Grant Cycle 8 (GC8)
Prioritization Guidance: Malaria

Issued 13 April 2026

Updated 13 April 2026

Context & purpose of this GC8 guidance

The Global Fund Partnership is committed to its mission of advancing the end of HIV, TB and malaria as health threats while investing in resilient systems that improve health outcomes. Within a context of constrained financing, this requires optimizing the use of *all* available resources through rigorous programmatic prioritization.

With countries and communities in the lead, success requires a relentless focus on efficiency and effectiveness, on making tough trade-offs in the face of inescapable funding gaps, on tackling barriers to accessing life-saving services for those most at risk, and on acting at pace to innovate and adapt.

This prioritization guidance serves to equip national stakeholders in determining additive, high impact Global Fund investments in national responses.

*The six (6) **Strategic Shifts** for GC8, shared with the Board in February 2026. This guidance reinforces <u>all</u> shifts, with an emphasis on 3, 4 and 5*

What are some of the changes in the guidance?

Increased focus on prioritization. With constrained global health resourcing, this guidance was developed with technical partners to equip stakeholders in determining additive, prioritized investment from the Global Fund. This was further streamlined in line with the Strategic Shifts.

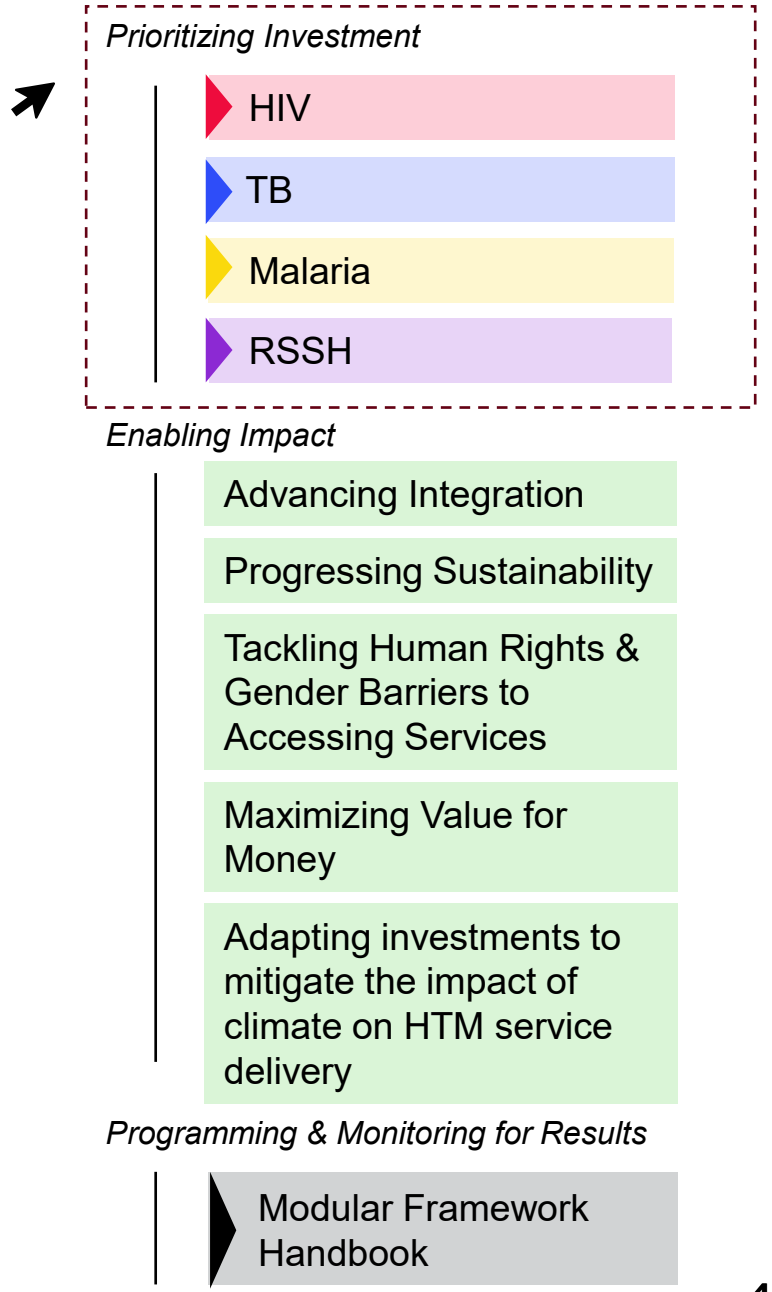
Reduced complexity. Stakeholders have repeatedly requested more concise materials, including slide decks to summarize key points in CCM meetings and cascade to diverse audiences during country dialogue.

