UNITED STATES AFRICA COMMAND NOTICE

J00-SG
ACN 4200.02

20 September 2011

HEALTH AND MEDICAL
Change 2 to ACM 4200.03, Force Health Protection Procedures for Deployment and Travel

Reference: Defense Intelligence Reference Document, "(U) Using National Center for Medical Intelligence (NCMI) Malaria Risk Assessment to Support Chemoprophylaxis Choices" August 23, 2011.

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1. **PURPOSE**. This notice provides a change to ACM 4200.03, Force Health Protection Procedures for Deployment and travel.

2. **CANCELLATION**. None.

3. **APPLICABILITY**. In accordance with Department of Defense (DoD) and Service-specific guidance, this directive applies to all DoD military and civilian personnel, to include non-DoD interagency personnel who have been appointed to HQ U.S. Africa Command, and DoD contractor personnel traveling or deploying with U.S. Forces within the U.S. Africa Command AOR. However, DoD contractor personnel are only included to the extent provided in applicable contracts or IAW DoD and Service-specific policy. Shipboard operations that are not anticipated to involve operations ashore are exempt from the deployment requirements of this message except for recording individual daily deployment locations or when potential health threats indicate actions necessary beyond the scope of shipboard occupational health program or per the decision of the commander exercising operational control. In addition to deploying personnel, this instruction applies to personnel on official travel or assignment to HQ U.S. Africa Command and the AOR.

4. **SUMMARY OF CHANGES**. This notice provides a change to verbiage regarding malaria prevention. It identifies and defines the National Center for Medical Intelligence (NCMI) classifications for malaria transmission and the U.S. Africa Command's chemoprophylaxis guidance for "high-transmission, low-transmission, and non-endemic settings in the U.S. Africa AOR."

5. **BACKGROUND.** Malaria is caused by Plasmodium parasites and it's transmitted by mosquitoes. Plasmodium falciparum is the most widespread type of malaria in Africa and compared to other strains, is the most commonly fatal type of malaria. Malaria prevention is achieved through personal protective measures (bednets, insect repellant,

permethrin-treated uniforms/clothing), vector control, and chemoprophylaxis. Food & Drug Administration (FDA) – approved medications available for chemoprophylaxis in Africa are listed in Table 1. Although all listed medications are effective against malaria if used appropriately, data on efficacy, effectiveness, tolerability, safety profile and risk of breakthrough has resulted in new prioritization for Africa. In addition, risk of malaria transmission for a particular country in Africa will now guide medication choice.

6. **ACTION OR PROCEDURE**. Change ACM 4200.03, Force Health Protection Procedures for Deployment and Travel, 14 April 2010, as follows:

a. Page B-B-C-2. Add paragraph f. to read: "For the purpose of this policy, malaria transmission risk is classified as high-transmission, low-transmission, or non-endemic as determined by the National Center for Medical Intelligence (NCMI), accessible at https://www.intelink.gov/ncmi/index.php. High transmission refers to areas with an expected attack rate of 11% or more per month in the absence of countermeasures. Low transmission refers to areas with a potential monthly attack rate of<0.1%, or 1-10% in the absence of countermeasures. The U.S. Africa Command Surgeon's Office (J00-SG) will be adjudicating authority for questions regarding transmission risk."

b. Page B-B-C-2. Add paragraph g. to read: "Chemoprophylaxis is administered as a force health protection measure under command authority as follows:

(1) High-transmission settings. Chemoprophylaxis is required for travel to high transmission areas in Africa. Atovaquone-proguanil (Malarone) is recommended as the drug of choice for the prevention of malaria in these areas. For individuals unable to receive atovaquone-proguanil due to intolerance or contraindication, doxycycline will be the preferred second-line therapy. Use of mefloquine prophylaxis is a third-line recommendation and should be restricted to individuals unable to receive either of the other regimens. Before using mefloquine as prophylaxis, care should be taken to exclude the presence of contraindications.

