World Health Organization

Thursday, 13 March 2014

Time	Session	Purpose	Type
9.00 am	Session 5; Global Technical Strategy (cont.) Overarching themes and the pathway to elimination *(P Alonso)*	For information and input	open
10.30 am	**coffee**		
11.00 am	Session 6; Global Technical Strategy (cont.) Break-out groups to discuss Strategic Directions	For information and input	open
12.30 pm	**lunch**		
1.30 pm 2.30 pm 3.00 pm	Session 7; Global Technical Strategy (cont.) Report back from the GTS break-out groups *(P Alonso)* Global Malaria Action Plan II *(F Nafo-Traore)* Regional Consultations *(E Shutes)*	For information and input For information For information and input	open
3.30 pm	**coffee**		
4.00 pm	Session 8; Global Technical Strategy (cont.) Update on Global Plan for *P. vivax*, incl. synergy and integration with the Global Technical Strategy *(R Cibulskis)*	For information and input	open
5.30 pm	**End of day**		

World Health Organization

GLOBAL MALARIA PROGRAMME

Malaria 2025: Accelerate to Eliminate

The Global Technical Strategy for Malaria: 2016 - 2025

Overarching themes & the Pathway to Elimination

Pedro Alonso, GTS Steering Committee Chair

Geneva, 13 March 2014

Overview of document structure

Draft document structure	Section titles
Introduction	• List of Abbreviations • Foreword (to be developed) • Strategy at a Glance (to be developed) • Executive Summary (to be developed)
Core concepts	• The need for a new Global Technical Strategy for Malaria • Global Progress to Date • Challenges • Core Values • Vision, Strategic Directions, and Goals • Malaria Pathway to Elimination
Strategic directions	• Surveillance and Response • Preventing Cases and Reducing Transmission • T3: Test, Treat, Track • Innovation and Implementation Research • Development and Health Systems Strengthening
Conclusion	• Call to Action • Glossary • Annexes (to be developed)

Challenges

Purpose of Challenges section

- Although significant progress, it is critical to highlight the barriers and obstacles that prevent acceleration of impact against malaria
- Acknowledging challenges also provides relevant contextual information

Key questions

- Are there significant additional challenges that should be included in this section?
- Should existing information be presented differently?

Overview of challenges

Drug resistance	• The long-term usefulness of ACTs is threatened by fostering the emergence or spread of resistance to artemisinin
Insecticide resistance	• Pyrethroids are key to vector control but resistance is widespread
Infectious reservoir	• Millions of people with undetected malaria infection represent a large reservoir of parasites that can fuel transmission.
P. vivax	• *P. vivax* poses numerous unique diagnostic and therapeutic challenges that disproportionately affect vulnerable groups
Outdoor biting mosquitoes	• These mosquitoes are not targeted by core vector control methods and pose a challenge for prevention of transmission
Unregulated private sector	• Many people seek treatment in the private sector where there is poor regulation of diagnostic and therapeutic practices
Health systems	• Shortages of human and material resources and poor infra-structure adversely affect case management and surveillance
Financial resources	• The greatest threat to continued success in malaria efforts is financial

Core Values

Purpose of Core Values

- Core values are the foundation on which this document is built; they represent the principles which are fundamental to the enduring worth of the Strategy
- Core values establish the principles that underlie the purpose of each strategic direction

Key questions

- Are the current proposed core values appropriate?
- Are the current proposed core values comprehensive? Should there be more, or less?
- Is each proposed core value presented and defined clearly?

Five fundamental guiding principles

Country leadership

The aim is for countries to provide meaningful input and to lead implementation of the strategy

Using data for programmatic decisions

Surveillance is a key component of strategic planning; data should guide selection of the most appropriate mix of interventions

Acceleration

The strategy should enable country programmes to accelerate progress to reduce burden and transmission, and achieve elimination

Sustained success

Commitment and financial support are mandatory to sustain success and prevent resurgence of malaria burden

Equity

Equity is a goal of, and a road to, malaria reduction and elimination; the most vulnerable populations must have access to malaria interventions.

Vision and Goals

Purpose of Vision and Goals section

- This section is core to the GTS, by setting the direction and providing concrete targets that the malaria community should aim for in the coming decade
- Vision and Goals provide the strategic frame to regional and local level programmes when developing their own strategies

Key questions

- Are the proposed vision / goals sufficiently aggressive and ambitious to drive change and accelerate impact in the coming decade?
- Is the overall strategic frame clear, consistent, and comprehensive?

Vision and Goals

Long-term Vision

A single vision: *a world free of malaria*

GTS Vision

To accelerate progress to a world free of malaria

Goals

Goal 1 – to reduce malaria mortality rates globally by 75% compared to 2015

Goal 2 – to reduce malaria case incidence globally by 75% compared to 2015

Goal 3 – to eliminate* malaria from 20 countries that had ongoing transmission of malaria in 2015**

*eliminate refers to no indigenous transmission of malaria; not certification

** 20 countries to be confirmed

Pathway to elimination

Purpose of the Pathway to elimination

- The pathway to elimination broadly illustrates the route that countries and sub-national areas can take to reach and sustain elimination
- Reduce includes both the initial scale-up of high coverage of interventions and the strengthening of interventions using data in areas where further reductions are required
- Progression along the pathway is dependent on both the level of endemicity and the ability of health systems to track and respond to every case

Key questions

- Are the concepts clearly defined and appropriately conveyed?

