BENEFITS OF SEASONAL MALARIA CHEMOPREVENTION
WHO-recommended intervention

Malaria remains a leading cause of ill health. The disease caused an estimated 207 million cases of clinical malaria and 627,000 deaths in 2012. Almost 80% of malaria cases and 90% of malaria deaths occur in sub-Saharan Africa. 77% of those who die are young children who have inadequate immunity to malaria.¹

In Africa’s Sahel sub-region most childhood malaria mortality and morbidity occurs during the rainy season, which generally lasts 3 to 4 months. Giving effective prophylactic treatment to healthy children at intervals during this season has been shown to prevent illness and death from malaria in this vulnerable population. This intervention is known as Seasonal Malaria Chemoprevention (SMC).

In March 2012, WHO issued a recommendation for the use of SMC. For the SMC strategy to have an impact on malaria control, it should achieve high sustained coverage during successive transmission seasons.

SMC STRATEGY
WHO recommends SMC with sulfadoxine-pyrimethamine and amodiaquine (SP+AQ) in areas with high seasonal malaria transmission in the Sahel sub-region of sub-Saharan Africa, where Plasmodium falciparum is sensitive to both these antimalarial medicines. A complete treatment course of SP+AQ should be given to children aged between 3 and 59 months at monthly intervals, from the start of the transmission season, for a maximum of 4 months. SMC is a complementary strategy to already existing malaria control interventions. It can be given alongside other health programmes such as community case management of malaria or vitamin A administration.

Our data suggest that seasonal malaria chemoprevention has the potential to avert several million malaria cases and tens of thousands of childhood deaths each year if successfully delivered to the populations at risk.³

Cairns et al. (2012)
SMC – THE FACTS

A meta-analysis of 7 SMC studies in West Africa, where a course of antimalarials was given periodically to children under 5 years during peak malaria season, showed 80% reduction in clinical attacks of malaria and a similar reduction in the incidence of severe malaria. In addition, both overall and malaria hospital admissions fell showing a substantial reduction in childhood mortality during the transmission season.

In Senegal, SMC using trained community health workers (CHWs) was implemented at large-scale through the existing health system. More than 790,000 treatment courses were administered to more than 140,000 children (coverage >90%). No drug-related serious adverse events were identified.

SMC has been administered to more than 175,000 children between 3 months and 5 years of age in intervention areas in Mali and Chad. Preliminary results from the programme show that the number of cases of simple malaria dropped by 65% in Mali, and by up to 86% in Chad. A significant decrease in cases of severe malaria was also recorded.

SUMMARY

There is strong evidence to support the adoption of SMC for malaria control in areas of seasonal malaria transmission. The potential for SMC to reduce morbidity and mortality significantly in these large areas of Africa is substantial.

To help achieve this, community participation and ownership of the SMC implementation programme should be encouraged. Raising awareness of SMC strategy and its benefits ahead of SMC delivery is vital, as is effective training to ensure that coverage is high for all treatment cycles.

As such, the opportunity for policy adoption and implementation should be seized quickly.

“...the initial results of our intervention show a spectacular decrease in the number of malaria cases.”

Dr. ESTRELLA LASRY, MALARIA SPECIALIST MÉDECINS SANS FRONTIÈRES

CHILDREN AGED 3 - 59 MONTHS LIVING IN THE SAHEL REGION COULD BENEFIT FROM SEASONAL MALARIA CHEMOPREVENTION EVERY YEAR.