Annex C: Malaria vaccine programme update

Section 1 – Executive Summary

The Malaria Vaccine Programme (MVP), identified as a strategic priority under Gavi 5.1, has continued to progress in response to sustained country demand and remains broadly on track as it transitions into the Gavi 6.0 strategic period. To date, the Independent Review Committee (IRC) has recommended 26 countries for sub-national introduction of malaria vaccines[1], including a subset approved for further scale-up in moderate- to high-transmission areas. As of March 2026, 25 countries have introduced the vaccine, with 13 countries scaling up to reach between 85-100% of eligible children in moderate and high transmission areas. Additional countries are forecasted to introduce and scale-up the vaccine in Gavi 6.0.As part of the transition to the Gavi 6.0 strategic period, the scope of the Malaria Vaccine Programme is now capped at up to 70% of the population in moderate to high transmission areas, compared to the previous cap of 85% instituted in June 2024. Countries currently implementing beyond 70% will be supported through a proportional reduction in 2027 and 2028, while maintaining programme continuity and minimising disruption to ongoing delivery. Mobilisation of additional domestic resources and external financing will be key in maintaining and expanding malaria vaccine programmes.

The programme is increasingly focused on achieving and sustaining high coverage and optimising delivery strategies. Countries are strengthening programme performance through ongoing learning on integrated service delivery, routine immunisation strengthening, and targeted community engagement. Early evidence indicates continued improvements in vaccine uptake across multiple countries after 9 to 12 months of introduction. The malaria vaccine learning agenda has also advanced, including the completion of key analytical components in ongoing implementation research projects in seven countries focusing on uptake increase and seasonality, to inform programme optimisation and policy decisions. This annex summarises programme performance, scale-up progress, and key lessons learned.

[1] One country is IRC-approved for subnational malaria vaccine introduction, but will be required to submit a new holistic application (Gambia).

Section 2 – Country Implementation

2.1 Progress update through December 2025

		Through Dec 2025	Status	Cumulative Target (2025)
Impact	Malaria deaths averted	Targets to be established in Gavi 6.0		
Outcomes	Number of Malaria vaccine introductions & scale up	24 10	●	23 9
	Malaria vaccine coverage in Gavi57 (annual figures)	NA		Targets to be established in Gavi 6.0
	Number of children immunised	NA		
Output	Countries approved for: initial intro & scale up	26 15	●	26 14
	Countries with VIGs disbursed for: initial intro & scale up	24[1] 10	●	23 9
	Number of countries with TA deployed	Ph1: 22[1] Ph2: 25	●	Ph1: 23 Ph2: 24
	Number of countries that received first shipment	25	●	23

● On track ● Moderate delays / challenges ● Significant delays / challenges ● No update

1: VIGs and TA for vaccine implementation for 3 countries (Kenya, Ghana and Malawi) received as part of MVIP
2: Currently defined on Total Doses on Gavi Decision Letters up to 2025 for initial introductions
NOTE: Ph1 TA is for application support; Ph2 TA is for vaccine implementation support

The Malaria Vaccine Programme (MVP) has continued to make strong progress against its implementation milestones, with the pace of malaria vaccine roll-out remaining among the fastest observed across Gavi-supported programmes. Country demand remains high, with 30 countries having formally expressed interest in introducing malaria vaccines. To date, 26 country applications have been recommended for approval by the Independent Review Committee (IRC), including 15 countries approved for both introduction and subsequent geographic scale-up in moderate- to high-transmission settings.

Between January to December 2025, seven countries (Burundi, Mali, Ethiopia, Uganda, Guinea, Togo and Zambia) introduced malaria vaccines in their routine immunisation bringing to a total of 24 countries introducing since the start of the Gavi malaria programme. In 2025, nine countries (Mozambique, Uganda, Kenya, Burkina Faso, Liberia, Cote d'Ivoire, Congo Democratic Republic, Sudan and South Sudan) have scaled-up to additional geographic areas following their initial introductions in 2024. With the ongoing expansion of the programme, approximately 10 million children are now targeted annually with the malaria vaccine. Additional countries are planning introduction or scale up in Gavi 6.0, reflecting continued momentum in programme expansion. As one of the approved countries in 5.1, Guinea-Bissau introduced the malaria vaccine in January 2026, bringing a total of 25 countries implementing the malaria vaccine to date.