Malaria Pathway to Elimination

Pathway to elimination	1 Reduce	2 Eliminate	3 Sustain
Objective	Scale-up key interventions to significantly reduce malaria transmission Strengthen intervention coverage in high transmission areas where further reductions are needed	Deploy targeted interventions to interrupt local transmission	Sustain elimination through high quality surveillance and response to prevent reestablishment of malaria

Accelerate

Five strategic directions

Surveillance and response

Prevent cases and reduce transmission

“T3: Test, Treat, Track"

Innovation and implementation research

Development and health systems strengthening

Overview of strategic direction: Surveillance and Response

Why Surveillance and Response?

- Surveillance is an essential part of all stages on the pathway to malaria elimination
- Effective surveillance enables programmes to both target resources where they are needed most and provides indicators of programme performance

Structure of the section

1. Successes and challenges in malaria surveillance
2. The five building blocks of malaria surveillance
3. Features of surveillance systems in different epidemiological settings
4. Five strategies for strengthening surveillance systems and the use of information
5. Stratification for programme planning
6. Using data to improve programme performance

Overview of strategic direction: Preventing cases and reducing transmission

Why prevent cases & reduce transmission?

- Prevention of human infection with *Plasmodium* is fundamental to the global strategy to fight malaria
- The two current pillars of prevention are vector control and preventive chemotherapy

Structure of the section

1. **Vector control**
   - Long-lasting insecticidal nets
   - Indoor residual spraying
   - Complementary vector control methods – larval source management and integrated vector control
2. **Insecticide resistance monitoring and management**
3. **Medicines to prevent malaria and reduce transmission**
   - Intermittent preventive treatment in pregnancy (IPTp)
   - Intermittent preventive treatment in infants (IPTi)
   - Seasonal malaria chemoprevention (SMC)
   - Chemoprophylaxis in travelers
   - Transmission-blocking chemotherapy

Overview of strategic direction: T3: Test. Treat. Track.

Why T3: Test. Treat. Track.?

Malaria-endemic countries must ensure that every suspected malaria case is tested, that every confirmed case is treated with a quality-assured antimalarial medicine, and that the disease is tracked through timely and accurate surveillance systems to guide policy and operational decisions

Structure of the section

1. **Test – Parasitological testing**
   - Rapid diagnostic tests
   - Microscopy
   - Diagnostics in the elimination setting
   - Diagnosis of *Plasmodium vivax*
2. **Treat – Artemisinin-based combination therapies**
   - Integrated community case management
   - Parasite resistance to antimalarials
3. **Track – Surveillance for decision making**

Overview of strategic direction: Innovation and Implementation Research

Why Innovation and implementation research?

Numerous countries have eliminated malaria using currently available tools, and more are currently doing so, but in high transmission and receptive, settings new tools are needed for elimination

Structure of the section

1. **Near-term innovation (next 5 years)**
   - Vaccines
   - Diagnostic Tests
   - Antimalarials
2. **Medium-term innovation (next 5-10 years)**
3. **Long-term innovation (10+ years)**
4. **Implementation research**
   - Mass Screening and Treatment and Mass Drug Administration

Overview of strategic direction: Development and health systems strengthening

Why Equity, access, & development?

Ensuring that everyone has access to needed malaria interventions regardless of wealth or proximity fixed health facilities is critical

Structure of the section

1. **Equity**
2. **Health Systems Strengthening**
   - Health systems access
   - Hard-to-reach populations
   - Human resource capacity
   - Private Health Sector Challenges
3. **Development and Governance**

Equity

- There are multiple socioeconomic determinants of malaria
- Poverty particularly strongly linked to malaria
- National malaria programmes must ensure equitable distribution of preventive measures and equal access to diagnosis and treatment
- Communities can be empowered through the sharing of knowledge about malaria and its burden

Health Systems Strengthening

- Efficient and effective health systems are essential for equitable distribution of individual health care and public health services
- HSS means addressing key constraints related to health worker staffing, infrastructure, health commodities, logistics, tracking progress and effective financing
- Health policies should explicitly cite equitable access, treatment and coverage as foundational principles of health service delivery

HSS – health systems access

- Engage community members as health service providers (e.g. iCCM)
- Integration and coordination of malaria activities with other programmes can create synergies and improve efficiency
  - Programmes examples: Maternal and child health, EPI, NTDs, WASH
  - Activity examples: outreach, IEC, BCC
- Malaria elimination activities are highly specialized (e.g. focus investigation, active infection detection) and not well suited for integration
- Decentralization can improve provision of special, locally appropriate services; activities must fit within the context of national programmes
- There must be no financial obstacle to health care access

HSS – hard to reach populations

- Certain populations are particularly difficult to reach with health services due to:
  - occupation
  - nomadic or migrant lifestyle
  - geographic location
  - other factors (social, ethnic or religious)
  - military (suggested yesterday)
- Special and innovative approaches will be needed for each individual situation
- Political acceptance of all groups and affirmation of the right to health care are vital
- Hard-to-reach populations can be engaged, educated, empowered through IEC/BCC and through health services provided by trained community health workers

