# CORRECTED COPY - UPDATE TO MALARIA CHEMOPROPHYLAXIS FOR ENTRY TO

**Originator:** CDR USAFRICOM J3 STUTTGART GE

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**Prec:** Priority

**DAC:** General

**To:** 3 AF RAMSTEIN AB GE, CDR USCENTCOM MACDILL AFB FL, CDR USEUCOM EPOC JOC VAIHINGEN GE, CDR USSOCOM MACDILL AFB FL, CDR USTRANSCOM SCOTT AFB IL, CDR USTRANSCOM TCJ3 SCOTT AFB IL, COMSOCAFRICA STUTTGART GE, CDR USAREUR-AF WIESBADEN GE, CDR SETAF-AF VICENZA IT, CJTF HOA, COMMARFORAF STUTTGART GE, COMMARFORAF STUTTGART GE, HQ USAFE A3 RAMSTEIN AB GE, HQ USAFE CC RAMSTEIN AB GE, HQ USAFE COMMAND CENTER RAMSTEIN AB GE, TASK FORCE 94-7, JOINT STAFF J3 CAT WASHINGTON DC, JOINT STAFF J3 DEP-DIR GLOBAL OPS WASHINGTON DC, JOINT STAFF J3 DEP-DIR REGIONAL OPS WASHINGTON DC, JOINT STAFF J3 WASHINGTON DC, COMUSNAVEUR COMUSNAVAF NAPLES IT, DIRECT HQ USEUCOM

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RUEHAN/AMEMBASSY ANTANANARIVO
RUEHAE/AMEMBASSY ASMARA
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THE USAFRICOM THEATER

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SUBJ/(U) CORRECTED COPY - UPDATE TO MALARIA CHEMOPROPHYLAXIS FOR
ENTRY
TO THE USAFRICOM THEATER//

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REF/H/DOC/-/CDC/25JUN24//
REF/I/DOC/-/CDC/28MAR24//
REF/J/DOC/-/AFHSD/01OCT23//
REF/K/DOC/-/USAFRICOM/30JUN25//
REF/L/DOC/-/DHA/01MAY24//
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NARR/(U)
Ref A is the Clarification to Malaria Chemoprophylaxis Guidance for
Entry to U.S. Africa Command (USAFRICOM) Theater.
Ref B is the ACI 4200.09B Force Health Protection Requirements and
Medical Guidance for Entry into the U.S. Africa Command Theater.
Ref C is the World Health Organization Map of Countries with
Indigenous Malaria Cases
(https://www.who.int/data/gho/data/themes/malaria).
Ref D is the United Nations Foundation overview of Malaria Global
Trends in 2024.
Ref E is the Centers for Disease Control and Prevention Website on
the
Symptoms of Malaria.
Ref F is the Centers for Disease Control and Prevention Website on
how
Malaria Spreads.
Ref G is the Defense Health Agency Procedural Instructions 6490.03
Deployment Health Procedures.
Ref H is the Centers for Disease Control and Prevention Website on
Testing Guidance for Malaria.
Ref I is the Centers for Disease Control and Prevention Algorithm for
Diagnosing and Treatment for Malaria in the United States
(https://www.cdc.gov/malaria/hcp/clinical-guidance/diagnosis-
treatment.html).
Ref J is the Armed Forces Health Surveillance Division Health Medical
Surveillance Monthly Report on Force Protection Risk due to Rapid
Diagnostic Failures in Falciparum Malaria.
Ref K is the Annex Q to USAFRICOM Campaign Order FY25-26 Health
Service.
Ref L is the Defense Health Agency Communicable Disease Toolkit for
Armed Forces Reportable Medical Events
(https://ph.health.mil/cdt/cphe-cdt-entire-book.pdf).
Ref M is the Centers for Disease Control and Prevention Website on
Blood Donor Screening.
Ref N is Update to Malaria Chemoprophylaxis for Entry to the
USAFRICOM
Theater.//

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GENTEXT/REMARKS/
1. (U) This GENADMIN provides updated guidance on Malaria Chemoprophylaxis for U.S. Africa Command (USAFRICOM) Area of Responsibility (AOR) (Ref A) and ACI 4200.09B (Ref B) in reference to Malaria chemoprophylaxis for the USAFRICOM theater. The health and well-being of Service Members, Civilians, and contractors traveling to
the USAFRICOM AOR is of the utmost importance to the Office of the USAFRICOM Command Surgeon. Personnel traveling to the African continent on official or leisure travel must understand the "all hazards" threat they will encounter and follow Force Health Protection
(FHP) policies and procedures outlined in Ref B, to decrease the risk of infectious diseases exposures. Ref A is rescinded as the information is outdated. This GENADMIN rescinds and replaces Ref N.

