Monthly malaria chemoprevention shows potential in an area of very high, perennial malaria transmission

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Methods

Children between 6 and 24 months of age were randomised to receive daily trimethoprim-sulfamethoxazole (TS), monthly SP, monthly dihydroartemisinin-piperaquine (DP) or no intervention. All study participants were given LLINs. Follow-up continued to 36 months of age. The primary outcome was incidence of uncomplicated malaria, treated with artemether-lumefantrine (AL).

Findings

Between 6 and 24 months of age, children without chemoprevention experienced almost seven malaria episodes per person-year, despite apparently high LLIN use. Monthly SP provided no protection against clinical malaria and possibly increased incidence of moderate–severe anaemia: protective efficacy (PE) 70% (95% CI 184% to 2%). Daily TS reduced clinical malaria by 28% (95% CI 7% to 44%) despite antifolate resistance. Monthly DP reduced clinical malaria by 58% (95% CI 45% to 67%) and possibly moderate–severe anaemia: PE 47% (95% CI 1% to 72%). Self-reported adherence was high but the reliability of this was unclear. There were no significant differences in incidence of complicated malaria or hospitalisation, although numbers were low. Between 24 and 36 months of age, children experienced close to 11 episodes per person-year, regardless of prior intervention group.

Commentary

A 58% reduction in malaria incidence in an area of such high burden reflects an important potential public health impact. However, efficacy is lower than expected given the regularity of dosing and the high efficacy of DP. Monthly DP given as directly observed therapy reduced clinical malaria by 96% among Ugandan school children.2 This suggests adherence to monthly DP was not optimal under trial conditions, which is a concern. Lack of reliable information on adherence may also undermine the finding that piperaquine did not affect the QTc interval, although other studies have partly allayed these concerns.3 ACTs such as DP are not ideal for chemoprevention because the artemisinin component is eliminated rapidly, leaving the partner drug as monotherapy soon after administration. New regimens specifically for chemoprophylaxis are needed.

Chemoprophylaxis requires careful supervised delivery. This is because suboptimal adherence could accelerate development of resistance to the drugs used, if either incomplete courses are taken, or drugs are not readministered each month and concentrations fall below subtherapeutic levels. However, in areas of very high incidence, drug pressure on ACTs will be large even in the absence of chemoprophylaxis: after the intervention period, children received 11 courses of AL per person-year. Well-administered chemoprophylaxis may avoid these issues and help prolong the life of ACTs used for treatment. Community-based health workers may be one means to improve adherence, increase coverage outside the context of a trial, and may be more cost-effective per dose administered, as for monthly seasonal malaria chemoprophylaxis.4

Implications for practice

Chemoprophylaxis is currently recommended for children under 5 years old in areas of high and seasonal malaria transmission and in infants in areas with high malaria transmission and low SP resistance.5 6 Adapting chemoprophylaxis to areas with high, year-round transmission and/or high SP resistance could have a substantial impact. Additional research in this area is crucial to inform future changes in practice. Further studies are needed to evaluate adherence and delivery, the safety and pharmacokinetics of repeated treatments and selection for resistant parasites.

Despite exceptionally high transmission, the burden of clinical and complicated malaria was higher in the postintervention period in this study. Providing chemoprophylaxis to a wider age range could potentially increase impact further. If monthly chemoprophylaxis is given for longer, there may be more scope for rebound morbidity later in life, concerns also faced by preventive approaches including malaria vaccines.

While it is unclear how widely year-round chemoprophylaxis will be appropriate, it will be most cost-effective in areas with very high incidence: control policy needs to be tailored to local epidemiology. Focusing on fewer areas may also limit the impact of chemoprophylaxis on resistance. This will require policymakers to have accurate and regularly updated information on malaria epidemiology and drug resistance markers.

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