Human resource capacity

- Strengthening human resource capacity is a critical part of reinforcing health systems
- Pre-service/in-service training needed for:
  - Physicians
  - Nurses
  - Lab technicians
  - Vector control specialists
  - Programme management (added yesterday)
- District level skills particularly important where the health system is decentralized and with increasingly heterogeneous nature of malaria
- Also need supportive supervision, incentives to retain trained personnel, identification of opportunities for career progression
- Malaria is being used as an entry point for human resources capacity building in a number of countries

Private Health Sector Challenges

- Private sector provides a significant proportion of patient services in many malaria-endemic countries
- Private sector can be an excellent platform for IEC and BCC activities
- For certain hard-to-reach populations, the private sector may be the only source of health services – private providers may be particularly important in reaching these populations
- Private sector poses challenges with respect to regulation – strengthening and enforcing regulations essential
- Private sector typically not included in facility-based data collection through health information systems – can lead to incomplete understanding of disease burden, intervention coverage and impact

Development

- Sustainable malaria reduction and elimination requires expanding malaria strategies to include socio-economic development
- Multisectoral Action Framework led by RBM and UNDP presents concrete, implementable actions to transform malaria responses to a multi-faceted, multisectoral approach
- Wide range of stakeholders must be engaged – advances can be made at little or no cost to health or malaria programmes
- Multisectoral approach especially important in settings where efforts to reduce malaria have been successful, to solidify progress and prevent resurgences (as when countries pre-maturely divert resources to other diseases when malaria viewed as no longer a public health problem)

Call to action

- To meet or exceed the Goals for 2025, the malaria community needs to
  1. Maximize the use of today's tools
  2. Develop innovations in anticipation to challenges
  3. Maintain political and financial momentum
- Achieving universal coverage in at risk populations and improving the quality of care is key to success
- Biological threats including antimalarial and insecticide resistance must be eliminated where possible and managed carefully to prevent the loss of current tools
- Adequate and predictable financing from both affected countries and international partners is critical to success
- Scientific community and private sector are essential partners in developing new tools and providing access to the at risk population

List of proposed annexes

- Countries and organizations that contributed to the elaboration of the GTS
- Process of development of the document (Steering committee, regional consultations, joint process with GMAP2)
- Assumptions and methodology for establishing goals – quantitative work by Azra's team
- Costing and funding methodology and assumptions
- Recommended indicators

RBM Partnership

Global Malaria Action Plan 2

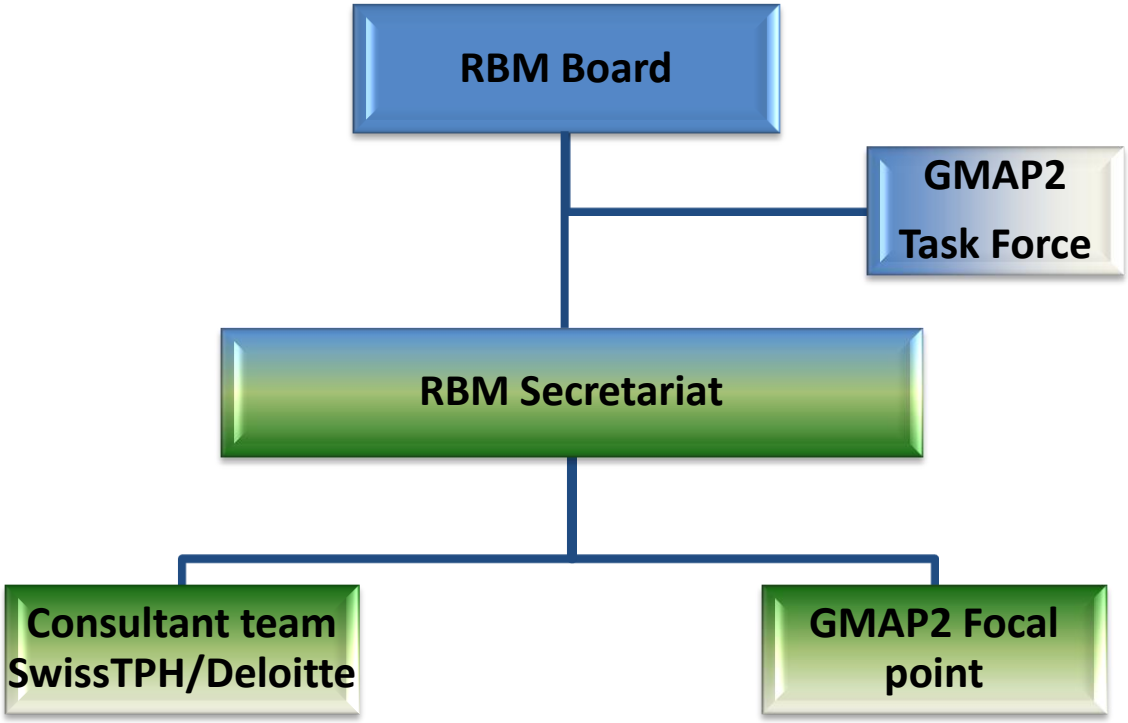
Dr. Fatoumata Nafo-Traoré
Executive Director, RBM

ROLL BACK MALARIA

Content

- Organizational structure of GMAP2 network
- Consultation process
- Proposed contents of GMAP2
- Work plan overview

