Field performance of malaria rapid diagnostic test for the detection of *Plasmodium falciparum* infection in Odisha State, India

S.S. Sahu, K. Gunasekaran & P. Jambulingam

*Vector Control Research Centre (ICMR), Puducherry, India*

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**Background & objectives:** Rapid diagnostic tests (RDTs) have become an essential surveillance tool in the malaria control programme in India. The current study aimed to assess the performance of ParaHIT-f, a rapid test in diagnosis of *Plasmodium falciparum* infection through detecting its specific antigen, histidine rich protein 2 (PfHRP-2), in Odisha State, India.

**Methods:** The study was undertaken in eight falciparum malaria endemic southern districts of Odisha State. Febrile patients included through active case detection, were diagnosed by Accredited Social Health Activists (ASHAs) for *P. falciparum* infection using the RDT, ParaHIT-f. The performance of ParaHIT-f was evaluated using microscopy as the gold standard.

**Results:** A total of 1030 febrile patients were screened by both microscopy and the RDT for *P. falciparum* infection. The sensitivity of ParaHIT-f was 63.6% (95% CI: 56.0-70.6) and specificity was 98.9% (95% CI: 97.9-99.5), with positive and negative predictive values (PPV and NPV) of 92.6% (95% CI: 86.0-96.3) and 93.0% (95% CI: 91.0-94.5), respectively. When related to parasitaemia, the RDT sensitivity was 47.8% at the low parasitaemia of 4 to 40 parasites/µl of blood.

**Interpretation & conclusions:** The results showed that the performance of the RDT, ParaHIT-f, was not as sensitive as microscopy in detecting true *falciparum* infections; a high specificity presented a low frequency of false-positive RDT results. The sensitivity of ParaHIT-f was around 60 per cent. It is, therefore, essential to improve the efficiency (sensitivity) of the kit so that the true *falciparum* infections will not be missed especially in areas where *P. falciparum* has been the predominant species causing cerebral malaria.

**Key words** Microscopy - Odisha - ParaHIT-f - *Plasmodium falciparum* - *P. vivax* - rapid diagnostic test

Malaria presents a diagnostic challenge to laboratories in most countries. An accurate species-specific diagnosis is becoming increasingly important, in view of the rising problem of drug resistance in *Plasmodium falciparum*, the parasite species causing cerebral malaria. Microscopy of stained thick and thin blood smears remains the gold standard for confirmation of diagnosis of malaria. However, microscopy requires a functioning laboratory, significant skills, and time that limit the access to the...
facilities and thereby causing therapeutic delays. Where
diagnosis by microscopy is not possible, an alternative
is the use of a rapid diagnostic test (RDT) which is
simple to perform, requires no equipment or electricity
and gives a result within 15 to 20 min. Further, the
use of RDTs will minimize delays in treating malaria
cases, especially *P. falciparum* infections that are
known to cause complications. There are currently
over 200 rapid diagnostic test products commercially
available. WHO and the Foundation for Innovative
New Diagnostics (FIND) evaluated the sensitivity of
168 RDTs for the diagnosis of *P. falciparum* and *P.
vivax* malaria. The threshold of detection by these
rapid diagnostic tests is in the range of 100 parasites/μl
of blood compared to 5 to 10 parasites by thick film
microscopy. RDTs that are based on recognition of
the circulating parasite antigens, detect a variety of
proteins, including *P. falciparum* histidine-rich protein
2 (PfHRP2) and *P. falciparum* lactate dehydrogenase
(PfLDH), and also *Plasmodium* lactate dehydrogenase
(PfLDH) and aldolase, enzymes shared by the five human pathogenic
*Plasmodium* species. Since 2009, the National Vector
Borne Disease Control Programme (NVBDPC) in
India has been supplying ParaHIT-f, a rapid diagnostic
test that detects PfHRP2, to Odisha State for diagnosis
of *P. falciparum* infection in areas, where microscopy
results are not obtainable within 24 h of blood smear
collection. RDTs are manufactured by different
companies and hence there may be differences in their
accuracy in diagnosing malaria infections. To date, no
information on the performance of RDTs supplied by
the NVBDPC to the Accredited Social Health Activists
(ASHAs) in *falciparum* endemic villages of Odisha
State is available. Therefore, the current study was
carried out with an aim to find out the accuracy of the
RDT, ParaHIT-f by comparing its diagnosis results
with a high quality microscopy in eight southern
districts of Odisha State, inhabited predominantly by
tribes and are hyperendemic for *falciparum* malaria
since many decades.