2. (U) Background.
2.A. (U) Mosquitoes pose major health risks to travelers in Africa, because they carry malaria, dengue fever, yellow fever, West Nile virus, chikungunya, and many other viral and parasitic diseases.
2.B. (U) Malaria, caused by a protozoan parasite that is found in certain mosquitos, the Anopheles mosquito, remains the most frequent infectious cause of death for travelers to tropical and subtropical countries (Ref C); however, the risk of infection significantly decreases when utilizing antimalarial medications and personal protective measures that protect against mosquito bites.
2.C. (U) ) Malaria in humans is caused by five types of Plasmodia parasites; Plasmodium falciparum, P. vivax, P. ovale, P. malaria and P. knowlesi. The deadliest form of malaria is P. falciparum.
2.D. (U) Africa has an estimated 94% of malaria cases globally and 95%
of malaria deaths and the majority of these occur in sub-Saharan Africa (Ref D).
2.E. (U) The risk of acquiring a malaria infection varies markedly, even within the same country. Estimating this risk of infection takes
into account a variety of factors, including: traveler's itinerary, location of travel within a country, mosquito vector species, type of accommodation utilized, anticipated activities, season of travel, likelihood of an individual following appropriate insect precautions (i.e., minimize exposed skin, application of insect repellant), and duration of travel.

3. (U) Malaria Symptoms.
3.A. (U) Malaria symptoms can include: fever, jaundice (yellow color in skin and eyes), headache, muscle aches, chills, nausea, vomiting and diarrhea.
3.B. (U) The incubation is 7 to 30 days on average (Ref E). However, in some cases, the malaria parasite can be inactive in the liver for months to years before the onset of symptoms.
3.C. (U) If not diagnosed and treated promptly, malaria can cause serious illness. Severe cases can result in organ failure, seizures, coma, and death.

4. (U) Transmission.
4.A. (U) The vast majority of malaria cases occur after an individual is bitten by a female Anopheles mosquito that is infected with the malaria parasite (Ref F).
4.B. (U) Malaria can also spread through pathways other than mosquito bites, including; blood transfusion, organ transplant, contaminated needles, and congenitally.

5.(U) Malaria Chemoprophylaxis.
5.A. (U) All therapeutic or chemoprophylactic medications, including antimalarials, will be prescribed IAW Food Drug administration (FDA) guidelines (Ref G).
5.B. (U) Atovaquone-Proguanil (Malarone) or doxycycline are acceptable
as first-line prophylactic medications for the USAFRICOM AOR (Ref G).
5.C. (U) Tafenoquine, a Primaquine analogue, is a new option for primary chemoprophylaxis that may be appropriate for certain travelers. G6PD testing (Blood test used to detect deficiency in the enzyme glucose-6-phosphate dehydrogenase) is required for all travel to malaria endemic countries, and individuals who are G6PD-deficient will not be prescribed Primaquine or Tafenoquine.
5.D. (U) Use of Mefloquine prophylaxis should be reserved for individuals with intolerance or contraindications to both Atovaquone-Proguanil and Doxycycline.
5.D.1. (U) Mefloquine should be used with caution in persons with a history of Traumatic Brain Injury (TBI) or Post-Traumatic Stress Disorder (PTSD) and will not be prescribed for prophylaxis in patients
with major psychiatric disorders. It is contraindicated in personnel with a psychiatric diagnosis of depression, schizophrenia, or anxiety disorders.
5.D.2. (U) Each Mefloquine prescription will be issued with a wallet card and current FDA safety information indicating the possibility that neurologic side effects may persist or become permanent.
5.E. (U) Chloroquine will not be used as a malaria chemoprophylaxis medication for any country in the USAFRICOM AOR due to widespread resistance.
5.F. (U) Presumptive Anti-Relapse Therapy (PART) or terminal chemoprophylaxis for malaria with Primaquine is generally not recommended for individuals prescribed primary malaria chemoprophylaxis unless prolonged exposure to relapsing forms of malaria (Plasmodium vivax or Plasmodium ovale) is likely to occur. Generally, terminal chemoprophylaxis will be considered for individuals traveling for more than 30-days to a malaria-endemic area where greater than 10% of malaria cases are due to Plasmodium vivax or
Plasmodium ovale. References with current information on levels of P. vivax or P. ovale include the CDC Yellow Book (https://www.cdc.gov/yellow-book/index.html) and Shoreline Travax (https://www.travax.com/).
5.F.1. (U) If prescribed, terminal chemoprophylaxis will begin once the potential for disease transmission ends (departure from the risk area) and will overlap with the primary malaria prophylaxis medication. Primaquine is the first-line drug for terminal chemoprophylaxis. Primaquine is not required if the individual was prescribed Tafenoquine as primary prophylaxis.
5.F.2. (U) If terminal chemoprophylaxis is not prescribed, individuals
shall be counseled on the potential risk for relapsing malaria. The counseling should emphasize the need to seek medical care immediately if the traveler develops a fever after returning from Africa, as well as the importance of informing healthcare providers of their travel history and potential for relapsing malaria.
5.F.3. (U) When prescribed, commanders and supervisors at all levels will ensure that all individuals for whom they are responsible are issued terminal prophylaxis immediately upon leaving malaria endemic area.
5.F.4. (U) Individuals who are G6PD-deficient will not be prescribed terminal chemoprophylaxis.
5.G. (U) Malarone, doxycycline, Primaquine and Tafenoquine are all

