
Himanshu Gupta, Eusebio Macete, Helder Bulo, Crizolgo Salvador, Marian Warsame, Eva Carvalho, Didier Ménard, Pascal Ringwald, Quique Bassat, Sonia Enosse, Alfredo Mayor

One of the fundamental steps toward malaria control is the use of antimalarial drugs. The success of antimalarial treatment can be affected by the presence of drug-resistant populations of *Plasmodium falciparum*. To assess resistance, we used molecular methods to examine 351 *P. falciparum* isolates collected from 4 sentinel sites in Mozambique for K13, pfmdr1, pfcrt, and pfdhps polymorphisms and for plasmeisp2 (pfpm2) and pfmdr1 copy numbers. We found multiple copies of pfpm2 in 1.1% of isolates. All isolates carried K13 wild-type alleles (3D7-like), except 4 novel polymorphisms (Leu619Leu, Phe656Ile, Val666Val, Gly690Gly). Prevalence of isolates with pfcrt mutant (K76T) allele was low (2.3%). Prevalence of isolates with pfdhps mutant alleles (A437G and K540E) was >80%, indicating persistence of sulfadoxine/pyrimethamine resistance; however, markers of artemisinin were absent, and markers of piperquine resistance were low. Piperquine resistance isolates may spread in Mozambique as dihydroartemisinin/piperquine drug pressure increases.

During the past decade, malaria control strategies have substantially reduced the malaria burden worldwide; several countries are advancing toward malaria elimination (1,2). A fundamental pillar for contributing to the reduction of the malaria burden has been artemisinin-based combination therapy. Unfortunately, the effectiveness of antimalarial drugs used for malaria treatment and chemoprevention during pregnancy has been threatened by the emergence of drug-resistant parasite populations (2–5).

The emergence of artemisinin resistance in *Plasmodium falciparum*, with reduced in vivo susceptibility to artesunate, was reported in Southeast Asia (3,6). Detectable polymorphisms in the Kelch 13 (K13) propeller domain in *P. falciparum* associated with artemisinin resistance have subsequently provided an additional tool for monitoring resistance to antimalarial drugs (7,8). In Cambodia, polymorphisms in the K13 propeller domain (mainly Y493H, R539T, I543T, and C580Y) were associated with in vitro prolonged parasite survival rates and in vivo delayed parasite clearance rates (8,9). Recently, plasmeisp2 (pfpm2) copy number and pfcrt C101F polymorphism have been associated with piperquine resistance (10–12). In addition, increased pfmdr1 copies have been associated with resistance to mefloquine (in vivo, in vitro, or both) and partially to lumefantrine (13–18). Specific point polymorphisms (at codons 86, 184, 1034, 1042, and 1246) of the pfmdr1 gene have also been linked to resistance to antimalarial drugs (19,20). In field isolates tested in vitro as well as in laboratory lines, N86Y polymorphism was associated with chloroquine resistance (21). Further, polymorphisms in the pfcrt gene have also been shown to affect parasite susceptibility to chloroquine (22), amodiaquine (23,24), and artemether/lumefantrine (25). Recently, a nonsynonymous polymorphism in the pfcrt gene was shown to be prevalent in the genetic background of K13 mutant artemisinin-resistant isolates (26). In addition, polymorphisms in pfldhfr and pfldhps genes, specifically the quintuple mutant, including the pfldhfr substitutions N51I, C59R, and S108N, as well as the pfldhps substitutions A437G and K540E, have been associated with a failure of sulfadoxine/pyrimethamine treatment against uncomplicated *P. falciparum* malaria (27). In Africa, the pfldhps K540E polymorphism has been considered a useful epidemiologic marker of the quintuple mutations (28).

Author affiliations: ISGlobal, Barcelona Institute for Global Health, Hospital Clínico, Universitat de Barcelona, Barcelona, Spain (H. Gupta, Q. Bassat, A. Mayor); Centro de Investigación em Saúde de Manhiça, Maputo, Mozambique (E. Macete, H. Bulo, Q. Bassat, A. Mayor); Instituto Nacional de Saúde, Ministério da Saúde, Maputo (C. Salvador, S. Enosse); World Health Organization Global Malaria Programme, Geneva, Switzerland (M. Warsame, P. Ringwald); World Health Organization, Maputo (E. Carvalho); Malaria Molecular 16 Epidemiology Unit, Institut Pasteur du Cambodge, Phnom Penh, Cambodia (D. Ménard); Institut Pasteur, Paris, France (D. Ménard); ICREA, Barcelona (Q. Bassat); Pediatrics Department, Hospital Sant Joan de Déu (University of Barcelona), Barcelona, Spain (Q. Bassat)

DOI: https://doi.org/10.3201/eid2401.170864

These authors contributed equally to this article.
Drug-Resistant Polymorphisms in *P. falciparum*

The development of drug resistance could be influenced by multiple factors such as polymorphism rate, fitness costs, overall parasite load, strength of drug selection, treatment compliance, transmission intensity, host immunity, and erythrocyte disorders (29–31). Naturally acquired immunity plays a major role in the emergence and clearance of artemisinin-resistant parasites (32). Because of increasing concern over the effectiveness of the nationally recommended antimalarial drugs, the Mozambique Ministry of Health has made several changes in antimalarial drug policy. In 2002, chloroquine monotherapy was replaced with sulfadoxine/pyrimethamine/amodiaquine as the first line of treatment against uncomplicated malaria (33); 2 years later, this combination was replaced with artesunate/sulfadoxine/pyrimethamine (33). In 2008, artemether/lumefantrine was introduced to replace artesunate/sulfadoxine/pyrimethamine (34). Molecular markers for antimalarial drug resistance have been considered useful for confirming parasite resistance, a major factor causing treatment failure. To determine whether parasites carrying these polymorphisms or gene amplifications exist in Mozambique, we conducted molecular surveillance targeting *K13*, *pfmdr1*, *pfcrt*, and *pfdhps* polymorphisms and *pfpm2* and *pfmdr1* copy numbers in field isolates collected from 4 sentinel sites.