Technical assistance (TA) has been a critical enabler of both application development and programme implementation under Gavi 5.1. As of December 2025, centrally managed TA support through the Malaria Vaccine Programme has been transitioned to align with a more integrated and holistic approach to country support across Gavi programmes. This shift, coinciding with the close of the 5.1 strategic period, presents

potential risks to the continuity and timeliness of support to malaria programmes. To mitigate these risks, Gavi and Alliance partners are supporting countries to transition malaria vaccine-related assistance into the Targeted Country Assistance (TCA) framework under Gavi 6.0, ensuring continuity in planning, implementation, and programme monitoring. In 2026, targeted malaria-specific TA support is being prioritised for countries with significant scale-up and operational needs, including Nigeria, the Democratic Republic of Congo, and Mali, through the TCA envelope in Gavi 6.0, thereby enabling the continuation and consolidation of existing expanded partner support.

During Gavi 6.0, malaria vaccination coverage estimates will be determined using the administrative and official malaria vaccination coverage reported annually through the WHO/UNICEF Joint Reporting Form on Immunization (JRF). These coverage data will be reported to the Programme and Policy Committee in October 2026.

2.2 Experiences and lessons from country introduction

As additional countries introduce malaria vaccines and early implementers continue to expand coverage, Gavi and Alliance partners are systematically capturing and synthesising implementation experience to inform programme optimisation. Learning has been embedded throughout programme implementation, drawing on post-introduction evaluations (PIEs) and the Malaria Vaccine Coordination (MVCT) through regular updates and a survey of TA partners on good practices and lessons learned. Preliminary findings from the MVCT survey indicate:

- Strong coordination between immunisation and malaria programmes is essential to deliver malaria vaccination as part of a comprehensive malaria control strategy. Cross-programme technical working groups and joint planning processes continue to underpin data-driven targeting and consistent messaging, while strengthening collaboration remains a priority for effective and efficient service delivery.

- Defaulter tracking has emerged as a critical determinant of vaccination schedule completion, particularly for later doses, requiring standardised tools and systematic follow-up approaches.

- Additional and complementary resource mobilisation (both domestic and external) is needed to address systemic issues beyond the malaria vaccine programme. Routine immunisation and health system strengthening are critical, including regarding data and information systems, and community health.

- Supply planning and management remain an area requiring close attention, with reported challenges related to delays in customs clearance, co-financing payment, and in-country stock-outs due to national or sub-national supply chain capacity.

Section 3 – Scope of Gavi support, key design updates and outlook

3.1 Programme scope

In December 2025, the Gavi Board approved a recalibration approach to scoping and pacing for malaria and other vaccine programmes based on available resources, technical consultations and additional work undertaken through the Country Vaccines Budget Task Team. In Gavi 6.0, the malaria programme is defined as a discretionary vaccine programme and the support for malaria vaccines is capped at 70% of moderate and high malaria transmission areas; a further reduction from the 85% cap instituted in June 2024. This cap applies both to countries which are not yet implementing above 70% and to countries already implementing above 70%. A transition period is available for countries that are already implementing above 70% of moderate-high transmission areas, with 2026 as a grace period (no changes expected to scope), and a proportional reduction over the next 2 years (i.e., 2027 and 2028) from 85% to 70% by 2029. To calculate the vaccine budgets, the Board approved the introduction of a "floor" for discretionary funding for Initial self-financing (ISF) countries covering the forecasted cost of existing immunisation programmes, as well as malaria scale up and new introductions in up to 70% of moderate-high transmission areas. The floor does not apply for Preparatory Transition and Accelerated Transition countries. Gavi and partners will be supporting countries with programme prioritisation — encouraging domestic resource mobilisation and other sources for funding gaps. The malaria vaccine programme remains a priority in Gavi 6.0, as we transition to a more holistic approach to vaccine portfolio optimisation, application process and grant management including for malaria. In addition, progress continues toward a strengthened comprehensive malaria control approach with other malaria donors and partners.

