evaluate determinants of uptake across MN-CMS sites, developed standardised reporting methodologies, and supported interpretation of findings for programme governance. Through embedding of data collection within routine clinical workflows, the additional documentation burden was minimised while generating high quality data for programme evaluation. While the current evaluation has demonstrated what can be achieved through collaboration between pharmacy, informatics, clinical teams and public health, maintaining this level of evaluation and continuous quality improvement requires permanent analytical capacity rather than programme-specific or seasonal support. Reliance on temporary programme funding limits sustainability and continuity of expertise. Embedding these roles within routine service delivery would enable ongoing monitoring, rapid identification of emerging issues, and timely reporting to support operational and strategic decision making.

In addition to supporting programme analytics, pharmacy made a broader contribution to the clinical governance and implementation of the RSV Immunisation Pathfinder Programme. Pharmacy leadership supported the development of the national medicine protocol, the standard operating procedure and clinical guidance used to ensure the safe, effective and standardised use of nirsevimab across maternity units and community settings. Pharmacy teams contributed to medicines storage and distribution processes, staff education and training, medication governance, and the provision of expert clinical advice throughout programme delivery.

While the MN-CMS sites were able to embed data collection within routine clinical workflows and generate high-quality electronic datasets for detailed analysis, the remaining maternity units relied on duplicate paper-based data collection forms to capture equivalent information. Although these forms successfully supported local clinical documentation, they require manual collation before meaningful national analysis can be undertaken. Consequently, a substantial volume of valuable programme data currently remains unavailable for timely evaluation, limiting opportunities to fully understand determinants of uptake and service performance across all maternity units. This experience demonstrates that investment in integrated electronic health records, supported by dedicated pharmacy informatics expertise, is not only important for clinical documentation but is fundamental to enabling efficient national programme evaluation.

Continued collaboration across all MN-CMS maternity sites should be prioritised. This collaborative model represents one of the first examples of nationally co-ordinated maternity pharmacy informatics supporting real-world evaluation of a national medicines programme. The development of standardised analytical methods, collaborative reporting and shared code has enabled meaningful comparison across hospitals while reducing duplication of effort. Expansion of this collaborative model to include all and future MN-CMS sites nationally would strengthen benchmarking, improve consistency of reporting, and support equitable service improvement across maternity services.

The next phase of programme maturity should focus on enhancing data linkage capabilities. Linking MN-CMS immunisation records with national surveillance systems and clinical outcome datasets would enable more comprehensive assessment of programme effectiveness, rather than relying on international effectiveness estimates. Such linkage would provide a stronger evidence base for evaluating clinical effectiveness and informing future national immunisation policy.

Several operational constraints identified during the pathfinder programme could also be addressed through further digital development. Greater standardisation of electronic documentation across sites, improved completeness of routinely collected demographic variables such as ethnicity, and automated reporting pathways would reduce manual data collection, improve data quality, and support near real-time programme monitoring. These enhancements would strengthen both service evaluation and broader quality improvement initiatives.

More broadly, the analytical framework developed through this programme has applications beyond RSV immunisation. The combination of shared electronic health records, pharmacy informatics expertise, and collaborative national reporting provides a scalable model that is directly transferrable to the evaluation of other medicines optimisation initiatives, immunisation programmes, and maternity quality improvement projects. Continued investment in this infrastructure will support evidence-based decision making, strengthen national collaboration, and improve the delivery of data-driven healthcare.

Appendix H: Informal Feedback from Roma Health Workers

Feedback from Roma Health Workers on their work in promoting participation in the RSV survey with Roma parents in the South East

23rd April 2026

The feedback below is from the Roma Health Workers in South Tipperary, Wexford and Waterford the South East. The Roma Health Worker for Carlow & Kilkenny is new into post.

Tipperary Roma Health Project

Overview:

- On 09 April 2026, the Tipperary Roma Health Project (TRHP) engaged with five Roma mothers to assess awareness, experiences, and decision-making relating to RSV immunisation for infants.
- Babies were born between July 2025 and January 2026, including firstborn and subsequent children. Mothers ranged from under 17 years to 29 years of age.

