



# Disparities in the Susceptibilities of ABO and Rh Blood Antigens to Severe *Plasmodium falciparum* in Children Under Five Years; A Cross-Sectional Study among Rural Dwellers, North East Region, Ghana

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### Authors' contributions

This work was carried out in collaboration among all authors. Authors CN, KM, SKA, SBB and VGA conceived and designed the study. Authors CN, KM, FO-B, VGA, SD, GA, and DS wrote the protocol and the first draft of the manuscript. Author VGA participated in the data collection and authors CN, SKA, KM, YQ, CAEW, MOT and VGA performed the laboratory work. Authors CN, DS, FO-B and VGA analyzed and interpreted the data. Authors CN, SD, SKA, DS, CAD, RVD, FAA, YQ, VGA, TK, MOT, GA, HAO and KM managed the literature searches. Authors CN, DS, KM, FO-B, SKA, FAA, SD, YQ, MOT, HAO, CAEW, GA, TK, SBB, RVD, CAD and VGA drafted the manuscript. All authors critically reviewed, revised and approved the final manuscript.

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## ABSTRACT

**Aim:** To determine the association between ABO and Rh blood antigens, and severe *Plasmodium falciparum* malaria among children under five years.

**Study Design:** Hospital-based cross-sectional study

**Place and Duration of Study:** Janga District Hospital, North East Ghana from April to August, 2022.

**Methodology:** The study recruited 410 children below five years of age. Three millilitres of venous blood were collected from each participant for haemoglobin (Hb) estimation, thick and thin blood films for malaria parasites, and blood antigen determination. The data were analyzed with STATA version 16.0 and  $P < .05$  was considered statistically significant.

**Results:** About one-third (32.68%) of the participants had severe *Plasmodium falciparum* malaria, and 264 (64.39%) had uncomplicated malaria. Blood group O Rh 'D' Positive (O+) was the most predominant blood antigen. Severe malaria commonly occurred in A Rh 'D' Positive (A+), 54/134 (40.30%) subjects compared to the other blood groups, while uncomplicated malaria was highest in the O+ group, 150/264 (56.82%). Complicated malaria patients were about seven times, and thrice likely to be of blood groups A+ and B Rh 'D' Positive (B+), respectively compared to blood group O+ (A+ vs O+: OR=7.60, 95% CI:4.27-13.51,  $p < .001$ ; B+ vs O+: OR=3.11, 95% CI: 1.80-5.37,  $p < .001$ ).

**Conclusion:** The study identified a relatively higher prevalence of *P. falciparum* malaria in children below five years in the Janga district. About one-third of the participants had severe malaria. Individuals with blood groups A+ and B+ are more susceptible to severe *P. falciparum* infection than those with blood type O+. Incorporation of blood antigen determination into the routine management of malaria is recommended.

**Keywords:** ABO and Rh antigens; *Plasmodium falciparum*; parasitaemia; susceptibilities; thick and thin blood films.

## 1. INTRODUCTION

Malaria is a life-threatening parasitic infection spread by the bites of infective female *Anopheles* mosquitoes [1]. Malaria is a major public health

concern in Ghana and Africa at large, and its burden poses a threat to life, especially to children. In sub-Saharan Africa, malaria causes over 2 million fever episodes and one million deaths [1]. The 2019 World Health Organization

(WHO) report estimated 409,000 malaria deaths worldwide, of which 67% were children below five years of age [1]. The prevalence of malaria among children under five years is 21% in Arba Minch Zuria District, South Ethiopia [2], 33% in Mali [3], and earlier studies in Ghana have also revealed similar findings [4–6]. *Plasmodium falciparum* is the most common cause of severe clinical manifestations in Africa, out of the five species that infect humans [7]. According to WHO, *P. falciparum* contributed to 99.7% of malaria cases in African Region, from an expected 229 million cases worldwide in 2019 [8].