Decreased duplication within existing materials. The Modular Framework Handbook includes eligible modules, interventions and activity descriptions. As requested by stakeholders, this guidance includes further information on how to prioritize in GC8.

Recognized maturity of national responses. With decades of experience across most countries & communities and readily available technical and normative guidance, the reconfiguration of GC8 investment guidance is in step with most countries' self-reliance and leadership.

How to use this guidance

- This Prioritization Guidance is based on **evidence-based normative and technical guidance** from across the partnership and includes relevant references.
- The guidance informs **country-led decision-making** on how to maximize the impact of Global Fund resources, used together with National Strategic Plans to ensure alignment with overall spending plans, including domestic resourcing and external funding from other sources.
- The guidance **complements** the Global Fund's Modular Framework Handbook, which describes the interventions eligible for Global Fund investments, and a separate cross-cutting guidance on "Enabling Impact".
- Each section of this guidance (HIV, TB, Malaria, RSSH), **lays out overall priorities for GC8** (expanded for HIV and TB as Program Essentials), and suggests the prioritization approach and considerations for each intervention, including higher priority activities, potential optimization and efficiency opportunities, and (in some cases) lower priority activities which may no longer be necessary.
- This document will be updated as necessary to reflect innovations and change in technical guidance.



Definitions: Key Populations and Key and Vulnerable Populations

For **HIV**, Key Populations (KP) are defined by UNAIDS as those particularly vulnerable to HIV and frequently lack adequate access to services. These five groups are gay men and other men who have sex with men, sex workers, transgender people, people who inject drugs and prisoners and other incarcerated people (definition). Key and Vulnerable Populations (KVP) include KP, adolescent girls and young women (AGYW) and other vulnerable populations (OVP) at risk.

For **TB**, KVP are defined by Stop TB Partnership as populations at high risk and people in vulnerable situations (definition).

For **malaria**, WHO defines populations vulnerable to malaria as those at increased risk of infection and severe disease, particularly children under five, pregnant women and girls, people with immunocompromising conditions such as HIV, non-immune populations such as travelers, mobile populations, and populations with limited access to prevention and treatment services including in humanitarian settings; vulnerable groups vary by context.

Malaria is on a troubling trajectory. The world is significantly off track to meet the SDG 3 target of ending the disease by 2030.

To get back on track, GC8 investments should prioritize access to the most cost-effective interventions for all at-risk populations, protect against biological threats and invest in critical health system capabilities.

- ✓ **Outlines** areas of investment that are high priority and those the Global Fund is unlikely to fund or that require strong justification from countries.
- ✓ **Emphasizes** how to optimize investments and drive value for money to maximize results.
- ✓ **Drives** access to services for those communities most affected by malaria.
- ✓ **Reinforces** that Global Fund investments should focus on evidence-based interventions and approaches for malaria that are critical for impact, as recommended in WHO normative guidance and in line with National Strategic Plans.

Priorities in Grant Cycle 8 (GC8)

- **Prioritize** high-impact, evidence-based interventions drawn from sub-nationally tailored national strategic plans based on an analysis of the local context.
- **Aim** to reduce malaria morbidity and mortality through timely, universal access to quality diagnosis, treatment and prevention services.
- **Maintain** an appropriate balance between case management and prevention. Any scaling back of prevention in areas with high or moderate transmission will likely trigger a malaria resurgence, driving up case management needs and costs and often offsetting any short-term financial savings achieved by scaling back.
- **Invest** in essential surveillance, monitoring and evaluation to guide impactful plans and implementation.
- **Optimize** access to lifesaving services by reducing key barriers, including human rights and gender-related barriers, to such services and strengthening community systems for health.
- **Ensure** social and behavior change (SBC) is right-sized, mapped to the needs of populations and sub-nationally targeted.
- **Incorporate** operational efficiencies in delivery for all interventions.
- **Consider** all malaria interventions and related health systems investments, including those not funded by the Global Fund, for appropriate, holistic prioritization and to avoid duplication or fragmentation.
- **Plan** and outline where and when human resources, program management and/or other service delivery costs typically funded by the Global Fund can be transitioned to government support, leveraging analyses of the local context and utilizing community expertise.