Organizational structure of GMAP2 network



Organizational structure of GMAP2 network

INTERACTIVE CHANNELS

- Overlapping members (GTS steering committee, and GMAP2 Task force)
- Back to back meetings GTS/GMAP2
  - Including regional consultation process
- Regular information exchange

Consultation process

Key informant interviews

Individual interviews of various stakeholders

- Opinion/experience about current GMAP
- Awareness level of stakeholder groups regarding GMAP in country
- Role of GMAP2 in regards to reducing malaria in the next decade
- Business case approach to mobilise and clarify return of investment

Pre - regional consultations

Through online surveys

Regional consultations

Through back-to-back sessions with GTS meetings

Working groups

Country level consultations

Toolkit development for all countries

10 selected in-country meetings

Consultation process

Suggested participants

- Ministries of planning, foreign affairs, finance
- Regional Economic communities/cooperations/councils
- NGOs / Civil society
- Multilateral organizations (WHO, UNICEF, UNDP, WB…)
- Bilateral partners
- Telecom/Media/other private sector
- Research & Academia
- Donors (Global Fund, Development banks, Industry…)
- MOH officials & malaria managers
- other development sector

Consultation process

Pre - Regional consultation questionnaire (online)

Introduction

This survey is designed to collect preliminary information which will be used to guide the upcoming regional consultation session. Prior to the regional consultations, please review and provide responses to the questions below.

GMAP Questions

1) Are you familiar with GMAP and its functions?
2) How did you make use of the current GMAP?
3) Did you face any challenges in implementing GMAP?
   If yes, which?
4) Do you think these challenges will continue to exist during the timeframe of GMAP2?
5) How do you think they could be overcome?
6) What needs to happen in the next decade to accelerate malaria reduction and elimination?
7) How can that be made to happen?
8) Which stakeholders will need to come on board?
9) What needs to be included in GMAP2 to enable you to mobilise new stakeholders and resources?

Consultation process

Regional consultations

Through back-to-back sessions with GTS meetings

Location	Dates
AFRO/Brazzaville	March 20th – 21st
PAHO/Panama	April 3rd – 4th
AFRO/Harare	April 10th – 11th
EMRO/Casablanca	April 17th – 18th
SEARO/New Delhi	April 30th - May 1st
WPRO/Manila	June 12th - 13th

Proposed contents of GMAP2

Part 1) Overview

- Role of RBM partnership
- Progress under GMAP
- How GMAP2 builds on GMAP
- Summary of GTS

Key themes and chapters

Part 2) Developing a business case for malaria reduction

Part 3) Mobilising people and resources

- Creating an effective multisectoral response
- Incentivizing partners to engage and commit (global, regional level)
- Creating a social movement for an effective malaria response

Part 4) Accelerating action on the pathways to elimination

- Pre-empting common barriers through the business case approach
- Encouraging accountability and maintaining momentum
- Facilitating alignment
- Overcoming implementation challenges (e.g. related to scale-up, elimination, preventing re-introduction, etc.)

Proposed contents of GMAP2

Working group topics in regional consultations

1. Developing a business case for malaria reduction

- Impact of malaria on different group of people
- Who and how much is being invested
- What is the expected return of investment

2. Mobilising people and resources

- Communication and advocacy
- Extent of multisectoral engagement including barriers
- Could the country invest additional resources if engaged differently?

3. Accelerating action on the pathways to elimination

- Identify bottle necks in the implementation of malaria control
- Accountability issues
- What linkages are needed between GMAP 2 for global and regional processes?

Consultation process

Proposed agenda

09.00-09.15	Welcome by WHO / RBM	DAY 1
09.15-09.30	**Purpose of GMAP 2 by RBM**	
09.30-09.45	Objectives, focus areas for the consultation	
09.45-10.00	**Summary of GTS**	
10.00-10.30	Feedback on review of GMAP (findings from pre-consultation questionnaire)	
10.30-11.00	Coffee break	
11.00-12:30	**Breakout Session I: Developing a business case for malaria reduction**	
12.30-13:30	Lunch	
13.30-14.30	Breakout Session I: Report back	
14.30-14.45	Introduction to RBM/UNDP Multisectoral Action Framework	
14.45-15.45	**Breakout Session II: Mobilising people and resources**	
15.45-16.00	Coffee break	
16.00-17.00	Breakout Session II: Report back	
17.00	Wrap up	
09.00-09.30	Welcome and status summary	DAY 2
09.30-10.40	**Breakout Session III: Accelerating action on the pathways to elimination**	
10.40-11.00	Coffee break	
11.00-11.45	Breakout Session III (continued)	
11.45-12.45	Breakout Session III: Report back	
12.45-13.45	Lunch	
13.45-14.45	**Making GMAP 2 work at global, regional, and national level**	
14.45-15.00	Evaluation of consultation	
15.00-15.15	Wrap up and next steps	
15.15-15.30	Official close by WHO / RBM	
15:30-16.00	Coffee break	