3.2 Gavi's role in managing product allocations, co-financing, and country affordability

Through Gavi's successful multi-vaccine market shaping strategy, the malaria vaccine supply is sufficient to meet country demand. In addition, Gavi has secured commitments for prices of malaria vaccines to decline: RTS,S/AS01 from currently US$ 10.7/dose to less than US$ 5/dose progressively by 2028, R21/Matrix-M from currently US$ 3.9/dose to US$ 2.99/dose should be expected from end-2026. Gavi continues to support the two WHO-prequalified malaria vaccines, which have demonstrated strong safety, efficacy, and cost-effectiveness profiles. To ensure supply security and sustain a healthy multi-vaccine market, Gavi will continue to implement its "no brand choice" policy under Gavi 6.0, including maintaining restrictions on elective product switches and applying product matching principles for new introductions that balance country preferences with considerations of affordability, supply availability, and long-term market stability. This approach also helps manage emerging country preferences and potential requests for product switching, ensuring alignment with supply availability and market sustainability objectives. Although both vaccine manufacturers have announced price reductions for the Gavi 6.0 period, there will remain a significant price difference between the two vaccines in the near term.

The Secretariat will continue to balance market shaping objectives with country affordability, particularly in the context of differentiated product pricing and the revised programme scope under Gavi 6.0, while supporting countries to progressively increase their financial contributions over time. Self-financing will become increasingly critical under Gavi 6.0, given the gap between current implementation levels and countries' desired coverage, in the context of the 70% programme scope cap and more constrained Vaccine Budgets. While vaccines financed may be funded and directly procured from UNICEF by countries beyond Gavi scope of support, these costs incurred by countries are expected to influence both country demand and the overall trajectory and scale-up of the malaria vaccine programme.

Section 4 – Malaria Vaccine Programme Learning Agenda

The Malaria Vaccine Programme Learning Agenda (MVLA) supports evidence generation and knowledge translation to inform optimisation of the malaria vaccine programmes. Drawing from the *Global Research Agenda for Malaria Vaccine Introduction and Implementation* (https://iris.who.int/handle/10665/380228) and reflecting essential questions for the MVP, Gavi commissioned a set of implementation research projects through a competitive request for proposal. In collaboration with Alliance partners, seven implementation research projects were selected and four consortia including global and local research institutions were contracted.

The awarded implementation research projects address the MVLA aims as follows:

1. Identify approaches and interventions to increase the uptake of malaria vaccine and other health interventions during routine visit timepoints/ touchpoints (Burkina Faso, Mozambique, Kenya and Liberia), including both supply and demand-related barriers and enablers for vaccine uptake.

2. Conduct a comparative assessment on the feasibility and effectiveness of alternative schedules and delivery strategies of malaria vaccines in areas of highly seasonal malaria transmission (Guinea, Benin and Nigeria)

The uptake-focused implementation research projects (Burkina Faso, Mozambique, Kenya and Liberia) and one seasonality-focuses implementation research project (Nigeria) are nearing completion in Q1 2026, while the remaining two seasonality-focused implementation research projects (Guinea and Benin) are scheduled for completion in Q4 2026.

As the Gavi implementation research portfolio reaches maturity, Gavi, with the support of Sabin Vaccine Institute, convened a capstone workshop in Kisumu, Kenya, in March 2026, bringing together representatives from the seven implementation research projects, the MVLA advisory committee, and key partners including WHO, UNICEF, the Global Fund, and the RBM Partnership to End Malaria, to share findings, synthesise cross-project learning, and develop a collective roadmap for knowledge dissemination and translation.

Preliminary results available from all seven implementation research projects indicate:

1. Learning from the uptake-focused projects indicates that improving malaria vaccination coverage is primarily about strengthening routine health systems and ensuring consistent implementation of existing good practices. Systematic screening of vaccination status at every touchpoint, integrated service delivery (with other antigens, malaria prevention, and child health services), and robust defaulter-tracing mechanisms anchored by community health workers have been consistently associated with improved uptake and completion.

2. Findings from the seasonality-focused projects are testing alternative delivery strategies in highly seasonal settings through seasonal or hybrid approaches (vs. age-based delivery) and show significant improvement in uptake when supported by adequate planning, coordination, and supply readiness. Aligning vaccination with malaria transmission periods, leveraging seasonal malaria chemoprevention platforms for identification and referral of un- and under-vaccinated children, and strengthening pre-season community engagement have all emerged as cost-effective strategies in highly seasonal malaria transmission settings.

Both project-specific and cross-project learning are being synthesised for structured dissemination and knowledge translation in 2026 and beyond to inform current and future MVP implementation and optimisation through country dialogue, portfolio planning, and inter-agency collaboration in Gavi 6.0.