The ABO blood group is a collection of carbohydrate antigens found on human erythrocytes [9,10]. Studies have discovered the associations between the ABO blood group system and some disease conditions like skin cancer [11], schistosomiasis [12], onchocerciasis [13], hepatitis [14] and HIV infection [15]. There have also been reports linking the ABO blood group system to *P. falciparum* malaria susceptibility, resistance, and severity [16,17]. Changes in the clinical outcome of *P. falciparum* malaria may be related to the various erythrocyte polymorphisms [9]. The ability of infected red blood cells (RBCs) to cling to uninfected ones, resulting in cell rosetting, has been linked to *P. falciparum* pathogenicity [18]. The link between ABO blood types and malaria parasitaemia has been reported in several studies. Severe malaria has largely been reported in blood group "A" individuals, whilst people with blood group "O" have been diagnosed with low parasitaemia and uncomplicated *P. falciparum* malaria [9,17,19–21]. A recent study in Ghana observed that, 16.1% of complicated cases had blood group "O" against 40.9% of uncomplicated controls [22]. In addition, a link between blood group 'AB' and severe malaria have been established in some populations, including Sri Lanka [21], Mali [23], and Ethiopia [10].

There are few hospital-based, comparative studies on the link between blood group types and the severity of malaria infections in Ghana and West Africa at large [9,17,19–21]. Again, most of the studies in Ghana did not consider the Rh blood antigen. Thus, there is a paucity of data regarding the relationship between blood group antigens and severe *P. falciparum* malaria in children under the ages of five in West Mamprusi District. This study examined the association between ABO and Rh blood antigens, and

severe malaria among children below five years in West Mamprusi District.

## 2. MATERIALS AND METHODS

### 2.1 Study Design and Setting

This hospital-based, cross-sectional study recruited children who had been diagnosed with *Plasmodium falciparum* malaria, from April to August, 2022, at Janga Hospital, West Mamprusi District of the North-East Region, Ghana. The hospital has a 31-bed capacity and offers Outpatient and Inpatient services, internal medicine, surgery, obstetric, laboratory, pharmaceutical, public health and reproductive health services. The hospital has male and female surgical and in-patient wards, a labour ward, a paediatric ward and an emergency ward. Janga hospital found in the West Mamprusi district is located in the central part of the North East region. This region has an estimated land size of 646.9 km<sup>2</sup>, and a population size of 588,800 [24].

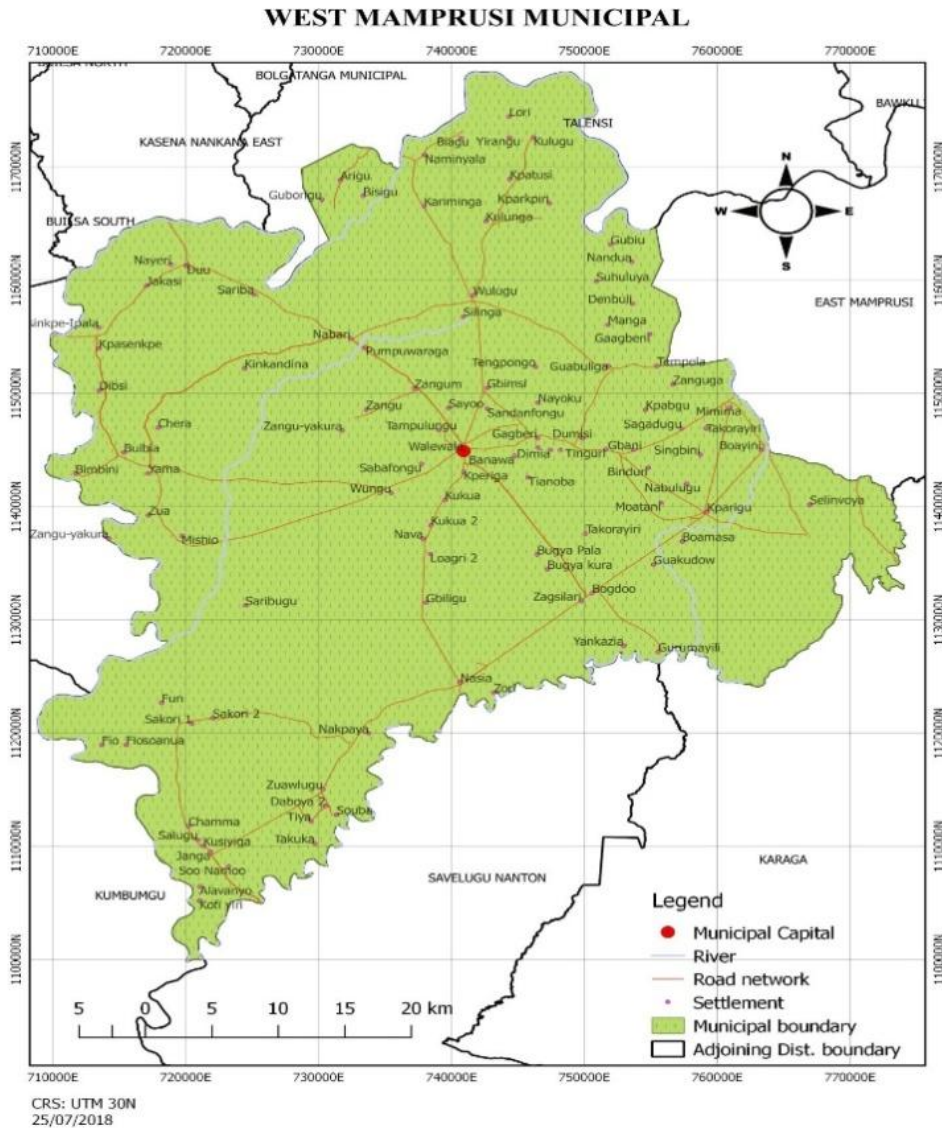
### 2.2 Study Population, and Inclusion and Exclusion Criteria

