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COUNTRY: Nepal PROJECT NO.: 367-11-510-014
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SUBMISSION DATE: ORIGINAL: Yes

PROJECT TITLE: Malaria Eradication

U.S. OBLIGATION SPAN: FY 1954 through FY 1973

PHYSICAL IMPLEMENTATION SPAN: FY 1954 through FY 1973

GROSS LIFE-OF-PROJECT FINANCIAL REQUIREMENTS:

U.S. dollars	: $ 8,696,000
U.S.-owned local currency	: $ 7,216,000 (equivalent)
Cooperating country cash contribution	: $ 5,634,000 (equivalent)
Other donor (WHO)	: $ 2,516,000
Totals	$24,062,000

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DRAFTED BY	OFFICE	PHONE NO.	DATE	APPROVED BY:
SFChen, RD-HE	HG		12/6/67	John S. Bens Director

AID AND OTHER CLEARANCES
AIStaffon, RD-HE
REFort, RD
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I. Introduction

The Malaria Eradication Program in Nepal is a continuing project and forms a part of the world wide health effort of AID. Presently AID, in connection with the US Public Health Service, is supporting Malaria Eradication Programs in 17 countries in Asia, Africa and Latin America. Since June 1965 the technical direction of the US portion of the program has been the responsibility of the National Communicable Disease Center and the WHO Malaria Eradication Program Organization. The purpose of this PAR is to obtain AID/W agreement to the current technical estimate of time required to successfully complete the project.

Malaria has long been the number one health problem in Nepal and its prevalence has stagnated some of the potentially most productive areas of the country. Other factors attributable to the disease are reduced work productivity in general and a high death rate among productive workers. Malaria also indirectly results in death from other diseases among people already debilitated by the disease. While these factors are difficult to measure in precise terms of dollar and cents they do have a seriously adverse impact on the development effort.

Basically malaria is a rural disease. It strikes in where income is lowest and in vital areas of Nepal's food production. In areas where malaria has attained epidemic proportions crops are often not harvested due to lack of healthy laborers. Within USAID/Nepal the Malaria Eradication Program is a part of the Rural Development Division and as such is considered to be a vital and integral element of our rural development effort.

While attempts are made to follow a definite time table it is often necessary to make revisions in order to fit particular conditions within the country. In August of 1965 the estimated completion date of the project was extended to 1973 and the CAP prepared at that time so indicated. The lack of trained GON personnel was one of the main factors necessitating an extension of the estimated completion date. In any program dealing with as many variables as does malaria eradication it is not always possible to predict several years in advance an exact course of action. In spite of its numerous problems the program has resulted in a striking reduction of malaria and at this time we anticipate that USAID support to the project can be terminated in 1973.

A possible alternative to a malaria eradication program is a program of malaria control in which malaria is not eliminated from the country but only reduced to a low level. While a malaria eradication program is more expensive initially it has a definite time table and after eradication there is less cost. In the case of malaria control relatively higher control costs go on indefinitely. Under a control program there is always the possibility of further epidemics. It is technically feasible to eradicate malaria. As has been shown in the cases of other diseases such as small-pox, total eradication is preferable to control.

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There are few aid programs within Nepal which have the direct impact on large numbers of people as has the Malaria Eradication Program. House spraying and surveillance activities are often the only programs of GON which reach the humblest people. It is generally agreed that the administrative organization of the Nepal Malaria Eradication Program is one of the best in Nepal. Through in-country training and training outside of the country a cadre of trained workers is now being built up which can be later utilized in other health or similar programs. The overall leadership of GON officials has been good. A large percentage of GON's total health budget goes to support the malaria eradication program.

The Malaria Eradication Program is a joint effort of GON, USAID and WHO. WHO provides technicians and transport for their technicians. USAID provides technical advisors, dollar-funded commodities, participant training and local currency.

Overall policy is recommended and implemented by the Nepal Malaria Eradication Organization (NMEO) Program Committee which consists of GON's Chief of NMEO, the USAID/PHS Chief Malaria Advisor and the senior malariologist of WHO.