(2) Low-transmission settings. In general, areas where potential rates are expected to be 0.1% per month or less do not require chemoprophylaxis in Africa. This is particularly true if there is little or no P. falciparum transmission and if the duration or nature of travel suggests a low likelihood of infection. For areas where monthly potential rates are assessed as <1% or 1-10%, chemoprophylaxis is generally indicated when night exposures are anticipated. Regional risk assessment will be provided by the National Center for Medical Intelligence (NCMI) and updated periodically. When chemoprophylaxis is to be used, either doxycycline or atovaquone-proguaniul are acceptable first-line prophylactic medications. Selection may be based on individual preference or tolerance, unit uniformity, side-effect profile, or desire for side benefits such as antibacterial activity of doxycycline. Individuals intolerant of the selected drug should receive the alternative first-line agent. Mefloquine should be reserved for individuals with intolerance or contraindications to both first-line medications. Before using mefloquine as prophylaxis, care should be taken to exclude the presence of contraindications.

(3) Non-endemic settings. Chemoprophylaxis is not needed in non-endemic settings."

c. Page B-B-C-2. Add paragraph h. to read: "Monitoring compliance with chemoprophylaxis is the responsibility of unit commanders. Directly Observed Therapy (DOT) is strongly recommended when chemoprophylaxis is implemented and is critical in high-transmission areas of Africa. Once again, chemoprophylaxis should be viewed as the last component of a comprehensive malaria prevention program to supplement personal protective measures and vector control.

d. Page B-B-C-2. Insert, below paragraph f, new table at Enclosure as "Table B-B-C-1, Chemoprophylaxis Regimens for Africa".

e. Page E3. Add to references: "qq. Defense Intelligence Reference Document, (U) Using National Center for Medical Intelligence (NCMI) Malaria Risk Assessment to Support Chemoprophylaxis Choices" August 23, 2011."

f. Page GL. Add to Glossary of Acronyms and Terms:

"21. Transmission settings (Malaria).

(a) High-transmission settings: Chemoprophylaxis is required for travel to high transmission areas in Africa. Atovaquone-proguanil (Malarone) is recommended as the drug of choice for the prevention of malaria in these areas. For individuals unable to receive atovaquone-proguanil due to intolerance or contraindication, doxycycline will be the preferred second-line therapy. Use of mefloquine prophylaxis is a third-line recommendation and should be restricted to individuals unable to receive either of the other regimens. Before using mefloquine as prophylaxis, care should be taken to exclude the presence of contraindications.

b. Low-transmission settings: In general, areas where potential rates are expected to be 0.1% per month or less do not require chemoprophylaxis in Africa. This is particularly true if there is little or no Plasmodium falciparum transmission and if the duration or nature of travel suggests a low likelihood of infection. For areas where monthly potential rates are assessed as <1% or 1-10%, chemoprophylaxis is generally indicated when night exposures are anticipated. Regional risk assessment will be provided by the National Center for Medical Intelligence (NCMI) and updated periodically. When chemoprophylaxis is to be used, either doxycycline or atovaquone-proguaniul are acceptable first-line prophylactic medications. Selection may be based on individual preference or tolerance, unit uniformity, side-effect profile, or desire for side benefits such as antibacterial activity of doxycycline. Individuals intolerant of the selected drug should receive the alternative first-line agent. Mefloquine should be reserved for individuals with intolerance or contraindications to both first-line medications. Before using mefloquine as prophylaxis, care should be taken to exclude the presence of contraindications.

c. Non-endemic settings: Chemoprophylaxis is not needed in non-endemic settings."

7. **RELEASIBILITY**. RESTRICTED. This notice is approved for restricted release. Authorized users may obtain copies on the appropriate U.S. Africa Command SJS network portal page.

8. **EFFECTIVE DATE**. This notice is effective upon receipt and will remain in effect until otherwise revoked or rescinded.

H. D. POLUMBO JR.
Major General, USAF
Chief of Staff

Enclosures:
A. Table B-B-C-1. Chemoprophylaxis Regimens for Africa

ENCLOSURE A

Drug	Dose	Dosing Instructions
Atovaquoone-proguanil (Malarone)	250/100mg (1 tablet) Daily	Begin 1-2 days prior to entry into malarious area. Continue dosing 7 days after departure from malarious area.
Doxycycline	100mg daily	Begin 1-2 days prior to travel to malarious areas. Take daily with food. Continue until 28 days after leaving malarious areas.
Mefloquine	228mb (base) weekly	Begin 1-2 weeks prior to arrival in malarious area. Take weekly during travel and continue for 4 weeks after departure from malarious area.

Table B-B-C-1. Chemoprophylaxis Regimens for Africa