**Material & Methods**

**Study area**: The performance of the RDT, ParaHIT-f
was assessed during September 2010 to August
2011 in the eight southern districts viz. Rayagada,
Nowrangpur, Kalahandi, Nuapada, Bolangir, Khandhamal,
Gajapati and Ganjam of Odisha State, as a part of a study on vector bionomics in relation
to transmission of malaria and its control. Most of
these districts are located in hilly and forested areas.
Malaria has been endemic in these districts with
two transmission peaks in a year; one during post
rainy months (October to November) and the other
during summer (March to May). The annual parasite
incidence (API) in the districts during 2009 ranged
from 4.2 (Ganjam district) to 49.6 (Khandhamal
district) with 89 reported malaria deaths. Among
the total malaria cases, infection due to *P. falciparum*
accounted for $>90$ per cent in this region, with the
remainder being predominantly *P. vivax*.

**Selection of villages**: For this study, 0.5 per cent of the
villages in each of the eight districts were selected,
giving a total of 65 villages. Selection of villages from
all the blocks (sub-districts) of each district was not
possible due to practical constraints. Therefore, two
blocks were randomly selected in each district, with
all villages of the selected block then divided into three
categories according to ecotype (hill-top, foot-hill and
plain). Finally, 0.5 per cent of the villages in each
district were randomly selected proportionate to the
total number of villages present under each ecotype-
category in the two selected blocks.

**Fever study**: Three fever surveys, one during each of
the three prevailing seasons; summer, rainy and winter,
were carried out in the 65 selected villages, covering
a population of 19,615. The fever surveillance using the
RDT kit, ParaHIT-f was done in the morning hours by
the ASHAs of the respective villages in the presence
of research team from Vector Control Research Centre,
(VCRC), Puducherry, which ensured the quality of
testing by ASHAs. Every member of household present
at the time of survey was covered.

**Microscopic examination**: Thick and thin smears were
prepared by ASHAs on clean slides using the finger
prick blood samples obtained from any household
member with an axillary temperature of $>37.5$°C. All
blood smears were stained with 1:10 Giemsa diluted in
pH 7.2 phosphate buffer and examined for the presence
of malaria parasites at 5x100 magnification with oil
immersion lens searching 100 fields (0.25 μl of blood)
in each thick smear. Blood smears were examined
in the field-camp laboratory by an experienced
microscopist of the research team to whom the results
of the RDTs were blinded. Smears were considered
negative, if no parasite was seen in 100 oil immersion
fields on a thick blood smear. To indicate the level of
parasitaemia or parasite density in the positive cases,
the number of parasites in thick smears was graded
using the plus system scale: + (1 to 10 parasites per
100 thick film fields); ++ (11 to 100 parasites per
100 thick film fields); +++ (1 to 10 parasites per one
thick film field); +++++ (>10 parasites per one thick film field). Using these scores, the parasite density was estimated: + = 4 to 40 parasites/μl; ++ = 40 to 400 parasites/μl; +++ = 400 to 4,000 parasites/μl; ++++ = >4,000 parasites/μl.

Quality check: As a standard quality control procedure\(^6\), all positive blood smears and 10 per cent of randomly selected negative blood smears were cross-examined. The results of the slides selected for cross-checking were blinded to the microscopist who cross-examined the slides independently and the results were obtained. In case of discrepancies, the investigator re-examined the slides and confirmed the results.

