



Guiding principles for
prioritizing malaria
interventions in resource-
constrained country
contexts to achieve
maximum impact

Second edition

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Abbreviations

IRS	indoor residual spraying
ITN	insecticide-treated net
NMP	national malaria programme
SMC	seasonal malaria chemoprevention
SNT	subnational tailoring
WHO	World Health Organization

1 Background

In line with the goals of the *Global technical strategy for malaria 2016–2030* (1) and with Sustainable Development Goal 3 – to ensure healthy lives and promote well-being for all at all ages – the World Health Organization (WHO) Malaria and Neglected Tropical Diseases Department continues to promote the principle that no one should die of malaria given the tools and systems available. To this end, effective malaria interventions must be accessible, acceptable and responsive to the needs of all populations, in particular those who are underserved or face barriers to access, and no population group should be excluded from effective prevention, diagnosis and treatment services.

Due to the heterogeneous distribution of malaria transmission and its determinants, subnational tailoring (SNT) provides an analytical framework for countries to determine the most appropriate intervention packages for maximum impact, as defined in their national strategic plan (2). The WHO Malaria and Neglected Tropical Diseases Department recommends the use of subnational data on disease epidemiology and other relevant local contextual factors to facilitate the SNT process. Once the strategies and intervention mixes have been defined, countries can prioritize objectives, interventions and activities to ensure effective programming and maximize impact on reducing malaria burden.

The prioritization process involves ranking objectives, interventions and activities based on criteria such as importance, urgency and impact. In the context of malaria, different local factors, including epidemiological and ecological conditions and interventions already in place, should be considered in ranking individual interventions and combinations of interventions for maximum impact. This process requires programmes to make difficult choices to minimize the negative impact of withholding some interventions that have been proposed and included in the national strategic plan. Prioritization differs from optimization, which is defined as the process of optimally allocating human, material and financial resources to achieve objectives under set financial constraints. In the context of malaria,

optimization is done during operational planning to ensure the most efficient and effective use of resources; this may involve scaling back or removing low-priority interventions that were included in the strategic plan, reallocating interventions based on cost-effectiveness and eliminating operational inefficiencies.

Prioritization must be guided by the basic principles of universal health coverage to ensure that no one dies of malaria. These principles include patient-centredness, community empowerment, self-determination, accessibility, acceptability, equity, quality, intersectoral collaboration, value and sustainability, accountability and transparency, ensuring a rights-based approach that promotes non-discrimination, gender responsiveness and meaningful community participation. Prioritization of malaria interventions should be aligned with broader national health prioritization processes and the development of health benefit packages, consistent with the principles of primary health care, country ownership, cost-effectiveness, financial risk protection and political acceptability (3).

Prioritization decisions must be informed by a good understanding of the baseline (historical) transmission intensity and knowledge of the main determinants of current disease burden in a given area, as the current situation may reflect the impact of interventions already being deployed. The magnitude of change from baseline that is likely attributable to the interventions will help to determine the risk of resurgence and, by extension, the potential impact of deciding to remove those interventions, particularly in areas where the receptivity and underlying environmental and socioeconomic factors driving malaria have not changed. The baseline period is considered the time before preventive interventions and efficacious antimalarial medicines were scaled up.

In response to ever increasing financial constraints, the WHO Malaria and Neglected Tropical Diseases Department and regional offices, in consultation with selected national malaria programme (NMP) managers and technical partners, published the first edition of

Guiding principles for prioritizing malaria interventions in resource-constrained country contexts to achieve maximum impact in May 2024.

The guidance on prioritizing malaria interventions is based on WHO recommendations for malaria interventions contained in the *WHO guidelines for malaria* (4), in particular early diagnosis and treatment, vector control interventions for large-scale deployment, malaria vaccines and chemoprevention. The guidance provides principles for prioritizing high-impact interventions in areas of moderate to high transmission¹ in situations where resources are limited. While several principles included in this document may also apply to areas of low to very low transmission, specific guidance should be developed on prioritizing malaria interventions under

resource constraints in those settings and in countries nearing malaria elimination.

