THE GLOBAL FUND

Malaria Information Note

Grant Cycle 8

Core Guidance

Date published: 15 December 2025

Cover photo: The Global Fund/Vincent Becker

Table of Contents

Adapting GC8 to new realities on the path to self-reliance

The result of the Global Fund Eighth Replenishment, while still partial, reflects the increasingly challenging global health landscape that the partnership must now navigate. Whereas the Global Fund's unique model remains strong, it is clear that **the approach to Grant Cycle 8 (GC8) must evolve**. With less funding, the partnership will need to work smarter and collaborate even more effectively.

In GC8, most countries will receive reduced allocations. Those with higher economic capacity and lower disease burden will see a more significant reduction. However, all countries will need to make difficult but necessary decisions to selectively target investments to protect HIV, TB and malaria outcomes and sustain momentum, **and more rigorously use Global Fund investments** in a catalytic manner, in complementarity with domestic budgets and other funding.

The Global Fund will introduce significant changes and strategic shifts in GC8, including revamping its approach to co-financing, sharpening the focus on transition planning, supporting public financial management, integration, and other changes being discussed by its governance bodies. Country context will inform sustainability and transition pathways.

During this phase, countries can start preparing by planning how to:

- **Accelerate the path to self-reliance.** All countries will be expected to determine what changes are needed on the path to self-reliance and sustainability. Increasing domestic financing for health will be essential to advance sustainability progress across all portfolios. The Global Fund will continue to support to accelerate transitions from its investments effectively and responsibly with progressive take-up by governments, especially for human resources for health and commodities.
- **Rigorously prioritize investments and strengthen value for money.** Countries can expect a strong emphasis from the Global Fund on strategic prioritization of investments that advance equitable access to essential services for the most vulnerable populations and strengthen health and community systems. Optimization of investments and streamlined implementation arrangements to maximize value for money will be key. Community leadership and engagement will continue to be central to the partnership's approach.
- **Maximize health outcomes and sustainability through integration** of health systems and service delivery. Optimizing and sustaining HIV, TB and malaria outcomes requires integration to strengthen results, promote equitable access, and enhance efficiency and cost-effectiveness. This should be pursued based on countries' specific context and priorities. Other enablers include removal of barriers to human rights and gender equality, to reach most at-risk populations.
- **Consistently advance access to innovations.** Ensuring faster introduction and scale-up of innovations, whether in products, delivery platforms, or data systems, will be central to

achieving accelerated results across HIV, TB and malaria. But innovations must be integrated into people-centered service packages so those who can benefit the most can access them.

GC8 Information Notes: guiding prioritization

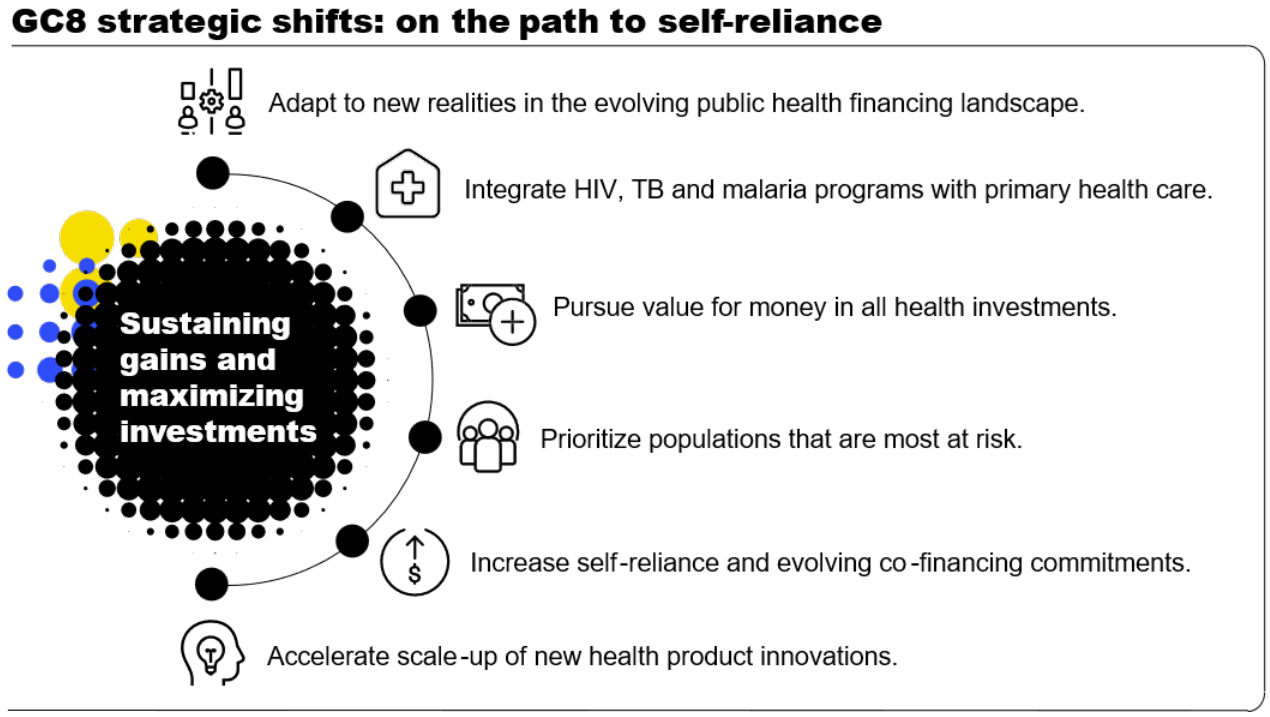
GC8 investment guidance more clearly outline areas of investment that are high priority and those the Global Fund is unlikely to fund or that require strong justification so countries can decide accordingly. The guidance emphasizes how to optimize investments and drive cost effectiveness to maximize results.

Countries should identify priorities for **integration of HIV, TB and malaria services** into primary health care and across health and community systems pillars. **Community, human rights and gender** considerations should be planned holistically and specific investments should enable equitable access to services.

Two other areas of attention include health product management for all essential medicines from all sources (including non-grant procurement) and **support for introduction and scale-up of innovations.**

Areas of focus to transition from Global Fund financing include: health worker remuneration, program management and maintenance and operating costs for equipment and infrastructure. Countries should **progressively use domestic financing for essential diagnostics and medicines** such as first-line treatment for HIV and TB, drugs for malaria in pregnancy and malaria rapid diagnostic tests.

What's new across all the investment guidance notes:



Additional Considerations

Safeguarding Human Rights standards ensures the provision of safe, people-centered services, are an obligation under the Code of Conduct for Recipients of Global Fund Resources and an integral part of grant agreements. These include: granting non-discriminatory access to services for all; employing only scientifically sound and approved medicines or medical practices; not employing methods that constitute torture or that are cruel, inhuman or degrading; respecting and protecting informed consent, confidentiality and the right to privacy concerning medical testing, treatment or health services rendered; and avoiding medical detention and involuntary isolation.

Sustainability, Transition and Co-Financing. The Global Fund's approach to sustainability focuses on the ability of the health system to both maintain and scale up service coverage to a level that will provide for continuing control of a public health problem of national and potentially global concern and support efforts to successfully manage and eliminate the three diseases beyond financing by the Global Fund or other external partners. See the Global Fund's Sustainability, Transition and Co-Financing (STC) Policy and Sustainability, Transition and Co-Financing Guidance.

Value for Money. Value for money considerations (effectiveness, efficiency, equity) are embedded throughout Global Fund information notes. For RSSH focus should be on: strong systems for monitoring health system performance and linking them to financial and other resource data to support planning to fill gaps and optimize resource use and reach underserved groups; making progress on integration; achieving good systems for cost management in major areas of HSS spend including health product management, HRH and program management costs. For more information, please see the Value for Money Technical Brief.