Prioritization approach & considerations

Interventions	Prioritization considerations

Insecticide treated nets (ITNs) distribution	**Areas prioritized for GF investment**
	Vector Control general points
	• Maintain existing coverage as far as possible: cuts = more cases, deaths, case management costs. Do not use vaccine plans (or other prevention tools) deployment as a reason to pull back vector control deployment.
	• Align with international guidance and sub-nationally tailor by operational, epidemiologic, entomologic and sociocultural context.
	• Prioritize ITNs; these remain the most cost-effective option in most settings. IRS needs a strong rationale given costs & sustainability challenges; supplementary tools must be carefully prioritized but may well play a role in certain settings based on barriers.
	ITNs
	• Use a sub-national tailoring strategy to ascertain local epidemiology, vector profile and resistance and historic use to ensure access to effective nets for all populations at risk, prioritizing where necessary high/moderate burden areas and biological risk groups.
	• Revisit the previous ITN approach with fresh eyes. Review and reconsider the following, sub-nationally tailoring each as needed:
	  • Channels: consider whether mixes of continuous distribution channels may be an alternative (or addition) to campaigns, draw on AMP guidance: *ITN channel selection.*
	  • Coverage: consider lowering coverage targets, if necessary, rather than dropping some at-risk areas completely.
	  • Operational approaches: e.g., campaign design of door-to-door or fixed-point may vary by context.
	• Manage gaps: if coverage drops, plan how the risk of resurgence will be tracked and mitigated.
	• Target SBC to most critical needs and populations, e.g., where use is low despite access or where new approaches need communicating.
	• Ensure appropriate product selection and procurement (follow Global Fund Quality Assurance Policy and Procurement Guidance):
	Opportunities to increase optimization & efficiency
	• Consider options for integration across other malaria or public sector activities in planning, operation, surveillance and data use.
	• Use digital platforms, applying multi-purpose tools for malaria and other campaigns.
	• Ensure operational efficiency - this requires revisiting previous operational approaches and re-examining models for training, surveillance, distribution, SBC, monitoring and evaluation with efficiencies in mind. Follow AMP guidance: *ITN distribution operations: Considerations for optimizing limited resources.*

Prioritization approach & considerations

Interventions	Prioritization considerations
Insecticide treated nets (ITNs) distribution	**Activities of lower priority (context dependent)** • Do not procure pyrethroid-only ITNs in areas of pyrethroid resistance; chlorphenpyr Dual AI ITNs are the best current choice, provide rationale if proposing PBO ITNs given better likely performance of CFP Dual AI (e.g., where price differential is important). Pyriproxyfen Dual AI nets are not appropriate given the current WHO recommendation sequence. • Do not specify fabric, brand, pyrethroid type and insecticide/PBO concentration. Nets are bulk-packed for campaigns and individually packed for routine channels. If non-standard color, size, shape or bulk/individual packaging is requested, strong justification and additional approval are needed. • Exclude major urban areas from mass ITN campaigns where appropriate; exclude hang-up campaigns and campaign launch events.
Indoor residual spraying *and* Other vector control measures (supplementary tools) *and* Entomological monitoring *and* Social and Behavior Change (SBC)	**Areas prioritized for GF investment** **IRS** • Maintain or expand IRS only if long-term sustainability is likely; in most settings, it will be necessary to transition to chlorfenapyr Dual AI ITNs as part of sustainability plans. • Acknowledge IRS remains a key intervention for outbreak response in some settings. • Follow WHO guidance in the 'Operational manual on indoor residual spraying'. • Ensure appropriate commodity selection, procurement and management in line with Global Fund Quality Assurance policies and procurement guidance, including the use of insecticide resistance data to inform product choice. • Include insecticide resistance management strategy, insecticide resistance surveillance plan, waste/environment management approach and occupational health and safety measurements. **Supplementary tools (as defined in the WHO Guidelines for Malaria Control)** • Justify use of supplementary tools in a prioritization approach; only if core tools (ITNs, IRS) have gaps and may well play an important role in some settings. Spatial emanators: newly recommended tool for use indoors with ITNs/IRS, may be considered in complex operating environments on a case-by-case basis if no other tools are appropriate, with relevant evaluation. • Use of Larviciding: sites must be few, fixed and findable, may be important in *An. Stephensi* areas. **Activities of lower priority (context dependent)** • Limit use of house screening: assess feasibility, cost-effectiveness and acceptability. • Not eligible for funding given the current status of WHO recommendation: Larvivorous fish, treated clothing, topical repellents and other tools not recommended by WHO.

Prioritization approach & considerations

Interventions	Prioritization considerations
Indoor residual spraying *and* Other vector control measures (supplementary tools) *and* Entomological monitoring *and* Social and Behavior Change (SBC)	**Areas prioritized for GF investment** **Other considerations** • Address *An. Stephensi*: review WHO guidance; include surveillance and control as appropriate, given prioritization discussions - larviciding, habitat modification/manipulation allowed if feasible and multisectoral and paired with surveillance. • Entomological surveillance must be planned for decision needs; prioritize resistance monitoring; include other aspects as appropriate, given the VC plan. **Opportunities to increase optimization & efficiency** • Promote integrated vector management (IVM) for overlapping diseases; leverage malaria activities for broader IVM, but malaria needs should lead for Global Fund investments - encourage collaboration and data-sharing under IVM committees.