To strengthen the evidence base of the prioritization guidance, in July 2024, WHO launched a collaborative project to mathematically model the health impact and cost-effectiveness of various mixes of malaria control interventions. The results of the *malariasimulation* and OpenMalaria models were reviewed by WHO and independent experts, including NMP managers, with inputs by the Malaria Policy Advisory Group in April 2026. These discussions form the basis for this second edition of the *WHO Guiding principles for prioritizing malaria interventions in resource-constrained country contexts to achieve maximum impact*.

¹ In this document, the following WHO definitions of levels of malaria transmission are used:

- high: > 450 cases per 1000 population per year or *Plasmodium falciparum* prevalence rate > 35%;
- moderate: 250–450 cases per 1000 population per year or *P. falciparum*/*P. vivax* prevalence rate 10–35%;
- low: 100–250 cases per 1000 population per year or *P. falciparum*/*P. vivax* prevalence rate 1–10%;
- very low: < 100 cases per 1000 population per year or *P. falciparum*/*P. vivax* prevalence rate > 0 and < 1%.

2 Prioritization of interventions

This guidance document has been developed against a backdrop of increasing global and regional risks to malaria progress (5). Biological threats continue to be a major concern, with antimalarial drug resistance emerging as one of the most pressing and complex challenges. The undetected and unaddressed spread of drug resistance could have devastating consequences, undermining years of progress. At the same time, changes in the genetic make-up of parasites in some locations are undermining the reliability of rapid diagnostic tests, and insecticide resistance is reducing the effectiveness of core vector control tools. Beyond biological determinants, climate change, conflict and population displacement continue to amplify malaria transmission and disrupt health service delivery. Sudden and drastic cuts to foreign aid in 2025 have also compounded chronic underinvestment in health systems in many countries. The consequence has been severe disruption of services, shortages of medicines and increased out-of-pocket payments, elevating the risk of malaria morbidity and mortality.

This second edition of the *Guiding principles* document has incorporated outcomes from the malaria multi-model comparison. The modelling results suggest that malaria costs and impact results are extremely heterogeneous and local context matters. Therefore, under tight resource constraints, there is no single combination of priority interventions that is most cost-effective in all situations. These findings confirm that, under severe resource constraints, intervention combinations should be guided by programme priorities and operational feasibility alongside evidence of cost-effectiveness. The analysis underscores that prioritization should be guided by the local context and that SNT should be the primary framework for country-level decision-making on the appropriate packages of interventions and allocation of resources for a given area to ensure maximum impact on transmission and burden of disease. In the face of limited resources, the following principles should guide the prioritization of malaria interventions:

1 No one should die from a curable disease in any transmission setting.

The primary objective is to prevent and minimize malaria-related deaths. This is assured by providing access to early diagnosis and effective treatment of all malaria cases, irrespective of the malaria transmission intensity. Prompt access to malaria diagnosis and treatment by maintaining existing services across all levels of the health care delivery system, including at community level, should be prioritized and guaranteed for all as a basic human right. Particular attention should be given to populations at high risk of mortality (children under 5 years of age and pregnant women) and those facing barriers to access, including women and girls, rural and remote communities, migrants and other underserved groups. Scaling back access to early diagnosis and treatment is not an option under any level of financial constraint. Surveillance for antimalarial drug resistance and histidine-rich protein 2 (HRP2) deletions remains a priority and is essential for deploying more effective diagnostics and diversified therapies to respond to antimalarial drug resistance.

2 Primary health care is the cornerstone of malaria case management.

In remote areas in all transmission settings, community-level case management of acute febrile illnesses should be expanded to reach the unreachable; the expansion of community services is dependent on the primary health care system, the level of community engagement and the degree of institutionalization of community health workers, and should ensure gender-responsive approaches that consider gender norms, decision-making power and care-seeking behaviours. Similarly, new investments to improve malaria case management in the private sector should be part of the national private sector engagement strategy (6).

3 Prevention of malaria in pregnancy should be part of sexual and reproductive health.

Chemoprevention for pregnant women and girls, i.e. intermittent preventive treatment, should be prioritized in antenatal care services at the health facility level. Scaling this preventive treatment back is not an option in the case of resource constraints.