The study included children with fever below five years of age who sought medical care at the outpatient department (OPD) of Janga District Hospital during the study period. These children were recruited into the study after they had further been diagnosed with *Plasmodium falciparum* malaria. A total of 410 children were included in the study. Under-five children who had received anti-malarial medication, and blood transfusion recently, and withheld consent from caretakers were excluded from the study.

### 2.3 Sample Size Determination

The sample size was determined using Cochran's formulae [25] below:

$n = \frac{Z^2 pq}{e^2}$ , where  $n$  is the estimated sample size;  $Z$  is the critical score based on the desired degree of confidence;  $p$  is the prevalence rate of malaria, 41.3% [22];  $q$  is the complement of the proportion ( $1-p$ ) and  $e$  is the desired margin of error. Based on the above formula, an approximate value of 373 was obtained. However, an error margin of 10% was allowed for non-responses to questionnaires, and hence a total sample size was 410.



Map of West Mamprusi District, Ghana (Source: <https://wmma.gov.gh/about-us/>)

## 2.4 Sampling Technique and Procedure

Children with fever under the age of five who sought medical care at Janga Hospital were selected using a convenient sampling technique. Any under-five child with fever whose caretaker consented to participate in the study was sampled at the OPD unit. Each day, this process was repeated until the sample size was obtained.

## 2.5 Data Collection

Data was collected using a standardized questionnaire consisting primarily of closed-ended questions with a few open-ended ones. The survey questionnaire elicited information

regarding the socio-demographic background of the respondents (age, sex, and place of residence). The questionnaires were responded to by the children's guardians or caretakers. A separate form was designed for recording the malaria status and blood group antigens of the respondents.

## 2.6 Blood Sample Collection

In the outpatient department, rapid diagnostic testing for malaria (CareStart Malaria Pf kit) was performed as an initial screening test using finger-prick capillary blood, and results were verified by microscopy. Using a single-use, sterile butterfly needle kit, trained Phlebotomists

aseptically collected approximately 3 mL of venous blood from the antecubital fossa from each participant and the blood was quickly dispensed into evacuated EDTA blood collection tubes (Becton Dickinson, USA) for haemoglobin concentration (Sysmex XP-300, Japan), malaria parasite identification and counts (microscopy), and ABO and Rh blood typing.

## 2.7 Preparation of Thick and Thin Blood Smears

The preparation, fixing and staining of blood smears were adapted from White et al [26] and WHO [1], as described below. Thick and thin blood films were made on a microscope slide for each participant to identify, speciate and estimate parasitaemia. For the thick blood film preparation, a small aliquot of blood (6  $\mu$ L) was placed 10 mm from the frosted end of the slide using micropipette and spread evenly in a circular motion to cover a diameter of 1.0-1.2cm. A second (2 $\mu$ L) blood was then placed 1.0 cm from the thick film and spread uniformly along the length of the same slide using the edge of a second slide to make a thin film. The thin smear was fixed in absolute methanol after the slides were airdried. The thick and thin films on each slide were then stained in a freshly prepared 10% Giemsa stain solution using a buffer of pH 7.2 for 15 minutes, and rinsed under a mild stream of water and air dried. Finally, the films were observed under the microscope using a X100 objective lens (Olympus CX 21 light microscope).