**Materials and Methods**

**Study Sites and Population**

We performed a descriptive observational study on blood samples collected before artemether/lumefantrine treatment (on day 0) in 2015 from 352 symptomatic children at 4 sentinel sites in Mozambique (Figure 1): 1) Hospital Rural de Montepuez in Cabo Delgado Province (northern region), 2) Centro de Saúde de Dondo in Sofala Province (central region), 3) Hospital Provincial de Moatize in Tete Province (central region), and 4) Hospital Rural de Chokwe in Gaza Province (southern region). In Mozambique, transmission usually peaks during the rainy season (November–April). Transmission intensity in southern Mozambique is generally low, although areas of high transmission may still occur (33). To determine molecular markers of drug resistance, we analyzed samples collected during a clinical trial conducted in 2015 (registration no. ACTRN12616001680459); the trial aimed to assess the efficacy and safety of artemether/lumefantrine for treatment of uncomplicated *P. falciparum* malaria in children <5 years of age. The National Mozambican Ethical Review Committee (Mozambique) and Hospital Clinic (Barcelona, Spain) ethics review committees approved the study, and signed written informed consent was obtained from all participants’ guardian or parent.

**Molecular Procedures**

We extracted DNA from half of a 50-µL dried blood drop on Whatman 3-mm filter paper by using a QIAamp DNA Mini kit (QIAGEN, Hilden, Germany) according to the manufacturer’s instructions. We used an ABI PRISM 7500 HT Real-Time System (Applied Biosystems, Foster City, CA, USA) to amplify purified parasite DNA templates, following a previously described method (36,37). A standard curve was prepared from an in vitro culture of 3D7 strain containing known numbers of ring-infected erythrocytes. The development of drug resistance could be influenced by multiple factors such as polymorphism rate, fitness costs, overall parasite load, strength of drug selection, treatment compliance, transmission intensity, host immunity, and erythrocyte disorders (29–31). Naturally acquired immunity plays a major role in the emergence and clearance of artemisinin-resistant parasites (32). Because of increasing concern over the effectiveness of the nationally recommended antimalarial drugs, the Mozambique Ministry of Health has made several changes in antimalarial drug policy. In 2002, chloroquine monotherapy was replaced with sulfadoxine/pyrimethamine/amodiaquine as the first line of treatment against uncomplicated malaria (33); 2 years later, this combination was replaced with artesunate/sulfadoxine/pyrimethamine (33). In 2008, artemether/lumefantrine was introduced to replace artesunate/sulfadoxine/pyrimethamine (34). Molecular markers for antimalarial drug resistance have been considered useful for confirming parasite resistance, a major factor causing treatment failure. To determine whether parasites carrying these polymorphisms or gene amplifications exist in Mozambique, we conducted molecular surveillance targeting *K13*, *pfmdr1*, *pfcrt*, and *pfdhps* polymorphisms and *pfpm2* and *pfmdr1* copy numbers in field isolates collected from 4 sentinel sites.

**Materials and Methods**

**Study Sites and Population**

We performed a descriptive observational study on blood samples collected before artemether/lumefantrine treatment (on day 0) in 2015 from 352 symptomatic children at 4 sentinel sites in Mozambique (Figure 1): 1) Hospital Rural de Montepuez in Cabo Delgado Province (northern region), 2) Centro de Saúde de Dondo in Sofala Province (central region), 3) Hospital Provincial de Moatize in Tete Province (central region), and 4) Hospital Rural de Chokwe in Gaza Province (southern region). In Mozambique, transmission usually peaks during the rainy season (November–April). Transmission intensity in southern Mozambique is generally low, although areas of high transmission may still occur (33). To determine molecular markers of drug resistance, we analyzed samples collected during a clinical trial conducted in 2015 (registration no. ACTRN12616001680459); the trial aimed to assess the efficacy and safety of artemether/lumefantrine for treatment of uncomplicated *P. falciparum* malaria in children <5 years of age. The National Mozambican Ethical Review Committee (Mozambique) and Hospital Clinic (Barcelona, Spain) ethics review committees approved the study, and signed written informed consent was obtained from all participants’ guardian or parent.

**Molecular Procedures**

We extracted DNA from half of a 50-µL dried blood drop on Whatman 3-mm filter paper by using a QIAamp DNA Mini kit (QIAGEN, Hilden, Germany) according to the manufacturer’s instructions. We used an ABI PRISM 7500 HT Real-Time System (Applied Biosystems, Foster City, CA, USA) to amplify purified parasite DNA templates, following a previously described method (36,37). A standard curve was prepared from an in vitro culture of 3D7 strain containing known numbers of ring-infected erythrocytes.

**Figure 1.** Location of sampling sites and distribution of resistance markers of *Plasmodium falciparum* in Mozambique, 2015.
The standard curve was run in triplicate for each test with 5 serially diluted points. Parasitemia in the clinical samples was quantified by extrapolation against the standard curve.

