

Original Research Article

Antimalarial Susceptibility Profile of *Plasmodium falciparum* Isolated from Human Population in Selected Health Facilities in Keffi Metropolis, Nasarawa State, Nigeria

ABSTRACT

Aim: This study was aimed to determine the susceptibility profile of *Plasmodium falciparum* to antimalarial drugs to assess the efficacy of the ones in use.

Study design: This is a hospital-based cross sectional study design.

Place and Duration of Study: Department of Microbiology, Faculty of Natural and Applied Sciences, Nasarawa State University, Keffi, between December 2023 and November 2024.

Methodology: A total of 385 blood samples were collected and screened for malaria parasites by microscopy. Species-specific screening was done using RDT. Stock/working solutions of selected antimalarial drugs were prepared using standard protocols. The parasite cultivation and its susceptibility to selected antimalarial drugs was determined using the WHO protocol. Matured schizonts were quantified. The degree of antimalarial drugs inhibition of schizonts maturation was determined and the drugs 50% inhibitory concentration (IC_{50}) required to prevent parasite schizont maturation indicating resistance was determined.

Results: Malaria prevalence by microscopy was 29.9% (95% CI = 25.34 to 34.71%) and 26.7% by RDT. The RDT had a sensitivity of 89.6% (95% CI = 82.48% to 94.49%), specificity of 100.00% (95% CI = 98.64% to 100.00%), Positive Predictive Value of 100.00% (95% CI = 96.48% to 100.00%); and Negative

Predictive Value of 95.8% (95% CI = 92.94% to 97.46%). The accuracy of the RDT was 96.88% (95% CI = 94.62 to 98.38%). Six out of the 35 isolates showed 17.1% resistance to Artemether + Lumafantrine.

Conclusion: Malaria is present in the study population and is resistant to some of the antimalarial drugs in use. The need for periodic antimalarial drugs surveillance to determine the efficacy of drugs in use is highly recommended.

Keywords: Plasmodium falciparum, Microscopy, Antimalarial, Resistance, Nasarawa.

1. INTRODUCTION

Plasmodium falciparum is one of the 5 species of malaria parasite infecting humans. Malaria generally, is a vector-borne, obligate intracellular parasitic disease caused by the protozoan parasite of the phylum Apicomplexa and the genus *Plasmodium* and remains a major public health challenge in Sub-Saharan Africa [1, 2]. It is estimated to cause 241 million clinical episodes and 627,000 deaths with an estimated 94% of deaths occurring in the World Health Organization's (WHO's) African Region [3, 4]. Nigeria has the highest number of global malaria cases with 27 % of global malaria cases in 2019 with the highest number of global malaria deaths which stands at 23% [5]. It is also reported that 50% of the Nigerian population suffers from at least one episode of malaria each year and this accounts for over 45% of all out-patient visits and 30% hospitalizations especially among children under 5 years of age [6, 7].

Of the 5 species of malaria parasites infecting humans, *Plasmodium falciparum* is the deadliest [3]. This particular virulence is due to its ability to subvert the physiology of its host during the blood stages of its development [8]. Malaria treatment and control relies heavily on vector control, administration of antimalarial drugs and recently, the use of malaria vaccines [3]. Despite the use of antimalarial drugs in the treatment of malaria there is emergence/spread of Artemisinin-resistance parasites and WHO recommends the use of Artemisinin-based combination therapies (ACTs) as the first-line drugs for the treatment of uncomplicated malaria [9, 10, 11]. The emergence of drug-resistant parasites over the last few decades has affected the epidemiology of malaria and options for its treatment and now there is evidence of decreased sensitivity to the Artemisinins [12]. The resistance posed by *Plasmodium* species to antimalarial drugs with its attendant consequences entails the need for periodic antimalarial susceptibility testing in order to detect the parasites resistance to antimalarial drugs. This study therefore aims to

determine the Antimalarial Susceptibility Profile of *Plasmodium falciparum* Isolated from Human Population in Selected Health Facilities in Keffi Metropolis, Nasarawa State, Nigeria.

2. MATERIAL AND METHODS

2.1 Study area:

This hospital-based cross sectional study design was conducted in Keffi, the headquarters of Nasarawa West Senatorial District. Geographically, Keffi is located in Nasarawa state which lies between latitudes 8°51' and 8°53' North of the equator and longitudes 7°50' and 7°51' East of the Greenwich meridian. It is about 128 km away from Lafia, the State capital and 57 km away from Abuja, the Federal Capital Territory of Nigeria. Keffi is the smallest Local Government Area in Nasarawa State, with a total land area of approximately 140 km² [13, 14].