Protection from Sexual Exploitation, Abuse and Harassment (PSEAH) is an obligation under the Code of Conduct for Recipients of Global Fund Resources and an integral part of grant agreements. During the planning and design of program interventions, and in accordance with the principle of 'Do No Harm', applicants should consider how to mitigate any risk of SEAH, and how to keep children safe. Program-related risks of SEAH to beneficiaries, and to people involved in service provision (particularly outreach workers, peer educators and CHWs) should be identified in the proposed interventions, which should also include necessary mitigation measures to ensure that services are provided to, and accessed by, beneficiaries in a safe way.

Challenging Operating Environments (COEs). In portfolios where the Global Fund's challenging operating environment policy can be applied,[1] the Global Fund suggests that applicants consider an appropriate mix of humanitarian and systems strengthening approaches that focus on building resilience when addressing responses to crises and/or emergencies. This will enable a continuum from emergency response to sustainability.

Climate and Health. RSSH investments directly and indirectly contribute to managing climate risks and increasing climate resilience of health systems under the current and future climate scenarios, including more robust supply chains, environmentally sustainable waste management

and clean energy systems (including solarization), climate-informed health information and surveillance systems, and human resources for health. See the Technical Brief on Climate and Health.

Align RSSH digital investments in HRH, including CHWs, surveillance, health information and laboratory systems to strengthen digitalized disease surveillance and programmatic response monitoring systems.

1. Malaria investment approach

Given the challenging funding landscape for health, the malaria investment approach should first consider what human resources, program management and other service delivery costs typically funded by the Global Fund can be transitioned to government support. This could include campaign service delivery costs as well as support for primary health care service delivery and community health workers providing iCCM. While every country context will be different, the funding requests should all outline what is planned to be transitioned to domestic resources over the course of the grant.

Optimizing malaria control with limited resources requires a careful balance between comprehensive case management and sustained preventive interventions. Reducing either will inevitably lead to more cases and deaths. In the case of prevention, scaling back coverage in areas with high or moderate transmission potential is likely to trigger a resurgence of malaria, driving up case management needs and costs and often offsetting any short-term financial savings achieved by scaling-back. Maintaining this balance is critical when developing funding requests.

Funding requests to the Global Fund should prioritize **high-impact, evidence-based interventions** drawn from **subnationally tailored national strategic plans**, and **aim to reduce morbidity and mortality through timely and equitable access to quality diagnosis, treatment and prevention interventions.**

These should be backed by essential surveillance, monitoring, evaluation and learning to guide impactful implementation.

- A subnational tailored response includes targeting of interventions and implementation strategies, based on the analysis of:
- the malaria epidemiology and historical/current transmission, and other malaria-relevant data;
- functionality and gaps in the health system;
- geographic, economic, social, environmental and climate data;
- information pertaining to barriers to care, equity, human rights and gender equality;
- a country's political and socio-cultural context;

- an assessment of intervention coverage, quality and performance data at the lowest possible level of the health system;
- opportunities for support and synergies to increase effective coverage of complementary interventions.

Programmatic prioritization should include consideration of all malaria interventions and related systems for health investments (including those not funded by the Global Fund as well as relevant interventions not directly managed by the malaria control program) across total planned and available external and domestic funding to maximize impact, minimize duplication, reduce fragmentation, and highlight persistent gaps. Refer to the latest WHO Guiding principles for prioritizing malaria interventions in resource-constrained country contexts.[1]

This holistic plan should be communicated in the funding request with an indication of planned and approved investments financed by other donors such as Gavi, the Gates Foundation, bilateral funders and any other donors in addition to a clear indication of committed domestic resources at local and national levels.

The WHO Subnational Tailoring Manual[2] is a useful resource to guide this process. While the funding request needs to cover the full three-year period of the grant cycle, the Global Fund encourages annual reviews considering the malaria response and adaptations may need to be more dynamic.

Key cross-cutting concepts that remain critical to the most efficient and effective malaria response include:

1. **Integrated, accessible, quality services** across public, private, and community sectors are essential, leveraging primary health care and related platforms. Programs should consider leveraging service delivery platforms/mechanisms able to maximize reaching target populations by identifying and addressing key service delivery and health system challenges and opportunities, including but not limited to service organization, supply chain, data systems/surveillance and human resources for health along the continuum of care across facility, outreach and community levels. See the Global Fund Technical Brief on Integration.
2. **Program management.** Strong leadership at national and local levels, including partners beyond the malaria program and the Minister of Health, such as community actors and civil society, is critical to implementing a successful subnational tailored program. This includes strong cross-cutting health systems programs for successful malaria programming as the majority of malaria interventions are integrated in primary health care. Key personnel with sufficient capacity should be funded through government resources and the program should be adequately resourced to carry out routine activities. In circumstances where Global Fund support is needed, applicants should provide strong and clear justification and a transition plan for future coverage through domestic resources. Please refer to the Health Sector Governance section of the RSSH-PPR Information Note.
3. **Barriers to access to malaria services related to equity, human rights and gender** must be explicitly addressed in subnational tailoring and implementation to ensure inclusive and

equitable people-centered services. Particular attention is required in fragile settings/emergencies as these situations exacerbate other barriers and need to be addressed holistically. Programs should consider sociocultural, economic and political factors that influence risk, access, and engagement. While often implicit in malaria programming, these issues should be clearly reflected in funding requests, including relevant interventions from the human rights and gender modules under Resilient and Sustainable Systems for Health (RSSH) in the Global Fund Modular Framework. Barriers to malaria services extend beyond the health sector and should be tackled through comprehensive, coordinated and multi-sectoral responses. Country/local context-specific, malaria-relevant disaggregated data and assessments based on equity, human rights, gender and key social drivers (e.g., socioeconomic status, migrant/refugee status) can guide tailored interventions. Useful references from the Global Fund include: How to Strengthen Gender Approaches within the Malaria Response and the Technical Brief on Equity, Human Rights, Gender Equality and Malaria.

4. **Community leadership and engagement**, including through community-led organizations, should be integrated into malaria planning, service delivery and monitoring at all levels. This includes meaningful participation in decision-making platforms (including in Country Coordinating Mechanisms (CCMs)) and support for community-led monitoring to improve service access, quality and responsiveness. Special focus should be given to high-risk and underserved populations (see the Technical Brief on Equity, Human Rights, Gender Equality and Malaria, in particular Table 3 on p. 19 for examples of high-risk and underserved populations).
5. **Pandemic preparedness and response** (PPR) efforts can leverage malaria/primary healthcare programmatic platforms, especially for acute febrile illness and community health. Broader PPR efforts should include malaria to strengthen surveillance, laboratory, community awareness/social behavior change, and human resources (including community) capacities. Malaria-specific and broader health and humanitarian platforms should include holistic responses to humanitarian/public health emergencies, including malaria epidemics.
6. **Environmental and climatic factors** disproportionately influence malaria transmission and should inform subnational tailoring and broader national planning. National programs should explore multisectoral partnerships including communities for prediction, response and mitigation for malaria outbreaks and extreme weather events. Refer to the Technical Brief on Climate and Health for further information related to malaria and climate change.
7. **Challenging operating environments** (COEs) require adaptive approaches with emphasis on integration, including support for internally displaced people, migrant populations and refugees at malaria risk, and collaboration with humanitarian actors.[3] The Emergency Fund remains available in GC8 and can provide short-term funding in certain contexts.
8. **Sustainability planning** should address financial, governance, political and service delivery dimensions throughout program design, recognizing that Global Fund funding request timing is not always aligned with national health sector strategic planning. The Global Fund's Sustainability, Transition and Co-financing Guidance *(forthcoming)* includes detailed guidance on national planning related to sustainability, including the importance of partnering with

relevant stakeholders, including ministries of health, universities, NGOs[4], civil society, communities, and private sector partners in coordinating planning activities and their implementation.

