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Prevent and Treat Malaria During Pregnancy

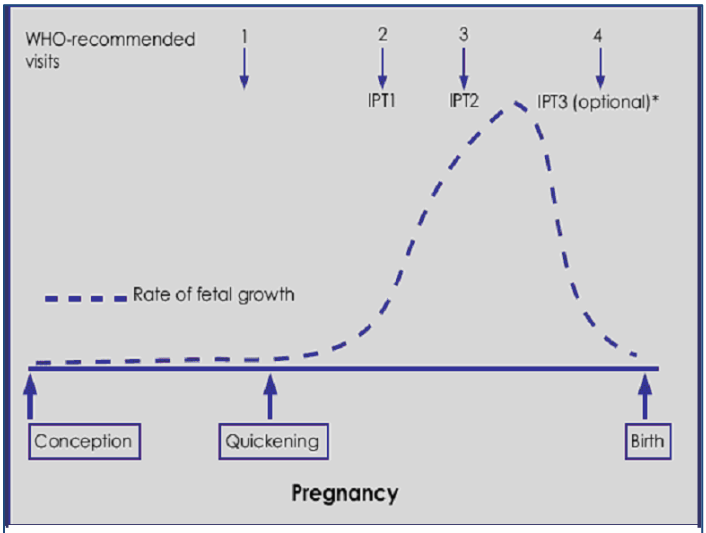
- ***Intermittent preventive treatment of pregnant women has a beneficial impact on maternal and infant health.***
- ***Fetal loss, premature delivery, and death can be avoided through prompt disease recognition followed without delay by high-quality treatment of malaria.***
- ***Pregnant women should sleep under an insecticide-treated bednet.***

Each year more than 30 million African women living in malaria-endemic areas become pregnant and are at risk for *Plasmodium falciparum* infections. For these women, malaria is a threat both to themselves and to their babies. Prevention and prompt treatment protects pregnant women from possible death and anemia and also prevents malaria-related low birth weight in infants, which is responsible for between 100,000 and 200,000 infant deaths annually in Africa.

Pregnant women residing in high-transmission areas should take intermittent preventive treatment[1]

Intermittent preventive treatment of pregnant women (IPTp) involves the administration of two or three full, curative treatment doses of an efficacious, preferably single-dose, anti-malarial drug (e.g., sulfadoxine-pyrimethamine) at predefined intervals during pregnancy, beginning in the second trimester after quickening[2]. IPTp can significantly reduce maternal anemia and low birth weight.

Women should receive **at least two doses** of IPTp, each at least **one month apart.** IPTp can be administered under direct observation in the clinic or be given in the community. WHO recommends a schedule of four antenatal care (ANC) visits, with three visits after quickening. Women should thus be encouraged to seek ANC. The delivery of IPTp with each scheduled visit after quickening will help ensure that a high proportion of women receive at least two doses.



IPTp can be given during regularly scheduled antenatal care visits.

*HIV infection diminishes a pregnant woman's ability to control *Plasmodium falciparum* infections. Women with HIV infection are thus more likely to have symptomatic infections and to have an increased risk for malaria-associated adverse birth outcomes and a minimum of three doses of IPTp are required to obtain maximum protection. In areas where HIV prevalence among pregnant women is > 10%, a third dose of IPTp should be administered at the last scheduled ANC visit.

[1] Antenatal chemoprophylaxis with chloroquine has been shown to be of limited effectiveness. Therefore, chloroquine chemoprophylaxis no longer has a role in national policies for the control of malaria in pregnancy in the Africa region.

[2] The first perception of the baby's kicking and movement is referred to as quickening. Quickening usually occurs between 14-26 weeks of pregnancy.

Anemia can be prevented and needs to be managed

Anemia is one of the most important consequences of malaria infection during pregnancy. As part of routine antenatal care, every woman should receive iron/folate supplementation. All women should also be screened for anemia, and those with moderate to severe anemia should be managed according to national guidelines. In malaria-endemic areas pregnant women with severe anemia must be treated presumptively with an effective anti-malarial, whether or not peripheral parasitemia is present or whether or not she has a history of fever.

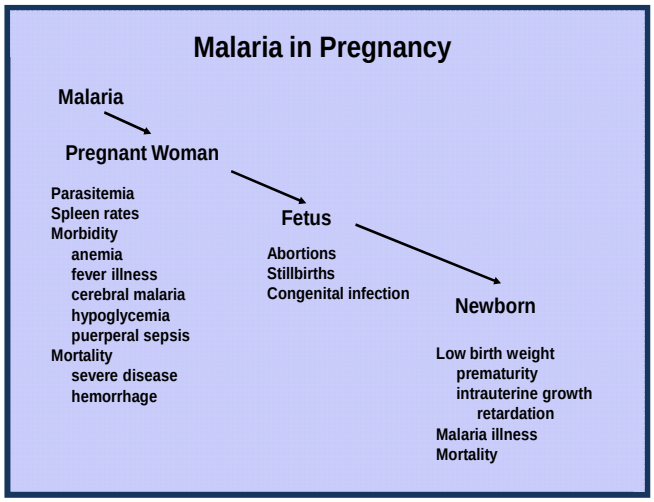
Insecticide-treated bednets should be provided to all pregnant women

Malaria prevention during pregnancy includes the use of **insecticide-treated bednets (ITNs).** Women should be encouraged to use ITNs as early in pregnancy as possible, throughout pregnancy, and in the postpartum period. Long-lasting insecticidal nets should be promoted where available.

Pregnant women with symptomatic malaria need treatment urgently

Case management of malaria illness is an essential component of malaria control during pregnancy. Treatment aims to completely cure the infection, as any level of parasitemia has consequences for mother and fetus.

In areas with a low level of resistance to sulfadoxine-pyrimethamine (SP), this drug is the recommended drug for treatment of uncomplicated malaria. Quinine is an alternative in areas where both chloroquine and SP are not effective, and it is the drug of choice for treatment of uncomplicated malaria in the first trimester of pregnancy. Drugs that should not be used during pregnancy are tetracycline, doxycycline, primaquine, and halofantrine.



PMI Targets

85% of women who have completed a pregnancy in the last two years will have received two or more doses of IPTp during that pregnancy;

and 85% of pregnant women will have slept under an ITN the previous night.

References:
USAID Technical Reference Material, http://www.childsurvival.com/documents/trms/tech.cfm
Roll Back Malaria Web site, http://www.rbm.who.int
WHO's Strategic Framework for Malaria Prevention and Control during Pregnancy in the Africa Region.
http://www.malariaconsortium.org/data/files/pages/prg_10.pdf
Refer to Bednets Reduce Malaria.Technical Brief.

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