WHO's Recommended Interventions for Malaria Prevention and Control during Pregnancy (in Areas of Stable Transmission)

This summary of recommendations is from *A Strategic Framework for Malaria Prevention and Control during Pregnancy in the African Region* (2004), a collaborative effort of the Malaria Control Program and the Safe Motherhood Program of the Regional Office for Africa of the World Health Organization (WHO/AFRO) and the Roll Back Malaria and Making Pregnancy Safer teams of WHO Headquarters. The document provides information on malaria's effects on pregnant women and their babies, development of effective malaria prevention and control programs, recommended interventions and how to deliver them, program implementation, monitoring and evaluation, and research priorities.

The policy for malaria prevention and control during pregnancy in areas of stable transmission should emphasize a preventive package of intermittent preventive treatment (IPT) and insecticide-treated bed nets (ITNs) and ensure effective case management of malaria illness and anemia.

Intermittent Preventive Treatment

All pregnant women in areas of stable malaria transmission should receive at least 2 doses of IPT after quickening. The World Health Organization recommends a schedule of 4 antenatal clinic visits, with 3 visits after quickening. The delivery of IPT with each scheduled visit after quickening will assure that a high proportion of women receive at least 2 doses. IPT-SP doses should not be given more frequently than monthly.

The most effective drug for IPT is sulfadoxine-pyrimethamine (SP) because of its safety for use during pregnancy, effectiveness in reproductive-age women, and feasibility for use in programs, as it can be delivered as a single-dose treatment under observation by the health worker.*

Insecticide-Treated Nets

ITNs should be provided to pregnant women as early in pregnancy as possible. Their use should be encouraged for women throughout pregnancy and during the postpartum period. ITNs can be provided either through the antenatal clinic or other sources in the private and public sectors.

Case Management of Malaria Illness and Anemia

Effective case management of malaria illness for all pregnant women in malarious areas must be assured. Iron supplementation for anemia should be given to pregnant women as part of routine antenatal care. Pregnant women should also be screened for anemia, and those with moderate to severe anemia should be managed according to national reproductive health guidelines.

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*Current scientific evidence suggests the following: 1) At least 2 IPT doses are required to achieve optimal benefit in most women; 2) One study of IPT in HIV-infected pregnant women has demonstrated that monthly dosing of IPT (with most women getting 3-4 doses) was necessary to achieve optimal benefit; 3) In settings with HIV prevalence in pregnant women greater than 10%, it is more cost effective to treat all women with a 3-dose regimen than to screen for HIV and provide this regimen only to HIV-infected women; 4) There is no evidence that a third dose of IPT causes any additional risk, that more than 3 IPT doses during pregnancy offers additional benefit, or that receiving 3 or more doses of IPT with SP will result in an increased risk of adverse drug reactions. Research to assess the safety, efficacy, and program feasibility of other antimalarial drugs for use in IPT is ongoing.

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