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## Consequences of restricting antimalarial drugs to rapid diagnostic test-positive febrile children in southwest Nigeria

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### ABSTRACT

**Objectives:** To investigate the consequence of restricting antimalarial treatment to febrile children that test positive to a malaria rapid diagnostic test (MRDT) only in an area of intense malaria transmission.

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**Methods:** Febrile children aged 3-59 months were screened with an MRDT at health facilities in south-west Nigeria. MRDT-positive children received artesunate-amodiaquine (ASAQ), while MRDT-negative children were treated based on the clinical diagnosis of non-malaria febrile illness. The primary endpoint was the risk of developing microscopy-positive malaria within 28 days post treatment.

**Results:** 309 (60.5%) of 511 children were MRDT-positive while 202(39.5%) were MRDT-negative at enrolment. 18.5% (50/275) of MRDT-positive children and 7.6% (14/184) of MRDT-negative children developed microscopy positive malaria by day 28 post treatment ( $p=0.001$ ). The risk of developing clinical malaria by Day 28 post-treatment was higher among the MRDT-positive group than the MRDT-negative group (adjusted OR 2.74; 95% CI, 1.4, 5.4). A higher proportion of children who were MRDT-positive at enrolment were anaemic on day 28 compared with the MRDT-negative group (12.6% versus 3.1%;  $p = 0.001$ ). Children in the MRDT-negative group made more unscheduled visits because of febrile illness than those in MRDT-positive group (23.2% vs 12.0%;  $p = 0.001$ ).

**Conclusion:** Restricting ACT treatment to MRDT-positive febrile children only did not result in significant adverse outcomes. However, the risk of re-infection within 28 days was significantly higher among MRDT-positive children despite ASAQ treatment. A longer-acting ACT may be needed as the first line drug of choice for treating uncomplicated malaria in high transmission settings to prevent frequent reinfections.

**Keywords:** Consequences, malaria RDT for malaria diagnosis

## INTRODUCTION

Malaria continues to be a major cause of morbidity and mortality in sub-Saharan Africa in spite of the scaling-up of interventions for its control [1]. In 2013, it was estimated that 100 million cases of malaria and more than 300,000 malaria-related deaths occurred in Nigeria [2]. In areas with a high burden of malaria, early diagnosis and effective treatment of childhood fevers remains one of the key malaria control strategies [3-6]. Accurate parasite-based diagnosis at all levels of the healthcare delivery system is crucial in order to promote early and effective treatment of childhood malaria [7]. This will also lead to early identification and appropriate management of non-malarial childhood fevers by encouraging institution of further laboratory tests for identification of causes of non-malarial fevers such as bacterial infections. Furthermore, a confirmative diagnosis of malaria is essential to support an effective surveillance system in areas where the prevalence of malaria has been decreasing [8]. The emergence and spread of strains of *Plasmodium falciparum* resistant to

chloroquine and sulfadoxine-pyrimethamine, which necessitated the use of the more expensive ACTs, further underscores the need for the confirmation of malaria diagnosis, in order to facilitate more targeted treatment [9].

The current Nigerian national treatment guidelines for diagnosis and treatment of malaria, in line with the WHO directive [9,10], recommend that, where possible, malaria diagnosis should be confirmed with microscopy or rapid diagnostic test prior to starting treatment. The major advantage of this treatment policy is that patients with malaria will receive timely treatment, and those with non-malaria febrile illnesses can be investigated and managed appropriately early [6,11]. As microscopy is often not available in primary healthcare facilities, malaria rapid diagnostic tests (MRDT), which require minimal training to use and a short waiting time for the results, are the viable options for parasite-based diagnosis in lower-level health facilities [10,11]. However, false positive and false negative results from MRDT are not uncommon. Malaria antigenemia clears very slowly, and so false positive MRDT results may occur within two to four weeks of a successfully treated malaria infection [12 -14]. Cross-reactivity of some heterophile antigen, such as in patients with rheumatoid arthritis, may also lead to a false positive result [15]. False negative results usually occur at low parasite densities, but also occasionally at significantly high parasite densities, in what is referred to as “the prozone effect” [16]. Although uncommon, false negative results have also been observed where short molecules of the HRP-2 gene have been deleted [14, 17] or where overwhelming infection and high levels of antigen have bypassed the collection mechanism of the device.