4 Large-scale and affordable malaria vector control interventions should be promoted.

- a. Interventions recommended for large-scale deployment are: i) insecticide-treated nets (ITNs) that are prequalified by WHO; and ii) indoor residual spraying (IRS) with products prequalified by WHO (4). The choice of which of these two interventions to deploy should be informed by contextual data, such as insecticide susceptibility, vector behaviour, intervention use, ITN durability, insecticide residual efficacy, community acceptability and relative cost-effectiveness. WHO does not recommend co-deployment of both IRS and ITNs. Surveillance and management of insecticide resistance remains a priority and is essential for selecting effective vector control interventions.
- b. For countries or parts of countries where ITN deployment is considered the appropriate choice, maintaining case management and ITN delivery should be prioritized. The modelling suggests that, particularly in areas with moderate to high transmission, the removal of ITNs leads to worse health outcomes and, in some scenarios, may increase total costs because of additional malaria cases requiring treatment. In these settings, relying on case management alone may be less impactful and more expensive than maintaining both case management and ITNs.
- c. Decisions on ITN replenishment in areas where vectors are resistant to pyrethroids should be guided by the following principles, drawing on the recommendations in the *WHO guidelines for malaria* (4):
 - i. With a view to maximizing impact, pyrethroid-chlorfenapyr ITNs should be prioritized, followed – in order of preference – by pyrethroid-piperonyl butoxide ITNs

or pyrethroid-pyriproxyfen ITNs. The deployment of pyrethroid-only ITNs should be the last option.

- ii. To inform this prioritization, the available resources, resistance status of malaria vectors and cost of ITNs should be considered, and the durability of the ITNs should be monitored to inform future procurement decisions. Funding gaps that impede effective coverage with ITNs that control pyrethroid-resistant vectors should be identified and this information should be shared with potential funders. The situation should be reassessed on a regular basis as the WHO guidelines for new ITN types and the market prices of ITNs evolve; price and availability have a major impact on programmatic coverage.
- d. If resources are constrained, all areas with very low current and historical malaria transmission (e.g. < 1% *Plasmodium falciparum* prevalence rate) can be excluded from ITN campaigns. This applies to most urban areas, where other appropriate means of vector control, including larviciding, should be considered based on microstratification, ensuring that vulnerable populations within these areas are not excluded from access to appropriate prevention and care (7).
- e. IRS capacity and supplies should be maintained in countries that are prone to epidemics, as part of preparedness and response. For areas with stable transmission, countries need to carefully consider the resource implications of sustaining IRS instead of transitioning to ITNs. At current prices, IRS is relatively more expensive than ITNs per population at risk protected, although further cost-effectiveness analyses are needed. Under resource constraints, countries should not prioritize the introduction or scale-up of IRS at the expense of more affordable and appropriate vector control interventions. If countries are unable to maintain their IRS campaigns at the right times with effective coverage, it may be advisable to switch to ITNs in areas of pyrethroid resistance, following the guidance provided in paragraph 4c, and invest in social and behaviour change communication to ensure the effective use of ITNs.

- f. When changes made to large-scale vector control interventions lead to decreased/suboptimal intervention coverage of either IRS or ITNs, or when a vector control intervention such as IRS is withdrawn, countries should prioritize establishing a strong surveillance and response capacity to mitigate a potential malaria increase.

5 Malaria vaccines provide substantial prevention among young children.

WHO recommends the RTS,S/AS01 and R21-Matrix M malaria vaccines for the prevention of *P. falciparum* malaria in children living in malaria-endemic areas, prioritizing areas with moderate to high transmission. Decisions to expand vaccination to low transmission settings should be made at the country level based on the overall malaria control strategy, affordability, cost-effectiveness and programmatic considerations, including whether inclusion of these areas would simplify vaccine delivery (8). At the country level, vaccine introduction is led by the national immunization programme, in collaboration with the NMP and with the technical support of partners, and should be considered in the context of comprehensive malaria control plans, as part of a lifesaving multi-intervention approach to malaria prevention. The malaria vaccine should also be incorporated into the national immunization strategy (NIS), with decisions guided by evidence-based recommendations from advisory groups, including the National Immunization Technical Advisory Groups. Malaria vaccine supply is currently sufficient to meet demand, and vaccine introduction should ensure equitable access across populations, particularly among those with limited access to routine immunization services or living in underserved settings. In moderate and high transmission settings, young children are at the highest risk of severe malaria and mortality. In addition to ensuring access to case management and ITNs, protecting young children through appropriate chemoprevention and vaccination is a priority across different geographies and time horizons.