Consultation process

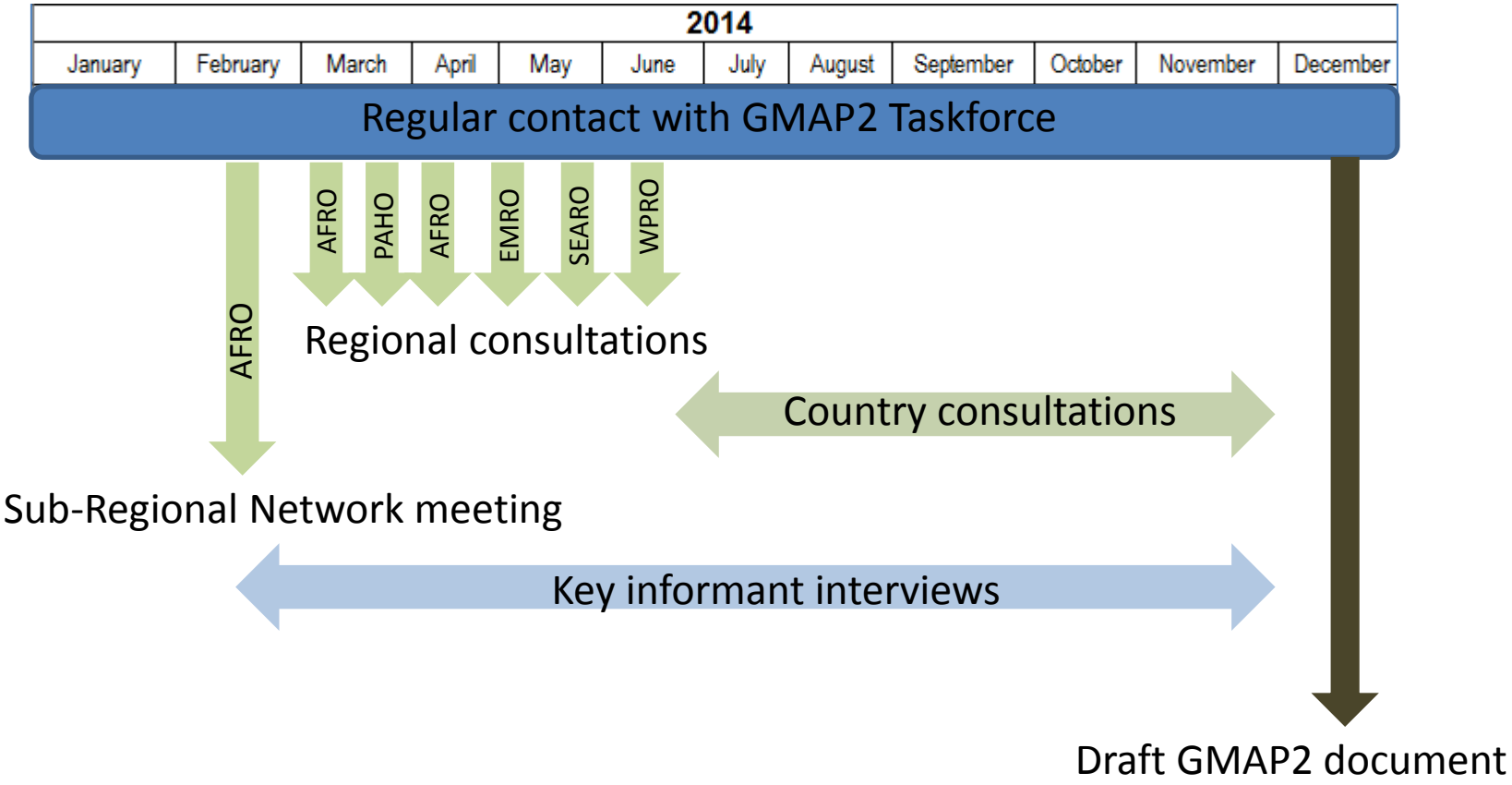
Country level consultations

Toolkit development for all countries, as well as 10 selected in-country meetings

- opportunity to sensitize and engage countries on GMAP 2

- gathering primary data to ensure tailoring of GMAP2 in country specific scenarios