**RDT for malaria diagnosis:** The RDTs used by the ASHAs in the field were procured and supplied by the NVBDCP. Prior to initiation of this study, the ASHAs were trained by the Medical Officers of the respective Community Health Centres (CHCs). Moreover, in the current study, the ASHAs conducted the rapid diagnostic tests in the presence of the research team. Concurrent with collection of blood smears from the patients with fever, RDTs were performed by ASHAs in the presence of the research team on the same finger prick blood samples, transferring them directly to the sample pad using the sample applicator. All RDTs were labelled with patient ID and results were recorded 15 min after adding four drops (300 μl) of clearing buffer. Appearance of both control and test bands indicated a *P. falciparum* infection and presence of only the control band indicated a negative result. In cases, where the control band did not appear, the results were considered invalid and the tests repeated. During the study, different lots/batches of RDTs were used. Internal quality check included an immediate second reading of all RDTs by a different person to whom the results of the first reading were blinded. In case of discordance, one of the trained technicians, who did entomological collections simultaneously in the village re-examined independently the RDT results\(^8\). Also, the results of the RDTs were blinded to the microscopist who examined the corresponding blood smears of the fever patients.

The fever patients diagnosed with *P. falciparum* infection using ParaHIT-f were administered with artemisinin combination therapy (ACT) [Artesunate 4mg/kg body weight for 3 days plus sulphadoxine (25 mg/kg body weight) and pyrimethamine (1.25 mg/kg bodyweight) on the first day and primaquine (0.75 mg/kg body weight) on second day] by ASHAs according to the national guidelines\(^10\). Further, on the basis of microscopy results, the *P. falciparum* infections that were not detected by the RDTs, were administered with ACT and *P. vivax* cases with radical treatment (Chloroquine 25 mg/kg body weight divided over three days i.e. 10 mg/kg body weight on day 1, 10 mg/kg body weight on day 2 and 5mg/kg body weight on day 3 and Primaquine 0.25mg/kg body weight daily for 14 days\(^10\) by ASHAs. All *P. vivax* cases were removed from the data-set for further analysis. The mixed infections of *P. falciparum* and *P. vivax* were treated as *P. falciparum* infections for the analysis purpose. The isolated presence of *P. falciparum* gametocytes was not considered indicative of acute malaria.

**Statistical analysis:** Based on the microscopic results, the RDT results were considered true positive (TP), true negative (TN), false positive (FP), and false negative (FN). Sensitivity and specificity were calculated as TP/ (TP+FN) and TN/ (TN+FP), respectively. Positive predictive value (PPV) [the proportion of true malaria cases (positive blood smears) among the total number of positive RDTs] and negative predictive value (NPV) [the proportion of true negative malaria cases (negative blood smears) among the total number of negative RDTs] were also calculated. Sensitivity of the RDT was further calculated according to the level of parasitaemia. Sensitivity, specificity and predictive values of ParaHIT-f and their respective 95% confidence intervals (CI) were estimated using microscopy as the reference diagnosis (gold standard)\(^11\) using the software EPIINFO 6.0 version (Centre for Disease Control and Prevention, Atlanta Georgia, USA). Season-wise analysis of sensitivity and specificity of the RDT was also done.

**Results**

A total of 1059 fever patients (534 males and 525 females) of age ranged from 2 months (infants) to 70 yr, were screened through the fever surveys for malaria infection using the RDT kits, ParaHIT-f along with microscopic examination of blood smears. During the survey, only two strips of ParaHIT-f did not show the control band and the tests were repeated with two other valid strips.