9. **Procurement** should consider the following:

- **Reference pricing**. For all procurement channels, health product management templates should use the pooled procurement mechanism reference pricing for health products and associated services.
- **Market intelligence**. Principal Recipients should monitor any changes in the Global Fund's advice on lead times page to enable procurement orders to be placed on time should lead times for some products be extended.
- **Optimized procurement channels for grant and domestic financing**. Using the Global Fund's pooled procurement mechanism (PPM)/Wambo is recommended where possible. It allows countries to benefit from negotiated terms, prices and quality-assured products from a diversified and sustainable supply base. This also supports optimization of the Global Fund's purchasing power to sustain access and pricing. It can also simplify orders, especially for lower volume products such as children's drugs, that may become scarce on the global market.
- **Ending customization** of, for example, labels and leaflets increases flexibility for the Global Fund to be more responsive to supply needs. This includes customization labels for insecticide treated nets (ITN).
- **Equipment.** Since purchase of lab and other health product equipment is generally not prioritized within funding requests, it is important to prioritize service, maintenance and warranty coverage of existing equipment to ensure precision of investments and maximize the useful life of the equipment.
- For **quality assurance and supply management**, follow Global Fund Quality Assurance Policies and health product guidelines. See the Global Fund's Guidelines for Health Product Procurement and Supply Management for more details.
- **New product introduction.** Throughout GC8 implementation, programs should monitor market developments and consider the introduction of new offerings where relevant, once products become eligible for Global Fund procurement.

2. Malaria investments

Global Fund-supported **interventions, products and implementation modalities are required to be aligned with WHO normative guidance.** As such, the sections below focus only on specific considerations for requests for Global Fund support on each technical intervention area for malaria.

2.1 Case management

Key messages

- Ensure equitable, uninterrupted access to early diagnosis and effective treatment.
- Strengthen service quality and integration with relevant services (e.g. maternal, newborn and child health) and packages of services along the continuum of care across facility, outreach and community levels.
- Promote routine data collection and use for continuous quality improvement of intervention implementation and monitoring of malaria trends to inform the broader programmatic response.
- Identify and address all barriers to care, including but not limited to equity, gender and human rights-related factors and health system challenges to expand access and improve service quality and equity.
- Ensure evidence-informed selection of antimalarial drugs and diagnostics. See the RSSH-PPR information note for further guidance on supply chain strengthening and information management. For malaria forecasting and quantification, consider analysis of consumption and testing data, potential impact of reduced coverage of prevention interventions, and incorporating climate/disaster risk into distribution plans. See more information on Global Fund Supply Chain.

Diagnosis

The Global Fund continues to support confirmation of parasitological diagnosis with quality-assured microscopy or rapid diagnostic tests (RDTs), in line with WHO guidance.

Product selection and quality assurance of RDTs

- Select RDTs based on local species epidemiology, i.e., prioritize *Plasmodium falciparum* (*Pf*)-only RDTs in *Pf*-dominant settings. The Global Fund will only support use of *Pf*/Pan RDTs where clinically significant non-*Pf* infections are documented; use of *P*f/Pan RDTs in settings with a prevalence of non-*Pf* infections below 5% will require justification.
- Use shared-buffer kit formats rather than individually packaged test kits where appropriate to lower logistics costs.
- Within species categories, and in the absence of high prevalence of pfhrp2/3 deletions, the RDT brands included in the Global Fund's product eligibility lists are considered interchangeable and are not a selection criterion. The Global Fund does not support brand-specific procurement and training.
- Maintain diagnostic quality through integrated supervision and external quality assessment (EQA).
- **Not supported.** Routine use of nucleic acid tests (e.g., loop-mediated isothermal amplification (LAMP), polymerase chain reaction (PCR)) and highly sensitive RDTs for low-density infection

detection are not currently recommended for clinical management and not supported for procurement by the Global Fund for routine case management. Similarly, multi-disease diagnostics and automated or AI[5]-assisted RDT diagnostics are not currently recommended and will not be supported.

Microscopy

- Limit microscopy to settings where it is essential (e.g., elimination tiers, in-patient facilities).
- Leverage cross-program procurements, EQA systems, and RSSH grants to strengthen laboratory infrastructure and expertise needed for molecular analyses, including for therapeutic efficacy studies (TES) genotyping, PCR correction, and *Pf*hrp2/3 gene deletion studies financed under malaria grants. This approach will help countries gradually build local capacity and ensure continuity of critical biological threat surveillance. (See RSSH-PPR information note for details on integrated support for lab strengthening).

Biological threats – *pfhrp2/3* gene deletions

- If a program has not yet conducted baseline surveillance for *Plasmodium falciparum* Histidine-Rich Protein 2 and 3 (*pfhrp2/3)* gene deletions, this is a priority for GC8 funding. Afterwards, periodic surveys (q2-3 years) can be supported.
- In the event of confirmed *pfhrp2* deletions in line with WHO updated threshold guidance, the Global Fund supports the procurement of alternative RDTs to HRP2-only RDTs for detection of *Pf*. Current product availability is limited to those with a recommendation by the Expert Review Panel for Diagnostics (ERPd), a bridge in advance of WHO pre-qualification. Procurement of ERPd approved RDTs will require justification and periodic review for subsequent procurements.
- "Next-generation RDTs" (e.g., with improved lactate dehydrogenase sensitivity and possibly combined with HRP2) may become available and WHO pre-qualified during GC8. As guidance on use cases for next generation RDTs evolves, the Global Fund may consider their procurement as part of a strategy to proactively mitigate *pfhrp2* deletions in line with developing guidance.

(a) Treatment of uncomplicated malaria

The Global Fund supports improving access to quality diagnosis and treatment of malaria at public, private and community levels of the health system through integrated platforms.

- Procurement of WHO-recommended, prequalified artemisinin-based combination therapies (ACTs), in line with national guidelines and the Global Fund's Quality Assurance Policies and Guidelines for Health Product Procurement and Supply Management.
- Support transmission reduction with single low-dose primaquine co-administered with ACT for confirmed *Pf* cases, as per WHO recommendations (currently in low transmission settings, pending updated guidance in 2026) where feasible and cost-effective.

- For support to improve access and quality of care through all channels, please refer to the RSSH-PPR Information Note for further details in addition to the points below:
    - Continuous quality improvement should be integrated (e.g., with on-site support for integrated management of childhood illness); standalone malaria-specific training and supervision will need strong justification. The Global Fund encourages prioritizing support for districts/facilities that do not consistently meet national targets.
    - Support at the community level should be provided through the primary health care platform with strong linkages between communities, community cadres and health facilities to improve accessibility, capacity, quality and timeliness of diagnosis, treatment and referrals to care and prevention interventions. Ensure monitoring and support across the care continuum from community to health facility. Support for non-malaria integrated community case management commodities can be included but applicants are strongly encouraged to use domestic resources for this area (if so, these can be counted as co-financing).
    - Consider outreach in remote or insecure areas and among vulnerable populations (e.g., mobile/migrants, refugees, internally displaced persons (IDP) and those in areas where complex emergencies, weather events, displacement or other factors limit access to health services.
    - Global Fund can support the development of private sector strategies and strengthening of routine reporting and quality of case management including ensuring confirmation of malaria infection with diagnosis before treatment, particularly where care-seeking in the private sector is significant. Consider leveraging private sector initiatives across other disease programs. Global Fund support for the private sector co-pay of ACTs is no longer available.
    - Support for evidence-based social and behavior change communication (SBCC) should be integrated into service delivery to promote early care-seeking and address harmful social and gender norms, stigma and discrimination.
    - Initiatives such as Breaking Down Barriers in Grant Cycle 7 (GC7) to reduce equity, human rights and gender-related barriers to malaria services may be available; if confirmed, details will be shared with applicants.