## 2.8 *P. falciparum* Parasitaemia and Severity Estimation

The number of parasites was counted against approximately 200 or 500 White Blood Cells (WBCs), depending on the number of malaria parasites counted under the microscope, to determine parasitaemia using hand tally counters, as adopted from the study by Zerihun et al. [17]. The number of parasites per microliter of blood was then determined using the equation below:

$$\text{Parasite Density per } \mu\text{L of blood} = \frac{\text{Parasite counted} \times 8000}{\text{Set range of WBC (200/500)}}$$

Parasitaemia was calculated from counts of *P. falciparum*-infected RBC per 400 RBC when >1%, or else from counts of parasites per 200/500 WBCs in the thick smear, and estimated to parasites per  $\mu$ L of blood using the measured RBC or WBC counts. Again, severe malaria was

confirmed when participants exhibited any life-threatening symptoms coupled with the presence of *P. falciparum* in their blood.

## 2.9 Quality Control Measures

Following the manufacturer's instructions, the CareStart Malaria Pf kit test was done in parallel with a blood film analysis using the same blood sample. Three consecutive observers, the first of whom was always the one administering the tests, took readings after 20 minutes (the manufacturer's recommended reading time), in daylight with the help of a regular electric lamp. Observers two and three took their readings in about five minutes intervals after the initial readings by the first observer. The observers were unaware of each other's readings and the microscopy results. Consensus was used to determine the test results, which meant that the same result read by at least two out of three observers was withheld. In the event of a disagreement, the results of the first reader were taken into account. Positive and negative values, as well as line intensities, were used to test inter-observer agreement. A test was deemed invalid if no control line showed, and it was repeated. Again, two Microscopists examined the stained slides independently, and average counts were considered as the final count.

## 2.10 Determination of ABO and Rh Blood Antigens

ABO and Rh blood types were determined using anti-A, B, and D reagents in an agglutination test. The tube method was used to identify blood groups. In a test tube, a suspension of washed red blood cells was mixed with antisera (or plasma, for reverse grouping). The mixture was centrifuged to separate the cells from the reagent, and then gently agitated to resuspend the cells. The patient's blood type was; "A" if only the anti-A serum agglutinated; "B", if only the anti-B serum agglutinated and the agglutination of RBC with both anti-A and anti-B test sera shows an "AB" blood type, whereas no agglutination in both test sera indicates a donor of blood group "O". To determine the Rh status of the patients, an anti-D blood-induced Rh-positive test of agglutinating RBCs was done [26].

## 2.11 Data Analysis

The statistical software STATA version 16.0 was used to analyze the data. The data was checked

for normality using Kolmogorov-Smirnov and Shapiro-Wilk test. Categorical data were presented as frequencies and percentages, and normally distributed continuous data were presented as means and standard deviations, whilst skewed data, were presented as medians and interquartile ranges (25<sup>th</sup>-75<sup>th</sup> percentiles). To examine the prevalence of other blood groups, such as 'A', 'B', 'AB', non-'O', and 'Rh', in severe and uncomplicated malaria, the blood group 'O' was used as a reference [27]. To investigate the link between blood types and severe malaria or distinct clinical manifestations, Fisher's exact test or Chi-square test was used appropriately. Statistical significance was set at  $p < .05$ . Additionally, odds ratios and 95% confidence intervals were calculated.

### 3. RESULTS

#### 3.1 Sociodemographic, Clinical and Haematological Characteristics of the Study Participants

The study recruited 410 children below five years of age, with median age of 25.83 (8.62-48.23) months. Majority of the participants, 172/410 (41.95%) were aged 0-12 months, males 213/410 (51.95%) and resided in the rural setting 377/410 (91.95%). In addition, almost all participants 400/410 (97.56%) had symptoms of malaria, coupled with low Hb level 403/410 (98.23%). A higher proportion 182/410 (44.39%) of the participants were of blood group O+ and the median parasite density was 702.42 (658-836) p/μL of blood (Table 1).

