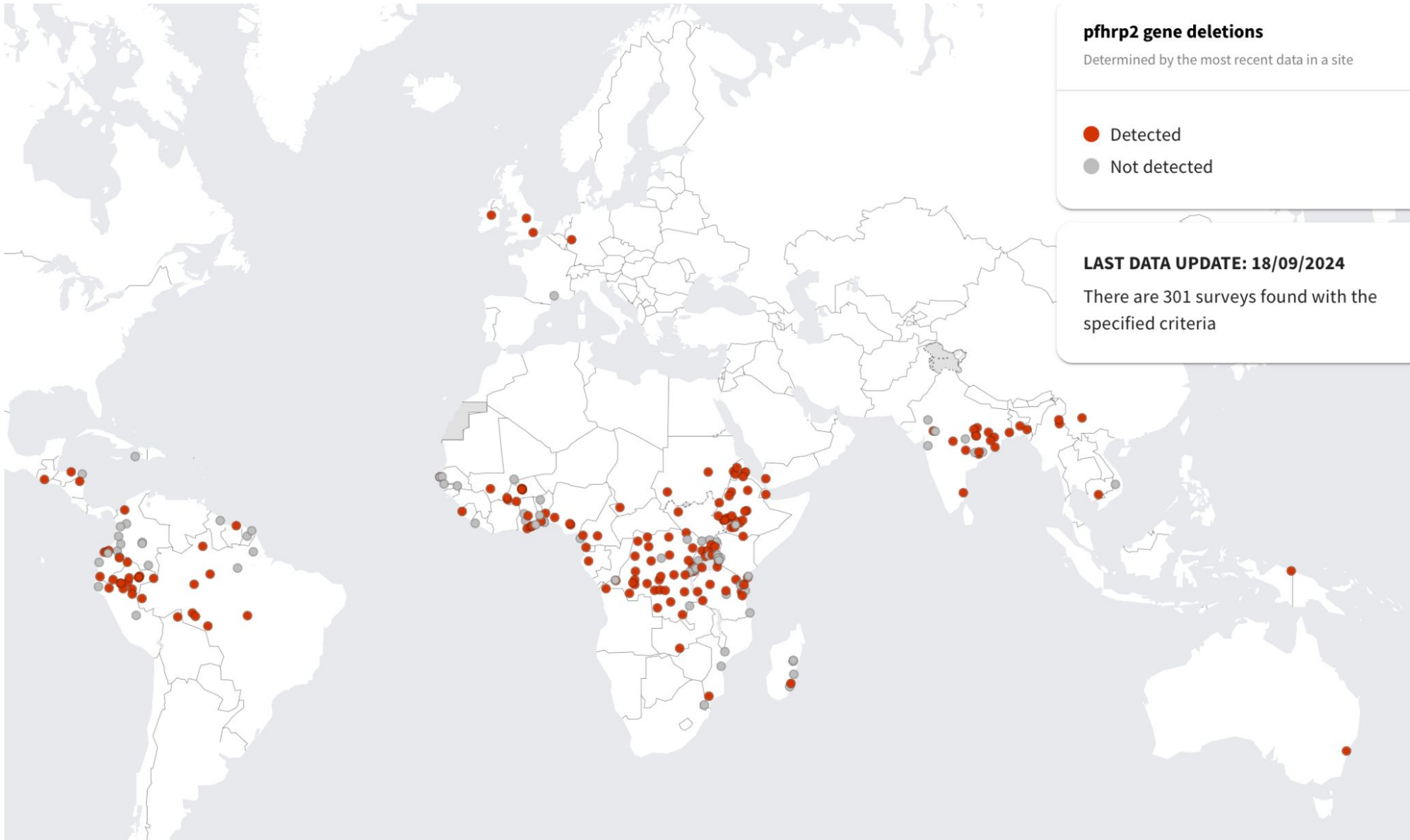


Malaria Molecular Surveillance Study Design Workshop

Module 5: The DRpower tool

Global landscape of *pfhrp2* deletions



The WHO master protocol



Global Malaria Programme



Response plan to *pfhrp2* gene deletions



Map the **distribution** and
frequency of *pfhrp2/3*
deletion mutants

Build an **international
network of laboratories** to
perform the complex
molecular confirmation
required for mapping and
identify new and/or efficient
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The WHO master protocol