2.2 Sample size determination

The sample size was calculated with a 95% Confidence Interval (CI) and precision level of 5% using the standard sample size calculation formula as described by [15].

2.3 Subject selection (eligibility criteria)

2.3.1 Inclusion criteria:

Patients who had clinical symptoms of malaria determined by headache, body aches and febrile condition of 37.5°C and above and have not taken antimalarial drug in the preceding week prior to visitation to the health facility were recruited in the study. Similarly, only consenting Patients residing within the senatorial district and attending the selected health facilities that were enrolled in the study.

2.3.2 Exclusion criteria:

Patients residing outside the senatorial district, without clinical symptoms of malaria and have taken antimalarial drug were exempted from the study.

2.4 Sample collection:

A total of 385 blood samples were collected by venipuncture from the study participants at the collection sites namely: South Atlantic Medical Centre, Nasarawa State University, Keffi and Nagari Hospital, Keffi

using standard protocol. The collected blood samples were let into labeled EDTA containers and immediately conveyed to Microbiology Laboratory, Nasarawa State University, Keffi for laboratory analysis.

2.5 Laboratory analysis:

2.5.1 Microscopy (the gold standard):

Thin and thick blood films were made on well labeled clean grease free slides, air dried and stained for 10 min using a 1 in 10 dilution of freshly prepared Giemsa stain in buffer water of pH 7.2. The stained dry films were microscopically read by two independent Microscopists and discrepancies (if any) were resolved by a third reader.

2.5.2 Rapid Diagnostic Test:

Whole blood collected from the participants were also tested for malaria parasites using specie-specific random diagnostic test (RDT) (SD bioline®) which test specifically for plasmodium falciparum following manufacturer's instructions.

2.5.3 Determination of RDT diagnostic performance indices:

Since it is *P. Falciparum* (the most prevalent specie in the study area) whose susceptibility to antimalarial drugs is to be tested, the need to test the diagnostic performance indices of the RDT for specie specific results became necessary. The diagnostic indices namely: sensitivity, specificity, positive predictive value, negative predictive value, and accuracy of the RDT were determined using standard protocol as described by ^[16]. Details of these calculations are presented in appendix B.

2.5.4 Performance of the In-vitro Micro-test (Mark III test):

Cultivation and eventual susceptibility testing of Plasmodium parasites to antimalarial drugs was performed on blood samples with mono infection whose level of parasitaemia following parasite density determination was within the acceptable limit of 1000 – 80,000 parasites/ μ l of blood as described by ^[17] using the following steps.

2.5.4.1 Preparation of stock/working solutions and dosing of microtitre culture plates:

The stock and working solutions of Chloroquine, Artesunate and a combination of Artesunate plus Amodiaquine and Artemether plus Lumefanrine were prepared as earlier described by ^[18].

Key: well A is the control (drug free well). wells B - F represent Chloroquine concentrations of 0.2; 0.4; 0.8; 1.6 and 3.2 μmol per l blood sample. the concentrations are expressed in $\mu\text{mol/l}$ blood as the malaria parasite shows selective uptake of Chloroquine. The peak plasma level is at 0.8 μmol .

2.5.4.3 Examination of the post culture blood slides

The post culture-stained thick blood films were examined microscopically using the 100x objective and the number of schizonts with three or more nuclei out of 200 asexual parasites were counted using digital microscope and compared with the control. The schizont counts were expressed as a percentage of the control as described by ^[19]. The percentage inhibition was then calculated as earlier described by ^[17]. The individual percentage schizont maturation inhibitions were converted to probit, while the various drug concentrations used were converted to log concentration. This was done by feeding the values directly into Microsoft excel. using linear regression lines, their inhibitory concentrations (IC_{50}), was determined. Drug resistant *P. falciparum* parasites were then identified as parasites with IC_{50} values greater than the peak plasma concentration of the tested anti-malaria drugs.