A major concern in implementing MRDT-based treatment for children with febrile illness is the risk of a false negative result leading to a missed opportunity for administering appropriate treatment. Restricting the use of ACT to MRDT-positive children would deny the MRDT-negative children, who would have received an antimalarial treatment based upon presumptive diagnosis of malaria, the benefit of the post-treatment chemoprophylactic effect. This could, in theory, lead to increased frequency and severity of clinical malaria in children who are denied ACT on account of negative MRDT results. There is also concern for patients with no or little malaria immunity, particularly infants who would be left without antimalarial therapy due to a false-negative RDT that the risk of developing severe malaria may be high [18]. However, a study from Benin reported that treating only MRDT-positive children for malaria provided adequate management of fevers among children aged 5 to 15 years [19].

A better understanding of treatment outcomes of MRDT-negative children has the potential to enhance the acceptability of MRDTs by healthcare workers and caregivers of children. Thus, there is a need to investigate treatment outcomes of MRDT-based diagnosis of febrile illnesses in children

under five years old. This study, therefore, addresses the question of whether or not limiting ACT treatment to MRDT-positive febrile children only results in significant adverse outcomes within 28 days of post-treatment.

## **METHODS**

### ***Study design and subjects***

This prospective cohort study compared the risk of malaria during the 28-day post-treatment period among MRDT-positive children who received an ACT (MRDT-positive group), and MRDT-negative children who did not receive antimalarial treatment (MRDT-negative group) at enrolment. Children aged 3 to 59 months presenting with fever (axillary temperature  $\geq 37.5$  °C) or history of fever within 48 hours at the study health facilities. Participants were enrolled consecutively from the middle of November 2013 to the middle of November 2014. The following children were excluded from the study: (1) resided > 15km away from the study health facilities; (2) parent/caretaker refused informed consent; (3) child had a history of allergy to artesunate or amodiaquine; (4) had a danger sign or symptoms/signs of severe malaria as defined by the WHO [20].

### ***Study area and sites***

The study was carried out in an urban secondary health care facility (St Mary's Hospital, Eleta, Ibadan) and in a rural primary health centre (Idi-Ayunre in Oluyole LGA, Oyo State). St. Mary's Hospital is used by a wide range of socio-demographic groups from the city of Ibadan, while Idi-Ayunre PHC (located 35 km away from Ibadan) is used mainly by the population from the surrounding villages. All laboratory investigations except MRDT testing were carried out at the University College Hospital, Ibadan; the Institute for Advanced Medical Research and Training (IAMRAT), University of Ibadan; and the Molecular biology Laboratory of Ladoke Akintola University, Oshogbo (LAUTECH).

### ***Sample size***

The primary end-point for estimating the sample size was the risk of clinical malaria within 28 days of initiating treatment at the time of enrolment among MRDT-negative children, compared to that in MRDT-positive children. We assumed that the relative risk of clinical malaria (RR) in MRDT-negative febrile children who were not given ACT, compared with MRDT-positive children who were given ACT, will be 2.0. A previous study in Ibadan showed that 7% of children aged 6 months to 10 years treated with artesunate-amodiaquine (ASAQ) had clinical malaria by day 28 [21]. Thus, to detect a RR of 2 at 95% significance and 90% power, a sample size of 430 per group will be required.

Assuming the loss to follow up at day-28 post-treatment would be about 10%, we estimated that the study will require 956 febrile children. However, the study was able to enrol only 511 children over the study period.

### **Enrolment and follow up procedures**

Eligible children were screened for malaria using an HRP II-based malaria RDT (MRDT) [SD Bioline™, Standard Diagnostics Inc, Korea]. At enrolment, data on demographic and socio-economic characteristics, the history of current and past illnesses and any previous treatments received were collected. Children were examined by a medical officer and relevant clinical findings were documented. In addition to conducting a MRDT, blood samples were collected for malaria microscopy, PCR and for investigating other causes of febrile illness.