Global Malaria Programme



Response plan to *pfhrp2* gene deletions



Map the **distribution** and **frequency** of *pfhrp2/3* deletion mutants

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Master protocol for surveillance of *pfhrp2/3* deletions and biobanking to support future research



Standardized protocols for *P. falciparum* endemic countries to use to **determine prevalence of *pfhrp2/3* gene deletions** causing false-negative RDTs

Surveillance and biobanking protocols available

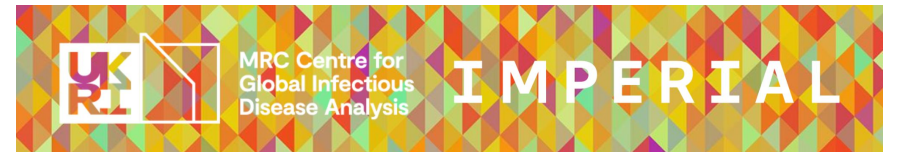
Each country will tailor protocol to their situation

- Multi-cluster survey in a region with the following primary end-points:
 1. Prevalence of **suspected false-negative HRP2 RDT** results among symptomatic patients with *P. falciparum* malaria
 2. Prevalence of **pfhrp2/3 gene deletions** among symptomatic falciparum patients with a false-negative HRP2 RDT result
 3. Prevalence of **pfhrp2/3 gene deletions causing false-negative HRP2 RDTs** among all symptomatic *P. falciparum* confirmed cases

- WHO recommends **a nationwide change to non-HRP2-based RDTs** when the prevalence of clinically-significant *pfhrp2/3* deletions (ie deletions causing false-negative RDT results) reaches 5% **in any region**
- The rationale for this threshold was that this was roughly the prevalence at which the *pfhrp2*-deleted infections detected by non-HRP2-based RDTs **would be outweighed by the reduced sensitivity of these RDTs**
- Literature review of published comparison data 2011–2022 showed the **5% threshold is still valid**

This is a **major policy change**, so it is crucial we get our study design right!

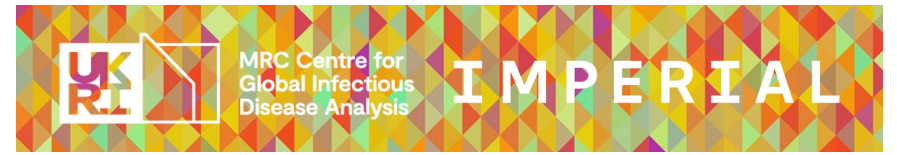
When to suspect HRP2 deletions?



In a patient

negative results on an HRP2 test line of at least two quality-assured malaria RDTs

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positive on the pan- or pf-pLDH test line, when a combination test is used