To assess polymorphisms in the K13, pfcrt, pfmdr1, and pfdhps genes, we amplified purified DNA templates by using a 2720 Thermal Cycler (Applied Biosystems), following protocols described for K13 PCR (38) and pfcrt PCR (35). To genotype polymorphisms in pfmdr1 and pfdhps genes, we designed new assays by using Sanger sequencing and restriction fragment length polymorphisms (online Technical Appendix, https://wwwnc.cdc.gov/EID/article/24/1/17-0864-Techapp1.pdf). A total of 6 positive controls with known K13 alleles, provided by the Institut Pasteur in Cambodia, and 4 parasite lines (3D7, 7G8, Dd2, and V1/S) with known pfcrt and pfmdr1 alleles, available in the laboratory, were also processed, amplified, and sequenced at the same time as the studied samples (PCR characteristics in online Technical Appendix Table). To determine the detection limit of Sanger sequencing, we used artificially mixed DNA samples of *P. falciparum* laboratory strains containing various known proportions of wild- and mutant-type alleles of pfcrt (K76T) and pfmdr1 (Y184F and S1034C) genes. To estimate polymorphism frequency, we considered isolates with mixed alleles to be mutated.

We assessed copy numbers of pfpm2 and pfmdr1 genes as described elsewhere (11) with minor changes (online Technical Appendix) by using quantitative PCR (qPCR). We performed amplification in 20-µL reaction mixtures for pfpm2, pfmdr1, and pfsβ-tubulin genes, separately. We used the pfsβ-tubulin gene as an endogenous control. All samples with estimated copy numbers >1.5 were defined as containing multiple copies and repeated for confirmation. The estimated copy numbers were the average of the copy number of each clone in the isolate.

### Data Analyses

We calculated the proportion of the mutant alleles and isolates with multiple copies of pfpm2 and pfmdr1 genes on the basis of the number of samples with wild- and mutant-type alleles as well as isolates with single and multiple copies of the gene from *P. falciparum* isolates from each study site. To compare continuous data and categorical data between sites, respectively, we performed analyses of variance and χ² tests. We defined statistical significance as p<0.05.

### Results

#### Demographics and *P. falciparum* Infection

Among the 352 blood samples collected before artemether/lumefantrine treatment (on day 0) during 2015, and followed up as part of the clinical trial, 351 (99.7%) were *P. falciparum*–infection positive according to 18S-RNA qPCR. The mean (± SD) parasitemia (by qPCR) was 100.229 ± 325.214 parasites/µL. Among participants, 159 (45.2%) were female, mean (± SD) age was 2.8 ± 1.3 y, mean body temperature was 38.1 ± 1.1°C, and mean hemoglobin level was 9.2 ± 1.9 g/dL. We also compared demographic data and parasite densities according to study site (Table 1). Efficacy of artemether/lumefantrine in the in vivo study was high, and for nearly all patients (349 [99.4%] of 351), parasitemia reverted to 0 in the first 3 days; however, for 2 patients, parasites were still detectable by microscopy: 1 from Moatize (514 parasites/µL) and 1 from Chokwe (3,763 parasites/µL). PCRs targeting msp1, msp2, and glurp genes were used to differentiate recurrence (same parasite strain) and reinfection (different parasite strain). We noted recrudescence of *P. falciparum* infections for 5 children (1 in Chokwe, 3 in Moatize, and 1 in Montepuez) on days 21 and 28 after artemether/lumefantrine administration and reinfection for 7 children (3 in Moatize and 4 in Montepuez); 3 were reinfected on day 21 and 4 on day 28 (39).

The polymorphism analyses of K13, pfmdr1, pfcrt, and pfdhps genes were successful for 98.3% to 100% isolates. Because no amplifications were noticed in negative controls (with water and human genomic DNA), PCR assays were specific to *P. falciparum* genomic DNA only.

#### Detection Limit of Mixed Samples by Sanger Sequencing

We identified “A” alleles of pfcrt (K76T) and pfmdr1 (Y184F) codons in artificially mixed samples by using Sanger sequencing when the proportion of target DNA was ≥10%. However, we identified “C” and “T” alleles of pfcrt (K76T) and pfmdr1 (Y184F) polymorphisms, respectively, in mixed samples when their proportion was ≥20% (online Technical Appendix Figure 1). For pfmdr1 (S1034C) polymorphism, the minor allele was detected when its proportion was ≥20% in a mixed sample (online Technical

### Table 1. Characteristics of study participants with *Plasmodium falciparum* malaria, by site, Mozambique, 2015

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Montepuz, n = 87</th>
<th>Dondo, n = 88</th>
<th>Moatize, n = 89</th>
<th>Chokwe, n = 88</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female, no. (%)</td>
<td>36 (41.4)</td>
<td>40 (45.5)</td>
<td>41 (46.1)</td>
<td>42 (47.7)</td>
<td>0.63</td>
</tr>
<tr>
<td>Age, y, mean ± SD</td>
<td>2.4 ± 1.1</td>
<td>2.7 ± 1.1</td>
<td>2.7 ± 1.1</td>
<td>3.1 ± 1.1</td>
<td>0.0002</td>
</tr>
<tr>
<td>Temperature, °C, mean ± SD</td>
<td>37.9 ± 0.9</td>
<td>38.5 ± 1.1</td>
<td>38.1 ± 1.0</td>
<td>37.9 ± 1.5</td>
<td>0.0043</td>
</tr>
<tr>
<td>Parasite density, parasites/µL, mean ± SD</td>
<td>1.2 × 10⁵ ± 1.3 × 10⁵</td>
<td>3.7 × 10⁴ ± 4.4 × 10⁴</td>
<td>1.2 × 10⁵ ± 6.1 × 10⁵</td>
<td>1.2 × 10⁵ ± 1.8 × 10⁵</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Hemoglobin, g/dL, mean ± SD</td>
<td>8.9 ± 2.2</td>
<td>8.7 ± 1.8</td>
<td>9.8 ± 1.7</td>
<td>9.2 ± 2.0</td>
<td>0.0018</td>
</tr>
</tbody>
</table>

*By quantitative PCR.*
Appendix Figure 1, panel C). For positive controls, we used several parasite lines with known K13, pfmdr1, and pfcrt alleles. As expected, sequencing analysis of all positive controls revealed wild- and mutant-type alleles of K13, pfmdr1, and pfcrt polymorphisms.