MRDT-positive children were treated with a fixed-dose preparation of artesunate plus amodiaquine (ASAQ™; Sanofi Aventis) at standard dosage under supervision on days 0, 1 and 2. MRDT-negative children were treated with an appropriate drug regimen based upon the diagnosis of non-malarial febrile illness. Both MRDT-positive and MRDT-negative cohorts were followed up at the health facilities on days 1, 2, 3, 7, 14, 21 and 28 in order to assess the resolution of clinical symptoms and signs. Capillary blood samples were collected on days 7, 14, 21 and 28 post-treatment for repeat haematocrit, MRDT and thick blood smear for malaria parasites detection and quantification. MRDT-negative children who became MRDT-positive during follow up or unscheduled visits were treated with ASAQ™.

### **Laboratory procedures**

Dried thick blood smears were stained with 10% fresh Giemsa at pH 7.2 and were read by two independent microscopists blinded to the MRDT results for presence and quantification of malaria parasites. Parasite density was calculated by counting asexual malaria parasites against roughly 200 white blood cells (WBC) using an assumed total white cell count of 8000/mm<sup>3</sup>. A blood smear was considered negative if no parasites at asexual stage were seen after 100 high power fields had been screened. Discordant results were read by a senior investigator (COF); otherwise the mean of parasite densities by the two microscopists was recorded as the final reading.

DNA was extracted using QIAamp DNA Mini kit™ (QIAGEN Germany) according to the manufacturer's instructions. Genotype of each *P. falciparum* isolate was characterised based upon the fragment size of alleles of Merozoite surface protein-1 (*msh-1*), *msh-2* and Glutamate Rich Protein (*glurp*) after amplification of 18srRNA by nested PCR, to detect *Plasmodium specie*.

Infections were defined as polyclonal if parasites in matched primary and post-treatment samples

from the same patient showed more than one allele of K1, MAD20 or RO33 and FC27 or IC1/3D7 families of *m*sp-1 and *m*sp-2 respectively. If an isolate had one allele at each of the families, the clone number was taken to be one. Absence of allelic identity in the three allelic families of *m*sp-1 (K1, MAD20 and RO33) or the two families of *m*sp-2 in matched primary and post-treatment samples indicated a newly acquired infection.

Blood culture for bacteraemia was carried out using the Bactec Technique [22]. Isolation and sensitivity testing of bacteria from midstream urine, throat, ear and skin swabs were carried out using standard techniques.

### ***Study consent and ethical approval***

Ethical approvals for the study protocol were obtained from University of Ibadan/University College Hospital Ethical Review Committee, the Oyo State Ministry of Health Ethics Committee and The London School of Tropical Medicine and Hygiene IRB. Participation in the study was voluntary and based on written or witnessed verbal informed consent of parent or caregiver of children who fulfilled the inclusion criteria. The study conformed to the principles embodied in the Declaration of Helsinki.

### ***Statistical analysis***

All data were double-entered in a database and verified/cleaned using EpiData Version 3.1 [23]. Data analysis was performed using SPSS for Windows 18.0 (IBM-SPSS Inc., IL, USA). The primary endpoint was clinical malaria defined as the detection of asexual malaria parasite by microscopy at any time point between days 7 and 28 post initiation of treatment at enrolment. The result of microscopy was used as reference to assess the performance of MRDT. The socio-economic background of the family was classified using the method described by Oyediji [24], in which scores were awarded to each child, based on the occupations and educational attainment of the parents or their substitutes. Average scores of 1 and 2 were assigned “high”, a score of 3 was assigned “middle” while scores of 4 and 5 were assigned “low”. The Chi-square test was used to compare categorical variables while Student *t*-test was used to test associations between continuous independent variables and the dependent variable. Logistic regression analysis was used to estimate the odds ratios (ORs) and 95% confidence intervals (CIs) of clinical malaria within 28 days of treatment in MRDT-negative versus MRDT-positive children. All covariates with a *p*-value <0.05 in bivariate analysis were included in the final multivariable logistic model.