2.6 Statistical analysis:

Data obtained was entered in Microsoft Excel and analyzed to obtain frequency of occurrence and inhibitory concentrations (IC_{50}) which is the concentration at which 50% of parasite growth was inhibited at 95% confidence intervals and 5% precision was determined using linear Regression. Using microscopy as the gold standard, the performance of the Rapid Diagnostic Test (RDT) was compared to it using MedCalc version 22.009 statistical package (MedCalc Software Ltd. Diagnostic test evaluation calculator). Values were considered significant at 95% confidence interval ($P = .05$).

3. RESULTS AND DISCUSSION

3.1 Prevalence of malaria

This study examined the *Plasmodium falciparum* susceptibility to selected antimalarial drugs. A total of 385 blood samples were collected during the period of this study. Microscopy detected 115 sample positivity (29.9%) RDT detected 103 (26.7%) positive samples. This result gives a performance rate of 89.6% (103/115) sensitivity of the RDT test method. The prevalence of malaria parasite in the study area is presented in Table 2

Table 2: Prevalence of malaria parasite by Microscopy and RDT

Facility	Microscopy		Prevalence	RDT		Prevalence
	Number collected	Number positive	(%)	Number collected	Number positive	(%)
Nagari Hospital, Keffi	155	46	29.7	155	41	26.5
SAPETR O, NSUK	230	69	30.0	230	62	26.9
Total	385	115	59.7/2 = 29.9	385	103	53.4/2 = 26.7

This observed mean prevalence of 29.9% is similar to a study conducted by ^[20] in Cameroon who had (29%) and ^[8] in Nigeria. It is also closely related to the WHO African regions' current malaria prevalence report of 26.6% ^[21]. The observed prevalence is however lower than reports from other parts of Nigeria namely: 53% in Asaba ^[22]; 64.9% in Kano ^[23] and 82.7% in Ondo ^[4]. This mean prevalence obtained in this study emphasizes

the fact that malaria still remains endemic in the study area and is a public health concern considering all known intervention programs aimed at halting malaria parasite transmission.

3.2 Determination of RDT diagnostic performance indices:

The sensitivity, specificity and accuracy of the RDT was determined using standard protocols ^[16]. Results shows that the sensitivity of RDT was 89.6% (95% CI = 82.48% to 94.49%) while its specificity was 100.00% (95% CI = 98.64% to 100.00%). The Positive Predictive Value (PPV) was 100.00% (95% CI = 96.48% to 100.00%) while the Negative Predictive Value (NPV) was 95.8% (95% CI = 92.94% to 97.46%). The mean prevalence of malaria using microscopy in this study population was 29.9% (95% CI = 25.34 to 34.71%). The false negative rate was 74.4%. The accuracy of this diagnostic tool was 96.88% (95% CI = 94.62 to 98.38%) (Appendix B) meaning it was fit as a diagnostic tool for this research.

The sensitivity, specificity and accuracy of the RDT obtained in this study shows that the RDT is strongly reliable as an alternative test method of malaria parasite particularly in areas with no electricity, where an experienced Microscopist is not available and where time is of essence in emergency situations. This high rate of specificity and sensitivity of RDT is consistent with literature of other researchers ^[24, 25, 22, 26, 8].

3.3 Evaluation of in-vitro susceptibility of *P. falciparum* isolates to antimalarial drugs

Out of the 103 *P. falciparum* RDT positive samples, only 35 of the samples were evaluated for antimalarial drugs susceptibility. Some samples were discarded due to failure of schizonts to mature satisfactorily, while others were lost due to poor staining. Results of the schizont maturation counts in Chloroquine and Artesunate (as mono-therapy), then Artesunate + Amodiaquine and Artemether + Lumefantrine as ACTs were determined. Results of the number of schizonts counted per slide per well in all the drugs tested relative to the control well was recorded. The Schizont maturation counts obtained were used in determining the degree of Antimalarial drugs inhibition of Schizont maturation in percentages (%) at different antimalarial concentrations (μM).

3.4 Determination of inhibitory concentrations

The results of the Degree of Antimalarial drugs inhibition of Schizont maturation in percentages (%) against schizont maturation at different antimalarial concentrations (μM) was also recorded. The *in-vitro* response of malaria parasites to various drug concentrations are expressed as the IC_{50} value. This is the concentration of an antimalarial drug that inhibits 50% of schizont maturation as compared with the development in drug-free

control wells [19]. The drug-resistant *P. falciparum* parasites were identified as isolates with IC₅₀ values greater than threshold values for sensitive parasite isolates (Table 3 - 6). A summary of the threshold values compared were Chloroquine: IC₅₀ > 0.8 µM; Artesunate: IC₅₀ > 28.6 µM, Artesunate + Amodiaquine: IC₅₀ > 5.4 µM and Artemeter + Lumefantrine: IC₅₀ > 13.4 µM. The in-vitro susceptibility results are presented (Table 6). From the results, only 6 isolates (17.1%) (the ones in red - table 6) had values higher than the compared peak plasma level of Artermether (PPL =13.4), an Artemisinin derivative and therefore are resistant. The remaining antimalarial agents had 100% susceptibility.