**Table 1. Sociodemographic, Clinical and Haematological Characteristics of the Study Participants**

| Characteristics                           | Category  | Frequency (n=410)  | Percentage (%) |
|---|-----------|--------------------|----------------|
| <b>Age in months</b>                      |           | 25.83 (8.62-48.23) |                |
|   | 0-12      | 172                | 41.95          |
|   | 13-24     | 82                 | 20.00          |
|   | 25-36     | 65                 | 15.85          |
|   | 37-48     | 91                 | 22.20          |
| <b>Sex</b>                                | Male      | 213                | 51.95          |
|   | Female    | 197                | 48.05          |
| <b>Residence</b>                          | Urban     | 33                 | 8.05           |
|   | Rural     | 377                | 91.95          |
| <b>Symptoms of fever, convulsion, etc</b> | Yes       | 400                | 97.56          |
|   | No        | 10                 | 2.44           |
| <b>Blood group</b>                        | A+        | 90                 | 21.95          |
|   | A-        | 7                  | 1.71           |
|   | AB+       | 14                 | 3.41           |
|   | B+        | 113                | 27.56          |
|   | O+        | 182                | 44.39          |
|   | O-        | 4                  | 0.98           |
| <b>Hb level (mean±SD)</b>                 |           | 7.35±1.30          |                |
|   | Normal Hb | 7                  | 1.71           |
|   | Low Hb    | 403                | 98.29          |
| <b>Parasite Density, p/μL</b>             |           | 702.42 (658-836)   |                |

A+ = A Rh (D) Positive; A- = A Rh (D) Negative; AB+ = AB Rh (D) Positive; B+ = B Rh (D) Positive; O+ = O Rh (D) Positive; O- = O Rh (D) Negative, Hb= Haemoglobin; p/μL= Parasites per microliter of blood. Categorical data are presented in frequencies, with corresponding percentages, and continuous data presented in medians (25th-75th percentiles)

### 3.2 Prevalence of Severe *Plasmodium falciparum* Malaria among the Study Participants at Janga Hospital, 2021

Fig. 1 portrays the prevalence of *Plasmodium falciparum* malaria severity among the study participants. There were 134 (32.68%) cases of severe *P. falciparum* malaria, and 264 (64.39%) cases of uncomplicated *P. falciparum* malaria. Apparently healthy individuals who had no malaria parasite (*P. falciparum*) seen after examining their blood samples accounted for 2.93%.

### 3.3 Age, Haemoglobin Concentration and Parasite Density Stratified by *Plasmodium falciparum* Malaria Severity among the Study Participants

There was no statistically significant difference in the ages of participants diagnosed with severe *P. falciparum* malaria and the uncomplicated malaria group [24.94 (12.33-41.52) months vs 26.26 (12.86-46.66) months,  $p=.40$ ]. The children who had been infected with severe *P. falciparum* malaria had significantly reduced Hb levels compared to those with uncomplicated malaria ( $6.40\pm 0.86$  vs  $7.82\pm 1.22$  g/dL,  $p<.001$ ). The

mean parasite density (% of Parasitized RBCs) in participants diagnosed with severe *P. falciparum* malaria was higher compared to participants with uncomplicated malaria ( $15.75\pm 3.99$  vs  $2.79\pm 1.1.60$ ,  $p<.001$ ) (Table 2).

### 3.4 Association between ABO and Rh Blood Antigens, and *Plasmodium falciparum* Malaria Status

There was a significant association between blood antigens and the *P. falciparum* status of the children ( $p<0.0001$ ) (Table 3). There was a high percentage of blood group A+ patients, 54/134 (40.30%) in children with severe *P. falciparum* malaria compared to their counterparts with uncomplicated *P. falciparum* malaria, 35/264 (13.26%) and healthy controls, 1/12 (8.33%). Blood group B+ and O+ made up 32.09% (43/134) and 22.39% (30/134), respectively of severe *P. falciparum* malaria patients compared to 24.62% (65/264) and 56.82% (150/264) of the uncomplicated, respectively. There was a low percentage of blood group AB+ (4/134, 2.99%), A- (3/134, 2.24%), and O- (0/134, 0.00%) patients in the severe malaria category than in uncomplicated malaria AB+ (6/264, 2.27%), A- (4/264, 2.24%), and O- (0,264, 0.00%).