**Copy Numbers for pfpm2 and pfmdr1**

We successfully analyzed 351 (100%) samples for copy number variation in the pfpm2 and pfmdr1 genes. PCR efficiencies were 98.4% for pfpm2, 97.2% for pfmdr1, and 99.2% for pfβ-tubulin genes. As expected, the estimated pfpm2 and pfmdr1 copy numbers for the positive controls were 3–4 copies. The estimated mean (interquartile range) copy numbers were 3.51 (3.37–3.62) for pfpm2 and 3.62 (3.51–3.79) for pfmdr1 positive controls. When we used a copy number threshold of 1.5 to define multiple copies, only 4 (1.1%) and 5 (1.4%) of the 351 isolates had multiple copies of pfpm2 and pfmdr1, respectively (Table 2; Figure 2). The range of estimated pfpm2 copy numbers was 0.59–1.79 and of pfmdr1 was 0.58–1.88. The copy number of pfpm2 and pfmdr1 genes did not significantly differ between isolates from different sites. The proportion of isolates with multiple copies of the pfpm2 gene was the highest at Chokwe (2.3% of 87). Only 1 (1.1%) of 88 samples from Dondo had multiple copies of pfpm2 and pfmdr1 genes.

**K13 Polymorphisms**

We successfully achieved K13 PCR and sequencing for all 351 isolates. None of the isolates analyzed contained the polymorphisms most frequently found in isolates from Cambodia (8). However, we observed 4 novel polymorphisms at nt 1725147 (codon 619; 0.28% [1/351]); 1725032 (codon 656; 0.28% [1/351]); 1725000 (codon 666; 0.57% [2/351]); and 1724927 (codon 690; 0.85% [3/351]) of the K13 gene. All polymorphisms were synonymous except for 1 at codon 656, which led to a change from phenylalanine to isoleucine. When we compared frequencies of new polymorphisms between sites, the difference was significant (p<0.0001). In the studied isolates, the mutant (F) allele at codon 101 was absent. Isolates from patients with parasitemia on day 3 and recrudescence contained wild-type pfcrt gene polymorphisms.

**pfmdr1 Polymorphisms**

We successfully amplified all 351 samples for pfcrt and sequenced the amplification products; mutant alleles were found at codons M74I, N75E, and K76T only in 8 (2.3%) samples. The mutant alleles (M74I, N75E, and K76T) were present only in isolates collected from Chokwe (8 [9.2%] of 87). When we compared frequencies of mutant alleles between sites, the difference was significant (p<0.0001). In the studied isolates, the mutant (F) allele at codon 101 was absent. Isolates from patients with parasitemia on day 3 and recrudescence contained wild-type pfcrt gene polymorphisms.

**pfpm2 Polymorphisms**

We successfully amplified and sequenced pfmdr1_f1 for 351 (100%) samples and pfmdr1_f2 fragments for 350 (99.7%) samples. We identified 15 polymorphisms all across the pfmdr1 gene, including 5 (33.3%) with nonsynonymous polymorphisms and 10 (66.7%) with synonymous polymorphisms. Among nonsynonymous polymorphisms, 3 (T1192A, F1194S, and Y1197N) were newly identified and 2 (N86Y and Y184F) had been previously reported (41). Among synonymous polymorphisms, 7 (L1030L, D1061D, D1127D, S1137S, L1174L, D1179D, and N1189N) were newly identified and 3 (G102G, G182G, and T1069T) had been previously reported (41). Among the 351 isolates, we found 11 (3.1%) N86Y and 164 (46.7%) Y184F mutant alleles (Table 3). All newly identified nonsynonymous mutant alleles were present only once, except for Y1197N, which was found twice (0.6% [2/350]). The frequency of polymorphisms (N86Y and D1179D) differed significantly between isolates from the 4 sites (Table 3). The proportion of N86Y and D1179D polymorphisms was highest in isolates from Chokwe. We observed none of the other most frequent polymorphisms (S1034C, N1042D, and T1246Y) of the pfmdr1 gene among the analyzed samples. Isolates from patients with parasitemia on day 3 and recrudescence contained wild-type pfmdr1 gene polymorphisms.

**pfhps Polymorphisms**

Polymorphism analysis by PCR followed by sequencing for S436F and A437G polymorphisms was successful for 345 (98.3%) samples and analysis by PCR–restricted fragment length polymorphism for K540E polymorphism for 348 (99.1%) samples. Among all isolates, 10 (2.9%) of 345

<table>
<thead>
<tr>
<th>Site</th>
<th>pfpm2 No. (%)</th>
<th>pfmdr1 No. (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>≤1.2</td>
<td>1.2–1.5</td>
</tr>
<tr>
<td>Montepuez, n = 87</td>
<td>82 (94.3)</td>
<td>5 (5.7)</td>
</tr>
<tr>
<td>Dondo, n = 88</td>
<td>66 (75.0)</td>
<td>21 (23.9)</td>
</tr>
<tr>
<td>Moatize, n = 89</td>
<td>73 (82.0)</td>
<td>15 (16.9)</td>
</tr>
<tr>
<td>Chokwe, n = 87</td>
<td>77 (88.5)</td>
<td>8 (9.2)</td>
</tr>
</tbody>
</table>

| Drug-Resistant Polymorphisms in *P. falciparum* |
contained S436F, 289 (83.8%) of 345 contained A437G, and 286 (82.2%) of 348 contained K540E mutant alleles. At codon 436, we also found 3 mutant alleles: S436C (0.9%), S436A (4.9%), and S436H (0.6%). When we compared frequencies of 3 single-nucleotide polymorphisms at different sites, we noted significant differences (Table 4). The proportion of isolates with A437G and K540E polymorphisms was the highest at Moatize, and the proportion with S436F, S436C, S436A, and S436H alleles was highest at Montepuez.

