

Why is WHO failing women with falciparum malaria in the first trimester of pregnancy?

In this year's opening to the World Malaria Report entitled "Leaving no one behind in the march to a malaria-free world" the World Health Organisation (WHO) Director General notes that the scourge of malaria continues to strike hardest against pregnant women and children in Africa. He reports that "some 11 million pregnant women in sub-Saharan Africa were infected with malaria and, consequently, nearly 900 000 children were born with a low birthweight. Malaria in pregnancy compromises the mother's health and puts her at greater risk of death. It impacts the health of the fetus, leading to prematurity and low birthweight, major contributors to neonatal and infant mortality".¹ In Sub-Saharan Africa, *Plasmodium falciparum* is responsible for an estimated 50,000 maternal deaths and 200,000 stillbirths each year, in addition to substantial adverse neonatal morbidity (preterm birth, small for gestational age) predisposing to death in infancy and non-communicable diseases in later life.² This intolerable carnage is preventable.

Artemisinin combination treatments (ACTs) are first-line treatments for falciparum malaria throughout the world, and they are recommended by the WHO as the treatment of choice for women in the second and third trimesters of pregnancy, but puzzlingly they are still not recommended by WHO in the first trimester. Concerns over the use of artemisinin derivatives in the first trimester have been systematically addressed.^{2,3} In 2015 an Evidence Review Group convened by the WHO's Global Malaria Programme (WHO GMP) reported a detailed review of all available data and recommended that the clear benefits exceeded any potential risks and that ACTs *should* be used to treat uncomplicated falciparum malaria in the first trimester. The WHO GMP's own malaria policy advisory group then recommended "review of the WHO Guidelines for the treatment of malaria to consider the timely inclusion of ACT as a first-line therapeutic option for uncomplicated falciparum malaria"⁴, a process WHO GMP initiated through its Treatment Guidelines Committee in 2017. Yet today, over four years after the original recommendation, WHO still recommends quinine – a drug for which there are few data on safety in the first trimester. Quinine is poorly tolerated, poorly adhered to, and therefore less effective than ACTs.^{2,3} Hospitals, antenatal clinics and malaria control programmes all have to retain quinine for this one unnecessary indication.⁵ Why is WHO leaving behind women in the first trimester of pregnancy? Nothing has justified this four year delay. We urge WHO to heed the advice of the Evidence Review Group and revise its outdated recommendations on the treatment of malaria in early pregnancy as a matter of urgency.

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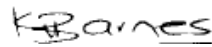


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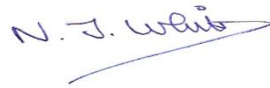
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