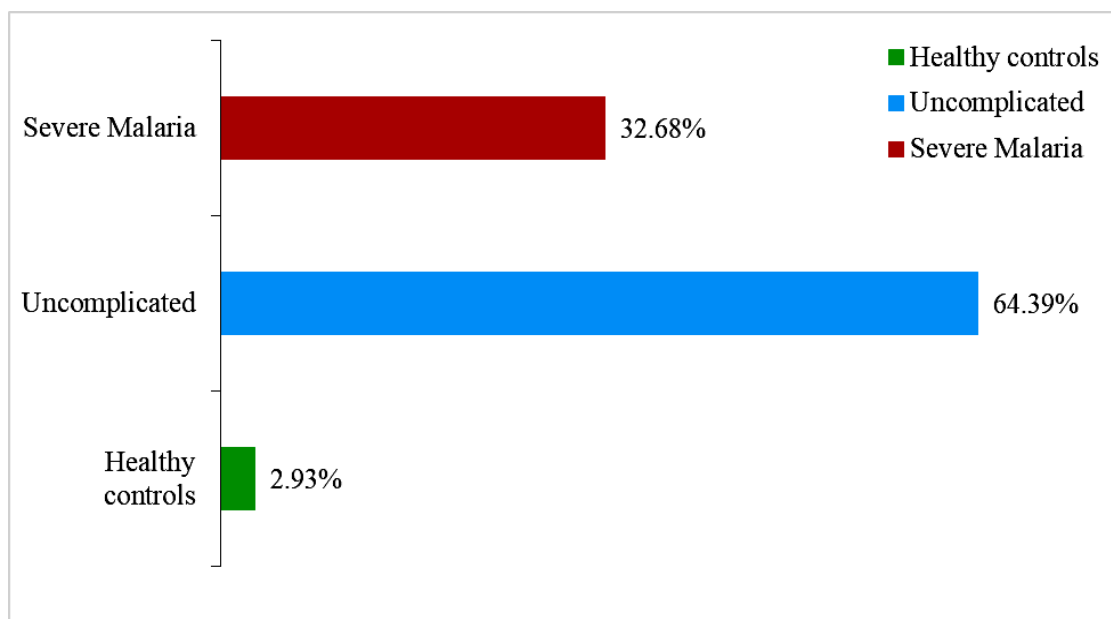


Fig. 1. Prevalence of Severe *Plasmodium falciparum* Malaria among the Study Participants at Janga Hospital, 2021

**Table 2. Age, Haemoglobin Concentration and Parasite Density Stratified by *Plasmodium falciparum* Malaria Severity among the Study Participants**

| Variables                                | <i>P. falciparum</i> Malaria Severity |                       | p-value |
|--|---------------------------------------|-----------------------|---------|
|  | Severe Malaria                        | Uncomplicated Malaria |         |
| Age (months)                             | 24.94 (12.33-41.52)                   | 26.26 (12.86-46.66)   | .40     |
| Hb (g/dL)                                | 6.40±0.86                             | 7.82±1.22             | <.001*  |
| Parasite Density (% of Parasitised RBCs) | 15.75±3.99                            | 2.79±1.1.60           | <.001*  |

Hb: Haemoglobin; g/dl: grams per decilitre. \*Statistically significant at  $p < .05$ . Hb and Parasite Density were compared using Student T-Test, and Age was compared with Mann-Whitney U-test

**Table 3. Association between ABO and Rh Blood Antigens, and *Plasmodium falciparum* malaria status**

| ABO/Rh             | Healthy controls<br>n (%) | Malaria Status         |                 | P-value          |
|--------------------|---------------------------|------------------------|-----------------|------------------|
|                    |                           | Uncomplicated<br>n (%) | Severe<br>n (%) |                  |
| <b>Blood group</b> |                           |                        |                 | <b>&lt;.001*</b> |
| A+                 | 1 (8.33)                  | 35 (13.26)             | 54 (40.30)      |                  |
| A-                 | 0 (0.00)                  | 4 (1.52)               | 3 (2.24)        |                  |
| AB+                | 4 (33.33)                 | 6 (2.27)               | 4 (2.99)        |                  |
| B+                 | 5 (41.67)                 | 65 (24.62)             | 43 (32.09)      |                  |
| O+                 | 2 (16.67)                 | 150 (56.82)            | 30 (22.39)      |                  |
| O-                 | 0 (0.00)                  | 4 (1.52)               | 0 (0.00)        |                  |

A+ = A Rh (D) Positive; A- = A Rh (D) Negative; AB+ = AB Rh (D) Positive; B+ = B Rh (D) Positive; O+ = O Rh (D) Positive; O- = O Rh (D) Negative. Data are presented in frequencies with percentages in parentheses.