6 Where transmission is highly seasonal, seasonal malaria chemoprevention (SMC) is an effective and affordable intervention.

There is no evidence to inform when to scale back SMC and countries should do their utmost to

maintain the intervention. However, if resources are not available, scale-down should be based on the principle of “least harm” – de-prioritizing areas where incidence was the lowest at the pre-SMC baseline, while minimizing disproportionate impacts on high-risk or underserved populations. Deployment of effective ITNs, expansion of case management, and better epidemiological and entomological surveillance, preparedness and response should be prioritized in these areas. New chemoprevention strategies should not be prioritized over and above case management and vector control in any given population. Geographical or age expansion of SMC, introduction of community deployment of intermittent preventive treatment of malaria in pregnancy, perennial malaria chemoprevention, post-discharge malaria chemoprevention and intermittent preventive treatment of malaria in school-aged children should not be implemented at scale at the expense of access to case management and effective vector control.

7 Investment in malaria surveillance is essential for effective decision-making.

A strong malaria surveillance system is needed across all transmission settings. Such a system can serve as a dynamic tool to guide resource allocation and intervention planning, enabling countries to use data to target high-burden areas and populations, identify inequities in burden and service access, anticipate and prevent outbreaks, support the transition to elimination, and reduce the risk of re-establishment in malaria-free areas (9). The performance of the surveillance system should be assessed through regular evaluations, and platforms such as national malaria data repositories (10) can facilitate decision-making, including prioritization and de-prioritization processes. Additional technical support is needed to support NMPs in developing transition plans for the de-prioritization of malaria interventions, particularly when data are limited. Newer interventions have limited operational knowledge, data and expertise compared to long-standing interventions, and investments are needed in data collection, monitoring and evaluation to document real-life costs and impact when de-prioritizing interventions. Investment in improving epidemiological surveillance and the quality and effectiveness of interventions should not be reduced as part of prioritization, as these are essential to inform the timely investments required

to achieve impact. This includes strengthening the collection, analysis and use of disaggregated data (e.g. by sex, age, geography and relevant factors) to identify and address inequities in access and outcomes. It also includes resources to secure the coverage and competence of health workers to provide quality care, as well as resources for social behaviour change communication to increase public awareness on care-seeking and increase the acceptance and use of interventions. NMPs should always consider what needs to be prioritized from the malaria budget to ensure that implementation is optimized, assuring timely and effective access to malaria interventions (e.g. procurement, training, supervision and surveillance) and the enabling health services components that depend on the national health development plan (e.g. staff salaries, supply management and distribution, private sector engagement, institutionalization of community health workers).

These guiding principles provide a framework for country decision-making to define the most appropriate mix of malaria interventions for specific geographical areas or risk groups when resources are constrained. This process should be complemented at the national level by a budget optimization analysis to estimate the health impact of the different scenarios under consideration.

Prioritization is an iterative process that will need continuous revision as costs and funding opportunities change over time; as malaria epidemiology changes due to various factors, including man-made and natural disasters; when surveillance does not show the expected impact; when assessment of programme performance shows changing requirements to ensure the effectiveness of interventions; when new tools and knowledge become available; or as new threats emerge. Accordingly, the WHO Malaria and Neglected Tropical Diseases Department will ensure that these guiding principles are considered a “living document” that will evolve alongside new evidence in order to bridge the gap between global modelling and local operational realities, as well as new WHO recommendations, supporting malaria programmes in their decision-making processes.

Mobilizing additional resources is a continuous effort that should be pursued during and after the prioritization planning, based on the evidence-informed national strategic plan. In addition to planning operations based on existing/known resources, national programmes are encouraged to conduct further analyses to identify priority interventions that could be funded should additional resources become available. Such scenario planning will support resource mobilization efforts, including for domestic resources.