Table 3. Inhibitory concentration (ic) in micromoles (µm) of chloroquine (ppl = 0.8) against schizont maturation

Isolate	IC ₅₀	Remarks*	R ²
1	0.448221	S	0.921151
2	0.403557	S	0.865399
3	0.410732	S	0.947305
4	0.338151	S	0.876581
5	0.343186	S	0.859845
6	0.411174	S	0.957254
7	0.370455	S	0.914332
8	0.360963	S	0.924658
9	0.382063	S	0.929665
10	0.308984	S	0.904816
11	0.399505	S	0.90634

12	0.36535	S	0.950525
13	0.315584	S	0.914843
14	0.331142	S	0.920306
15	0.231309	S	0.934689
16	0.291329	S	0.921563
17	0.377219	S	0.966994
18	0.322195	S	0.898598
19	0.285378	S	0.929886
20	0.327978	S	0.931626
21	0.338698	S	0.928133
22	0.407253	S	0.831309
23	0.670915	S	0.973282
24	0.333329	S	0.894209
25	0.45439	S	0.939497
26	0.49071	S	0.889998
27	0.388292	S	0.923162
28	0.348312	S	0.914716
29	0.42856	S	0.977308
30	0.321035	S	0.891774
31	0.486962	S	0.976902
32	0.399259	S	0.908232

33	0.39755	S	0.917531
34	0.423394	S	0.986692
35	0.430042	S	0.976367

*S = Sensitive; R² = Regression constant; Peak Plasma Level = 0.8 *The remarks is based on comparison of IC₅₀ with peak plasma level of the test drug*

Table 4. Inhibitory concentration (IC) in micromoles (µM) of Artesunate (PPL = 28.6) against schizont maturation

Isolate	IC ₅₀	Remark s*	R ²
1	16.8832	S	0.984522
2	15.9056	S	0.898268
3	13.98326	S	0.937982
4	16.26453	S	0.981835
5	13.65754	S	0.946283
6	13.58368	S	0.922245
7	12.22406	S	0.936933
8	15.65312	S	0.980324
9	13.3076	S	0.916627
10	13.52528	S	0.935115

11	13.87395	S	0.901688
12	12.28914	S	0.920207
13	13.01908	S	0.909576
14	14.53565	S	0.92062
15	13.41887	S	0.899564
16	12.87836	S	0.923775
17	13.40372	S	0.926663
18	14.4696	S	0.892208
19	15.38027	S	0.971749
20	14.33525	S	0.909532
21	53.1706	S	0.990983
22	11.55901	S	0.980328
23	13.7433	S	0.963577
24	10.87019	S	0.876835
25	15.39003	S	0.944705
26	9.86941	S	0.942665
27	16.00334	S	0.964228
28	18.28928	S	0.856908
29	12.90444	S	0.924658
30	10.99708	S	0.919732
31	14.2787	S	0.961162

32	12.75367	S	0.916972
33	13.50535	S	0.894876
34	16.82945	S	0.903506
35	13.11524	S	0.925562

*S = Sensitive; R² = Regression constant; Peak Plasma Level = 28.6 *The remarks is based on comparison of IC₅₀ with peak plasma level of the test drug*

Table 5. Inhibitory concentration (IC) in micromoles (µM) of Artesunate + Amodiaquine (PPL = 5.4) against schizont maturation

Isolate	IC ₅₀	Remarks*	R ²
1	2.721715	S	0.976468
2	2.669114	S	0.886012
3	2.424742	S	0.932864
4	2.472819	S	0.975827
5	2.617441	S	0.946089
6	2.335194	S	0.91584
7	1.965862	S	0.934152