With the corresponding results of the microscopy taken as the 'gold standard', the sensitivity and specificity of malaria RDT were calculated as  $TP/(TP + FN)$  and  $TN/(TN + FP)$ , respectively. Positive predictive values (PPV) were calculated as  $TP/(TP + FP)$  and negative predictive values (NPV) as  $TN/(TN + FN)$ , where TP = True positive, TN = True negative, FP = false positive, FN = False negative. Accuracy which is defined as the proportion of the test method that gives a positive result correctly was calculated using the following formula -  $(TP + TN)/(TP + TN + FP + FN)$ .

## RESULTS

Four hundred and twenty-nine of the 511 (84%) children enrolled completed the study (Figure 1). Of the 82 (16%) children who dropped out, two from the MRDT-positive group were referred to other health facilities for further treatment, parents of 25 children withdrew consent and 55 were lost at the follow up. The parents of most of the children lost to follow up moved out of the study area. The dropout rate in the MRDT-positive (17.2%) and MRDT-negative (14.4%) groups did not differ significantly ( $p = 0.422$ ). The age and gender distribution of the children who dropped out from the MRDT-positive and MRDT-negative groups were also similar.

At enrolment, 309 children (60.5%) were MRDT-positive while 202 (39.5%) were MRDT-negative. A higher proportion of MRDT-positive children was from the rural than the urban site (80.9% vs 19.1%;  $p < 0.001$ , adjusted OR = 3.58, 95% CI = 2.30, 5.57). A comparison of the socio-demographic characteristics in MRDT-positive and MRDT-negative children is shown in Table 1.

The mean age of MRDT-positive children was higher than that of the MRDT-negative group (29.4 vs 21.9 months;  $p < 0.001$ ). The proportion of children from the lower social class was higher among the MRDT-positive group than in the MRDT-negative group (35.0% vs 18.8%;  $p < 0.001$ ).

The proportion of febrile (temp  $\geq 37.4^\circ\text{C}$ ) children having malaria parasitaemia at enrolment was significantly higher among children in the rural than the urban site (53.4 vs 24.0%;  $p < 0.001$ , adjusted OR = 3.2, 95% CI = 2.07, 5.02). The geometric mean parasite densities were 8,206 (range, 20-360,000/ $\mu\text{L}$ ) and 6,774 (range, 40-611,600/ $\mu\text{L}$ ) for the rural and urban site respectively ( $p = 0.081$ ).

### ***Risk of malaria during 28 days of follow-up post-treatment***

Sixty-four of 454 (14.1%) children who completed follow up had microscopy-positive malaria on or before day 28 (Table 2).

**Table 1.** Socio-demographic characteristics of under five years old children with fever in south west Nigeria.

Variables	Total Population (N = 511)	MRDT – Positive (N = 309)	MRDT- negative (N = 202)	P- value	UOR	95% CI	AOR	95% CI
Study sites								
Rural	343 (67.1)	250 (80.9)	115 (56.9)	<0.001	3.21	2.15, 4.77	3.58	2.30, 5.57
Urban	168 (32.9)	59 (19.1)	87 (43.1)		1	-	1	-
Gender								
Male, n (%)	301 (58.9)	188 (60.8)	113 (55.9)	0.271	1.22	0.85, 1.75	1.16	0.78, 1.72
Female, n (%)	210 (41.1)	121 (39.2)	89 (44.1)		1	-	1	-
Mean Age (months)	26.4 ± 15.6	29.4 ±15.3	21.9 ±15.0	<0.001	1.03	1.02, 1.05	1.04	1.03, 1.05
Nutritional status								
*Malnourished, n (%)	61 (11.9)	41 (13.3)	20 (9.9)	0.251	0.72	0.41, 1.27	0.61	0.33, 1.13
Not- Malnourished, n (%)	450 (88.1)	268 (86.7)	182 (90.1)		1	-	1	-
Ethnicity								
Yoruba, n (%)	447 (87.5)	266 (86.1)	181 (89.6)	0.500	1	-	1	-
Ibo, n (%)	30 (5.9)	20 (6.5)	10 (5.0)		1.36	0.62, 2.98	0.79	0.34, 1.83
Others, n (%)	34 (6.7)	23 (7.4)	11 (5.4)		1.42	0.68, 2.99	1	-
Number of mother's children								