contraindicated during pregnancy. The preferred anti-malarial medication for pregnant travelers to Africa is Mefloquine depending on the resistance patterns in the specific country.
5.G.1. (U) Pregnancy will not be considered for a medical waiver for deployment IAW Ref B.
5.G.2. (U) Pregnant personnel requesting temporary duty or leave, for travel less than 30 days, during the 1st or 2nd trimester must request a medical waiver.

6. (U) Diagnostic Testing.
6.A. (U) Malaria symptoms are non-specific, and malaria should be considered in any febrile person deployed to or traveling from a malaria endemic country in the weeks to months preceding symptoms onset (Ref H).
6.B. (U) Malaria can be diagnosed by blood smears microscopy (Gold standard), Rapid Diagnostic Test (RDT), and Polymerase Chain Reaction (PCR) testing (Ref I). Military Treatment Facilities (MTFs), DoD-participating laboratories and the Laboratory Response Network (LRN) can provide testing for clinicians who suspect a malaria diagnosis. Role 2 and 3 facilities must have PCR testing capabilities (such as a Biofire or GeneExpert) or another method for confirmatory testing. Role 1 facilities should have RDT capabilities then utilize role 2 and 3 diagnostic capabilities to confirm suspect cases.
6.B.1. (U) The only FDA approved RDT is the BinaxNOWTM which differentiates from falciparum vs. nonfalicparum malaria.
6.B.2. (U) In Africa, the emergence of mutant P. falciparum parasite leading to false-negative results from BinaxNOWTM and other similar RDTs (Ref J).
6.B.3. (U) Alternative diagnostic test must be utilized in individuals who present with a fever or clinical suspicion on malaria and a negative RDT.
6.B.4. (U) Both positive and negative RDT results must be confirmed with blood microscopy (Ref H). Blood smears should be repeated every 12-24 hours for a total of three sets before the diagnosis of malaria can be ruled out (Ref I).
6.B.5. (U) If available, perform the BioFire Global Fever Special Pathogens Panel. This panel can test for malaria, dengue fever, yellow fever, and other Viral Hemorrhagic fevers (e.g. Ebola).
6.B.6. (U) Patients with a strong suspicion for malaria who have a negative RDT and BioFire panel performed will require expert consultation through the Advanced Virtual Support for Operational Forces (ADVISOR) line at DSN: 312-429-9089 or commercial: +1-833-238-7756.
6.C. (U) For overseas MTFs or shipboard locations, laboratory testing may also be offered by host nation facilities; for further information on accepting laboratories or hospitals contact International SOS (ISOS) Call Center (24/7/365) at +44 20 8762 8384.