II. History

The NMEO began its malaria eradication activity with joint AID and WHO sponsorship in late 1958. In 1955-58, a WHO pilot project demonstrated the feasibility of eradicating malaria in the Rapti Valley and demarcated the malarious areas as up to 4000 foot elevation. A series of malariometric surveys made in 1955-58, revealed a wide hyperendemic belt of malaria in Nepal including the forested area of the Terai and its fringe and most of the inner Terai Valleys. Hypo-and mesoendemic areas extended along the river valleys into hill areas and southward to the Indian border.

III. Targets

The goal is to terminate the transmission of malaria in Nepal by 1973 through systematic house spraying with insecticide, monthly or fortnightly surveillance for fever cases, and drug treatment of residual positive cases. This will eventually lead to eradication of the disease.

IV. Strategy

The overall strategy of the malaria eradication program follows closely the principles of the World Health Organization which were originally stated in 1958 and have been revised periodically by Expert Committees since then. Briefly the phasing of the Malaria Eradication Programs in all countries is as follows:

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(1) Preparatory - includes malariometric surveys, geographical reconnaissance, training of national staff and the ordering of equipment and supplies. This phase has been completed with the exception of some western hill areas.

(2) Attack - insecticide house spraying to reduce disease transmission and inter house visits to detect and treat remaining cases. This phase is in progress in all malarious areas except the mountains in the West Zone. This phase is expected to end in 1971.

(3) Consolidation - the object of this phase is to intensify the surveillance work through house visits in order to eliminate the last residual positive cases by drug treatment among the population. House spraying is suspended during this phase except possibly some focal spraying. This phase is expected to last through 1973.

(4) Maintenance - the General Health Service of the Government of Nepal will take over the responsibility of maintaining vigilance against reintroduction of malaria into the country.

V. Present Status

Spraying operations have been successfully carried out throughout the country with the exception of some western hill areas where, due to relative inaccessibility, case detection procedures were established in order to effect treatment of positive cases. Efforts have resulted in the protection of 9.5 million people by spraying and surveillance. Acreage of highly productive agricultural land is being added to the economy (e.g. The Rapti Valley). As a result of these improved health conditions in the Terai area, a noticeable migration of people from the unproductive hills is taking place.

Malaria Eradication in Nepal is well within the attack and consolidation phases. Withdrawal of considerable spraying from areas with low malaria incidence and graduation to the consolidation phase is planned in late 1968. Gradual withdrawal of spraying in most other attack areas is planned during the period 1969 to 1971.

The malaria eradication Program in Nepal is expected to achieve its goals by 1973 provided that GON succeeds in its efforts to build an effective rural health service organization to take over following the consolidation phase and to follow up positive malaria cases.

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Proposed population phasing estimates are as follows:

	1968	1969	1970	1971	1972	1973
Total Population (000)	10,600	10,500	10,900	11,100	11,300	11,500
Population, Malarious Areas	5,500	5,650	5,800	5,950	6,100	6,250
Attack Phase	2,500	1,350	700	60	-	-
Consolidation Phase	3,000	4,300	5,100	2,890	1,800	-
Maintenance Phase	-	-	-	3,000	4,300	6,250

M. E. Target Date for Consolidation and Maintenance Phase by Zones

			1968	1969	1970	1971	1972	1973
RMEO	Central Zone A	Consolidation	70%	80%	100%	-	-	-
		Maintenance	-	-	-	70%	80%	100%
	Central Zone B	Consolidation	60%	75%	100%	-	-	-
		Maintenance	-	-	-	60%	75%	100%
	East Zone	Consolidation	20%	60%	100%	-	-	-
		Maintenance	-	-	-	20%	60%	100%
	West Zone	Consolidation	-	-	40%	100%	-	-
		Maintenance	-	-	-	-	-	100%

VI. Financial Support

(a)	US Technicians, Participants & Commodities (in thousand $)	888	732	582	450	350	250
(b)	Local Currency Support in $ equivalent	1,042	900	650	500	350	250
(c)	Number US Technicians	7	7	5	3	2	2

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