1-4, n (%)	422 (82.6)	248 (80.3)	174 (86.1)	0.087	0.65	0.40, 1.07	0.79	0.46, 1.35
>4, n (%)	89 (17.4)	61 (19.7)	28 (13.9)		1	-	1	-
Social Class								
High, n (%)	60 (11.7)	25 (8.0)	35 (17.3)	<0.001	1	-	1	-
Middle, n (%)	305 (59.7)	176 (57.0)	129 (63.9)		5.10	1.07, 9.37	5.91	1.07, 8.44
Low, n (%)	146 (28.6)	108 (35.0)	38 (18.8)		11.36	2.31, 19.91	13.16	2.26, 22.23

UOR – Unadjusted Odds Ratio

Adjusted Odds Ratio

\*Weight-for-age Z score <2.

**Table 2.** Risk of Developing Clinical Malaria (both recrudescence and new infections) within 28 Days Post-Treatment among MRDT-positive or negative Febrile Children

Post treatment days	Microscopy Results*		Unadjusted odds ratio (OR)			Adjusted odds ratio (AOR)**		
	MP Negative n (%)	MP Positive n (%)	OR	95% CI	ρ - value	AOR	95% CI	ρ - value
Day 1 -7								
Day 0 MRDT-ve	182 (98.9)	2 (1.1)	-	-	0.083	-	-	0.993
Day 0 MRDT- positive	275 (100.0)	0 (0.0)						
Day 1 -14								
Day 0 MRDT-ve	173 (96.6)	6 (3.4)	0.22	0.05, 1.13	0.068	0.21	0.04, 1.18	0.077
Day 0 MRDT- positive	257 (99.2)	2 (0.8)						
Day 1 -21								
Day 0 MRDT-ve	161 (94.7)	9 (5.3)	1.94	0.88, 4.26	0.095	1.87	0.81, 4.35	0.145
Day 0 MRDT- positive	231 (90.2)	25 (9.8)						
Day 1 -28								
Day 0 MRDT-ve	170 (92.4)	14 (7.6)	2.76	1.48, 5.16	0.001	2.74	1.40, 5.37	0.003
Day 0 MRDT- positive	220 (81.5)	50 (18.5)						

MRDT-negative: Negative MRDT result

MRDT-negative: Positive MRDT result

\*Malaria parasite by microscopy on days 7, 14, 21 or any time within 28 days of treatment with Artesunate-amodiaquine for malaria.

\*\*Variables included in logistic regression model: "day 0 MRDT results", site, age and socio-economic status

†Fisher's exact test reported

Fifty of 275 (18.5%) children were in the MRDT-positive group, while 14/184 (7.6%) belonged to the MRDT-negative group ( $p=0.001$ ). The risk of developing clinical malaria (including recrudescence and re-infection) between days 1 and 28 post-treatment was higher among the MRDT-positive group (adjusted OR 2.74; 95% CI 1.4, 5.4) (Table 2). *Plasmodium falciparum* in 30 paired blood spots (taken at enrolment and parasite recurrence) that were successfully extracted and genotyped using *msh-1*, *msh-2* and *glurp*, were confirmed as re-infections since the parasite profiles of day 0 and recrudescence day were different.

### **Risk of anaemia and other clinical outcomes**

The proportion of children having anaemia (haematocrit <30%) was higher in the MRDT-positive group at enrolment (37.9% vs 10.0%;  $p < 0.0001$ ) (Table 3).

**Table 3.** Risk of anaemia among febrile under 5 years old children in Ibadan, Nigeria

Characteristic	MRDT-Positive on day 0	MRDT-Negative on day 0	p-value	UOR (95% CI)	*AOR (95% CI)
Anaemia day 0	125/309 (40.5%)	26/202 (12.9%)	<0.001	4.59 (2.87, 7.36)	5.37 (3.20, 9.02)
Anaemia Day 28	29/231 (12.6%)	5/160 (3.1%)	0.001	2.33 (1.07, 5.05)	2.35 (1.02, 5.38)

Anaemia was defined as haematocrit less than 30%

\*Variables included in logistic regression model: “day 0 MRDT results” are as follows: study site, age and socio-economic status

The proportion of children with anaemia at day 28 post-treatment reduced in both groups. However, a significantly higher proportion of children in the MRDT-positive group were anaemic compared to MRDT-negative children at day 28 post-treatment (12.6% vs 3.1%,  $p=0.001$ ).