7. (U) Personal Protective Measures and Prevention.
7.A. (U) To minimize risk of malaria, personnel entering the USAFRICOM AOR will travel with enough malaria prophylaxis to cover anticipated duration of travel and return from travel IAW Ref G. Country specific recommendations for malaria prevalence and chemoprophylaxis can be found in the CDC Yellow book or Travax.
7.B. (U) It is critical that travelers understand the importance of

adherence to malaria and mosquito precautions. Individuals will take malaria medication as prescribed. Missing one dose of malaria prophylaxis, or failing to complete prescribed post-exposure regimen, places personnel at increased risk of infection. Not using insect repellent places individuals at increased risk for severe disease from
vector-borne diseases.
7.C. (U) Malaria prophylaxis is not 100% effective against malaria, and it is imperative to seek immediate medical attention for fever or influenza-like illness within three months after travel to a malaria risk area.
7.D. (U) The threat of Malaria can be minimized by using a Permethrin-
treated uniform, N,N- Diethyl-Meta-Toluamide (DEET), Picaridin, or IR3535 on exposed skin.
7.D.1. (U) Apply approved insect repellant (containing at least 25% DEET or 20% Picaridin) to exposed skin and outer clothing, unless pre-
treated. One application of DEET lasts 6-12 hours and one application
of Picaridin lasts 8 hours. More frequent application is required for
personnel experiencing heavy sweating and/or immersed in water.
7.D.2. (U) Personnel should wear treated clothing and minimize exposed
skin (both military uniforms and civilian attire) while in Africa. For uniforms, the label indicates whether the uniform is factory-treated and for how many washes the treatment is effective. Typically, treated uniforms provide 90% protection for up to 50 washes. Do not retreat permethrin-treated uniforms. When treating civilian clothing, permethrin binds best with clothing containing 50% cotton fibers. Follow the manufacturers' recommendations for reapplication frequency.
7.E. (U) Use Permethrin or other approved treated bed nets properly in
at-risk areas to minimize exposure during rest/sleep periods, to include when staying in a fixed facility.

8. (U) Biosurveillence and Case Reporting.
8.A. (U) Service Components.
8.A.1. (U) Ensure routine biosurveillance is conducted, to include entomological surveillance, across the USAFRICOM AOR and reports trends to USAFRICOM Surgeon General during the monthly FHP Sync (Ref K).
8.A.2. (U) Ensure confirmed malaria cases are repRorted to USAFRICOM Command Surgeon's FHP section within 24 hours or the next duty day, whichever is sooner (Ref K).
8.A.3. (U) Combined Joint Task Force - Horn of Africa (CJTF-HOA) will coordinate with Base Operating Support-Integrator (BOS-I) Components regarding FHP that impacts CJTF-HOA area of interest (AOI).
8.B. (U) DoD Expeditionary Medical Facility (EMF), MTF, shipboard responsibilities.
8.B.1. (U) Providers will notify public health staff immediately, within 24 hours, when identifying suspect malaria cases.
8.B.2. (U) Based on the current Armed Forces Reportable Medical Events
(RME) case definition, the MTF will report suspected and confirmed cases of malaria in Disease Reporting System Internet (DRSi), as outlined by the 2022 Armed Forces RME Guidelines and Case Definitions (Ref L). It is crucial to utilize the Mosquito-Borne Investigation Worksheet that includes malaria species (if known), travel/deployment history, demographics, clinical information and chemoprophylaxis

regimen and adherence in this report (Ref L).
8.B.3. (U) The DRSi can be accessed at https://drsi.health.mil/DRSi or
contact the DRSi help desk at dha.apg.pub-health-a.mbx.disease-epidemiologyprogram13@health.mil or 410-417-2337.
8.B.4. (U) MTFs or forward deployed medical facilities with confirmed case of malaria are required to notify their Public Health Emergency Officer (PHEO) or Public Health advisors who will forward the information to their Service Component Command Surgeon's FHP section.
8.B.5. (U) Minimum information to be reported includes: recent travel/deployment history, demographics (AD, CIV, CTR), occupation of member, chemoprophylaxis regimen and adherence information, speciation, treatment, and confirmation of reporting in DRSi (Y/N, date).
8.C. (U) MTFs and/or Public Health advisors should respect host nation
public health reporting requirements and provide additional information as required by the host nation if applicable.
8.D. (U) Service Components/Joint Task Force FHP contact information.
8.D.1. (U) U.S. Air Forces Europe and Africa: usafesg.sgp.usafe-afafricasgp@us.af.mil.
8.D.2. (U) U.S. Naval Forces Europe and Africa: NAVEUR/NAVAF-Fleet-Medical@us.navy.mil.
8.D.3. (U) U.S. Marine Forces Europe and Africa: hss_mfe@usmc.mil.
8.D.4. (U) Combined Joint Task Force - Horn of Africa: africom.lemonnier.hoa-surgeon.mbx.surgeon-cell@mail.mil.
8.D.5. (U) Southern European Task Force - Africa: usarmy.usag-italy.setaf-af.lists.surgeon-fhp@army.mil.
8.D.6. (U) Special Operations Africa: SOCAFRICA.HQ.SG.DL@socom.mil or SOCAFRICA.HQ.SG.ALL.list@socom.smil.mil.