Of the five respondents, one baby received RSV immunisation, three did not, and one immunisation status was unknown. Decision-making was strongly influenced by family advice, particularly among younger mothers, and by online information accessed in mothers' own languages. Several mothers reported encountering misinformation online, including claims that RSV immunisation causes serious harm or infant death. This contributed directly to refusal of the immunisation.

Two respondents reported that their babies were later hospitalised with RSV infection. In these cases, mothers expressed regret about declining immunisation and subsequently encouraged other family members to consent to RSV immunisation for their babies. In contrast, the mother who consented to RSV immunisation did so following a family member's prior experience of RSV-related hospitalisation, highlighting the impact of lived experience on health decisions.

Limited recall of hospital-provided information, particularly among under-17 and first-time mothers, was noted. Some mothers were unaware of whether RSV immunisation had been administered, indicating gaps in communication and follow-up.

Overall: findings indicate that RSV immunisation uptake within this group is shaped less by opposition to healthcare and more by information gaps, misinformation, and reliance on trusted family sources. The engagement reinforces the value of culturally appropriate, community-based health education, and the ongoing role of the Tipperary Roma Health Project and Traveller/Roma Public Health Nurse in supporting informed consent, follow-up, and catch-up opportunities for RSV immunisation.

Wexford Roma Health Project

Overview: This report outlines feedback on the uptake and perception of RSV immunisation within the Roma community. While access to RSV vaccination is being achieved in some cases, significant concerns and misunderstandings remain.

There is a notable level of mistrust and misinformation about the RSV vaccine among community members. Older family members, particularly grandmothers, have a strong influence on parental decision-making and often advise against immunisation due to longstanding beliefs or fear of vaccine harm.

Despite some children receiving RSV immunisation at birth within the recommended timeframe, uncertainty persists among mothers. Several have approached healthcare professionals afterward with concerns about vaccine safety, indicating ongoing anxiety and limited confidence even after consent and administration.

These findings suggest that vaccination challenges extend beyond access and availability. Trust, cultural beliefs, and clear, consistent communication play a critical role in shaping perceptions and acceptance of immunisation.

Key Issues Identified:

- Ongoing misconceptions about vaccine safety
- Strong influence of older generations on parents
- Continued maternal anxiety post-immunisation
- Gaps in understanding the purpose and safety of RSV vaccination

Improving culturally sensitive communication and building trust within the community are essential to increasing confidence in RSV immunisation and supporting better health outcomes for children.

Waterford Roma Health Project

Overview: Feedback on RSV immunisation within the Roma community was gathered through conversations with five women (two currently pregnant) and five supporting online surveys. All women had babies within the past 18 months.

Uptake and Experiences

- Four of the five women reported that their babies received RSV immunisation in hospital shortly after birth.
- These women expressed satisfaction with the immunisation, and the two currently pregnant participants intend to have their new babies immunised.
- Hospital-based delivery was viewed positively, as it removed the need to attend additional clinics.

Barriers and Missed Opportunities

- One woman reported that her baby did not receive RSV immunisation because they were outside the hospital delivery timeframe and she was unaware of community catch-up clinics.
- Her baby later contracted RSV and became seriously unwell, reinforcing her willingness to accept RSV immunisation in future, preferably through a GP setting.
- All participants indicated a desire to be informed about catch-up options if hospital immunisation is not possible.

Vaccine Hesitancy

- One participant expressed significant hesitancy due to a previous adverse reaction experienced by one of her children, which she said resulted in ongoing disability.
- Although her youngest child received RSV immunisation at birth, she is reluctant to vaccinate her unborn baby until the cause of the prior reaction is clarified.

Decision-Making and Trust

- Healthcare decisions, including vaccinations, are typically made jointly by both parents when both are involved.
- Where trusting, long-term relationships with healthcare providers exist, women are more open to discussing vaccination choices and available options.

Key Insights

- Hospital-based RSV immunisation at birth is widely accepted.
- Clear communication about catch-up clinics is essential.
- Trust and past experiences strongly influence vaccine decisions.

Appendix I: Evaluation Surveys

Catch-up Programme Parents' Information Leaflet/Poster and Survey
(Immunised Infants)



Respiratory Syncytial Virus (RSV) Immunisation Programme Parent Survey

**Please
take part in
this quick
survey**

Your baby's
experience will
help inform future
RSV immunisation
programmes in Ireland.