3 Process of development

For the first edition of this guidance document, the initial draft was developed by a core team within the WHO Global Malaria Programme (now part of the Malaria and Neglected Tropical Diseases Department) to respond to NMP managers' and technical partners' demand for guidance. The initial draft was shared for input by senior staff members of the Global Malaria Programme and WHO regional malaria advisers. The consolidated draft was shared for engagement with multiple external stakeholders, including NMP managers from selected countries (Burkina Faso, Cameroon, the Democratic Republic of the Congo, Nigeria, Rwanda and Zambia), as well as financial and technical partners (African Leaders Malaria Alliance, Gates Foundation, the Global Fund to Fight AIDS, Tuberculosis and Malaria, RBM Partnership to End Malaria and the United States President's Malaria Initiative). The feedback received from external stakeholders was used, at WHO's discretion, to refine the draft. A subcommittee composed of members of the WHO Malaria Policy Advisory Group served as peer reviewers, and their inputs contributed to the technical development of the document. As external contributors, their declarations of interest were assessed by WHO, and no conflicts were identified. The final draft was presented for discussion at the 24th meeting of the Malaria Policy Advisory Group in October 2023. As advised by Malaria Policy Advisory Group members, the revised document was circulated for further engagement with a number of NMP managers who had received technical support from WHO on SNT to develop their national malaria strategic plans, as well as with financial and technical partners. The feedback received through this additional consultation with external stakeholders was used, at WHO's discretion, to inform the final review by WHO

contributors. The draft was submitted to the peer reviewers and presented for endorsement to the Malaria Policy Advisory Group at its 25th meeting in March 2024.

To strengthen the evidence base of the first edition of the guidance document, in July 2024, WHO launched the "Multi-model comparison of prioritized interventions" (M3CPI) project, which used mathematical modelling to identify optimal intervention combinations and sequencing based on cost and impact. This project was led by the WHO Research for Health Department, with the involvement of the Malaria and Neglected Tropical Diseases Department and Immunization, Vaccines and Biologicals Department. The modelling work was conducted by teams from Imperial College London (*malariasimulation*) and the Swiss Tropical and Public Health Institute (*OpenMalaria*), with oversight from WHO independent experts from the Immunization and Vaccines-related Implementation Research Advisory Committee, which convened in two meetings in 2025. In addition, WHO convened three technical consultations on 16–18 December 2024, 3–4 June 2025 and 9–10 December 2025 to define the scope, timelines, review methodology, preliminary results and external communications. On 23–25 March 2026, WHO convened an ad hoc advisory group to review the final results and provide advice on how these findings should inform updates to the *Guiding principles* document. The report of the ad hoc advisory group meeting was submitted to the Malaria Policy Advisory Group convened on 28–30 April 2026 to seek advice on the proposed changes to the document before its finalization by the WHO Secretariat from the Malaria and Neglected Tropical Diseases Department.

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² All references were accessed on 20 May 2026.

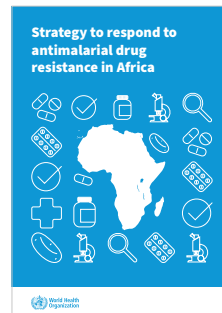
Annex. Additional reading³

Antimalarial drug resistance



Multiple first-line therapies as part of the response to antimalarial drug resistance: an implementation guide

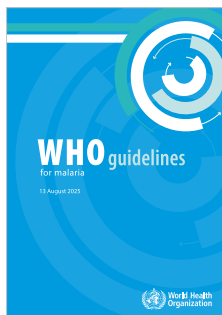
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Strategy to respond to antimalarial drug resistance in Africa

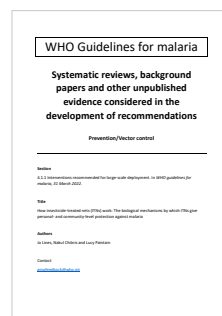
Geneva: World Health Organization; 2022 (<https://iris.who.int/handle/10665/364531>). Licence: CC BY-NC-SA 3.0 IGO.

ITN ownership and usage to achieve personal and community protection



Interventions recommended for large-scale deployment: insecticide-treated nets

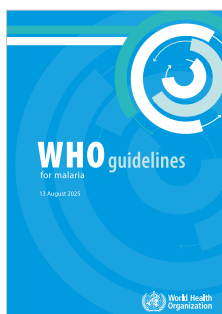
In: WHO guidelines for malaria, 13 August 2025. Geneva: World Health Organization; 2025 (<https://iris.who.int/handle/10665/382254>). Licence: CC BY-NC-SA 3.0 IGO.