The microscopy detected a total of 205 malaria positives and of them, 164 (80.0%), 29 (14.1%) and 12 (5.9%) were *P. falciparum*, *P. vivax* and mixed infections with *P. falciparum* and *P. vivax* parasites, respectively. Since, the study focused on the accuracy
of the monovalent RDT that can detect only \( P. falciparum \), in comparison to microscopy, the 29 fever patients found positive for \( P. vivax \) infection were removed and the results of the remaining 1030 fever cases (including the 12 fever cases detected with mixed infections) were considered for further analysis. Of the 176 (164 single infections with only \( P. falciparum \) + 12 mixed infections with \( P. falciparum \) and \( P. vivax \)) \( P. falciparum \) positives by microscopy, only in eight cases gametocytes were found along with asexual stages and hence included for the analysis. No blood smear was found positive exclusively for \( P. falciparum \) gametocytes.

Of the 1030 fever cases screened, 121 (11.7%) and 176 (17.1%) were \( P. falciparum \) positives by ParaHIT-\( f \), and by microscopy, respectively (Table I). As shown in Table II, the RDT accurately diagnosed 112/176 true \( P. falciparum \) cases, indicating a sensitivity of 63.6% (95% CI: 56.0-70.6). Of the 854 negatives by microscopy, RDT detected 845 negatives and nine false positives, showing a specificity of 98.9% (95% CI: 97.9-99.5). The positive predictive (PPV) and the negative predictive values (NPV) were 92.6% (95% CI: 86.0-96.3) and 93.0% (95% CI: 91.0-94.5), respectively. Season-wise analysis showed that the sensitivity of ParaHIT-\( f \) was 75.0% (95% CI: 61.7-88.3), 65.7% (95% CI: 53.6-77.8) and 52.5% (95% CI: 39.1-65.8) in summer, rainy and winter seasons, respectively and the corresponding specificity was 97.0 (95% CI: 94.6-99.4), 99.3 (95% CI: 98.2-100) and 100.0% (95% CI: 99.9-100).

The sensitivity of the RDT, ParaHIT-\( f \) in detecting \( P. falciparum \) infection in relation to the degree/ level of parasitaemia is illustrated in Table III. Among the 176 positives by microscopy, the maximum number (69) was with a parasite density of +, followed by ++ (65); the positive cases with +++ (20) and ++++ (22) density were lower in number. When related to the level of parasitaemia, the sensitivity of the RDT was found to be 47.8% (95% CI: 36.0-59.6), 64.6% (95% CI: 53.0-76.2), 80.0% (95% CI: 62.5-97.5) and 95.5% (95% CI: 84.5-100.0) at the parasite density of +, ++, +++ and ++++, respectively.

### Table I. Detection of \( P. falciparum \) infection by microscopy and RDT (ParaHIT-\( f \)) in the eight southern districts of Odisha State

<table>
<thead>
<tr>
<th>District</th>
<th>(Number of villages surveyed)</th>
<th>Blood samples examined by microscopy and RDT</th>
<th>( P. falciparum ) positives by Microscopy</th>
<th>Microscopy positives but RDT negatives</th>
<th>Microscopy negatives but RDT positives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rayagada(7)</td>
<td>120</td>
<td>39</td>
<td>27</td>
<td>112</td>
<td>1</td>
</tr>
<tr>
<td>Nowrangpur(9)</td>
<td>133</td>
<td>19</td>
<td>8</td>
<td>12</td>
<td>1</td>
</tr>
<tr>
<td>Bolangir(8)</td>
<td>156</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Nuapada(7)</td>
<td>58</td>
<td>6</td>
<td>4</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Kandhamal(8)</td>
<td>133</td>
<td>11</td>
<td>9</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Ganjam(7)</td>
<td>146</td>
<td>23</td>
<td>17</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>Gajapati(8)</td>
<td>134</td>
<td>53</td>
<td>39</td>
<td>39</td>
<td>14</td>
</tr>
<tr>
<td>Kalahandi(11)</td>
<td>150</td>
<td>25</td>
<td>17</td>
<td>16</td>
<td>9</td>
</tr>
<tr>
<td>Total(65)</td>
<td>1030</td>
<td>176</td>
<td>121</td>
<td>64</td>
<td>9</td>
</tr>
</tbody>
</table>