8	2.75843	S	0.977285
9	2.267524	S	0.908006
10	2.355269	S	0.931714
11	2.451442	S	0.897659
12	2.22641	S	0.867787
13	2.264102	S	0.906496
14	2.525778	S	0.916026
15	2.574813	S	0.901851
16	2.130628	S	0.917975
17	2.595759	S	0.927365
18	2.698614	S	0.894182
19	3.136195	S	0.914722
20	2.67671	S	0.885267
21	2.895354	S	0.882319
22	2.759943	S	0.857164
23	2.626389	S	0.838602
24	2.701199	S	0.87689
25	2.846487	S	0.909549
26	2.471566	S	0.8503
27	2.617588	S	0.889931
28	2.825038	S	0.882251

29	2.362436	S	0.78338
30	2.556836	S	0.876435
31	2.54794	S	0.888508
32	2.553378	S	0.903695
33	2.291745	S	0.884869
34	2.08503	S	0.885096
35	2.546427	S	0.848776

*S = Sensitive; R² = Regression constant; Peak Plasma Level = 28.6. *The remarks is based on comparison of IC₅₀ with peak plasma level of the test drug*

Table 6. Inhibitory concentration (IC) in micromoles (μM) of Artemether plus Lumefantrine (PPL = 13.4) against schizont maturation

Isolate	IC ₅₀	Remarks*	R ²
1	5.343815	S	0.967485
2	7.34989	S	0.895837
3	6.439249	S	0.93801
4	5.776725	S	0.972794
5	6.398987	S	0.946283
6	6.001331	S	0.918683
7	4.162396	S	0.929576

8	18.92401	R	0.9836
9	3.876319	S	0.88074
10	5.206609	S	0.9268
11	5.154025	S	0.88869
12	15.46259	R	0.9618
13	4.61932	S	0.89526
14	5.307944	S	0.903753
15	4.978081	S	0.88822
16	3.976024	S	0.907145
17	5.28862	S	0.920274
18	5.417809	S	0.878258
19	4.744729	S	0.857728
20	15.82783	R	0.9630
21	6.942021	S	0.900459
22	15.47544	R	0.9872
23	7.454756	S	0.957972
24	6.407866	S	0.940827
25	5.614074	S	0.998137
26	5.334651	S	0.929233
27	6.515576	S	0.954357
28	16.32995	R	0.9822

29	6.005842	S	0.895429
30	7.266943	S	0.992582
31	5.71134	S	0.928737
32	15.380554	R	0.9812
33	6.285105	S	0.92894
34	5.419045	S	0.930512
35	5.110199	S	0.926922

*S = Sensitive; R = Resistant; R² = Regression constant; Peak Plasma Level = 13.4. *The remarks is based on comparison of IC₅₀ with peak plasma level of the test drug*

The in-vitro susceptibility of *P. falciparum* isolates to antimalarial drugs in this study revealed that of the 4 studied antimalarial drugs tested, 6 out of the 35 isolates (17.1%) had an IC₅₀ that exceeded the peak plasma level (PPL) concentration of 13.4 µM for Artemether plus Lumefantrine (Coartem). The PPL concentration of a drug in the bloodstream higher than the expected or desired therapeutic range could pose the risk of toxicity as the body may not be able to handle the excess drug and continuous use may cause potential side effects. The 6 isolates were therefore considered resistant to Artemether + Lumefantrine. This could be as a result of continuous prescription of the drug posing the challenge of drug pressure on the study population which lead to the resistance observed.

A summary of the in-vitro resistance profile of *Plasmodium falciparum* isolates to selected antimalarial drugs in this study is presented in table 7.

Table 7. In-vitro resistance profile of *Plasmodium falciparum* isolates to selected antimalarial drugs.

Antimalarial drugs	No cultured	No susceptible n(%)	No resistant n(%)
Chloroquine	35	35(100)	0(0)
Artesunate	35	35(100)	0(0)
Artesunate + Amodiaquine	35	35(100)	0(0)
Artemeter + Lumefantrine	35	29(82.9)	6(17.1)

It has been documented that the removal of drug pressure exposes resistant parasites to increased competition leading to a decline in the frequency of resistance conferring mutants (Shafik et al., 2020). Chloroquine, whose usage was discontinued as a result of mutation and subsequent resistance was seen to be susceptible in this research. This probably may be as a result of reduction in its use resulting to clearance of the resistance genes (*P.fcr1*, *P. fmdr-1*). This result of the return of Chloroquine-susceptible *Plasmodium falciparum* parasites is reported in other studies [27, 28]. Mekonnen *et al.*, (2014; Hailemeskel et al., 2019). This result is also consistent with Olasehinde *et al.*, (2014) who reported 100% susceptibility of *Plasmodium falciparum* isolates to Artesunate, an Artemisinin derivative. This research result however differs from reports of other researchers who reported a high percentage of resistance in the use of antimalarial drugs such as Artesunate, Chloroquine and Artesunate + Amodiaquine (Mekonnen, 2014; Olukosi *et al.* 2014; Jimoh, 2016).