Work plan overview

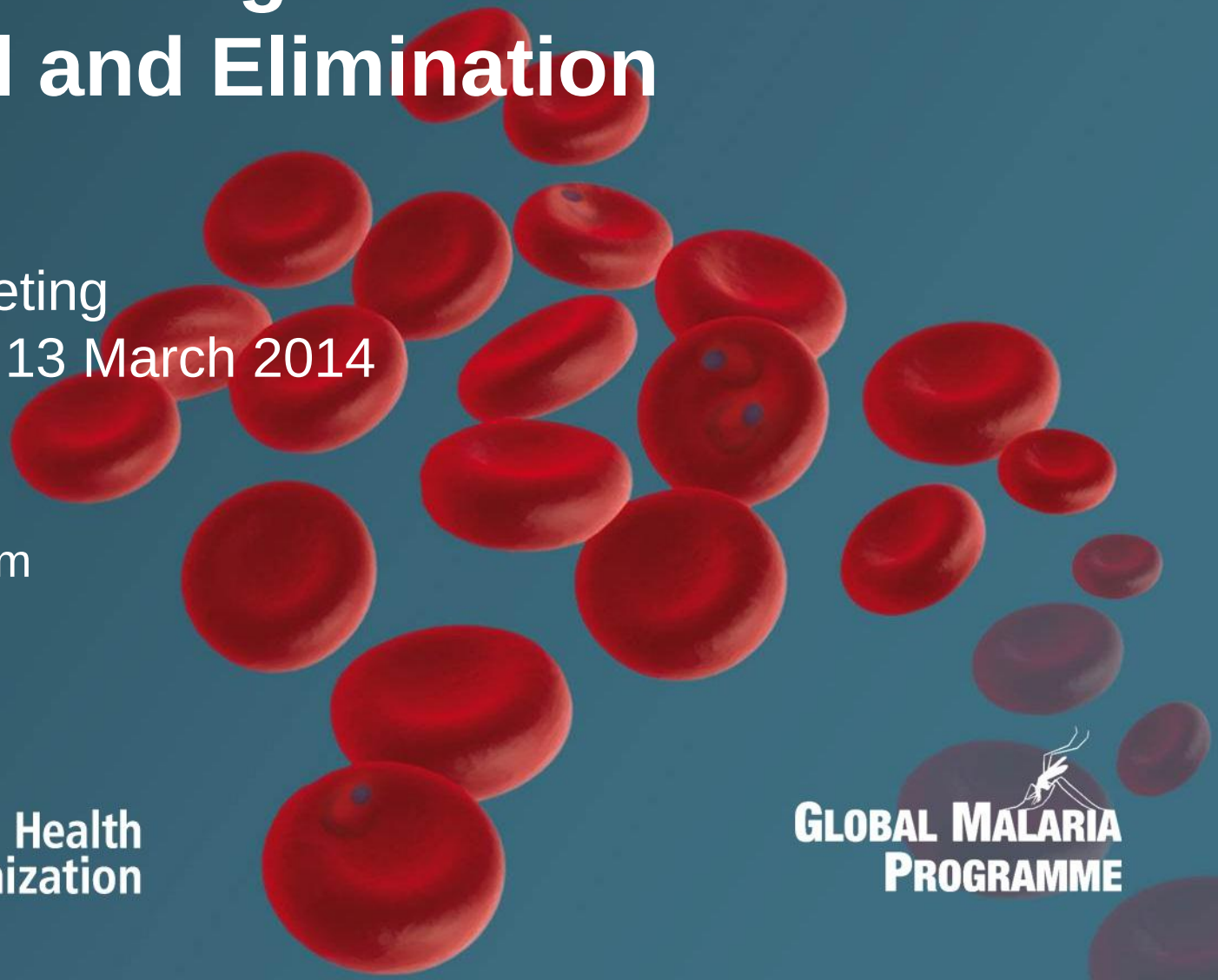


Thank you

Global Strategic Plan for *P. vivax* Control and Elimination

MPAC meeting
WHO HQ, 13 March 2014

P. vivax team



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GLOBAL MALARIA PROGRAMME

Origins

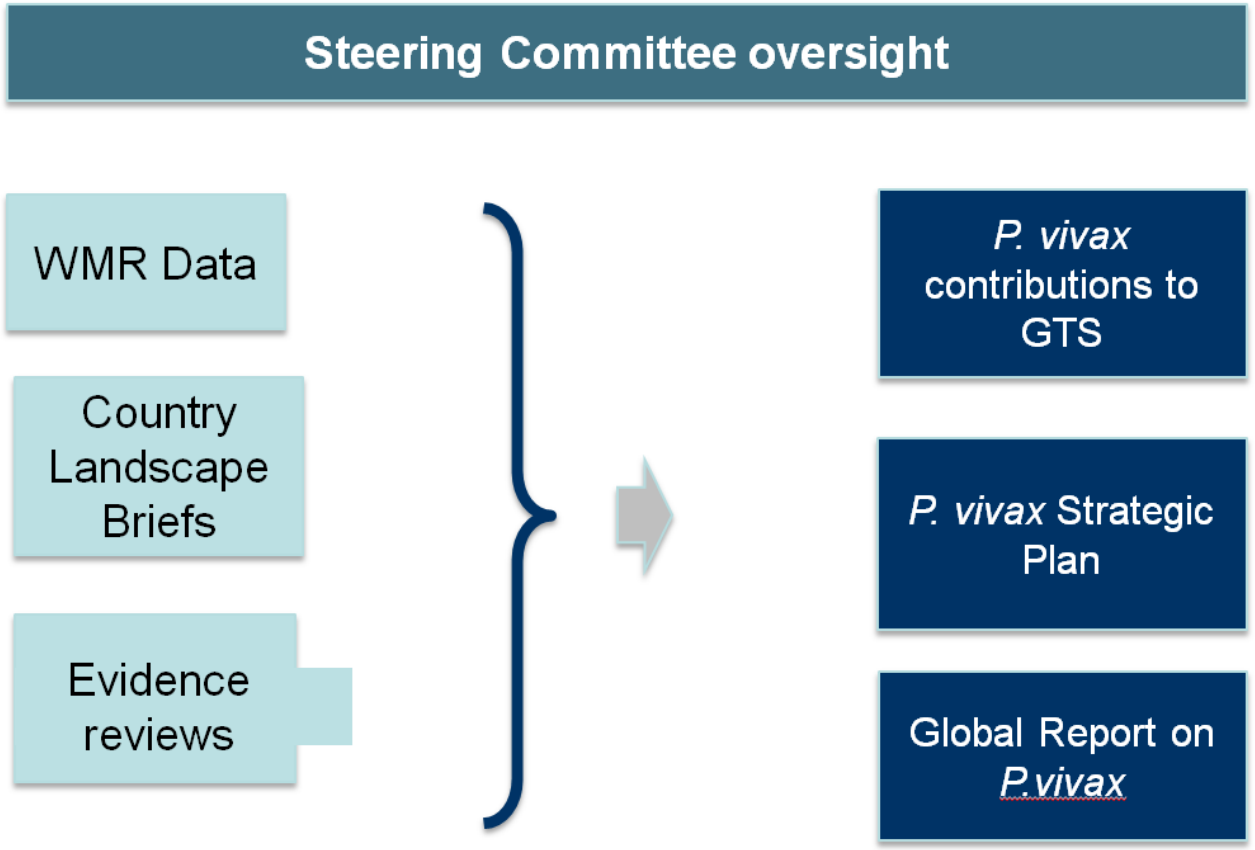
Malaria Policy Advisory Committee to the WHO: conclusions and recommendations of September 2012 meeting:

- a global strategy for *P. vivax* malaria was urgently needed
- it should fall under the umbrella of the overall Global Technical Strategy for Malaria Control and Elimination, 2016–2025
- to be commissioned as a separate piece of work to ensure that it is fully developed
- establishing a small steering committee to be convened before the end of 2012
- hiring of a consultant to support the entire process

Progress

- Funding: Medicines for Malaria Venture (MMV)
- 1st steering committee meeting in Nov 2012
  - Kevin Baird Chair.
  - Kamini Mendis, MPAC member, to help link PVSP and GTS
- Writing Committee established
  - contribute to evidence reviews
  - review and/ or bring together information from
    - GMP databases
    - Thematic Reviews
    - Country Landscape Brief
    - help to draft PVSP
- Consultant hired: Chansuda Wongsrichanalai
- Writing Committee convened in May and Nov 2013
- Each Thematic Review section has been done
- 10 countries selected for Landscape Briefs

Inputs and outputs



Regional consultations

Thematic Reviews

- *P. vivax* biology
- *P. vivax* epidemiology
- Vector control considerations for *P. vivax*
- Diagnosis and treatment
- Surveillance and elimination
- Cost-effectiveness of interventions
- Research priorities

Country landscape briefs

- Summary of epidemiology, policies, programme coverage and trends in disease

Objectives of *P. vivax* strategic plan

- Highlight key issues that need to be addressed if the *P. vivax* infection and disease is to be reduced and eliminated.
- Provide guidance on how to use the most appropriate tools for different settings to achieve specific goals
- Provide practical advice to malaria programmes to reduce and eliminate *P. vivax*.

Guiding principles

- High coverage of vector control is critical: *P. vivax* parasite is transmitted even before patients present for treatment.
- Improved diagnosis of *P. vivax* is essential: RDTs less sensitive and/ or bivalent RDTs are not as widely used (compared to RDTs that detect *P. falciparum*).
- Complete coverage of hypnozoite therapy must be ensured in order to stop relapse and continued transmission; as such, point-of-care G6PD testing is important.
- Pregnant/ lactating women and infants are at risk of both parasite and drugs; this risk has to be mitigated by improved prevention.

1a. Surveillance and Response

	Guidance in PVSP	Rationale	Basis of recommendation
Improving surveillance systems for *P.vivax* malaria	*P.vivax* in general: Ensure correct diagnostic testing, recording and reporting of *P. vivax* malaria in all settings where cases occur including in aggregate records	Species specific data enable better understanding of the local *P.vivax* epidemiology and permit effective planning and implementing evidence-based and targeted interventions against *P.vivax*.	WHO recommendation
	Severe vivax malaria: • Record and report details for all in-patient *P.vivax* cases. Investigate all suspected *P.vivax* deaths.	• Severe *P.vivax* malaria and *P.vivax* deaths are often unascertained and known to be under-reported.	Expert opinion?
Preventing reintroduction of *P.vivax* into malaria-free areas.	• Screen travellers and migrants from endemic areas before entry into receptive malaria-free areas. Sustain good surveillance even when case numbers are close to zero.		Expert opinion with evidence of success in some settings.

1b. Surveillance and Response

	Guidance in PVSP	Rationale	Basis of recommendation
Routine monitoring of chloroquine efficacy by therapeutic efficacy studies (TES) (or '*in vivo*' studies).	• Conduct TES to determine the efficacy of chloroquine against *P.vivax* according to standard procedures as laid out in the WHO Methods for Surveillance of Antimalarial Drug Efficacy (2009). • Ensure to include measurement of chloroquine content in blood and report early parasite clearance	Early identification of antimalarial resistance help to extend the operational life span of drugs. TES data are useful for evidence-based therapeutic policy planning.	WHO recommendation.