Two children from the MRDT-positive group required referral to a tertiary care hospital on account of severe anaemia. 70% (216/309) of children had blood slide-positive malaria at enrolment in the MRDT-positive group and 84.3% (182/216) of them completed day 28 follow up. The day 28

adequate clinical and parasitological cure rate (ACPR) for ASAQ among these children was 78.0% (142/182). There was no case of early treatment failure. Twenty-five (13.7%) had late parasitological failure while 15 (8.2%) had late clinical failure. After PCR correction (30/40 cases were re-infection), the day 28 ACPR of the per protocol population was 94.5%. Twenty-nine (14.4%) children who were MRDT negative at day 0 converted to MRDT positive before day 28. There was no significant difference in the conversion rate among children enrolled at the rural (16.5%) and urban site (11.5%) ( $p = 0.312$ ).

Eighty-four (16.4%) children made at least one unscheduled visit during the 28-day follow up period because of their caregiver's concerns about a delay in symptoms being resolved. A higher proportion of children from the MRDT-negative group made unscheduled visits than from the MRDT-positive group (23.2% vs 12.0%;  $p = 0.001$ ).

#### ***Causes of fever among study children***

Malaria diagnosed by microscopy was the most common infection 44.4% (227/511), followed by bacterial infection 27.59% (141/511) and presumptive viral infections 32.48% (166/511). The distribution of the causes of febrile illness between day 0 and day 28 among the MRDT-positive and MRDT-ve groups is shown in Table 4.

**Table 4.** Common causes/sites of infection identified in under five years old febrile children in south west Nigeria

Infectious agents	MRDT-positive on Day 0	MRDT-negative on Day 0
Malaria parasitaemia (by microscopy)	217/309 (69.9%)	10/202 (4.5%)
Bacterial infections		
• UTI (Urine Culture)	50/247 (20.2%)	29/145 (20.2%)
• Bacteraemia* (Blood culture)	7/297 (2.4%)	5/196 (2.6%)
• Skin infection	14 (4.5%)	23 (11.4%)
• Otitis media	8 (2.6%)	5 (2.5%)
Measles	1 (0.3%)	4 (2.0%)
Probable viraemia	56 (18.1%)	105 (52%)

Possible viral infection, urinary tract infection, sepsis of skin, bacteraemia and otitis media were the common causes of the non-febrile illness among both groups.

### ***Performance of SD-Bioline™ Malaria Rapid Diagnostic Test Compared to Microscopy***

There were ten cases of false negative MRDT results and 93 cases of false positive MRDT results. The geometric mean parasite density of the cases with false negative result was 480/μL (range 76μL - 5539μL), while that for true positive was 8,888/μL (range 40μL – 611,600/μL). Compared to malaria microscopy results as the reference standard, the sensitivity of SD - Bioline™ RDT for the diagnosis of malaria on day 0 was 95.6%. Specificity was 67.4% however, while positive and negative predictive values were 69.9% and 95.1% respectively. The estimated accuracy for SD - Bioline™ RDT in this study was 79.8%.

### **DISCUSSION**

Our results show that restricting ACT treatment to MRDT-positive children only does not result in significant adverse health outcomes. In addition, the risk of developing microscopy-positive malaria within 28 days was remarkably higher among MRDT-positive children than MRDT-negative children. The burden of malaria was higher among children in the rural study site, where it was the cause of fever in 52.9% of cases vs. 23.3% in urban study site. The MRDT-positive children came from a relatively lower socio-economic class than the MRDT-negative group. These findings are consistent with previous studies from Nigeria, which suggested that children from urban and wealthier households are less likely to report fever attributable to malaria [ 25-28]. Our data also showed that children in the MRDT-positive group were relatively older than the MRDT-negative group. This disparity in age among RDT-positive and RDT-negative children is consistent with the findings from south west Nigeria [4] and Ghana [29]. A high proportion of children in the MRDT-positive group were from middle to lower socio-economic classes from the rural study site. Although children acquire immunity to malaria from repeated exposure and episodes of malaria attacks [30], it has also been reported that children from wealthier backgrounds were less likely to have malaria [31].