Prioritization approach & considerations

Interventions	Prioritization considerations
Facility-based treatment *and* Integrated community case management (iCCM) *and* Private sector case management *and* Epidemic preparedness *and* Intensified activities for elimination *and* Surveillance of biothreats to malaria intervention efficacy *and* Social and behavior change (SBC)	**Areas prioritized for GF investment** **Ensure universal, uninterrupted access to early diagnosis and effective treatment, leveraging all sectors in each country's context.** • Provide continuous quality improvement activities, including training and supervision integrated within PHC or across programs (MNCH). • Use community case management integrated within the PHC platform with strong community-facility linkages and targeted to rural, hard-to-reach populations. • Utilize outreach for remote, insecure and vulnerable populations (e.g., migrants, refugees, IDPs, areas with limited health access) based on assessment of barriers to accessing care. **Address biological threats to case management interventions.** • Develop an antimalarial drug resistance (AMDR) strategy, strengthen quality case management, diversify antimalarials, consider MFTs and sustain antimalarial drug efficacy and resistance monitoring (e.g., TES, iDES). • *Pfhrp2/3 gene deletions*: baseline surveillance and periodic surveys. Switch to non-HRP2 RDTs where deletions are confirmed, in line with WHO guidance. **Ensure appropriate commodity selection and procurement, in line with WHO treatment guidelines, Global Fund Quality Assurance policies and procurement guidance.** • Use mRDTs based on local species epidemiology (i.e., *Pf*-only RDTs in *Pf*-dominant settings) and hrp2/3 gene deletion status. • Use rational ACT selection to reduce selective pressure; ensure quality of antimalarials in all sectors including private sector. • Provide single low-dose PQ with ACTs for *Pf* cases for transmission reduction benefits in line with WHO guidance. • Implement the radical cure package for *Plasmodium vivax* (Primaquine or Tafenoquine and G6PD testing). • Leverage Next-Generation Market Shaping: for alternative RDTs, antimalarials – initiatives such as Access Funds (GC7) may be available to introduce these products in GC8. **Opportunities to increase optimization & efficiency** • Promote routine data collection and use for continuous quality improvements prioritizing lower performing districts/facilities. • Consider leveraging private sector initiatives across other disease programs to support development of private sector strategies and strengthening of routine reporting. **Activities of lower priority (context dependent)** • Limit use of malaria microscopy in limited situations (e.g., elimination tiers, in-patient facilities) and leverage RSSH investments for procurement, capacity building and EQA. • Use of LAMP, PCRs, HS RDT, AI-assisted diagnostics for routine case management is *not supported.* • Use of severe malaria drugs in line with WHO guidance, quinine as third line would require justification for exception.

Prioritization approach & considerations

Interventions	Prioritization considerations
Intermittent preventive treatment (IPT) - in pregnancy *and* Seasonal malaria chemoprevention (SMC) *and* Other chemoprevention interventions in children (PMC, IPTsc, PDMC)	**Areas prioritized for GF investment** • Use sub-national tailoring of SMC, with priority on high burden, hard-to-reach areas for U5s. • Strengthen integration for holistic package of ANC services for malaria in pregnancy, with targeted investments to increase ANC access and drive quality improvement; if have community based IPTp, should be fully embedded in CHW package (responsible transition). • Maintain perennial malaria chemoprevention (PMC) where already introduced. **Opportunities to increase optimization & efficiency** • Explore opportunities for SMC integration within malaria (ITNs, vaccine) and/or beyond (Vit A, malnutrition screening) and similar ops efficiencies as outlined with ITNs. • Consider handing over management of MIP and PMC to MCH with malaria program providing TA role (although, as PMC is new, may need a bit more support from the malaria program). • Leverage low-cost groups (trusted peer ante/postnatal groups) for SBCC, and to support women's decision-making power for their own health and their children's health. • Use sub-nationally tailored quality of care improvements based on data/performance. • Share digital platforms; share data across programs on population denominators. **Activities of lower priority (context dependent)** • Limit use of SMC for older age groups, in lower burden areas and urban areas. • Deprioritize the introduction of PMC. • Limit use of mass drug administration (see elimination slide). • Limit siloed approach to improvement in uptake of MIP services.