2. Preventing Cases

	Guidance in PVSP	Rationale	Basis of recommendation
Protecting communities with appropriate vector control measures	• Ensure good coverage with appropriate strategies based on epidemiology and local vector surveillance data, including the variation of vectors behaviours (e.g. outdoor / indoor biting). Provide full coverage for vulnerable and untreatable populations unable to be treated with primaquine (pregnant/lactating mothers and infants) with long-lasting insecticidal bed nets (LLINs) and indoor residual spraying (IRS).	• Unlike *P. falciparum*, *P.vivax* gets transmitted very early in the course of infection, even before clinical symptoms develop.	WHO?
Protecting high risk sub-populations in endemic countries (e.g. migrants, travellers and military) from *P. vivax* infections using chemoprophylaxis.	Chemoprophylactic approaches may include: • Travellers taking chemoprophylaxis throughout the duration of their stay in an endemic area and one week after return. • Presumptive anti-relapse therapy (PART) in travellers returning from endemic *areas* • Intermittent treatment strategies, including 'spring treatment' (treatment at the beginning of transmission seasons). • MDA, including a full therapeutic dose of anti-relapse therapy.	• To prevent disease and establishment of hypnozoite in the liver • To prevent relapse and further transmission of *P.vivax*.	PART, spring treatment and MDA are practiced in some *P. vivax* endemic countries but are not currently recommended by WHO.

3a. Test, treat, track: Test

	Guidance in PVSP	Rationale	Basis of recommendation
Ensuring universal access to quality assured diagnosis	• Provide good quality microscopy at facilities that provide microscopy services especially to identify low parasitaemias and mixed infections. • Deploy approved* bivalent RDTs at clinic and community level to improve access to timely diagnosis and treatment. **In line with WHO product screening and FIND assessments.*	• It is important to identify all *P. vivax* infections presenting to health facilities even if parasite densities are low or *P. vivax* occurs in the masked by the presence of *P. falciparum*.	WHO recommendation
	• Maintain diagnostic capabilities even when malaria is eliminated or close to elimination.	•	WHO?
	• Ensure good quality PCR or other high sensitivity tools to identify asymptomatic and sub-patent infections.	• Low density infections may contribute to continued transmission of *P vivax*.	WHO?
Introducing G6PD testing to provide safe radical cure.	• Provide G6PD testing facilities within existing health services (possibly with referral from lower to higher level health facilities)	•	WHO?

3b. Test, Treat, Track: Treat

Key elements of PVSP		Guidance in PVSP	Rationale	Basis of recommendation
3.2 Treat	Treating blood- and liver-stage (hypnozoite) parasites.	• Ensure timely access to treatment to achieve clinical cure and prevent progression to severe disease. • Ensure availability and adherence (providers and patients) to radical therapy in low transmission settings.	• Early treatment is key for malaria therapy. Radical cure is the goal of *P.vivax* treatment. It protects the individual from relapses and associated health impact (anaemia, developmental retardation, cognitive effects, etc.) and the community from reservoir of infection.	WHO recommendation
		• Provide radical cure under all transmission settings.	To achieve control and elimination, anti-relapse therapy should be applied regardless of transmission settings.	Under consideration as a WHO recommendation
3.3 Track	Tracking coverage, cases and trends to facilitate timely response. See section 1: "Surveillance and Response"			?

4. Research and Innovation

	Guidance in PVSP	Rationale	Basis of recommendation
Improving investment in fundamental and operational research on *P. vivax*	• Develop higher sensitivity diagnostic tools that can better detect sub-patent, latent, and asymptomatic infections and are applicable in the field. • Develop better drugs, shorter dosing regimens, and accurate point-of-care G6PD testing for targeting hypnozoites. • Validate ACT co-administered with primaquine therapeutic options for radical therapy. • Develop improved drug screening assays. • Develop continuous in vitro cultivation of *P. vivax* blood- and liver-stages. • Define site-specific role of vector species and behavioural traits. • Perform robust estimates of morbidity and mortality burdens from key endemic zones. • Conduct research to better understand *P.vivax* pathophysiology. • Perform operational research on combinations of interventions to be used in different settings and how they should be delivered.	• *P.vivax* research is much behind that of *P.falciparum*. However, some research areas can results in new tools to accelerate *P.vivax* control and elimination; some are seen as presently reachable.	?

5. Governance and Advocacy

	Guidance in PVSP	Rationale	Basis of recommendation
Improving equity of access to key interventions amongst vulnerable groups, including the rural poor.	• Increase investment in research, development and implementation of *P.vivax*-specific interventions.	• There is a general perception that *P.vivax* malaria is 'benign' and attention and investment should focus on *P.falciparum*.	?

Next steps

Activity		Date
• 1st Draft PVSP	For review by regions	mid-March 2014
• Regional	1. PAHO (Panama City)	3 Apr 2014 (1-day)
Consultations	2. EMRO (Casablanca)	14 Apr 2014 (1/2 day)
	3. SEARO (Delhi)	30 Apr 2014 (1 day)
	4. WPRO (Manila)	11 June 2014 (a GTS group discussion)
	5. EURO (Copenhagen)	
• WC Wrap-Up meeting	Manila	12 June 2014?
• Revising PVSP and Global Pv Report		Jun-Aug 2014
• Presenting to MPAC; finalizing the documents		Sep 2014

Questions for MPAC

- Comments on particular recommendations
- What type of document would be most useful to complement the GTS
  - A parallel plan?
  - Nothing at all?
  - Summary of current WHO recommendations for *P. vivax?*
  - Summary of challenges and potential ways forward?
  - Call for action in programme implementation and research
- What should it be called?