Addressing antimalarial drug resistance (AMDR) and multiple first-line treatment deployment

In sub-Saharan Africa, overreliance on a single ACT (artemether-lumefantrine) is one of the major drivers for artemisinin-partial and partner-drug resistance. The Global Fund strongly encourages all countries in sub-Saharan Africa to diversify their ACTs and supports adoption of multiple first-line treatments to slow this spread of drug resistance in line with WHO recommendations.[6] The funding request should reference the status of AMDR mitigation strategies and planning. Support can be requested for policy development, drug procurement, implementation, surveillance and technical assistance and should be considered in conjunction with other partner support and initiatives for AMDR.

- While at the time of writing there are significant price differences between some ACTs, all WHO prequalified ACTs are available for procurement with Global Fund resources. The Global Fund continues to work with partners and manufacturers on market-shaping to make existing ACTs more affordable and to encourage new ones in the market.
- Particularly in sub-Saharan Africa, where reliance on artemether-lumefantrine is currently high, funding requests are encouraged to support a full policy shift with enabling environment (e.g., health systems readiness, procurement plans) that allow effective deployment of multiple first line therapies. Forecasting, quantification and procurement planning should include incorporation of alternative ACTs. Exclusive reliance on artemether-lumefantrine (or any particular ACT) throughout the grant cycle is not encouraged.
- Initiatives such as the Access Fund in GC7 (NextGen Market Shaping Strategic Initiative) to promote availability of antimalarials to be used for multiple first-line treatment approaches may be available; if confirmed, details will be shared with applicants.
- The Global Fund can support monitoring of ACT and RDT use in the private sector, to inform private sector strategies for quality case management and drug resistance response (e.g., ACTwatch Lite[7]).

(b) Management of severe malaria and referral

- Parenteral artesunate (preferentially per WHO recommendations) and intramuscular artemether can be supported for severe malaria in all age groups, including pregnant women.
- A strong justification for procurement of parenteral quinine is needed for Global Fund support even if it is included in treatment guidelines.
- For community-level pre-referral care, rectal artesunate suppository for children under 6 years old continues to be supported. If included in the funding request, ensure plans include attention to functional referral systems.

(c) Management of *Plasmodium vivax*

- In contexts with a significant burden of *Plasmodium vivax (P. vivax)*, the Global Fund continues to support procurement of primaquine and implementation for radical cure as well as determination of patients' glucose-6-phosphate dehydrogenase (G6PD) status to prevent hemolysis. The Global Fund can support procurement of G6PD diagnostics that are eligible according to the Global Fund Quality assurance list for in vitro diagnostic (IVD) in line with WHO recommendations for the treatment of vivax malaria. For regimens including tafenoquine or 7-day primaquine (high dose), only semiquantitative G6PD tests can be used to inform G6PD activity and treatment decision making. Countries must demonstrate systems for pharmacovigilance, including patient education, follow-up and referral mechanisms and monitoring of relapses to assess cure efficacy.
- At the time of writing, WHO only recommends the use of tafenoquine in South America. Global Fund support can be used for procurement (and for required G6PD testing) in this setting. Procurement outside of South America may be considered if criteria are met, including in-country registration of tafenoquine and G6PD near-patient test, inclusion in national guidelines

and support by a plan for controlled deployment or operational research, with approval subject to review by the Global Fund and WHO.

- For the roll-out of shorter regimens (e.g., seven-day primaquine or tafenoquine), consider leveraging partner support for implementation.

(d) Therapeutic efficacy studies and surveillance

- Routine TES should be prioritized for Global Fund support under essential surveillance if not covered by another partner. Funding should be sufficient to enable their quality implementation in line with WHO protocols and standards, including funding for molecular markers of resistance, any needed technical assistance and laboratory analyses.
- Where external technical assistance support is needed, applicants may request support from WHO TES consultant roster and other partner support. Associated costs may be included in the funding request, while efforts should be made on better leveraging national/regional research institutions to strengthen local capacity for sustainability.

2.2 Vector control

Key messages

- Vector control saves lives. Reducing coverage – which may be necessary in areas of severely constrained resources, and potentially appropriate in some areas -risks more cases, deaths and higher treatment costs in areas with current transmission or receptivity. The balance between prevention and treatment must reflect this risk.
- Proposed approaches should be aligned with current international guidance and follow national strategies which should be tailored subnationally based on currently available data (e.g, epidemiologic, entomologic, equity, climate and environment, use and use context, funding availability or other relevant areas).
- WHO recommends ITNs and Indoor Residual Spraying (IRS) as the interventions to be used at scale, noting that either intervention should be deployed at a level that provides the best value for money while reflecting programmatic realities. Given ITNs currently offer the lowest cost per person protected with an effective recommended intervention for use at large scale, and that this is – a particular consideration when aiming to maximize coverage of at risk populations in resource constrained settings, it is likely that in many settings they will be the most pragmatic and value for money approach for Global Fund grants. Where IRS is proposed, beyond epidemic response, rationale and plans for financial sustainability must be explained.
- Supplementary interventions (e.g., larviciding, spatial emanators) require strong justification if there are gaps in core interventions but may well play a role in certain settings.

(a) Insecticide-treated nets

Describe the ITN strategy, indicating target populations, ITN types (e.g. Dual Active-Ingredient, pyrethroid-piperonyl butoxide (PBO), pyrethroid-only, or new classes that may be recommended),

coverage targets and operational approaches (i.e., distribution channels, SBCC activities and other elements). All aspects are expected to be subnationally tailored to local epidemiology, vector profile (including insecticide resistance), historical ITN access and use, behaviors by subpopulation and equity needs as well as other appropriate contextual information – as informed by most recent available data. Additional considerations are outlined below.

Target populations/geographic areas

- Clearly outline targeted areas/populations prioritizing coverage in high and moderate burden areas and biologically vulnerable groups (i.e., children under 5, pregnant women or other populations at increased risk, such as people with least access to care, people living in climate-vulnerable areas (e.g. flood-prone, deforested) and, if ITNs are an appropriate tool for these groups, people living in displacement (e.g., internally displaced people) mobile and migrant populations in high risk areas.
- In areas where historic coverage cannot be maintained (but with ongoing transmission), explain how the risk of resurgence will be mitigated, such as ensuring sufficient surveillance and case management provisions.
- Due to differences in transmission, ITN use and socio-economic factors, major urban areas should generally be excluded from mass ITN campaigns, with alternative strategies used to ensure access to malaria services. A strong justification is required if included; for example to support contexts such as urban slums, or areas with *Anopheles (An.) stephensi,* or higher transmission/receptivity areas, where there is reason to believe ITN distribution may be efficient and feasible, and evidence demonstrating that, given access, good use can be achieved.