An important finding from this study is that the odds of clinical malaria was significantly higher in the MRDT-positive than MRDT-negative group by day 28, even after adjusting for study site, age and socio-economic background. This finding correlates with the report from Ghana [29], which showed that fewer children who tested negative to RDT and did not receive ACT developed clinical malaria within a short period compared to the children who were MRDT-positive and received ACT in a high transmission setting [29]. This finding suggests that the children who were MRDT-positive at enrolment have some unfavourable factors that predispose them to recurrent malaria infection. These factors include relative poverty and environmental factors that increase the risk of malaria infection. The fact that all 30 cases of parasite recurrence that were characterised by PCR were due

to re-infection supports high transmission and special pre-disposition. The MRDT negative to positive conversion rate of 9.4% over a 28-day period appears low compared to 18.5% found in a cohort of children in Ghana [29], which, like south west Nigeria, has malaria transmission all year round.

The prevalence of anaemia among MRDT-positive group (37.9%) in this study is comparable to that observed among children with uncomplicated malaria in Ibadan, Nigeria [32]. The finding of anaemia is not surprising, as previous studies [32-34] have demonstrated that children who have malaria are at greater risk of developing anaemia, and this was apparent even after controlling for parasitaemia and nutritional status.

The PCR uncorrected ACPR of 78% for ASAQ among the per protocol population in this study is lower than that reported from an urban hospital setting in the same area in 2007-2008 [34]. This can be explained by very high malaria transmission in the rural study site and the possible development of tolerance to ASAQ over time. The day 28 ACPR observed in this study is lower than that reported by several studies in sub-Saharan Africa [35-38]. However, the ACPR observed in this study needs to be interpreted with caution, because this is not a clinical efficacy study of ASAQ and it did not have strict inclusion/exclusion criteria, such as specific parasite density cut off or absence of any co-morbidity. It is of note though that the PCR corrected day 28 ACPR for ASAQ was high (94.5%). Given the high level of re-infection within 28 days post treatment in the study area, a long acting antimalarial combination such as Dihydro-artemisinin plus piperazine needs to be considered as first line treatment for malaria in high transmission areas [39].

Overall, the performance of SD Bioline™ malaria Ag-*Pf* kit used in this study compares well with recent findings reported from screening of malaria patients at Bangui, Central African Republic and Nigeria [40-41]. The sensitivity of the MRDT was 95.6% and the false negative results did not result in any adverse clinical outcomes in this study. However, in a routine health care delivery system without robust follow up, one should be concerned about the consequences of false negative MRDT results. All cases of malaria that occurred during the follow-up period in this study were detected early and offered an appropriate treatment. The procedures set up in our study to ensure adequate follow-up of the children may not be replicated in routine clinical practice. As some children with a false negative malaria diagnosis may report late to the health facility, and thereby run the risk of developing severe malaria, restricting ACT to MRDT-positive children may still pose some danger in routine health care delivery systems. The recent developments of ultrasensitive MRDTs would be safer than the currently available MRDTs. [42].

The estimated sample size of 959 was not achieved and this could be a limitation of this study. However, with 7.6% of MRDT –negative group becoming microscopy positive between days 1-28 and the odds of MRDT- positive group that received an ACT becoming microscopy positive malaria during this period was >2, we would require only 175 children in each group to achieve a power of 80%. Thus, the sample size achieved is sufficient to reach a valid conclusion regarding the risk of malaria during the 28 days post-treatment period.

In conclusion, offering antimalarial treatment to MRDT-positive children only in this high transmission setting did not increase risk of developing malaria during the 28 days post treatment period among MRDT-negative children. However, the risk of re-infection within 28 days was significantly higher among MRDT-positive children, even though they were treated with ASAQ. A longer-acting ACT may be needed as the first line drug of choice for treating uncomplicated malaria in high transmission settings to prevent reinfections.

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**Figure 1: Study Flow Chart for Consequences of Restricting ACT Treatment to malaria RDT Positive children only**