Discussion
We provide evidence for the presence of multiple copies of pfpm2 in 4 (1.1%) of 351 P. falciparum isolates circulating in southern Mozambique despite the absence of piperaine drug pressure. Thus, with adequate drug pressure, isolates resistant to piperaine may spread in Mozambique, as occurred in Southeast Asia (10,42,43). In selected areas of Cambodia in 2008, piperaine was introduced as a partner drug of artemisinin (44). Soon after its introduction, as early as 2010, piperaine resistance in western Cambodia emerged at an alarming rate (45). Subsequent reports confirmed a rapid increase in failure of dihydroartemisinin/piperaine in other parts of Cambodia (42,46,47). The most frequent K13 mutants associated with artemisinin resistance were absent in the isolates from Mozambique. We also determined that prevalence of pfcr (K76T) and pfmdr1 (N86Y) markers of resistance are low, supporting previous evidence for the return of parasites carrying pfcr wild-type alleles in Mozambique (35), in contrast to persistence of pfhdps (A437G [83.8%] and K540E [82.2%]) polymorphisms, markers of sulfadoxine/pyrimethamine resistance (34). The well-characterized polymorphism in pfmdr1 (Y184F [46.7%]) was also prevalent in Mozambique.

We found very low prevalence (<1%) for 4 new polymorphisms (Leu619Leu, Phe656Ile, Val666Val, and Gly690Gly) in the K13 gene of P. falciparum isolates from Mozambique. All polymorphisms except Phe656Ile were synonymous. Previously, V494I K13 nonsynonymous polymorphism has also been reported in Mozambique (48). In Africa, K13 nonsynonymous polymorphisms have also been reported at low frequencies in isolates from Cameroon, Central African Republic, Democratic Republic of the Congo, Gabon, The Gambia, Kenya, Madagascar, Malawi, Mali, Rwanda, Togo, Uganda, Zambia, and Equatorial Guinea (38,40,49–50; references 51,52 in online Technical Appendix). The association of nonsynonymous polymorphisms with delayed parasite clearance has only recently been identified in Africa (reference 52 in online Technical Appendix).

Resistance to both chloroquine and amodiaquine has been mainly associated with a single K76T mutant allele in the pfcr gene (22–24). In our study, its prevalence in 8 (2.3%) of 351 samples was significantly lower than that found in previous studies in Mozambique (33,34;
reference 53 in online Technical Appendix). Our pfcr
t data
align with previous evidence for the return of parasites
carrying pfcr wild-type alleles in Mozambique (35) and in
other countries in Africa, such as Ethiopia (reference 54 in
online Technical Appendix), Malawi (reference 55 in on-
line Technical Appendix), and Cameroon (reference 56 in
online Technical Appendix). The selective disadvantage
of mutant parasites in the absence of drug pressure has been
proposed as the leading factor contributing to the reem-
gerence of chloroquine-susceptible parasites (reference 57 in
online Technical Appendix). Because artemether/lumefan-
trine has been shown to select for the wild-type pfcr 76K
allele (25), this reemergence might be accelerated because
of the increased use of artemether/lumefantrine as a first-
line treatment for uncomplicated malaria in Mozambique
(reference 53 in online Technical Appendix).

Our study also provides evidence for the presence of
every few P. falciparum isolates with multiple copies of the
pfmdr1 gene (5 [1.4%] of 351) circulating in southern
Mozambique (34). Increased pfmdr1 copies have been
associated with resistance to mefloquine and partial resis-
tance to lumefantrine (13–18). Our study found that
prevalence of the pfmdr1 N86Y mutant allele has de-
creased and the Y184F mutant allele has increased over
time, in contrast with findings of other studies from Mo-
zambique (34; references 55,58 in online Technical
Appendix). We identified 10 new polymorphisms (L1030L,
D1061D, D1127D, S1137S, L1174L, D1179D, N1189N,
T1192A, F1194S, and Y1197N) that had not been pre-
own described for the pfmdr1 gene. Among the 15
polymorphisms identified in the pfmdr1 gene, we ob-
ser
d significant differences between sites for the N86Y
and D1179D polymorphisms only.

Of 351 children who had received adequate treatment
with artemether/lumefantrine (6 doses), 2 were still posi-
tive for parasitemia on day 3 (39). These isolates contained
wild-type K13 gene polymorphisms. P. falciparum–po-

tive patients for whom artemether/lumefantrine treatment
failed had parasites that carried wild-type pfcr and pfmdr1
polymorphisms. This observation suggests that in vivo
artemether/lumefantrine resistance may be caused not only
by variations in the pfcr and pfmdr1 genes but possibly
by parasite selection of variations in other genes; however,
drug bioavailability issues may also have contributed.

A high proportion of the P. falciparum isolates from
Mozambique contained K540E (82.2%) and A437G
(83.8%) mutant alleles. These mutant alleles may still
not jeopardize the effectiveness of sulfadoxine/pyrimeth-
amine for malaria prevention in Mozambique; recent
findings suggest that only >90% prevalence of a pfdhps
K540E polymorphism could reduce the effectiveness of
intermittent preventive therapy to clear peripheral para-
sites and prevent new infections during pregnancy (refer-
ce 59 in online Technical Appendix). Therefore, sul-
doxine/pyrimethamine remains effective for intermittent
preventive therapy during pregnancy, despite the high
frequency of quintuple mutants; thus, the World Health
Organization continues to recommend the use of intermit-
tent preventive therapy to prevent malaria during preg-
nancy (references 60–62 in online Technical Appendix).