Product specific issues

- The Global Fund will no longer procure pyrethroid-only ITNs where pyrethroid resistance is documented. Pyrethroid-chlorfenapyr dual active ingredient ITNs or pyrethroid-piperonyl butoxide ITNs should be deployed based on the insecticide resistance profile (decision making between these should consider cost-effectiveness tradeoffs). Should other non-pyrethroid-only ITNs become available during GC8, Principal Recipients may wish to reassess their selection. Noting that insecticide resistance data is surveillance site based, programs should indicate how available data has been extrapolated.
- Given the cascade of WHO recommendations on net types, reflecting current costs and effectiveness data, there are no settings where the Global Fund would currently envisage supporting pyrethroid-pyriproxifen nets.
- For cost-effectiveness and optimization reasons, ITNs must be rectangular and one of the standard sizes (currently 180x160x150cm and 180x190x150cm; requests for other sizes need robust justification and additional approvals). Colour (white or light blue) can be specified for procurement. The following cannot be specified for procurement: material, pyrethroid type, insecticide or pyrethroid-piperonyl butoxide concentration.

- If applicants request non-standard sizes, shapes (such as insecticide-treated hammock) or specific fabrics, these requests must be supported by local evidence of significant impact on differential ITN use given ITN access and/or durability, or be linked to specific use situations related to otherwise excluded groups (e.g. for hammock nets). If necessary, funding for this evidence generation can be supported. Pyrethroids are considered one class and specific pyrethroid insecticides cannot be requested on any type of ITN (pyrethroid-only, pyrethroid-PBO, pyrethroid-chlorfenapyr).
- Environmental and waste management plans for ITNs should be explained.

Deployment strategy

- Campaign, continuous (e.g., school-based or other) and routine channels (e.g., antenatal care (ANC), Extended Program of Immunization (EPI)) can be considered as well as alterations in the standard three-year frequency of ITN campaigns and through lower coverage campaigns (targeting only children under 5 or all households at reduced coverage), depending on available resources. Applicants should include a description of how the proposed combination of channels and frequencies varies subnationally to efficiently achieve target coverage. An explanation of how prioritization decisions have been made within available funds should be discussed in the overview of the proposed ITN strategy (see 2.2a introduction).
- Different deployment strategies should be proposed to maximize equitable access to ITNs – as one channel will not be sufficient. The channel mix may vary subnationally. While not all channels directly target vulnerable groups, data consistently show that when ITNs in a family are too few, the most vulnerable members are prioritized.

Operational approaches and budgeting

- The Alliance for Malaria Prevention guidelines should be followed including guidance on ITN deliveries in resource-constrained settings.[8]
- Distribution activities should be integrated wherever possible with other malaria or public sector platforms and activities to improve efficiency and reach, such as routine ITN distribution through maternal and child health programs and the EPI); malaria campaigns integrated with vaccination, neglected tropical disease mass drug administration or other health campaigns.
- The Global Fund encourages an integrated, multi-purpose digital platform for malaria campaigns as well as other campaigns and activities (e.g., seasonal malaria chemoprevention (SMC), vaccination, considering different levels of digital literacy and accessibility (by gender, disability, literacy levels and socioeconomic status), and informed by surveillance intelligence on achievements of coverage and equity.
- If technical assistance is needed for planning of ITN distribution or campaign digitization (e.g., Alliance for Malaria Prevention technical assistance), programs should include this in funding requests.

ITN use and care

- SBCC should be targeted where use is a concern given limited access, based on most recent available data (e.g. as summarized here). Evidence-based SBCC promoting net care may be warranted. As with other activities, efforts should be made to integrate interventions that are specific to SBCC with wider malaria SBCC or primary health care messaging and opportunities.

(b) Indoor residual spraying

- IRS is the second intervention recommended for use at large scale by WHO and is appropriate in certain settings. Currently, IRS cost per person protected with an effective intervention recommended at large scale is considerably higher than ITNs. Given this, and the risks of upsurges if IRS is stopped suddenly, IRS should only be initiated or expanded with Global Fund financing if there is confidence in long term sustainable financing. IRS can be used for outbreak response or other acute short-term need such as acute displacement where ITNs are not appropriate.
- Plans to sustain IRS with Global Fund financing should demonstrate strong visibility on long-term financial sustainability, which could reflect current moves to reduce IRS costs. If not assured, Global Fund grants should support a transition to ITNs, deploying pyrethroid-chlorfenapyr dual active ingredient insecticide-treated nets at the time of the next planned spray cycle (rather than the next ITN campaign cycle). Cases should be monitored for upsurges, and the ability to respond needs to be ensured, e.g., by considering an additional case management buffer.
- An insecticide-resistance management strategy and waste/environmental management approach need to be described, as well as occupational health and safety measures. Routine monitoring of quality and coverage is required.
- The selection of IRS products should be made from the WHO list of prequalified products and those listed on the Global Fund list of eligible IRS products.

(c) Supplementary vector control interventions

In line with WHO guidance, strong justification is required for the inclusion of supplementary interventions (as defined by WHO) if there are gaps in coverage plans for IRS and/or ITNs. Each supplementary tool also has some additional aspects to consider:

- **Spatial emanators:** conditionally recommended by WHO for deployment as a supplementary measure alongside established vector control strategies, such as ITNs and IRS and potentially in settings where these primary interventions face limitations, such as in humanitarian emergencies. The evidence base is still limited and case by case decisions will need to be made. The WHO on guidance on what to consider when deciding whether to deploy spatial emanators (quoted below) should be carefully reviewed, and reflect on in funding requests:

- In deciding whether to deploy spatial emanators as a supplementary intervention, malaria programmes should:
  - ensure that targeted coverage levels of interventions recommended for large-scale deployment (ITNs, IRS) are achieved and sustained;
  - determine whether resources are adequate to cover the extra costs, especially given the residual efficacy of the specific spatial repellent product under consideration;
  - generate additional information or conduct analyses with the aim of maximizing impact through targeted deployment (e.g. stratification of malaria risk, assessment of the characteristics of local vectors, such as local vector susceptibility to the active ingredient);
  - note that only indoor use of spatial emanators has been assessed in the development of this recommendation, and therefore the recommendation only covers the indoor use of spatial emanators at this time; and
  - note that WHO recommends selecting spatial emanators that are prequalified by WHO for deployment.

- **Larviciding:** conditionally recommended, include data demonstrating appropriateness, feasibility and cost-effectiveness, and that larval habitats are **few, fixed and findable;** potentially more achievable given some newer technologies. Note that larviciding is recommended as core intervention for *An. stephensi* response.
- **House screening:** conditionally recommended, include assessment of appropriateness, feasibility, cost-effectiveness, acceptability and impact on equity.

Explanation should be included as to how supplementary tools fit within a wider Integrated Vector Management (IVM) plan, and how coordination with environmental and municipal sectors will be ensured (as appropriate).

Interventions currently not eligible for funding, as they are not WHO-recommended: topical repellents, space spraying, insecticide-treated clothing and plastic sheeting, larvivorous fish, habitat modification or manipulation (see exception below).

(d) Additional considerations

Anopheles stephensi

Applicants are strongly encouraged to review the WHO documents advising on surveillance and control for *An. stephensi* and include appropriate activities. Larviciding, habitat modification and manipulation can be considered if feasible and part of a multisectoral response. Associated surveillance would be useful to determine continued usefulness.

Integrated vector management

WHO's Global Vector Response 2017–2030 promotes an integrated, multisectoral approach to the prevention and surveillance of vector-borne diseases, also known as integrated vector

management (IVM). This approach is important as many vector-borne diseases are on the rise and increasingly overlapping with malaria due to factors such as urbanization, land use, climate change and the spread of *An. stephensi*.

The Global Fund's IVM investments will continue to prioritize activities central to the malaria response. Commodities or interventions solely targeting non-malaria vector-borne diseases will not be supported. However, the Global Fund strongly encourages leveraging, or purposefully designing, malaria-focused activities as part of broader integrated vector management efforts. Opportunities for inter-program collaboration (malaria, dengue, chikungunya etc) and data-sharing under national IVM steering committees, or similar, should be encouraged.