Prioritization approach & considerations

Interventions	Prioritization considerations

Cross cutting	**Areas prioritized for GF investment**
	• Develop prevention of re-establishment plan, including planning for transition and sustainability.
	• Target vector control to remaining foci and areas of ongoing transmission.
	• Optimize case detection and case management
	  ◦ Include gametocytocidal primaquine.
	  ◦ Continue use of RDTs as the main diagnostic method, especially for hard-to-reach populations.
	  ◦ Maintain a high level of quality microscopy in designated facilities, integrated with other disease activities.
	• Strengthen surveillance systems to detect symptomatic cases and notify, report and investigate all malaria infections.
	• Use routine surveillance, active case detection and foci investigation are recommended, as is response planning and outbreak preparedness.
	
	Opportunities to increase optimization & efficiency
	• Integrate approaches that reduce barriers to accessing life-saving malaria services, such as human rights and gender-related barriers, and strengthen community engagement and systems.
	• Leverage cross-border collaboration, data sharing (with appropriate person data safeguards) and coordinated responses.
	• Transition planning should include considerations of integration of malaria program functions and capacity at the national level and for service delivery at the regional/district levels.
	
	Activities of lower priority (context dependent)
	• Use of targeted MDA for transmission reduction in the context of intensified elimination efforts for specific vulnerable populations can be supported, but prioritizing MDA must be balanced with funding for interventions that have longer-term effects on burden or transmission.
	• Use passive case detection for surveillance in resource-constrained settings, as active and reactive case detection strategies are more costly.

Prioritization approach & considerations

Prioritization considerations

Areas prioritized for GF investment

- Strengthen routine data, systems and capacity building for national/sub-national decision-making.
- Integrate surveillance systems with national HMIS and other data departments.
- Integrate private sector surveillance, seasonality/meteorological data, IDSR data and other priority data sets.
- Improve shared core data, including population data, data governance, facility registries and geospatial mapping.
- Strengthen SNT functions guided by the WHO Subnational Tailoring Manual: TWGs, national data repositories, personnel and processes for routine stratification, data-driven MTR/MPR, district intervention coverage monitoring, and data-driven tailoring/targeting of quality improvement efforts.

Opportunities to increase optimization & efficiency

- Transition plan towards government funding of remaining areas of HMIS and routine data, including a data governance and integration plan if not already developed.
- Use data digitalization for timely and robust reporting, analysis and visualization (through secure digital systems for health).
- Support for ANC1 surveillance: this can support routine surveillance with timely, granular prevalence estimates and be used as a data source for reporting.
- Support targeted small sample surveys (e.g., LQAS, cLQAS) for estimations of coverage/behavior. These can be used for national decision-making and as a data source for reporting.
- Support costing of NSPs as part of an SNT approach.

Activities of lower priority (context dependent)

- Use of standalone data platforms not integrated into HMIS is highly discouraged.
- Prioritize a fully funded routine system. Malaria Indicator Surveys and malaria modules in DHS can occur every three to five years but require justification of utility and a plan to transition to routine data systems for timelier, more granular information.

Contextual considerations

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 sub-national tailoring analyses and national strategic plan development.

The Global Fund strongly encourages GAVI-malaria vaccine eligible countries to plan their malaria approach holistically, prioritizing appropriately across all external and domestic funds and across all intervention areas (vector control, case management, vaccine, chemoprevention and surveillance).

This guidance was developed with expertise and input across the technical partnership.

The prioritization recommendations draw from deep technical resources linked here as well *(non-exhaustive)*

WHO guidelines for malaria (MagicApp)

WHO Guiding principles for prioritizing malaria interventions in resource-constrained country contexts

WHO Subnational tailoring manual

WHO Strategy to respond to antimalarial drug resistance in Africa

WHO Multiple first-line therapies as part of the response to antimalarial drug resistance

WHO Response plan to pfhrp2 gene deletions, second edition

Alliance for Malaria Prevention - Key guidance toolkits

Johns Hopkins - ITN Access and Use Report (country use:access ratios and other use indicators)

WHO Seasonal malaria chemoprevention with sulfadoxine-pyrimethamine plus amodiaquine in children: a field guide (2nd edition)

Community deployment of intermittent preventive treatment of malaria in pregnancy with sulfadoxine-pyrimethamine a field guide, 16 January 2024, Manual

WHO position paper on the malaria vaccine

Diagnostic tests for detecting risk of Plasmodium vivax relapse, Preferred Product Characteristics, 8 April 2024, Technical Document

WHO Prevention of re-establishment of malaria transmission

RBM Surveillance, M&E Working Group Resources

RBM Social and Behavior Change Working Group Resources

Malaria Matchbox