\*Statistically significant at  $p < 0.05$

**Table 4. Binary Logistic Regression Analysis of Predictors of Severe *Plasmodium falciparum* Malaria Development**

| Variable            | Odds Ratio | 95% Confidence Interval |       | P-value |
|---------------------|------------|-------------------------|-------|---------|
|                     |            | Lower                   | Upper |         |
| <b>Blood groups</b> |            |                         |       |         |
| A+                  | 7.60       | 4.27                    | 13.51 | <.001*  |
| A-                  | 3.80       | 0.81                    | 17.86 | .09     |
| AB+                 | 2.02       | 0.60                    | 6.89  | .26     |
| B+                  | 3.11       | 1.80                    | 5.37  | <.001*  |
| O+ (Reference)      | 1 (Ref.)   |                         |       |         |
| O-                  | 1          | -                       | -     |         |

A+ = A Rh (D) Positive; A- = A Rh (D) Negative; AB+ = AB Rh (D) Positive; B+ = B Rh (D) Positive; O+ = O Rh (D) Positive; O- = O Rh (D) Negative. Data generated by a binary logistic regression model. \* Statistically significant at  $p < .05$

### 3.5 Binary Logistic Regression Analysis of Predictors of Severe *Plasmodium falciparum* Malaria Development

To assess whether blood antigens (ABO and Rh) were predictors of the severe course of *P. falciparum* infection, binary logistic regression analysis was conducted. As shown in Table 4, the odds of developing severe *Plasmodium falciparum* malaria were 7.60 times greater in persons with blood group A+ compared to blood

group O+ (OR=7.60; 95% CI:4.27-13.51;  $p < .001$ ). Persons with blood group B+ were three times more likely to have complicated *Plasmodium falciparum* malaria compared to blood group O+ (OR=3.11; 95% CI: 1.80-5.37;  $p < .001$ ).

## 4. DISCUSSION

Malaria is the leading cause of illness and mortality in Africa, especially among children,



and accounts for the highest number of hospital visits [28]. Studies conducted in Malawi [29], Guinea [30], and Ethiopia [2], have all shown an increased prevalence of *P. falciparum* malaria. The relationship between the severity of malarial infection and the patient's blood antigens has recently piqued attention in the search for solutions to the factors influencing the clinical course of the disease. This study investigated the susceptibilities of ABO and Rh blood antigens to severe *P. falciparum* malaria among children under five years in Janga District Hospital.

This study revealed that feverish and unwell children had considerably higher malaria parasitaemia than ostensibly healthy children who visited the Janga Hospital. Similarly, Onanuga and Lamikanra found that the prevalence of malaria infection was substantially greater among unwell children than among seemingly healthy children [31]. This could probably show that malaria is one of the primary causes of frequent hospital visits among children in these age groups, and that malaria parasites can make a person more susceptible to other diseases or disorders.

The overall prevalence of *P. falciparum* malaria in the study population was 97.07%, with 32.68% having severe *P. falciparum* malaria and 64.39% of uncomplicated *P. falciparum* malaria cases. The prevalence in this present study is higher than findings from previous studies in malaria-endemic regions in Ghana: 22% by Afoakwah *et al.* [22], and 39% by Yankson *et al.* [6]. Studies in other parts of Africa had recorded a relatively lower prevalence of *P. falciparum* malaria among children: 21.0% was reported in Arba Minch Zuria District, South Ethiopia [2], 22.8% in Ethiopia by Mengistu *et al.* [32], 33% in Mali by Zgambo *et al.* [3], and 19.0% in Uganda [33]. These differences in malaria prevalence might be due to variations in season, variations in population characteristics, variations in the effectiveness of the implementation of existing and new malaria control prevention and anti-malaria therapy used.