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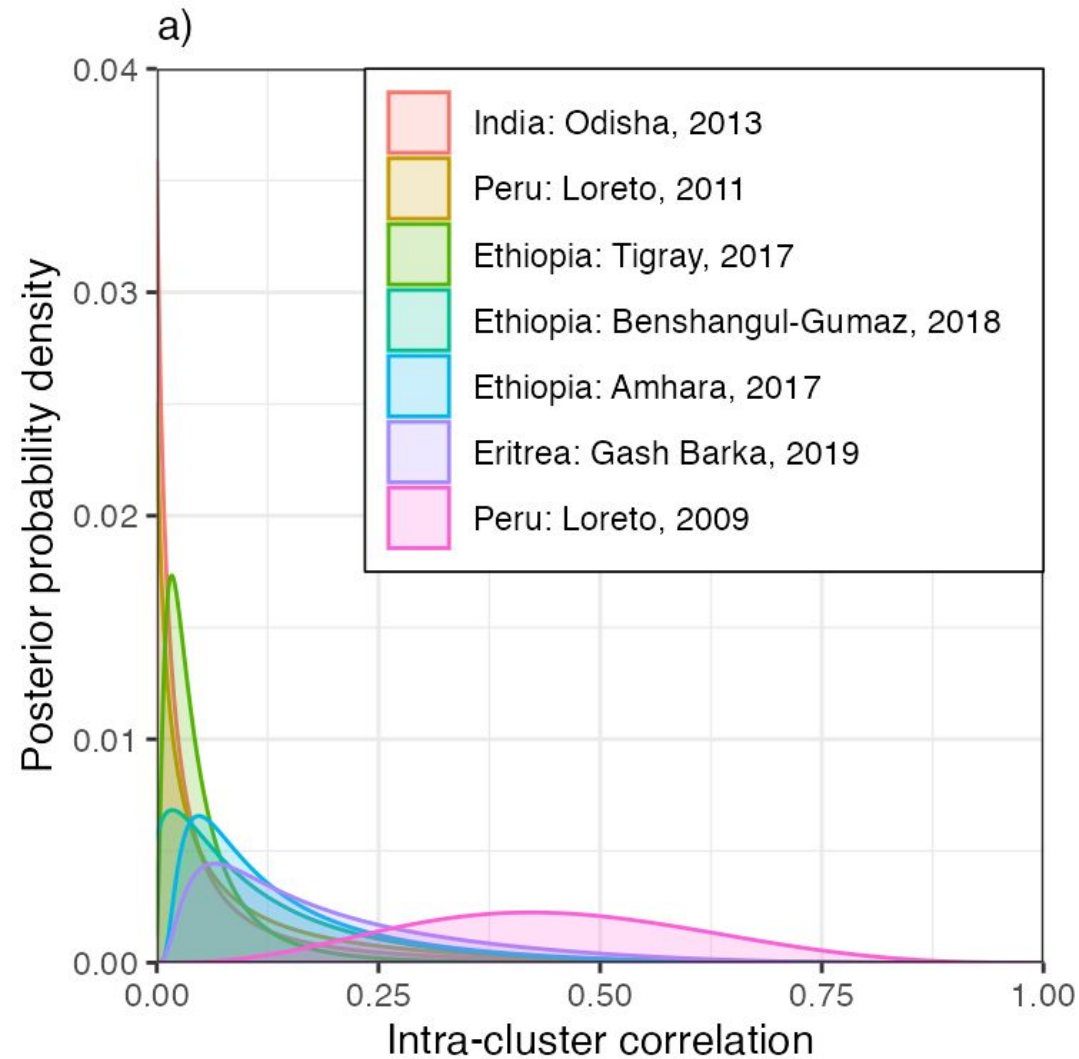
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Also consider *travel history* to areas with high prevalence of HRP2 deletions e.g. Peru, Brazil, Eritrea, Djibouti, Ethiopia

STATISTICAL ANALYSIS FRAMEWORK

- **Bayesian** framework comparing between two alternative hypotheses
- Estimate **intra-cluster correlation** automatically (incorporate *prior* information)

Historical analysis of ICC



STATISTICAL ANALYSIS FRAMEWORK

1

Estimate
prevalence and
95% credible
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STATISTICAL ANALYSIS FRAMEWORK

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Estimate
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Estimate the
probability that
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STATISTICAL ANALYSIS FRAMEWORK

1

Estimate prevalence and 95% credible interval (CrI)