9. (U) Treatment.
9.A. (U) Malaria should be identified early and treatment initiated to
prevent serious morbidity or mortality.
9.B. (U) Treatment for malaria should not be initiated until the diagnosis is confirmed.
9.C. (U) Malaria treatment is guided by; the patient's clinical presentation (uncomplicated vs. severe malaria), Plasmodium species, drug susceptibility, and previous use of antimalarial medications for malaria chemoprophylaxis (Ref I).

10. (U) Operational Virtual Health Consultation Resources and Medical Evacuations.
10.A. (U) The ADVISOR (ADvanced VIrtual Support for Operational foRces) Line provides 24/7 telephonic access for urgent/emergent on-demand consultation services by calling 833-ADVSRLN (833-238-7756) or DSN 312-429-9089. Includes access to specialists in: Orthopedic Surgery; Pediatrics; Toxicology; Infectious Disease; Hematology/Oncology; OB/GYN; Dental; Ophthalmology; Neonatology; Emergency Medicine; Critical Care; General/Trauma Surgery; Neurosurgery; Burn Care; Veterinary Care; and Chemical Casualty Care.
10.B. (U) Overseas MTFs/locations. If at any time a patient requires a
higher level of care contact, coordinate transfer though the International SOS (ISOS) Call Center (24/7/365) at +44 20 8762 8384.
10.C. (U) For medical evacuations, contact TPMRC-E (DSN: 314-480-8040/Comm: +49-6371-478040) or International SoS (+44 20 8762 8384). TPMRC-E Validating Surgeon has final authority on all movements.

11. (U) Travel to the USAFRICOM AOR.
11.A. (U) Travelers to the USAFRICOM AOR will continue to follow FHP

guidance, policies, and procedures IAW Ref B and adhere to the Host Nation requirements found in the Electronic Foreign Clearance Guide (eFCG)
11.B. (U) Commanders will educate their personnel traveling to the USAFRICOM AOR about the risk for malaria and how exposure can be avoided.
11.C. (U) Units may consult the USAFRICOM Command Surgeon's office or Component Surgeon's Office for additional insight or updates on malaria prevention.
11.D. (U) Aircrew.
11.D.1. (U) In endemic malaria areas, Aircrew are at risk, even if not
departing the aircraft, to include when the aircraft doors are open and when cargo is loaded/unloaded.
11.D.2. (U) Aircrew should understand the importance of FHP guidance for the prevention of malaria, and will take antimalarial medications,
even during brief layovers, where the prevalence of malaria is high. References with current information on endemic malaria areas include the CDC Yellow Book (https://wwwnc.cdc.gov/travel/page/yellowbook-home) and Shoreline Travax (https://www.travax.com/).
11.E. (U) Shipboard.
11.E.1. (U) To protect personnel against mosquito-borne disease, units
may use permethrin-treated uniform, N,N- Diethyl-Meta-Toluamide (DEET), Picaridin, or IR3535 on exposed skin as described in 7.D.
11.E.2. (U) To protect personnel against mosquito-borne disease, units
will enter the AOR with sufficient malaria chemoprophylaxis supply to support their crew, detachments, shore-going or top-side personnel, or
pier-side personnel.
11.E.2.A. (U) Medications must be available at least 7-days prior to arrival in the USAFRICOM AOR.
11.E.3. (U) Waivers or exceptions to policy for malaria chemoprophylaxis are not authorized.
11.E.4. (U) Units will brief their personnel on health threats (including malaria) and mitigation strategies based on geographic destinations. Briefs shall be requested from Navy Environmental and Preventive Medicine Unit SEVEN (NEPMU-7) at usn.rota.usnmrtc-rota.mbx.nepmu-7@health.mil.
11.F. (U) Travelers to malaria endemic area are not permitted to donate blood for 3 months after travel (Ref M).

12. (U) Points of Contact.
12.A. (U) USAFRICOM J004 (Office of the Command Surgeon). Ms. Michelle
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13. (U) This GENADMIN is approved for release by COL Michael I. Cohen,
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