The distribution of ABO blood groups varies from population to population in the world and the ratio of blood antigen O to A is higher in regions where there is a presence or history of malaria endemicity [10,27]. A very high prevalence of blood group O is found throughout sub-Saharan Africa, where *P. falciparum* persists, whilst blood antigen A is the predominant blood group in the

coastal regions of the Earth where malaria is endemic [28]. In a community-based study in a tribal population in Odisha, where malaria is widespread, the blood group 'O' was shown to be more prevalent [34]. In other malaria non-endemic states in India, such as Maharashtra [20,35], and Uttar Pradesh [36], a decreased incidence of the 'O' blood type has been recorded, showing a selective advantage of this blood group in endemic areas. The ABO and Rh blood antigens distribution in this study showed blood group O+ was the predominant type. It occurred in more than twice the frequency of each group's A+ and B+, while the O- blood group was the least encountered. Our study agrees with other studies in Nigeria [37,38] which reported the highest frequency of the ABO blood group as O, followed by groups A and B. Changes in the clinical outcome of *P. falciparum* malaria may be related to the various erythrocyte polymorphisms [9].

This study observed a significant association between malaria status and blood group systems: ABO and Rh. The rosetting of parasitized erythrocytes and cytoadherence have been implicated in the disparities in susceptibility and severity of *P. falciparum* malaria infection among the "A," "B," "AB," and "O" blood groups [18,39]. Previous studies observed that during *P. falciparum* infection, rosetting is reduced in blood group "O" erythrocytes compared to non-O blood groups (A, B, and AB) [40,41], even though, the protective mechanism is not well understood.

Interestingly, severe malaria was significantly higher in the A+ subjects than in the other blood groups, while uncomplicated malaria was higher in the O+ group than in the other blood types in this study. This confirms the claims that, individuals with blood group "A" are particularly vulnerable to *P. falciparum* malaria whilst those with blood group "O" are said to be protected against severe malaria [16,17,19]. Contrary to our findings, a study done in Ethiopia by Tekeste *et al.* [10] indicated that people with blood group O were the dominant blood type in malaria cases. A link between blood antigen 'A' and malaria severity has also been established in Gabon [42], Ethiopia [10] and Zimbabwe [43]. A similar study conducted in Ghana found that blood group O was present in a few complicated cases compared to uncomplicated controls [22]. In this study, more malaria cases were recorded among subjects with the B+ blood group. The plausible explanation for this observation is not well understood. However, diverse rosetting

capacity, heterogeneous population groups, and distinct infective strains may all contribute to the diversity of observations made for different blood groups [44]. Increased rosetting phenomena have been linked to blood groups 'A' in Uganda and Gambia [41,45] respectively, 'B' in Thailand [41], and 'AB' in Kenya [46].

The likelihood of developing severe *P. falciparum* malaria was 7.60 times greater in persons with blood group A+ compared to blood group O+. In addition, persons with blood group B+ were three times more likely to have complicated *falciparum* malaria compared to blood group O+. Previous studies [10,22], showed that individuals with complicated malaria were about twice as likely to be of blood groups A or B compared to group O. Again, the cross-sectional study in Awash, Ethiopia, by Tekeste and Petros discovered that severe malaria was almost twice more likely to be of blood antigens A or B than type O [10]. This therefore reaffirms that ABO and Rh blood groups are associated with the severity of *Plasmodium falciparum* malaria in children [10].

The study was limited by the inability to establish the exact pathophysiology of ABO and Rh blood antigens in the development of severe *Plasmodium falciparum* malaria.

## 5. CONCLUSION

The study recorded a relatively higher prevalence of *P. falciparum* malaria among children below five years of age in Janga District Hospital. The blood antigen O+ was the predominant ABO and Rh antigen in the study area. Severe malaria was significantly higher in the A+ subjects than in the other blood groups, while uncomplicated malaria was higher in the O+ group than in the other blood types. The odds of developing complicated *P. falciparum* malaria were greater in persons with blood groups A+ and B+ compared to blood group O+. Incorporation of blood antigen determination into the routine management of malaria is recommended. Further in-depth studies are recommended to establish the roles of ABO and Rh blood antigens in the development of severe *P. falciparum* malaria in children.

## ETHICAL CONSIDERATIONS

The 'Declaration of Helsinki-Ethical Principles for Medical Research' was adhered to strictly throughout the study. This study was approved by University for Development Studies

Institutional Review Board (UDS/RB/027/22). Permission was sought from the Management of Janga District Hospital and the West Mamprusi Municipal Health Directorate. Caretakers or guidance of the children either thumb-printed or signed to confirm their consent, and participants were assured of the confidentiality of all data provided.

## COMPETING INTERESTS

Authors have declared that no competing interests exist.

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