Table 3. Distribution of Plasmodium falciparum pfmdr1 polymorphism (mutated allele) frequencies among 4 sentinel sites,
Mozambique, 2015*

<table>
<thead>
<tr>
<th>SNP</th>
<th>Montepuez, no. (%)</th>
<th>Chokwe, no. (%)</th>
<th>Moatize, no. (%)</th>
<th>Dondo, no. (%)</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>N86Y</td>
<td>1 (1.1)</td>
<td>6 (6.9)</td>
<td>0</td>
<td>4 (4.5)</td>
<td>0.03</td>
</tr>
<tr>
<td>G102G</td>
<td>1 (1.1)</td>
<td>2 (2.3)</td>
<td>2 (2.2)</td>
<td>1 (1.1)</td>
<td>0.88</td>
</tr>
<tr>
<td>G182G</td>
<td>4 (4.6)</td>
<td>1 (1.1)</td>
<td>3 (3.4)</td>
<td>1 (1.1)</td>
<td>0.37</td>
</tr>
<tr>
<td>Y184F</td>
<td>45 (51.7)</td>
<td>39 (44.8)</td>
<td>42 (47.2)</td>
<td>38 (43.2)</td>
<td>0.69</td>
</tr>
<tr>
<td>L1030L</td>
<td>0</td>
<td>0</td>
<td>1 (1.1)</td>
<td>0</td>
<td>0.40</td>
</tr>
<tr>
<td>D1061D</td>
<td>0</td>
<td>1 (1.1)</td>
<td>0</td>
<td>0</td>
<td>0.40</td>
</tr>
<tr>
<td>T1089T</td>
<td>10 (11.5)</td>
<td>5 (5.7)</td>
<td>4 (4.5)</td>
<td>8 (9.2)</td>
<td>0.28</td>
</tr>
<tr>
<td>D1127D</td>
<td>1 (1.1)</td>
<td>7 (7.8)</td>
<td>2 (2.2)</td>
<td>0</td>
<td>0.50</td>
</tr>
<tr>
<td>S1137S</td>
<td>2 (2.3)</td>
<td>0</td>
<td>2 (2.3)</td>
<td>0</td>
<td>0.25</td>
</tr>
<tr>
<td>L1174L</td>
<td>0</td>
<td>9 (10.3)</td>
<td>2 (2.2)</td>
<td>0</td>
<td>0.0001</td>
</tr>
<tr>
<td>D1179D</td>
<td>0</td>
<td>1 (1.1)</td>
<td>0</td>
<td>1 (1.1)</td>
<td>0.57</td>
</tr>
<tr>
<td>N1189N</td>
<td>0</td>
<td>0</td>
<td>1 (1.1)</td>
<td>1 (1.1)</td>
<td>0.40</td>
</tr>
<tr>
<td>T1192A</td>
<td>0</td>
<td>1 (1.1)</td>
<td>0</td>
<td>0</td>
<td>0.40</td>
</tr>
<tr>
<td>F1194S</td>
<td>1 (1.1)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.40</td>
</tr>
<tr>
<td>Y1197N</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1 (1.1)</td>
<td>0.57</td>
</tr>
</tbody>
</table>

*SNP, single-nucleotide polymorphism.

Table 4. Distribution of Plasmodium falciparum pfdhps gene polymorphism (mutated allele) frequencies among 4 sentinel sites,
Mozambique, 2015*

<table>
<thead>
<tr>
<th>SNP</th>
<th>Montepuez, no. (%)</th>
<th>Chokwe, no. (%)</th>
<th>Moatize, no. (%)</th>
<th>Dondo, no. (%)</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>S436F/C/A/H</td>
<td>30 (34.5)</td>
<td>2 (2.4)</td>
<td>0</td>
<td>0</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>A437G</td>
<td>51 (58.6)</td>
<td>79 (84.1)</td>
<td>82 (93.2)</td>
<td>77 (89.5)</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>K540E</td>
<td>50 (57.5)</td>
<td>77 (80.6)</td>
<td>83 (93.3)</td>
<td>76 (87.4)</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>A437G + K540E</td>
<td>47 (54.1)</td>
<td>77 (81.7)</td>
<td>80 (90.5)</td>
<td>76 (88.4)</td>
<td>&lt;0.0001</td>
</tr>
</tbody>
</table>

*SNP, single-nucleotide polymorphism.
However, alternative antimalarial drugs for intermittent preventive therapy during pregnancy are needed because the prevalence of the K540E polymorphism in Mozambique is close to the threshold.

In conclusion, we report that prevalence of isolates with multiple copies of pfpm2 is lower than that found by previous studies in Cambodia (34.3%) and Vietnam (54.3%) (10,43), and we report the absence of K13 polymorphisms known to be associated with artemisinin resistance. We also report the return of parasites carrying pfcrt wild-type alleles (except in Chokwe) and persistence of parasites with pfdhps mutations associated with sulfadoxine/pyrimethamine resistance in Mozambique. Sulfadoxine/pyrimethamine-resistant isolates may be maintained by the constant use of intermittent preventive therapy during pregnancy, use of drug outside of hospitals, the very common use of co-trimoxazole (as prophylaxis for HIV-infected persons), and the low fitness cost of the polymorphisms (33; references 63,64 in online Technical Appendix). In contrast, the fitness cost of the pfcrt mutant allele seems to be high, probably accounting for the return of parasites carrying pfcrt wild-type alleles in Mozambique (reference 57 in online Technical Appendix). Current regional elimination efforts, as part of the G8 Malaria Elimination Initiative, may lead to more aggressive strategies involving population-wide distribution of antimalarial drugs, such as dihydroartemisinin/piperaquine, resulting in significantly increased drug pressure. Our findings might provide baseline prevalence data that enable us to directly determine the effects that increasing malaria control efforts or elimination programs will have on resistance evolution.