2

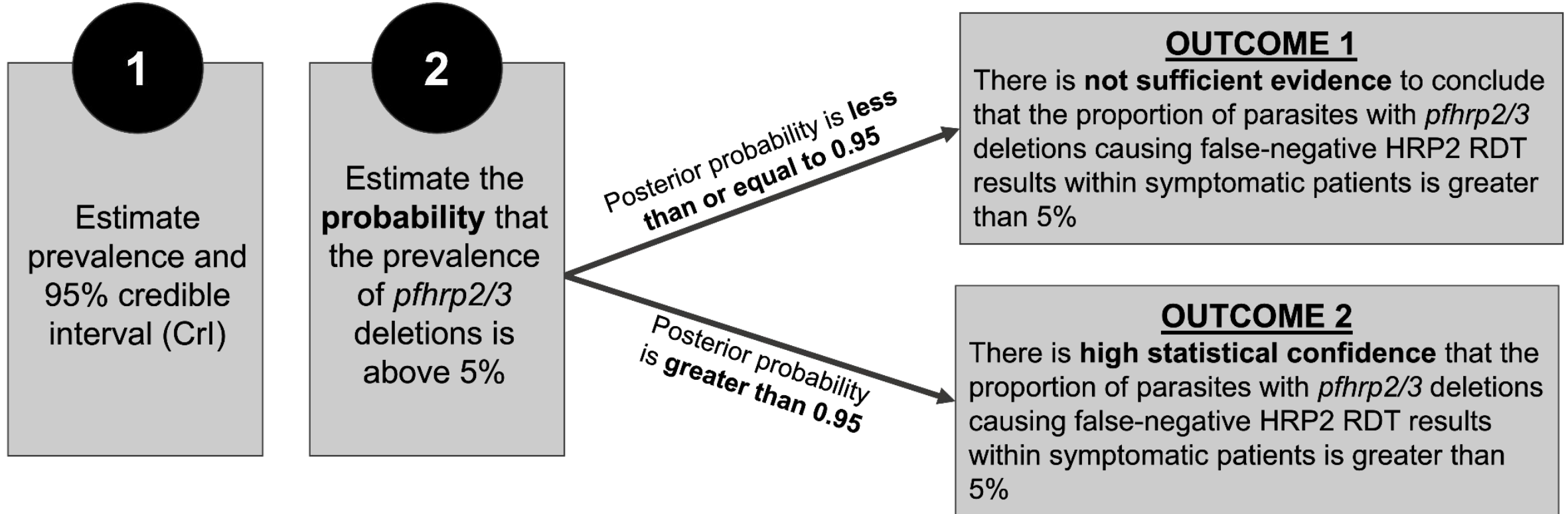
Estimate the **probability** that the prevalence of *pfhrp2/3* deletions is above 5%

Posterior probability is **less than or equal to 0.95**

OUTCOME 1

There is **not sufficient evidence** to conclude that the proportion of parasites with *pfhrp2/3* deletions causing false-negative HRP2 RDT results within symptomatic patients is greater than 5%

STATISTICAL ANALYSIS FRAMEWORK



The DRpower *pfhrp2/3* planner tool



- Easy-to-use web interface, uses the DRpower R package in the back-end
- End-users can: design their study and/or analyse study results

The screenshot shows the web interface of the 'pfhrp2/3 Planner'. At the top, there is a dark blue header with the text 'pfhrp2/3 Planner' and a hamburger menu icon. Below the header is a light blue main content area. On the left side of the main content area is a dark blue sidebar with white text and icons for 'Home', 'Explore', 'Design', 'Analysis', and 'FAQ'. The main content area features the UKRI logo, the MRC Centre for Global Infectious Disease Analysis logo, and the Imperial College London logo. Below the logos is the heading 'Welcome to the *pfhrp2/3* Planner'. Underneath this is a section titled 'How to use this tool' which contains a paragraph explaining the tool's purpose and a numbered list of two ways to use it: 1. In the 'design phase' (before data have been collected) to help guide the appropriate number of clusters and a sample size per cluster. 2. In the 'analysis phase' (once data are available) to estimate prevalence of deletions and determine if they are above a set threshold. Below the list is a paragraph stating that the ideal plan would be to perform both steps, and that it is valid to analyse data even if sample sizes were chosen using a different method (see FAQs). At the bottom, a paragraph invites users to look at the 'DRpower R package' for more background information and advanced analyses.

Explore sample sizes

- How many samples? How many health facilities (or clusters)?
 - DRpower includes pre-computed sample sizes per health facility to achieve 80% power

Number of health facilities	1%	2%	3%	4%	5%	6%	7%	8%	9	10%	11%	12%	13%	14%	15%	16%	17%	18%	19%	20%
2													344	140	62	38	33	22	18	14
3												172	69	41	26	20	16	14	12	9
4											128	60	33	22	16	13	10	9	8	7
5										496	75	36	22	16	10	7	7	5	5	5
6										113	47	25	16	12	9	6	5	5	5	5
7										68	30	18	13	10	7	6	5	5	5	5
8									416	51	23	15	10	9	7	5	5	5	5	5
9									138	37	20	13	10	8	6	5	5	5	5	5
10									85	30	15	12	8	6	5	5	5	5	5	5

Blank = >2000

Design your study

Browser: shiny.dide.ic.ac.uk/DRpower-app/

pfhrp2/3 Planner

Home | Explore | Design | Analysis | FAQ

Final health facility sizes [Generate report](#)

Refine your health facility sizes

Sample size tables assume you will collect the same number of samples in every health facility, but this may not be possible in practice. Here, you can enter your final target sample size in each health facility and then estimate power directly. Generally, surveys will focus on health facilities but the 'cluster' could be different in specific situations.