Lines J, Chitnis N, Paintain L.

How insecticide-treated nets (ITNs) work: the biological mechanisms by which ITNs give personal- and community-level protection against malaria, version v1. Zenodo. 2022 (<https://doi.org/10.5281/zenodo.6393253>).

ITN requirements at population level

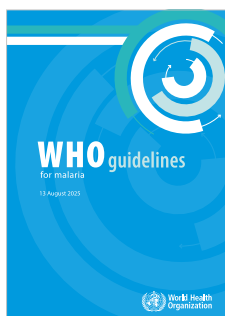


Insecticide-treated nets: practical info

In: WHO guidelines for malaria, 13 August 2025. Geneva: World Health Organization; 2025 (<https://iris.who.int/handle/10665/382254>). Licence: CC BY-NC-SA 3.0 IGO.

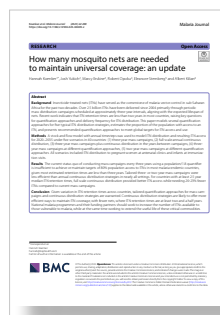
³ All references were accessed on 20 May 2026.

ITN campaigns and continuous distribution



Insecticide-treated nets: practical info

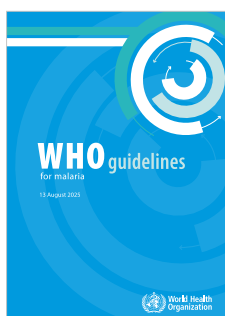
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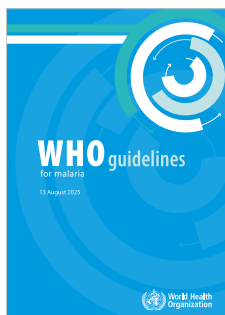
Access to ITNs or IRS at optimal coverage levels



Co-deploying ITNs and IRS: practical info

In: WHO guidelines for malaria, 13 August 2025. Geneva: World Health Organization; 2025 (<https://iris.who.int/handle/10665/382254>). Licence: CC BY-NC-SA 3.0 IGO.

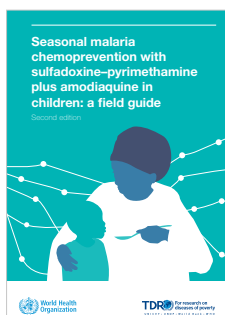
No scale-back of vector control in areas with ongoing malaria transmission



No scale-back in areas with ongoing local malaria transmission: practical info

In: WHO guidelines for malaria, 13 August 2025. Geneva: World Health Organization; 2025 (<https://iris.who.int/handle/10665/382254>). Licence: CC BY-NC-SA 3.0 IGO.
SMC distribution strategies

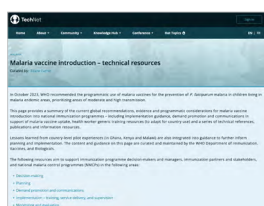
SMC distribution strategies



Seasonal malaria chemoprevention with sulfadoxine–pyrimethamine plus amodiaquine in children: a field guide, second edition

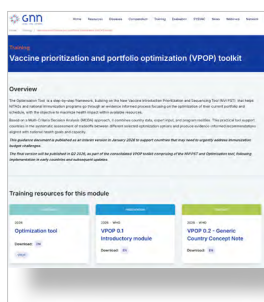
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Malaria vaccines implementation



Malaria vaccine introduction – technical resources [website]

TechNet (<https://www.technet-21.org/en/malaria>).



Vaccine prioritization and portfolio optimization (VPOP) toolkit [online training]

NITAG Resource Center (<https://www.nitag-resource.org/training/building-and-strengthening-technical-competencies/vaccine-prioritization-and-portfolio>).

For further information, contact:

Malaria and Neglected Tropical Diseases department

World Health Organization

20, Avenue Appia

1211 Geneva 27

Switzerland

<https://www.who.int/teams/global-malaria-programme>

<https://www.who.int/teams/control-of-neglected-tropical-diseases/overview>