Entomological surveillance

Entomological surveillance should emphasize efficient data collection approaches and be specifically tied to program decision making. Insecticide resistance monitoring is a priority for Global Fund investments, at a scope and scale relevant to inform ITN and insecticide product choice.

2.3 Preventive therapies

Key messages

- Chemoprevention strategies should be guided by local epidemiology, transmission intensity, seasonality, service access, and other factors, as relevant.
- While most approaches already target vulnerable populations, if prioritization is needed, consider high-burden and/or hard-to-reach areas, including areas with limited access to healthcare (whether due to insecurity, displacement or difficult geographic terrain).
- Strengthen integration for routine chemoprevention and explore integration for services provided within and outside the health system.

(a) Seasonal malaria chemoprevention

Where SMC is in a funding request, include the following: (1) justification for SMC in line with WHO criteria (e.g., local age pattern of severe malaria admissions, duration of high transmission season); (2) overview of the implementation plan with strong monitoring and evaluation, including pharmacovigilance (linked to existing, integrated health ministry pharmacovigilance strategies and drug resistance monitoring); (3) strategies to improve efficiency and quality of service delivery while addressing equity, gender, human rights and other barriers to health services. For example, digitalization and integration with interventions such as ITN distribution, malnutrition and immunization screening, referrals for vaccination, Vitamin A supplementation and others, particularly in challenging operating environments; and (4) consideration of the cost-effectiveness of SMC (i.e., considering geographical and age-related burden of disease).

Key points to consider:

- Prioritize children under 5, who face the highest mortality risk, and focus on geographic areas with the greatest malaria burden, especially those with limited access to health services,

whether due to insecurity, displacement, difficult geographic terrain or extreme weather events.

- Consider deprioritizing urban areas given access to care and logistical challenges, noting however, that some areas, such as urban slums, may have limited access to care.
- Consider evidence of impact from combining interventions (e.g., SMC and vaccination; ITNs and SMC, etc.) for high-risk populations both for greater impact as well as provision of efficient, holistic care. Also consider delivery strategies, such as using community health workers (providing integrated community case management (iCCM) or other services).
- Review data on duration of peak transmission season (using epidemiologic, climatic and other data sources) to optimize the number of cycles. Where possible, use climate data to adjust timing and number of cycles, noting that changes in weather patterns may impact the timing of SMC campaigns.

(b) Preventive therapies provided through routine services

Intermittent preventive therapy for pregnant women (IPTp), perennial malaria chemoprevention (PMC) and routine ITN distribution should be fully integrated into ANC or EPI programs through which they are delivered. This includes communication, social behavior change, and coordination. Ideally, the maternal and child health (MCH) or EPI departments should manage these interventions, with the national malaria program providing active technical guidance and coordination, including through the national technical working group. Resources to support integration with MCH/EPI can, if needed, be requested through Global Fund RSSH support (Please refer to the Global Fund RSSH-PPR Information Note for more details). Additional resources to support cross-programmatic integration with EPI can also be requested through Gavi funding mechanisms.

Additional considerations for IPTp and PMC

For both IPTp and PMC:

- Procurement of sulfadoxine-pyrimethamine should ideally be funded by the government. If Global Fund support is needed, the government should develop and put in place a plan to transition procurement to government funding .
- Training and supervision should be integrated within the MCH/EPI quality improvement package. Malaria-specific training and supervision will require strong justification.
- SBCC should be embedded within service provision at both facility and community levels (e.g., for intermittent parasite clearance). Consider the use of low-cost options such as peer antenatal/postnatal care groups or group ANC cohorts (often supported by the government) and partnerships with community-led organizations.
- Ensure that MCH/EPI departments' data systems and reporting include these interventions.

For IPTp:

- If requesting activity support for malaria in pregnancy, the IPTp3[9] indicator as well as the RSSH indicator on antenatal clinic attendance[10] should be included in the malaria performance framework to better understand and minimize missed opportunities.
- Community IPTp can increase coverage; this approach should be integrated within the community health worker strategy, particularly in hard-to-reach areas and other areas based on local assessment of operational feasibility.

For PMC:

- As PMC is a newer intervention, national malaria programs may need to be closely involved in policy adoption and startup; but the EPI program should manage initial implementation and roll out of integrated delivery with the malaria program's technical support, including through the relevant MNCH technical working groups.
- PMC can be integrated into other existing channels (e.g. community health platform) to increase coverage with a similar management approach (i.e., through the EPI program with technical support from the malaria program). This is particularly important to consider given the drop off seen in PMC administration outside of the routine EPI schedule.

Mass Drug Administration

The Global Fund can support mass drug administration (MDA) for emergency burden reduction (including malaria outbreaks and malaria control in public health emergencies and humanitarian settings) with strong justification[11], given the short-effect duration. MDA for transmission reduction can be supported in the context of intensified elimination efforts targeting all or specific vulnerable populations, noting the need to address barriers to reaching these populations. MDA is currently not recommended for *P. vivax* elimination. Funding for MDA must be balanced with funding for interventions with longer-term effects on burden or transmission. Susceptibility to the drug deployed and interaction with the first-line ACTs must be monitored.

Other chemoprevention strategies

Support for intermittent preventive treatment for school children or specific populations such as forest-goers, and post discharge malaria chemoprevention can be requested but should not compromise chemoprevention interventions for those carrying the highest burden of severe disease (i.e., children under 5).

(c) Additional considerations: malaria vaccine

Given that Gavi, the Vaccine Alliance, will continue to fund the malaria vaccine, the Global Fund does not currently fund vaccine procurement or its direct rollout. The Global Fund *can* support complementary activities, particularly those related to health systems strengthening and integration such as in subnational tailoring analyses and national strategic plan development.

2.4 Surveillance, monitoring and evaluation

Key messages

- Global Fund investments in surveillance systems and data collection and analysis, should focus on data needed for national and sub-national decision-making.
- Digitalize data collection where possible to support streamlined operations and timely use; consider different levels of digital literacy and digital equity, as applicable. Digitalization should be interoperable with the national health management information system (HMIS) (e.g., DHIS2) via open standards/application programming interfaces (API), and comply with data protection (role-based access, audit trails, privacy safeguards). Avoid standalone platforms.
- The health management information system along with routine surveillance practices and analysis remain the foundations of a malaria surveillance system. This is complemented by intervention, drug efficacy, entomological, climate, environmental, and community-level surveillance data.
- Routine, sustainable and granular (e.g. district, health facility, village) alternative methods should be prioritized over large-scale national surveys for near real-time data that allow for stratification and prioritization.
- Applicants are encouraged to integrate external malaria related data into national data repositories (e.g. temperature, rainfall and humidity patterns, geolocation of health facilities, intervention coverage) – into malaria surveillance to assist with forecasting tools, stratification and timing of interventions.
- For information on the types of surveillance systems supported, including sentinel surveillance, early warning systems and case-based surveillance, please see the RSSH-PPR information note

(a) Subnational tailoring

As programs work towards domestically-funded human resources and data systems for subnationally tailored approaches, the Global Fund can support targeted, well-justified capacity strengthening. This may include short- or long-term support to national and district malaria programs to develop and update subnationally tailored strategies and plans, as well as capacity and training needs in data storage, management, generation, quality, stratification, triangulation and use where they are related to subnational tailoring. The WHO manual on subnational tailoring (SNT) should be consulted to develop an implementation plan where technical assistance needs and capacity building support can be specified as well as longer-term domestic financing and sustainability of systems, staff and activities.