When choosing sample sizes, remember this is the number of *confirmed malaria positive* individuals. Check with local teams to see how many cases can realistically be recruited within the study period based on local incidence trends. You can also use this table to account for drop-out, which can occur for many reasons from participants withdrawing consent to failure of lab samples. Local staff and technicians may be able to advise on sensible values for assumed drop-out.

1. Enter sample sizes specific to your study

Choose one:

☐ Enter values manually

☒ Upload a .csv file

Please use the [template provided](#) and ensure your file matches exactly.

Upload your sample size table (.csv):

Browse... pfhrp2_design.csv

Upload complete

File uploaded: pfhrp2_design.csv

Health facility	Target sample size	% drop-out
Dese	100	10
Motta	30	10

pfhrp2/3 Planner: Design report

Downloaded on: 2024-07-02 | DRpower interactive app v1.0.1

Background

This report presents the results generated by using the [pfhrp2/3 planner web application](#). This application was used to help guide the appropriate number of health facilities (or sites) and a target sample size per health facility for the design of a *pfhrp2/3* deletion prevalence study. For more information on the statistical method used, see the [DRpower R package website](#).

Final sample sizes

The adjusted sample sizes based on the expected drop-out proportion in each of the 3 health facilities are shown below and should be considered for study design.

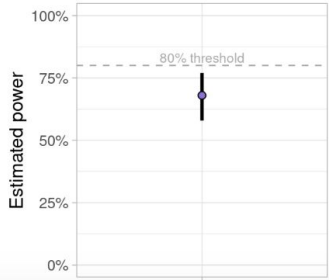
Health facility	Target sample size	Dropout (%)	Adjusted sample size
1	500	10	556
2	500	10	556
3	500	10	556
4	100	3	104
Total samples	1600	–	1772

Estimated power

To estimate the power of the study assuming the target sample sizes as per above, we used the [DRpower R package](#) with the following parameters:

- Prevalence of 10%
- Intra-cluster correlation of 0.05
- 100 simulations

The estimated power is 68% (95%CI: 58 - 77%).