### Table II. Results of microscopy in comparison to that of rapid diagnostic tests (ParaHIT-\( f \)) for detection of \( P. falciparum \) infection

<table>
<thead>
<tr>
<th>Microscopy</th>
<th>Rapid diagnostic test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive</td>
<td>Negative</td>
</tr>
<tr>
<td>Positive (176)</td>
<td>112</td>
</tr>
<tr>
<td>Negative (854)</td>
<td>9</td>
</tr>
<tr>
<td>Total (1030)</td>
<td>121</td>
</tr>
</tbody>
</table>

Sensitivity (RDT): 63.6% (95% CI: 56.0-70.6)
Specificity (RDT): 98.9% (95% CI: 97.9-99.5)
Positive predictive value: 92.6% (95% CI: 86.0-96.3)
Negative predictive value: 93.0% (95% CI: 91.0-94.5)
Discussion

Malaria continues to be one of the major public health problems in India. The existing and the accepted gold standard technique for malaria diagnosis is the microscopic examination of stained thick and thin blood films. However, in many places there are no laboratory support to provide the malaria microscopy. Wherever it is available, several factors reportedly affect the quality of diagnosis by microscopy. In Odisha State, particularly in the southern districts, where high malaria transmission continued to occur, fever is often treated presumptively as malaria, resulting in misdiagnosis and overuse of anti-malarial drugs as reported elsewhere. Therefore, there is a need for rapid and accurate diagnosis of malaria to ensure rational use of anti-malarial drugs. To offer such diagnostic facility, many rapid diagnostic tests (RDTs) have been developed. One such test kit is ParaHIT-f supplied by the NVBDCP, for the diagnosis of *P. falciparum* malaria in Odisha State. In Tanzania and other African countries also, ParaHIT-f is used for malaria diagnosis.

There are 30 districts in Odisha State and among them the 10 districts, situated in the southern part of the State, are highly endemic for *falciparum* malaria since many decades. The current study, carried out on the request of the Government of Odisha, generated entomological and epidemiological information in the eight districts to formulate evidence based suitable site specific strategies for the control of malaria. However, restricting only to the endemic districts could be a limitation of the study as continuous exposure to malaria parasites might help in acquiring some kind/amount of immunity against malaria parasites and reduce the parasite load among patients; as a result, the RDTs, which have limitations in detecting malaria positives with low parasitaemia, would not diagnose all true malaria cases in the field and their sensitivity would become lower.

In the current study, the sensitivity of ParaHIT-f in detecting *P. falciparum* infection was found to be low, but the studies conducted outside India reported a still lower sensitivity; 29.8 in Tanzania and 9.6 per cent in Philippines. Another study conducted in a rural area of Tanzania reported that of the total 743 samples screened, 31.8 per cent (236/743) was found positive for *P. falciparum* infection by microscopy, while only 3.4 per cent was detected positive by the RDT (ParaHIT-f); showing a sensitivity of 10.7 per cent (95% CI, 6.7-14.7), specificity of 100% (95% CI, 97.4-102), PPV of 100% (95% CI, 99.1-100.2) and NPV of 70.9% (95% CI, 66.9-74.9). In our study, nearly 36 per cent of the *P. falciparum* cases were not correctly diagnosed by the RDT (ParaHIT-f), thereby missing a number of *P. falciparum* positives. Consequently, such missed positive cases in the field without any treatment may constitute an important reservoir for transmission. The level of agreement between microscopy and the RDT warrants more investigations in different transmission settings and clinical situations. In an earlier study, the performance characteristics of ParaHIT-f was assessed among the ethnic tribes in four districts of Central India with different transmission levels and the overall sensitivity, specificity and accuracy of the RDT were reported to be >90 per cent. HRP2-based ParaHIT-f RDTs were introduced for routine patient care in Rufiji district, Tanzania, from December 2007 to