4. CONCLUSION

The prevalence of malaria obtained in this study indicates that malaria is still endemic in Keffi metropolis. The performance of the RDT kit was superb and this makes it a valuable tool where facilities for microscopy are not available and immediate time for diagnosis is of essence. The endemicity of malaria in the study population could be as a result of failure to adhere to preventive/control measures. It could also be as a

result of antimalarial drug abuse and misuse whose consequence is drug resistance hence the persistence of the parasite in the study area. I therefore recommend adherence to preventive/control measures as well as correct use of antimalarial drugs only when prescribed by Professionals. The need to also explore the reintroduction of Chloroquine in the treatment of malaria may also be considered since it is cheap, effective, readily available and a quick parasite clearance antimalarial drug. Considering the fact that overuse of the ACTs (a WHO recommended 1st line drug for malaria treatment) may exert drug pressure which may lead to resistance, the need for periodic antimalarial drugs surveillance for introduction of new drugs and to determine the efficacy of other antimalarial drugs in use is therefore highly recommended.

CONSENT

All authors declare that 'written informed consent was obtained from the patient (or other approved parties) for publication of this case report and accompanying images. A copy of the written consent is available for review by the Editorial office/Chief Editor/Editorial Board members of this journal.

ETHICAL APPROVAL

The ethical approval was obtained from the Research and Ethical Committee of the Health Services Department, Nasarawa State University, Keffi, Nigeria (Appendix A).

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APPENDIX A:

Calculations for the accuracy of RDT as a diagnostic method

The Sensitivity, Specificity, Positive Predictive Value, Negative Predictive Value, False Positive rate, False Negative rate and Accuracy/efficiency of the RDT test method was calculated as follows:

$$1. \text{ Sensitivity} = \frac{\text{TP}}{\text{TP} + \text{FN}} \times 100 = \frac{103}{103 + 12} \times 100 = \frac{103 \times 100}{115}$$

Sensitivity therefore = 89.6%

$$2. \text{ Specificity} = \frac{\text{TN}}{\text{TN} + \text{FP}} \times 100 = \frac{270}{270 + 0} \times 100 = \frac{270}{270} \times 100$$

Specificity therefore = 100%

$$3. \text{ Positive Predictive Value} = \frac{\text{TP}}{\text{TP} + \text{FP}} \times 100 = \frac{103}{103 + 0} \times 100 = \frac{103 \times 100}{103}$$

Positive Predictive Value therefore = 100%

$$4. \text{ Negative Predictive Value} = \frac{\text{TN}}{\text{TN} + \text{FN}} \times 100 = \frac{270}{270 + 12} \times 100 = \frac{270}{282} \times 100$$

Negative Predictive Value therefore = 95.8%

$$5. \text{ False Positive rate} = \frac{\text{FP}}{\text{FP} + \text{TN}} \times 100 = \frac{0}{0 + 270} \times 100 = \frac{0}{270} \times 100$$

False Positive rate therefore = 0.0%

$$6. \text{ False Negative rate} = \frac{\text{FN}}{\text{FN} + \text{TP}} \times 100 = \frac{12}{12 + 103} \times 100 = \frac{12}{115} \times 100$$

False Negative rate therefore = 10.4%

$$7. \text{ Accuracy/efficiency of the test} = \frac{\text{TP} + \text{TN}}{\text{TP} + \text{FN} + \text{FP} + \text{TN}} \times 100 = \frac{103 + 270}{103 + 12 + 0 + 270} \times 100$$

$$= \frac{373}{385} \times 100 = \underline{\underline{96.9\%}}$$

8. While the Prevalence of malaria (using microscopy) = $\frac{TP + FN}{TP + FP + FN + TN} \times 100$ =

$$\frac{103 + 12}{+ 0 + 12 + 270} \times 100 = \frac{115 \times 100}{385} = \underline{29.9\%}$$

103

APPENDIX B:

Layout of a 96 well Microtitre culture plate