Prevalence estimates

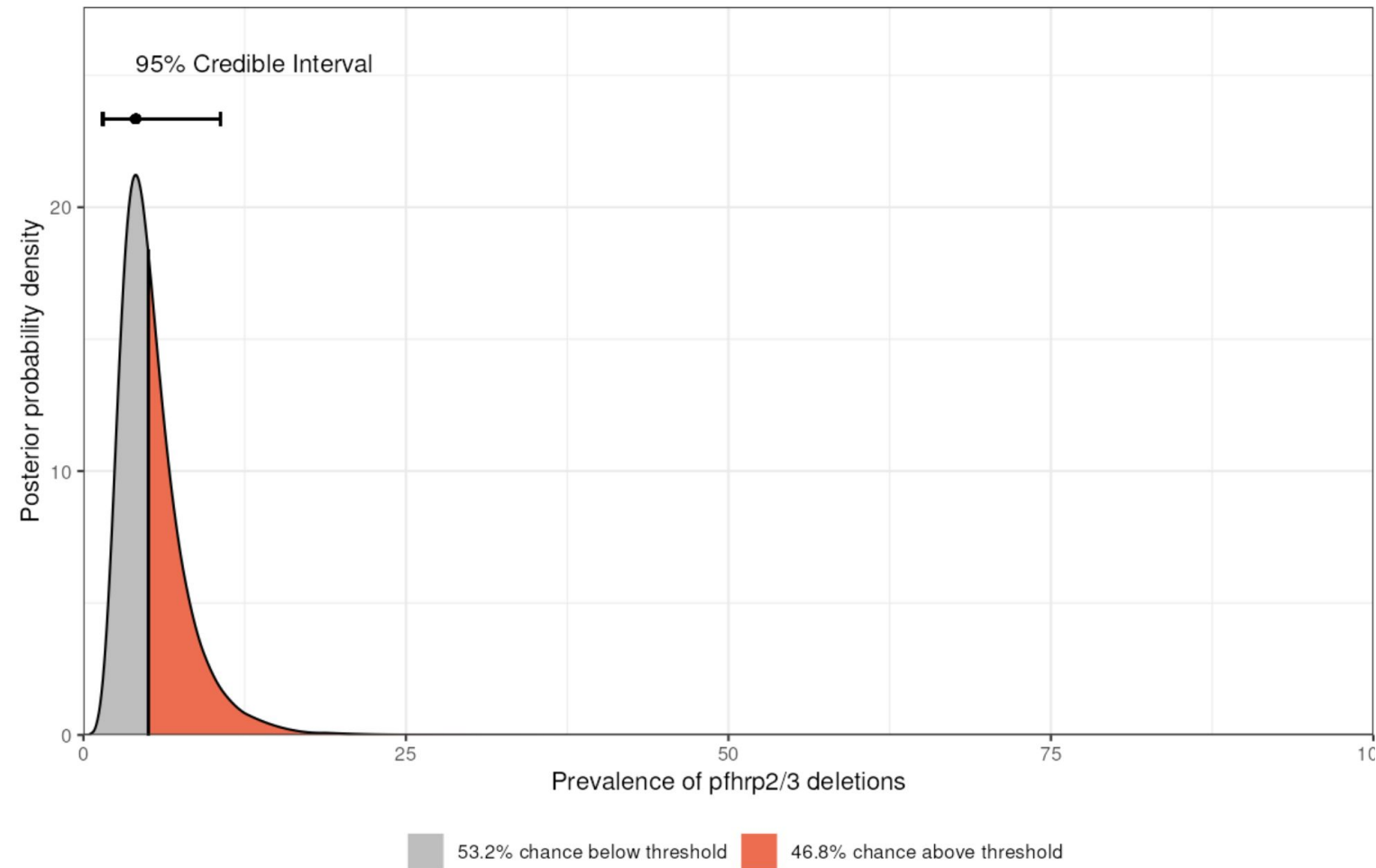
The table and the plot below show the maximum a posteriori (MAP) estimate of the prevalence, along with a 95% credible interval (CrI). The MAP estimate can be used as a central estimate of the prevalence, but it should always be reported alongside the CrI to give a measure of uncertainty.

Prevalence estimate (%)	Lower CrI (%)	Upper CrI (%)	Probability above threshold (%)
4.05	1.50	10.61	46.75