Acknowledgments

We thank all study participants, field workers, laboratory workers, and everyone who supported this study directly or indirectly. We also thank Silvie Huijben, Mercedes Rubio, and Nilo Ortiz de Zugasti Carrón for their useful comments on this manuscript.

We thank the World Health Organization for providing the funds for this study, as well as the Instituto de Salud Carlos III (PI13/01478 cofunded by the Fondo Europeo de Desarrollo Regional, and CES10/021-3ISSN) to A.M. A.M. is also supported by the Departament d’Universitats i Recerca de la Generalitat de Catalunya, Agència de Gestió d’Ajuts Universitaris i i de Recerca (2014SGR263). H.G. has a fellowship from the Overseas Postdoctoral Fellowship program by the Science and Engineering Research Board, Department of Science & Technology, Government of India (SB/OS/PDF-043/2015-16). The Centro de Investigacao em Saude de Manhica receives major core funding from the Spanish Agency for International Cooperation. ISGlobal is a member of the CERCA Programme, Generalitat de Catalunya.

M.W. and P.R. are staff members of the World Health Organization. These authors alone are responsible for the views expressed in this publication, and they do not necessarily represent the decisions, policy, or views of the World Health Organization.

Dr. Gupta is a postdoctoral fellow at the ISGlobal, Barcelona Centre for International Health Research, Hospital Clinic, Universitat de Barcelona, Barcelona, Spain. His research focus is use of molecular tools for the active surveillance of emerging drug resistance, gene deletions, and afebrile malaria in malaria-endemic regions.

References


Address for correspondence: Alfredo Mayor, ISGlobal, Barcelona Ctr. Int. Health Res. (CRESIB), Hospital Clínic, Universitat de Barcelona, Carrer Rosselló 153 (CEK Bldg), E-08036 Barcelona, Spain; email: alfredo.mayor@isglobal.org

---

**Now on Exhibit**

**David J. Sencer CDC Museum**

**EBOLA: People + Public Health + Political Will** is an investigation of the historic 2014–16 Ebola Fever Virus epidemic in West Africa, the United States, and around the world. As the crisis unfolded in Guinea, Liberia, and Sierra Leone in 2014, it evolved into both a health and humanitarian crisis. When it became clear that Ebola could potentially spread exponentially, threatening global health security, there was a coordinated, massive response.

**Hours**
- Monday: 9 a.m.–5 p.m.
- Tuesday: 9 a.m.–5 p.m.
- Wednesday: 9 a.m.–5 p.m.
- Thursday: 9 a.m.–7 p.m.
- Friday: 9 a.m.–5 p.m.
- Closed weekends and federal holidays

**Location**
1600 Clifton Road NE
Atlanta, GA 30329
Phone 404-639-0830
Admission and parking free
Government-issued photo ID required for adults over the age of 18

**Free admission**

Technical Appendix

Sanger Sequencing

*pfmdr1* polymorphisms

*pfmdr1* gene was divided into two separate fragments (*pfmdr1_f1* and *pfmdr1_f2*). The *pfmdr_f1* and *pfmdr_f2* fragments were amplified separately in 25μl reactions including 5μl of template DNA, 0.5μM of each forward and reverse specific primer set for *pfmdr_f1* and *pfmdr_f2* fragments (Technical Appendix Table) and 1xHOT FirePol Master Mix (Solis BioDyne; Riia, Tartu, Estonia), reaction volume was raised by PCR-grade water. In a thermocycler, both the fragment amplification followed the same PCR conditions, the template DNA was denatured at 95°C for 15min, followed by 35 cycles of amplification (95°C for 1min, 60°C for 1min, and 72°C for 1min 30s) and a final extension at 72°C for 10min. PCR products were run on 2% agarose (Invitrogen, Carlsbad, CA, USA) gels in 1× TBE buffer (Invitrogen, Carlsbad, CA, USA) to determine the presence and size of the amplified DNA and PCR products were visualized using a UV trans-illuminator. The expected size of PCR products for *pfmdr1_f1* and *pfmdr1_f2* fragments was 610bp and 1295bp respectively. Whenever enough amplified products were not obtained, re-PCR were performed using the same primer sets and PCR conditions mentioned above for both *pfmdr1_f1* and *pfmdr1_f2* fragments, 5μl of PCR products were used as DNA templates for re-PCRs. To sequence the f1 and f2 fragments of *pfmdr1* gene, two new pairs of sequencing primers were used (Technical Appendix Table). The sequencing primer pair, specific for *pfmdr1_f1* fragment, covers 45 – 209 aa and *pfmdr1_f2* specific sequencing primer pair covered 984 – 1277 aa of PfMDR1 protein. The specificity of all primer sets was tested against human genomic DNA and no DNA template control.
For *pfhdps* gene amplification, a single PCR based assay was designed. In brief, amplification was performed in 25μl reaction including 5μl of template DNA, 0.5μM of each forward and reverse specific primer set for *pfhdps* (Technical Appendix Table) and 1x HOT FirePol Master Mix, reaction volume was raised by PCR-grade water. The template DNA was denatured at 95°C for 15min in a thermocycler, followed by 32 cycles of amplification (95°C for 1min, 54°C for 1min, and 72°C for 1min) and a final extension at 72°C for 10 min. The expected size of the PCR product was 875bp was visualized as mentioned above covering 357- 647 aa of PfDHPs protein. PCR products were sequenced using a forward primer of PCR and new reverse sequencing primer (Technical Appendix Table) covering 357 – 477 aa of PfDHPs protein. Positive and negative (water instead of template DNA) controls were added in every PCRs and plates. The specificity of all primer sets was tested against human genomic DNA and no DNA template control.