<table>
<thead>
<tr>
<th>Parasite density</th>
<th>Positives by microscopy</th>
<th>Rapid diagnostic test</th>
<th>Sensitivity (%)</th>
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<tbody>
<tr>
<td></td>
<td>Positive</td>
<td>Negative</td>
<td></td>
</tr>
<tr>
<td>+ , 4 to 40 parasites/µl of blood</td>
<td>69</td>
<td>33</td>
<td>36</td>
</tr>
<tr>
<td>++, &gt;40 to 400 parasites approximately/µl of blood</td>
<td>65</td>
<td>42</td>
<td>23</td>
</tr>
<tr>
<td>++++, &gt;400 to 4000 parasites/µl of blood</td>
<td>20</td>
<td>16</td>
<td>4</td>
</tr>
<tr>
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<td>21</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
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October 2008, and their performance was assessed; the sensitivity was 90.7 per cent (range 85.7-96.5%) and the specificity was 73.5 per cent (range 50.0-84.3%)17.

Four brands of RDTs, when tested for their field performance in malaria diagnosis in Philippines, showed wide variability in their sensitivity during repeated surveys and such variability was found associated with both high and low parasitaemia16. Some other studies reported a wide variability in sensitivity at lower parasite densities and occurrence of false negative results at higher parasitaemia18-20. In the current study, the sensitivity of ParaHIT-f was found to be lower with a higher proportion of false negatives, at lower parasite densities (+ and ++). When the parasitaemia was at +++ and ++++ levels, the sensitivity was also higher. Since, the study was conducted along with the routine malaria control programme in the State and the blood smears were examined in the field-camp laboratory, it was not possible to count the parasites following the standard techniques and hence the + system was used to grade the parasitaemia. A 95 per cent sensitivity at 100 malaria parasites/µl of blood has been recommended as a target for RDT performance by the WHO31. In this context, the results of the current study pointed out that the RDT met the WHO performance criteria only at the parasitaemic level of >4000/µl or at a parasite density of ++++, otherwise its field performance was poor.

Although, all the RDT kits were used before the expiry date, the poor performance of ParaHIT-f recorded in the current study could be due to manufacturing defects of the test strips or problems related to transport, utilization and storage at peripheral level as reported elsewhere6,22. The RDT kits were not stored according to the manufacturer’s instructions; refrigerators were not available with ASHAs and hence the RDT kits were stored at room temperature. The ambient conditions at the time of testing can also affect the quality of the tests as high temperature and humidity were reported to cause a loss of monoclonal antibodies from the strip33. Although, the southern districts of Odisha State record more than 40 °C during May-June every year6, the seasonal analysis of the results showed that neither temperature nor humidity interfered with the accuracy of ParaHIT-f, as the sensitivity of this RDT was found to be higher in summer than in rainy and winter seasons. It has also been pointed out in Round 3 of the WHO/TDR/ FIND/CDC evaluation that this RDT is heat stable and can withstand high temperature (40°C) for a couple of months34. Therefore, the temperature and humidity might not be the cause for the low sensitivity of ParaHIT-f. The other possible reason could be the fact that a major proportion (76.1%) of positive cases had low parasitaemia (+ and ++), perhaps due to intake of drugs by them or a high acquired immunity on continuous exposure to parasites. Yet another limitation of the study was that the history of anti-malarial drugs intake by the patients in the last two weeks was not recorded as the tests were performed by ASHAs in the villages as a part of their routine activities under malaria control programme.

The poor sensitivity of the RDT, ParaHIT-f, compared to microscopy, in detecting P. falciparum infection might hinder its reliability or utilization for malaria diagnosis especially in areas where microscopic facility is poor or not available. There is a need to further improve the quality of ParaHIT-f by enhancing its sensitivity in diagnosing falciparum malaria.

Acknowledgment

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Conflicts of Interest: None.

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Reprint requests: Dr K. Gunasekaran, Vector Control Research Centre (ICMR), Medical Complex, Indira Nagar, Puducherry 605 006, India

e-mail: k_guna@yahoo.com