

## COMMENTARY

### INTERMITTENT PREVENTIVE TREATMENT AND MALARIA RAPID DIAGNOSTIC TESTS

Malaria remains a major public health problem in sub-Saharan African countries. It remains a major cause of hospital attendance and still contributes to childhood morbidity and mortality. Early recognition of suspected cases and treatment usually start at home. In the last decade or more several interventions have been introduced that have resulted in public health gains. These interventions include insecticide-treated nets, intermittent preventative treatment, rapid diagnostic kits and improvement in access to artemisinin combination treatment. Evaluation of some of these interventions has not been conducted from the perspective of the community. In this issue of the journal we publish a report by Kpormegbe and Ahorlu<sup>1</sup> of an evaluation of IPTc plus timely treatment from the perspective of the community. The results suggest that engaging the community in the planning and implementation of the intervention contributed to its success. Of particular interest was the involvement of the community in the selection of the project assistants.

Treatment of malaria has been based on presumptive diagnosis for a long time until the introduction of Rapid Diagnostic Tests. The WHO now recommends the use of the kits to confirm clinical suspicion of malaria before treatment is instituted. Baiden *et al.*, review the basis of the recommendation and its implication for malaria treatment in Ghana.

The availability of malaria Rapid Diagnostic Test (mRDT) and the realisation that treatment can be effectively conducted at the community level have the potential to revolutionize malaria control. Correct diagnosis and treatment can now be implemented at the household level, especially if the mRDTs are widely adopted. However, the potential may not be realised if some challenges are not addressed. For example, a good stock management system will be required to ensure that there are no stock outs as this will dampen the interest and confidence in the use of the intervention. This is all the more important as the kits are obtained from outside the country.

In the long term, the country may explore the possibility of going into agreement for local manufacturing of the kits with an eye on the Economic Community of West African States (ECOWAS) market. There is also the risk of importation of non-WHO prequalified kits into Ghana. This will require the Ghana Food and Drugs Authority (FDA), the regulatory body, to be very vigilant in their assessment of the various kits that are licensed for use in the country. The use of sub-standard kits has huge implications for credibility of the tool in clinical care as well as patient confidence. Above all, it is hoped that health providers will adhere to the recommendation to test for malaria before treating and also believe the results and treat their patients accordingly.

The implementation of the recommendation calls for regular review of its application especially in the context of management of febrile illness. As we explore the best ways of providing basic health to the population, for example, through the Community-based Health Planning Services (CHPS) initiative, the service should upgrade facilities beyond the CHPS compound to be able to do further testing for causes of fever beyond the basic RDT's so that the use of RDTs and the treatment of malaria can be brought closer to the homes. The overuse of antimicrobial agents in the face of negative mRDT may then be reduced.

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#### REFERENCES

1. Kpormegbe S.K And Ahorlu C. K. The role of community participation in intermittent preventive treatment of childhood malaria in southeastern Ghana *Ghana Med J* 2014; 48(2): 58-65
2. Baiden F, Malm K, Bart-Plange C, Hodgson A et al Shifting from presumptive to test-based management of malaria – technical basis and implications for malaria control in Ghana *Ghana Med J* 2014;48 (2);112-122