For bi-directional sequencing, ≈1200ng of PCR products (quantified using EPOCH Biotech system) were sent to Genewiz (Takeley, United Kingdom), following safety instructions for the accurate shipment of PCR amplicons. The variations in the test sequences of *K13, pfcrt, pfmdr1* and *pfhdps* were identified by sequence alignment against PF3D7_1343700, PF3D7_0709000, PF3D7_0523000 and PF3D7_0810800 reference sequence of 3D7 respectively, retrieved from PlasmoDB.

**pfhdps** - Restriction fragment length polymorphism

To detect the K540E polymorphism in *pfhdps*, the restriction fragment length polymorphism (RFLP) was performed. The PCR products of 875bp (described above) of *Pfdhps* gene were digested with FokI enzyme (New England Biolabs, Ipswich, MA, USA) as per manufacture instruction’s which generated 538bp, 315bp and 22bp fragments whenever mutant allele was present, and two fragments of 853bp and 22bp were seen for wild type allele.

**pfmdr1 and pfpm2 gene copy number - qPCR**

The quantitative PCR (qRT-PCR) was used to assess variations in the copy number (CN) of *pfpm2* and *pfmdr1* genes as described elsewhere (1) with minor changes. In brief, 96-well plates were prepared containing separate 20μl reaction mixtures for *pfpm2, pfmdr1* and *pfβ-tubulin* genes. *Pfβ-tubulin* gene was used as an endogenous control. Each reaction mixture had
2X Power SYBR® Green PCR Master Mix (Thermo Fisher Scientific, Warrington, WA, UK), 0.25 μM of each forward and reverse primers and 5μl of template DNA, reaction volume was makeup by PCR-grade water. Amplifications were performed with a holding for 3mins at 50°C, initial denaturation for 10mins at 95°C, followed by 40 cycles of 95°C for 15s and 58°C for 45s, extra dissociation stage was added to ensure the specificity of primer pairs. The 20μl reaction mixtures in a 96-well plate were amplified in a 7500 HT Real-Time System (Applied Biosystem, Foster City, USA). For each run, the **pfpm2** and **pfmdr1** copy numbers of each sample were measured in triplicate. The PCR efficiencies of the **pfpm2**, **pfmdr1** and **pfβ-tubulin** genes were measured using ten-fold dilutions of 3D7 DNA. The specificity of three primer pairs against human genomic DNA was also determined. Along with no template control, we also included one positive control with the known 3-4 copies of **pfpm2** gene provided by Dr. Didier Ménard (Pasteur Institute, Cambodia) and another positive control for **pfmdr1** gene, genomic DNA of DD2 parasite line with known 3-4 copies of **pfmdr1**. All samples with **Ct** >33 for **pfpm2**, **pfmdr1** and **pfβ-tubulin** were not considered for the CN analysis. The **pfmdr1** and **pfpm2** genes CNs were estimated as described previously (1). All samples with estimated CN values above 1.5 were confirmed two more times.

**Reference**

**Technical Appendix Table.** The sequence of the oligonucleotides used for PCR and sequencing, PCR annealing temperature (Tm), several cycles, the size of amplicons and covered amino acids

<table>
<thead>
<tr>
<th>Gene</th>
<th>Conventional PCR</th>
<th>Sequencing</th>
<th>Covered amino acids</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PCR primers</td>
<td>Annealing Temp (°C)</td>
<td>Cycles</td>
</tr>
<tr>
<td>K13</td>
<td>OuterF:cggaggtacccaaacttggga</td>
<td>58</td>
<td>30</td>
</tr>
<tr>
<td></td>
<td>OuterR:gggaactggttgtaaagc</td>
<td>60</td>
<td>40</td>
</tr>
<tr>
<td></td>
<td>NestedF:gccaagctgccatttgcatttg</td>
<td>50</td>
<td>35</td>
</tr>
<tr>
<td></td>
<td>NestedR:gccaagctgccatttgcatttg</td>
<td>50</td>
<td>35</td>
</tr>
<tr>
<td>pfcr</td>
<td>OuterF:ccggaggtacccaaacttggga</td>
<td>52</td>
<td>25</td>
</tr>
<tr>
<td></td>
<td>OuterR:ccggaggtacccaaacttggga</td>
<td>52</td>
<td>25</td>
</tr>
<tr>
<td></td>
<td>NestedF:ttggtaggtggaatagatcctt</td>
<td>50</td>
<td>35</td>
</tr>
<tr>
<td></td>
<td>NestedR:ttggtaggtggaatagatcctt</td>
<td>50</td>
<td>35</td>
</tr>
<tr>
<td>pfmdr1_F1</td>
<td>F:ccggaggtacccaaacttggga</td>
<td>60</td>
<td>35</td>
</tr>
<tr>
<td></td>
<td>R:ccggaggtacccaaacttggga</td>
<td>60</td>
<td>35</td>
</tr>
<tr>
<td>pfmdr1_F2</td>
<td>F:ccggaggtacccaaacttggga</td>
<td>60</td>
<td>35</td>
</tr>
<tr>
<td></td>
<td>R:ccggaggtacccaaacttggga</td>
<td>60</td>
<td>35</td>
</tr>
<tr>
<td>pldhs</td>
<td>F:ccggaggtacccaaacttggga</td>
<td>54</td>
<td>32</td>
</tr>
<tr>
<td></td>
<td>R:ccggaggtacccaaacttggga</td>
<td>54</td>
<td>32</td>
</tr>
</tbody>
</table>
Technical Appendix Figure. Assessment of the detection limit by Sanger sequencing in artificially mixed DNA samples, containing various proportions of *pfcr* (K76T) and *pfmdr1* (Y184F and S1034C) alleles. Panel A: K76T polymorphism of *pfcr* gene; Panel B and C is for Y184F and S1034C polymorphisms of *pfmdr1* gene, respectively.

Additional Text References