(b) Routine information systems and data use

Investing in a robust routine information system and surveillance, monitoring and evaluation (SME) program is the foundation of malaria surveillance and response. Please consult with the newly updated Malaria SME while creating and updating your SME plans and funding requests. While many of the areas of investment below are likely covered through domestic resources, the

Global Fund can continue to fund gaps. If support is requested, a plan to transition to government resources needs to be part of the funding request. Areas of investment include:

- Creation, maintenance, improvements and use of national malaria data repositories and required staffing and equipment. Create or maintain malaria data repositories focused on embedding them into the national HMIS architecture; avoid duplicative systems. Fund staffing where tied to routine data quality and use at sub-national level.
- Data digitalization for timely and robust reporting and analysis, which should be tied to integrated digitalization plans including data visualization and user-friendly, fit-for-purpose dashboards.
- Data quality strengthening activities, including routine data quality assessment tools (RDQAs), data reviews and action plans, targeted supervision and associated activities.
- Data use, including mapping of subnational continuous quality improvement activities, including audits, and results to address quality issues in a targeted and timely manner both in data and malaria services and in interventions.
- Data sharing and access policies and strategies, including providing data to cross-borders and to multi-sectoral stakeholders, technical assistance providers, partners, donors and WHO for ease of reporting, visibility and analysis.
- Surveillance assessment: regular surveillance assessments, to evaluate current performance, address drivers of low performance, and monitor progress over time. More information.
- Malaria program reviews and mid-term reviews, including potential capacity building needs, with an aim to ensure more of the work can be done by national stakeholders.

(c) Other data sources, approaches and methodologies

- Malaria Indicator Surveys, malaria components to demographic and health surveys (DHS) and other national surveys can occur every three to five years but a justification of their utility for national decision-making should be presented and a transition to routine data analysis for timeliness and granularity should be documented.
- Incorporating malaria testing for all women at their first antenatal care visit for routine monitoring of prevalence (first antenatal care (ANC1) surveillance) is a potential new strategy for program consideration that would require additional resources for introduction and continuation, such as recalculation of ACTs and RDTs needed during antenatal care (and included in the overall quantification). I Refer to the RBM Surveillance, Monitoring and Evaluation Brief of ANC1 surveillance Start-Up for considerations on use and introduction of antenatal care surveillance, including potential limitations.
- Surveys of antimalarial medicine, diagnostics and use in the private sector can be supported in contexts with high private sector care-seeking. Refer to the case management section of this document.
- Monitoring coverage, access and use outcomes to inform programmatic decision-making can be supported using cost-efficient methodologies such as targeted lot quality assurance

sampling (LQAS) or other small-scale surveys where the number of households is reduced and thresholds of use and access are established and focused on data needed for specific decisions. Nationwide LQAS is not recommended as a cost-efficient approach. More information on LQAS methodology, protocols and costing guides can be found on the Alliance for Malaria Prevention website.

- Beyond entomological surveillance, ITN durability studies (or other recommended surveillance of field performance) and therapeutic efficacy studies (see Vector Control and Case Management sections, respectively), targeted behavioral surveys and specific, and targeted operations research to inform access and delivery bottlenecks, can be considered when they are time-bound and directly linked to planned programmatic changes.
- Assessments related to barriers in access to services related to equity, gender, and human rights, such as the Malaria Matchbox, can be considered. The Global Fund strongly encourages integrating these assessments into program reviews, mid-term reviews, and similar.
- Integrated community-led monitoring for access and quality of service delivery and gender or human rights violations at primary health care facilities can be funded. This includes support for tracking access, affordability, quality and equity of malaria services, including gender and human rights dimensions related to these health services, and support for capacity building of community organizations and networks to collect and use data to advocate for and support service improvement.
- Malaria programs can consider efforts to strengthen financial data intelligence and management systems, with activities to: (1) assess the funding landscape, including program expenditure by key program areas and source; (2) understand the unit costs of key interventions, main cost drivers and variation across regions and delivery platforms; (3) compare cost-effectiveness of interventions for a given area, taking into account service accessibility, program feasibility and patient costs; and (4) delineate potential resource needs to implement subnationally tailored response or intervention mixes given the disease burden and program reality; (5) where feasible, costing exercises should feed into transition compacts, fiscal space analyses, and annual co-financing discussions, ensuring alignment between Global Fund support, government budgets, and long-term financial sustainability.
- These activities should also embed value for money principles—assessing economy, efficiency, effectiveness, and equity—and explicitly inform sustainability and transition planning. See the Global Fund's Value for Money Technical Brief.

2.5 Social and behavior change communication

- Funding requests that include SBCC activities should outline evidence-based data, the rational for the proposed SBCC interventions (e.g.targeted issues and populations) and include plans to monitor and evaluate their effectiveness of proposed SBCC approaches. Activities are expected to build on existing best practice and efforts in other health areas/programs (e.g., maternal and child health, community systems). The RBM Social and Behavior Change Working Group (SBC WG) has provided valuable resources for evidence-

based SBCC programming at country level. Refer to the RSSH-PPR information note and Reducing human rights and gender-related barriers to HIV, TB and malaria services technical brief for additional guidance on reducing gender- and human rights-related barriers to health services.

- Tailor communication (content, style, and medium) to diverse audiences to communicate equally effectively at all levels. Understand target audience underlying needs, concerns and motivations and communicate effectively in sensitive situations.
- To maximize impact and resource efficiency, malaria SBCC should be integrated into broader health and the development sector SBCC frameworks. Messaging should evolve to include digital platforms and social media, which are increasingly influential in shaping health behaviors globally. In contexts with large rural populations and nomadic communities where access to health facilities is limited, investments in community-based platforms are essential to effectively deliver SBCC activities and ensure equitable reach.

Specific considerations when including SBCC activities include:

- Account for differences amongst and within populations that may affect equitable access and utilization of interventions.
- Address identified barriers to uptake and use of malaria interventions (and health services generally), including those related to equity, human rights and gender.
- Address issues related to provider behaviors, such as adherence to case management guidelines, respect for fee policies and respectful care.
- Identify opportunities for coordination and/or integration of SBCC activities with other public health programs (e.g., EPI).
- Address risk perception by communicating changes in the transmission dynamics and associated risks.

Modalities considered for Global Fund support:

- Interpersonal communication embedded in existing services (e.g., facility health workers, community health workers, peer cadres).
- Community engagement models, including those addressing barriers to health services related to gender, human rights and social norms.
- Large mass media campaigns only with strong justification, as they often deliver limited sustained change.
- While integration is highly encouraged, advocacy efforts, such as “Zero Malaria Starts with Me” activities, can also be requested.

2.6 Elimination

Achieving and maintaining malaria elimination is a complex and long term endeavor which requires country ownership and sustained political commitment, targeted approaches to reach underserved and hard-to-reach populations, robust surveillance systems including case-based

surveillance and case investigations-response, effective cross-border collaboration, continuous innovation in both products and service delivery, and early planning for prevention of re-establishment of malaria transmission. Funding requests should include the relevant information on progress, challenges and plans to address any gaps to meet these standards.