Thank you



**Scan this QR code to
access the survey**





Respiratory Syncytial Virus (RSV) Immunisation Programme Parent Survey

**Please
take part in
this quick
survey**

Your baby's
experience will
help inform future
RSV immunisation
programmes in Ireland.

Thank you



**Scan this QR code to
access the survey**



RSV Immunisation Pathfinder 2.0

Catch-up Programme

Provider Feedback Survey

Thank you for taking the time to complete this survey; your opinion is highly valuable and will be used to improve future services.

This survey is:

- **Voluntary and anonymous:** you don't have to take part, and your answers can't be linked back to you.
- **Used only for service improvement:** the information you provide will only be used to improve our service.

The survey complies with GDPR.

- **How are survey data managed?**

These data will be used by the HSE to evaluate the RSV Nirsevimab immunisation programme. These survey data will be deleted from the online survey platform (Qualtrics) within 6 months of the survey being completed. The survey data will be downloaded to the HSE-HPSC server. Data security will be maintained at all times at HSE-HPSC, which is accredited for Information Security Management ISO 27001. HPSC is compliant with the requirements of data protection legislation, specifically the General Data Protection Regulation (GDPR) and the Data Protection Act 2018.

Your consent to participation in this survey is implied should you choose to complete the survey. Participation is voluntary and you can exit the survey at any point.

If you have any questions, please contact: Dr Kevin Brown (HSE):
kevin.brown1@hse.ie.

Thank you for your time and feedback.

To take the short survey, just scan the QR code below using your phone:



Appendix J: Overview of HSE Communications ‘RSV immunisation Communications evaluation 2025-2026’

Purpose & Objectives

The communications programme aimed to increase awareness and understanding among parents and guardians about RSV immunisation, provide clear and accessible information on the importance of immunisation, address hesitancy, and motivate action by parents and guardians (bookings and attending appointments).

Approach

The national communications programme was led by HSE Communications and Public Affairs, in partnership with Public Health, HPSC, and Health Regions. It utilised paid and unpaid communications, PR activities (including expert interviews), social media campaigns, and information materials.

Key messages to be communicated included the safety, effectiveness, and free availability of RSV immunisation for babies born between 1 March 2025 and 28 February 2026, with the advice to avail of immunisation early as it would only be available for a limited period.

Target Audiences

The communications strategy defined the target audience as parents-to-be, parents of babies aged 0–6 months, and underserved communities. This approach of targeted messaging prioritised reaching relevant audiences for maximum impact, rather than broad population reach.

Communication Channels

A range of communication channels were utilised and included:

- Patient information materials (leaflets in 9 languages, posters).
- National and regional press releases, personal stories, and interviews.
- Social media ads (Meta, TikTok, Pinterest) and digital campaigns.
- HSE staff communications (articles, emails).

Evaluation Results - Performance & Impact

Research conducted in Sept 2025: showed 36% of adults had heard about RSV immunisation recently; 57% among those caring for children aged 0–3. Most awareness came from news or social media; healthcare professionals were also influential.

Social Media Impact: 15.1 million impressions, 2.4 million reach, 3.23% CTR (above public health benchmarks). Meta® was the strongest platform; TikTok® and Pinterest® extended reach.

Mop-up Clinics Communications: Urgency-led ads (Nov–Dec 2025) drove 7,374 link clicks (2.07% CTR), with consistent campaign visuals reinforcing trust. Impressions 1.6M with reach of 271K were recorded for this aspect of the campaign.

Press Activity: Multiple national and regional releases, interviews, and op-eds amplified the campaign. Coverage included Virgin Media, RTÉ, Irish Independent, and others.

Website: The RSV immunisation webpage had over 80,000 visits, with peaks at campaign launch and mop-up clinic announcements.

Paid Search Ads: Ran from Sept 2025–Feb 2026, with most clicks in Sept, Dec, and Jan. Top search terms were “RSV symptoms baby,” “Baby RSV vaccine,” and “RSV vaccine” with 41.8K impressions, 6.4K clicks (15% CTR)

Recommendations

Continue targeted social media and press activity, share personal stories, and consider starting search ads earlier.

Support regional communications and leverage SMS for reminders, drawing on HSE Digital’s expertise.

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