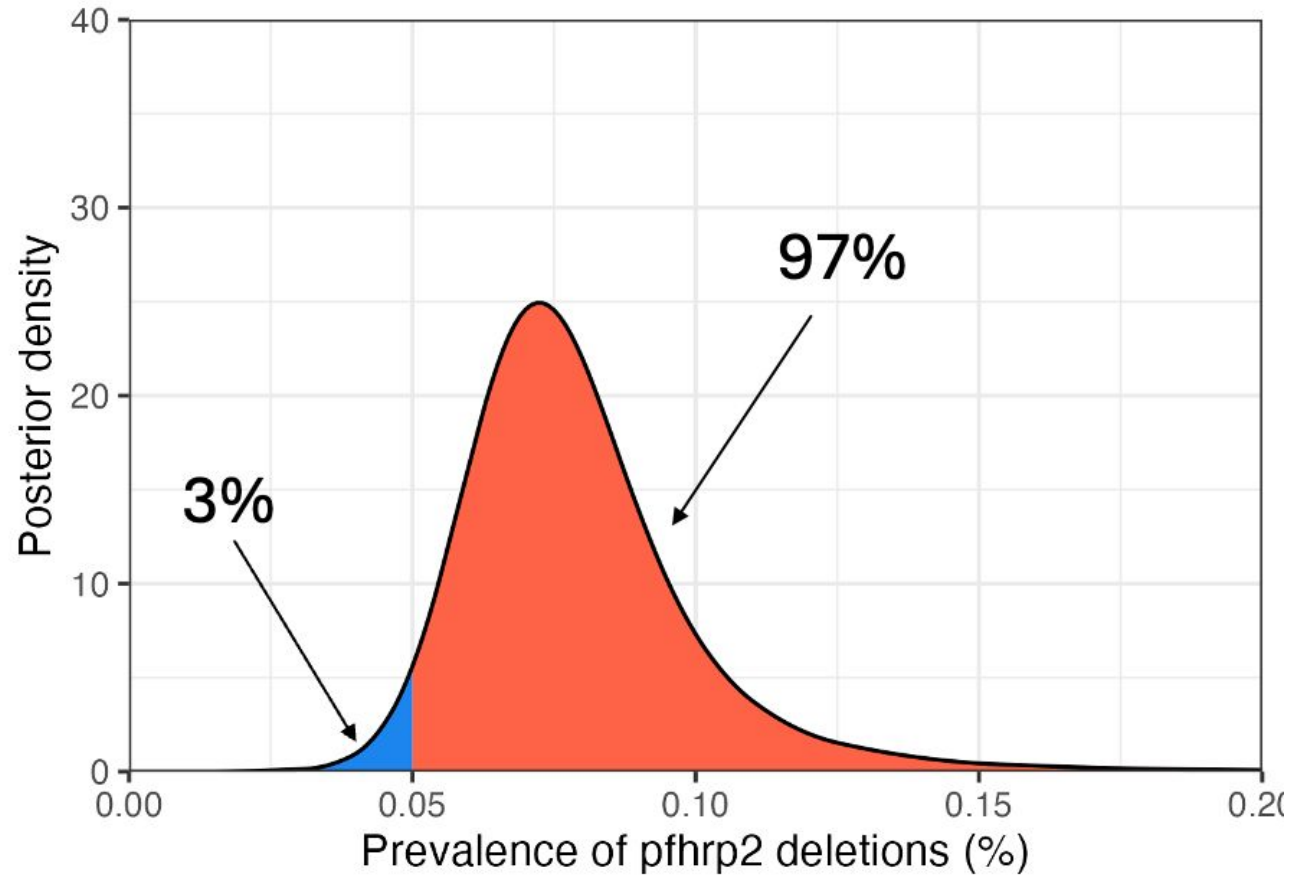
RESULT: We estimate that the prevalence of *pfhrp2/3* deletions is 4.05 % (95% CrI: 1.5 - 10.61 %). The probability that the prevalence is above the 5% threshold is estimated at 46.75 %. *We require greater than 95% probability to confidently conclude that prevalence is above the 5% threshold.*

CONCLUSION: The prevalence of *pfhrp2/3* deletions causing false-negative HRP2 RDTs is **below** the 5% threshold.

Analyze your results



Analyze your results



Downloadable reports

pfhrp2/3 Planner: Analysis report

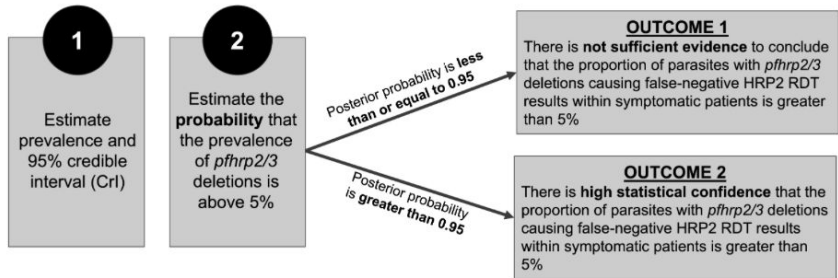
Downloaded on: 2024-07-02 | DRpower interactive app v1.0.1

Background

This report presents the results generated by the *pfhrp2/3* planner web application. This application was used to analyze data from a *pfhrp2/3* deletion prevalence study to estimate prevalence and determine if it is above the WHO recommended prevalence threshold of 5%. This software uses a Bayesian hierarchical model implemented in the DRpower R package to estimate the prevalence of *pfhrp2/3* deletions causing false-negative HRP2 RDT results while accounting for correlations within clusters or health facilities/sites. For more information on the statistical method used, see the DRpower R package website.

