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| **Essential** | **Combination of primaquine with a blood schizontocide known to have high efficacy in the study population,** to minimise the risk of recrudescent infections. Primaquine efficacy may vary with partner drug and this must also be confirmed (see Box 3). |
| | **Prolonged duration of follow-up** (12 months) – Since relapses can occur over a 12 months period it is important to conduct studies with long duration of follow-up. |
| | **Inclusion of a control arm** – The risk and timing of *P. vivax* relapse varies with the location of the study site, hence the efficacy, safety and risk-benefit of primaquine needs to be gauged where ethically acceptable by comparison with a control arm (given no antirelapse medication). |
| | **Assessment of adverse events with particular attention to haemolysis**. Primaquine can cause haemolysis particularly in patients with G6PD deficiency and varies with the study population. |
| | **Multicentre assessment.** The risk of relapse varies between *P. vivax* strains and the intensity of sporozoite inoculation. The risk of hemolysis is related to the G6PD deficiency genotypes prevalent . Both vary regionally. Risk and benefit should be assessed in a range of locations. |
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| **Desirable** | **Retreatment and following patients through multiple recurrences** with same treatment regimen. The clinical consequences of relapsing infections and the benefits of their prevention require characterisation of the total number of relapses following an initial infection. |
| | **Quantification of haematological recovery**. Both malaria and primaquine result in haemolysis, and thus risk benefit needs to be confirmed through close monitoring of haematological recovery. |
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