Proposed interventions for support and their justification include:

- A description of local stratification and targeting by malaria transmission intensity, receptivity, importation risks and other key characteristics.
- Vector control that targets remaining foci and areas of ongoing transmission.
- Optimizing case detection and case management, including support for quality assurance and reference laboratories with 100% parasite-based, quality-assured diagnosis, and universal access to appropriate treatment, including gametocytocidal primaquine where deemed effective. While RDTs will continue to be the main diagnostic method, especially for hard-to-reach populations, countries may want to maintain a high level of quality microscopy in designated facilities, which must be integrated with other disease activities. Special attention needs to be given to ensure that cases diagnosed in the private sector are included as part of reporting and quality assurance approaches.
- Strengthening surveillance systems to detect symptomatic cases and notify, report and investigate all malaria infections. Routine surveillance, active case detection and foci investigation are recommended, as is response planning and outbreak preparedness. Outbreak preparedness and response should include clear alert mechanisms as well as decentralized systems to enable rapid access to malaria commodities and response teams. In resource-constrained settings, passive case detection should be prioritized, as active and reactive case detection strategies are more costly.
- Other activities aimed at accelerating malaria elimination (e.g., community engagement and communication campaigns to promote and sustain awareness and avoid malaria reintroduction).
- Activities for the prevention of re-establishment with a plan for transition to domestic resources in the longer term. Applicants are also asked to include a description of plans for addressing prevention of re-establishment of malaria and the plan for WHO certification of elimination.

Annex 1: Links to partner guidance

- Pre-referral treatment with rectal artesunate of children with suspected severe malaria: a field guide. World Health Organization, Global Malaria Programme. 8 November 2023, Manual.
- Technical consultation to assess comparative efficacy of vector control products: meeting report, World Health Organization, Global Malaria Programme. 5 and 9 June 2023, Meeting Report
- Report of the first and second meetings of the Technical Advisory Group on Malaria Elimination and Certification, 13–14 September 2022 and 27 January 2023, Meeting Report
- WHO initiative to stop the spread of Anopheles stephensi in Africa, 15 August 2023, Update

- The use of rectal artesunate as a pre-referral treatment for severe Plasmodium falciparum malaria, 2023 Update, 4 July 2023, Information Note
- Technical consultation to review the effectiveness of rectal artesunate used as pre-referral treatment of severe malaria in children, 18–19 October 2022, 21 June 2023, Meeting Report
- Partners convening: a regional response to the invasion of Anopheles stephensi in Africa: meeting report, 8–10 March 2023, 16 June 2023, Meeting report
- Seasonal malaria chemoprevention with sulfadoxine–pyrimethamine plus amodiaquine in children: a field guide (2nd Edition), 26 May 2023, Manual
- Monoclonal antibodies for malaria prevention, Preferred product characteristics and clinical development considerations, 20 April 2023, Technical Document
- Malaria chemoprevention, Preferred product characteristics, 20 April 2023, Technical Document
- Vector control products targeting outdoor malaria transmission, Preferred product characteristics, 4 April 2023, Technical Document
- Technical consultation to assess evidence on community-based delivery of intermittent preventive treatment in pregnancy for malaria, 21–23 June 2022, 2 March 2023, Meeting report
- Pilot decision workshop to aid prioritization of resources for malaria control in Ghana, 12–13 September 2022, 16 January 2023, Meeting report
- Master protocol for surveillance of pfhrp2/3 deletions and biobanking to support future research, second edition, 6 December 2024, Technical document
- Surveillance template protocol for pfhrp2/pfhrp3 gene deletions, second edition, 6 December 2024, Technical document
- Response plan to pfhrp2 gene deletions, second edition, 6 December 2024, Response Plan
- Multiple first-line therapies as part of the response to antimalarial drug resistance, An implementation guide, 20 November 2024, Manual
- Tackling malaria in countries hardest hit by the disease: ministerial conference report, Yaoundé, Cameroon, 6 March 2024, 25 September 2024, Meeting Report
- Surveillance and control of Anopheles stephensi, Country experiences, 2 July 2024, Publication
- Data requirements and protocol for determining comparative efficacy of vector control products, 17 May 2022, Technical Document
- Guiding principles for prioritizing malaria interventions in resource-constrained country contexts to achieve maximum impact, 27 May 2024, Normative Guidance
- Safety of artemisinin and non-artemisinin antimalarials in the first trimester of pregnancy, Review of Evidence, 10 April 2024, Report
- Diagnostic tests for detecting risk of Plasmodium vivax relapse, Preferred Product Characteristics, 8 April 2024, Technical Document
- Operational manual on indoor residual spraying: Control of vectors of malaria, Aedes-borne diseases, Chagas disease, leishmaniases and lymphatic filariasis, 13 February 2024, Manual
- Community deployment of intermittent preventive treatment of malaria in pregnancy with sulfadoxine-pyrimethamine a field guide, 16 January 2024, Manual

- WHO position paper on Malaria Vaccines, May 2024, WHO position paper
- Subnational tailoring of malaria strategies and interventions,13 October 2025, WHO reference manual
- The Comprehensive Multisectoral Action framework - Malaria and Sustainable Development, 26 August 2022, UNDP

Annex 2: List of Abbreviations

ACT	Artemisinin-based combination therapy
ANC	Antenatal care
ANC1	First antenatal care
An.	Anopheles (stephensi)
API	Application programming interfaces
CCM	Country Coordinating Mechanism
CIFIR	Case investigations and focus investigations and responses
COE	Challenging operating environments
CSO	Civil society organizations
DHS	Demographic and health surveys
DTIR	Diagnostic, treatment, investigation and response
EPI	Expanded Program on Immunization
EQA	External quality assurance
ERPD	Expert Review Panel for Diagnostics
GC7	Grant Cycle 7
GC8	Grant Cycle 8
G6PD	Glucose-6-phosphate dehydrogenase deficiency
HMIS	Health management information system
iCCM	Integrated community case management

IDPs	Internally displaced persons
IPTp	Intermittent preventive therapy in pregnancy
IPTp3	Pregnant women attending antenatal care at least once and receiving at least three doses of intermittent preventive treatment of malaria for pregnant women
IRS	Indoor residual spraying
ITN	Insecticide-treated net
IVD	In vitro diagnostic
IVM	Integrated vector management
LQAS	Lot quality assurance sampling
LAMP	Loop-mediated isothermal amplification
MCH	Maternal and child health
MDA	Mass drug administration
PBO	Piperonyl butoxide
Pf	Plasmodium falciparum
pfhrp2/3	Plasmodium falciparum Histidine-Rich Protein 2 and 3
PMC	Perennial malaria chemoprevention
PPM	Pooled procurement mechanism
PPR	Pandemic preparedness and response
P. vivax	Plasmodium vivax
RDQA	Routine data quality assessment tool
RDT	Rapid diagnostic test
SBC	Social and behavior change
SBCC	Social and behavior change communication
SMC	Seasonal malaria chemoprevention
SNT	Subnational tailoring

TES	Therapeutic efficacy studies
WHO	World Health Organization

[1] Guiding principles for prioritizing malaria interventions in resource-constrained country contexts to achieve maximum impact. World Health Organization; 2024, https://www.who.int/publications/i/item/B09044.
[2] Subnational tailoring of malaria strategies and interventions. World Health Organization; 2025, https://www.who.int/publications/i/item/9789240115712.
[3] Malaria Control in Emergencies: Field Manual. World Health Organization; 2025. Licence: CC BY-NC-SA 3.0 IGO.
[4] Non-governmental organization
[5] Artificial intelligence
[6] Multiple first-line therapies as part of the response to antimalarial drug resistance: An implementation guide. World Health Organization; 2024.
[7] ACTwatchLite (ACtwatch Lite) · GitHub
[8] Alliance for Malaria Prevention guidelines reference(s)
[9] Pregnant women attending antenatal care at least once and receiving at least three doses of intermittent preventive treatment of malaria for pregnant women
[10] Percentage of women and girls with a live birth in a given time period that received antenatal care four or more times
[11] For example, rational of why MDA proposed over intensified case management and prompt prevention with vector control.