The statistical analysis framework involves calculation of a point estimate of the prevalence of deletions along with a 95% credible interval (CrI) to summarise results, with the probability that the prevalence of *pfhrp2/3* deletions is above 5% used to categorize study domains into outcome 1 or 2, as follows:

STATISTICAL ANALYSIS FRAMEWORK



Study details

A total of 8 health facilities (or sites) were surveyed in this *pfhrp2/3* deletion prevalence study. The observed counts of *pfhrp2/3* deletions causing false-negative HRP2 RDTs and the sample sizes in each health facility are shown below:

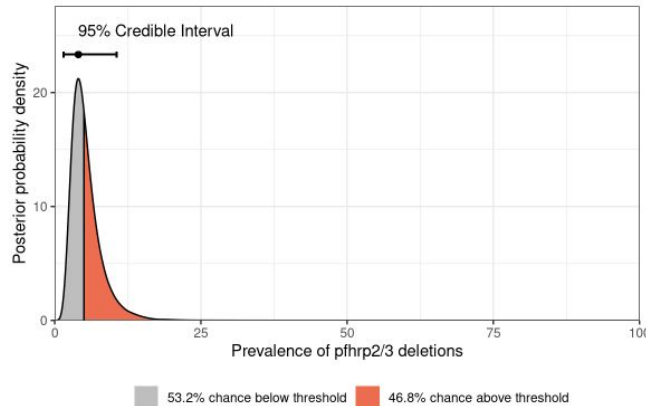
Health facility	Number of deletions	Sample size
Northwestern Health Facility	0	60
Northern Health Facility	0	60
Western Health Facility	1	60
Eastern Health Facility	2	60
Central Health Facility	5	60
Southern Health Facility	5	51
Southeastern Health Facility	3	51
Community Health Facility	0	20

Estimated prevalence

To estimate the prevalence of *pfhrp2/3* deletions causing false-negative HRP2 RDTs, we used to test whether the observed prevalence in this study was above or below the

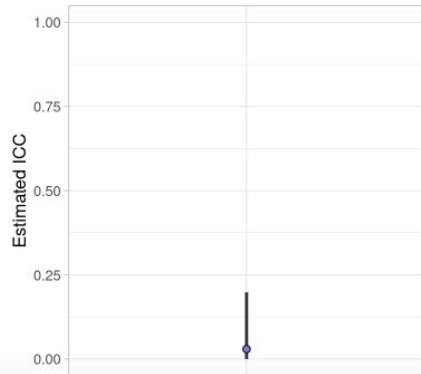
RESULT: We estimate that the prevalence of *pfhrp2/3* deletions causing false-negative HRP2 RDTs is 4.05% (95% CrI: 1.5-10.61%). The probability that the prevalence is above the 5% threshold is estimated at 46.75%. We require greater than 95% probability to confidently conclude that prevalence is above the 5% threshold.

CONCLUSION: The prevalence of *pfhrp2/3* deletions causing false-negative HRP2 RDTs within symptomatic *P. falciparum* patients is below the 5% WHO threshold.



Estimated intra-cluster correlation (ICC)

We estimate that the intra-cluster correlation is 0.03 (95% CrI: 0-0.2).



- Global priority to monitor *pfhrp2* gene deletion prevalence
- The updated WHO master protocol will recommend a new method based on a Bayesian framework
- This framework is more powerful, but more mathematically complex
- We developed the DRpower *pfhrp2/3* planner tool where users can design multi-cluster *pfhrp2/3* surveys, and also analyze results once collected
- The DRpower R package also has functionality for more than just *pfhrp2/3* deletion surveys (eg detection of rare variants, sample size based on MOE)

Learning outcomes

- Use the **DRpower *pfhrp2/3* planner** tool
- How to **design** a multi-cluster *pfhrp2/3* deletion study.
- How to **analyse and interpret the results** of a *pfhrp2/3* deletion study.
- How to **account for intra-cluster correlation** in other study designs, such as prevalence surveys and presence/absence studies.

<https://tinyurl.com/bd4um5mj>