Malaria remains widespread across Southeast Asia. In Indonesia, 2 million cases of malaria are reported each year, with *Plasmodium falciparum* and *Plasmodium vivax* the 2 major reported causes [1]. Among other species contributing to human infections, *Plasmodium malariae* malaria may require hospitalization in the eastern province of Papua [2] but is not frequently encountered in western Indonesia. *Plasmodium knowlesi*, a parasite of long-tailed and pig-tailed macaques, is also known to infect humans. The morphological features in the blood stage are similar to those seen in *P. falciparum* and *P. malariae*, which in routine practice has led to frequent misdiagnosis [3–5]. High *P. knowlesi* parasitemia occurs in some individuals and has been reported to cause fatal disease [6]. Despite this, a proportion of *P. knowlesi* infections are asymptomatic and submicroscopic across all age groups [7]. A small number of human cases of *P. knowlesi* malaria have been documented in the province of Kalimantan, Indonesian Borneo [8] and in Aceh province [5], but this species has not yet emerged as a major cause of human malaria and is not considered in Indonesian government guidelines.

The Ministry of Health of Indonesia has implemented malaria control, aiming for elimination by 2030. Malaria surveillance relies on passive case detection by microscopic examination and rapid diagnostic tests (RDTs) at primary health care centers [9]. These tests are sufficient to detect clinical malaria infection caused by the 2 major species in Indonesia, *P. falciparum* and *P. vivax* [10]. However, identification of less common species, particularly at low-density parasitemia, is more difficult, which can lead to underdiagnosis [11]. Modeling of data from low-endemicity areas predicts that submicroscopic parasites may contribute 70%–80% of all malaria infections [12], and in vivo studies demonstrate that these contribute to ongoing malaria transmission [13]. Hence, the use of routine microscopy and RDTs in malaria surveillance fails to detect a substantial proportion of the human reservoir of infection and so may compromise malaria elimination strategies. One solution is to deploy molecular assays for parasite detection, because these can provide excellent sensitivity and specificity [14–17].

In preparation for a study of antimalarial drug efficacy in vivo, we performed intensive malaria screening in 3 regencies of the Province of North Sumatera, western Indonesia. In